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HANSEN: OK. All right. Good afternoon 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 parts of Stanton Counties and I serve as Chair of the Health and Human Services Committee. I'd like to invite the members of the committee to introduce themselves starting on my right with Senator Ballard.

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

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

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

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

HANSEN: Also assisting the committee is our legal counsel, legal counsel Benson Wallace, our committee clerk Christina Campbell, and our pages for today, Ethan and Delanie. A few notes about our policy procedures. Please turn off or silence your cell phones. We'll be hearing four bills and we'll be hearing them in the order listed on the agenda outside of the room. On each of the tables near the doors of the hearing room, you will find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Christina when you come up to testify. 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 will be using a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will turn green. When the light turns yellow, that means you

have one minute left. When the light turns red, it is time to end your testimony and we will ask that you wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last name. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill, then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. On a side, on a side note, the reading of testimony that is not your own is not allowed unless previously approved. And we do have a strict no-prop policy in our committee. So with that, we will open today's hearing with LB488 and welcome Senator Hunt to open. Pardon all the hammering in the background, too.

HUNT: That's OK. We had it yesterday, too, in this room. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. I'm Megan Hunt, M-e-g-a-n H-u-n-t, and I'm here to present LB488, the Sexual Assault Emergency Care Act. This bill would require hospital emergency rooms to provide medically accurate information about emergency contraception to patients who are victims of sexual assault and dispense a complete course of the medication if the patient requests it. Emergency contraception refers to a concentrated dose of hormone found in many regular birth control pills that can prevent pregnancy when taken shortly after unprotected intercourse. It's a backup birth control method used to prevent unintended pregnancy after unprotected sex or sexual assault. Emergency contraception works by delaying or inhibiting ovulation and it will not work if the woman is already pregnant. The medication is effective if taken within 120 hours after unprotected intercourse or assault. Some people confuse emergency contraception, which you may hear called "Plan B", with medication abortion which is sometimes called the "abortion pill." These are two completely different things. Medication-induced abortion is used to terminate an existing pregnancy, whereas emergency contraception prevents fertilization from ever occurring, meaning emergency contraception is not in any way abortifacient because fertilization has not yet occurred and there's no existing pregnancy. So it's a completely different mechanism and purpose for these drugs and emergency contraception is not in any way related to abortion and it cannot cause an abortion. When a rape victim has endured what is likely one of the most

traumatic events of their life, taking that step to go to an emergency room can be extremely emotionally fraught in a time that they're already in shock. A survivor will have to disclose what happened to them probably several times, reliving that trauma. And sometimes the rapist is somebody they know, as is most often the case. Maybe they have complicated feelings about coming forward or naming their attacker. Perhaps they're afraid of letting their family know what has happened to them. So when a sexual assault survivor has the courage to go to an emergency room, the last thing they should have to worry about is, is this hospital going to provide me with medically accurate information that I need? And yet a sizable share of Nebraska hospitals do not offer information about or dispense emergency contraception to sexual assault survivors. Organizations that advocate for survivors have heard many stories. And I have too personally, I've heard lots of stories of Nebraska hospitals who have either not provided this information or have not provided the treatment. But it's difficult to get hard data on this because hospitals don't publish any policy on the record. I've heard from several sexual assault survivors specifically that CHI Health is not providing this care, and that's a major healthcare provider in Nebraska. Because the law is currently silent on this matter, any hospital is free to choose not to provide this information or medication. And that's why we need this bill to be enacted into law. I can't, you know-- yeah, emergency contraception is safe. It's established and widely accepted in the medical profession. Twenty-one states require emergency rooms to provide emergency contraception related services to sexual assault victims. Nothing in law, obviously, can force a person to take the medication but it should be part of the information that survivors receive when they go to the hospital. The American Medical Association and the American College of Obstetricians have both issued recommendations that physicians provide sexual assault survivors with emergency contraception upon request. LB488 would provide uniformity and a guarantee to Nebraskans who might one day visit an emergency room that all hospitals follow the standard of care when it comes to emergency contraception. The last time a traumatized rape survivor should have to be responsible for is tracking down a hospital policy or a person on the phone at a hospital who can tell them whether or not the hospital will provide them emergency contraception. And imagine that they do know about this. Imagine that someone survives an attack and they, they do know about the existence of this law and they're in the ambulance after

surviving a horrible attack and they're just saying please don't take me to CHI. That's what I would be saying. I'd say I can't be in up there for a crime like this. I think we should also consider that as Nebraska is poised to pass an abortion ban, we should be doing everything possible to prevent the need for abortion especially for rape victims and people who experience assault. Especially because it's unclear under the abortion ban that's before the Legislature in practice how rape survivors will be able to access abortion in Nebraska. Thank you. I will turn it over to testifiers and I might be able to share some more information at close, but I'm happy to answer any questions.

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

M. CAVANAUGH: Thank you. Thank you, Senator Hunt, for bringing this bill again. My question is actually more for CHI but I don't know if they're testifying. Are you aware if they're testifying today?

HUNT: I don't know.

M. CAVANAUGH: OK. I'm going to put it to you since you brought them up. So do they offer emergency contraception at all? It's not available?

HUNT: I, I don't think so.

M. CAVANAUGH: OK.

HUNT: I don't know. I know that we've heard stories that patients have not been able to get it there.

M. CAVANAUGH: OK.

HUNT: I don't know if that means they don't have it or they won't give it or how often they refuse to give it, because we don't have any data about that and there is no published policy about it either.

M. CAVANAUGH: They don't have a published policy about it.

HUNT: Right.

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M. CAVANAUGH: OK. Interesting. Well, I hope that they're somewhere in the room and going to come testify so I can ask them some questions. But thank you.

HUNT: You know, every time I introduce this does this bill that is the question. And it's interesting that we don't know. I mean, don't we want to know if hospitals are at least giving this information to patients because what we hear from patients is that they're not so--

M. CAVANAUGH: Right.

HUNT: --at least we should figure that out.

M. CAVANAUGH: Right. Thank you.

HANSEN: Any other questions from the committee?

M. CAVANAUGH: Oh, actually--

HUNT: Senator Cavanaugh again.

M. CAVANAUGH: I'm sorry. Sorry. The department has a, a neutral letter. I don't know if you've had a chance to look at it.

HUNT: Yes, I have.

M. CAVANAUGH: But in it, it--

HUNT: I don't know if I have a copy of it here but, yeah, I have.

M. CAVANAUGH: I'll just review the sentence about the report: requires a report to be submitted to the Clerk on December 1, even number years. The bill requires that complaints related to sexual assault are confidential, yet the requested report is required to include the nature of the complaint and the hospital about which the complaint is made. Providing this information would no longer make the complaint confidential or nonidentifiable. And again, not for you to answer but since they submitted a letter I'm assuming they're not coming so give you an opportunity to speak to this. I feel like there's other reports that hospitals have to make that are, I mean, not related to sexual assault but--

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HUNT: I mean, we haven't talked about-- you know, for the record, you and I haven't spoken about this. I don't know what you've been asking.

M. CAVANAUGH: No, we haven't actually. Sorry.

HUNT: No, I, I read that letter over my lunch break and I don't really agree with that assessment. I mean, it's not saying, you know, put the Social Security number of the patient and say what happened to them. It's--

M. CAVANAUGH: Right.

HUNT: --it's possible to give a report to the Legislature on the use of emergency contraception without violating anybody's privacy.

M. CAVANAUGH: Assumedly, if CHI, for example, treats-- I don't even know how many, thousands, tens of thousands of patients a year-- if people are filing complaints against CHI, having us know that CHI as a hospital is having complaints filed by victims of sexual assault would not tell us who those victims are.

HUNT: Right.

M. CAVANAUGH: OK.

HUNT: Right.

M. CAVANAUGH: Yeah.

HUNT: There's all kinds of reports we get where you can't identify the person outlined in the report, whether that's a complaint or a report about, you know, opioid treatment or like all kinds of things that we have--

M. CAVANAUGH: OK.

HUNT: --reports on.

M. CAVANAUGH: Thank you.

HANSEN: Any other questions from the committee? I think Senator Cavanaugh took my question. That's what I was going to ask because I was concerned about the report, because I think there has to be some

identifiable, identifiable information on there because then I think the hospital then has the ability to appeal the decision the department might make, which can then have a hearing. So then, I think, but I don't know for sure how that works. You're right, I think we do reports like the opioid stuff or like a PDMP, if we have any information on that, but that doesn't have identifiable-- it can't-- they can't divulge identifiable information. So I'm curious how the report will work. That's, that's--

HUNT: I agree with you. I think my intention with the bill is clear. And you know there's-- if there's an amendment that makes it more palatable for the committee or it makes it work better for the department, that's what I want. I mean, I, I don't care how we get there. I think, I think my intention is clear with the purpose of the bill for sure.

HANSEN: Cool. All right. Thank you.

HUNT: Thank you.

HANSEN: Seeing no other questions, you're sticking around to close?

HUNT: Um-hum. Thanks.

HANSEN: Cool. All right. We'll take our first testifier in support of LB488. Welcome.

JULIE LUBISI: Hello. My name is Julie, J-u-l-i-e, Lubisi, L-u-b-i-s-i. And forgive me, I'm a little nervous as I'm going to be telling my personal story.

HANSEN: We're all staring right at you--

JULIE LUBISI: I know.

HANSEN: --so don't worry about it.

JULIE LUBISI: It's very intimate. As a sexual assault survivor, a long term-- a longtime advocate and a gender-based violence researcher, I urge you to support LB488. The high prevalence of sexual violence, specifically rape, is undeniable. One in four women have experienced a completed or attempted rape in their lifetime, with most incidents occurring before the age of 25. Unfortunately,

many victims do not report sexual assault due to several barriers including shame, fear of not being believed, safety concerns especially when intimate partner violence is present, and a lack of access to care. The reporting process can, and most often does, retraumatize victims of sexual assault. However, when victims do report they are likely to reach out to a healthcare professional primarily in the emergency department. A recent trend study showed that 1,533 percent increase in sexual assault related emergency department visits from 2006 to 2019. Victims of sexual assault trust that they will receive adequate care when engaging the health system. Adequate care is the inclusion of emergency contraception with post rape care. The World Health Organization and the American College of Obstetricians and Gynecologists, ACOG, recommend emergency contraception as an effective, immediate response that prevents unintended pregnancy for patients who were sexually assaulted. The recommendation is fitting considering the national rape-related pregnancy rate is 5 percent or that's 32,000 births per year among women 12 to 45 years old. Like all clinical interventions, the response to rape should be trauma-informed and involve medically accurate information and all the available options that promote health and well-being. Victims of sexual assault should not have to worry about unintended pregnancy after enduring rape. Unintended pregnancy-- excuse me, unintended pregnancy leads to poor maternal and infant outcomes and increased costs for the healthcare system. Furthermore, unaddressed sexual violence leads to short- and long-term health consequences beyond unintended pregnancy including pelvic-- chronic pelvic pain, severe forms of depression, and post-traumatic stress disorder. Therefore, early detection and intervention are critical to the health and well-being of victims and survivors. Emergency contraception provides early intervention for victims of rape during the first 72 hours after exposure when it is most effective. However, it can be effective up to five days or 120 hours after the sexual assault has occurred. Response time is critical and cannot withstand judgment nor lack of action based on the religious values of the provider nor the institution. Technically, victims can buy emergency contraception over the counter. However, this option may pose issues related to confidentiality and cost, not to mention the absence of medically accurate information and the support from a trained healthcare professional. Like many women in the United States, I've had the option of taking emergen-- I've never had the option, excuse me, of

taking emergency contraception after sexual assault. And like some women, I had an unintended pregnancy that resulted in a miscarriage and PTSD. Advances in science and healthcare policy have made emergency contraception a viable option that protects victims and survivors from further harm. Requiring providers and their institutions to provide emergency contraception and patient education with adequate oversight honors the safety, dignity, and future well-being of victims and survivors. Thank you for your support.

HANSEN: Thank you for your testimony. You did great. Well, let's see if there's any questions from the committee first. Are there any questions? All right. Seeing none, thank you.

JULIE LUBISI: Thank you.

HANSEN: We'll take your next testifier in support.

CRISTON MacTAGGART: Good afternoon, members of the committee, Chairperson Hansen. My name is Christon MacTaggart, spelled C-h-r-i-s-t-o-n, last name M-a-c-T-a-g-g-a-r-t. I'm the executive director of the Nebraska Coalition to End Sexual and Domestic Violence, our network-- and testifying on behalf of our network of 20 programs who collectively cover all 93 counties in Nebraska and provide direct services, crisis intervention services to survivors of domestic violence, sexual assault, and human trafficking. Sexual violence is prevalent in Nebraska. The 2020 Nebraska Statewide Intimate Partner and Sexual Violence Survey found that over 50 percent of Nebraska women experience rape in their lifetime. Survivors of sexual assault experience a variety of mental and physical health consequences, including unintended pregnancy. That same study also found that more than 50,000 Nebraskans have experien-- have experienced unintended pregnancy due to rape. So provision of emergency contraception is important and is well-established as a best practice in post sexual assault care. Both the World Health Organization and the International Association of Forensic Nurses, excuse me, recommend that survivors of sexual assault be offered emergency contraception as part of post sexual assault care as it has been found to be both safe and effective in preventing unintended pregnancy. The passage of LB488 would increase survivors' access to this in Nebraska. Currently, that access varies widely from community to community, and it's particularly challenging in rural communities. Staff at a number of our programs serving rural

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communities reported that the emergency department at their closest hospital does not offer emergency contraception, and in addition, it's not always available at their local pharmacy and so survivors in these communities sometimes have to travel hours to access it after a sexual assault when they're in trauma. It is most effective when taken in a timely manner. So when they have to travel, they risk missing the medication window of effectiveness as well. The other thing I would just share to your question, Senator Cavanaugh, if I could. We have-- CHI is a statewide health network and so we know that access to emergency contraception is crucial because sometimes they have the only hospital in that community. I've worked with them a lot. I would say that they-- I feel comfortable in saying that they can provide emergency contraception. I think there is some-- there has been discussion that because they are affiliated as a Catholic hospital network, they cannot. But the U.S. Conference of Catholic Bishops years ago allow-- released a statement allowing EC as part of sexual assault care and not in conflict with beliefs so many hospitals in the CHI network, I believe, actually do provide it. I just don't believe it's provided consistently and the two CHI hospitals in the Lincoln dioceses I know do not. So that is our understanding of that question since you asked that specifically. I, I don't-- I would also say I don't believe that they're the only hospitals that are, are not always providing it. Like I said, we also see this in rural communities in particular. And, and, you know, that's coupled with the fact that it's hard to get locally at pharmacies. So overall, we really recognize that access to this is imperative to the emotional and physical health of survivors of sexual assault. We support increasing access to emergency contraception for survivors at every community in our state. So we support the passage of LB488 and we hope that you will vote it out of committee. I'm happy to answer any questions that you might have.

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

M. CAVANAUGH: Thank you. Thanks for being here. I'm not familiar enough with Lincoln's hospital system so what are the, what are the hospitals in the Lincoln area, if you know?

CRISTON MacTAGGART: So it is my understanding that there's one hospital in Lincoln and then I believe that, that Grand Island is a

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CHI hospital that's within the Lincoln dioceses and so then that would be the other one.

M. CAVANAUGH: But what is the name of the hospital here in Lincoln?

CRISTON MacTAGGART: So I believe St. Elizabeth is--

M. CAVANAUGH: OK.

CRISTON MacTAGGART: --the hospital in Lincoln that does not provide emergency contraception.

M. CAVANAUGH: Does St.-- or not St., does Bryan?

CRISTON MacTAGGART: I believe so.

M. CAVANAUGH: Is there another hospital within Lincoln?

CRISTON MacTAGGART: Nope.

M. CAVANAUGH: I don't-- yeah, you don't have to give me a geography lesson on hospitals. So when it comes to rural hospitals, besides the, the CHI hospital in Grand Island, do you know of any other hospitals in other communities that are not offering this?

CRISTON MacTAGGART: Yeah, we've-- I mean, we've heard from programs in central-- north central Nebraska, northeast Nebraska. And again, I think it might be-- there might be inconsistency. Maybe sometimes they have it on hand. Maybe sometimes they don't provide it. I don't know all the details, but we hear regularly from our programs in rural areas that they have hospitals that don't always provide it. I think that for, for hospitals or, or areas of the state that have perhaps more well-established sexual assault response programs in the hospital, they might be more likely to provide it.

M. CAVANAUGH: OK. I have a whole slew of other questions but I feel like they're for hospital people so I'm hoping that they're going to come testify. So I'll, I'll leave you at that. Thank you.

HANSEN: All right. Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. I'm kind of a woke on terms of facts and one of the questions that I have is I'm

trying to figure out the years because I, I-- I'm struggling, I guess, to own the piece that says and I, quote, the same study found that more than 50,000 Nebraskans have experienced unintended pregnancies due to rape. It seems like an incredibly high number to me and I'm trying to figure out what the reference here is and there is a reference.

CRISTON MacTAGGART: It is, it's cited in there. It's actually 5 percent of Nebraska women of which is 50,000.

RIEPE: I've never heard of this, Nebraska Co-- I mean, I'm trying to validate their integrity or their credibility, I guess, would be a better word.

CRISTON MacTAGGART: It's-- I'm happy to provide you that information. It's actually-- so there is a national study called the NISVS that is widely renowned as like the one in five women, one in-- you know, one in five women who have experienced domestic violence, you see that data used pretty regularly. In 2020, Nebraska did their own version of that study. That was our research that we commissioned. We used HTI Labs to conduct that research, which is a local research firm in Omaha that does only research relating to domestic sexual violence and trafficking. They're very well-established. They work in lots-- they work with lots of systems folks, both direct services, law enforcement, prosecution. So I'm, I'm happy to give you more information about that research study. The full report is on our website and it's cited there so you're welcome to go to it. It also has some of the methodology that was used in the study as part of it.

RIEPE: Well, before we can really address problems, we have to understand what the problem is.

CRISTON MacTAGGART: For sure.

RIEPE: And at this point in time, I'm struggling with the 50,000 who have had unintended pregnancies in a state of 2 million. I'm just--

CRISTON MacTAGGART: Yeah, it's a shocking statistic.

RIEPE: --I'm having a hard time believing that. Thank you.

CRISTON MacTAGGART: Yeah, I understand that. I was also shocked.

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RIEPE: OK. I have no further questions. Thank you, Mr. Chairman.

HANSEN: Any other questions from the committee? Senator Ballard.

BALLARD: Thank you, Mr. Chairman. Thank you for being here. I know the bill specifically addresses hospitals, but would this also impact any clinics that offer emergency care?

CRISTON MacTAGGART: That's a good question. I'm trying to recall the language of it and so Senator Hunt might be better to, to, to address that.

BALLARD: Yeah, I probably should ask-- I apologize, I probably should probably ask this to the introducer but, yeah, just so we have it-- if you-- that's OK if you don't know the answer to that. Thank you.

HANSEN: Any other questions from the committee? Seeing none, thank you for testifying. And we'll take our next testifier in support of LB488. Welcome.

TIA MANNING: Welcome. Hello. Welcome-- huh? Good afternoon, Chairperson Hansen, and members of the Health and Human Services Committee. My name is Tia Manning, T-i-a M-a-n-n-i-n-g, and I'm the Freedom from Violence project manager at the Women's Fund of Omaha. At the Women's Fund, we are committed to supporting survivors of gender-based violence in our local communities, which includes survivors of sexual assault and domestic violence. As such, we offer our full support for LB488 and recognize its efforts to ensure survivors are provided trauma-informed, medically accurate and comprehensive health post-- healthcare, excuse me, post assault. In just one year, 1,592 cases of sexual assault occurred in our state, and that number is probably low considering sexual assault cases are historically underreported. When survivors first enter a hospital to seek care, many are in the midst of experiencing trauma associated with the assault. During this time, it's, it's critical that medical care providers and advocates provide timely, appropriate, and compassionate care so a survivor's immediate injuries are appropriately taken care of and equally important to reduce the likelihood of retraumatization. Emergency contraception to delay or prevent ovulation is integral-- is an integral component of comprehensive medical response to sexual assault. Denying or withholding information and access to emergency contraception leaves

survivors vulnerable to an unplanned pregnancy. About 18 million people have experienced vaginal rape in their lifetime, and survivors who were raped by a current or former intimate partner were four to five times more likely to report a rape-related pregnancy than those raped by acquaintances or a stranger. Carrying an unplanned pregnancy to term can be incredibly traumatic to a survivor and detrimental to their short- and long-term well-being. Considering the intersection between rape-related pregnancy and intimate partner violence, carrying an unplanned pregnancy to term can also take it increase-- can also make it increasingly difficult for a survivor of sexual and domestic violence to leave an abusive partner. I just lost my spot. I apologize. In fact, one of the most dangerous times for a woman to-- woman in an, in an abusive intimate partner relationship is when she is pregnant with homicide as the leading factor of death during pregnancy and the postpartum period for women. Furthermore, a person's odds of experience intimate partner violence increases by 10 percent with each pregnancy. No survivor should have to face the reality of being forced to remain pregnant as a result of an assault, coupled with the trauma they are already experiencing from the event. For some Nebraskans, this legislation will be life-changing. We urge this committee to show their support for survivors of sexual assault and domestic violence and invest in their healing post assault by voting yes to LB488. And with that, I'll take any questions.

HANSEN: Thank you. Are there any questions from the committee? Seeing none, thank you for coming. Appreciate it. We'll take our next testifier in support of LB488.

SCOUT RICHTERS: Good afternoon. My name is Scout Richters, S-c-o-u-t R-i-c-h-t-e-r-s, here on behalf of the ACLU of Nebraska in support of LB488. I first want to thank Senator Hunt and the committee for its time today. Sexual assault and other forms of gender-based violence deprive women and girls of their fundamental ability to live with dignity. Women and girls experience domestic violence and sexual assault at truly alarming rates. Governments, institutions, laws, and policies contribute to the systematic devaluation of the lives and safety of women and girls by failing to respond to gender-based violence and discriminating against those subjected to such violence. Emergency contraception, as you've heard, is vital healthcare for sexual assault survivors. It's a safe way to prevent pregnancy after contraceptive failure, unprotected sex, or sexual assault. But again, as you've heard, only if taken quickly it's most effective within 12

hours, with effectiveness decreasing every 12 hours after that. By requiring hospitals that provide care to sexual assault survivors to also provide those patients with medically accurate information about emergency contraception and make this care available, we ensure that patients receive comprehensive medical care and are able to make autonomous, fully informed decisions about their own bodies and their own futures. We offer our full support of LB488 and urge the committee to advance this legislation.

HANSEN: All right. Thank you.

SCOUT RICHTERS: Thank you.

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

SCOUT RICHTERS: Thanks.

HANSEN: Is there anybody else wishing to testify in support of LB488? Welcome.

ALEX DWORAK: Thank you, Chairman Hansen, senators of the HHS Committee. My name is Alex Dworak, A-l-e-x D-w-o-r-a-k. I'm here representing myself. My sincere apology is that of the six copies of testimony I printed 15 copies of, this wasn't one of them. I have it here and I'm happy to forward it along if that would be helpful. I'll preface this by saying I'm going to talk about some horrible things which friends, colleagues of mine and of yours and patients of mine have survived. I do this in the hope that this committee will advance this step towards caring for those who survive this heinous crime. Medical and factually accurate information is something that is very important to me as a physician, of course. I applaud and strongly support the text which refers to the currently accepted standards of professional care, recognizes accurate and objective by leading professional organizations in the field of obstetrics and gynecology. It's refreshing to hear a bill highlight the expertise of physicians who have dedicated their lives to the practice of medicine. I would add emergency medicine, family medicine, psychiatry, infectious disease, and most sadly, pediatrics, as of the disciplines whose care and compassion are needed in the face of this horrible trauma. I also specifically applaud the language referring to offering emergency contraception to the sexual assault survivor, unless they decline.

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Recognizing the autonomy of someone shortly after it has been viciously stolen from them in the most intimate way is the least that can be done. I also think it bears repeating that emergency contraception is not abortion, as the article that I've-- that I did remember to print off summarizes. Forcing someone to carry the child of their rapist whether intentionally or by omission of a medically appropriate option is one of the only ways I can imagine of making survivorship even worse. Caring for survivors is also a justice issue that defines who we are as a society, and the prevalence of assault does that too. Over half of women and almost one in three men have experienced physical sexual violence. One in four women have experienced completed or attempted rape. More than two in five Native and multiracial women have been raped in their lifetime. Almost half of transgender people are sexually assaulted at some point in their life, and 46 percent of bisexual women have been raped. And I do have those references there at the bottom where that can be cited. This is hard for me to say, my brain, my entire being wishes it were untrue, but that is the bleak reality in our nation. Clearly, we as a society have a lot of work to do. Advancing a bill which centers the autonomy of the survivor in one of the worst moments in their life is far from the end of the work before us but I believe it is a good start. Thank you so much for your time and your service to our states, especially in moments such as this when it requires contemplating terrible things. I'll be glad to take any questions.

HANSEN: Thank you. Are there any questions from the committee? Seeing none, thank you for coming in. Anybody else wishing to testify in support? OK. Seeing none, is there anybody who wishes to testify in opposition to LB488? Welcome.

EDWARD DeSIMONE: Edward DeSimone, E-d-w-a-r-d D-e-S-i-m-o-n-e, and thank the Chairman and the committee members for this opportunity to speak today. I've been a pharmacist for 51 years. I'm licensed to practice pharmacy in Nebraska. I spent the last 46 years as a pharmacy educator and I'm a member of Pharmacists for Life International, Professional-- Business and Professional People for Life on the Board of Directors, and the Catholic Medical Association. However, today I am here speaking on behalf of myself. As a Catholic and as a father and grandfather of multiple females, this is a tragic situation. However, we don't want to make-- we don't want to turn one victim into two victims and this is what I want to talk about. And with all due respect to Senator Hunt, the information on mechanisms

of action of Levonorgestrel were not correct. And I've provided published articles that attest to that fact. But I want to start with one thing, because one of the critical issues here is when does fertilization-- when does pregnancy occur? And so I've given you several example definitions from medical texts. One of my favorites is this one, and I, quote, Embryonic invasion of the uterus occurs during a specific window of implantation eight to ten days after ovulation and fertilization when the conceptus is a blastocyst. Unfortunately, people who promote the use of these, quote, contraceptives have tried to use a false narrative that pregnancy occurs at implantation. Unfortunately, that's not true. Pregnancy occurs at the time of fertilization and implantation takes place so many days later. And that's a critical talk point about this issue. Let's talk about Levonorgestrel. And since that's been on the market, I can speak to the fact that many pharmacists have been-- have lost their jobs because they refuse to dispense this drug. Medical researchers are actually divided on the mechanism of the drug and to-- this is out of clinical pharmacology, which is my primary drug information resource. It's online. It says, quote, The exact mechanism of action, however, is unknown. They also say: Other actions of progestins include alterations in the endometrium that can impair implantation. Another source and there's a copy of this in Attachment A: Levonorgestrel's total effectiveness at preventing pregnancy is usually estimated at between 58 percent and 95 percent depending on when the drug is administered relative to intercourse and its effectiveness in merely preventing ovulation is, is estimated to be only about 50 percent. You know, I, I gave this-- I gave a lecture in our ethics course about conscience, conscientious refusal. And I just gave my lecture on that last week, ironically, and I, I use an analogy with the students, I say if I, if I handed you a gun with one bullet, just one bullet and spin that cylinder and I say you can take this gun and go shoot somebody you don't like whoever is over there, would you do that? And of course not. That's the answer I get in class and I said that's the exact situation that we're talking about here. We don't know when this drug prevents ovulation and we don't know when this drug actually impedes implantation. When it impedes implantation, then it is now an abortifacient drug and not a contraceptive. OK? So there is a Catholic protocol on the treatment of, of rape victims and I've included that in my voluminous handout for you. And the National Catholic Bioethics Center has produced this document and you have a copy of it and it goes through what

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procedures need to be done in order to afford some relief for the victim of rape. OK? And I'm not going to read this to you have a copy of that, but there is a Catholic document that provides that information. OK? So my time is up.

HANSEN: Yep.

EDWARD DeSIMONE: You have plenty of reading material. If you have any questions, I'd be happy to answer them.

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

M. CAVANAUGH: Thank you. Thank you for being here. What is the standard of care at a hospital when a rape victim comes in?

EDWARD DeSIMONE: I'm sorry, I'm having trouble with the hearing aid.

M. CAVANAUGH: Sorry. What is the standard of care at a hospital when a rape victim comes in?

EDWARD DeSIMONE: What is the standard of care in hospitals for rape victims?

M. CAVANAUGH: Yes, if a rape victim is brought into the emergency room, what is the standard of care?

EDWARD DeSIMONE: Rape victims need to be treated, their mental health needs to be addressed, if there are--

M. CAVANAUGH: What's the process?

EDWARD DeSIMONE: --any physical-- what's that?

M. CAVANAUGH: A victim comes in of sexual assault, a victim comes in of sexual assault into the emergency room, what is the process of care for that victim?

EDWARD DeSIMONE: I'm, I'm-- I don't work in a hospital anymore. I don't know what the standard of care-- it's certainly-- the first thing about standard care is "first, do no harm." And so harm has already been done to this unfortunate individual.

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M. CAVANAUGH: Well, any person that comes into an emergency room presumably has had some harm done to them outside of the emergency room. I think the "do no harm" statement is reflective of, of your interaction with the patient, not what's already been done to them. Correct?

EDWARD DeSIMONE: I'm sorry, I'm having a problem with my hearing aid. You're just going to have to speak up a little louder.

M. CAVANAUGH: You said the "do no harm," but harm has already been done to them. But I believe that that statement of "do no harm" is in the context of your interaction as a medical professional with the patient. Most people who come in to an emergency room for care have had some harm, whether it's a viral harm or a physical harm done to them so the "do no harm" is the patient-doctor relationship.

EDWARD DeSIMONE: Correct.

M. CAVANAUGH: OK. So when a patient comes in, they've already had harm done to them. They've been sexually assaulted. They come into the emergency room. But I understand now in asking you and you have answered that you actually do not work in a hospital setting--

EDWARD DeSIMONE: Right.

M. CAVANAUGH: --so this is-- you're not the appropriate person for me to ask this question to, so. Took us a second to get there.

EDWARD DeSIMONE: OK.

M. CAVANAUGH: Thank you. Thank you for testifying. Thank you for answering my question.

EDWARD DeSIMONE: OK.

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

EDWARD DeSIMONE: Thank you.

HANSEN: Is there anyone else wishing to testify in opposition? Welcome.

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TOM VENZOR: Good afternoon, Chairman Hansen and members of the HHS committee. My name is Tom Venzor, T-o-m V-e-n-z-o-r. I'm the executive director of the Nebraska Catholic Conference. Typically, you'd have Marion Miner here on this particular issue, but he's in a different committee so you've got the B team. So LB488 would impose a legal mandate on hospitals to dispense emergency contraception to a woman who has been a victim of sexual assault. Emergency contraception in the bill is defined broadly as a drug approved by the federal Food and Drug Administration that prevents pregnancy after sexual intercourse, but which does not disrupt an existing pregnancy. Due to the legislation's lack of clarity in terms, this includes drugs with interceptive and abortifacient effects, drugs which have-- which would have for their effect after fertilization and thus would kill a new human life. The Catholic Church does have a set of what are called "ethical and religious directives" for hospitals and healthcare professionals to follow when these certain circumstances arise. Among those circumstances provided for is when a woman, when a woman checks into a hospital after having been sexually assaulted. And the directive for that situation reads as follows, quote, Compassionate and understanding care should be given to a person who is a victim of sexual assault. Healthcare providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum. Because when a new, unique, and distinct human being comes into existence at the moment of fertilization, administration of emergency contraception after fertilization results in the direct termination of that human life. This is a line that any medical professional who knows life begins at fertilization and objects to abortion cannot cross. While making better attempts than previous legislative proposals to treat this nuance, Senator Hunt's bill does not fully take into account the presence of a new human life who is owed protection under law. The hospital's failure to comply with this mandate would lead, first, to a formal rebuke and then assurance that the deficiency has been

corrected; and second, to the imposition of $1,000 fine for each individual failure to comply. This bill requires the performance of practices that healthcare professionals at various hospitals will not and simply cannot perform because of the abortifacient aspect of this. The result will be that skilled medical providers will be driven out of emergency medical care because their moral objections to participate in taking the life of an innocent preborn child at its earliest stages of human development. There will be tremendous downward pressure on physicians and hospitals with moral objections to either comply with the moral practices or get out of certain fields of healthcare. And nothing in this bill protects the conscience rights of physicians or hospitals not to participate. And just mention real briefly there's sort of references multiple times of, you know, the bill being about trying to obtain data, of course, that's one element of the bill. Another element of the bill is if you don't comply with it, you're subject to, you know, serious fines. And so it's not simply about data. Also, there's a claim, you know, that these are just about religious values. And, and I would remind you that, of course, the position of the Catholic Church is one rooted in a theological understanding of the human person, but it's also one that's rooted in basic science, in a basic understanding of when human life begins and, and, and the moral principle that we should not take the life of an innocent human being. So I just wanted to make mention of those couple things. Otherwise, I'll be happy to take any questions.

