HARDIN: Welcome to the Health and Human Services Committee. I'm Senator Brian Hardin, representing Legislative District 48. And I serve as chair of the committee. The committee will take up the bills in the order posted. This public hearing today is your opportunity to be a part of the legislative process and to express your position on the proposed legislation before us. If you're planning to testify today, please fill out one of the green testifier sheets that are on the table at the back of the room. Be sure to print clearly. Fill it out completely. Please move to the front row to be ready to testify. When it's your turn to come forward, give the testifier sheet to the page. On LB147, how many of you are planning to testify today? Just a bunch of you. And we'll have lots of other fun things going on, so feel free to stick around for later on. It's, it's more fun than you can possibly poke a stick at. If you do not wish to testify but would like to indicate your position on a bill, there are also yellow sign-in sheets back on the table for each bill. These sheets will be included as an exhibit in the official hearing record. When you come up to testify, please speak clearly into the microphone. Tell us your name, and spell your first and last name to ensure we get an accurate record. We will begin each bill hearing today with the introducer's opening statement, followed by proponents of the bill, then opponents, and finally by anyone speaking in the neutral capacity. We will finish with a closing statement by the introducer if they wish to give one. We will be using a three-minute light system for all testifiers. When you begin your testimony, the light on the table will be green. When the light-- yellow light comes on, you have one minute remaining. And the red light indicates you need to wrap up your final thought and stop. Questions from the committee may follow, which do not count against your time. Also, committee members may come and go during the hearing. This has nothing to do with the importance of the bills being heard. It's just part of the process, as senators are doing the exact same things in other committees. A few final items to facilitate today's hearing. If you have handouts or copies of your testimony, please bring up at least a dozen copies and give them to the page. Props, charts, and other visual aids cannot be used simply because they cannot be transcribed. Please silence or turn off your cell phones. Verbal outbursts or applause are not permitted in the hearing room. Such behavior may be cause for you to be asked to leave the hearing. Finally, committee procedures for all committees state that written position comments on a bill to be included in the record must be submitted by 8 a.m. the day of the hearing. The only acceptable method of submission is via the Legislature's website at nebraskalegislature.gov. Written position letters will be included in the official hearing record, but only those testifying in person before the committee will be included in the

committee statement. I will now have the committee members with us today introduce themselves, starting with Senator Riepe.

RIEPE: Welcome. I'm Merv Riepe. I represent Omaha, and that's Millard, along with the city of Ralston. It's Legislative District 12.

HANSEN: Senator Ben Hansen, District 16, which is Washington, Burt, Cuming, and parts of Stanton County.

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

MEYER: I'm the almost late Glen Meyer from District 17, northeast Nebraska: Dakota, Thurston, Wayne, and the southern part of Dixon County.

QUICK: Dan Quick, District 35: Grand Island.

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

HARDIN: Also with us today i-- on our committee is our legal counsel, John Duggar; to my far left is our committee clerk, Barb Dorn. Our pages for the committee today are Sydney Cochran and Tate Smith. Sydney, would you mind standing up and telling everyone what you are studying at UNL?

SYDNEY COCHRAN: So I'm Sydney Cochran. I'm a first-year at UNL, and I study business administration and U.S. history.

HARDIN: Tate, would you stand up and tell everyone what you're studying at UNL?

TATE SMITH: Yes. I'm studying political science and I'm a third-year right now.

HARDIN: Thanks for being here today, guys. Today's agenda's posted outside the hearing room. And with that, we will begin today's hearings with LB147. And Senator Hansen. Welcome.

HANSEN: Thank you. Good afternoon, Chairman Hardin and members of the HHS Committee. My name is Senator Ben Hansen. That's B-e-n H-a-n-s-e-n. And I am once again looking to remove the mandate on our municipalities of fluoride in the water supply. The fluoride mandate has been in place since 2008 in Nebraska for all water systems and cities with populations over 1,000. Certain cities had an option to opt out before

2010. And of the 61 communities who brought the question of fluoridation to the ballot, 49 refused it. So again, when we gave them the option, 61 communities took it to the ballot and 49 of them refused it. In fact, more citizens have voted to get rid of fluoride in Nebraska than to add it. Of the communities that had the option, 227,000 Nebraskans voted against fluoride, while only 31,000 voted for it. People don't want to be forced to take medications in their water. But Nebraska's dental associations and health departments would say they don't care about what people think. We should mandate this drug. In my opinion, people don't need a reason to deny a drug they don't want to take. Let's just explore a few logical rationales a person might have for refusing fluoride. While fluoride is a naturally occurring element already found in most water sources, the fluoride we add to our water system is a chemical called fluorosilic acid. It is a corrosive acid that is captured by air pollution control devices, or scrubbers, of the phosphate fertilizer industry. The 1940s' belief that fluoride needs to be ingested has been challenged by Dr. Lanphear. You know all the studies we rely on for the dangers of neurotoxins. We've seen many of them here in this committee. Those were done by Dr. Lanphear, and modern medicine has implemented policies based on his findings for years. He is a principal investigator for a study examining fetal and early childhood exposures to prevalent environmental neurotoxins, including lead, pesticides, mercury, alcohol, PCBs, and environmental tobacco smoke. Dr. Lanphear recently testified that there are similarities between lead as a neurotoxin and fluoride. He stated, quote, fluoride exposure during early brain development diminishes the intellectual abilities in young children. This is the expert in neurotoxins in children. Yet the state thinks it knows better and mandates this neurotoxin in our water system. The leading medical agencies in our country are also leery about fluoride. At the recent federal court case and Toxic Substances Control Act trial, both CDC representatives and Stanley Barone Jr-- an EPA neurotoxologist-- agreed that fluoride has the ability to interfere with the functions of the brain and body by both direct and indirect means. We are finding that fluoridation is not just a dental issue when it is ingested. It is affecting the body as a whole. The National Toxicology Program just released a systemic review-- systematic review of the concerning fluoride exposure, neurodevelopment, and con-- and cognition. It included 74 studies. In high levels of fluoride exposure, they concluded that there is a scientific evidence that showed an association of fluoride and lower IQ in children. The Journal of American Medicine Pediatrics. A lot of us are familiar with that. We see that many a time used by the medical-- by experts that come here testifying for various reasons. The Journal of American Medicine

Pediatrics also just published a review in January stating they found inverse associations between fluoride measurements in urine and drinking water and children's IQ. During utero, fluoride is able to cross the blood-brain barrier, affecting development. The harm continues when babies who are on formula receive an overwhelming amount of fluoride. Members of the Department of Environmental Medicine and Public Health, along with the Department of Pediatrics, released a study stating 60% of fluoride is excreted in urine by the kidneys in adults and 45% in adolescents. The kidneys-- followed by the liver-- accumulates fluoride, making them suseshible-- susceptible to its effects. But what is worse is the fact that babies on formula are unable to excrete fluoride efficiently, causing their bodies to hold on to 30% more than adults, so much so that New Hampshire passed a law requiring that communities who fluoridate their water system release reports that recommend infant formula not be made from tap water. Yet the state thinks it knows better and mandates this substance in our water system that can harm children. Other states have started removing fluoridation mandates. More than 25% of the country's water systems are not fluoridated. Florida is making strides to remove fluoride under the recommendation of their surgeon, surgeon general, and it was reported yesterday that the Senate passed legislation that bans fluoride outright. This is Florida. Just yesterday. Utah just passed legislation that bans fluoride as well. And beginning in May, May of this year, there will be no added fluoride in their water systems. One water manager from Weber Basin Water in Utah reported yesterday-- this-- I-- this just a story. I have to go off track here a little bit. I was doing some investigation on Utah's process of getting fluoride out of their water. And so this is a new-- a local news story that they did. So they're asking, I believe, the city administrator about how they're going to get fluoride out of their water. So they're doing an interview with him. Here's what he says. I just thought this is interesting. He says the removal is very regulated because it is toxic waste and hazardous material. The operators are getting severe migraines just because of their walking in and out of the building every day. He says there are health effects because the off-gassing of the fluorocilic acid. He says it's a toxic waste and hazardous material that we're putting in our water supply. Yet our state thinks that water managers view as toxic waste should be put in our water systems. I brought a letter from one of our own Nebraska utility supervisors who is a state-certified water operator. The people of Gordon, for instance, have asked for the removal of the chemical from their water for years. The city manager, with their support of the members of the council, submitted their support. Their constituents are being forced to ingest a chemical without consent. But the state doesn't care. Unless

something changes, we will force them to continue. Why do we do this? You-- and something you'll hear: it's for their teeth. The studies show, and holistic biological dentist associations have found, that ingestion of fluoride is an endocrine disruptor that negatively affects the body's organs, bones, brain, thyroid gland, and pineal gland, and blood sugar levels. However, the state refuses this information and focuses on the teeth. So let's look at the teeth. The CDC representative Casey Hannan and Dr. Edward O'Hannon [SIC] with the EPA have reported that the predominant benefit of fluoride in dental health is through topical application-- what you find in toothpaste, what the dentist does when you go to visit them. Dentists across the world have realized this and have started speaking out about the hesitations they have with the ingestion of fluoride. On a side note here, again, have you guys ever-- when you brush your teeth, have you noticed on the side of the bottle it says, do not ingest? If you look on-- if you look at your toothpaste on the side of the bottle, it says, do not ingest, which I found kind of odd. And that's the most, from my understand, clean version of fluoride as opposed to what we have in our water supply. Last year, a study called the Lotus study was published in the United Kingdom. It used data on 17.8 million adults and adolescents who attended dental practices in England between 2010 and 2020. They found that tooth decay was only 2% lower in optimally fluoridated groups and that the results had very small positive health effects, which may not be meaningful for the individuals. And while fluoride ingestion is supposed to be helpful, according to the dental associations, recent CDC surveys have found that 70% of teenagers now have dental fluorosis, up from 41% from the 2-- early 2000s. Fluoros-- fluorosis is a tooth enamel defect and a visible side effect of overexposure to ingested fluoride during-- or, deve-- early development. Anybody who has kids or knows kids might notice those little white spots on their teeth. Mottle-- a kind of mottled look on the teeth sometimes. That's fluorosis. Something isn't right. This is more than just a dental issue. This is why I brought LB147. This is a cleaner bill than last year's, which some of you have heard before. It simply removes the mandate. That's all we're doing. We're not telling cities what they have to do. We're not changing the amounts. We're not doing anything. We're saying-- we're giving the local authorities-- which is what we always claim we want to do all the time-- the option and the decision on what they want to do with their water supply. If local communities want to fluoridate their water supplies and their constituents ask for it, they can. But with LB147, the state will no longer claim it knows better and we should overlook people's right to have concern about forced medication. You will notice that since last year, DHHS lowered the suggested level of fluoride in our water. I don't know if anybody

no-- no-- noticed that. It was 0.7 to 1.5 milligrams per liter of water. Now the maximum you can put in the water is 0.7. Isn't it interesting that what used to be the minimum is now the maximum? They had a public hearing before lowering the levels, and not once did they allude to the fact that maybe the previous levels were harmful. But if they weren't harmful, then why lower them? And if they were wrong, why is this new number right? We know that the fluoride added to our water is a neurotoxin. I understand they will bring studies led or supported by their associations, but let's look at the concept of force. Even doctors are hesitant to prescribe the ingestion of fluoride. The only fluoride supplements the FDA has reviewed have been rejected. Yet we are adding a prescription strength dose of a drug to our water supply. I would like the 50-plus dental students and 50 dentists who co-- commented online in opposition to LB147, what makes you think that the state should have the authority to coerce a patient into giving their child a drug that poses unreasonable risk without consent? Just about done. I'm with you. Let's keep advancing dental services, implementing dental education in our communities, encouraging topical uses of fluoride, promoting healthy diets, all for Nebraska's children and their teeth. But let's not use our water systems for drug distribution. With that, I want to thank you for your time today. And I just wanted to kind of pose a couple things to you on my opening here before I bring up those in support. And one of the testifiers I have in support-- which I would highly encourage you to ask any question, any doubt you have, because this is probably by far the best expert in this topic I've ever seen. He has testified numerously in front of many states and legislatures about this very topic. And his job here is to kind of-- is to give you an objective, data-driven, statistical-based information and to answer any questions you have if you have any doubt. So I just want to pose one thing here. And you've heard me say this before, but I'm gonna do it again, maybe for those who haven't heard me before. Imagine we didn't have fluoride in the water now. Right? And here I come to you with a bill that says, I want to add fluoride in the water to help children's teeth. And with the information I just shared with you-- which says a lot more about the, the side effects of it-- would you ever consider voting for something like that? I know none of you would. So why do we have it now? And one other thing I would encourage the committee members to do is ask those in opposition-- and maybe they can state it themselves-- if they are 100% certain, without a doubt, no question that putting fluoride in our water supply causes no ill side effects or no ill heal-- health effects at all. Because if you come in opposition, you better be 100% certain, without a doubt, that it's completely safe. Because if not, why the hell are we putting it in our water supply? We don't put any other kind of drug in our

water supply. What if I came to you today and said, I want to put antidepressants in our water supply, but just a little bit? Everyone's going to be a lot happier. Maybe. What if I came to you and said, I want to put chole-- anticholesterol medication, statins in your water supply-- which maybe a lot of people here are already on. But just a little bit, though. How many lives would that save? None of you would ever consider that. And we're talking about teeth, which is important, don't get me wrong. But comparatively to behavioral issues with antidepressants and cardiac issues with cholesterol medications, how many lives could we save? Just want to pose those few things to you. Thank you, Mr. Chairman.

HANSEN: Thanks. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Hansen. Always very compelling openings from you. I always appreciate them. So I, I, I appreciate the studies you handed, handed out and information you provided. I, I'm ju-- I'm kind of curious-- and maybe this might be a good question for the testifier you had, you had mentioned. Are-- you know, obviously, I think any, any substance in kind of, like, really highly concentrated amounts can be, can be lethal or fatal or, or, or toxic, for that matter. Is there a safe level of fluoride for drinking water?

HANSEN: If you look at the-- especially the recent data, my-- the expert testifier would be able to answer this a lot more thoroughly.

FREDRICKSON: OK.

HANSEN: I would say no.

FREDRICKSON: OK. OK.

HANSEN: Because the data is inconclusive.

FREDRICKSON: OK. Thank you.

HANSEN: Senator Riepe.

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

HANSEN: Yep.

RIEPE: You're obviously very knowledgeable about this. My question is, with all the farm wells that we have in the state of Nebraska, do we--

how much exposure do you think or do studies show that we get out of a well that doesn't have added fluoride?

HANSEN: So you're talking about naturally occurring fluoride?

RIEPE: Yeah.

HANSEN: From my understanding, it varies throughout the state of Nebraska. Now, what levels I'm unsure.

RIEPE: OK.

HANSEN: Typically, it's minimal.

RIEPE: OK. I'd like to talk to you later about this antidepressant add.

HANSEN: On some days, it might be good in our water supply here in the Legislature, so.

RIEPE: Thank you. Thank you, Chairman.

HARDIN: You mentioned this a little bit. How does this bill contrast with the one that we had last year?

HANSEN: So last year, we were actually talking about capping certain amounts, and we were allowing the cities to take it to a vote of the people. Here, we're just removing the mandate. The city can decide what they want to do. They can continue to use it all they want. If they think the evidence is compelling, that they like it and they want to keep it-- or vice versa, if they feel evidence it's not compelling and it might-- and it's harming children, they may want to take it to the vote of the people or through an ordinance, or just get rid of it. We're leaving it up to the local authorities. And-- here we go: we're getting rid of an unfunded mandate. I have to throw that out there.

HARDIN: Other questions? Will you be with us at the end?

HANSEN: I will.

HARDIN: Great. Thanks. Proponents, LB147. Welcome.