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

M. CAVANAUGH: Thank you. Thanks for being here. I feel like we've come a million miles in the four years that I've had this bill here on this bill-- or on your testimony and I appreciate it. I want to start with it sounds like some of the things that you're testifying in opposition to might be technical and could be addressed. Have you reached out to Senator Hunt's office to offer some language changes that would address some of your concerns?

TOM VENZOR: No, we haven't. We've just typically offered our testimony at the committee level, so.

M. CAVANAUGH: OK. I would suggest doing so because from what I heard in Senator Hunt's opening and what I've heard in some of your

opposition it sounds like it's a communication error more than an opposition, because what she talked about in her opening was trying to prevent the fertilization, which when you talked about the indented portion of your testimony here, that that is in line-- very much in line with the values of the Catholic Church, the taking a test, ensuring that fertilization hasn't occurred and then providing appropriate care. So it seems like there could potentially be a path forward.

TOM VENZOR: Yeah, possibly. I think that's a good question and I think as you heard from Dr. DeSimone earlier, I think you also have questions of when you're going to define things like the term pregnancy. If you're going to define terms like pregnancy as being at the point of implantation, then that would be a problem because, because the understanding is that the human person, you know, you know, begins to exist in their unique form at the moment of fertilization and so those are two different points in times. But, yeah, I mean, if those are things that can be overcome and dealt with we can certainly have further conversations on those, because I think you're right the ethical and religious directives of the church recognize that there is sort of a right to defense against the perpetrator of sexual assault which extends to the point of, of just prior to, you know, conception.

M. CAVANAUGH: And my understanding, and I don't want to put words in Senator Hunt's mouth, but my understanding of the intent of this bill is to ensure that when victims are seeking medical care, that they get-- I mean, emergency contraception isn't going to work if all of these other things have happened and so the intention is to get that emergency contraception as quickly as possible and not delay. And so if the-- if it is in line with the values that you are-- I mean, I'm sure it will come as no shock to you, it's neither here nor there to me if you are in, in opposition to this, I still am going to feel the way I'm going to feel about it. But if there's an opportunity to get to some middle ground on the objective of helping victims of sexual assault get access to the care immediately or as quickly as possible it seems worthy of the conversation.

TOM VENZOR: Yeah, again, happy to have further conversation. There's going to be other discussions in there, too. And I think, again, Dr. DeSimone raises from the science, which is you're also going to have some basic and fundamental questions about the instances where the

emergency contraception is going to act in a way that stops, let's say, conception or fertilization versus when it's going to do things like stop implantation. And so--

M. CAVANAUGH: But wouldn't that be what the, the pregnancy test would reveal?

TOM VENZOR: Yes, those types of tests do assist in, yeah, determining whether ovulation is about to occur or has already occurred or things of that nature. Yep. Um-hum.

M. CAVANAUGH: So what I'm saying is, it sounds like there's opportunity here.

TOM VENZOR: Yeah, yeah, happy to have discussion, but the bill is written in the bill in the past and, you know, credit to Senator Hunt, you always kind of working on, you know, listening to what objections have been made in the past, so. But yeah, so, but the bill as written currently is not acceptable because it would provide-- it would require the dispensation of emergency contraception that would act as an abortifacient.

M. CAVANAUGH: OK. Just one last thing is that--

HANSEN: Sure.

M. CAVANAUGH: --I, I would very much encourage you to carry this conversation forward but also your testimony does not identify specific language changes or things-- specific parts of the bill that-- so for me in following along with your testimony and the bill, I, I personally am having challenges figuring out what, what the specific-- I understand globally what the problems are, but specifically, and so if you could maybe follow up with like-- if Section 4 lines, blah, blah, blah, we're struck that would alleviate-- does that make sense?

TOM VENZOR: Sure. Yep, that makes sense. And for example, the first paragraph in my testimony raises concerns about the definition of emergency contraception itself. So that's the-- that's really the first and fundamental concern. I certainly think there's going to be other concerns about conscience rights issues and then I think there's also going to be just concerns about the, the punitive aspect of this bill if you don't participate. Because you might have

legitimate moral, scientific, medical issues, you don't participate you're going to start getting complaints. Those complaints are going to pile up. You're going to be fined over and over if you don't, if you don't sort of fix those things, etcetera. So, yeah, those are-- happy to discussion those, too. But I mean, the first and fundamental one is the one laid out there in paragraph one. But yeah, thank you.

M. CAVANAUGH: Thank you.

HANSEN: Senator Riepe.

RIEPE: Thank you, Chairman Hansen. Thank you for being here. I've-- I'm trying to recall, I think Dr. DeSimone said that there is some period of time between the actual occurrence of a rape and the fertilization, if you will, of the-- of an egg that may be there. If that's the case then, because most of these rapes are not inpatient situations in the hospital so that-- and to be able to take a pregnancy test would not be effective, I don't believe, I'm not a physician, obviously. But so I'm trying to say does it then become a hospital issue or problem because the patient will have been discharged as an outpatient prior to understanding whether they are or are not pregnant?

TOM VENZOR: Yeah, so I think-- so, yeah, you know, scientifically, you know, there, there is obviously a period of time between the assault that occurs and when conception might actually occur and that's just going to vary, you know, sort of in every situation, you know, depending on ovulation and things of that nature. But I think in a hospital setting, your run-of-the-mill pregnancy test, of course, is not going to be something that can help detect pregnancy that early of a stage. But you are going to have other forms of testing like testing the LH surge in, in, in the, in the, in the woman to make determinations about the-- whether ovulation has occurred or not. And those are the things that go to, I think, some of the things that, for example, the Catholic hospital, you know, when, when, when you read the ERD and it says if after appropriate testing, those would be the types of appropriate testing that could be done to make that determination about whether conception has occurred or not. So if that's helpful.

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

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

TOM VENZOR: All right. Appreciate it. Thank you.

HANSEN: Anybody else wishing to testify in opposition to LB488? Just making sure. OK. Just to make sure, anybody else wishing to testify in opposition? OK. Seeing none, is there anybody who wishes to testify in a neutral capacity? All right. Seeing none, we will welcome Senator Hunt back up to close. And for the record, we had 18 letters in support, 3 letters in opposition, and 1 letter in the neutral capacity for LB488. Welcome back.

HUNT: Thank you, Chairman Hansen and hello again, colleagues. In closing, one thing I want to mention is that the sexual assault payment program, which is in Nebraska, and they have reports and tracking on the Attorney General's website and the most recent report from the 2019-2020 fiscal year showed that 43 percent of the medical forensic exams that provided to assault victims were provided to children aged 12 and under. So, you know, the Attorney General of Nebraska is reporting 43 percent of the sexual assault victims they're looking at are 12 and under. So emergency contraception here is really vital to protect these children from unwanted pregnancy. You know, is a six-year-old getting pregnant? It's happened in history, but probably not, you know, super likely to happen. Is a 12-year-old getting pregnant? Yeah, that's super, that's super possible. And these reports provide overviews of those sexual assaults that are reported to medical providers and they provide reimbursement for the sexual assault exams that they do. So this isn't the entire universe of sexual assaults in Nebraska because we know that so many aren't reported, but it does reflect how many young people this type of thing really affects. Look what emer-- you know, you can have your feelings about when life begins, but the fact is emergency contraception does not terminate an existing pregnancy. It just doesn't. It just doesn't. Like, people feel certain ways about contraception, condoms, anything going on inside, around or about a uterus is really interesting to a lot of people, but the medical facts are that emergency contraception prevents ovulation. It doesn't prevent an existing pregnancy from continuing. And a standard part of any intake for a sexual assault survivor is also a pregnancy test. So if the person was pregnant, you know, they wouldn't be able to get this anyway. You know, once again, I think we're going to be

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legislating perhaps from a philosophical religious place instead of a science-based place in a way that is actually going to be really harmful to Nebraska women, especially if we move forward in this state banning abortion. And with the statistics that we see from the Attorney General's Office, we know how many of these people affected could be children as well. So with that, I'll close and I'd be happy to answer any other questions. Oh, I got one more thing, actually. This-- I, I got a copy of the handout from Tom Venzor at the Catholic Conference and my ears perked up when he was reading the, the directive from the Catholic church that says: A female who has been raped should be able to defend herself against a potential conception from the sexual assault. I don't know what that even means. I don't know if this is some Thomas Hilgers, you know, legitimate rape type of argument, like if it was a legitimate rape that she wouldn't be pregnant, which is an argument that, that he has made and that many politicians have repeated, but that has no basis in fact. So, I mean, even just reading that on the handout makes me kind of discount the logic of this type of argument. But if there's a medication that a rape survivor can take who is not pregnant that we know will prevent her from becoming pregnant with her rapist's baby, we should let her take that. And that's what the science shows and that's what the medical consensus is that hospital should do. Oh, one other thing, one more time. Nothing in this bill says that an individual provider is forced to give this medication to somebody. So if somebody has a medical or a religious objection or something like that, if there's a doctor who says I'm not going to be giving out emergency contraception because I believe the stuff in this pamphlet, they don't have to, they can have somebody else give it. The law just-- or the bill just says that the hospital has to provide it so a nurse could give it or anybody else in the hospital. And it also wouldn't affect any clinics, just hospitals. And I am finished. Thank you so much.

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

RIEPE: Thank you, Chairman Hansen. Because I do like facts, you said that 43 percent of the assaults were 12 years old and under.

HUNT: Um-hum.

RIEPE: Along with percentages, I always like absolute numbers. How many-- do you have a number on that?

HUNT: Yes, the number is-- so this is from the Attorney General's news release from January 27, 2021, and it says: Over the course of the sexual assault payment program, 4,086 medical exam payments and 43 percent of them were to children under 12. So--

RIEPE: You said 4,000?

HUNT: 4,086 so 40--

RIEPE: Over what time period, please?

HUNT: --43 percent of that. The last three years.

RIEPE: The last three years?

HUNT: Yes.

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

HANSEN: Any other questions from the committee? I had one. You mentioned-- and I, I-- unless I missed it, is there in the bill the requirement that they in order-- before they provide emergency contraception that they have to take through the pregnancy test or check for luteinizing hormone?

HUNT: It wouldn't be in the bill because that's already the standard of care.

HANSEN: OK.

HUNT: It'd be like putting in the law that you have to take someone's blood pressure. Like, they already do it.

HANSEN: OK. Well, I was just kind of curious about that part. Senator Cavanaugh.

M. CAVANAUGH: Thank you. In answer to Senator Riepe's question, those numbers are based on those that have had a rape kit conducted.

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HUNT: That's right. And so we know that this does not represent, you know, probably a portion of the actual assaults that happen in the state.

M. CAVANAUGH: Thank you.

HANSEN: Just to make sure. Any other questions from the committee? All right. Seeing none,--

HUNT: Thank you.

HANSEN: --thank you. All right. And that will close our hearing on LB488. And we will now open it up for LB62 and welcome Senator Cavanaugh to open. Welcome to your Health and Human Services Committee.

M. CAVANAUGH: Thank you so much for having me, friends. OK. We've got an amendment being passed out. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Machaela Cavanaugh, M-a-c-h-a-e-l-a C-a-v-a-n-a-u-g-h, and I am here today to introduce LB62. This bill improves language access in Medicaid by requiring coverage for interpretation and translation services. It is needed-- a needed step to ensure everyone is able to receive the healthcare they need even if English is not their first language. Language access improves outcomes and ultimately reduces healthcare costs. Language barriers harm patients and their families without language services that people with language access needs may suffer from more medical errors, reduce quality of care, unnecessary testing, misdiagnosis, and increased incidences of hospitalization. Children are sometimes tasked with interpreting for their families at medical appointments, which can be particularly challenging and stressful for a child. Not only is this detrimental to health outcomes, all of this leads to increased payer costs. However, evidence indicates that increased access to interpretation services improves patient satisfaction, adherence, shortens admissions, and reduces likelihood of adverse events. Recent policy changes in our Medicaid-- our state Medicaid program have demonstrated the need to specifically require that language access be covered. This will provide certainty and consistency in the language access reimbursement policies that will benefit both patients and providers. In 2022, a change was made to at least one Managed Care Organization's policy that left providers and patients in a scramble.

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This bill will require coverage and ensure stability and consistency across our Managed Care Organization's practices, which is important for both patients and providers. The bill provides necessary support to our state Medicaid providers, which can help address our Medicaid workforce shortage. This bill also directs DHHS to maximize federal Medicaid funding, which is available to cover many costs associated with the changes required by this bill. Enhanced federal funding may be available for language services provided to specific populations like children and the Medicaid expansion group. Additionally, other states provide, other states provide Medicaid coverage for language services in a variety of ways. For example, Iowa and Minnesota have reimbursement models where providers seek reimbursement from Managed Care Organizations or the state Medicaid program directly. Understanding that language access is a crucial part of healthcare continues to gain traction across the country. I am also submitting an amendment to LB62, AM644 adds language stating that Medicaid may reimburse providers directly. This is to reflect the intent of the bill to ensure that providers are able to utilize the appropriate interpretation services they need to provide for a particular type of care being provided. As you will hear from providers, coverage alone may not allow for the patchwork of translation services they already use especially smaller providers and rural providers, thus the language to reimburse providers. There is a fiscal impact, but the Fiscal Office calculations are different than the department's calculations. The difference is due mostly to the percentage of federal amounts-- match in the calculations. The narrative in the fiscal note fully explains the calculations. I'm going to pause on my written testimony here. So the big discrepancy between the two fiscal notes is child language services, because we are reimbursed at a different rate. And so that would actually lower-- increase the FMAP for child language services so we would get an increased federal match on that side, which is why our fiscal is lower. The department didn't take into consideration the calculation of the full population that this would be serving. It just assumed an adult population. So that's why the two fiscal notes are a little bit different. As you know, I love a good fiscal note.

RIEPE: Yes, thank you.

M. CAVANAUGH: LB62 with AM644 improves access to healthcare and outcomes, leads to reduced healthcare costs, and provides certainty to Nebraskans. I urge the committee to support and advance LB62. I'd

be happy to answer any questions that you have. I will note that the AM644 as we know the start of session was a mad dash with the drafting and introduction of bills and inadvertently language that I had intended to be included was removed during the Bill Drafting process. So this is just putting that language back in to give a more complete picture of the intention of the bill. And with that, I will take any questions.

HANSEN: All right. Thank you for that opening. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman Hansen. And thank you, my fiscal hawk friend. One of the questions, I do have a concern, this has a substantial fiscal note on it.

M. CAVANAUGH: It does.

RIEPE: And so I'm trying to look and say, what did we do before?

M. CAVANAUGH: So that's an excellent question. I don't know what we were doing before, necessarily. I will say, yes, this has a substantial fiscal cost to it. And as we have had some robust conversations about how we're spending our tax dollars and these kind of programs, this will impact our rural healthcare more than anybody else, because they have to, especially places like in-- not that Grand Island is rural, but Grand Island has a large not-- English not as a first language speaking population. And so having these, these more-- more and more of these populations in our rural communities where English is not the first spoken language and getting that medical care, they are, they're seeking, they're getting translation services, but they're just not getting reimbursed for them. So that's just one of the many things if we're chipping away at the financial problems for our rural healthcare, this is just another way to help chip away at that.

RIEPE: May I have another?

HANSEN: Yes.

RIEPE: I don't want to get in the weeds too far, but we used to use what we called the "blue phones" and you'd get a translator.

M. CAVANAUGH: Was that bat phone?

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RIEPE: I'm not sure exactly what the terminology was, but we used those four years very effectively and it's a very cost-effective way to get-- we didn't have to do it in person. We didn't have to do it with high tech other than a telephone--

M. CAVANAUGH: Sure.

RIEPE: --the blue phone, and we were able to because we had a clinic at, at the Creighton site, which, you know, was more of an inner city and so we had more bilingual issues, if you will. And my other follow-up question on that would be is, is this a federal mandate that requires state participation?

M. CAVANAUGH: Well, it's not a federal mandate because we don't have to do it.

RIEPE: Oh, I thought we did. I thought I read someplace that--

M. CAVANAUGH: The bill, the bill-- the, the, the state fiscal note calls this bill a mandate, which I like to remind everyone that laws, which we're law lawmakers, are also sometimes described as mandates. This law would require the Medicaid program to do something. So if you want to call a law a mandate, which is totally fine, but this is curr--

RIEPE: I would think if it's a law, it's a mandate.

M. CAVANAUGH: It is, but it currently is not mandated.

RIEPE: Oh, OK.

M. CAVANAUGH: And that-- this would be us, you and I and 47 other folks, deciding that we wanted to mandate it.

RIEPE: OK. Because my other comment, if I may, sir,--

HANSEN: Um-hum.

RIEPE: --is, and I have a note here that says since 2018, Nebraska has signed on virtually every opportunity to expand Medicaid and along with it, its associated cost.

M. CAVANAUGH: So this is where you--

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RIEPE: I would take a moment to give some-- my own lecture opinion on that, but I will spare you and the testifiers here that moment of expression.

M. CAVANAUGH: This is, this is where you and I are going to have to get together outside of this building and have a long chat, because I think we-- this is where Senator Riepe and Senator Machaela Cavanaugh diverge in our opinions, is that I am a firm believer in drawing down all federal funds available to us. And so I, I like, I like drawing down our federal Medicaid funds. But that said, I do think that there are some times where we can find common ground on that when it helps reinforce our medical community in some of the lower income parts of the state.

RIEPE: And I vehemently respect and honor your right to be wrong.

M. CAVANAUGH: I-- ditto.

RIEPE: Oh, is that allowable, sir? OK.

HANSEN: Yes.

RIEPE: Thank you very much. Thank you for testifying.

M. CAVANAUGH: Thank you.

HANSEN: For everybody here new to the HHS committee, this banter is not uncommon and it's entertaining sometimes.

RIEPE: Sometimes.

M. CAVANAUGH: Sometimes.

HANSEN: Yeah. I have a question. Maybe a couple questions.

M. CAVANAUGH: Yes.

HANSEN: My-- I would assume-- my personal definition of translation and interpretation services are communication from one person to another where there's a language barrier. Is that pretty much correct?

M. CAVANAUGH: I would like to say yes, but I'm not an expert. I will say that this was brought to me--

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HANSEN: OK.

M. CAVANAUGH: --and so I'm not-- this is not something that I have become extremely well versed in, but that seems correct to me, but maybe there will be somebody that can answer it or I'll come back and answer it for you.

HANSEN: OK. And I'm, I'm trying to figure out, like-- because that-- this helps me get an idea of what we mean, like, what we're trying to do.

M. CAVANAUGH: Um-hum.

HANSEN: I know in my office, whenever we have a language barrier, I just have Google translate, and that works great. So why don't we just give everybody Google Translate because that covers every language service or is it-- I know it's not personal--

M. CAVANAUGH: Right.

HANSEN: --but that's how I-- we, typically, communicate then.

M. CAVANAUGH: So that, that is a really good question and the reason, I, I think that that can serve an appropriate purpose. But as Senator Riepe was discussing the blue phone and I think that-- I don't know exactly the mechanisms for how this is implemented currently across the state, but I imagine the blue phone still exists. Some of this is probably done via telehealth, especially in our more rural areas where it's hard to get a person in person. But that, that ability to translate medical terminology and cultural competency is why an automated service just wouldn't work.

HANSEN: Gotcha.

M. CAVANAUGH: It'd be-- in that particular instance, having the child would probably actually be better.

HANSEN: OK.

M. CAVANAUGH: Not that that's a good solution, but, but, yeah.

HANSEN: OK. All right. Well, thank you for that. Appreciate that. Any other questions? Not seeing any, we'll see you at close.

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M. CAVANAUGH: I will stay here for closing.

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

ANDY HALE: Chairman Hansen, members of the Health and-- let me start again. Chairman Hansen and members of the Health and Human Services Committee, my name is Andy Hale, A-n-d-y H-a-l-e, and I'm vice president of Advocacy for the Nebraska Hospital Association, and I'm here to testify in support of LB62. Offering patient access to medical, medical interpreters can help healthcare organizations achieve multiple goals, ranging from delivering competent care to avoiding legal or regulatory noncompliance issues. Medical interpreters bridge the gap when patients and providers do not speak the same language. A provider is only as good as they are interpreted. Approximately 18,000 Nebraskans on Medicaid have limited English-language proficiency, and just over 4,000 have some sort of difficulty hearing, that is 5.75 percent of the total Medicaid population in Nebraska that would qualify for these services. While the practice of healthcare interpretation has grown over the past couple of decades with advances in technology, the field still faces significant challenges related to the reimbursement of those services by insurers. Hospitals and health systems that receive federal funds are required to provide free interpretation services under the Title IX, the Civil Rights Act, but neither Medicaid nor Medicare are required to reimburse providers for those services. As a result, healthcare entities are often responsible for covering the full cost of medical interpreter services. One of our bigger systems provided language services bill that they spent last year for around $800,000. Another of one of our bigger systems estimated they spent $3 million last year. A significant portion, if not all of this, was not reimbursed through Medicaid or Medicare. Uncompensated services increase the total cost of care for all patients. And I think you've heard myself and many of my colleagues from the Hospital Association talk about how dire of a financial situation hospitals are and so this only furthers the burden. I would like to thank Senator Cavanaugh for introducing LB62, and I'd ask the committee to advance the bill. One of the things, Senator Hansen, if I could say briefly before taking questions is the way I remember it is an interpreter is interpreting what you and I are talking about in person, and a translator oftentimes is translating what is a written document to that individual as well, if that makes sense. So an interpreter is person to person. As well as Google, oftentimes I've been caught in

that trap using Google as my sources and not on-- not always what we see or hear on the Internet is true and reliable. Also, when you do something like that, I don't know if, if all of you feel secure enough that you're not being watched from Jeff Bezos or Zuckerberg or any of those and so there are some HIPAA issues with compliance. As far as, Senator Riepe, your question with the olden days when we used to call the operators, yet that at times are still in use, but there is still a cost associated whenever we're picking up that phone and using those. So with that, I'll take any questions.

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

RIEPE: Of course. Thank you. And as providers, we eat those cost. That was cost of doing business. And I, I still think that maybe they are-- they functioned, they functioned well at the time. My question is this, though, now. Most of the hospitals are charitable organizations, is that fair to say?

ANDY HALE: All of our hospitals are nonprofits. Correct.

RIEPE: Nonprofits or not for profit.

ANDY HALE: Not for profit.

RIEPE: Thank you.

ANDY HALE: Thank you.

RIEPE: And you also require to have a community service report on an annual basis, I believe.

ANDY HALE: Correct. The community benefits report that we print out that is required by federal law that shows exactly where we're giving this money back to the community.

RIEPE: So we can help you out by having you pick up the tab on this instead of the state. You can put that on-- list that in your community report.

ANDY HALE: I would assure you it would go with several other pages of charitable contributions we make across the state.

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RIEPE: OK. The other thing-- and this is-- and I will give you an opportunity to respond to this. You know, having a person have to match up with when the appointment is, is extremely inefficient to get the, the interpreter in there at the same time the patient's in there and on a, and on a personal basis. I think whether it's Google, whether it's the blue phones, or whether it's video, the manpower, having a person, assuming you can get someone an interpreter to meet your needs is a very, very expensive option as composed-- as compared to a more technical option.

ANDY HALE: I would agree with that--

RIEPE: Thank you.

ANDY HALE: --and we are mandated federally to provide these services.

RIEPE: Yeah, well, we could get into a long discussion on that. The federal government's good on mandating things but not coughing up the money, if you will, or coughing up their full share, but they impose upon us all these other costs. So I'm, I'm a little-- I'm not offended at you, I'm offended at the federal government for the way they approach things.

ANDY HALE: We--

RIEPE: And I am a strong opponent to a national health insurance so I'd get that on the record, too. Thank you, Mr. Chairman.

ANDY HALE: If I could comment,--

RIEPE: Oh, well, I don't know.

ANDY HALE: --Senator Riepe and, and Chairman, I, I would agree with you on that where there are several unfunded, unfunded mandates that the government puts on us. But just to your question as well, yes, it is difficult having an individual be actually in the room. But with technology changes and, and the way that we use tablets and other things, especially in our rural parts of the community, it's, it's impossible to have somebody be there. And so we're utilizing all of those technologies to, to alleviate that problem of having that individual. Ideally, that would be the perfect situation. But at the end of the day, there's still a cost to providing those services. I know that you've done so much work on telehealth with primary care

when you were back in your first term and you understand that but the way the reimbursement rates, whether it's telehealth in general, there's always a cost associated with doing these.

RIEPE: Mr. Chairman.

HANSEN: Yes. Yep.

RIEPE: Is there any opportunity we could contract with Amazon to do this?

ANDY HALE: I do not know that. But if, if, if there's any way we can do it to where it's, it's not coming on the backs of our hospitals, we would be more than happy to sit down with anyone.

RIEPE: But part of my concern gets to be is when you look at fiscal year '24-25, and it's fundamentally $4 million, project that out for ten years and, you know, that's-- it gets to be a lot of money and gets to be one of the mandates that is very difficult to claw back.

ANDY HALE: I would agree with you.

RIEPE: And that's one of the challenges we face in healthcare.

ANDY HALE: Yeah, absolutely. Absolutely.

RIEPE: And I still appreciate you coming here and taking my abuse. Thank you.

ANDY HALE: Anytime, Senator. Anytime.

RIEPE: Anytime? Thank you.

HANSEN: Yes, Senator Hardin.

HARDIN: I happen to have a company that does international travel medical, so there are about 7,000 languages spoken on the earth. Can you narrow that down for us in terms of which languages are most pertinent to our needs here in Nebraska or can you kind of give us a top four or something like that?

ANDY HALE: I-- obviously, Spanish would be. And then depending on, on the population and where you go, I think it differs. Again, for our urban systems, as, as Senator Riepe alluded to earlier, you're going

to have different languages and, and different requirements. Don't quote me on this, Senator Hardin, but I thought at one point we were required to have all of our documents that need to be, be displayed in signs in 15 different languages, but I, I could look for that to see what our top four, but I would imagine it would vary by, by population and, and by demographic.

HARDIN: If we were just to at least start somewhere of those 15, if we were to do Spanish, for example, do you know what percentage of those 18,000 who need that help that might take care of?

ANDY HALE: I do not. I based-- I did some research coming in last week and then I did some-- if you look at the fiscal note, they did a pretty good job of defining who it was. I don't know if they broke down exactly, again, that, that language or the demographic, but who that population is on Medicaid that, that needs to be served.

HARDIN: OK. I didn't see that breakdown in there. But I'm just wondering if we can somehow divide and conquer.

ANDY HALE: Sure. I appreciate any, any solution we can get through this.

HARDIN: And additionally, I happen to know for a fact there are third-party organizations out there that can provide these types of HIPAA-oriented services. We use them.

ANDY HALE: Send them our way.

HARDIN: We shall talk.

ANDY HALE: Thank you, Senator.

HANSEN: Any other questions from the committee? I might have just a couple here. Who else besides hospitals will be eligible for this? Is a pretty much anybody offering Medicaid services?

ANDY HALE: That I don't know. I think you might have to ask Senator Cavanaugh or if anyone else is going to--

HANSEN: OK. And how many hospitals now already provide this service?

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ANDY HALE: All of them provide interpretations. We are required to do so.

HANSEN: Is it, is it under the ADA?

ANDY HALE: Yeah.

HANSEN: OK.

ANDY HALE: Well, under Title IX of the Civil Rights Act. If you receive federal funds, hospitals and health systems is where I got that language, you are required to provide free interpreter--

HANSEN: OK, I thought, I thought they--

ANDY HALE: --services not to-- yep, it could be as well.

HANSEN: OK. OK. I think that's all I had. Yeah. Any other questions? All right. Seeing none, thank you very much.

ANDY HALE: Thank you, Senator.

HANSEN: Take the next testifier in support of LB62. Welcome.

LESLIE SPRY: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Leslie Spry, L-e-s-l-i-e, Spry, S-p-r-y, and I'm testifying, testifying in support of LB62 on behalf of the Nebraska Medical Association. I'm a kidney guy here in Lincoln, and I have previously served as a member of the Nebraska State Board of Health, as well as the president of the Nebraska Medical Association. Nebraska Medical Association supports Senator Cavanaugh's bill, LB62, which would require coverage for necessary translation and interpretation services under the Medical Assistance Act. These services are important as communication is foundational to the physician-patient relationship. Medical providers need to be able to understand their patients' needs, and patients need to understand the treatment options and recommendations that we are making. Title VI of the Civil Rights Act or-- and other federal requirements under OCR are mandates for Medicaid and CHIP providers to provide appropriate language services available to patients. And I think there was a question about where this came from and it came from the OCR Act, but it, it identified specifically physicians as contractors to Medicare. And so we became under this, but prior to

that, we weren't under that, but about 15 years ago we came under that act as a result of being called contractors rather than providers. And we have to supply appropriate language services available to patients with limited English proficiency. However, without a requirement for those programs to reimburse providers for interpretation services, physicians and other healthcare providers are left with the bill. This can be a costly service for providers. When in-person translation services are necessary, the fiscal note for LB62 estimates the cost at $195 per visit. And that's-- I have personal experience with that. We have used the blue phone. We have used Face Time. We have used-- we are currently using AT&T services. Never used Google because Google just does it one word at a time and usually comes up with garbage that you can't understand. So at least that's been my experience, especially when you're talking to folks in the office. Telephone and video services, maybe $30 to $40 for just a 15-minute session. If the patient has a last-minute change of plans or misses an appointment, interpreter still has to be paid when they show up. In primary care settings, physicians may take financial loss for treating patients who need translation services. This is increasingly difficult in this area-- era of inflation and overall reimbursement rates that have not kept up with our costs. Reimbursement for these necessary interpretation services will reduce financial strain on physicians and healthcare facilities and promote good care. Ultimately, good interpretation services can reduce cost by helping patients understand what their providers are asking them and telling them, which increases compliance with treatment recommendations and avoids repeat visits. These are the reasons that the Nebraska Medical Association encourages your support for LB62. Thank you for your time and I'm happy to answer any questions.

HANSEN: All right. Thank you for your testimony. Are there any questions from the committee? I always look here first because I know the questions are coming from over here. Are there any questions?

RIEPE: You're looking at the empty chair, but, no, there are no questions.

HANSEN: All right. Good. From my understanding, they do make devices. And I'm just curious about, like, in this, in this tech-savvy world that we got here, I would think there'd be some kind of device or technological invention that would be able to accomplish what we're

trying to do here and much more cost-effective means as opposed to having--

LESLIE SPRY: Well, now Google services doesn't do all languages, and we have some very unusual. We have Houthi in our dialysis unit. We have Arabic. We have, we, we have a number of different languages, Iranian, which I believe is-- I mean, so there, there's a number of different languages that we have to, to translate for. And it's difficult. Now, AT&T has, has come the closest because I think they have-- I'm going to remember 138 different languages available that allow us to, you know, ask for specific translators and for specific languages and, and dialects, for example.

HANSEN: OK.

LESLIE SPRY: Yeah, but we tried Google and neither the person I was talking to or I understood what this device was trying to tell me.

HANSEN: Because I know they got some-- it almost looks like a little-- size of a remote control on an iPod. That, that dates me probably.

LESLIE SPRY: OK. Could be.

HANSEN: Yeah, that's-- and, and you, and you can pick the language you want, they have like over 40 or 50 different languages and you can-- they speak into it, it interprets it, and vice versa. You know what I mean?

LESLIE SPRY: Oh, I said, we tried-- I know we tried Google. And that was awful.

HANSEN: OK.

LESLIE SPRY: My experience with Google was awful. The blue phone was pretty good, but then the blue phone went away. AT&T is the closest thing we have to that right now. And I must admit, I don't know the cost of that right now, but again, I'm pretty sure it was like 138 different languages that we were told of that, that they could translate.

HANSEN: OK. All right. Any other questions just to make sure? Not seeing any, thank you very much. Take the next testifier in support. Welcome.