STUART COOPER: Thank you. Thank you, Mr. Chair and members of the Senate-- or, Health and Human Services Committee. My name is Stuart Cooper, C-o-o-p-e-r. And I'm the Executive Director of the nonpartisan, nonprofit, the Fluoride Action Network, founded in 2000 by a coalition of concerned dentists, physicians, scientists, and parents with the goal of educating the public about the potential risks of known side

effects of overexposure to fluoride, particularly ingestion in fluoridated drinking water. We're an international leader on the topic and currently have over 5,500 medical and scientific professionals in our network. Nebraska is currently one of only 12 states that have fluoridation mandates, with the remaining 38 giving local governments and residents authority over fluoridation decisions. The trend is absolutely moving away from fluoridation manma-- mandates. All attempts by the dental lobby to pass new mandates over the past 15 years have been rejected by legislatures. Georgia and Michigan successfully amended their fluoridation mandates to allow communities to exempt themselves. The country of Israel-- which is one of two countries that mandated fluoridation-- their Minister of Health reversed that law in 2017 due to concerns about the neurotoxicity that we're go-- we're going to discuss today. In this legislative session right now, bipartisan bills have been introduced in 9 of the 12 mandate states to reverse those laws. Kentucky has-- first-- is the first to act. They already-- their bill has over 40 cosponsors. That's passed out of the House with a 2/3 vote. And Arkansas just passed their bill out of Senate committee with a recommendation of all to pass. There are also bipartisan bills to prohibit fluoridation completely that have been introduced this session in ten states. More bills are expected to be introduced in other states in the coming weeks. The bill in Utah was passed overwhelmingly by both the House and Senate by 2/3 vote, and the governor has publicly sai-- stated this week that he plans to sign it into law. Florida state surgeon general, Dr. Ladapo, held a press conference in November 22 to announce that the state of Florida is advising all communities within the state to stop any water fluoridation due to, to-- due to the neurotoxic risks the practice poses to the developing brain. Since then, more than half the communities in Florida have stopped. And the remaining communities, including Miami this week, are discussing it. The governor supports that effort, and now there's an amendment on the farm bill that has support of the Senate to do so. The Iowa Department of Natural Resources is now doing a similar step, calling on communities to end water fluoridation. Its point-- it's important to point out that 98% of Europe and 95% of the world has never fluoridated, and most European countries actively passed resolutions prohibiting the practice. We're the extreme outliers in this. Why is all of this happening? Well, primarily because the NIH has funded ten studies looking at developmental neurotoxicity. All ten found developmental neurotoxicity. The NTP did a nine-year systematic review. They published that review in August. Out of 72 studies on this matter, 64 found developmental neurotoxicity. That's an 89% consistency. Of the highest quality

studies-- there were 19-- 18 found neurotoxicity. That's 95% consistency. Most of those were at levels that--

HARDIN: Please continue.

STUART COOPER: --that we see at the optimal level: 0.7. And then in September, we sued-- or, six years ago, we sued the EPA in federal court over this developmental neurotoxicity. The judge ruled in September on 20-- the 26th, and he ruled that water fluoridation at 0.7 parts per million poses an unreasonable risk to human health. The EPA is now obligated by law to promulgate rules that will eliminate that risk. They have two years to promulgate rules. And TSCA gives them two options: they can either pass a warning or require a warning that pregnant women and children not consume fluoridated tap water, or they can prohibit the commercial use of fluoridation chemicals. That's why we're seeing all of this activity. So it's a, it's a combination of the science plus our federal ruling. And just in the past three months, over 60 cities across the United States-- representing 4.5 million people-- have ended water fluoridation. So, you know, that's-- this is, this is a growing trend. You guys got ahead of it last year. I hope that you're getting ahead of it this year. It's important to point out that what you're going to hear from proponents is primarily-- I do these hearings week in, week out. You're gonna hear talking points. These-- the-- a lot of these folks are well-meaning, but they don't know the subject matter. They're reading talking points provided to them by the American Dental Association, who's been lobbying for this for 60 years. And they've been written by a gentleman by the name of Johnny Johnson in Florida, a dentist there. He's, he's, he's being beat off in Florida as the state is ending it. So I can assure you that while they claim there's safety, remember the NTP looked at all studies on this matter. They did not find safety. They found 64 out of 72 studies showing harm. We-- as part of our lawsuit-- we deposed the CDC. We deposed the ADA. We deposed many experts. I sent you guys an email I think yesterday. It's called "CDC Under Oath." I included deposition videos. They're all under two minutes. You can watch them. And they, they, they-- the CDC acknowledges they have no safety data on water fluoridation. They acknowledge that there's no benefit whatsoever to the fetus. There's no benefit whatsoever to an infant. They don't have teeth. And the American Academy of Pediatrics' representative, when we deposed her, she said that six to seven IQ point loss-- which is equivalent-- it's on par with lead-- is a fair trade-off for water fluoridation. And you can watch those videos yourself. I've sent them in your email. I do want to point out that while you will hear-- that-- it is assured that it's safe, that not a single randomized, controlled trial-- an RCT-- has ever been conducted in 80 years on the safety or

effectiveness of water fluoridation. That's the gold standard of science. And, you know, I can keep going, but I know I'm, I'm-- I'll be respectful of your limit. I just want to point out that we do have evidence of overexposure. The CDC tracks with their NHANES survey. They track every few years dental fluorosis rates. Dental fluorosis isn't just esthetic. It's a biomarker of overexposure, overingestion of fluoride during infancy, a time that we now know is critical to brain development and a time where we know, according to these other studies, the child is most vulnerable to brain harm. So our CDC show-- data showed that in early 2000s, dental fluorosis rates in the United States were about 41% of our teens had it. In 2010, it was about 60%. And now the latest research shows that it's somewhere between 70% and 87% of our adolescents have dental fluorosis, meaning they've been overexposed. So I'll just leave you with this. A cavity can be repaired, right, but damage to the brain is permanent and has lifelong consequences. There are no second chances with brain development, and that's why other states and other cities are taking this very seriously.

HARDIN: Thank you.

STUART COOPER: And I open to any questions if you have any.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. You did quote the federal judge that I think his invocation-- or, his-- was that it is an unreasonable risk.

STUART COOPER: Correct.

RIEPE: He went on to say, but this is not conclusive, and certainly that fluoride water is injurious to public health and-- but warrants a response. So he qualified his declaration that it was off limits. And my question gets to be a little bit this, is-- I'm concerned that one federal judge can make such a declaration when he's-- he's one person. Gets in his pants the same way the rest of us do. So I have some respect, but not totally ob-- obedience. And he's also not a dentist. And-- so.

STUART COOPER: Yeah.

RIEPE: I don't know that he's qualified to make, make-- say-- make such a declaratory statement.

STUART COOPER: Well, the judge-- this trial spanned over eight years, is-- it had several months of testimony. And he heard testimony from the foremost experts. For instance, on our side, we have Phili-- Philippe Grandjean, who the EPA has based their merc-- methylmercury regulations on, as well as their PFOA regulations on. He testified on our behalf as our expert witness. Bruce Lanphear, who the EPA bases their lead regulations on, he testified on our behalf, as well as Kathleen Thiessen and others. So we heard expert testimony. There was also hundreds of hours of deposition footage that he reviewed-- again, that showed that the, the CDC and the ADA and those who promote it have no safety data whatsoever. And he actually based a lot of it off the NTP report, the National Toxicology Program, which is the-- really are the, the toxicologists, the experts that our government relies upon to look at this issue. So that is-- it was really scientific. And what, what came out during the trial-- I mean, there was some undisputed facts that even the EPA agreed to. For instance, fluoride passes through the blood-brain barrier. It passes through the placenta. Then there's no benefit whatsoever to the child, to the-- to a fetus, or to an infant. So when you coun-- take that science into account and you take all that expert testimony into account and you also take into account the fact that the EPA acknowledged that when they assessed the petition originally, they didn't follow the guidelines, their TSCA guidelines. And if they had, they would have had to regulate it as a hazard. He then made that judgment. And if you look into the ruling, you will see that he not only clearly says that optimally fluoridated water is what poses a risk and not high levels, but he actually talks about do-- dose benchmark, dose analysis, where he says that even if-- according to the EPA's own standards of a safety factor of ten-- if you use the EPA's own standards, you would have to drop the allowable levels of fluoride in water to 0.15 parts per million.

RIEPE: Well, the re-- reporting story says that the EPA will appeal. And so it's not a concluded-- you know.

STUART COOPER: That's true.

RIEPE: That's his opinion.

STUART COOPER: Yeah.

RIEPE: And it's probably-- will be some time before we get resolution.

STUART COOPER: Correct. I can tell you the deadline for appeal has passed and they-- the, the, the outgoing, temporary EPA administrator did submit a letter of intent to appeal. But that wasn't an actual

appeal. And so that deadline has passed. And I can tell you the new administration is intent on moving forward with neurotoxicity science.

RIEPE: OK. Thank you, Chairman.

STUART COOPER: Oh, and to answer your question from earlier, well water and most surface and groundwater sources have trace amounts. So we're talking less than 0.2 parts per million. But it can fluctuate. There's certain areas that have lots of phosphate rock, particularly in Texas or in the Rockies, that it can be higher.

RIEPE: OK. Thank you. I appreciate your being here. Thank you.

STUART COOPER: Of course.

RIEPE: Thank you, Chairman.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for, for being here and for your testimony. I'm assuming this is the one Senator Hansen was saying ask your questions of. So thank you for being here. Similar question I asked the introducer: is, is there, is there a safe level of fluoride for drinking water? Or is that, that something to-- can you kind of shed some light on that for us?

STUART COOPER: Of course. So I'll-- so the NTP authors-- we have something unique. The NTP worked eight years on their report, their systematic review. And whe-- it was intended to be published in May of 2022. And it was actually censored. The American Dental Association-- we have FOIA documents that showed that the American-- or, a watch-- a whistleblower came to us from NTP and they said the report's being censored because it shows it's a developmental neurotoxin. So we did FOIA requests. The FOIA requests showed the ADA contacted congresspeople and congresspeople in the ADA contacted CDC, and they contacted Admiral Rachel Levine, who then blocked the publication of the report. The reason that I'm bringing that up is because we were able to use the, the judge to subpoena the NTP to release it. And when they did, it released all of the peer reviewer comments and then the NTP author responses. And the NTP authors responded to that exact question, and they found no safe level of fluoride in water, that the, the, the, the harm was linear, meaning the first level of exposure caused harm. And that was from the NTP authors themselves after years of, of research. And that's also what Philippe Grandjean's-- the only dose-- benchmark dose analysis that's been conducted on fluoride also found the harm was linear. And an IQ drop of one point starts where the

mother's urinary fluoride level reaches 0.28 milligrams, which-- you might say, what's that mean? So NIH-funded studies have been conducted in the United States looking at maternal urinary fluoride levels in fluoridated communities, and they're double those of nonfluoridated counterparts. And they can reach-- exceed over 1.5 milligrams per liter. So there's your six or seven IQ points on par with lead.

FREDRICKSON: OK. And the-- why, why, why did we start fluoridating water in, in the U.S.?

STUART COOPER: It was well-meaning. The idea was-- there was a-- it was in, in the '30s and '40s at a time when toothbrushing and fluoride toothpaste didn't exist. And so scientists-- there's a long story, but it was, it was well-meaning. It was-- it-- the-- scientists have found that certain people had Colorado brown stain. I'm sure you've heard that story. And it was-- that's dental fluorosis. And it's from certain naturally occurring level-- high levels of fluoride in the Colorado area. And the dentist looked and said, where do we see this brown stain-- that's dental fluorosis-- and where do we see reduction in decay? And at what level? And in the '30s, they determined that around 1 part per million. They saw some fluorosis, but less decay. So that was, that was the original intent. But what people don't realize is that the health studies were never conducted. They just looked at potential efficacy, you know, prior to toothpaste even existing. So you have a lot of efficacy studies, but you had no health studies. And that's why it's important to point out that in 2007-- or, '17, that was the first time our U.S. federal government actually funded and, and looked at fe-- brain-- or, or, you know, I guess, brain harm from fluoridated water in infants. In 2017. After 75 years of water fluoridation. And it found harm. And since then, NIH has funded, as I said, nine other studies, and they all found the exact same harm.

FREDRICKSON: OK. And my last question for you is-- you mentioned in your testimony the, the ADA, the American Dental Association, being a, a large opponent of, of, of removing fluoride from the water supply. You expressed a number of concerns about possible negative impacts of, of fluoride. Help me understand. How, how, how would it be in the ADA's best interest to maintain fluoride? Why would they-- yeah.

STUART COOPER: Well, when you, when you make statements like-- and you're going to probably hear today-- unless people change their statements now-- when you hear statements like, water fluoridation's one of the top ten public health achievements of the 20th century, it's hard to walk that back and-- without losing all credibility. When you're the primary proponent of something and-- anytime someone

questions it, you've ridiculed them as a tinfoil hat or a conspiracy theorist or Dr. Strangelove, it's hard to walk that back, especially when you've done it to over a dozen Nobel Prize winners in medicine and science who came out opposing water fluoridation. So there's credibility at stake. And also what people don't realize is the American Dental Association has a conflict of interest. They receive millions of dollars from dental product manufacturers annually whose number one active ingredient in their product is fluoride. So they have a conflict of interest. They have a reason to promote water fluoridation not only for the credibility but for the profit of their industry association. It's not some objective public health association. It's a lobbying organization.

FREDRICKSON: OK. And is, and is your argument that people receive enough fluoride from things like toothpaste these days that they don't need it in the water? Am I understanding that correctly?

STUART COOPER: That's what the studies show. Yeah. We're-- we don't-- I don't-- we don't oppose topical fluoride. In fact, it-- you, you can receive-- the CDC even acknowledges now that any benefit comes from topical exposure and any risk comes from ingestion. There's no-- it's almost like the, the theory of ingesting sunscreen hoping it'll secrete out your pores and, and protect your skin. It's-- it-- you're going to expose all other tissues in your body to potential risk. So, yeah. Toothpaste. And that's what the-- when you heard Senator Hansen talking about those new studies, the Lotus study, the CATFISH study, these large modern studies, that's what they found, was that top-- there's enough top-- access to topical fluoride that-- water fluoridation just poses a risk because it's dangerously redundant.

FREDRICKSON: Thank you.

HARDIN: Senator Meyer.

MEYER: Thank you, Chair Hardin. Fluoridation is relatively widespread in the United States for quite some time. And we've got some evidence-- or, some testimony that some communities have stopped fluoridating their water. Have, have there been any negative or positive outcomes that could be quantified by stopped fluoridating the water?

STUART COOPER: Well, we would be protect-- well, you would-- first off, we know it would reduce dental fluorosis rates because the EPA has acknowledged that 60% to 80% of your fluoride exposure comes from tap water or from beverages made with tap water. So you would have a reduction in dental fluorosis, which is also mottling of the teeth. It

does weaken the enamel. But as far as-- you know, I'll give you some examples. Utah. One of-- the, the, the governor just did an interview two days ago and said, you know, half the state wasn't fluoridated and half the state was, and we saw absolutely no difference whatsoever in dental decay. We look at the World Health Organization data, and there's absolutely no difference whatsoever in dental decay rates between fluoridated or nonfluoridated countries at all after 80 years. And I, I've been to many of these hearings and I've heard about Calgary, the study out of Calgary. And it's funny because the Cochrane Collaboration-- it's a-- it-- they're-- they, they're considered the gold standard in reviewing medical interventions. And they recently did a review of fluoridation's efficacy and all the studies on it. It's a meta analysis. And what they concluded was-- they didn't include the Calgary study that you've probably heard about, or the Juneau study. These are the two studies that the, the proponents of water fluoridation love to tout. They didn't include them because they didn't meet the criteria for inclusion because they're of such low quality. The Calgary study, which you-- somebody might bring up-- they-- what they don't tell you is they looked at Calgary, which was fluoridated and then ended it, and they looked at Edmonton, which was always fluoridated. What they fail to tell you is that Edmonton, even though it was always fluoridated, always had a significantly higher rate of dental decay than Calgary, which wasn't. They also don't tell you that there were, there were two data points, and they look at in the study: when Calgary was fluoridated and then when it wasn't. And they say, well, look, it-- decay increased faster in Calgary after it ended water fluoridation as opposed to increasing in Edmonton. They omitted a third data point, which they had, which is why now there's a rebuttal article along with the published-- in that journal-- along with that published article. They omitted a data point right before Calgary ended water fluoridation, which showed that almost all of that increase in dental decay occurred while Calgary was still fluoridated. That's why it's, it's been debunked. And then the Juneau study that sometimes people bring up, what they-- it says right introduct-- introduction of the study, because it looked at Medicaid reimbursements, and they said, here's when Juneau fluoridated and here's when Juneau didn't. And Medicaid spending on child-- children's oral health went up. What they tell you in the in-- introduction but they don't apply as, like, cofounder is the fact that Medicaid-- the state dramatically increased Medicaid reimbursements for oral health. And so what that, what that hap-- what happens when states do that is you have more spending on Medicaid and you have more preventative services, dentists provide a more comprehensive service. So that's why the Cochrane review did not include those two studies.

MEYER: If I may. We've heard a great deal about the negativity of fluoridation. Are there any positives to it?

STUART COOPER: Of water fluoridation?

MEYER: Or fluoridation in general.

STUART COOPER: OK. I would say--

MEYER: Because we're going to-- in, in some form or fashion, we're going to be exposed to fluoride.

STUART COOPER: Yeah. No. There, there is something called a halo effect. If you live in a, in a, in a nonfluoridated part of Nebraska but you drink the beer or the water or a, a processed beverage or food from a fluoridated community, you will also be consuming fluoride, as well your child if they're consuming juice or whatever.