KRISTEN RODRIGUEZ: Good afternoon, Chairperson Hansen and members of the Health and, Health and Human Services Committee. My name is Kristen Rodriguez, K-r-i-s-t-e-n R-o-d-r-i-g-u-e-z, and I'm testifying on behalf of Heartland Family Service in support of LB62 and we would like to extend our great appreciation to Senator Cavanaugh for bringing this bill and any potential amendments forward. Founded in Omaha in 1875, Heartland Family Service, as you can read, provides a plethora of services to a number of-- large number of individuals in the, the local area of east central Nebraska and southwest Iowa. The vast majority of Heartland Family Service's clients are Medicaid beneficiaries who already are experiencing a multitude of barriers in their lives to include with language. As service providers, part of our role is to promote equity and reduce barriers to care for those seeking services from us. We can't and won't turn clients away. Due to Medicaid systems, a client with Medicaid in need of translation services has less access to care in our services, in our-- excuse me, have less access to care in our services than a client not in need of translation services. This is a huge equity issue and often leaves Heartland Family Service in a position where we're obliged to utilize other translation and interpreter services at our own expense. Requiring Medicaid to reimburse for interpretation and translation for all behavioral health services is worthy and the right thing to do. It will make an impact for our clients and for us as an agency. At the same time, from our perspective, this requirement would only solve part of the access and equity barriers clients experience and, thus, HFS would still find ourselves in a position where we need to pay out of pocket for translation and, and interpretation services on behalf of our clients. A few examples here: Medicaid translation services have to be scheduled in advance, which means that a Medicaid beneficiary is only able to utilize any-- is not able to utilize any open access or same day services which are considered to be best practices at this point in time. It's an equity issue. Currently, MCOs are not required to and will not cover translation and, and interpreter-- excuse me. I'm sorry. I keep having to say that over and over and I'm getting a little tongue-tied.

HANSEN: Like, during an interpretation of language,--

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KRISTEN RODRIGUEZ: Yes.

HANSEN: --but also having the hardest time.

KRISTEN RODRIGUEZ: Yes, my apologies.

HANSEN: That's all right.

KRISTEN RODRIGUEZ: Anyways, the MCOs are not required to and will not cover these services for clients participating in residential treatment. Due to the number of hours needed over time, these costs for translation services are very high and if not paid they pose both access and equity issues for our clients. We at one point at Heartland Family Service had an individual who-- whose first language is sign language, and for the average length of stay is six months. And if you think about residential and a therapeutic community, someone who needs to be able to communicate with peers and clinical providers for about 30 hours a day, that was over $32,000 worth of translation services that needed to be paid for. Medicaid translation and interpretation services are difficult to set up and the services provided can be inconsistent making it problematic for us to use these services. Translation services set up through Medicaid often no show for appointments leaving, leaving Heartland and the client with no way to communicate for a service. Additionally, sometimes the translators show up to the wrong locations. It's important to know for those of you who have already asked the questions, Chairperson Hansen and Senator Riepe, that the use of call-in translation services are often inadequate and very impersonal for those who are most in need of them. I'm sure you can all imagine having really personal conversations with someone and having to talk to somewhere out there in the abyss or something on the Internet and going through something very difficult in your life and, and having to kind of do that. It's-- it doesn't feel right. It doesn't feel nice for the person who's having to share and do really difficult, often clinical work in order to kind of get them over the hump in their lives. You know, I'm sure many of you would, would prefer to actually have an interpreter sitting in person. Body language is also very important clinically as well. Sorry. I'm having a few technical difficulties here today. My apologies. Thank you for bearing with me. For these reasons, Heartland often pays out of pocket for translation and interpretation services on behalf of our clients. Companies we contract with, an hour of translation services can cost us anywhere

from $30 to $90 an hour, which adds to our already underfunded loss for providing these services. Over the span of treatment rendered for a client, especially in residential with financial burden, the financial burden of these costs are significant, unjust, and greatly impact our bottom line financially. We urge you to bear this financial burden in mind as you also consider the plethora of other examples of rate and reimbursement struggles that HFS and other agencies like ours endure across the board. For our financial, for our financial survival as an agency, we not only need Medicaid to be required to cover translation services but also for agencies to be reimbursed for translation and interpretation services so that we can uphold the needs and best practices, access, and equity on behalf of our clients, the people who live in, in the state. Please pass LB62 out of committee and consider any amendments in support of reimbursement alongside with that. Thank you for your time.

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

RIEPE: Thank you, Chairman. You noted the importance of the face-to-face and I, I want to give you one and, and ask you to respond to it because it's my understanding that telemarketing-- tele-- telehealth has been extremely successful in mental health, and particularly for youngsters who don't necessarily want to share their concern with an adult, but they're willing to share in a video conference. And so I would kind of go counter to the idea that you do need to have face-to-face to have a relationship.

KRISTEN RODRIGUEZ: So I think both to answer your question. I think that there are some generational impacts here. We have a population of people who really technology is not their thing. We also have a lot of young folks who, who that, that works for. I think some of the difficulties with essentially a, a telehealth platform is really the expense of also ensuring that it's HIPAA compliant. You know, there are a lot of platforms out there, but they cost money. And so we, we do explore those things and we use those opportunities whenever we can. Arguably, you know, something like FaceTime or something face-to-face, a telehealth thing, is in some ways also clinical because it does give us some information about how a client would be presenting. A lot of time someone who's struggling in their life also struggles with their, their hygiene, their presentation. Those are, are realities for the people that we're working with. And so that,

that clinical information for the people who are providing those services is, is really important, which is why as much as possible as we can have at a bare minimum the, the visual if it's not going to be in person is, is really vital to, to us being able to provide proper treatment and, and services.

RIEPE: My response to that would be is because we've had telehealth for a number of years, the HIPAA issue is fundamentally resolved, might be isolated cases. I think on the technology basis, I think that technology for a variety of ages is, is, is not a barrier. In fact, is in mental health it's been an advantage and it's been more productive than it has with face-to-face so there's some-- I would take some issue with some of your points.

KRISTEN RODRIGUEZ: And that's fine, but I also need to remind you that Heartland Family Service is an agency who primarily works with folks who, who have no means. So one thing I think that we do need to consider is privilege. Often, our folks do not have phones or do not have Internet or the capability to even participate in a venue like that.

RIEPE: OK. I have no more questions. Sir, thank you. Thank you.

HANSEN: I, I have one question.

KRISTEN RODRIGUEZ: Sure.

HANSEN: Are there any-- I don't know, not companies but, like, nonprofits or other industries that exist that help provide for this cost or provide for this service free of charge or a reduced cost, do you know?

KRISTEN RODRIGUEZ: Not that I'm aware of.

HANSEN: Just out of curiosity sake because I don't know either.

KRISTEN RODRIGUEZ: Yeah. Yeah. I, I mean, we've, we've yet to find them. If anybody has any ideas, we're, we're open to them. At times, you know, we, we do make an effort, particularly in, in residential, to explore other opportunities of, of funding. You know, is the person or the, the entity who's providing the referral willing to help with some of these costs. But it's, it's not a requirement for them either so it really-- it puts us in a bind.

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HANSEN: OK. Thank you.

KRISTEN RODRIGUEZ: Um-hum.

HANSEN: All right. Seeing no other questions, thank you for your testimony.

KRISTEN RODRIGUEZ: Thank you.

HANSEN: Anybody else wishing to testify in support of LB62? Welcome.

MEGAN WATSON: Hello, my name is Dr. Megan Watson, M-e-g-a-n W-a-t-s-o-n. Thank you for your time. I feel like I'm really low. Is this normal? Sorry.

HANSEN: Yeah, it's a weird chair.

MEGAN WATSON: OK. I appreciate your time here today. I'm going to talk as a provider, so hopefully I can shed some light to some of the questions that have been asked or the concerns. I want to just take a minute to talk about what happened last year when the changes occurred. So we used to bill under code T1013. That's how we paid our interpreters when we did our work. So I'm a psychologist, I'll start with that. So I work in mental health, I'm in private practice. And so last year, we had no communication. We had no idea that this code that we have used for many years to pay our interpreter-- interpreters was going to not be, not be reimbursed any more. So there were a lot of interpreters who didn't get paid. There was, there was a mad scramble. We just were told by our billing agency that it was no longer being reimbursed. We had no idea that was happening, no communication, no idea what to do with-- I have a fairly large refugee caseload so I wasn't sure what to do. Clients were really upset, I was really upset, trying to figure out-- it took us weeks to figure out what was happening, why we weren't being reimbursed and what to do differently. When we were told what to do differently, we were told to call beforehand, you know, schedule this appointment, and then either someone would show up or, or we would be on the phone with an interpreter that we didn't know. In my work and the work that I do, these relationships are really important. The phone, it doesn't work for us, right? I have refugees coming in to talk about some of the most difficult things that you can imagine and trust is huge, rapport is huge. So the interpreters that I work with,

they are trained in mental health, they are reliable and consistent, you will hear from one today who is really good, and we, we establish a relationship together, a safe place to talk about these really difficult things. And these interpreters also understand the work that we do, the timing and pacing in terms of sharing this information in the room, talking about these difficult things, talking about the interventions, describing coping mechanisms, how to debrief, how to ground these kind of things. And the interpreters know those things and can help me communicate that to provide the best care. You know, I want you to imagine going to your therapist every week, I hope you do because everyone should go to their therapist every week, and taking a stranger with you or calling a stranger and sharing all of these things with someone you've never met, you have no idea. These are people who, again, highly traumatized population. There's a lot of really understandable paranoia because of what they've been through. And so that's a really scary scenario and so a lot of my clients wouldn't do it. They won't do it. They, they had formed these relationships, this atmosphere that they felt safe in and don't feel comfortable using the stranger on a phone or a stranger that was sent. You know, we do lots of body work and, and lots of-- it's really important that I'm able to describe what it is that we're doing, that they're able to tell me what they've been through. And a lot of times with the phone line, it's the wrong dialect. The person on the other phone, they don't show up, the call drops or they leave early. This is super detrimental to care. So as I'm, I'm helping them kind of process these things, if that call drops and we're just staring at each other, it's really harmful. And I'm left kind of not knowing how to help or what to do to, to get this person in a good place. It's really important that I can trust what this person is saying to me and that they can-- I can trust that what I'm saying to them is getting through to them. So with the trained interpreters that I utilize, I can trust that. I can trust that that's going through and that, that I am providing good care and appropriate care. The gold standard of care in mental health and working with refugees is, is to have face and face-- face-to-face interpretation in the room. That is what we are trained to do in terms of our gold standard. And until last year, that's what we were able to do. I think those are the main points. I'm happy to take any questions.

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HANSEN: Thank you for, thank you for that. Are there any questions? Yes, Senator Riepe.

RIEPE: Thank you. My question would be this is on a, whatever a typical patience is, say, to refugees, how many visits would they have in, say, six months? Like, is it a weekly visit, twice weekly?

MEGAN WATSON: It's usually weekly visits. Sometimes depending on the, the, the case, of course, it might be more depending on what the presenting issues are and how severe that case is. The majority of, like, my refugee population I see on a weekly or biweekly basis.

RIEPE: OK.

MEGAN WATSON: It also depends on things like transportation and, and ability and things like that. But, yeah.

RIEPE: What's the length of a session?

MEGAN WATSON: Generally speaking, it's a 45-minute session.

RIEPE: Forty-five minute session?

MEGAN WATSON: Yep.

RIEPE: I'm just doing the math here where the math--

MEGAN WATSON: Absolutely.

RIEPE: --based on the fiscal note says--

MEGAN WATSON: Sure.

RIEPE: --it's $97.50 an hour or--

MEGAN WATSON: I will tell you what we will reimburse for that code, but--

RIEPE: So that's, that's about $195 per visit.

MEGAN WATSON: But that's not what, what was being paid. That, that code, T1013, that's, that was the code we used to pay the interpreter. So for a 45-minute session, that interpreter was getting paid, I think, $28.

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RIEPE: OK.

MEGAN WATSON: So that's what Medicaid reimbursed.

RIEPE: Well, that's a far cry from what fiscal note is talking about here.

MEGAN WATSON: I don't know. It might be different in-- outside of behavioral health, I can tell you that is what was true for us in behavioral health. That was what was happening before.

RIEPE: At least it's broken down on an hourly basis.

MEGAN WATSON: We-- yeah, typically do a 45-minute session. It was broken down-- the units of that code is being broken down into 15-minute units.

RIEPE: OK. Thank you. Thank you, Chair.

HANSEN: Any other questions from the committee? I think he was touching on a couple questions maybe I had. I think they did the fiscal note, maybe Senator Cavanaugh can correct me later, per claim. I think they did so to figure out the fiscal note. On average, the cost per claim was $50.42. So for a two-hour session might be somewhat close to that.

MEGAN WATSON: Yeah. Yeah.

HANSEN: Another question is if we started covering this-- actually, let me preface it with one other thing.

MEGAN WATSON: Yes.

HANSEN: Do you always use in-person interpretation?

MEGAN WATSON: Always.

HANSEN: And because I'm wondering now if we cover this, some people might-- because according to the fiscal note, they-- they're using in-person telephone video. If we start covering this, I would think everybody would want in-person now since we're paying for it. So what's the likelihood, and I'm thinking, OK, how many interpreters

are there out there and that's going to make it much more difficult to kind of--

MEGAN WATSON: Sure.

HANSEN: --facilitate the process of getting them there--

MEGAN WATSON: Sure.

HANSEN: --and then-- well, then would their cost go up, because now it's a supply and demand issue? For other people who are not Medicaid covered, you know, I mean, services now, instead of $100-- $97 an hour, it goes up to $150. You know, I'm kind of figuring out, like, how that works and-- because once the government starts paying for stuff, it's amazing how, how the dynamics and things kind of change.

MEGAN WATSON: Sure. Yeah. I, I can certainly understand those concerns. The fiscal concerns, of course, aren't mine. Right?

HANSEN: Well, they kind of are if they're taxpayer dollars.

MEGAN WATSON: Sure. Well, they are, but I, I am still totally in favor of that because we can't provide good care. So what's the point of sending someone to appointments where they don't understand what happened, aren't actually getting better. Right? I mean, if, if we're talking about providing good care and helping people to get better, it needs to be good care. This is good care. If, if you're not providing good care, that feels like a waste of money.

HANSEN: And, and my personal opinion, I think you're correct. I think if you can have an in-person translator, I think it's better than pretty much anything else you can have. It's just trying to figure out the logistics of it all. Any other questions from the committee? All right. Seeing none, thank you.

MEGAN WATSON: Thank you.

HANSEN: We'll take our next testifier in support. Welcome.

SAMIA AHMED ABDEL MAWLA: Hi. Good afternoon, members of the Health and Human Services Committee. My name is Samia Ahmed Abdel Mawla. This is spelled S-a-m-i-a A-h-m-e-d A-b-d-e-l M-a-w-l-a. I have worked as Arabic interpreter since 2004 with LanguageLinc and I am

Middle Eastern community advocate at the Asian Community and Cultural Center in Lincoln. I am representing myself in support of LB62. I have noticed lots of changes and differences with interpretations since I have-- I, I first started working about 18 years ago. Over the years, medical offices have started to cut down using interpretation on-site and instead they started using over the phone and video services. For example, I used to do in-person interpretation for everything started from lab work to deliveries and surgeries. But now I no longer do this. Most recently, Medicaid stopped paying for interpretation at mental health therapy appointments. Mental health interpretation is very important for refugees, and I used to do lots of that work. I have refugee clients who have suicidal thoughts. Some are a survivor of genocide and war. They are alone for the first time in our country with a different language, culture, and no support, and the need to talk to a medical professional. They are sometimes in crisis because Medicaid stopped reimbursing in-person interpretation and no longer receive the care they need. Most of my clients quit going to therapists because medical provide-- providers require over the phone interpreters. This type of interpretation service is not always the best for my clients and people in our community. For example, there are many Arabic accent and dialects. Iraqi people do not understand Sudanese people and the opposite. So I have heard from my clients who ask for an Arabic interpreter, but they don't understand their interpreter, even if their interpreter understands them. This delays the help or the times that the clients are able to receive medical assistance and for providers to help their client. Also, it is important to remember that the culture is different for my clients. It is uncomfortable for a Muslim woman to call the language line and talk to a male interpreter about her personal issues, especially if it's in delivery. This can also be an issue as we worry about privacy. Lincoln is very small community, so clients are worried about interpreters who might talk about their patients in the community. Thus, interpreters may be different every time, and we would like to use the same interpreters that they feel comfortable with and trust. Sometimes these interpreters can be unreliable or may not be telling the doctor all the, all the issues the client is having and people are not satisfied with this kind of interpretation, but they don't have a way to tell their providers that. I have had clients who tell me that their interpreters are brief with them over the phone and they don't have the English language skills to tell their doctors

these things. It also makes me wonder if they pay for interpreters through that language line then why not use an in-person interpreter that the clients choose and reimburse them through Medicaid? Immigrants and refugees in Nebraska are not getting the help they need. I ask that you please vote yes for LB62 to help interpreters like me support our community. Thank you so much.

HANSEN: Thank you. Are there any questions from the committee? All right. Seeing none, thank you very much. Take our next testifier in support of LB62. Welcome.

CHRIS TONNIGES: Yeah. Good afternoon, Chairman Hansen, members of the Health and Human Services Committee. My name is Chris Tonniges, C-h-r-i-s T-o-n-n-i-g-e-s, appearing before you today as president and CEO of Lutheran Family Services and a proud member of NABHO, the Nebraska Association of Behavioral Health Organizations, in support of LB62 and the coverage of translation interpretation services under the medical assistance program. Lutheran Family Services is grateful for the Legislature's commitment to the overall mental and physical health of the people of the great state of Nebraska. As you know, the ability to access care is critical in the mental and physical health success of individuals that we serve. According to the Nebraska Language and Limited English Proficiency Report Card in 2021 from the Department of Health and Human Services Division of Public Health, Office of Health Disparities and Health Equity, there are over 133,000 foreign-born residents in the state of Nebraska who represent 7 percent of the population. Of those individuals, where English is not the primary language spoken in the home, there are roughly 33,000 households that are non-Spanish speakers where languages like Vietnamese, Mandarin, Somali, Nepali are the primary, if not the only language spoken. This has grown in the last several years due to our refugee resettlement work to include Farsi, Pashto, Ukrainian, and even Russian. Lutheran Family Services currently serves corporate and individual clients with over 60 languages through our Global Language Solutions program, offering translation and interpretation services on a fee-for-service basis. We were proud to assist Governor Ricketts' administration with the services to distribute information during the COVID crisis. While many organizations partner with our program, we have found that very few of those that serve individuals at or below the poverty line, and particularly those in the nonprofit space, utilize our services because of the already daunting task of providing quality services within the reimbursement structure that

exists today. We believe that this bill will allow for additional access to much needed services, remove barriers for those which English is their second, third, or maybe even fourth language, and provide for greater outcomes for all Nebraskans. LB62 is about removing barriers for those Nebraskans who seek assistance with navigating daily life in the United States. This small investment will allow people to thrive in our great state and provide much needed funding through small acts of meeting people where they are to have the greatest impact. LFS recommends the Health and Human Services Committee advance LB62 that moves the state in the direction of implementing a comprehensive plan that focuses on all Nebraskans and focused on the long-term outcomes.

HARDIN: Thank you.

CHRIS TONNIGES: Yeah.

HARDIN: Any questions? Seeing none, thank you.

CHRIS TONNIGES: You're welcome.

HARDIN: Anyone else in support of LB62? Welcome.

MARK HANKLA: Hello, my name is Mark Hankla, M-a-r-k H-a-n-k-l-a. I'm a LIMHP level therapist in private practice who works with many clients covered by Medicaid. And my experience with this issue came working with Yazidi clients, very horribly traumatized and, and-- people and some of them, of course, were brought into the United States out of their refugee camps. Many of them do not have formal education, cannot read or write, and do not speak English. They have limited resources, so they couldn't pay for interpreters. However, in order to do therapy with them, certainly they need an interpreter. This was possible up until a year or so ago as insureds provided a mechanism to have an interpreter who was paid by providers who were then reimbursed through Medicaid. And that worked very well for, for months for us. And one thing about that is that we were actually able to get an interpreter from that community that knew them and knew their, their language very well and their customs and all of those things. So-- and-- but that all ended when claims for interpreter services became just rejected. First, we were told they were not covered by Medicaid, but that wasn't the end of it. Working with insurance agents, we supposedly found out the claims were being

rejected because they were not coded correctly. So they, they did some back pay on, on rejected claims and we went forward again thinking the problems were ironed out, but then they again stopped payment on interpreters service claims. And we thought that once again they would kind of fix this and figure it out so we kept on seeing some of these clients, but then eventually it just became quite clear that we're not going to pay. And then they told us all sorts of reasons why they were not-- Medicaid does not, does not reimburse for that. And, and that left with some cases, you know, for providers, interpreters, thousands of dollars of unpaid fees that we were just out of it. And the only way it is possible in an effective, ethical manner to do therapy with this population is to have professional interpreters who understand and abide by confidentiality rules who are familiar with the therapeutic process. Many of these people rely on their children who have learned English to help them interpret and function in their day-to-day lives. However, in many cases it would be very inappropriate and ineffective to have those family members or even sometimes neighbors interpreting during therapy sessions. And as providers-- we as providers are contracted, you know, by Medicaid to provide a service and it made no rational sense for us. We couldn't afford to pay for those interpreters out of our, you know, what we're reimbursed. But that's what we were being told we had to do. And so, you know, very few providers, I, I think, could afford that. And, and we, we just can't accept those terms in order to do this kind of work. I mean, I understand that, you know, people who work for insurance payers is, you know, they're, they are kind of tasked with ways to try to control costs, save money, and not necessarily be centered on, you know, what's best for the people or the customers. And that's the way it's always been and that's the way it'll probably always be. And I'm sure they have a tough job and pressures to control costs. However, you know, it would be imperative for, for this-- I guess, therefore, it would be imperative for this bill to really spell out specifically how interpreter services are to be provided. Because right now if you ask them, they will say we, we do provide interpreters. You have to call, you know, their number and, and then, you know, get somebody on the end of the telephone. But that's, that's very difficult that-- from what we've heard from other providers who do use that service that you can't really schedule, like, consistent therapy sessions. It may take 15 or 20 minutes to find somebody. And then, and then you have a voice on the end of the line. And that's just isn't really conducive to doing this

kind of work. So, so, I guess, with that, I, I hope that something can be done. And I, and I do want to, to make it clear that I think the, the very language of how this is going to be done will be extremely important.

HARDIN: Well, thank you. Questions? Can I ask a few?

MARK HANKLA: Yes.

HARDIN: How many, how many folks did you have the opportunity to work with before it became evident that it didn't seem like there was a financial way forward?

MARK HANKLA: I was seeing five of these Yazidi clients.

HARDIN: OK.

MARK HANKLA: Again, if you're familiar with what they went through, the ISIS had attacked them when they lived in Iraq and they-- in their own homeland, basically.

HARDIN: Yes.

MARK HANKLA: And they were massacred. And, you know, the women and girls were taken, you know, hostage or, or, or sex slaves or just killed outright, all these kind of things, but--

HARDIN: Where were you able to find someone in Lincoln or Omaha?

MARK HANKLA: Yeah, we, we had an interpreter who was-- actually came from their community.

HARDIN: OK.

MARK HANKLA: And it was possible for them to be-- I don't know if they were credentialed or whatever by Medicaid that, you know, they were allowed to be reimbursed and, and we paid them and then we were, we were reimbursed from the--

HARDIN: Before this experience, did you have other situations, perhaps with other languages, that were similar? Did you have other kinds of challenges?

MARK HANKLA: This was my first experience with using interpreters.

HARDIN: I see.

MARK HANKLA: So like I say, this is-- that's how it played out for us. I was brought a number of these people because they were so horribly traumatized that the people they had been seeing felt they, they weren't able to give them that level of care.

HARDIN: Gotcha.

MARK HANKLA: And so in our practice, we specialize in trauma disorders. And, and so they brought them to us. And then I-- like I said, I had five of them who felt they couldn't function at all because they were living in constant flashbacks and panic and all sorts of things.

HARDIN: Understood. Thank you. Any other questions? Seeing none, thank you.

MARK HANKLA: Thank you.

HANSEN: Welcome back.

ALEX DWORAK: Good afternoon again, Senators. My name is Alex Dworak, A-l-e-x D-w-o-r-a-k. It is my honor to come before the HHS Committee again in support of this bill. I'm not speaking on behalf of any organization. My thanks to Senator Cavanaugh for introducing it. As a primary care physician who's dedicated his career to the care of the underserved, this is near and dear to my heart. I'm able to speak fluently and competently with my Spanish-speaking patients, whether it's asking if abuelito is catching any fish at Halleck Park in Papillion or having heavy discussions about cancer or dialysis. My blunt grandfather chastised me for not taking Greek or Latin in high school like a smart kid would, but choosing Spanish, quote, like the dummies did. However, that choice in high school, along with following my beliefs to the Dominican Republic in college, have indelibly marked my career. I don't speak any Czech, French or Italian, the languages of my ancestors, but I could order dinner and drinks or start a bar fight with what I've learned of Russian and German too. I cannot tell you how many times I've had adult patients and even fellow medical practitioners recount for me how they were needed to serve as interpreters for family members. For several coworkers, that is what their impetus was to get into medicine. Many

clinics and hospitals will provide interpretive services, which I do believe is a Title III ADA requirement, but I can attest this doesn't always happen. Having a dependent child interpret for a parent is exactly as problematic and prone to bad outcomes as you might expect. Having a spouse interpret is also laden with problems too. Right now, clinics must either choose to hire bilingual providers and staff like me, recruit and retain professional, bilingual and bicultural interpreters who can pick up on the nuances that the language and just the words might miss or rely on an expensive telephone interpretive services for which they are not compensated. I was texting with some coworkers at the FQHC where I work in Omaha. We spent $170,000 on this in fiscal year 2022. That is with pretty universally Spanish-speaking staff, nurses, doctors that we have worked very hard to recruit and retain. That's just for other languages. And it also does not include our Karen-speaking, bilingual, bicultural interpreter that we've hired or any community people who are doing this as volunteers. We're seeing a lot of Karen-speaking refugees from Myanmar. Other languages include Spanish, Russian, Kanjobal, Arabic-- or Arabic, Mandarin, French, Nepali, Karen and Vietnamese. Those are the top ones. I, for one, haven't had the free time to learn Karen in my forties just yet. Maybe in the next couple of years. Recent immigrants such as these folks are more likely to be on Medicaid, which is already not accepted by many private clinics because of poor reimbursement, thus they come to a place like our FQHC. Adding an extra time and financial burden makes it even harder for good healthcare to happen for these people despite their embodying the famous phrase at the bottom of the Statue of Liberty. Ensuring coverage for quality interpretive services for all people will lead to better individual and public health outcomes. By keeping immigrants healthier and better able to be entrepreneurs and laborers and pursue the American dream, it will also be a good long-term economic investment. Thank you very much for your time. I hope I've answered some of the questions that I heard come up during others' testimony, but I'm glad to take any others that any of you may have.

HANSEN: Thank you. Are there any questions from the committee? All right, seeing none, thank you very much. We'll take our next testifier in support. Welcome.

CARLIE JONAS: Hi. Good afternoon. My name is Carlie Jonas. I'm, I'm testifying on behalf of the Center for Rural Affairs. Medicaid

providers are required to provide translation services and interpretation services to clients as needed. The federal government offers cost-sharing reimbursement for these services at a rate of 60 percent, with the state covering 40 percent. However, there is no mandate for states to use these federal funds. This often leaves providers with no option but to eat the costs of making these services accessible to their patients. This is especially disadvantageous for rural clinics who do not have the budgets to cover these excess costs. To fill the translation gaps, often these clinics turn to family members, including children, bilingual staff who take time away from their regular responsibilities to provide translation or free online tools like Google Translate, which are not 100 percent accurate and result in more confusion and frustration for patients and providers. There has been a growth in immigrant populations in Nebraska's rural communities, particularly from Latin America. Cost of living and job opportunities bring them to these communities. However, these jobs are often low paying and do not provide employer-sponsored health insurance. So individuals and families rely on Medicaid to receive healthcare. Translation services can be expensive, especially for rural clinics that already struggle due to low reimbursement and staffing shortages. Some providers may lose money too. Physicians are reimbursed by Medicaid roughly $30 to $50 per office visit, while translation services can cost $35 to $90 per hour and sometimes more, depending on the service being used. LB62 would provide these clinics with much-needed reimbursement and they will be able to more effectively provide quality care to their patients who have limited English proficiency. Nebraska needs to opt in to receiving federal funds for translation services. Patients having access to translation services is associated with better health outcomes. If these services are not available, there are additional costs that can be avoided when a patient is unable to effectively communicate with their doctors, unnecessary tests and treatments may be given. Patients may also utilize urgent care and emergency rooms because they are not able to get effective treatment or wait to seek treatment for illness or injuries because of the language barrier that comes with making an appointment with the primary care provider. When these services are accessible, accessible, patients have a better understanding of their diagnosis, are better able to follow their treatment plans and have better understanding of information and test results and are able to

schedule appointments. Yeah, so we hope that you vote to pass this bill out of committee.

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

CARLIE JONAS: Thank you.

HANSEN: Anybody else wishing to testify in support of LB62?

SARAH MARESH: Hello, Chairperson Hansen and members of the Health and Human Services Committee. My name is Sarah Maresh. That's S-a-r-a-h M-a-r-e-s-h and I'm the health care access program director at Nebraska Appleseed testifying in support of LB62 on behalf of Appleseed. We're a nonprofit legal advocacy organization that fights for justice and opportunity for all Nebraskans. And one of our core priorities is working to ensure that all Nebraskans can access quality, affordable care. And a key part of that mission is ensuring folks have access to equitable healthcare as well. This bill requires Nebraska Medicaid to cover language services and to maximize federal funding in implementing this requirement. Because this bill can improve healthcare, healthcare outcomes, provide certainty and reduce disparities, Nebraska Appleseed supports this bill. Along with my testimony today, we're also handing out a fact sheet with some important information as well on there. Our organization has heard from people across Nebraska about the need for improved access and established language access requirements in the Nebraska Medicaid program. Data shows that language access is needed all across our state. Eighty-five Nebraska counties have limited English proficiency residents. Language access is a critical part of ensuring quality healthcare, as you've heard today. Language barriers impact healthcare at nearly every single stage individuals act with the healthcare system. People with LEP disproportionately experience poor health outcomes and statuses. Recent Nebraska-specific data also demonstrates this. The 2020 health disparities report showed that compared to proficient English speakers, LEP Nebraskans were almost 2.5 times more likely to perceive their health status as fair or poor, 1.8 times more likely to have ever had a heart attack and more likely to feel that their physical health was not good in ten of the last 30 days. Miscommunication caused by language barriers can lead to worse chronic disease management and increased hospitalizations. This bill also addresses urgent needs in our Nebraska Medicaid

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program. First, as you've heard today, abrupt changes surrounding Nebraska and Medicaid's interpretation reimbursement policies that took place last year demonstrates the need to require language access services be covered. This will provide certainty and consistency across managed care organizations, which will benefit both enrollees and providers. This bill's focus on improving language access in Medicaid is also particularly important because individuals with LEP make up a disproportionate share of the Medicaid enrollees. Finally, improved language access can also reduce healthcare costs for payers like the Nebraska Medicaid program by doing things like reducing diagnostic issues and improving patient compliance. While state Medicaid programs are not required by federal law to reimburse for interpretation services, as you know, they can seek federal matching funds for covering these services. At least 14 states have covered language services in their Medicaid programs in a variety of ways, including Iowa. Enhanced federal matching funds are also available for children and potentially the Medicaid expansion population as well. Nebraska Appleseed is committed to ensuring that all Nebraskans can access quality healthcare. And therefore, we support this bill and encourage you to do so. And I heard some technical questions come up early and we'd be happy to answer any of those as well.

HANSEN: Thank you. Are there any questions from the committee? I might have one question. So when did Iowa start doing this?

SARAH MARESH: Yeah, I could pull the exact facts up for you on when Iowa started doing this, but I think it was a number of years ago. But they have a reimbursement model where providers can be directly reimbursed.

HANSEN: OK.

SARAH MARESH: So similar to what's proposed here.

HANSEN: I'd be curious to see if their-- what it costs them is comparable to the fiscal note.

SARAH MARESH: Yeah, that's a good question. There is a good report cited in the fiscal note on the first page of that that goes through each of the 14 states and what their approach is and actually does have, like, a pull-out of what it costs each state.

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HANSEN: OK.

SARAH MARESH: So that would be a helpful-- yeah-- resources to check out.

HANSEN: Cool. Thank you.

SARAH MARESH: Yeah.

HANSEN: All right. Seeing no other questions, thank you.

SARAH MARESH: All right. Thank you.

HANSEN: We'll take our next testifier in support. Welcome.

SCOUT RICHTERS: Hi. My name is Scout Richters, S-c-o-u-t R-i-c-h-t-e-r-s, here on behalf of the ACLU of Nebraska in support of LB62. We want to thank Senator Cavanaugh for introducing this legislation. Everyone deserves to access healthcare meaningfully and without interruption. This includes the ability to communicate with their provider. As you've heard, behavioral and mental health services are impossible to provide if they're not adequate language interpretation services available between the patient and the provider. Again, as you've heard, many of those who are affected by the lack of reimbursement are immigrants and refugees who have experienced tragedy and trauma. Mental healthcare is essential for these folks to navigate their grief and trauma amid everyday life. We've heard that providers are willing and equipped to provide this care but cannot serve this population without reliable and professional language interpretation services. When these services are not also covered, providers are not able to provide the care at all due to the high cost of covering the language services themselves. And then one item I wanted to note from hearing the testimony was just to reiterate that Google Translate or other apps or technologies are simply not a replacement for live interpretation. Google can't recognize idioms or words that have different meanings or cultural context and, and really shouldn't be considered a substitute for live interpretation services. So with that, I would urge the committee to advance LB62.

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

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SCOUT RICHTERS: Thank you.

HANSEN: Anybody, anybody else wishing to testify in support of LB62? We got one more maybe? Welcome.

JACOB CARMICHAEL: Thank you. Sorry, I don't have a written copy. I wasn't originally planning on testifying on this bill. My name is Jacob Carmichael, J-a-c-o-b C-a-r-m-i-c-h-a-e-l, and I am here today in support of LB62. This feels like a kind of common-sense bill. I hope this passes this committee unanimously, but I kind of want to address some things. I just graduated. My degree is in linguistics and this is an industry that is needed. I was in New York during the COVID crisis, especially at the beginning. And at all of the clinics, the need for this type of resource was incredible. The lack of translators and the lack of funding for that type of thing limited access to English speakers and Spanish speakers in the most diverse city in the world at the moment and cut off care to a significant portion of the population. Providing funding provides equal access. That's a principle that we should be adhering to. That's mentioned on the Statue of Liberty. It's mentioned in numerous, numerous seminal American documents. And healthcare is-- I mean, this is the HHS Committee. I don't think I need to reiterate how important healthcare is to the life, liberty and the pursuit of happiness or any other important phrases that we want to use. Relying on online translation services are definitely not perfect, as I have worked on a number of them. We don't have predictive AI models that are good at translating idioms or especially translating more minor languages that just don't have the resources. And especially dealing with refugees or people from smaller countries without access to languages like English, Spanish, French native or high-fluency capacity. There's not equal access. If you believe in the power of Google Translate, I invite you to do what I did in high school and run your Japanese through a Google Translate and back into English. It will not turn out well. And that's just the reality of the situation that we're living in. I'm blanking because this is my third testimony of nine today so it's a long day. But yeah, this is important. This is common sense. Yeah, that's really it. Thank you.

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

JACOB CARMICHAEL: Thank you.

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HANSEN: Anybody else wishing to testify in support? All right, seeing none, is there anybody who wishes to testify in opposition to LB62? Seeing none, is there anybody who wishes, wishes to testify in a neutral capacity to LB62? All right, so with that, we will welcome back up Senator Cavanaugh to close. And for the record, we did have some letters. We had 20 letters in support, two letters in opposition and one letter in a neutral capacity to LB62.

M. CAVANAUGH: Thank you, Chairman Hansen, members of the committee, everyone who came to testify. I kind of want to just, like, revel in this moment of no opposition to a bill that I brought this year, which is-- was really nice. OK. So I just want to address some of the, the themes of questions. This was something that was reimbursed through billing code. In 2017, there was-- our MCOs changed that that they were no longer going to reimburse through the billing code and that change became effective in 2021. So we were doing this previously and the MCOs and-- perhaps weren't required and so they decided as a cost savings, as we saw in another bill this year in this committee, that the MCOs made a change to save money. That didn't really work in favor of especially our rural healthcare systems. The fiscal note is-- I think would deserve a little bit more digging in on, on my end. I haven't had a chance to do as much on it as I would like, but I do think that it's-- well, first of all, it's not, it's not that full amount if you look at it, of course. It's the General Funds and then the federal funds. And so it is-- any amount of money, taxpayer money is important and we should be good stewards of, but it would be $726,000 for this fiscal year and then pretty much double that for moving forward $1.4 million out of General Funds. So the reimbursement rate, I think, was a common theme and question and it's still unclear to me. It seems like there was one reimbursement rate when they were doing this as a billing code. The department thinks that it would be a higher reimbursement rate. So maybe that's something that we can dig in on with the department and get an answer, a more clear answer on. But essentially the idea here is that this is something that we've heard from many of our providers and we have a provider that it's hard to have Medicaid patients and having Medicaid patients that do not have English as their first language and need perhaps a complicated or thera-- especially-- I didn't even think about the therapeutic side of things, but need therapy services, that that's going to, that is going to require something more ro-- a more robust sort of translation service. And

we're going to see a reduction in providers taking on these patients as a result and I don't think we want that. And we, of course, want to make sure that our providers that are taking these patients are not eating the costs. Although I liked your idea of philanthropy through our hospital system, but I would agree that there's probably quite a few things that we are already pushing upon our medical system that aren't being reimbursed. And so if we have an opportunity to reimburse this, I think that we should consider it. So with that, this was a long hearing, surprisingly so, and I appreciate it and I also appreciate that it was so positive.

HANSEN: All right.

M. CAVANAUGH: I'll take any comments.

HANSEN: On that positive note, is there any questions from the committee? All right, seeing none, thank you.

M. CAVANAUGH: All right, thank you.

HANSEN: All right, that will conclude our hearing on LB62 and we will open it up now for LB204. Welcome, Senator Riepe.

RIEPE: Thank you, Chairman Hansen and the committee members. And this is another issue of Medicaid. We're going to talk about it. For the record, my name is Merv Riepe and that's M-e-r-v, last name is Riepe and it's R-i-e-p-e. I represent District 12, which consists of southwest Omaha and the good folks of Ralston. I have introduced LB204 on behalf of the Nebraska Pharmacists Association. LB204 would direct the Department of Health and Human Services to establish an enhanced fee for service pharmacy dispensing fee reimbursement of $10.38 per prescription for pharmacies participating in the medical assistance program. That's Medicaid. To establish dispensing fees moving forward, LB204 further requires the department to administer a cost of dispensing survey to be completed by all medical assistance program participating pharmacies every two years. There are two primary components to pharmacy reimbursement under the Nebraska Medical Assistance Act. One component is the cost of the drug, with the second component involving the dispensing fee. LB204 only addresses the dispensing fee component of pharmacy Medicaid reimbursement. Prior to 2015, dispensing fees were determined by Nebraska Medicaid on a case-by-case basis. Pharmacies providing home

delivery unit dose packaging and other services received a higher dispensing fees. At that time, dispensing fees ranged from $3.25 to $5. In 2011, the last time the Medicaid dispensing fee rate for fee for service was updated, Nebraska Medicaid established a dispensing fee of $4.65 for all pharmacies. However, when managed care was implemented in 2014, a dispensing fee of $4.65 was required to be paid only to independent pharmacies providing services to fee-for-service patients. The managed care organizations were authorized to negotiate a lower prescription dispensing fee. LB204 is patterned after a law in Iowa, which established a dispensing fee of $10.38 in 2021 for all prescriptions to all pharmacies for Medicaid patients to cover the average cost of dispensing. The state of Iowa conducts surveys every two years in order to establish the new Medicaid dispensing fee. The last time the state of Nebraska conducted a Medicaid cost of dispensing survey occurred in 2008 using 2006 data. Despite reflecting an average cost of dispensing prescription in the amount of $10.18, the Medicaid dispensing fee rate for fee for service was established in the amount of $4.65 in 2011 and has not been modified since. The establishment of Medicaid provider rates are vitally important in a number of areas, including the dispensing fee payable to pharmacies. Of the approximately 460 pharmacies in Nebraska that-- we have a total of 60 independent community pharmacies have closed between 2010 and 2019, with 25 pharmacies closing during the last year for which is available in 2019. While the impact of these pharmacy closures is certainly detrimental in the rural parts of our state, they also adversely impact the low-income communities where a large portion of Medicaid recipients reside. LB204, through the establishment of the Medicare prescription drug dispensing fee based on recurring surveys of pharmacies, will more accurately reflect the average cost of dispensing a prescription in Nebraska, curb the decline in the number of pharmacies located throughout the state and enhance service and access to pharmacy services for-- services for Medicaid recipients. Thank you for your time and attention. I will take questions you may have.

HANSEN: All right. Thank you for your opening. Are there any questions from the committee? Senator Hardin.

RIEPE: Yes, sir.

HARDIN: So currently, through all those numbers, would a-- do we have a uniform amount that's currently being charged for the fee today?

RIEPE: I believe-- and there will be people that follow me that are clearly more knowledgeable, particularly about details, facts. But I, I want to say it's at $4.65. So it's a big jump from $4.65 to $10 and some.

HARDIN: Since 2008.

RIEPE: And that's reflected in the fiscal note if you've had a chance to look at it. It's, it's a big number. It's about $32 million, I think, in the, the fiscal year '24-25.

HARDIN: Yes.

RIEPE: Not a small amount. And I think it's a bit reflective of everything that we're seeing in Medicaid, whether it's the nursing homes or it's the-- every, every service that's being provided on Medicaid is suffering from personnel, having to-- a lot of cost increases and so our Medicaid costs are being asked to be increased substantially.

HARDIN: Thank you.

RIEPE: I wish I had a better answer for you.

HANSEN: All right. Well, I'm looking at the fiscal note here and I remember them telling me how much it was right now they're paying out per-- it says $3.18 per claim on average is to pharmacies. And they're looking to take it up $10.38. I don't know. That's just what I saw in the fiscal note. I'm sure something behind you will probably explain it.

RIEPE: OK.

HANSEN: I'm kind of a little bummed that Senator Cavanaugh isn't here to go over the fiscal note with you. This is, like, the one time.

RIEPE: Really, I'll brief her later.

HANSEN: All right.

RIEPE: Well, we have our fiscal caucus is what I might--

HANSEN: That's right.

RIEPE: The fiscal hawk caucus.

HANSEN: All right. Well, thank you and I'm assuming you're going to stay to close.

RIEPE: Absolutely.

HANSEN: All right. OK, so we'll take our first testifier in support of LB204. Welcome.

DAVID KOHLL: My name is David Kohll, D-a-v-i-d K-o-h-l-l. I'm a pharmacist and member of the Nebraska Pharmacists Association. My family owns Kohll's Pharmacy. We have nearly 200 employees and are celebrating our 75th year serving Nebraskans, including some of your own families. When I was in Creighton University Pharmacy School, it became my mission to learn as much as I could to provide Kohll's patients/customers with the best possible care, better than if they went anywhere else. I believe this has been accomplished. About two years ago, we started turning away some Nebraska Medicaid patient prescriptions when we realized the cost of the drug with the dispensing fee, the cost of the drug was greater than the amount in Nebraska Medicaid paid for the prescription. This doesn't even include the many other expenses, such as labor, supplies, utilities. This move totally pains me, but it will keep-- it will help prevent Kohll's from closing additional locations that serves a higher percentage of Medicaid patients. Across the river, we don't have to turn Iowa Medicaid patient prescriptions away from Kohll's Iowa pharmacy because Iowa's reimbursement, like the vast majority of most other states, is over 100 percent greater than Nebraska's. Most pharmacies in low-income Medicaid Nebraska communities/neighborhoods have closed; six I could think of in Omaha. These continued closures have impacted some who need medications the most. Many of these people have mental health diseases. This in turn increases expensive emergency healthcare services. When mental health diseases are not treated with medication, this results in more dangerous criminal activity. Left untreated, these people can be harmful to themselves and others. This, of course, significantly increases costs to Nebraska taxpayers. Just three hours ago, I was contacted by my staff

on how a Medicaid patient will get their medication since we won't fill it because it was a $70 loss. The patient lives at Sarpy County Telecare, a facility that gets court-ordered patients that have mental health diseases. Kohll's packages and monitors all medications for the 15 residents at Sarpy. I contacted the Nebraska Medicaid plan and they suggested I send the prescription to CVS and CVS Caremark manages the pharmacy network. CVS said they would send it to their mail-order facility, which would send out-- they'd send out in five to six days. Because of the timeliness, this solution won't help. Getting this bill passed will help keep the remaining pharmacies in low-income areas, provide excellent care to Medicaid recipients and save Nebraska taxpayers money. And I welcome any questions.

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

DAVID KOHLL: You're welcome.

HANSEN: We'll take our next testifier in support.

MARCIA MUETING: Good afternoon.

HANSEN: Welcome.

MARCIA MUETING: My name is Marcia Mueting. It's M-a-r-c-i-a M-u-e-t-i-n-g. Yes and my voice is very hoarse. I think my husband's prayers have been answered. I'm a pharmacist, I'm the CEO of the Nebraska Pharmacists Association and I'm a registered lobbyist as well for the NPA. The NPA represents pharmacy professionals across the state. Thanks to Senator Riepe for introducing LB204, which would reimburse the estimated cost to pharmacies for dispensing prescriptions to Nebraska Medicaid patients. The calculation of reimbursement, as Senator alluded to, is very complicated. It contains the two pieces: the cost of the drug plus a dispensing fee, which is supposed to cover the overhead labor, heat light, paper, vials, sacks, the-- all the things that go into providing a prescription to a patient. The reimbursement is based on the sum of the cost of the drug plus that dispensing fee. In recent years, the estimated cost of the drug has decreased to reflect an average of what pharmacies across the country pay for the drug. It is really important to note that whenever we pay off of an average, we are going to underpay some pharmacies and others will be pay is-- and

they will be paid less than their acquisition cost and others will be overpaid. In January 2008, a report was issued to Nebraska Medicaid on the provider's cost of dispensing and that determined that the cost to dispense prescriptions in Nebraska, based on 2006 data, was $10.18. And I'm, I'm so-- I'm still confused because Medicaid made the dispensing fee $4.65. When managed care was implemented in 2015, the dispensing fee of $4.65 was required to pay-- to be paid only to independent pharmacies and only on fee-for-service patients. And as, as a point of reference, there's only about 10 percent of the patients in Nebraska Medicaid that are in fee for service. Everybody else is in managed care. So what that means is-- and it even shows on the fiscal note-- only 1,500 claims are estimated to be reimbursed at the higher rate of $10.08, I believe-- ten, $10.02, excuse me. So the remaining 90 percent of the claims are being paid at an average dispensing fee of $3.18. The managed care organizations have been able to negotiate a lower rate with the pharmacies by their pharmacy benefit managers. However, the pharmacy owners tell me that the contracts are take it or leave it with no opportunity to negotiate whatsoever for a higher reimbursement. According to the fiscal note, the managed care organizations paid an average of $3.18, which is well below the cost to dispense based on a survey recently done in Iowa. The fiscal note actually really accurately depicts the underpayment to Nebraska pharmacies on Medicaid prescriptions. In 2022, the state of Nebraska received a settlement-- and that was the handout that I supplied to you-- of over $29 million from one of the three pharmacy benefit managers participating in managed care in Nebraska for overcharging the state for prescription medications. That's what the settlement is for. I provided you with a copy of the settlement. In other states, including Arkansas, Illinois, New Hampshire, Mississippi, Texas, Ohio, New Mexico and the state of Washington, similar lawsuits were filed. And these funds were actually distributed back to the pharmacies to reconcile the underpayment of the pharmacy claims. If the question is whether the state can afford to adequately pay pharmacies for dispensing prescriptions to Medicaid patients, the answer is yes if the overpayments to the pharmacy benefit managers and managed care organizations are discovered and distributed to the pharmacies instead. The incentive of LB204 is to require a dispensing fee of $10.38 on all prescriptions to all pharmacies on-- for Medicaid patients to cover the average cost of dispensing as determined by a survey. A survey hasn't been done since 2008 and it was used-- and it

was-- the data was from 2006. Pharmacies in Nebraska have not received an increase in reimbursement in 22 years, but they have received cuts to reimbursement on both the cost of the drug and the dispensing fee. These underpayments are having ripple effects, forcing pharmacies to close, decrease hours and-- decrease the number of hours they're open for business. Decreased staffing as well, which is impacting patient care and access. We're not requesting reimbursement for pharmacies to profit, but to break even and not to continue to lose money on each claim on the cost of the drug and the cost to dispense. The NPA would respectfully request that the committee advance LB204 for further discussion by the full Legislature.

HANSEN: Thank you. Are there any questions from the committee? I have one quick-- oh, sorry. Senator Ballard.

BALLARD: Go ahead, go ahead, Mr. Chairman.

HANSEN: Oh, no, you--

BALLARD: Oh, thank you. You talked a little about the survey in your testimony. Can you unpack that further? Like, what, what information will be included and then kind of caveat that, has-- does Iowa or any other state require a survey?

MARCIA MUETING: CMS does allow-- the, the Centers for Medicare, Medicare and Medicaid Services do allow a state to use a neighboring state if it's similar in composition for their dispensing fee. CMS-- I mean, the federal government would like very much for each state, I believe, to do their own cost of dispensing fee survey. The last time one was done in Nebraska was 2008 so we've been using Iowa's dispensing fee survey. It doesn't make any sense to me because, we-- well, Iowa's survey says the cost to dispense is $10 and whatever and we're paying pharmacies $4. I'm not really sure how that happened or why that happened. And I know that all if many of the Medicaid providers are coming to you asking for an increase in fees. But I will tell you that if anybody here has a real recollection of the last time pharmacy came and asked you for an increase in fees, I don't remember it. It's been a long, long time since we've had an increase.

BALLARD: OK.

*Indicates written testimony submitted prior to the public hearing in accordance with the Legislature's guidelines on ADA testimony

MARCIA MUETING: So we're using data. Iowa's law passed and it requires them to do a survey every two years.

BALLARD: OK and how long have they been conducting this survey? Or is it just recently?

MARCIA MUETING: It is just recently. I think two years ago--

BALLARD: OK.

MARCIA MUETING: --was the first survey and then most recently in 2022. So 2020, 2020 and perhaps in 2022. I'd have to double check to be sure.

BALLARD: OK. Thank you.

MARCIA MUETING: Um-hum.

HANSEN: Any other questions? All right. I'm trying to wrap my head around this here a little bit. So when somebody comes in for a prescription who's on Medicaid--

MARCIA MUETING: Right.

HANSEN: --the reimbursement of that is broken down into two parts; so for the medication itself and then the-- I got to make sure I get it right-- the dispensing fee.

MARCIA MUETING: Right.

HANSEN: Do you charge people who are not on Medicaid a dispensing fee?

MARCIA MUETING: The usual and customary cost is, is-- when, when Marcia's perfect pharmacy submits a claim to Medicaid, I submit what I would charge anybody. And you know, some, some pharmacies have the $4 prescription plan. Medicaid only pays $4. If your usual customer is below the calculated reimbursement, that's what you get paid. Pharmacies and other healthcare providers can't have a cost for cash patients versus a cost for insurance patients. That's not allowed. So, yes, the answer is on an-- on a typical prescription, there's a margin that you would want to achieve on maintenance medications that cost-- that dispensing fee might be lower. On an acute medication, it

might be higher. But typically they-- there is a certain amount of money above the cost of the prescription that you'd like to make to cover heat, light, water, power, labor, rent--

HANSEN: Yeah.

MARCIA MUETING: --and all of the things.

HANSEN: And is that-- you were saying that's pretty much the purpose of the dispensing fee that Medicaid-- is for labor.

MARCIA MUETING: Right, labor, the vial, the bag, the label. It's-- kind of seems silly, but, you know, some of those, those amber vials are $1. And if you're getting paid 75 cents for the prescription, you're already losing money.

HANSEN: OK.

MARCIA MUETING: So the labels, I think the last time I looked, they were 25 cents, 50 cents. But that's what the cost is, is. That, that dispensing fee is supposed to cover the cost to provide the medication to the patient.

HANSEN: OK. I'm just trying to think if there are any other services Medicaid provides that has that same breakdown for, like, medical services or dental or anything else where they have, OK, here's your charge for the service, but then here's the charge for the person's labor--

MARCIA MUETING: Yeah, I--

HANSEN: --that they have to do-- I'm kind of curious--

MARCIA MUETING: That I do not know.

HANSEN: --or if it's unique just for you.

MARCIA MUETING: I don't know the answer to that question.

HANSEN: That's all right.

MARCIA MUETING: I will tell you that, you know, when a pharmacy sends a prescription out the door, you have actually lost money on a

product. You lose money on the service and a lot of providers lose money on the service.

HANSEN: I would say most do.

MARCIA MUETING: But we've actually invested and it walks out the door and I have to pay the invoice on that, whether I get my cost paid for the medication or not, under Medicaid.

HANSEN: OK.

MARCIA MUETING: Does that make sense?

HANSEN: Yes. OK.

MARCIA MUETING: So in the past, it kind of balanced out, the dispensing fee and then the amount that they were reimbursing for the cost of the drug. But now we're really have ratcheted that down to the nitty-gritty cost--

HANSEN: OK.

MARCIA MUETING: --of, of what it's costing pharmacies to purchase that drug.

HANSEN: OK. All right. Thank you.

MARCIA MUETING: Yes.

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

MARCIA MUETING: Yes, thanks for the opportunity,

HANSEN: We'll take our next testifier in support of LB204. Welcome.

RICH OTTO: Good afternoon, Chairman Hansen, members of the Health and Human Services Committee. I'm Rich Otto, R-i-c-h O-t-t-o, testifying in support of LB204 on behalf of the Nebraska Retail Federation and the Nebraska Grocery Industry Association. We do thank Senator Riepe for bringing this. As Marcia with NPA has alluded to, we do need to look at the dispense, dispensing fee and then also the survey model that Iowa has implemented. We fully support both those aspects. We do want to increase that. I do want to go into the survey a little bit

more. That is one of the pieces that we do want to touch on a little bit. We are concerned a little bit about the data and the language in the bill to potentially protect that data. I have reached out to NPA and also Senator Riepe's staff on that. I don't necessarily have the ideal language, but when we're looking at page 2, lines 22 to 23, it does have language to keep that information confidential. We would like to see that language potentially be stronger, ideally restricting the use of the data gathered to only the cost of dispensing study and then also potentially excluding the disclosure of that information under the state's Freedom of Information Act. Those are just something that we would want to consider. I know we have members that do business in Iowa are comfortable with the survey, survey and the data that's in that. I can get more details about that survey for you, Senator Ballard, so that you're comfortable with that. But we do want to protect that information in it. Again, as previous testifiers touched on, $3.18 is what 90 percent of the prescriptions are at and then only 10 percent are at that $10.02 level. It does need to be increased. And with that, I'll be happy to answer any questions you may have.

HANSEN: Thank you. Any questions from the committee? Seeing none, thank you. We'll take our next testifier in support. Three for three today.

ALEX DWORAK: Good afternoon, again. Thank you, Chair Hansen, members of the HHS Committee. Thank you, Senator Riepe, for representing the 12th District and bringing this bill forward. I was also not planning to testify, but hearing my fellow testifiers and getting a better understanding, I could not help myself and I wanted to express the patient and clinician perspective. The pharmacy closures that were mentioned have affected me and my practice in south Omaha. One of the local pharmacies that had been there for a long, long time, recently closed due to some funding issues. And particularly for the Medicaid patients who form a large amount of the people I take care of, anything that impacts their quality of care and makes it harder for them to get care is a big deal. They already face a lot of barriers and are swimming upstream. And for us, somebody has Medicaid, that's great. We take care of everybody at my clinic, whether they have insurance or not. Also seeing Kohll's represented. They have provided a lot of care and assistance to many of my patients. I'm thinking of one in particular who is on Medicaid, has severe mental illness due to being horribly traumatized when he was a child, has smoked a lot

as a coping mechanism and now he has bad lung disease. He depends on "nebulized" treatments, which are currently on a national shortage and Kohll's near us has been working very hard as one of the only places that can get that for him. And so I think that if these people who are here to help my patients are saying that they need this help, I see how this impacts my patients and I want to support them. Marcia Mueting, if I'm remembering everything right, has also personally picked up the phone and helped me with some extremely complicated substance use disorder cases who were on Medicaid back before we had the PDMP, which Senator Sara Howard had introduced and I-- that was the last time I was here testifying before this year. When people who have shown that they're dedicated to getting patients what they need, are advocating for things, I want-- that resonates with me and I want to support them. I am also extremely confident that Senator Riepe is thinking through the finance-- financial aspects of this very carefully. As a clinician, I focus on what does the patient need and I'm thankful that somebody else has to worry about all the financial aspects. But it really just seems like something that, again, I couldn't help but voice my support for. Thank you so much.

HANSEN: Excuse me, could you--

ALEX DWORAK: And my-- A-l-e-x D-w-o-r-a-k.

HANSEN: There you go. Thank you. All right, any questions from the committee? Senator Ballard.

BALLARD: Thank you, Mr. Chairman. Thank you for being here, Doctor. Can you talk a little about the burden or the burden that some of your patients have to undergo to, to access a pharmacy?

ALEX DWORAK: For hours, I imagine. Yes, sir. Thank you for the question. Specifically for this bill with Medicaid, I think that there are pharmacies who already don't do a lot of work with durable medical equipment, which is something like, canes, braces, wheelchairs that many of my patients, especially those with disabilities, of course, need. For getting medications, that can be-- that's a daily struggle where-- I'm fortunate to work at a federally qualified health center where we have the 340B program. Medicines that can cost $300,000, $600,000 a month, we're often able to get for substantially less to the point where it's almost miraculous. For me, that is an indication that our healthcare system is broken, that we

have to go through these things. And for Medicaid, we often struggle-- and private insurance too. We often struggle with prior authorizations, which we don't have time for. I spent 30 minutes on the phone last Wednesday trying to get something approved for a patient to not try the-- a very similar medicine for the one that had just made her fall and break her finger. And I was told, no, try this thing that's exactly the same. And so they're going to-- and if somebody like me isn't foolish or-- enough to keep trying that and keep trying to knock over that windmill, the patient's just not going to get it. And so if the pharmacies that help provide these things and who are also on the other end of the line saying, hey, I think we could get this instead, hey, have you considered this, this I think would get covered when I'm three patients behind and, like, I just know what's correct. I don't know what the formula is and I don't have time to find out if they're asking for help. Again, they, they're there for me when I need them for my patients so I'm happy to be there for them in this small capacity.

BALLARD: Thank you for being here.

ALEX DWORAK: Thank you.

HANSEN: Any other questions from the committee? Seeing none, thank you. Anybody else wishing to testify in support of LB204? All right, seeing none. Is there anybody who wishes to testify in opposition to LB204?

KEVIN BAGLEY: Thank you. Good afternoon, Chairman Hansen, members of the Health and Human Services Committee. My name is Kevin Bagley, K-e-v-i-n B-a-g-l-e-y. I'm the Director of the Division of Medicaid and Long-Term Care within the Department of Health and Human Services. I'm here to testify in opposition to LB204, which would require an increase for all pharmacy dispensing fees to $10.38 in addition to placing additional administrative burden on the state and imposing an estimated fiscal impact of over $31 million annually. I would like to say we appreciate Senator Riepe's willingness to meet with us and, and hear out some of the concerns we have around the fiscal impact of the legislation. As we've heard, dispensing fees are meant to cover the costs of filling a prescription. So, for example, the pill bottle and packaging. In 2022, Nebraska Medicaid paid nearly $14 million in dispensing fees across more than 4 million filled prescriptions. These fees currently are negotiated between the

managed care organization and the pharmacy under the current contracts. The current reimbursement methodology reflects not only the pharmacy type, such as larger chains, independent or specialty pharmacies, but also the volume as well. This legislation would take that scalability away. Large chain pharmacies such as CVS, Walgreens or Walmart often have a negotiated dispensing fee of less than $1 per prescription, while smaller independent pharmacies can negotiate fees upwards of $4 or more per prescription. As, as we've heard, some of these numbers go around, that average of $3.19 is, is really that overall average. Each individual pharmacy is able to negotiate their own fee. The model allowing negotiation ensures that dispensing fees are built to reflect various pharmacies' economies of scale. If all dispensing fees are increased to $10.38, regardless of farmer-- pharmacy size, it could represent a substantive windfall for large chain pharmacies while doing relatively little for smaller independent pharmacies across the state. To avoid unnecessary spending, any legislation considering dispensing fees must allow for flexibility in how these fees are set based on the relative size of each pharmacy's operation. LB204 also requires the department to complete a cost of dispensing survey every two years. Data from other states that complete cost surveys annually every two years or even every three years show that these states frequently use contractors at a cost of approximately $75,000 per survey. DHHS would similarly need to hire a contractor for this effort, given the time sensitivity of the data collected through these surveys. Appreciate the opportunity to testify today. I am happy to answer any questions the committee has.

HANSEN: All right, thank you. Any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you, Mr. Chairman. Thank you, Dr. Bagley--

KEVIN BAGLEY: Thank you.

M. CAVANAUGH: --for being here today. OK, I'm going to start with a statement. You have just stepped into my biggest pet peeve, which is I disagree fundamentally when state agencies come in opposition based on the fiscal impact because I do firmly believe that it is the role of the Legislature to determine how we are good stewards of taxpayer dollars. And I do firmly believe that it is the role of the agency in this dynamic to come in and tell us if what we're trying to do, what

we're trying to direct you to do is feasible, if there are things that we need to do differently and language changes. And so while I appreciate that you too are a good steward of taxpayer dollars, what I'm not seeing in your testimony today is are there technical complications with this bill? Is it difficult for you and your department to do your job effectively not based on the, the fiscal side of it, but just the practical side of it? So are there problems with how this bill is written for you to do your job? And if there are, are there solutions to those problems?

KEVIN BAGLEY: So, Senator Cavanaugh, I'm going to push back a little bit.

M. CAVANAUGH: That's fine. I said it was my pet peeve.

KEVIN BAGLEY: That's OK. I appreciate that. I would say in this case, my, my opposition is more rooted in the notion that we need to have scalability.

M. CAVANAUGH: OK.

KEVIN BAGLEY: And so, you know, I think as we look at this-- and I'm going to come up with some relatively fictitious numbers so I will caveat it with that. But if I pay, you know, my chain pharmacies, my large chain pharmacies, the Walmarts, Walgreens, CVS at, say, 50 cents-- or dispensing fee-- and they're willing to take that fee in negotiation with my managed care plans, forcing my plans to then pay $10.38 would take, based on some of the preliminary data I've looked at, probably two-thirds of this $30 million and put it toward those large chain pharmacies. And my opposition is not so much that we're spending that money. I agree the Legislature has the power of the purse.

M. CAVANAUGH: Thank you.

KEVIN BAGLEY: But I also think it's important for us as an agency to point out potentially problematic policy when we see it and so--

M. CAVANAUGH: Is it--

KEVIN BAGLEY: --my concern here is, is that we're not necessarily solving the underlying problem or if we are, we're doing it in a more expensive way than is necessary.

*Indicates written testimony submitted prior to the public hearing in accordance with the Legislature's guidelines on ADA testimony

M. CAVANAUGH: Well, I will say I am shocked by the large fiscal note of a Senator Riepe bill. But that said, is there an opportunity-- with that scalability question/problem, is there an opportunity to address that in a way that would bring off some of the opposition from this-- the agency?

KEVIN BAGLEY: So at the risk of stepping on another pet peeve, Senator, I, I think in this case, what I'd really like to be able to do is to sit down with a lot of our pharmacies around the state and really understand this better. I do think that there is an opportunity to do better, particularly for our rural, independent pharmacies. I can say, as I've met with members and providers around the state, particularly in rural parts of the state, it's important that they have the opportunity to talk with a pharmacist at those locations. That's more true, I think, for our Medicaid members than it is for a lot of other folks. But, you know, at the same time, I feel like this spends a considerable amount more money than maybe we need to solve the problem.

M. CAVANAUGH: OK. Thank you.

KEVIN BAGLEY: Yep.

HANSEN: Any other questions from the committee? You think you could answer that same question I asked earlier?

KEVIN BAGLEY: You may have to remind me of the question, Senator.

HANSEN: It's about other Medicaid rates that we pay other Medicaid providers that incorporate overhead.

KEVIN BAGLEY: Um-hum.

HANSEN: Is that usually how we determine rates? Like, I always thought it was, like, patient care, right? Like, a hospital provides patient care, but we're not paying for the lights to be on or staffing or do we? Is that incorporated in the total?