MEYER: I hope you mean from, from microbreweries and not--

STUART COOPER: Yeah. Yeah, from local microbreweries. That's right. Fluoride toothpaste topic-- topically used does reduce dental decay, and that's why we should rely upon topical applications. But as far as any other benefit, the only people that benefits are the phosphate fertilizer industry, who-- and they don't need this. They've even said this isn't that big of a moneymaker for them. They could sell it to, to other industries like computer chip etching and glass etching. That's how it's used. But this is li-- the, the silicofluorides-- this sounds crazy, but the silicofluorides used in water fluoridation, they're called fluorosililic acid, and it's scrubber liquor from the smokestacks of the phosphate fertilizer industry, predominantly Mosaic in Florida. So there's just this vapor mist. And it collect-- collects the pollutants. And that vapor's collected in a drum. And it's diluted 40% acid to 60% water. And it's untreated, unfiltered. It can't be dumped in the ocean or in a river, but it could be dripped into your water supply because the solution to pollution is dilution through your kidneys and liver. So that's, that's who it profits.

MEYER: Thank you.

HARDIN: Other questions? Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here. It's good to see you again. I, I've heard or read that you can filter fluoride out of your water. Is that, is that-- in your research, is that true?

STUART COOPER: Well, it's actually very difficult to filter fluoride out of the water, which is why it's really important to move on this bill. You [INAUDIBLE] don't give people much choice. This-- it's a-- this is a water equity issue. The on-- the fluoride ion is so small. The only way to remove it is with distillation or ver-- a very expensive reverse osmosis, which must be maintained. You might go online and see countertop filters and stuff. Numerous studies have looked at those. They do not remove fluoride effectively. They might remove some of it early on, but very quickly after a few gallons it loses all effectiveness. So what does that single mother do when they have to go to work and their, their child is, is exclusively bottle fed with reconstituted infant formula with tap water? They can't-- how are-- what, what are they-- how are they supposed to remove the fluoride for that infant? I mean, you know, something that I think all of you should kind of ask of those who come up here and promote this, especially the dentist, is, in a-- we can look at fluoride supplementation in a vacuum. If you look in a clinical setting, there's fluoride supplements, and they're the same dose you're getting in your water supply: about 1/4 milligram. That's about 10-ounce glass of fluoridated water. Fluoride supplement's about 1/4 milligram. The clinical guidelines for the American Academy of Pediatrics, the American Dental Association say very clearly you do not give children six months of age or younger fluoride supplements. It only poses a risk, and there's no benefit whatsoever. Water fluoridation can-- contradicts that directly because a bottle-fed infant will consume the highest amount of fluoride per pound of body weight of any citizen. And they're also the most vulnerable because of the brain development situation that we-- the studies are showing. So-- I mean, I would-- that's what I would just ask those people, those pediatricians, those dentists who may be here: look at your own clinical guidelines what you can do in an office setting. You cannot give this to infants. So why are we doing this with, with, with fluoridated water and reconstituted infant formula?

BALLARD: Thank you.

STUART COOPER: Yep.

HARDIN: Other questions? Seeing none. Thank you.

STUART COOPER: Thank you for your time.

HARDIN: Proponents, LB147.

JOSEPHINE LITWINOWICZ: Gotta catch the bus. Good afternoon, Senator Hardin and members of the HHS Committee. First of all, this-- the, the, the guy that spoke before me mentioned Dr. Strangelove.

HARDIN: Your, your name spelling, please.

JOSEPHINE LITWINOWICZ: OK. Josephine Litwinowicz, J-o-s-e-p-h-i-n-e L-i-t-w-i-n-o-w-i-c-z.

HARDIN: Thanks.

JOSEPHINE LITWINOWICZ: And the guy before me mentioned Dr. Strangelove. And I, I'm going to do it. I'm going to ride-- Slim Pickens, I'm going to ride it down for you. I, I, I don't appreciate-- or, I don't, I don't like chemicals. I have MS, and I'm supposed to avoid chemicals. And people like me, it's a di-- it's a neurological disease. And I-- you know, who knows what, what the-- what that's doing there? And some people might be more susceptible than me. And-- so I would just urge you to, to-- I don't see how it wouldn't pass, you know. So that, that's all I have to say. And maybe-- you know, Trump, he's going to put formaldehyde in it, but-- or, bleach. Just put less-- a "littler" amount. I have-- and this is-- our country-- man. I, I, I'm, I'm going to be twitching like Inspector Dreyfus, you know, from Pink Panther. I, I, I, I, I, I don't know what to do. It makes me physically sick. And he's going to drive it into the ground. We nee-- you know, you guys have to stand up and, and write a-- get a letter prepared. I mean, this is, this is awful. And that's it. But, yeah. The neurological thing with people like me and-- people are sensitive to other chemicals too with different ailments. All right. Thanks.

HARDIN: All right. Questions? Seeing none. Thank you. Next proponent, LB147.

ALLIE BUSH: Hi, guys. My name is Allie Bush, A-l-l-i-e B-u-s-h. I'm representing Nebraskans Against Government Overreach, the grassroots group. Nobody in our group opposed this. In fact, everybody that responded to our call to action was in support of this measure. We did prefer the bill from last year that would have taken it to a vote to add fluoride back in, but it's a good start to give at least local control back to the municipalities on what they prefer to do with the fluoride in their communities. It puts the responsibility of whether the communities fluoridate on to the constituents, whether they're going to work to go get that removed or not. Just recently, within the last week or so-- couple of weeks, Florida Governor Ron DeSantis stated, do we want forced medication or do we want people to be able to

choose medications? When you're forcing fluoride into the water supply, that's not really giving people a choice. Let people make decisions, not forced medications-- which has been a very strong point that Nebraskans Against Government Overreach has made for the last six years. It's-- aligns with what Thomas Jefferson said in 1871. If we allow the government to decide what foods people eat, medicines people take, we'll soon be living in as sorry a state as the souls living under tyranny. And we see that playing out. So please give people a choice. Pass this bill onto the floor so that it can be fully debated. And let the communities get to work on whether they want their water fluoridated or not.

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

ALLIE BUSH: Thank you very much. Have a good day, guys.

HARDIN: Proponents, LB147. Welcome.

LISA HATTERMAN: Thank you. My name is Lisa Hatterman, L-i-s-a H-a-t-t-e-r-m-a-n. I just want to thank Ben Hansen for bringing this forward and then bringing an expert into the room so I wouldn't have to try to reiterate what I know on my knowledge level. I am a single mom that just tries to do the best for my child. And I think-- my son is 15, unlike this baby that just left the room. And I wish I had known more about it because I did have to feed him formula. And I did filter my water. And I didn't know how much stuff was in there. But I've been in the state 60 years and-- I drink a lot of water. And I was proud that I was a water drinker versus a soda drinker and things like that. So I guess I kind of think about it like-- I'm, I'm very kind of like-- it's very interesting to me that this is even having to be brought up. That's, that's what I'd like to say about that. I, I don't believe that we should have it in our water-- obviously as a proponent to have it removed. And I will be fighting at my state-- or, my municipality level when it gets there, because I don't think people realize. I had a dentist this morning work on my teeth. And he said, you know, he didn't-- he's been here 45 years in this state practicing dental hygiene. And he said, well, gosh, it's done this. It's managed to enhance-- or, minimize extreme treatments for a certain subpopulation. And he said, but I didn't know about all this other stuff. I had no idea. So the, the neurotransmitter part of it is-- I almost wonder sometimes if my son has a, a problem keeping information in his head. But I'm also a health insurance producer, so I just wanted to say a little bit about that-- some of which has been described by the pote-- possible potential effects of fluoride in the water. The pineal gland in the brain is linked to hormone production, and calcification can

create other problems with your thyroid, melatonin production, gut issues, and even has been linked to reproduction. So I meet many people that have these problems in my industry, and they, they have no idea why. And people are seeking answers. So why can't we make it something as simple as removing something that we know is toxic from our environment? I shouldn't have to drink that water. And I do have one of those things that sit on my counter with the double filters. And it probably didn't work after the first, you know, 100 gallons to remove any of that. And that's, that's appalling to me. And I guess I-- the last thing I would like to say, with exponential growth of Alzheimer's and dementia for seniors and autism for children, could it be something as harmless as being in the water? I would rather put fluoride drops in my water or have it put on topically than have to be subjected to what is in our water.

HARDIN: Thank you. Any questions? Seeing none. Thank you.