KEVIN BAGLEY: You know, it varies. So I'll, I'll say pharmacy is a very unique animal from a reimbursement standpoint. And, and for me to even try to go into how some of that reimbursement works on, say, the cost of drug side, we could be here hours and I'd probably still not give an accurate description. But I will say so on, on physician

fees, for example, those are typically based on what's called a relative value scale. And so, you know, in those cases, they will incorporate some of that potential overhead into that fee. So it really varies based on methodology. I will say, you know, depending on, on the nature of the service, there might be more or less overhead built in. But yeah, pharmacy is unique in that we are paying a separate fee for that.

HANSEN: OK.

KEVIN BAGLEY: But--

HANSEN: That's what I was wondering because I don't remember hearing that from anything else, so.

KEVIN BAGLEY: Yeah. Yeah, usually they would be baked into a rate elsewhere. In the case of pharmacy, they're, they're not.

HANSEN: OK. If you know, does the fiscal note incorporate redetermination that we're going to be, that we're going to be doing here next year too?

KEVIN BAGLEY: You know, I'm not 100 percent sure.

HANSEN: I didn't see it in here, but I just didn't know. Because I'm assuming then every year, it's going to be less because there will be less people on Medicaid so I didn't know.

KEVIN BAGLEY: So we do anticipate that there will be somewhere between 10 and 20 percent fewer enrollees by the time this unwind period is done. So 12 months from, from the start of April so it would be by May 1, 2024.

HANSEN: OK.

KEVIN BAGLEY: It's unclear how other factors will come into play around that time. I'm not sure if this takes into account that change either.

HANSEN: OK. I just-- yeah, I didn't know if the-- what they're using for their base number of participants in this that are going to be-- that they're using for the-- for their formulas. I just didn't see any-- anything different, so.

KEVIN BAGLEY: Yeah, I don't think it's called out explicitly on the fiscal note so I'm not sure.

HANSEN: OK. Would it be more appropriate when you're talking about-- OK, I can ask another question hopefully here a different way. So right now, I'm trying to figure out previous testimony compared to what you just told me. They're saying we-- Medicaid has not given them a rate increase in 20 years. But then in your, your testimony, it says it's negotiated between MCOs and the pharmacies. Or is that, is that, is that-- what am I-- it seems like--

KEVIN BAGLEY: Yeah.

HANSEN: --two different things.

KEVIN BAGLEY: Yeah. So a couple of things on that. On the, on the fee for service side, so these are cases where we're paying for a service wherein it's not incorporated into managed care. Relatively few claims come into that space. That's typically going to be where in the short amount of time it takes to get someone enrolled in a managed care plan after they've become eligible for Medicaid, if they have a pharmacy claim, then we would pay that fee for service. That fee for service dispensing fee is actually $10.02. And so we would pay that amount on a fee for service claim today. There's just relatively few. I think 1,500 or so was the-- what was noted in the fiscal note.

HANSEN: OK. Would it be easier or more appropriate to just-- instead of increasing, like, just the base or, like, we're going to pay this much more, do on a percentage basis?

KEVIN BAGLEY: You know, I, I don't know.

HANSEN: Is that what-- you were talking about that that won't affect, like, the large-scale operations if you go on percentage wise or, you know, if a certain percentage of-- the smaller ones will go up a certain percentage. I don't know if that would be more appropriate.

KEVIN BAGLEY: You know, it may. I think-- I would love to really dig into this more with pharmacies. I want to be careful not to comment on their financial situations because I'm not a pharmacist. I don't run a pharmacy and so I don't think I'm qualified to, to answer that.

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But I do think it's important from a policy standpoint that we maintain some scalability there.

HANSEN: Sure. OK. All right, thank you.

KEVIN BAGLEY: Yeah.

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

KEVIN BAGLEY: Thank you.

HANSEN: Anybody else wishing to testify in opposition to LB204? Anybody wishing to testify in a neutral capacity to LB204? All right, seeing none. We'll welcome Senator Riepe back up here to close.

RIEPE: Thank you, Chairman Hansen and all the members of the committee. I also want to thank all of those who were here today in support of at least this discussion and also to all of those who testified, including the opposition. I think it's good to have that kind of a healthy dialogue. I think part of this goes down to the geography of Nebraska, that we have the issue of access and it's more complicated when we get out of the urban centers in terms of the survivability of access, including pharmacies. I also have a concern. I know Dr. Bagley talked about the benefits of-- too much of the benefit of the compensation piece going to large pharmacies. And yet I come from a philosophy that what you want to do for one you need to do for all. It becomes discriminatory if you don't. I am concerned with that. I think a lot of this changed with the-- when the managed care organizations came in and they were-- we were paying fee for service prior to that. But most of the Medicaid then-- obviously the medical side of it went over to Medicaid. So that created a whole new complication for us in terms of for the small pharmacies that weren't necessarily under contract with managed care organizations. And I think we-- as I said, this is kind of a part of the challenges that we have in the delivery of healthcare, particularly outside of the urban centers and nursing homes, home healthcare, everything else that we have that's a challenge to us, even me, a fiscal conservative. So with that, I, I would take questions if you happen to have them.

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

RIEPE: Uh-oh.

M. CAVANAUGH: Thank you. Well, I missed your opening.

RIEPE: Oh, you should have been here.

M. CAVANAUGH: I'm sure it was, I'm sure it was one for the history books.

RIEPE: Well, maybe not, but OK.

M. CAVANAUGH: So I just-- I was surprised by such a large fiscal note from you, Senator Riepe. I thought you were more of a fiscal conservative than this.

RIEPE: Well, I'm a compassionate conservative.

M. CAVANAUGH: You are a compassionate conservative. That is--

RIEPE: Compassionate conservative.

M. CAVANAUGH: That's, that's a great classification there. Do you think that there's an opportunity to work on this with the department to find a solution to this problem that's clearly a problem?

RIEPE: Well, I think because there hasn't been a survey, there's been a lot of time to do this. So I see something at-- Cinderella at the, at the 11th hour, all of a sudden saying, you know, I would gladly pay you Tuesday for a hamburger today. I've used that before. So I'm reluctant to say, you know, where were you when the dance started? Where were you when this should have been talked about maybe 15 years ago, ten years ago, sometime ago? It should have been some stair-stepping to kind of keep this in sync. So--

M. CAVANAUGH: And that's--

RIEPE: --I don't like the idea of coming in and saying, OK, I want to delay it, therefore it's a veto.

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M. CAVANAUGH: Is that part of the issue is that this should have been happening over the course of time with, like, a cost of increase, etcetera?

RIEPE: Well, hindsight's always perfect. Yes, but that's not only true of this. It's true, as we know, of a lot of trying to keep Medicaid rates up to what's going on in the economy. And particularly the cost of healthcare and the pharmaceutical piece is-- one of my concerns on the pharmacy side is some of these significant pharmaceutical products that are coming out that are maybe for a, for a care is maybe $2,000. I saw one that was $28,000. And how do you, how do you, how do you not have a-- that was in some of our earlier testimony was equity.

M. CAVANAUGH: Um-hum.

RIEPE: How do you not give that same Alzheimer's drug or that same other drug to someone who's on a medicaid program that you might give it to the richest guy in Omaha?

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

RIEPE: It's a tough-- it's an ethical, tough, tough question. And healthcare makes it that much worse because as it was stated early, it's not a constitutional requirement, but it's a very high expectation. And of course, being from healthcare, if you don't have your healthcare, you can't do a whole lot else in life.

M. CAVANAUGH: I think people are going to ask that you be moved to not sit next to me anymore after this.

RIEPE: What?

M. CAVANAUGH: That people are not going to want you and I sitting next to each other anymore with these kind of statements.

RIEPE: I know. You're rubbing off for me.

HANSEN: I enjoy it.

RIEPE: Maybe I could request it. Reseating arrangement? Yes, sir.

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HARDIN: Since you're not sitting there, but sitting there, I'll ask the question I think you would have asked if you were sitting there.

RIEPE: Uh-oh. That could be dangerous. Go ahead.

HARDIN: Since two-thirds of this cost is federal, is there any danger that the federal costs may adjust and we're somehow left holding the bag at some undetermined point in the future? Sometimes those federal allotments go down, leaving you to make up the difference. And we've opposed that a few times with various bills this year, so.

RIEPE: Well, I think it's always a concern. It was a concern years ago when we resisted spending what we predicted to expand Medicaid-- it was $1 billion-- because we had reason to believe, particularly some in education, where the federal government had reneged on some of their payment promises. And so that was a concern that we made the commitment and then they waltz off to the side and we're held back. We were told by Senator Kathy Campbell, who was the chairman of the board, she told me on the floor one day she said, Well, if that's the case, Merv, we'll just, we'll just take away the Medic-- I said, you know, Senator Campbell, we both know takeaways/clawbacks are, if not impossible, they're awfully, awfully close. Once you give it, you-- it's hard to take it away. I'm sorry. That's human nature. That's true for all of us, I think. Sorry for the lecture, but.

HARDIN: Thanks.

HANSEN: Any other questions? Seeing none, thank you and that will close the hearing for--

RIEPE: Thank you.

HANSEN: --LB204.

DAY: Are we--

WALZ: Yes.

HANSEN: What? Yes, we will actually-- we're going to-- I don't really have a choice. We're actually going to take a very quick break just so we can actually stand up for two seconds for just ten minutes. So we're going to reconvene at five till 5:00.

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[BREAK]

HANSEN: OK, so now we will open up the hearing for LB179 and welcome Senator Fredrickson--

FREDRICKSON: Thank you.

HANSEN: --to open.

FREDRICKSON: All right.

HANSEN: Welcome.

FREDRICKSON: Good afternoon. Good early evening. Thank you, Chair Hansen and members of the Health and Human Services Committee. For the record, I'm John Fredrickson, J-o-h-n F-r-e-d-r-i-c-k-s-o-n. I represent District 20 in central west Omaha. I'm happy to be here today to introduce LB179, a bill that protects children by prohibiting medical professionals from conducting conversion therapy on minors. Conversion therapy is a deceptive practice that seeks to alter an individual's sexual orientation or gender identity. This practice deploys a variety of shaming, emotionally traumatic and even physically painful stimulation in its attempts to change a person's sexual orientation and gender identity. The research is clear that conversion therapy is not rooted in medical science. It is both unethical and it causes substantial harm. That is why 20 states currently prohibit conversion therapy, including Utah, Virginia, Colorado, Nevada, New Mexico and Maine. It's why the city of Lincoln has its own ban on conversion therapy. It's also why all the leading medical organizations, including the American Academy of Pediatrics, the American Psychiatric Association, the American Psychological Association and the American Medical Association have all denounced the practice. And it's also why many of the people who used to engage in conversion therapy have since apologized for the harm that they have caused with this discredited practice. I've passed out a document from Born Perfect, a survivor-led movement working to end conversion therapy, that includes the names of some of those who have renounced their previous association with the practice of conversion therapy. I know from my own experience as a mental health professional the damage conversion therapy has caused to young people. I can tell you it's heartbreaking. I have worked with survivors of conversion therapy in my private practice and it is

difficult to believe some of the stories I have heard. These survivors are left not only navigating the trauma they experienced in this deceptive practice, but also with the months or years of their lives spent in anguish as a result of this abusive practice. Data shows that LGBTQ youth are four times more likely to attempt suicide than their peers. In fact, 50 percent of LGBTQ youth in Nebraska have seriously considered suicide in the last year and 15 percent attempted suicide in that same time period, according to the Trevor Project. According to the same study, 61 percent of LGBTQ youth reported experiencing symptoms of depression, 10 percent of LGBTQ youth were threatened with conversion therapy and 7 percent in the state of Nebraska reported being subjected to conversion therapy. And I want to be really clear here: LGBTQ folks are not genetically predisposed to suicide. These harrowing statistics are the result of environmental factors, including societal stigma and shaming, such as that perpetuated through conversion therapy. It is worth noting that this bill only prohibits licensed healthcare professionals from providing conversion therapy. It explicitly states in the bill that this does not apply to a practice or treatment conducted by clergy members or religious counselors who are acting in a pastoral or religious capacity and not in the capacity of a healthcare professional. I also want to provide you with a brief overview of the legal landscape surrounding conversion therapy bans around the country. While it is true that the 11th Circuit Court has a preliminary injunction on the enforcement of conversion therapy bans, which apply to Alabama, Georgia and Florida, the 9th Circuit Court earlier this year refused to reconsider its earlier order upholding Washington state's ban on conversion therapy. State laws prohibiting conversion therapy are in effect in 20 states and also here in the city we currently sit in, Lincoln, as I stated earlier. So we are on solid legal ground and in good company in passing LB179. I also bring before you today AM145, a white-copy amendment to LB179 that clarifies definitions for sexual orientation conversion therapy and gender identity conversion therapy. This amendment adds clarity to these terms. I ask that you advance LB179 to the floor so that we can begin this deceptive practice in Nebraska. With that, I'll be happy to answer any questions you may have.

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

M. CAVANAUGH: Thank you. Thank you, Senator Fredrickson, for bringing this bill today. Just as we have in other hearings along lines of these topics, I just want to take a moment to say that anybody in this room or watching at home that needs this, you-- if you need help, please call 1-800-6-- 1-866-488-7486. You are not alone. You are loved. You're important and there are people here to help you. I appreciate you bringing this bill today and mentioning the Trevor Project. That number is for the Trevor Project, 866-488-7486. Thank you.

HANSEN: Senator Riepe.

RIEPE: Thank you, Chairman. Senator, thank you for being here. I have two questions-- or maybe one is a concern-- is I was a little bit surprised that, as you said, the bill does not plan to practice treatment conducted by clergy. I would think that the clergy would be more critical, if you will, or maybe even more inclined to try to do conversion than a professional psychologist would. I-- that, that surprised me. But you said that's been tested. The other part that I have-- and you can respond to this if you choose-- is overall, I, I have some concern about freedom of speech involved in the process. I don't know how that plays out.

FREDRICKSON: Yeah. I mean, to address your first part, I mean, the, the reason that we don't apply this to-- you know, to your point, this is strictly to healthcare professionals. And, and the reason that that is something that we are creating an exemption for, so to speak, for clergy members is that we don't want to regulate religious freedom. You know, if a religious organization decides to prioritize this as what they offer, then that's, that is their business. But this is really for, you know, to end a deceptive practice in terms of if you're a licensed healthcare professional and you're acting in the capacity of a healthcare professional, that we do not want to enable deceptive practices to, to occur in those settings. So it's in the best interest of the state for that.

RIEPE: Do you think they can separate this being helpful being a clergy? I mean, it's who they are. I'm, I'm-- because I think you're saying not, not the act in the capacity of a religious, is that right?

FREDRICKSON: I'm not sure I understand. Are you asking me in the context of the--

RIEPE: The clergy, that they're being asked not to act in a religious perspective. Is that, is that not true?

FREDRICKSON: So this, this bill does not direct clergy members on what they should or should not do. This is--

RIEPE: Oh.

FREDRICKSON: This applies specifically to healthcare professionals. So the way the, the bill is written is that it does not, it doesn't apply to clergy members or religious counselors who are acting in a pastoral or religious capacity.

RIEPE: I'm interested in hearing and learning more so thank you. Thank you for being here.

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

BALLARD: Thank you, Chairman. Thank you for being here, Senator. Can you help me wrap my mind around this? When you, when you think of conversion therapy, you think of physically harmful tactics such as shock therapy. But that's-- that's banned in this, in this proposal, but that's not entirely what we're talking about, correct? Can you help me define conversion therapy?

FREDRICKSON: Yeah. So we-- the-- actually in the bill, we have an explicit definition, if you want to read the way it's written in the bill. I mean, in terms of just-- I'll speak to you from just, like, a clinical perspective. So the way that-- you know, conversion therapy is any practice that actively seeks to change a person's sexual orientation or gender identity. So best practice in mental health and in behavioral health in general, regardless of what you're talking about, whether it's depression, anxiety, identity, a therapist is really meant to, to play a neutral role. And so in the language in the bill, it specifies that if a counselor is providing services with a neutral perspective-- so they're not persuading a client one way or another-- that is, that is ideally best practice, right? You're sort of helping a client identify/explore their process and their identity. Conversion therapy proactively works to change a client's

identity. So if a client is coming in and saying that they identify as gay, for example, conversion therapy would be the practice of someone going into therapy and the therapist trying to change them to not be gay.

BALLARD: OK and can you give me an example of kind of language that would be prohibited in this? Yeah, what kind of language would-- a hypothetical.

FREDRICKSON: So the practice of persuading an individual to change their sexual orientation, that, that's what would be prohibited. So there's a whole-- I mean, there are different tactics that are used for that. So, you know, I can speak-- and we'll have testifiers today who are able to speak about experiences that they have had. In my own clinical practice, I've worked with folks who have been, you know, instructed by therapists to watch pornography that is heterosexual in nature. I've had patients who have been told to just try having sexual contact with someone of a different gender. You know, anything that is encouraging a patient to act that is outside of who they are is unethical. And so that's really what we're looking at here is we're looking to end this practice of trying to get people to change who they are.

BALLARD: OK. Thank you.

FREDRICKSON: You're welcome.

HARDIN: Any other questions? Senator Fredrickson, will you be around for closing?

FREDRICKSON: I'll be here till the beautiful end.

HARDIN: Very well. We will hear from the proponents, then the opponents, then those in the neutral. So will the first supporter of LB179 come on down? Yes, we will be-- we'll be going with five minutes. And again, just a reminder for those of you who came late, we do use the light system. Green light means you're good to keep going. Yellow light means you have a minute left. The red light means that-- well, Christina over there hits a button and it ejects you right out, so. Well, it's not quite that bad, but you get the idea.

ANNE BUETTNER: OK.

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HARDIN: Thank you.

ANNE BUETTNER: All right. OK, well, still good afternoon. Not to good evening yet. I'm Anne Buettner, A-n-n-e B-u-e-t-t-n-e-r. I am the legislative chair of the Nebraska Association for Marriage and Family Therapy. On behalf of our organization, we support LB179: prohibit conversion therapy. Oh, by the way, the amendments are excellent, providing clear and succinct definition of conversion therapy targeting those two groups, sexual orientation and gender identity. And in our humble opinion, it's the best language among all the 20 states and D.C. which have already prohibited conversion therapy. Well, in Nebraska, marriage and family therapists are part of the licensed mental health practitioners and mental health practitioners are the largest mental health workforce. There are 4,066 of us licensed, 4,066 as of February this year. And subsumed under that, there are the marriage and family therapists like ourselves and the social workers and the professional counselors. This is our way to let the committee know that all the major mental health organizations have policy statements against the use of conversion therapy. And so they include, but not limited to, American Association for Marriage and Family Therapy, the American Counseling Association and the National Association of Social Workers. The official position is that for therapy intended to change sexual orientation to heterosexual or change gender identity to birth-assigned sex, there is no credible scientific evidence that that work and there is significant potential that it will cause harm to participants. So conversion therapy is mental health malpractice. Now, to answer your question, Senator, conversion therapy attempts include a variety of different practices, ranging from talk therapy to therapy-- we can call it therapy or pseudo therapy-- focus on aversion, aversion, which can include subjecting the individual to emotional shaming, to physical pain, to noxious chemicals, to electric shocks as a response to their sexual desires or gender preferences. So many, many studies have find negative effects associated with conversion therapy, including increased level of depression, suicidal attempts, suicidal thoughts, substance abuse in adults, trauma, in fact-- and of course, trauma constitute abuse. Decades of research on sexual orientation suggests that sexual orientation, it's like right-handedness or left-handedness. It's not a characteristic that can be altered therapeutically and scientists conclude that sexual orientation is caused by a complex interplay of, of genetic and hormonal influences

and do not view it as a choice. Transgender and gender non-conforming children already-- or children and adolescents already carry the burden of feeling marginalized and they are always have increased risk of developing mental health disorder. As a matter of fact, there is a diagnosis called gender dysphoria. To impose conversion therapy on them definitely would increase the alienation and distress. Lastly, and this is a very important point, conversion therapy is based on the a priori, the presumption, the belief that LGBTQ lifestyles are bad and it is not a normal part of the spectrum of sexuality or gender expression or gender identity. So just the presumptive goal of these techniques-- that's why it's called conversion-- implies coercion bordering on abuse. So regardless of what your personal beliefs are about sexual orientation and gender identity, conversion therapy itself is considered unethical and harmful mental health practice. And thank you for considering my testimony.

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

ANNE BUETTNER: OK.

HANSEN: We'll take the next testifier in support, please. Welcome.

ADAM WITTE: Thank you.

HANSEN: You can begin whenever you'd like.

ADAM WITTE: All right. Thank you. Chairman Hansen and members of the Health and Human Services Committee, my name is Adam Witte. That's A-d-a-m W-i-t-t-e and I have lived in Omaha since 1992. I come to you as a gay survivor of conversion therapy here in Nebraska to speak in support of LB179 for three reasons. Conversion therapy is harmful, it is ineffectual and it exploits the panic of God-fearing Nebraskan parents for monetary gain. I sought this treatment myself beginning in the summer of 1998 when I was 16 years of age and terrified of disappointing my parents and church community by coming out as gay. My earnestness and genuine fear of discovery won over the receptionist at the treatment clinic I went to and she waived the parental authorization form so I could proceed alone. Afraid of my parents asking too many questions about my daily activities, I scheduled my sessions in the facility, facility's overnight hours.

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While many high school students will eventually admit to having sneaked out of the house at night to cause trouble, I did so twice a week for 15 months to subject myself to electric shock aversion therapy. Though the monstrous abuse of shock therapy is no longer commonplace thankfully, my wounds from the so-called counseling, which is still in use, linger as well. That is designed to associate fear and shame with, in my case, same-sex attraction. If those two feelings could ever have changed my sexual orientation themselves, I would not have needed to seek treatment in the first place. While my specific experiences may differ from others, the outcome does not. I have yet to encounter anyone whose orientation or gender identity has been changed by conversion therapy, though I have met and spoken with many, many survivors. You will hear from healthcare providers and virtually every professional association that this treatment has been debunked, disproven and disavowed almost universally. I was the poster child for someone this treatment should have worked on. I wanted nothing more in the world than for it to work and it did not. Note the lack of testimony from survivors who have been cured. Even if you believe abusing queer youth should be a protected action, as some of us seem to, the practice this bill seeks to ban allows parents' fear to be exploited and monetized by healthcare providers willing to offer treatment they know has never worked. I understand the very human, righteous desire to protect one's children. Indeed, I sought this treatment myself from a panicked sense of self-preservation. If conversion therapy ever achieved its stated purpose, this would be a different discussion. However, it is not only harmful, it also does not produce results. Supportive parents afraid of the difficulties and dangers associated with growing up LGBTQ+ in Nebraska, devout parents afraid of the social stigma, loss of relationship and moral consequences of having an LGBTQ+ child, all of them are being preyed upon by providers who know better. This bill, as discussed, does nothing to restrict religious anti-queer speech, counseling or action. It simply stops credentialed healthcare providers from fleecing terrified Nebraska parents by offering treatment they know does not work and in fact causes harm. Please pass this bill if not to protect queer youth, then to ensure no more frightened parents are taken advantage of. Thanks for your time.

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

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M. CAVANAUGH: Thank you. Thank you for your testimony. I really actually just want to take a moment to let everyone know that if they need it, that there are comfort buddies here available. I think that they're out in the hallway. So thank you for sharing your story and for testifying today.

ADAM WITTE: Absolutely.

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

ADAM WITTE: Thank you.

HANSEN: We'll take the next testifier in support. Welcome.

AARON AUPPERLE: Welcome. Thank you, committee members. My name is Aaron Aupperle, A-a-r-o-n A-u-p-p-e-r-l-e. In 1995 and 1998, I attended the largest ex-gay ministry in the nation called Love in Action. It was aimed to cure clients of homosexuality and other sexual sins from as broad of sins as bestiality to pedophilia. These sins, oddly enough, were all lumped together. I only returned a second time to the program because I never, quote, admitted homosexuality as a sin-- was a sin, and that, quote, I was powerless over it. Unfortunately, I was addicted to sex and the church I was brought up in, Christ Lutheran-Missouri Synod, lumped my addiction to sex to being a homosexual. Neither me or my family did any research of our own and trusted what our church affiliation had to say on the topic. In 1998, when I returned to Love in Action, I ended up having an affair with a man from work. They staged a mock funeral for me to teach me a lesson. My friends and clients in the program had to write eulogies of anger, frustration, disgust, you name it, while I played dead on a table. I wanted to leave and did two weeks later. However, before I left, they said two things I will never forget. They told me, quote, You will most certainly die if you leave here and quote, If you decide to join a gay-affirming church, you are creating your own religion so that God will accept you. I can't even fully explain how damaging that has been for me in my adult years. It stripped any hope from me, even to this day, to have a relationship with God. Recently, I am combating these lies of self-annihilation. On Netflix, there is an extremely important documentary I hope everyone in this room takes the time to watch. It's called, quote, Pray Away. In this documentary, many leaders of conversion therapy programs have stepped down after literally decades of leading these ministries. These were

trusted Christ-like, God-fearing Christians with major reputations in the Christian community. In a documentary called quote, This is What Love in Action Looks Like, they mentioned my conversion therapy leader, John Smid. He led Love in Action from 1990 to 2008, eighteen years. When a minor in the program blogged on MySpace of how he was put in the residential program against his will by his parents, the public responded overwhelmingly to free the young man. The protesters exclaimed, It's OK to be gay, but most profoundly, we love you, John Smid. After much contemplated thought, John finally listened. He was actually-- he shut down the program because of the love he was getting from the protesters. It was quite astounding. Something inside of him said, This isn't right. There isn't one man I have met who has changed his sexual orientation since I began this ministry decades ago. John is now happily married to a man and has been since closing down Love in Action in 2008. As an advocate to stop this inhumane practice, I plead with you to stop this psychological harm. It scars our most inner being. Some of us have reconciled our faith, but many of us feel cheated by our former Christian leaders and church affiliations, even if they have come to reconcile their sexuality. Let's reeducate and reevaluate ourselves and our psychological practices and truly see the harm it's causing. 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 in support.

KATIE McLEESE STEPHENSON: Good evening. Thank you. Chairperson Hansen and members of the Health and Human Services Committee, my name is Katie McLeese Stephenson, spelled K-a-t-i-e M-c-L-e-e-s-e S-t-e-p-h-e-n-s-o-n, and I serve as executive director of HopeSpoke where we provide behavioral healthcare in the Lincoln community across the lifespan with various programs, with the vast majority of who we serve as young people under the age of 19. Today I'm here representing the Nebraska Association of Behavioral Health Organizations, known as NABHO. We represent 53 member organizations from across Nebraska, both large and small, rural and urban. NABHO is a proponent of LB179, which would prohibit conversion therapy for children and youth under the age of 19 in Nebraska offered by professional therapists and does not include pastoral care. Conversion therapists base their service on the belief that those who identify as LGBTQ need to change their sexual orientation or gender

identity. This practice is known to be coercive and harmful in nature. A major focus in mental health therapy is to work with the client on self-exploration, self-acceptance and increasing insight. Ethical therapy involves meeting a client where they're at. Ethical therapy does not involve beginning with the premise that something is bad or wrong and my job as a therapist is to convert you away from this. Conversion therapy encourages people to conceal who they are, convincing them that their sexual orientation or gender expression is a source of shame and danger. Credible therapists do not identify that something is wrong and work with their clients to disavow that part of who they are. This is in direct opposition to how therapy is intended to work. Children and youth who are forced into conversion therapy may experience anxiety, suicidal thoughts and a sense of profound rejection. Conversion therapy has been shown to be ineffective and is based on the premise, again, that homosexuality is wrong and a disorder that requires treatment. Not only is conversion therapy ineffective, but it can also in fact be very harmful to children and young people. The Trevor Project published a peer-reviewed article in the American Journal of Public Health in July of 2020. One of their key findings was that LBGTQ youth who underwent conversion therapy were more than twice as likely to report having attempted suicide and more than two and a half times more likely to report multiple suicide attempts in the past year to-- compared to those who had not. Many highly respected associations have denounced conversion therapy and those are listed and have been mentioned previously. But in addition to those association, the-- those associations, the Substance Abuse and Mental Health Service Administration, commonly referred to as SAMHSA, which is a branch of the federal government, is in opposition to this practice as well. In 2020-- or excuse me, 2012, the World Psychiatric Association issued the following statement: there is no sound scientific evidence that innate sexual orientation can be changed. Furthermore, so-called treatments of homosexuality can create a setting in which prejudice, prejudice and discrimination flourish and can be potentially harmful. The provision of any intervention purporting to treat something that is not a disorder is wholly unethical. Additionally, the American Psychiatric Association shared their views on conversion therapy. They essentially torture people after exposing them to certain stimuli. Patients who have been exposed to these therapies often report significant experiences of trauma. These practices have no evidence of efficacy and can actually hurt people and further

stigmatize legitimate mental healthcare for this vulnerable population. The members of NABHO and other clinicians across the state work hard to provide therapeutic modalities that are evidence based and have been shown to be effective, backed by research to demonstrate positive outcomes. In addition, these clinicians work to ensure that there is a positive, authentic relationship established between themselves and their clients. Conversion therapy is not evidence based. Conversion therapy does not encourage a therapist to relate positively and authentically with their clients. Conversion therapy does not align with the code of ethics for various professional organizations. Conversion therapy is harmful and the children and youth of Nebraska deserve to be served in an affirming and supportive manner. For all these reasons and for the benefit of our children and youth, we are asking that you support LB179. We appreciate Senator Frederickson bringing this important issue forward. Thank you for the opportunity to represent NABHO and I'm open to any questions you might have.

HANSEN: Thank you. Are there any questions from the committee? I might have a couple because you seem like the right person to ask.

KATIE McLEESE STEPHENSON: Oh, OK.

HANSEN: Like, a hypothetical, right?

KATIE McLEESE STEPHENSON: OK.

HANSEN: So somebody is in school and they're gender confused, they might think they're a different gender. They've talked with their teacher about it and the teacher goes to the counselor. Say the counselor-- because we've had this issue with other bills. This might be kind of something similar. So the counselor doesn't agree with them in their gender identity for whatever reason, right? Do they have to partake in the counseling of that child or that-- what I'm wondering, if, like, the ramifications of this going against somebody who doesn't believe that.

KATIE McLEESE STEPHENSON: Well, in the situation you're describing where it's a school counselor, typically they wouldn't be engaged in therapy with a student. But what they should do is refer out to a therapist who can work with these issues.

HANSEN: Let's use that example.

KATIE McLEESE STEPHENSON: OK.

HANSEN: So say the parents find out about it and they want to take them to a counselor to discuss things and they find out the counselor doesn't maybe agree with that. What's the recourse the counselor has? What-- could they be charged with anything or would that be-- I don't know for sure how that works. It's kind of a legal question, maybe not. And Senator Fredrickson could probably ask-- answer that when he gets done. So if you don't know, it's fine.

KATIE McLEESE STEPHENSON: Yeah, I don't, I don't know that there's legal ramifications. I guess what I would speak to is ethical ramifications. And that if, if you are a therapist and you cannot fully support someone that you are working with, then your obligation is to make sure that they're connected to someone who can.

HANSEN: Refer them out. OK. OK, all right. Thank you very much. Appreciate it. Any other questions just to make sure? All right, seeing none, thank you. Welcome.

CLAIRE WIEBE: Thank you. All right, good evening, Senators. My name is Claire Wiebe. That's C-l-a-i-r-e W-i-e-b-e, and I am a senior manager of public affairs at Planned Parenthood North Central States. Planned Parenthood is committed to fighting for the bodily autonomy of our patients and our friends and neighbors across Nebraska. And part of this effort includes voicing opposition to and acting to dismantle systems that seek to coerce and undermine an individual's identity, expression and sexuality. Planned Parenthood is proud to support this bill, LB179, to ban conversion therapy, as everything about the hateful, unscientific and dangerous practice of conversion therapy flies in the face of our core values. At Planned Parenthood, we are a trusted healthcare provider for our-- for the LGBT community because we offer compassionate, non-judgmental care to all of our patients no matter what. At Planned Parenthood, we know the LGBTQ community faces higher rates of discrimination, including external efforts to try to fundamentally change or deny who they are. We also know that LGBTQ+ people living in states without protective policies, states like Nebraska, are five times more likely than those in states with protective policies to have two or more mental health disorders. And when LGBTQ people experience prejudice-related major life events

such as attempted or actual conversion therapy, they are three times more likely to have suffered a physical health issue in the year following that event. And the citation is in my testimony. This fact transcends age, gender, health history and employment. It is true across the board for all LGBTQ people. Practices with such quantifiable and negative health outcomes have no place in our state, where we pledge to offer our neighbors the good life. Nebraska historically has been a hostile place for LGBTQ people to live, work and raise their families. And with this bill, our state has the opportunity to do better, particularly for the young people living here who deserve to be safe and free from this coercive and emotionally violent practice. We must ensure LGBTQ+ Nebraskans are no longer subjected to practices that are peddled as healthcare and science, but are actually not supported by mainstream medical professionals. The list is in my testimony as well. You've all heard it before. Conversion therapy exploits negative feelings LGBTQ people or their parents may already have and the negative health outcomes for those subjected to them can include depression, anxiety and suicidal ideation. LB179 is an important step forward for Nebraska. Conversion therapy is not medical, it is not scientific, it is not ethical and it is not moral. It has no home here and hate has no home here. Thank you, Senator Fredrickson, for standing up for all of us Nebraskans and we would ask the committee to support LGBTQ+ Nebraskans in advancing this bill to General File. Thank you.

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

CLAIRE WIEBE: Great.

HANSEN: We'll take the next testifier in support.

ERIN FEICHTINGER: I'm with an earlier testifier. I think this chair is lower than normal.

HANSEN: We do it on purpose.

ERIN FEICHTINGER: Maybe something to get on? OK. That's fine. Chairperson Hansen, members of the Health and Human Services Committee, my name is Erin Feichtinger, E-r-i-n F-e-i-c-h-t-i-n-g-e-r, and I'm the policy director for the Women's Fund of Omaha. We are here testifying in strong support of LB79

banning the harmful practice of conversion therapy that inflicts further trauma on Nebraska's LGBTQ+ youth. As an organization promoting gender equity and freedom from violence for all Nebraskans through more trauma-informed laws, we recognize this bill as critical to keeping Nebraska youth safe and healthy. As Senator Fredrickson and other testifiers have mentioned, conversion therapy is a harmful and medically unsound practice of attempting to alter one's sexual orientation or gender identity. Youth are particularly vulnerable to this practice, as they may be forced or coerced by unsupportive family members. Major medical, mental health and educational experts assert the medically inaccurate nature and harmful impacts of this practice. The American Academy of Child and Adolescent Psychiatry finds no evidence to support conversion therapy and asserts the practice does not adhere to clinical methodology and is associated with harmful effects on those experiencing it, namely increased mental health challenges. As a result, the Academy holds that conversion therapy has no place in the behavioral health treatment of children and adolescents. As other testifiers have pointed out, LGBTQ+ youth whose identities are rejected by their parents for their sexual orientation or gender identity, such as through conversion therapy efforts, are more likely to attempt suicide and nearly six times more likely to report high levels of depression. These statistics are reflected in Nebraska in our schools, with more than 50 percent of Nebraska high schoolers who identify as lesbian, gay and/or bisexual reporting having seriously considered suicide compared to roughly 14 percent of their heterosexual peers and nearly 35 percent of LGB students who have attempted suicide. In Nebraska, LGB youth experience significantly higher rates of bullying, violence and discrimination than their peers. More than one in four of those students report being bullied on school property and nearly one in five report having not gone to school because they felt unsafe. By age four, most children have a stable sense of their gender identity. Research also shows that transgender youth experience their gender identities as strongly and as clearly as their cisgender peers, but Nebraska's LGBTQ+ youth continue to be particularly vulnerable to discrimination, violence and trauma and our laws must work to protect them. The continued allowance of conversion therapy will instead perpetuate the trauma experienced by youth in our state. LB179 would address this safety issue, prohibiting dramatic and discriminatory practices that threaten the well-being of Nebraska's youth. The Women's Fund supports safety and freedom from discrimination for all

Nebraskans and as such, respectfully urges the committee's support of LB179 and advancement to General File. And I am more than happy to answer any questions to the best of my ability in this tiny chair. Short chair is a better descriptor.

HANSEN: There we go. All right, thank you. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman Hansen. Thank you for being here. I just have a curiosity question. You noted that about-- you spoke vehemently just recently about here bullying in the school playground. But I'm trying to say-- trying to connect that back to the piece of legislation that's in front of us today, which is about the conversion thing and which to me didn't connect with bullying on the playground.

ERIN FEICHTINGER: Sure, I think--

RIEPE: It's likely to happen anyway.

ERIN FEICHTINGER: Sure. As someone who was bullied-- I think it's the glasses, maybe the shortness, I don't know.

RIEPE: I get bullied all the time.

ERIN FEICHTINGER: I'm, I'm certain that's untrue. Senator. I-- this just speaks to a larger issue. Previous testifiers have talked about how Nebraska is not particularly friendly to LGBTQ+ folks and this is, this certainly more dramatic and impactful for the youth. We have a lot of bills in the Legislature right now that would go so far as to make it so that teachers and schools are not safe spaces for LGBTQ+ youth. And I have a daughter and she learns way more at school about how to interact with people than she does at home and I think that that speak-- that ends up translating the sort of culture, the feeling, the environment of living in the state of Nebraska as an LGBTQ+ person. It's just-- it's not safe. It's-- doesn't-- that translates to the school playground. It does.

RIEPE: OK. Thank you.

ERIN FEICHTINGER: You're welcome.

RIEPE: Thank you, Mr. Chairman.

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ERIN FEICHTINGER: And I'm sorry that you're bullied.

HANSEN: Any other questions from the committee? Senator Ballard.

BALLARD: Thank you, Mr. Chairman. Thank you for being here. The introducer said that this excludes religious counselors and clergy. Can you help me understand the magnitude of the problem in Nebraska since we do exclude religious counselors? Is there-- I mean, looking for a-- is there a problem in Nebraska?

ERIN FEICHTINGER: Yeah, I would not be able to do real justice to that question with an answer so I will leave it for someone behind me--

BALLARD: OK.

ERIN FEICHTINGER: --to more fully address that--

BALLARD: Perfect.

ERIN FEICHTINGER: --for you.

BALLARD: Thank you.

HANSEN: Can I ask you a couple of questions too. And again, if you can't answer them, then maybe somebody else can.

ERIN FEICHTINGER: No, yes I can. I said, to the best of my abilities so as long as we're all operating under that.

HANSEN: Are you able to answer questions about the Uniform Deceptive Trade Practices Act? Like, the violation of this would be violation of that deceptive trade practice. Like, what are the ramifications of that? Like, what happens to somebody?

ERIN FEICHTINGER: Yeah, I would not be able--

HANSEN: OK.

ERIN FEICHTINGER: That would not be to the best of my abilities.

HANSEN: OK. Maybe one other one? Is there-- because we're talking about, I think, the shock therapy.

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ERIN FEICHTINGER: Um-hum.

HANSEN: Are there people still in Nebraska that do that or-- and if they are, you know, like-- it seems like they shouldn't be doing that anymore, but do people still--

ERIN FEICHTINGER: It seems like that.

HANSEN: --use shock therapy? Do you know, are there still practices that do that?

ERIN FEICHTINGER: I do not know. I really don't know the answer to that question. I'm happy to find that answer or if it doesn't get covered by someone behind me.

HANSEN: I hope. Thank you.

ERIN FEICHTINGER: Yep.

HANSEN: All right, seeing no other questions, thank you very much. We'll take our next testifier in support.

GABBY DOYLE: Thank you. Good afternoon and maybe evening is now more appropriate. My name is Gabby Doyle, G-a-b-b-y D-o-y-l-e, and as the advocacy campaign manager for the Trevor Project, the leading suicide prevention and mental health organization for LGBTQ youth, I'm grateful for the opportunity to speak in favor of LB179. At the Trevor Project, we work every day to save young LGBTQ lives by providing free and confidential crisis services 24/7 via telephone lifeline chat and text platforms. We also operate research, education and advocacy programs focused on the mental health needs of the youth we serve. Our crisis services responded to over 1,800 contacts from Nebraska last year alone, which we estimate is a small fraction of the number of LGBTQ youth in Nebraska who seriously consider suicide every year. To further our mission of ending LGBTQ youth suicide, Trevor is dedicated to seeing the end of efforts to change a young person's sexual orientation or gender identity at the hands of licensed professionals. We've seen with every reputable medical and mental health organization, as you've heard, in, in condemning these practices as harmful, ineffective, unethical and founded on unscientific theories that have been debunked for decades. At the Trevor Project, we have direct experience, extensive research observing the dangers of these practices themselves. In our 2022

national survey, which reflects the experiences of nearly 34,000 LGBTQ young people, we found that 6 percent reported experiencing conversion therapy and another 11 percent reported being threatened with it. Devastatingly, even more youth in Nebraska reported experiencing conversion therapy in 2022, above the national average. These youth who either experienced or were threatened with conversion therapy were more than twice as likely to report a suicide attempt in the past year. Our counselors don't ask about conversion therapy directly when a youth calls us in crisis, but in the last year alone, 1,300 contacts for more than 600 cities across the country explicitly raised the topic themselves. And finally, these practices also have a drastic financial cost for families in our country. In 2022, "Pediatrics," a journal of the American Medical Association, published a peer-review study using health economics to find the annual direct cost of conversion therapy in the U.S. to be $650 million. Worse, the indirect costs associated with the harms of conversion therapy, including elevated rates of depression, anxiety and substance use and risk of suicide totaled more than $8 billion annually. Ultimately, this issue is simple. Nebraska youth deserve to know that any professional they go to for help is providing them with care that is safe, effective, ethical and evidence based. Conversion therapy is none of these things and is actively harmful. It's time to pass this law to protect Nebraska's youth. Thank you so much and I'm happy to answer any questions I can.

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

M. CAVANAUGH: Thank you. I feel that since you are representing the Trevor Project, this is another good opportunity just to remind anybody that needs it that you're not alone. And if you need help, please call 866-488-7486. Thank you for being here today.

ERIN FEICHTINGER: Thank you.

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

ERIN FEICHTINGER: Thank you.

HANSEN: We'll take the next testifier in support. Welcome.

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CAMIE NITZEL: Thank you. Dear Senator Frederickson and members of the Health and Human Services Committee, my name is Dr. Camie Nitzel, C-a-m-i-e, Nitzel, N-i-t-z-e-l. I'm submitting this testimony in ardent support of the proposed LB179 banning the unethical and fraudulent practice of conversion therapy, inclusive of the proposed amendment made by Senator Fredrickson. I'm a licensed psychologist in the state of Nebraska, having completed a Ph.D. in counseling psychology from UNL. I've been practicing as a mental health provider in Nebraska for 27 years, with a specialized focus in working with LGBTQ populations. I'm the founder of Kindred Psychology, an inclusive and affirming mental health practice in Lincoln, and I have worked with survivors of conversion therapy. I also provide oversight and clinical supervision for students and emerging provisionally licensed mental health practitioners from mental health counseling, counseling psychology, clinical, clinical psychology and social work programs. As such, I am very well acquainted with the codes of ethics from each of these fields, as with the licensure expectations. Thirty-two states do not yet ban the practice of conversion therapy. The Williams Institute estimates that in these states, 16,000 youth will experience harm at the hands of their mental health providers through attempts at conversion therapy by the time they're 18. Clearly, this is a real danger from which vulnerable youth need protection by Nebraska's legislative body. LB179 is consistent with the established and public-- published ethical expectations for mental health fields upon which our regulatory statutes are built. First, the overarching guideline of the APA Code of Ethics is to do no harm. APA is particularly concerned about the significant risk of harm to minors from attempts at conversion therapy. LGBTQ youth are already exposed to individual, social and institutional levels of stigma, which negatively affect multiple mental health domains. Based on expert consensus, as Katie mentioned earlier, SAMHSA, an agency within the U.S. Department of Health and Human Services, also concluded that conversion therapy should be ended with minors, as it seriously harms youth and is not supported by the evidence. Moreover, LGBTQ+ youth are overrepresented in foster care, child welfare and juvenile justice systems, where they face significant exposures to further adverse childhood experiences. Conversion therapy in and of itself is an adverse childhood experience that places vulnerable youth at even greater harm. Second, the APA Code of Ethics stresses beneficence or the care provided by licensed mental health practitioners, licensed psychologists and such must be helping the

client. So not only do we not do harm, we must be helping. It's part of our ethical code. There's no credible, empirically supported evidence that sexual orientation change efforts can be successful. Thus, anyone who attempts to practice it cannot be helping their client. Instead, providers must use affirmative therapy or acceptance and commitment therapy or any of the other reputable, empirically supported treatments. APA also has advanced best practice guidelines, all of which outline affirmative approaches to working with LGBTQ youth. Further, the practice of conversion therapy violates APA's specific ethical principles of competence, integrity, respect for people's rights and dignity and social responsibility. The truth of conversion therapy is that it is rife with deception, explicit acts of harm and violence, is discriminatory and oppressive and hurts rather than heals youth during a vulnerable time. Practitioners who seek to provide conversion therapy are most definitely guilty of unprofessional conduct as described in the regulatory statutes. As such, I urge you all to pass LB179 to regulate the conduct of licensed providers and provide needed protection for Nebraska's LGBTQ+ youth.

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

M. CAVANAUGH: Thank you. Thank you for your testimony. We tend to have a lot of alphabet soup in this committee and I noticed that you said the APA Code of Ethics. Could you tell us what APA stands for?

CAMIE NITZEL: American Psychological Association.

M. CAVANAUGH: Thank you. That's very helpful.

HANSEN: Any other questions from the committee? Do you think you might be able to answer my question about the shock therapy? Do you know of any other-- I don't want to say-- practices that still continue to do that?

CAMIE NITZEL: I am aware that there is a practice in Lincoln and rumors about a practice in Omaha.

HANSEN: OK. All right, thank you.

CAMIE NITZEL: I do not know about practices in the western parts of the state and I would be also very concerned about the, the

practices, not-- that, that Lincoln has established in terms of conversion therapy not affording youth-- rural youth or youth in Omaha with the same safety that people are provided in Lincoln.

HANSEN: OK. All right, thank you. Senator Cavanaugh.

M. CAVANAUGH: Sorry. I actually did have more questions. It also occurred to me that you might be the last person to testify in the capacity that could answer these questions. So you talked about the code of ethics and, and the do no harm. So is conversion therapy still considered globally part of the standard of care?

CAMIE NITZEL: It is not--

M. CAVANAUGH: OK.

CAMIE NITZEL: --although it is still practiced.

M. CAVANAUGH: So without it being explicitly prohibited, it's permissible.

CAMIE NITZEL: Yes.

M. CAVANAUGH: OK and this would make it explicitly prohibited.

CAMIE NITZEL: Yes.

M. CAVANAUGH: Thank you.

CAMIE NITZEL: This would align our legal responsibilities with our ethical responsibilities.

M. CAVANAUGH: And I just want to-- for the record, one of the testifiers mentioned MySpace. And I just want to clarify that for those of us that are old enough, MySpace is the old person's Facebook. And I just thought the transcribers would be, like, what on earth is MySpace, so.

CAMIE NITZEL: Right.

M. CAVANAUGH: Thank you for your testimony.

CAMIE NITZEL: Of course.

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HANSEN: I heard it's coming back, though. I don't know.

M. CAVANAUGH: Oh, wow.

HANSEN: Any other questions from the committee? Seeing none, thank you for your testimony. We'll take the next testifier in support. Welcome back.

SCOUT RICHTERS: Hello. Thank you. Scout Richters, S-c-o-u-t R-i-c-h-t-e-r-s, here on behalf of the ACLU of Nebraska in support of LB179. I first want to thank Senator Fredrickson for bringing this bill. No child should be subjected to the dangerous and torturous practice of conversion therapy. As you've heard, the overwhelming medical consensus is that treatment regimens seeking to change a person's sexual orientation or gender identity provide no therapeutic benefit and are harmful, especially to minors. They are sham therapy-- therapies repudiated by the health, by the health professions for attempting to treat something that is not a disorder while endangering patients. Importantly, from the legal perspective, you know, the law has, has long recognized that the First Amendment does not prevent restrictions directed at professional conduct from imposing incidental burdens on speech, as is the case here. And LB179 addresses conduct that violates the professional standard of care and is most, and is most likely to cause harm, namely performing conversion therapy on minors. The ACLU is committed to protecting the rights of all Nebraskans to be who they are and love who they love and no child should be subjected to this damaging and debunked practice of conversion therapy. And we, we reiterate our thank you to Senator Fredrickson and urge the committee to advance this.

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

SCOUT RICHTERS: Thank you.

HANSEN: We'll take the next testifier in support.

CAMMY WATKINS: Hello. I'm Cammy Watkins. I'm-- spelling, C-a-m-m-y-- I didn't know there was going to be another Cammie here today. That was, like, a first in my lifetime-- W-a-t-k-i-n-s. I'm one of the executive directors at Inclusive Communities. We serve the entire state of Nebraska, as well as western Iowa and the Rosebud

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Reservation in South Dakota. Inclusive Communities expresses its strong support for LB179 prohibiting funding-- or prohibiting funding for the use of conversion therapy. As many of the folks that have testified before me have already stated, there are harmful causes of conversion therapy, a practice targeted predominantly LGBTQ2SIA+ community with youth has detrimental outcomes. I want to point out that to date, 20 states plus the District of Columbia and Puerto Rico have laws or regulations protecting youth from this harmful practice. Eight of these states enacted the laws under a Republican governor, including the state of Utah. At Inclusive Communities, our mission is to confront prejudice, bigotry and discrimination. Therefore, we are in support of the passage of this bill, as it will eliminate one of the forms of harm caused by societal prejudice that conversion therapy practices promote. So we urge you to strongly support LB179. Thank you.

HANSEN: Thank you for your testimony. Are there any questions from the committee? OK, seeing none, thank you. We'll take our next testifier in support.

LACIE BOLTE: Good evening.

HANSEN: Welcome.

LACIE BOLTE: My name is Lacie Bolte, L-a-c-i-e B-o-l-t-e, and I'm a representative of the Nebraska AIDS Project, a nonprofit organization that provides HIV supportive services to individuals across the state of Nebraska. Thank you to Senator Fredrickson for introducing this important legislation. I'm proud to say that I helped with-- in the effort to ban conversion therapy at the local level with the Lincoln City Council and I'm here today to request your support in ensuring this practice has been statewide. Nebraska AIDS Project leads the community to overcome HIV and its stigma through supportive services, advocacy and education. Our organization serves the entire state of Nebraska and works with many members of the lesbian, gay, bisexual, transgender and queer communities. Leaders of anti-LGBTQ movements have long used the threat of HIV and AIDS to recruit people struggling with their sexuality and identity. Additionally, parents of children who might be LGBTQ have been scared into sending their children into services, including conversion therapy. The incredibly sad truth about this pursuit is that it leads to far more psychological harm and elevated risks for HIV. From a public health

perspective, LGBTQ+ individuals are greater burdened by psychosocial health disparities, including depression and substance use across their lifetimes compared to their heterosexual counterparts. These disparities are even more pronounced when accounting for intersecting marginalized data, such as race and ethnicity and HIV status. Individuals face experiences of interpersonal stigmas, such as discrimination and violence, as well as internalized homophobia and sexual identity concealment. These experiences uniquely victimized same-sex attracted persons based on their perceived or known sexual minority status and often elicit chronic stress and poor psychosocial health, including depression and suicidality. Rooted in stigmatizing beliefs towards homosexuality, conversion therapies were developed to minimize or eliminate sexual minorities' same-sex attractions and are likely to co-occur with other sexual minority stressors like sexually related family rejection. However, there is no-- currently no valid scientific evidence demonstrating their effectiveness. Previous testifiers have talked about different forms of conversion therapy so I'm going to give-- skip over that next part, along with the associations who have expressed that they do not condone, according to their code of ethics, this practice. But I want to leave you with a quote from a young man who did receive conversion therapy after his parents believed it could cure his sexuality. This young man, his name is Sam Brinton, and this is from 2018. Quote, For over two years, I sat on a couch and endured emotionally painful sessions with a counselor. I was told that my faith community rejected my sexuality, that I was an abomination we had heard about in Sunday school, that I was the only gay person in the world. That it was inevitable I would get HIV and AIDS. As a form of homophobic and transphobic abuse and victimization, conversion therapies have no place in Nebraska and I urge you to pass LB179 and protect our vulnerable youth in our community. Thank you. Happy to answer any questions.

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

M. CAVANAUGH: Thank you. Thank you for being here. Did you mention that you worked on the Lincoln ordinance? So currently in Lincoln, conversion therapy is not allowed.

LACIE BOLTE: Correct.

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M. CAVANAUGH: And you might not-- even though you worked on the ordinance, you might not be familiar with this. Are you aware of any obstacles for healthcare or any issues that that has led to for individuals that might have been, as I would say-- the testimony today says adversely impacted. If they have conversion therapy now, they can't do that in Lincoln. Is Lincoln kind of a test pilot for the rest of the state?

LACIE BOLTE: I don't think I'm the best person to answer that question.

M. CAVANAUGH: That's fine. It just piqued my interest when you mentioned Lincoln, so--

LACIE BOLTE: Yes.

M. CAVANAUGH: --thank you.

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

BRENNA LASH: Senator Hansen and members of the Health and Human Services Committee, my name is Brenna Lash, B-r-e-n-n-a L-a-s-h, and I appear before you today in support of LB179. I am a doctoral student in clinical psychology at the University of Nebraska-Lincoln and I'm here testifying on behalf of the Nebraska Psychological Association, NPA. This testimony does not necessarily reflect the views of the University of Nebraska, which I am a student. The Nebraska Psychological Association supports this legislation to prohibit the use of therapy intended to alter sexual orientation and gender identity in minors. The APA, American Psychological Association, in agreement with numerous organizations which we have mentioned, opposes the practice of therapies intended to change one's sexual orientation because such therapies are not needed. There is no credible evidence that they work and there is significant evidence that they cause harm to those who are engaged in this type of intervention. In 1973, the American Psychiatric Association, due to mounting research evidence that having a same gender sexual orientation is not inherent to-- inherently pathological, decreed that homosexuality is not a mental illness. While LGBTQ+ individuals are more likely than cisgender heterosexual individuals to suffer from depression, anxiety and thoughts of suicide, a significant body

of research indicates that these mental health issues are directly caused by the discrimination that LGBTQ+ individuals face in society, not due to their sexual orientation or gender identities. To further support this point, a growing body of research indicates that when communities are accepting and supportive of LGBTQ individuals, they are not more likely to experience mental health issues than their heterosexual and cisgender neighbors. Not only are therapists attempting to change sexual orientation or gender identity actively harmful, they are also unsuccessful, as many of the testifiers have, have mentioned, based on the overwhelming research evidence that we have. A former student of one of our association members who had been forced into this type of therapy by his parents remarked that it's very frustrating to attempt to do something that cannot be undone. Therapies designed to change sexual orientation and gender identity have been shown to cause harm to participants, including increased risk of mental health concerns such as depression, anxiety, suicidality. As stated by the American Psychological Association, quote, The perceived self esteem and authenticity to others, increased self-hatred and negative perceptions of homosexuality, a loss of faith and a sense of having wasted time and resources, end quote. Such therapies often include inaccurate and very pejorative information about sexual orientation and gender identity. The former student mentioned earlier asserted that by being forced into this type of treatment, he felt rejected, rejected and negatively judged by his parents and his community, feelings that only deepened when he had felt-- when he felt that he had failed at this treatment. The primary ethical principle in healthcare is to do no harm. We have many reasons to conclude that conversion therapy serves no valid therapeutic purposes, while also causing significant harm to those who participate in it. The Nebraska Psychological Association urges you to vote to protect some of our state's most vulnerable children from this dangerous practice by advancing LB179. Thank you for your time and I'm happy to answer any questions.

HANSEN: Thank you.

BRENNA LASH: The lights are very bright, like, right here.

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

BRENNA LASH: Thank you.

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HANSEN: We'll take the next testifier in support. Welcome.

ANGIE PHILIPS: Hi. Hello. My name is Angie Philips. That's A-n-g-i-e P-h-i-l-i-p-s and I'm here today in support of LB179. I'm the founder of the Nebraska Legislative Study Group and to my amazement, study group has grown over the past five years in both size and momentum. Members from our group consist of Nebraskans across the state submitting online comments, testifying in person, watching the legislative sessions and taking action in general to push forward legislation that protects our freedoms and advances the working class. While my position is purely volunteer and grassroots, I do spend a significant amount of time and energy away from my family and my children in order to encourage Nebraskans to participate as the second house. But I have been wondering lately, Senators, if my efforts are in vain. Am I misleading people? Do their voices really matter to their state legislators? Are you listening or are you just going through the required motions of these public hearings? Because we showed up in full force to protect bodily autonomy of women, girls and trans people. We stood in line for hours to oppose the abortion ban and the anti-trans legislation. So many people showed up. Hundreds were turned away because the committee determined there were simply too many voices to be heard. Yet those bills were passed quickly through this committee and prioritized by the bigots that introduced them. But honestly, even before public hearings began, for those of us that study the Legislature, it's pretty clear that deals have been made, committees had been rigged and the majority party in this nonpartisan Unicameral already had a plan to push forward their agenda before bills were even introduced, let alone before we, the people, were given a voice in them. I was born and raised in Nebraska, born in North Platte, raised in the Grant/Ogallala area. I moved up to the Lincoln/Omaha area in my early twenties. My husband and I have made our home here. We are raising our children here, one of whom just started up at UNL for computer science on scholarship, full ride. As for the two still at home, we had hoped to finish raising them here in our home state of Nebraska, but now we're just not so sure. Having been raised in Grant, Nebraska, in the early 90s with a gay brother, I learned very early the bigotry of the Republican Party and the majority of Christian ideologies. But it had not been until this session that I have truly felt unsafe and attacked by those leading our state. We, the people, are struggling to make ends meet. We cannot afford the increased cost of groceries,

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fuel, utilities. If our cars break, we cannot afford to fix them or replace them. And this city and state definitely isn't pedestrian friendly. Our public schools and our healthcare facilities are in crisis and are lacking the professionals we need to help address the crisis. Yet, rather than work towards addressing these problems, the majority of this Legislature has decided to push forward a Christian nationalist agenda filled with bigotry and hate. And as a result, people want to leave or move-- or just not move here. And the crisis we face will not only go unaddressed, but it will be further exacerbated and the public will be forced into more extreme measures to ensure that our voices are heard. I urge you to move forward the positive LGBTQ legislation heard in this building today the way-- as quickly as you have moved forward and advanced those that are harmful to bodily autonomy, women, girls and children. Thank you.

HANSEN: OK, any questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Ms. Philips. I'd just like to address that you are heard and I do value when you come and testify. And I can appreciate the frustration that you are expressing today and the frustration that you're expressing on behalf of a lot of people. The process is hard, the process is messy and the part that you and others play in it is important and significant. I also would like to extend my appreciation to the Nebraska Legislative Study Group. You have created a platform that is nonpartisan, that engages people that you disagree with in this process and made something that has not been accessible in the past, accessible through technology and all the free means available to you. So I know it's not easy. I, I hear your frustration. I truly, truly do. I share a lot of your frustration. But I do want you to know that every day you might not feel this way, but I hope that right now, in this moment, you feel heard and seen.

ANGIE PHILIPS: Thank you, Senator, and thank you for the work that you're doing. You truly are, you truly are what keeps us feeling like we do have a voice in there when so many other senators are ignoring the public.

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

ANGIE PHILIPS: Thank you.

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HANSEN: We'll take our next testifier in support.

SPIKE EICKHOLT: Good evening, Chair Hansen--

HANSEN: Welcome.

SPIKE EICKHOLT: --and members of the committee. My name is Spike Eickholt, S-p-i-k-e, last name is E-i-c-k-h-o-l-t. I'm appearing on behalf of Voices for Children as their registered lobbyist. You're receiving a copy of my testimony so I'll just kind of summarize it. Voices for Children is an advocacy group. We're a nonprofit and we work with and on behalf of the children in the child welfare system and juveniles in the juvenile justice system. Nebraskans' children deserve to be loved-- deserve to love and to be loved for who they are. No one should be subject to practices that can source or aggravate mental health symptoms. Nebraska's children and young people should feel supported in how they identify and for these reasons, we do support this bill. You've heard earlier today about the harms of conversion therapy and the harms that they perpetuate and cause to young people and to families under the false premise that being LGBTQ+ is a mental illness. Conversion therapy is a discredited and harmful practice that's focused on changing individual's sexual orientation, gender identity or gender expression. Many studies have shown that conversion therapy does not work and instead can lead to depression, anxiety, drug use, homelessness and suicide. A number of other states have banned this practice, either 19 or 20, depending on who you heard testify earlier. A number of professional medical and mental health organizations outright condemn and warn that conversion therapy is not a legitimate type of therapy, that it is discredited, it is discriminatory and it is ineffective. You've heard other reasons. I don't need to repeat everything that's in my statement, but we would urge you to support the bill. I can answer, I think, part of what you asked earlier, Chair Hansen, about what the Uniform Deceptive Trade Practices Act. It's at Nebraska Statute 87-301. It's a series of statutes and it provides for some civil sanctions and some criminal sanctions for businesses or individuals that offer services and goods into the marketplace under false pretense. So it can be something as simple as a store having something on the shelf that's $1.99, but then it brings up $3.99 if the store is deliberately doing that. And I think-- and I can't speak for Senator Fredrickson, but I think what that reference is for is that if a therapist or a professional holds

out that they can convert a young person, for instance, that they can make a young person who might be gay straight, that that is-- that a provision to sort of hold that therapist accountable could be similar to a store owner that deceptively put something on the marketplace that represent that's it's an official Nebraska shirt from the University of Nebraska and it's not; the "N" is not quite right, but they still charge whatever they would charge, that sort of thing. And that's similar, I think, to the approach that-- what Senator Fredrickson is doing here and it's what a number of other states have done as well. And that's why I think-- maybe to kind of answer what Senator Ballard asked, that's why it's a little different when you talk about a pastor or a religious counselor because they aren't necessarily offering a service. They're not charging for that. They're meeting individually with somebody to talk about spiritual matters, church doctrine, that sort of thing. And that's why it's different. Perhaps that's part of what you're asking about. So I wanted to kind of provide a response to what you asked earlier and I hope that's helpful and I'll answer any questions if anyone has any.

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

BALLARD: Thank you, Chair. Thank you for being here, Mr. Eickholt. Can you walk me through-- maybe this is a question for--

SPIKE EICKHOLT: Sure.

BALLARD: --for the introducer, but can you walk me through the process of how complaints are filed through the deceptive trade practice?

SPIKE EICKHOLT: Well, I think it would be just calling the police. They could be contacting the Board of Psychiatry or something like that. If it's sort of brought to the attention of the state, if you will, then the authorities can get involved. And it can be for a variety of different things. I mean, the Attorney General investigates some of those complaints. I know the local police departments too. Sometimes prosecutors will bring charges. A lot of it's handled, in my experience, is done on a civil matter where the Attorney General's Office, civil division will contact a business or an organization that's doing something that may be in violation or counter to it.

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BALLARD: OK. So a patient believes they were subjected to--

SPIKE EICKHOLT: Right, a parent says, I paid $15,000 to this therapist and my kid still seems to be gay. That could be a perfect example. And they contacted fraud-- consumer fraud unit at the Attorney General's Office. That's how something like that could happen.

BALLARD: Oh, so it could go either way. A patient could say I was-- if this--

SPIKE EICKHOLT: Right.

BALLARD: --if this proposed bill passes, a patient could go to the Attorney General's Office, but also a parent could go.

SPIKE EICKHOLT: Yeah, I could see it happening a couple ways, exactly right. I mean, for a patient to say I was subjected to some of those things you heard earlier, shock or made to watch heterosexual pornography or something like that, and it just caused a lot of confusion. It caused me a lot of depression. I just think that you should know that this person or business is doing this. It's just not right. That could be one way. Or another way, just an example I gave there before, parents just aren't happy, right? They shell out a bunch of money and, and that's one way. And that's what I think is important. Senator Fredrickson can speak to the bill, but that was my read of why that reference is there. In addition to professional licensure and credentialing and sort of things for people who are doing this under the guise of a profession. This will provide for a remedy, if you will, if somebody is doing this with a pretense or promise that they can change someone's gender identity or something like that.

BALLARD: I'm kind of putting you on the spot here, but what kind of penalty does that, does that carry?

SPIKE EICKHOLT: I-- most of the crimes are fairly minor, misdemeanors. And most of the stuff is civil sanction type things where you pay a fine or you agree to desist in the practice, that sort of thing, or you pay the victims back, the rest-- restitution, that sort of thing.

BALLARD: OK. Thank you.

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HANSEN: Any other questions from the committee? Seeing none, thank you. We'll take the next testifier in support.