LISA HATTERMAN: Thank you.

HARDIN: Proponents, LB147. Welcome.

DIANNE PLOCK: Good afternoon, Senator Hardin and the committee. Thank you for the opportunity to promote LB147. And I'm glad that Mr. Hansen-- Senator Hansen introduced this bill again this year on a different note, because last year's wasn't quite as good as this year's. My name is Dianne Plock, D-i-a-n-n-e; Plock, P-l-o-c-k. If I said to you lead pipes were safe to transport water into our homes today, would you believe me? Of course you wouldn't. But you do know lead has many of the same toxic effects as fluoride. Neuro-- it's a neurotoxin and a byproduct of the fertilizer industry that interferes with the biological processes of many organs and tissues, including the heart, bones, intestines, kidneys, reproductive and nervous systems, impairs the brain development of children, and causes behavioral changes, reduced IQ, and learning problems. Studies have shown fluorosilic acid, a corrosive fluoride chemical added to pu-- public water supplies, can leach lead from pipes and increase lead levels in children's blood. This is because, because fluoride can destroy the protective coatings usually formed in lead pa-- pipes, making them more susceptible to corrosion. The EPA released the Lead and Copper Improvement rule in October of '24, which requires nearly every lead pipe in the country to be removed within the next ten years and mandates better lead testing requirements and a complete inventory of lead water, water pipes. Cities like Lincoln, Nebraska initiated programs to replace lead service lines at no cost to property owners, using criteria such as blood levels in children and the risk of lead

exposure to identify properties eligible for replacement. The city has identified 6,000 properties eligible for pipe-- lead pipe replacement, and received a $32.6 million loan from the Nebraska Department of Environmental Energy to fund the project. The city's plans are to-- are a part of an initiative called Lead Safe Lincoln, spearheaded by the Urban Development and Health Departments. And long before the proposed federal changes were announced, the Lincoln Transportation and Utilities officials had earmarked $2 million a year in the capital improvement plan to begin the replacement. Because fluoride helps destroy those pla-- pipes and we're paying to have fluoride added to our Lincoln water whether we want it or not, Lincoln taxpayers will also be the ones paying back whatever loan remains unforgiven by the Lincoln-- the Nebraska Department of Environment and Energy. As a Lincoln taxpayer, that's a kick in my gut. Fluoride not only destroys lead pipes and our health, it also impacts our finances negatively, which I am sure the city would disagree. Last year, during the hearing on Senator Hansen's LB1-- LB1387 fu-- fluoride bill, there were a number of individuals who stated fluoride was one of the top ten health achievements of the 20th century by the A-- CDC. The 20th century ended 25 years ago, and fluoride hasn't been on that list since that time. It's time for the dogma to end. In addition, for whatever reason, there were 30 online proponent testimonies, testimonies, 15 opponent testimonies, and 2 neutral testimonies received and an almost identical number of in-person proponent and opponent--

HARDIN: We have you on the red. If you can complete your final thoughts, would be great. Thank you.

DIANNE PLOCK: OK. I'm sorry. That kind of threw me off. I don't think that I'm probably saying anything more than what Mr. Cooper said-- which I'm glad he's here. But even if this bill passes, we're still going to have to go back to our city and get this removed or-- by either public vote or whoever-- the power that be that put this in our water in the first place. I don't have conformer consent. I don't want it in my water, but I'm forced to have it in my water because it's there.

HARDIN: Thank you. And-- questions? Seeing none.

DIANNE PLOCK: Thank you.

HARDIN: Thank you. Proponents, LB147.

TRACY AKSAMIT: Hi.

HARDIN: Welcome.

TRACY AKSAMIT: Thank you, senators. I'm Tracy Aksamit, T-r-a-c-y A-k-s-a-m-i-t. I set out in March 2023 to determine how Nebraskans were handling the basics. With ever increasing data tracking required by state workers to manage public health, fluoride treatment seemed to be a simple choice to investigate. You're receiving the results of my research and my efforts to lower the fluoride treatment level in Lincoln, stemming from a 2019 aha moment. Here's a portion of my results.

_____: Can you speak up a little bit?

TRACY AKSAMIT: Oh, certainly. On the first page of your binder, you'll find a pedition-- a petition signed by the state public health director to align the outdated 1983 fluoride dosing regulation with the CDC 2015 recommendation. This revision became effective in January. On page 2, Table 1, you'll find an excerpt from a 2009 study on fluorosis risk from the Journal of the American Dental Association showing that differences-- difference in decay prevalence between optimally and nonoptimally fluoridated communities is negligible. This provides a benchmark for missing state level data that Dr. Debra Esser confirmed last year was not available. Table 2a and 2b are summaries comparing results of the Nebraska Oral Health Surveillance reports with the Nebrask-- with the National Health and Nutrition Examination surveys for the period 1999 to 2022. The results are mixed, with some measures showing increased decay, while others suggest reduced decay associated with increased sealant use. Table 3 on page-- on page 3 shows the 75% increase from $5,500 to roughly $9,600 in the total per member cost for Medicaid and CHIP since 2000. What portion of this increase is assigned to oral health, as described by Dr. Esser last year as the most common chronic medical health condition? These results appear to revute-- refute the claim that systemic fluoride dosing reduces tooth decay by 25% and thereby reduces Medicaid cost. They also suggest the limited effectiveness of managing public health with data. Finally, for Lincoln, Figure 1 and Table 4 compare fluoride treatment goals and testing levels for Lincoln with the 2015 CDC level and MUD Omaha water quality reports for 2022 and 2023, both indicating opportunity to reduce Lincoln's treatment by 10% or more. To close, instead of managing dental health by systemic fluoride dosing, increasing-- and increasing the collection of data points-- currently over 50-- please consider improving self-reliance. Bring transparency and choice to policy and educational materials by including the benefits of nourishing traditions and by highlighting the impact of malnutrition on decay. Many parents would welcome the services of a biolo-- biological

dentist and learning to recognize and treat many dental conditions on their own. Please advance this bill. Thank you.

HARDIN: What's the prevalence of other cities throughout the state having done the kind of testing that Lincoln has done like you have on page 3, I think it is.

TRACY AKSAMIT: Page 3?

HARDIN: Figure 1.

TRACY AKSAMIT: Let me get with you here.

HARDIN: It's the city of Lincoln fluoride test reports. How, how common is that for our state? Do you know? Do we-- do others--

TRACY AKSAMIT: Help me understand your question.

HARDIN: Big towns, small towns, do they, do they have a, a table like that showing--

TRACY AKSAMIT: Like this?

HARDIN: --your-- no, I'm sorry. It's, it's actually this page.

TRACY AKSAMIT: Oh. Table 3.

HARDIN: Yeah. It says Figure 1.

TRACY AKSAMIT: Table 3? Up here? Is that what you said? Or Figure 1?

HARDIN: Yes, it would be Table 3, Figure 1 inside Table 3.

TRACY AKSAMIT: I created that. The-- there is-- that's the only one there is that I am aware of.

HARDIN: OK. That's a helpful thing.

TRACY AKSAMIT: I did that for--

HARDIN: You should do that for every town in the state.

TRACY AKSAMIT: I like charts.

HARDIN: I see.

TRACY AKSAMIT: Because that-- and that's why I provided you charts. Because the reports that I found, the surveillance reports are mostly text and don't show, you know, those easy to understand--

HARDIN: Right. Well, you made that easy to understand. That's why I--

TRACY AKSAMIT: Thank you.

HARDIN: --jumped on it. Thank you.

TRACY AKSAMIT: Thank you.

HARDIN: Other questions? Seeing none.

TRACY AKSAMIT: Thank you very much.

HARDIN: Thanks for the hard work on this.

TRACY AKSAMIT: Appreciate it. Thank you.

HARDIN: Proponents, LB147. Welcome.