ALEX DWORAK: Good evening once again. Senators, my name is Alex Dworak, A-l-e-x D-w-o-r-a-k. It is my honor to come before the HHS Committee in support of LB179. I am speaking on my own behalf as a doctor and as a bisexual man. Thank you for staying late once more to hear our voices. I provide PrEP, HIV care, substance use disorder services, including Suboxone and Naltrexone for opioid and alcohol use disorder, gender-affirming hormone therapy and mental health services as part of a full spectrum primary care practice. I didn't coordinate, but I'm also a NAP board member for the Nebraska AIDS Project. As my own representative from the 12th District has pointed out in a previous hearing, the state does indeed have a role in the regulation of quality medical care. Just like at that hearing, I am here for the same reason; protecting the mental health of queer youth and preventing suicide. I am also saying the same thing: affirming care is the medical standard, full stop. Conversion practices are ineffective, harmful and unethical. The reason for this is that the brain is the primary sex organ in the body. This is true for both sexual attraction and orientation, as well as biological sex in the context of gender. Our brain determines how we experience the world, how we identify and behave and who we love. For example, is a woman still a woman if she has a hysterectomy? What if she has a BRCA gene and also has a double mastectomy due to breast cancer? What about a man who develops gynecomastia, large breasts, due to low testosterone and feels a lot of distress about that? Or a wounded combat veteran who lost his legs and genitals to an IED? None of those things changes their gender or has anything to say about to whom they are attracted. It is their brain which determines this. The mounting scientific consensus, as well as our stridently raised voices in the queer community, both say this needs to be respected and affirmed, not shamed and erased by things like conversion practices. The National Alliance on Mental Illness, American Academy of Child and Adolescent Psychiatry and all other legitimate medical societies vehemently oppose conversion practices as ineffective and actively harmful. We have mentioned religion. I think it also bears mentioning that the Global Interfaith Commission on LGBT Lives condemns conversion. No less a person than its leader, Archbishop Desmond Tutu says this with his full religious and moral authority. Besides being unethical and deeply harmful, even potentially driving youth to

suicide, conversion practices are very costly to society. My fellow testifier beat me to the punch, but I've included some copies of that JAMA study for your review. In addition to costs of over $9.23 billion, it makes a forceful statement in concluding, quote, There are already multiple unambiguous statements from professional societies and human rights groups on the imperative to stop conversion because of its discriminatory nature and profoundly harmful effects. It is incumbent on policymakers to act to protect youths from and stop all funding for this unacceptable practice. Likewise, increasing access to affirmative therapy may promote health by empowering LGBTQ youth with skills and strategies to counteract minority stress. I'm here to call upon you to represent all Nebraskans and advance this bill. I appreciate Senator Fredrickson very much for introducing it. Queer youth belong here and deserve to be themselves. We, queer youth and adults, should not have to accept a state which tells us formally that it believes we shouldn't exist. I do believe that I could answer a couple of questions that were raised as well. The question of free speech, I-- in my opinion as a physician, I would say that this is not speech. If I tell a person with a substance use disorder not to take treatment or if I tell a person with HIV that I'm treating not to take their HIV medicines and to treat it with herbs, that isn't speech, but that's practice. There was a case of a surgeon who was using the surgical instruments to put his initials on the underside of people's livers while doing laparoscopies. That was not speech. That was malpractice and he lost his license and he should have. This is not something that impacts people's ability to think and feel whatever is right for them. Outside of the context of the practice of medicine, this is regulating medicine. Now I will add my voice to the previous testimony that I grew up here in Nebraska. I've got deep roots here in south Omaha. I never could have imagined wanting to go anywhere else. The very real prospect of leaving, leaving my wife a widow and leaving my two children fatherless when I was in the middle of it with COVID, before we had meds, before we had vaccines, before we had-- when we didn't even have enough masks, that didn't stop me. But this is making me stop and think and wonder is, is Nebraska still the place for me and my family? So I can answer some of the other questions that were brought up if time permits or if you desire. Once again, I want to thank you all very much for staying late to hear me and to hear all of us. I want to thank Senator Fredrickson again for

what he is doing and I would be glad to take any questions that you may have.

HANSEN: Thank you. Are there any questions from the committee? Thanks for sticking in there. Four for four. Thanks. We'll take the next testifier in support.

COURTNEY YOACHIM: Hello. So my name is Courtney Yoachim. That's C-o-u-r-t-n-e-y Y-o-a-c-h-i-m and I am an independently licensed professional counselor with Kindred Psychology. I specialize in working with LGBTQ clients and their families. I as an individual, I was born and raised in-- here in Nebraska in a very small farming town where my dad still runs the family farm. And I grew up in a Lutheran church all the way until I left for college. So I intimately understand the fears that queer youth and their families can go through when, you know, a kid first comes out. And a lot of those families are just trying to seek guidance. When these families reach out to a healthcare professional, they're looking for information so that they can truly do what is best for their child. To call a healthcare professional and have them offer your child treatments that have been proven many times over to harm an already vulnerable population is just unacceptable. Working with queer and gender-diverse clients, I specifically follow the WPATH standards of care as well as all of the ethical codes of my professional organizations, which are research-backed standards and recommendations to guide practice for trans and gender-diverse individuals. These standards clearly state, and I quote, treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth is no longer considered ethical. This is true as well when speaking about sexual orientation, I am legally obligated as a licensed professional to follow the ethical codes created by my professional associations. Not following these ethics is legally considered unprofessional conduct. For myself, I follow-- I fall under the American Counseling Association Code of Ethics, which states that I cannot provide any treatment known through research to cause harm. Knowing that conversion therapy has clearly been shown to harm clients, for any healthcare professional to provide conversion therapy is already considered unethical. I want to urge the committee today to support this bill explicitly-- to explicitly prohibit these practices, which would be just one more step in protecting Nebraska youth and families. Thank you.

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HANSEN: Thank you. Are there any questions from the committee? I got a question. You brought up an interesting point. So right now, could you be convicted, like, of an ethical crime for doing conversion therapy?

COURTNEY YOACHIM: Technically, that could be something-- so the-- I believe that the wording in the statute for Nebraska is that it's considered unprofessional conduct to not follow whatever code of ethics you professionally fall under. And at least for the American Counseling Association, there are very clear standards of you have to provide services that have been evidence backed to help. And you cannot provide services that have been of evidence backed to harm. Conversion therapy has been shown to be harmful. So to me, yes, that would be like something that's already legally prohibited, just not explicitly. And clearly there are still people who aren't-- like, aren't following those ethical codes.

HANSEN: OK. This might be kind of lawyer--

COURTNEY YOACHIM: This would be another way to protect--

HANSEN: --lawyer question too. Just kind of, just kind of curious if somebody could, like, charge you with an ethical crime for--

COURTNEY YOACHIM: So how it would go, I-- to my understanding, it would be a complaint against somebody's license and then that would be by what other-- by the licensure board would be investigated.

HANSEN: OK, thanks for that. I appreciate it. Any other questions from the committee? Seeing none, thank you.

COURTNEY YOACHIM: Thank you.

HANSEN: We'll take the next testifier in support. Welcome.

ABBI SWATSWORTH: Yeah, I agree with Erin. The chair is lower or the desk is higher, can't tell which one it is. Thank you, Chairman Hansen and members of the Health and Human Services Committee. My name is Abbi Swatsworth, A-b-b-i S-w-a-t-s-w-o-r-t-h. I'm the executive director of OutNebraska, a nonpartisan, nonprofit organization working to celebrate and empower 67,000 LGBTQ Nebraskans. OutNebraska supports LB179. It is time to add Nebraska to the growing list of states that have banned conversion therapy for

minors by statute, including states where similar legislation is being recognized with bipartisan support. We believe that all Nebraskans want our young people to be safe and to have every opportunity to thrive in our state. From a collaborative report from the Substance Abuse Mental Health Services Administration and the American Psychological Association, quote, Conversion practices aimed at a fixed outcome such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression and sexual orientation are coercive, harmful and should not be part of behavioral health treatment, end quote. We've already heard from survivors and many experts about how damaging conversion therapy can be. As a member of the LGBTQ community, I understand personally the danger of believing that some part of your identity is bad or that you are unlovable. While I am not a survivor of conversion therapy, I grew up in a church that regularly preached that AIDS was God's punishment for being gay and that all gay people would go to hell. This spiritual trauma stayed with me and I struggled with depression and substance misuse until I received affirming therapy in young adulthood and began the process of accepting myself, eventually coming to believe that I have inherent worth as a queer person. This legislation, as we've heard, will not impact parental or religious rights. Parents and churches will retain the right to their interpretation of biblical teachings. This legislation will only curb licensed professionals from using damaging practices that have been shown through research to produce serious, life-threatening harm for young people who are subjected to them, as we've heard again from experts and survivors today. OutNebraska believes that Nebraska should value and honor the lives of all of our young people and doing so means protecting them from conversion therapy. We respectfully urge you to declare that all young LGBTQ Nebraskans are born perfect by advancing LB179 to General File. Thank you.

HANSEN: Thank you. Any questions from the committee? Seeing none, thank you. Is there anybody else wishing to testify in opposition to LB179?

____________________: Anyone in support?

HANSEN: Oh, support. Geez Louise. Sorry, after 6:00, my brain turns to mush. Yeah, I meant support.

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JACOB CARMICHAEL: No, I was running out to do something else and great timing coming back in. Yeah, good evening, Senator Hansen and members of the HHS Committee. My name is Jacob Carmichael, J-a-c-o-b C-a-r-m-i-c-h-a-e-l, and I'm here today to testify in support of LB179. First, I would like to address a concern that Senator Riepe, you mentioned in Senator Fredrickson's introduction and I haven't really heard addressed about, like, freedom of speech and freedom of expression. I don't necessarily see how this places any restrictions on a provider's freedom of speech. They're free to not do their job. They have the certification and we hold all professionals to certain standards. You-- like, they're therapists. They're medical practitioners. If a doctor engages in a dangerous surgery that's proven to not be effective and be harmful to everyone it's done on, they're sued with malpractice. I don't see why it's any different in this case when we're talking about both through therapeutical, through mental health means or through electroconvulsion therapy, why we would consider that any different. At this point with what we know science wise, medicine wise, health wise, we shouldn't be treating these issues any different. Healthcare is healthcare. Mental healthcare is healthcare. Any medical professional should have to follow good medicine, evidence-based medicine, and conversion therapy is not that. This doesn't place any restrictions on any-- I forget the exact wording in the bill, but any pastors, anyone who wants to follow their religious expression or do it like that. It's on medical professionals who are doing their job. Even any company, if you do bad at your job, you get a bad evaluation and you're going to be fired. That's the basis of how a lot of jobs work. It's the basis of how medicine works in the vast majority of practices, except for these cases. I don't really have anything else to say because it's common sense and we need to treat this issue as it actually is. It's outdated to treat it as anything else. And I think as the HHS Committee, as practitioners, people that engage in this legislation, it should be a given that across the board, healthcare is healthcare. That's it. Thank you.

HANSEN: Thank you. Are we the last one you're testifying in today?

JACOB CARMICHAEL: I think I'm the last one.

HANSEN: You had nine you said that you were doing today. How many hearings are you testifying in? Is it--

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JACOB CARMICHAEL: I have testimonies in all three ones. It's seven testimonies total, but nine testifier sheets because I still have to go to Gov.

HANSEN: We're usually here last, so [INAUDIBLE] surprise.

JACOB CARMICHAEL: That's true, but Government probably has another hour left, so.

HANSEN: Oh, OK. I feel better. Any questions from the committee at all? All right, seeing none, thank you.

JACOB CARMICHAEL: Thank you.

HANSEN: Anybody else wishing to testify in support of LB179? OK, seeing none, is there anybody who wishes to testify in opposition to LB179? Welcome.

GREG BAYLOR: Thank you, Chairman Hansen and members of the committee. My name is Greg Baylor, G-r-e-g B-a-y-l-o-r, and I serve as senior counsel at Alliance Defending Freedom. So who gets to decide what counseling goals a person can pursue: the patient and his or her counselor or the government? This should be an easy question to answer, but LB179 allows government officials to insert themselves into the private conversations between patients and counselors to decide what goals can be pursued and what ideas can be discussed. The U.S. Supreme Court has long protected the First Amendment rights of professionals such as therapists and counselors and it recently questioned the constitutionality of laws in California and New Jersey that banned certain counseling related to a person's sexual attractions or gender identity, laws that are similar to LB179. The Florida ordinances prohibit-- pardon me, relying upon that precedent, the U.S. Supreme Court-- the U.S. Court of Appeals for the 11th Circuit struck down two local Florida ordinances that are virtually identical to the bill that you're considering here today. The Florida ordinances prohibited, quote, the practice of seeking to change an individual's sexual orientation or gender identity, including but not limited to efforts to change behaviors, gender identity or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings towards individuals of the same gender or sex. If you take that language and compare it to page 6, lines 3 through 7 of LB179, you'll see that it's nearly a word-for-word copy of that

language that was invalidated under the First Amendment by that other court. The 11th Circuit ruled that the Florida ordinances discriminated on the basis of the content of the counselor's speech in violation of the First Amendment. They said, quote, Whether therapy is prohibited depends only on the content of the words used in that therapy. And the ban on that content is because the government disagrees with it. And whether the government's disagreement is for good reasons, great reasons or terrible reasons has nothing at all to do with it. All that matters is that a therapist's speech to a minor client is legal or illegal under the ordinance based solely on its content. Now, to be sure, if a therapist engages in abusive or unethical conduct, he can and should be disciplined. If he forces a client to undergo therapy against his or her will, he can and should be disciplined and sued for malpractice. But the government cannot prohibit conversations between a therapist and client based solely on the content of that conversation. The 11th Circuit warned that, quote, People have intense religious, moral and spiritual views about counseling related to sexuality and identity. And that is exactly why the First Amendment does not allow communities to determine how their neighbors may be counseled about matters of sexual orientation or gender identity, end quote. Every person deserves the right to private conversations with the trusted counselors they choose, free from government censorship. LB179 interferes with that right. I heard Senator Fredrickson say that this is settled law or solid ground. That is not the case. Clearly, when one circuit, the 9th Circuit, which he mentioned, has one position on this question, the 11th Circuit, another circuit, has a position on-- a different position on this question, that's the definition of not solid law. There are other cases too that have struck down conversion therapy bans. This Schwartz v. New York City [SIC] case, the district court held that the conversion therapy found the counseling censorship law violated the free speech clause. More recently in the case called Vazzo v. City of Tampa, a Florida court struck down a counseling censorship law similar to the one here. I've heard it said that this is not speech, this is conduct. Well, some of the things that are embraced within the definition of what's being addressed here are not speech, clearly, but lots of what is addressed here is speech. And the Supreme Court said just because someone has a license doesn't mean that they're not engaging in speech. It is also said just because they have a license doesn't mean that government has plenary

authority to censor what they do. The last thing I would like to say, there's been a lot of assertions about the science and medicine. That's not my area of expertise, but I do plan to submit to the committee three affidavits that were done under oath in federal court that contradicts some of the assertions made here today. Thank you.

HANSEN: Thank you. Are there any questions from the committee? Senator Hardin.

HARDIN: Does this open up a litigious avenue into Nebraska? Will there be lawsuits over this?

GREG BAYLOR: I think if it passes, certainly there will be lawsuits. This violates constitutional rights. And we're aware of counselors around the country who oppose these counseling censorship laws because it takes away the ability for them not only to just express their views, but to do what they believe is good for people who want their help. Think particularly of children who are confused about their identity and there's distress about it and their parent takes them to a counselor's office. Under this law, what does that counselor to do? Is the only choice that the counselor has under this law to affirm and set that child on a pathway that conceivably and usually unfortunately ends with puberty blockers, cross-sex hormones, surgery that sterilizes a person and makes them unable to sexual-- function normally sexually. I'm afraid that this law will force every counselor to go down that pathway, that they won't have an option of starting to explore the reasons why the child is rejecting their natal sex. So I do think that this will generate litigation from the counselors who want to help children like that.

HARDIN: You mentioned just before you closed that you had other information to potentially share with us and well, that won't make it on to the camera so can you take a brief moment and share other thoughts?

GREG BAYLOR: Sure. On the question of whether talk therapy, not all these other things, but talk therapy is harmful, Dr. Christopher Rosik has testified under oath that, quote, no methodologically sound study supports the conclusion that conversational counseling to assist individuals who wish to achieve a reduction in same-sex attractions or an increase in opposite-sex attractions is harmful to most or even many participants. Another doctor, Dr. Stephen Levine,

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who is a pioneer in this area of psychological treatment, he said under oath earlier last month trans-- as to the question of whether conversational therapy is harmful or even increases the chances of suicide, transition and affirmation do not decrease and, and may increase the risk of suicide. There's a lot of unknowns in this area and we should proceed with caution. As for the helpfulness of talk therapy, Dr. Rosik testified under oath, recent careful studies find that such counseling is beneficial to mental health on average, I'm not talking about aversion therapy. I'm not talking about these things that have been discussed. I'm talking about a conversation between a therapist and a patient.

HANSEN: Senator Ballard. Do you--

BALLARD: I-- yes. Thank you, Mr. Chair.

HANSEN: Sorry, go ahead.

BALLARD: Yeah. The exclusion of clergy members and religious counselors, do you think that's enough protection for religious freedom in this, in this legislation?

GREG BAYLOR: Thank you for that question, Senator. I honestly do not believe it's sufficient. Think about the people who filed these cases challenging these bans on their speech. They weren't acting in a religious capacity, may have had religious beliefs, but they just simply wanted to counsel their patients consistent what they thought works. So it doesn't do them any good. The other scenario is lots-- I represent a lot of religious universities and they often have on staff licensed counselors to help the students at the university deal with the struggles that they're facing. And those people are acting-- yes, they may be in the context of a religious institution, but they're-- they would be governed by a law like LB179. So I don't believe that the modest carve-out for religious, church kind of settings is adequate to address the problems that I've raised.

BALLARD: Thank you.

HANSEN: Any other questions from the committee? Can I ask you a lawyerly question?

GREG BAYLOR: Sure thing. Yes you may.

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HANSEN: And then that even might give Senator Fredrickson a chance to respond when he comes up. It's more of a, of a situational kind of question.

GREG BAYLOR: OK.

HANSEN: So there's a minor who is confused about their gender.

GREG BAYLOR: Sure.

HANSEN: They go to a counselor with suicidal tendencies. The counselor is-- what is their recourse as a counselor? Would they be able to say, there's certain things I can't talk about; there's certain things-- some certain things I can talk about? Like, if this bill is passed, right? Like, would that, in your opinion, interfere with their ability to counsel that child appropriately?

GREG BAYLOR: I think it does. At the very least, the bill is uncertain. As I understand it, the three most common therapeutic approaches to child-- children who present with rejecting their natal sex, whether or not they're suicidal, but they come for help because they want it or the parents want it, the first one is something called watchful waiting and there are two variants of that. One of them is essentially not to try to do anything. And you wouldn't do this in this circumstance that you've described, of course, but you just watch and see what happens with the, with the child's disconnect, right, between their body and because-- between their self-conception-- perception. You have follow-up appointments, of course. And the reason why that's an accepted approach is because the data show clearly and unequivocally that somewhere between 85 and 98 percent of children who don't identify with their natal sex will do what the professionals call desist, that they're-- they will-- puberty is the medicine, in a sense, to, to enable children to harmonize their bodies, maybe their self-perception that's not consistent with their bodies. So that's why wait, possible waiting. And those kids, they avoid the social transitioning; the shots, the surgeries that sterilize them for life. That's what I'm worried about with this bill. It's going to send more kids down that pathway. The second approach is like a psychotherapy model, which I think would be appropriate. I mean, I'm not a doctor, but the psychotherapy model is probably what they ought to do. And in that circumstance, they would explore the reasons why the person is disconnected from their natal

sex. This is not necessarily a natural and a normal phenomenon. I mean, part of the reason we know that is because there's been an explosion, particularly of girls who now want to identify as boys, and it's because of-- it's not because of their identity or who they are, it's because of the pressures they face as girls in Western society in 2023. And then the last model is affirmation model, which is to affirm what's happening. I, I, I, I'm very fearful that this law would make approaches one and two impermissible and it would force counselors to go down path three because that's the only one that's clearly permissible under the statute.

HANSEN: OK. That was a lot longer answer than I thought I was going to get, so thanks.

GREG BAYLOR: Lawyers used to get paid by the word so it's an occupational hazard.

HANSEN: OK. All right, any other questions from the committee? All right, thank you.

GREG BAYLOR: Thank you.

HANSEN: We'll take our next testifier in opposition.

STEPHANIE JOHNSON: Hi.

HANSEN: Hello.

STEPHANIE JOHNSON: My name is Stephanie Johnson, S-t-e-p-h-a-n-i-e J-o-h-n-s-o-n, and thank you for the opportunity to speak to you today. I am speaking in opposition of LB179, but I want to first address electrotherapy. I heard in the previous comments, which I'm glad I was able to listen to that, but it was almost assumed that children in the state of Nebraska can receive shock therapy as a treatment for conversion therapy. And I did a quick search to see if I could receive shock therapy in Nebraska and I can at Bryan LGH and it says that it is a-- people who cannot take medication for mental health conditions for any reason can still receive ECT, it-- even pregnant women and it's 80 to 85 percent effective for patients who receive it. But according to Nebraska Statute 30-4415, people in the state in Nebraska must be 19 years or older to receive this. So I'm just going to move on from that. So the definition of conversion therapy in this bill is what really concerns me the most because it

does say in the bill that conversion therapy means a practice or treatment that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions, gender expressions-- remember, we're talking about children, children-- or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender. So knowing the definition of conversion therapy is important in understanding this bill in that we're not speaking about adults. We're speaking about children. So according to the definition in this bill, conversion therapy could be nothing more than talking with a child about choices they're facing now or will at some point in the future regarding how they feel about their gender identity or their expression of their gender, according to the definition in this bill. It prohibits the discussion by medical providers on that specific topic of gender orientation and gender identity. Remember, children. What's concerning is the possibility of a legislative creep down the road. What other subjects will the legislation come down on that we cannot talk about with our doctors regarding our children? What other subjects will become prohibited? These are very concerning to parents and to all Nebraskans. The APA, which is the American Psychiatric Association, was cited multiple times during this session. And even Senator Fredrickson himself, in his opening comments, referred to this. I sent you during this session the APA's 140-page document that's being cited all throughout this. I also sent you an article in which, based on if you want to talk about evidence-based practice, there is an article that cites that article that I sent you multiple times within that article in which the APA admits that it does not have evidence-based scientific research to support that specific topic. So it would be wise, as you're looking at this, to go through and see what the APA says. But then there's no scientific evidence or evidence-based practice to support that topic. For example, number one-- I'm just going to give you three examples. You can read the article. I sent it to you. Opposition of conversion-- of this therapy is based in part on the belief that people are born gay, probably as a result of a gay gene or some other biological factor at birth. This is why people are against conversion therapy. But the APA admits in its own article that I sent you, quote, There is no consensus among scientists about what causes homosexuality and that nurture may play a role. Point two, the APA admitted that scientific research has clearly shown that these sexual identities in adolescent-- adolescents particular-- that we're talking about, children-- that

population is targeted the most by these bans. Their gender identities are fluid. As we know, growing up, it's a part of going through puberty. It's not fixed. It's, it's a confusing time. And for us not to have the option to talk about this at our-- with our medical practices while our children are going through this is ridiculous to me, especially as a mother. Point three, where the APA doesn't have evidence-based scientific research to back their statement. There's many of them. I'm just giving you three. Most of the therapy bans that have been enacted or proposed are targeted specifically at minor clients. However, the APA acknowledges that there has been virtually no-- none-- no actual research whatsoever done on sexual orientation change efforts with children or adolescents. You can go and look at the article. The APA cites it itself. The statement and all of this is backed up. I'll make one more point with that. Legislative restrictions-- this is another one in the APA that they contradict themselves. Oh, man.

HANSEN: Your red light came on.

STEPHANIE JOHNSON: All right.

HANSEN: Sorry. Let me just see if there's any questions from the committee. Are there any questions from the committee? Senator Riepe.

RIEPE: Can I hear your last point?

STEPHANIE JOHNSON: Yes. Well, this is in the article, but legislative restrictions on sexual orientation change efforts with minors are based on the belief that such therapy always or usually occurs as a result of coercion by parents or other adults. However, in the article, the APA acknowledges that concerns about potential coercion could be mitigated by implementing a system of developmentally appropriate informed consent as a treatment which goes against virtually what what this bill states is the APA saying would be an alternative to what would actually make sense for children going through puberty.

RIEPE: OK. Thank you.

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

STEPHANIE JOHNSON: Thank you for your time.

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HANSEN: And we'll take the next testifier in opposition.

TOM VENZOR: Good evening, Chairman Hansen, members of the Health and Human Services Committee. My name is Tom Venzor, T-o-m V-e-n-z-o-r. I'm the executive director of the Nebraska Catholic Conference. The Catholic faith recognizes the supreme dignity of each and every person. Each of us is made in the image and likeness of God and the only appropriate response to this fundamental fact is charity, which is to will the good of the other. Charity extends to every aspect of our life, including the ways we counsel and assist others in their life's journey. LB179 attempts to address conversion therapy, gender identity conversion therapy and sexual orientation conversion therapy, which have been utilized in counseling situations. As defined by LB179, conversion therapy would not only-- would include not only problematic practices which are to be condemned, as you've heard already from proponents, but also include a number of benign practices. The task before us is to make critical distinctions between these two things. This committee and the Judiciary Committee in the past have heard numerous heartbreaking stories this year and over the last several years when LB167 and LB231 were considered. It seems universally acknowledged that the problematic practices of conversion therapy are unhelpful, unsafe, unethical. And professional licensing bodies, as you've heard already as well, can already discipline a licensed professional for engaging in these appropriate behave-- techniques and behaviors as violations of their codes of ethics. But LB179 is not simply restricted to harmful practices of conversion therapy. It also bans practices such as talk therapy, which amount to counseling censorship. This therapeutic technique would help clients in their own counseling goals through the ability to explore the issues they are presenting. Consider the following example, which would be captured by LB179's problematic definition of conversion therapy. An 18-year-old male experiences sexual or romantic attraction for somebody of the same sex. He considers these unwanted and undesired attractions. And rather than act on these attractions, he would prefer to live chastity by integrating his human sexuality with his moral or religious convictions. LB179 would prohibit a counselor from helping him realize his counseling goals. To provide contrast, if that-- the attraction were to somebody of the opposite sex, this same 18-year-old could seek such assistance to live chastity without any issue and this unequal treatment raises serious constitutional problems for LB179, as you've heard already

from Mr. Baylor. LB179 also purports to provide a religious accommodation. Besides being practically meaningless, it ultimately proposes a false understanding of the healthcare provider in their moral or religious commitments. Section 3(3) assumes that a person can strictly separate their pastoral and religious ministry from their capacity as a healthcare professional, as if one were hanging up their coat at the beginning of the workday only to be thrown back on when they leave the office. Certainly, counselors must suspend judgment and refrain from imposing their values onto their clients, but this subsection would force healthcare professionals who are clergy members or religious counselors, an undefined and otherwise unrecognizable statutory term, to check their religious and moral values at the door. This treats pastoral and religious considerations as having no bearing on the overall well-being and health of a client or patient. This faulty philosophical notion of forcing a separation between pastoral/religious values and healthcare is especially problematic when the patient or client seeks a healthcare professional who understands and respects their moral or religious commitments and seeks out a healthcare professional who can bring those moral and religious values to the counselor-client relationship. I would also add, too, there's been a lot of, I think, discussion about just kind of clinical experiences and other things of that nature. And I think those are obviously important to the conversation, but I think it's important to go back to look at the text of the bill and what the text of the bill says as to what is conversion therapy and not simply what our experiences of what people are experienced as being conversion therapy. Because I think those experiences are one thing and the, in the definition of the bill is, is another thing which is very broad. I think there was another claim earlier on that opposition to this bill is based on some a priori assumption, you know, that you can only affirm-- that basically, you know, you have to deal with same-sex attraction or gender identity or gender dysphoria in a certain way. But I would say that this bill also makes, I think, basically an a priori assumption, as you've heard already, that there's only one method involved in the counseling setting and that's affirmation. And so I think those are problems. But ultimately, I think what you have here, like we have with some of the other bills dealing with this topic, is basically if you hold the traditional view of marriage and human sexuality, you're not going to be able to seek out the counselor or the provide-- or provide the counseling to those seeking out those who want to affirm

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your values. And again, I think that just goes back to the kind of larger cultural issues that we're having right now, kind of in a post Obergefell world about issues of marriage and human sexuality and sort of the, the debates that are going on on that issue too. So I just wanted to make those last few notes and happy to take any questions.

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

M. CAVANAUGH: Thank you. Thank you for being here. I'm going to ask you a similar question that I asked you before. So I think it's clear that the introducer of this attempted to-- whether you agree with it or not, attempted to make an exception for religious clergy and that type of counseling. Have you expressed your concerns or-- your concerns with this--

TOM VENZOR: Yeah, not directly to Senator Fredrickson. These are concerns that we've raised probably in multiple iterations of this bill and--

M. CAVANAUGH: But it is a first year, so.

TOM VENZOR: Sure, sure. Yeah. No, no. Yeah, definitely get that. Yep, yep. No, fair enough, but these are definitely concerns we've raised in previous iterations of the bill.

M. CAVANAUGH: OK because I mean, he did make a point in his opening to state that that was something that he was attempting to address.

TOM VENZOR: Yeah. I think previous introducers of this bill have made that point as well to try to, I think-- and I'm not saying anything about his intentions, but I think that claim has been made in the past that this is somehow, you know, some level of religious accommodation for religious counselors or clergy members. And we continue to make the same argument in the past that it's, it's not sufficient and I think you heard that more extensively from Mr. Baylor.

M. CAVANAUGH: So-- and I take your point about, especially when you're talking about in a religious-- like, an individual who is seeking counseling in their marriage or situations like that. This specifically seeks for minors--

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TOM VENZOR: Um-hum.

M. CAVANAUGH: --and if you are taking your minor child to counseling, you, you do have to go into any sort of-- I mean, health care professional, whether it's a doctor setting, any medical setting, one would argue you go in with an expectation of a standard of care, right? Like, you take your kid to the pediatrician--

TOM VENZOR: Um-hum.

M. CAVANAUGH: --and you have a standard of care expectation. You don't go to the pediatrician and immediately say are you a Jehovah's Witness? Like, you assume that there's going-- because a Jehovah's Witness will not want to do a blood transfusion and maybe your kid is going to need a blood transfusion. You're assuming a standard of care. Now, maybe you personally do go in and ask if they're a Jehovah's Witness. I've never asked the religious affiliation of my childcare provider. So I think the point is-- that I'm trying to make to you is that when you take your child to a healthcare professional, there should be a standard of care that you can safely assume is being met. And this bill appears to be trying to set what that standard is, not addressing their religious concerns. Because as a parent, if I feel that my child needs the type of counseling that you are talking about, I would then take my child to the clergy member within my church, which would not be a medical setting. That would be a religious/pastoral setting.

TOM VENZOR: Yeah, so there's a couple of different things there I think that you're getting to. So one, this bill is establishing a legal standard of care.

M. CAVANAUGH: Yes.

TOM VENZOR: And our whole point about this bill is that while it's trying to address some, I think, really problematic practices and I think you've-- I think we can-- I think this is what--

M. CAVANAUGH: Yes.

TOM VENZOR: --we've said in the past is we can agree that there's a lot of problematic practices historically that have gone on and those things are generally understood to be unethical. And those things could be brought up against ethics committees, I think, you know, for

potential licensure issues. What I'm saying is that this bill goes well beyond those scenarios.

M. CAVANAUGH: OK.

TOM VENZOR: And so then it's establishing a way broader legal standard of care and one that I think is very much in dispute as to whether it's the correct standard of care that ought to be implemented into state law. So I think that's what I would say on that first point. I think on the second point, there might-- I think there might be some level of misunderstanding. What I'm saying is that you're going to have clergy members or religious counselors or let's say pastors or things of that nature who, who do maybe both-- they do pastoral work, let's say, on the weekend, you know? Maybe they're an evangelical pastor in a, in a, in a church somewhere. But then during the week, maybe they're a professional counselor and that's kind of how they pay the bill, so to speak. And people are seeking them out for two things; for both their religious and moral values, but also their professional counseling experience, so-- and that's why we're saying that you're going to have scenarios where this bill is trying to force a separation between those religious moral values, on the one hand, and their, and their, and their professional judgments as counselors and their ability to help with families and minors who are seeking them out as their preferred provider as a counselor.