STACEY SKOLD: Thank you. My name is Stacey Skold, S-t-a-c-e-y S-k-o-l-d. Good afternoon. I'm here to voice support for LB147. I became aware of issues related to fluoridation while working on my PhD dissertation and later coursework on chemical pollution from the textile industry and its impact on human health. Fluoride was addressed in the context of endocrine-disrupting chemicals, and I was surprised that much of what I learned at that time. This is including that the National Research Council has identified fluoride as an endocrine disruptor, endocrine disruptor. These chemicals are substances that can interfere with the body's endocrine system, which regulates our hormo-- hormones. I was also surprised that the natural form of fluoride was not used in fluo-- water fluoridation. As discussed, the main chemicals used are known as silicofluorides. These are not pharmaceutical-grade fluoride products but are unprocessed, industrial byproducts of the phosphate fertilizer industry. An article that I shared goes into great detail about that. During the production of the phosphate fertilizers, hydrofluorosi-- silic acid gas is captured by the wet scrubbers and combined with silica. This ultimately is classified as hazardous waste but is barreled up and sold unrefined to water treatment facilities. This solves a big waste problem for the phosphate fertilizer industry and is lucrative. According to a 2001 estimate, the phosphate industry sells approximately 200,000 tons of silicofluorides each year. In the air or river, these are pollutants, but it goes-- yet it goes into our drinking water system and it's not considered a pollutant. The

complexities of dosing also struck me. The toxicity of fluorite functions synergistically with other compounds. This is when chemical compounds or biological structures combine, resulting in a larger overall impact than the sum of their separate effects. For example, when fluoride is combined with aluminum, which is also prevalent in our environment and varies from person to person, fluoros-- fluoride toxicity increases. This is one of many reasons why a one-size-fits-all approach to medicating individuals is misguided. Fluoridation is indeed a medical intervention implemented without informed consent. Informed consent is also one of the nine core principles of the American Medical Association's Code of Medical Ethics and outlined in the Nuremberg Code. This practice has been rejected by most developed nations. The U.S. is an exception, although recently multiple states-- as we have heard-- are stopping the practice. I hope Nebraska is also one of them. If one desires to supplement with fluoride, topical fluoride application is the more direct and appropriate way to administer fluoride. But read the fine print, as you heard. One will find a warning on the toothpaste tube not to ingest it due to toxicity. Sadly, this recommendation is not heeded by our-- especially by our youth, and many children are now-- now exceed the recommended daily fluoride intake from toothpaste alone.

HARDIN: We're in the red. Can you comment-- we're concerned about people, but you've got a shocking picture in here on page 2 of a cow--

STACEY SKOLD: Yeah.

HARDIN: --on its front legs buckled up. Can you comment on what this looks like in, in, for example, the cattle industry, the hog industry? We do some of that here in Nebraska. And so I'm just curious, what does this look like for our livestock?

STACEY SKOLD: Well, this article is from the Fluoride Action Network. And I believe-- and maybe Mr. Cooper can comment, but I bel-- or, Dr. Cooper-- I believe this-- that image was from when it was released into the air, possibly, or water body. I'm not con-- I'm not 100% sure that it was from water fluoridation. But I would probably need to go back and reread that to [INAUDIBLE].

HARDIN: Just very curious what the effects were on animals. Clearly, we're most concerned about what are the effects on--

STACEY SKOLD: Sure.

HARDIN: --people and-- especially children, and so on and so forth. And--

STACEY SKOLD: Well, we definitely don't want it in the air or wat-- I mean, it's, it's-- you know, it needs-- this, this is a byproduct that needs to be dealt with, for sure--

HARDIN: OK.

STACEY SKOLD: --a different way.

HARDIN: Other questions? Senator Ballard.

BALLARD: Thank you, Chair. It's good to see you, Stacey.

STACEY SKOLD: Yup. Nice to see you.

BALLARD: And, and then I'm sorry to put you on the spot. And I know Mr. Cooper addressed this earlier, but I know you do your research. Other communities that have gotten rid of fluoride in their water, have we seen-- through your research, have you seen any po-- any-- is there a discrepancy in tooth decay? I know you-- I know you study this a lot.

STACEY SKOLD: I ca-- I-- yeah. Overall, what I've read is that there haven't been. And I think we've heard from other testifiers that-- mixed results. There can be mixed results. The one that jumps out right now is I did listen to the governor of Utah discussing their situation and how part of the state was under fluoridated water and the other part wasn't and that there wasn't a large difference. So I thought that was interesting and it was-- seemed to be a recent comparison, so.

BALLARD: Thank you so much for being here.

STACEY SKOLD: Mm-hmm.

HARDIN: Other questions? Seeing none. Thank you.

STACEY SKOLD: Yep. Thank you.

HARDIN: Proponents, LB147. Welcome.

KENDRA WHITE: Thank you. OK. Just want to thank you for the opportunity. My name is Kendra White, K-e-n-d-r-a W-h-i-t-e. District 2. I have a biology major, a chem minor, and a master's in bus-- business administration. During my career journey, I have performed genetics research and have also trained medical doctors to educate other doctors on genetic testing. I am asking Nebraska to follow Utah

and Florida's move to not mandate fluoride in public drinking water. So let's pretend for a moment that we each have two full glasses of water in front of us. All attributes the same, except one glass has fluoride like our city tap water and the other one does not. The human body does not need fluoride for any biochemical processes whatsoever. And the hazardous industrial waste that is added to our water supply, called fluorosilic acid, can eat through concrete when in full concentration. The ADA and CDC have touted a 25% reduction in cavities with water fluoridation. This 25% is from a 2007 review with lead author, CDC employee, Susan Griffin, PhD, who is not a medical practitioner. Gru-- Griffin later used the same data to manipulate even higher percentages. Griffin's 2007 review did not include children. It starts with, quote, to date, no systematic reviews have found fluoride to be effective in preventing dental caries in adults, unquote. This means that no one of their hand-picked 20 publications could stand on its own. They used what is called quantitative data synthesis. And they created an imaginary control group that, in their words, assumed one coronal carie per adult per year. A coronal carie is a cavity or significant tooth decay in a crown of a tooth. There is no evidence to suggest that an average person would have one coronal carie per year. The CDC made up data to do their math to get their 25%. Meanwhile, there's a mountain of evidence for us to want to leave fluoride out of our water supply. A study I reference on the documents I gave you found that only 50% of the ingested fluoride is excreted through the kidneys-- 60/40, depends on your study. 50% in the one I gave you. The remainder accumulates in the bones, the pineal gland, and other tissues. Fluoride is a proven neurotoxin. Fluoride accumulation in the pineal gland leads to reduced melatonin production and a, and an earlier onset of puberty, which we're seeing with our teenagers. And reduced melatonin production leads to obesity. We see plenty of that. Melatonin in proper amounts suppresses hunger. Low melatonin, however, levels can reduce the body's ability to metabolize fat. Fluoride causes newly formed bone to lack normal structure and strength, and scientists have found an association between osteoarthritis and fluorinated water. Fluorides mediates cell-signaling pathways, leading to changes in gene expression, cell stress, and even cell death. Fluoride toxicity in bones can prevent as-- present as arthritis. And now we can revisit our choice between the glass of water with fluoride and the one without. You can decide for yourself which one you want to ingest and share with those you care for. Please consider the long-term health of all Nebraskans in your decision regarding this very important issue. Thank you.

HARDIN: Thank you. Questions? Seeing none. Thank you. Proponents, LB147. Opponents, LB147. Those against. Welcome.

JESSICA MEESKE: Welcome. Thank you. Dear members of the committee, my name is Jessica Meeske, J-e-s-s-i-c-a M-e-e-s-k-e. And I'm President of the Nebraska Dental Association. I'm also a practicing pediatric dentist in Hastings and Grand Island. And I'm speaking in opposition. We have great respect for Senator Hansen and what he's done to promote oral health access in our state. And you'll hear a lot of testimony today, and it's going to be confusing. You've probably already figured that out. However, here's what you need to remember at the end of the day: water fluoridation is safe, it's cheap, and it works. And what I'd like to do is paint a picture of what it would look like if we stopped fluoridating. I know this firsthand because Hastings is not fluoridated. And every day, we have to block our schedule for kids that have toothaches and facial swelling and abscesses related to advanced decay. Every single day. Every day, I give little kids shots in the mouth and extract teeth, and it's stressful for them and their parents. And when I look at many of you, many of you may have not have grown up in the benefit of having fluoride, but likely your children did. Many of you likely have had fillings, crowns, root canals, even extractions. But many of your kids and your grandkids have never had a cavity. One thing we can be sure of is if we defluoridate, your grandkids will be the first generation to have worse teeth and oral health than you had. Furthermore, our kids from low-income families-- many who don't own a toothbrush-- will lose that benefit of 25% reduction in decay. They're going to miss more school. And this is all avoidable. We need to give our kids hope for oral health and a better life, not take it away. And when we talk about fluoride being a personal choice, these kids didn't get to choose. They don't choose where they live. They don't choose if their town is fluoridated. Or the fact that we have 52 dental shortage areas in our state. As a former school board member and president, I've never seen studies in our state that show low IQ related to fluoride use. But I've seen plenty of studies related to kids' absenteeism and poor academic outcomes. We're not here to tell every Nebraskan they must consume fluoridated water. We respect everyone's ability to choose how they get their water. You can drink it from the tap. You can get well water. You can choose to filter it. You can buy fluoridated water. However, what you should understand is it'll be impossible to avoid fluoride because it's ubiquitous in all of the foods, processed foods, foods we eat when we eat out. Do you think a parent who wants to be fluoride-free is reading the labels on all of these prepackaged products or what drink their kids get at McDonald's? Fluoride isn't even listed as an ingredient. In closing, there are some public policies the public doesn't get to choose. Things like, what makes for good speed limits? What things do we add to water to keep it safe? Do we really want to go down the slippery slope of allowing the public to

vote on how to keep our water safe? Next year, will we be debating whether chlorination is good to keep our water safe? The Nebraska Dental Association urges you not to vote this out of committee and maintain the public health practice which benefits the majority of Nebraskans. Thank you.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and testifying today. You mentioned your-- you practice in Hastings. You said the water there does not have fluoride.