M. CAVANAUGH: Could-- two more.

TOM VENZOR: Yeah, um-hum.

M. CAVANAUGH: Okay. So could potentially-- I appreciate that scenario. Could potentially that individual, that councilor who provides pastoral services in a volunteer capacity outside of their professional services, could this be accounting for the fact that in the professional services in which they are charging, getting insurance reimbursement, etcetera, that they don't offer this specific type of counseling, but they, they can offer the counseling in a non-- a fed-- non medically official capacity. This doesn't prohibit them from still counseling that exact same child or family in pastoral setting, but it does require them to operate under a specific standard of care in the clinical setting.

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TOM VENZOR: Right. And like we-- like I said earlier on, that's what's in dispute. The standard of care that this bill is seeking to set, you know, which is that if you seek to eliminate, reduce or diminish-- I think those are the three terms-- you know, sexual-- let's say, sexual attraction for somebody of the same sex or somebody's sense of gender identity, right? Those thing-- if you do anything in that realm, that's considered a violation of this bill. And that's where, that's, that's where I offered you the example of, for example, the 18-year-old, 17/18-year-old who comes in and says same-sex attracted, but I want to-- I, I don't want to act out on those attractions. I want to live sort of a life of chastity in according to my religious values. That counselor, under this bill, is not going to be-- do anything because it's going to be an elimination, reduction or, or diminishment of that person's sexual attraction in that context. But if you, if you take that same hypothetical and apply it to a heterosexual attraction, the counselor is going to say, Oh, yeah, well, I can help you now. And so that's the whole, I think, what Mr. Baylor is saying. That's, that sort of classic content-based view tent-- viewpoint discrimination that violates the First Amendment. And also I think it just sort of runs against common sense that the counselor could help in this situation, but they couldn't help in this situation. And what I'm saying is when you're, when you're expanding a scope of-- a standard of practice to constitute that, I think that's not something that the state should be adopting.

M. CAVANAUGH: I can't respond to that because I'm not a clinician, so-- and I believe that our introducer probably can in his closing so I'll leave that. I'll leave that there. My final question for you is this currently is the standard operating in, in the city of Lincoln. And so is the sky falling in Lincoln? Are we not able-- all of the thing-- all of the scenarios that you're talking about, that you're concerned about as, as a archdiocese in Lincoln, is this a problem currently? Is Lincoln facing litigation? Are there problems with providing quality care? Like, can you speak to that?

TOM VENZOR: So I can tell you that there's definitely concern about the Lincoln conversion therapy being an ordinance because--

M. CAVANAUGH: But practically, is there any litigation?

TOM VENZOR: Well-- so that's what I'm getting to here is the practical dynamic of it. There is, practically speaking, concern about the ordinance that's on the book right now because it's very similar to this legislation and has many of the same deeper problems that I've spoken about, that Mr. Baylor has spoken about, that we've seen in other cases around the country, including the 11th Circuit. So, yeah, there's concerns about it. What I would probably say, from my experience is, I don't think anybody is out there, you know, going around, looking to see if there's a-- you know, I'm not talking about the unethical practices, right? I'm talking about some of--

M. CAVANAUGH: Right.

TOM VENZOR: --the other stuff that we're talking about that's sort of in question. I don't know if there's anybody out there sort of, you know, seeking-- you know, looking for trouble or looking for counselors who are practicing things that are in violation of the ordinance. But I can tell you that those things, like anything in the free speech realm, those things tend to have a chilling effect. But I can also tell you that there have been people who've wanted to raise concerns about this in the counseling world, but they, they are fearful of professional repercussions in the way they'll be treated by the broader community in the normal--

M. CAVANAUGH: But to answer my--

TOM VENZOR: --thing-- the normal optics that occur. I'm telling you, part of the practical problems, which are--

M. CAVANAUGH: I know, but I feel like you're not answering my question.

TOM VENZOR: OK, fair enough.

M. CAVANAUGH: And so I just-- I'm looking-- I feel like I'm trying to follow what you're saying and I'm just really looking for a clear, definitive answer.

TOM VENZOR: People are concerned about it, yes.

M. CAVANAUGH: People are concerned--

TOM VENZOR: Yes, absolutely.

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M. CAVANAUGH: --but there isn't current litigation.

TOM VENZOR: There's not current litigation, but--

M. CAVANAUGH: OK. That--

TOM VENZOR: --I would not be surprised.

M. CAVANAUGH: --that--

TOM VENZOR: --if you saw litigation in the future.

M. CAVANAUGH: OK.

TOM VENZOR: Yeah, um-hum.

M. CAVANAUGH: So people are concerned, but there currently isn't litigation.

TOM VENZOR: Correct.

M. CAVANAUGH: Thank you.

TOM VENZOR: Yeah, um-hum.

M. CAVANAUGH: Thank you. I appreciate that.

TOM VENZOR: Yeah, you bet. Um-hum.

HANSEN: Any other questions from the committee? Seeing none--

TOM VENZOR: All right, thank you very much.

HANSEN: Is there anyone else who wishes to testify in opposition? Hello.

MARILYN ASHER: Hello. My name is Marilyn Asher, M-a-r-i-l-y-n A-s-h-e-r. I am against LB179 Fremont-- primarily because it muzzles doctors, nurses, pharmacists and professional counselors through controlling their free speech. Free, free speech is protected by the First Amendment, which is being disregarded in this bill. This is not the first attempt by progressive legislators to stop free speech in Nebraska. On June 4, 2019, Governor Pete Ricketts signed LB209 into law. LB209 required that information and medication regarding

continuing a viable pregnancy be accessible to women who have second thoughts about chemical abortion after they have taken the first pill. This bill was heroically introduced by Nebraska senators who respected the right to free speech and believed that pregnant women deserved to have access to this information in case they wanted to change their mind about chemical abortions. Senator Hunt and Senator Blood thought-- fought this bill in an attempt to block the free speech of medical professionals that could assist such women. But fortunately, the Nebraska Legislature overrode the assault on the First Amendment. I would liken LB17-- LB179, prohibit conversion therapy, to the same attempt to keep medical professionals from being free to counsel their patients and clients according to the medical data that is available to them. If we pass LB179, Nebraska medical professionals will be submitting their professional expertise to the subjective wishes of a certain segment of society. As was stated before, the Family Research Council states that the APA acknowledges that there's virtually no actual research done on sexual orientation change efforts with children or adolescents. So what troubles me is that the counseling per the LB179 specifications defies the scientific method and is not rational to do so when someone's entire future is hanging in the balance. I'm also concerned about the slippery slope of this poorly written bill because as pages 5 and 6 say, this section does not apply to a practice or treatment conducted by a clergy member or religious counselor who is acting in a pastoral or religious capacity. By what standard is a pastoral or religious counselor exempt from the mandates that medical personnel are given in this bill? What keeps them separate and what will keep the author of the bill from creating another bill next year that muzzles the religious professionals? Where does this legislation stop? So that's my, my view.

HANSEN: All right, thank you. Any questions from the committee? Seeing none, thank you. We'll take the next testifier in opposition.

AMBER PARKER: A-m-b-e-r P-a-r-k-e-r, Amber Parker. I am strongly opposed to LB179 that was introduced by freshman Senator Fredrickson. And I'm going to give a layout-- and I do apologize. I don't have handouts here, but everything that I am going to list out there is documentation of and I'll be glad to present it. Lot of hearings today. I first want to say that there is an attack in the United States of America upon families and the-- a recruitment of trying to persecute marriage between a man and a woman and recognizing

traditional families. When looking at this bill, I am aware that in the capital city, it's $100 fine, I believe, for a minor to be spoken to who wants the transitioning or LGBTQ, but, but to be talked against that or their parent to bring them in that situation that it's a $100 fine. And that's ridiculous. And quite frankly, I believe other attorneys are looking into that. There's a lot happening in the state and I want to set this up as the foundation because I want to let you know Luka, who testified on the Let Them Grow bill, this all goes together. This is truly a foundation of a Marxist bill, nanny state mentality. It is removing the mother, the father from the parents' care. If they don't want, if they don't want their child to go to a counselor-- and let's say they don't want to go to a church counselor, but they don't-- say they're Muslim. Say that they-- you know, telling them to go to a pastor, Senator Cavanaugh, would be greatly disrespectful to them. And so what you're doing then for that family is you've removed their rights in this LB179 bill because you are now saying if this were to pass-- and Senator Fredrickson, who introduced it-- all the counselors are going to have to go and abide by this and go against their own religious beliefs, which they're protected by in the Constitution of the United States of America. Nebraska Med Center has a questionnaire that's ages 13 to 18 years. It's 13 to 18 years form. Dr. Amoura and Megan Smith-Sallon's name is on there. There's no parental consent on that form. I am addressing this. This is at Nebraska Med Center, connected with the University of Nebraska Med Center. Kindred Psychology is in Lincoln, I believe. They had received federal funding and to aid to push of a transgender training for clinicians. Please hear me out. I believe that the groundwork of what is trying to be pushed is to silence the parents and any child who would be struggling with gender dysphoria to take it to bring persecution upon the, the health professional in this way. And that's exactly why I call this a, a bill-- foundation of a Marxist bill because it is going-- it's removing parental rights and it's also going into and it's giving a control of Big Pharma. Because if you look at it with clinicians, if you look with psychologists, psychologists, I believe they can hand out medications and things like that for students. I want to bring to your attention, if you go to the Nebraska Med Center, there was testimony that was given in the Let Them Grow bill that was greatly misleading. And it was this: people are coming forward and say letters after letters after letters from the psychologists and going through to make sure that a minor would have to go through steps before transitioning. That's not at

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all-- and I have documentation to prove it-- that's not at all the steps they had to do. And they even used one key word. I don't want to say something wrong because they don't have the paper in front of me. But interesting enough, if you copy and paste this link to share with you senators, as I had tried to do, it-- you can't see it. It's gone. You can't see it. So the copies that you had that were handed to you, that someone handed to you on the Let Them Grow bill is-- that was the way to get them into your hands because otherwise, if you send it to you guys, you can't track it, that form. And as well to share with you Luka's story. Luka came forward. She was 16 and got a double mastectomy. No reason for it. And she is going through detransitioning. So this transition and this LB179 and what is taking place here, the foundation is already here. They got what needs to be set in place. This would only put a fast track and we would have children making decisions that can even go to a rated-R movie, can't even vote hurting their bodies and tying the parents' hands, saying the counselors have to teach this way.

HANSEN: Thank you for your testimony.

AMBER PARKER: Thank you.

HANSEN: Is there any questions from the committee? All right, seeing none, thank you. We'll take our next testifier in opposition. Welcome.

JEANNE GREISEN: Good evening. Are you awake?

HANSEN: Oh, yeah.

JEANNE GREISEN: Oh, good.

HANSEN: It's early for us yet.

JEANNE GREISEN: Yeah. My name is Jeanne Greisen, J-e-a-n-n-e G-r-e-i-s-e-n, and I am here representing Nebraska for Founders Values and we are the protectors of the First and the Sec-- and Second Amendment rights in all 93 Nebraska counties with an emphasis on protecting children. And I am here to oppose LB179 for three reasons. When you talk about conversion therapy, conversion therapy can be nothing more than talking to your child about choices that they're facing now or in the future. Having conversations is something that happens as a child develops from an infant to a young

adult. It's called nurturing and I think we forgot how to nurture children. The second reason I'm opposed is this is clearly a violation of the First Amendment. As Senator Riepe initially said at the beginning of this hearing, plain and simple, if you take away someone's voice to talk to a child-- being as this bill is based at under 19-- you're taking away a practitioner's voice to talk to their patients. And the third is, according to Senator Fredrickson claiming that conversion therapy is deceptive practice, I wonder, according to who's definition? Because if we're really just having conversations, who's going to define if that's a deceptive practice? Children, if you're going to have a conversation with them, obviously you're going to provide them with facts, maybe short-term and long-term effects of their decisions, the same thing that you do when you nurture a child. And they do terrible things, even maybe when they're a teenager, and then you tell them to correct their behavior. You give them consequences. You go out and drink alcohol, you might get an MIP, you might end up in jail. You tell them what's going to happen, right? It's the same thing. So in conclusion, I'm not going to take too much long. The testifier before me was talking about Luka. Interesting that Fox News broke that story with her again. She is clearly going through-- after her double mastectomy, she's truly damaged and a hurt human being. And she-- had she been given conversion therapy, she may not have gone down the path that she did. And if you had a conversation with her, she would tell you that she was fearmongered and her parents were told that they were either going to have a dead daughter or they could have a son. So as a parent, what do you do? So if she was-- had all this fear and she was not given conversion therapy or given alternatives as to what she could have done or could have waited, her outcome would be different right now and she would not be struggling like she's struggling right now, but she is really broken. And how many kids have to be harmed? So this is a really bad idea and I am opposed to LB179.

HANSEN: All right, thank you for your testimony. Any questions from the committee? Seeing none, thank you. Anybody else wishing to testify in opposition? Welcome.

PATRICIA BARTELS: Thank you. Good evening. My name is Patricia Bartels, P-a-r-t-- however-- P-a-t-r-i-c-i-a B-a-r-t-e-l-s. I can't even spell my name tonight. I'm sorry. I'm going to come at this a little bit different. I obviously do not have all the, the right research, but I am an aunt and a grandma and a mother. And anyway, my

niece is gay and she chose that lifestyle 20 some years ago. And I will say when I-- I've sat here listening to all of this and the pros and the cons. I'm certainly not in favor of shock therapy or anything horrible like that. But I do think when the family goes for counseling and they can only affirm what that child says that, yeah, I'm gay, if you, if you can't tell them both sides of the story, if you can only confirm what they say, I think you're missing a lot, a lot of what's necessary to make a wise decision. My niece has gone on to be a lawyer. Obviously-- well, she's a judge now. Obviously, she's not stupid. So had those things been presented to her and laid out and, you know, well, you can do this, but we've seen that this happens or if you don't do this, this will happen. I just think that they need to have the ability to have both sides of the argument presented to them. That's just-- I just wonder how different our family dynamics would be had that been handled that way and to not, as parents or people that love them, to be able to talk to them and say, you are really going down a track here that you may not be able to come back from. She knows what we all think and how she was raised. And I mean, there's been a lot of parental discussions and a lot of tears and a lot of heartache with this. And you know what? We love her partner as much as we do her. It's not, it's not that it's anything against her partner because she's a fine, fine girl. But it's, you know, how, how different would that have been if the people that-- you know, going from here on, if, if a counselor can't say that this can be a problem later or this is what we see, if they just say, oh, yeah, well, good luck with that, we'll try and help you out. You know, again, I'm not professional at this. I'm just a auntie and a grandma. And I'm just saying there's more-- there's families. There's, there's a lot affected by this and it affects things for years. And so I would just say, you know, really consider how much we have to have. The thought-- I mean, just sitting here listening to this and people-- shock therapy or things like that makes me ill. But there has to be a way that the counselors can have the freedom to say what they need to say to the people. So that's what this auntie has to say.

HANSEN: OK. Good testimony, Auntie. Is there any questions from the committee? All right, thanks for coming.

PATRICIA BARTELS: Thank you.

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HANSEN: Is there anybody else who wishes to testify in opposition to LB179?

MERLYN BARTELS: Good evening, Senator Hansen. You're probably wishing you would have put a three-minute limit on the speeches instead of five.

HANSEN: This isn't too bad. Usually when it gets past 9:00, that's usually--

MERLYN BARTELS: So you're good yet for a little bit, right? So-- all right. Well, thank you for giving us your time here this afternoon and evening. And I, too, am in opposition of this bill and for all of the reasons that you've heard from the other speakers here before. Some of these people are lawyers and more versed in this than what I am. But as I was reading through this bill, I had trouble understanding a lot of it. But the thing that I'm bothered with and as I was sitting here is what some people call the muzzling of the counselors. I don't know what you would do. But the best I could understand it, it was-- would limit them to what they could counsel the person that was coming to them. And I guess we're especially talking about children here. So, you know, it's one thing if you're an adult and you want to change your gender. You're 21 or whatever age you are. You've probably thought about this a long time and you know what you're in for and know what the consequences or the change of your lifestyle is going to be. But when you're dealing with children that are impressionable and are seeking advice and seeking some answers, I feel like if they go to a counselor, doctor or whoever they go to, they should have the ability to hear both sides of it and not just one side or just an affirming answer at that time. So I would just urge you to oppose this bill and thank you for your time this evening.

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

MERLYN BARTELS: Thank you.

***HENRY BARTENBACH:** Protect kids of Nebraska. Don’t restrict counselors from helping children during development. Let them grow up first. As an adult, they can decide whether they want to continue being the sex they were born with.

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HANSEN: Anybody else wishing to testify in opposition? All right, seeing none, is there anybody who wishes to testify in a neutral capacity? All right, seeing none, we will welcome Senator Frederickson back up to close. And for the record-- I have to look here and see-- I know we have letters here. Yeah. We had 86 letters in support of LB179, 439 letters in opposition and one ADA letter in opposition as well and no letters in neutral capacity.

FREDRICKSON: Sounds good. All right. Well, thank you. I want to thank all the testifiers who came out today to make their voices heard. I am going to try to address-- I was making notes throughout with some of the questions that had come up on the committee so I'm going to try to address those as much as I can in my close. And of course, I'm open to questions afterwards if those are not answered. So, Senator Hansen, I think you had asked-- or Chair Hansen, excuse me, about sort of what would happen if there was a licensed professional who might have a certain belief system that, you know, would there be a penalty for them for not seeing a patient? So essentially-- so standards of care in the mental health field and I think just in general in the medical field is that it is considered unethical for us to provide treatment for something that we don't have an expertise in, right. So, for example, my expertise includes suicide, emotion dysregulation, LGBTQ mental health. So if someone comes to me with a specific disorder that I don't have expertise in, so maybe a form of schizophrenia with a psychosis, it would be considered-- it's actually preferred that I refer that person to someone who, who does have expertise on that and that's considered best practices. So in the cases of a, of a counselor or a professional who would not have the ability to provide this service, there would not be any penalty for them referring a person to another provider. That would actually be indicated and important to do. Senator Riepe, you had asked, I think, a little bit about the First Amendment. I think some other people have asked about the First Amendment as well. The Harvard Law Review published in June 2021 a response related to the 11th Circuit Court hearing that was also referenced a few times. I think this is an important argument to be made and I think it's important to highlight here in regards to the First Amendment with this. So it says, within the medical community, the right of professionals to speak on medical issues is paramount, especially when the professional-- especially when the profession has diverse views on treatment such as assisted suicide or medical marijuana. States

rightfully cannot ban doctors from freely debating or discussing the merits of such treatment, but states constitutionally can and do ban the practice of such treatment. Talk therapy, likewise, is medical treatment and the fact that it is effectuated through speech should not render it constitutionally protected speech immune from state regulation. So that kind of addresses this First Amendment concern that oftentimes comes up and I think that's important to consider. We're talking about a specific medical intervention here. I think, Senator Ballard, you had mentioned-- you had asked about the magnitude of this in Nebraska, sort of how many people are affected of this. Like most types of care, it's hard to get a specific number. What we do know from a survey that was conducted in 2022, so pretty recent data, 34,000 LGBTQ youth throughout the country were surveyed. From the Nebraska data, 7 percent of those contacted said that they had been subjected to conversion therapy. And I believe--let me see-- I want to say something like 10 percent were maybe encouraged to do it, but 7 percent were the type that-- that self-reported that had been, that had been subjected. So that's the closest I could find from, like, an actual measure or number of what we could find here. But that's-- again, might be challenging to sort of actually measure. Someone asked about the Deceptive Trade Practices Act and sort of what are the ramifications for that. So that's actually pretty clearly outlined. Provisions are specifically laid out in Nebraska Revised Statute 87-303. So the Attorney General has certain powers under that statute. Those include but are not limited to powers of cease and desist orders. I think Mr. Eickholt also spoke a little bit to, to that a bit more and hopefully kind of clarified that. But courts also could do a variety of things. So they could suspend licensure. You know, there might be civil action to be taken in those situations as well. But the deceptive trade practice is outlined in, in statute-- in Revised Statute 87-303. Someone asked-- oh, I think it was you, Senator Hansen-- about an ethical crime, if that was possible. I think it's, like, code of ethics or something about that with--

HANSEN: Not so much a crime, ethic-- yeah I said crime, but I think I meant ethical--

FREDRICKSON: Violation of sorts?

HANSEN: --complaint or something like that, yeah.

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FREDRICKSON: So, you know, again, the, the licensure board is sort of the recourse of action that is currently in place. So if someone has-- regardless of what the license profession is in the state, they are able to make a formal complaint to the licensure board. So that, that was the only thing I could, like, really think of would sort of be a course of action for that. But that's what I think the current trajectory would be. Again, to highlight the 11th Circuit response, I think it's important to acknowledge, you know, people have sort of kind of responded about this sort of solid or unsolid grounding with that on a legal status. You know, this is one diverging court ruling. Other rulings have upheld that. And I think it's important to acknowledge the facts are that this ban is in place in 20 states and its standing. So if that was really, truly shaky legal grounds, that just wouldn't be the law. There would be-- these court cases would prevail, right? And to Senator Cavanaugh, you were asking about the city of Lincoln. This is in place in the city we're in right now. There are no lawsuits currently in place. So I think, Senator Hardin, you had asked about whether or not there might be a legal risk here. The facts are this exists here in the city we're sitting in. And so if there were a legal risk here, one would think that there would be a lawsuit that was currently in place, but there is not one. Another thing that came up, so a lot of the opposition said that they mentioned that this isn't their area of expertise. That was very clear to me, where this is an area of my expertise. So I'm a licensed mental health provider, as, as all of you know. And so it was very clear as well that there seems to be, I think, a little bit of an education gap on what actually happens in psychotherapy and what happens in a therapeutic practice. There was this insinuation that this bill would require gender-affirming care. That is actually not at all true. In fact, if you open up the amendment to this bill and if you go on page 5 and you look at lines 13 through 15, it explicitly says conversion therapy does not mean a practice that does not seek to change an individual's sexual orientation or gender identity that is neutral with respect to sexual orientation and gender identity, is neutral. And that is standards of care across the board. So take-- you know, I know LGBTQ issues are hot button issue right now and they're-- you know, it gets people foaming at the mouth around this. But the reality is any type of therapeutic intervention, it is your role as a counselor to remain neutral. You are not supposed to persuade your patient to do one thing or the other. Conversion therapy, the ban is explicitly to ban trying to explicitly

change a patient and their identity. You can talk all you want about that identity. You can explore that identity. In fact, when I'm working with folks who are maybe questioning their sexual orientation or gender identity, we spend a lot of time exploring that. You know, what are underlying factors here? What are, what are-- tell me more about this. You know, we-- it would be unethical for me as a provider to say to them, you must be gay or you must be straight. That, that, that is, that is unethical practice. And so this idea-- and that is exactly what this bill is about, it is prohibiting the practice of explicitly trying to change a person's identity into something that they are not. And it is actually encouraging a neutral stance on that. So not persuading that in any way. So I think that's really important to clarify. And I think that there might be a little bit of a misunderstanding or it seemed to be a little bit of a misunderstanding from some of the opposition about what conversion therapy actually is and is not. I think that was all of the questions that I wrote down, but if there's anything that feels like it was unanswered still, I'm happy to take any other additional questions from the committee.

HANSEN: Yeah. Thank you. Are there any questions from the committee? I have a few.

FREDRICKSON: Did I answer them all?

HANSEN: I have a few. You touched on one I was going to ask you and I think you sort of answered it, but first I want to go back to one. I think in the original bill, you had gender identity defined specifically and it's not in the amendment. What was the difference there?

FREDRICKSON: I believe the amendment actually more explicitly defined that. That was my-- that was the intention of the amendment was to be more specific in the definition of that, so.

HANSEN: So, like, in the original bill on page 6, line 21, gender identity means an individual's internal sense of individual's own gender regardless of the sex the individual was assigned at birth. But that's not in the amendment.

FREDRICKSON: Sorry, I'm just getting my paper. You said page 6, line 21.

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HANSEN: In the original bill.

FREDRICKSON: And that-- you said that was taken out on the amendment?

HANSEN: Yeah, I didn't see it in the amendment. So you're not defining gender identity. You're defining what conversion therapy means.

FREDRICKSON: Sure. Yeah, that, that might have been an oversight. I mean, I don't, I don't see any-- if that is something we need to amend back in--

HANSEN: OK.

FREDRICKSON: --I'm open to that. I think that-- yeah.

HANSEN: Yeah, because I don't know-- I'm trying to think if gender identity is defined in statute at all anywhere.

FREDRICKSON: Oh, gosh. Chris, would you--

HANSEN: So might-- one thing you might want to check because--

FREDRICKSON: Yeah, let me check that.

HANSEN: --if you are, this is the first time we're defining gender identity in statute.

FREDRICKSON: Yeah, yeah.

HANSEN: So just--

FREDRICKSON: Yeah, I'm open to conversations about that. I don't know that it is.

HANSEN: I just thought I'd bring it up, so. I'm pretty sure it's not defined anywhere in statute, so.

FREDRICKSON: Yeah.

HANSEN: OK, so I kind, I kind of wanted to touch maybe when you were bringing up the 11th Circuit Court decision.

FREDRICKSON: Yes.

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HANSEN: And you said no states have overturned it at all. So are any of the states that are in 11th Circuit-- and I could be wrong because I'm-- that might be-- I'm not a lawyer, so I'm trying my best here. Any states in the 11th Circuit where it was found, found unconstitutional, did they pass the bill like this?

FREDRICKSON: I believe Florida did. And I think it's-- I-- and again, don't quote me on this, but I believe the original case was--

HANSEN: In Florida?

FREDRICKSON: --in Florida, which is sort of the-- yeah.

HANSEN: So they did pass it, but then they found it was unconstitutional so they couldn't do it.

FREDRICKSON: Right. And I don't know-- and someone from-- I'll have to get the legal expert on that. But again, the, the 20 states where this has passed and the circuit court for the state of Washington, for example, has, has upheld the ban, so.

HANSEN: OK, just-- you mentioned that. I was kind of, kind of bring just a kind of different opposing viewpoint to that one.

FREDRICKSON: Sure, yeah.

HANSEN: I'm going to ask one more question.

FREDRICKSON: Yeah.

HANSEN: It's just kind of-- it's kind of maybe an awkward question maybe. And it's not a gotcha question, but I'm hoping you can maybe even kind of help figure this out. Because you were talking about-- and I think I-- I only thought of this when one of the last testifiers mentioned it seems like somebody who goes to a counselor, not at a church, somebody who goes to a counselor can only affirm somebody's identity, right? And you kind of touched on this when-- just here answering some of these questions. So does every minor who has gender dysphoria or is confused about their gender, does every one of them eventually become transsexual?

FREDRICKSON: You mean trans-- like transgender?

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HANSEN: Transgender.

FREDRICKSON: Yeah.

HANSEN: Transgender. Yeah. Sorry.

FREDRICKSON: So, you know, that-- again, that would be a hard metric to, I think, measure because unless you're collecting data on a person's-- you know, the wide spectrum of identity and sort of, you know, doing follow-up studies. What we find is, you know-- in my experience, what we-- what you find when you, when you work with someone, especially if you're working with a younger person who might be exploring their gender, you, you want to spend significant time working with that individual to, to--

HANSEN: I can explain. It was a little bit of a leading question. So I just didn't want to--

FREDRICKSON: Sure.

HANSEN: The reason I asked that is because there might be-- maybe there might be times where the counselor-- the person comes and they're confused by their gender.

FREDRICKSON: Um-hum.

HANSEN: And the counselors would say, do you really think you're a boy or a girl, the, the opposite sex?

FREDRICKSON: Um-hum.

HANSEN: Because they're trying to find something else out about them. And they start-- you know, they, they have the conclusion that maybe they're, they are legitimately confused about their gender, but they can't ask them certain questions, like-- but only affirm their concern.

FREDRICKSON: So, I mean, I think, you know, best-- and, you know, there might be other therapists who might think otherwise, but I think best practices around that would-- you know, as a therapist, you'd want to be curious. So you might ask that patient something like, you know, can you tell me more about that? When, when you say you feel like-- so let's say someone was assigned the sex of male at

birth and maybe they're presenting it as treatment, saying that they, they feel as though they're female or they identify as a woman. You know, you might sort of explore that with them a bit more. So, you know, tell me more what you mean by that. Help me understand that. How long have you felt that way? You know, you-- and that's all very appropriate because what you're essentially doing is you're helping the patient and you're facilitating a better sense of what they're experiencing and what they're feeling. And you're hoping through that process that they are able to identify, Oh, you know what? Like, this, this has been really-- you know, on one hand, they might say this has been really consistent and this is-- you know, this is actually some that's been lifelong. This is something that-- you know, you might also have someone that might say, you know, it's kind of intermittent. I'm not quite sure. If that were the case, you know, you would want to continue that exploration process before you were to maybe pursue something that would essentially take it a step further for that individual. And so, you know, that's-- and again, I think that's another-- a bit of a misconception about-- you know, this is kind of maybe going to LB574 a little bit, this idea of gender-affirming care. But I think there's this misconception about what that actually looks like and what that actually is. You know, it is considered unethical to tell a patient they are something or something else. And so the best practice is really to have a neutral stance with that and to help that client explore that.

HANSEN: OK. And I think I, and I think I know where you're coming from. And I'm not delegitimizing somebody's journey from, you know, from going from one area to another in their life. It's just it was, it was kind of a-- not a First Amendment, but somebody's right to be able to-- a counselor to ask certain questions when they might-- may feel that somebody is genuinely confused, that maybe you are actually the gender you were assigned at birth.

FREDRICKSON: Um-hum. So--

HANSEN: And not, not, like, pushing that way, but, like--

FREDRICKSON: Yeah.

HANSEN: I'm concerned that this might prevent them from wanting to ask certain questions because they're concerned about--

FREDRICKSON: So, so to be clear, that would not be considered conversion therapy because that's a question, right?

HANSEN: OK.

FREDRICKSON: Conversion therapy is actively trying to change that person.

HANSEN: OK.

FREDRICKSON: So it's, you know, a question like, you know, oh, like, is this something that you might have felt because X, Y, Z? That's a genuine question, right? That's sort of asked in a genuine way. But proactively working with a patient saying no, Senator Hansen, like, you, you are, you're, you're not that way. You're this way. Like, this is what you need to do and taking proactive clinical intervention to put that onto someone. So people kind of mentioned all sorts of things. That actually reminds me someone had brought up about the shock therapy. I have something to say about that as well. But that's what conversion therapy is.

HANSEN: OK.

FREDRICKSON: That's the proactive trying to change. It's not exploration. It's not talking about gender. It's not, it's not assessing, you know, whether or not this is-- meets clinical criteria for gender dysmorphia, for example. This is-- it's-- and those are questions you would need to ask to sort of make that clinical assessment and diagnosis.

HANSEN: Yeah, I appreciate you answering that question because I'm not completely familiar with some of that and I-- with the law and especially how that works.

FREDRICKSON: We'll go out for a beer or coffee. I will talk your ear off.

HANSEN: Beer is fine. Actually wait. Coffee might be better.

FREDRICKSON: Coffee might be better. I know. I guess we're on the record right now. So the other thing-- so a few people that mentioned shock therapy. So I think we need to really clarify, you know, shock therapy that's used for conversion therapy versus ECT, which I think

is what I think one of the opponents had mentioned she had looked up online, what's available. So ECT is actually it's a clinically indicated treatment for treatment nonresponsive depression. So this is something that you can get on an outpatient basis. It is shown to be extraordinarily effective in treatment nonresponsive depression, among other clinical presentations that have been difficult to treat with psychotherapy and/or medication management. So, you know, ECT is, is considered ethical practice. Shock therapy in the context of conversion therapy is a form of aversion. So it's based in Pavlovian behavioral therapy and conditioning. So essentially what happens is that they would expose someone to-- so if someone's being treated for conversion therapy for being gay, for example, they would have you think about, like, same-sex behavior or something like that and then they would shock you. Like-- and the idea being it's sort of like they are behaviorally conditioning you to have an aversive response to something. That's the shock therapy that happens in conversion therapy, which is extraordinarily different from ECT, which is done for someone who has treatment nonresponsive depression to help. What it does, it sort of rewires the brain a little bit to sort of help with neurotransmitter regulation of-- yeah, so.

HANSEN: You brought me back to psycho-- I was a major in psychology so Pavlovian responses are like-- kind of brought back memories. OK. Any other questions from the committee? All right, seeing none--

FREDRICKSON: All right.

HANSEN: --thank you very much. Appreciate it.

FREDRICKSON: Thank you so much.

HANSEN: All right. Well, that will close the hearing on LB179 and that will close our hearings for tonight.