JESSICA MEESKE: Right.

FREDRICKSON: So I, I guess I'm a little confused because this bill says that they don't want-- do we-- currently-- are municipalities able to opt out of fluoride currently?

JESSICA MEESKE: They-- if they opted out, it had to be between 2008 and 2010. And so Hastings is a community that has never had fluoride in the water, and they haven't voted to put it in.

FREDRICKSON: OK. Thank you.

JESSICA MEESKE: Yeah.

HARDIN: Other questions? Senator Meyer.

MEYER: Thank you, Chairman Hardin. Thank you for being here today. I appreciate you coming. I read: however, you should be-- understand it would be impossible to avoid fluoride because it's ubiquitous in all, in all the other food and beverage we consume. And so if we don't have it in our drinking water, are we getting the po-- probability is we're getting it in our consumption anyway so we wouldn't have to fluoridate our water?

JESSICA MEESKE: Well, there is what you heard before, which is a little bit of that halo effect. So you do get some benefit from it. But what the research shows is when you drink it from the tap, you get it at that optimal amount, which is around that 0.7 parts per million. And that's-- it, it's getting a little bit throughout the day that has the beneficial effects to the teeth, both the systemic effect and the topical effect. If, if I could find a way to bring something to you that would deliver the same efficacy, I would come to you with a solution. It's just that we don't have anything better right now than fluoridating water. That's our, that's our best and our most safest.

MEYER: May I? Many of our, our groundwater has fluoride in it [INAUDIBLE] naturally. And, and so in combination with our food and beverages that we consume, it may be possible to get sufficient perhaps. We've had a lot of testimony today about the negative effects. Are you discreding the-- discrediting that in total with regard to the, the testimony and, and some evidence that's been presented?

JESSICA MEESKE: Yes, from the standpoint, as long as we consume it at the safe and recommended le-- levels, it is totally safe. If we're looking at places that are not in the U.S. that have more than the recommended amounts-- 2, 4, 10 times as-- amount-- yes, there are negative effects. That's not what we're talking about. In the U.S. and in Nebraska, they're well within those recommended limits that the CDC recommends as being correct. So, yes, I would refute it.

MEYER: And, and if I may just briefly. And so from, from my understanding-- and perhaps I didn't hear well enough when, when they were testifying. So many of the negative examples that were presented were not from the United States. They were from Europe or other parts of the world that have been exposed to fluoride in much greater amounts--

JESSICA MEESKE: That's correct.

MEYER: --but not in the water since many of them do not fluoridate their water. Is that, is that what I'm understanding?

JESSICA MEESKE: That's correct. Although there is research showing in other states where there are parts of the state that have exceptionally high levels of naturally occurring fluoride, you're going to have negative effects. But not what they're talking about. What we're talking about is the fluorosis or the mild white spots on the teeth. Some of the kids I see from Mexico that are in my practice have a more severe form of fluorosis because they grew up in Mexico. But I, I see so little fulor-- fluorosis in rural Nebraska, and my practice covers about a three-hour radius in three directions. So we're just not seeing the dental effects of it. And certainly I'll refute any of the neurotoxic effects of it at the recommended levels.

MEYER: Thank you.

JESSICA MEESKE: Yeah. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. Good to see you again. And I appreciate everything that you do for taking care of our kids. My question is this-- because you, you said in your openi-- you have Hastings and Grand Island.

JESSICA MEESKE: Mm-hmm.

RIEPE: And in research, we're always looking for twin studies. Is there a comparison-- does Grand Island fluoridate?

JESSICA MEESKE: They don't, but Grand Island has about half the amount of the recommended levels that occur naturally. So Grand Island does not fluoridate.

RIEPE: OK. I was just trying to look and say, if you saw more damage in Hastings than you do from Grand Island.

JESSICA MEESKE: So-- if you don't mind, if I could reframe the question between Hastings and Superior. Superior, Nebraska was the first town in Nebraska to fluoridate. And my children I see from Superior have much lower decay rates than my kids from Hastings. If that's helpful.

RIEPE: Do you antic-- or, can you judge anywhere-- on-- is their level of, of IQ level lower?

JESSICA MEESKE: Not that I can tell.

RIEPE: OK.

JESSICA MEESKE: And like I said, I was on school board for nine years. I've never seen any data like that. But plenty of studies-- if you miss a lot of school, your success, your academic performance will go down.

RIEPE: OK. Thank you.

JESSICA MEESKE: Yeah.

RIEPE: Thank you, Chairman.

HARDIN: Piggybacking on what Senator Meyer was talking about a little bit earlier. Socrates, Plato, Aristotle taught us that if we affirm and deny the same thing at the same time in the same respect, we have what is called a contradiction. And none of us are dentists and professionals like you are. But we did stay in a Holiday Inn Express last night.

JESSICA MEESKE: Absolutely.

HARDIN: And so what do we do with what we've heard this morn-- or, this afternoon?

JESSICA MEESKE: I, I really appreciate that question. That is such a thoughtful question. So those of us that are clinicians in the room-- and we take care of patients-- it's very rare that 100% of science and research supports one thing over another. It, it's rarely 100% and 0%. There's always what we call a preponderance of evidence. And so if the preponderance of evidence is such that the practice or the recommendation gives a high amount of effectiveness or therapeutic effect for what you're trying to accomplish and your risk factors for negative things happening are very low, it, it's, it's-- you weight the evidence. And you not only have to look at the preponderance of evidence, evidence of how much is on each side, but the quality of evidence. Who wrote the paper? Is there any conflicts of interest? So that's one of the things that we teach in dental school and I teach to the pediatric dentistry residents that rotate through my practice. Every time you look at a research study, you have to look at the quality of that study because there is a lot of flawed research out there.

HARDIN: So your questioning the quality of it. I kind of have no ability sitting in this chair at this moment to, to do that. I can dive into it later. I guess what I'm hearing is that you're saying this is completely safe for the teeth, and they're saying this is completely unsafe for the rest of you. And those are not contradictions.

JESSICA MEESKE: And what I'm saying is, I disagree with the proponents because--

HARDIN: Convince me. Because so far, I'm not convinced that it's safe for the rest of me if, if-- and so help me out.

JESSICA MEESKE: The-- we, we just haven't seen any studies that look at recommended levels of fluoride showing a lower IQ in kids, and that's why it's still even being debated at that level.

HARDIN: But is lower IQ the only-- because I heard other indicators discussed other than lower IQ. Believe me, I like that one because I was going to blame a whole lot of things in my life on that. But there were other indicators as well. And I guess I'm concerned about those other things other than lower IQ.

JESSICA MEESKE: Yes.

HARDIN: Just, are we introducing something that's generally unsafe for our neurology?

JESSICA MEESKE: So-- you know what? Your, your question is really good, and it's thoughtful. And we have three really capable physicians that-- I'm going to let you ask them that question because it's more of a broader health question.

HARDIN: Sure.

JESSICA MEESKE: I think that would be the fair thing to do.

HARDIN: All right. Thank you.

JESSICA MEESKE: All right.

HARDIN: Any other questions? Thanks for being here.

JESSICA MEESKE: All right. Thank you.

HARDIN: Opponents, LB147. Feel free to crowd right up to the front one after the next. And we'll-- we'll get you all in, I promise. Welcome, Dr. Tesmer.

TIMOTHY TESMER: Good afternoon. Please, before you start the clock, I want to make an-- a, an, an apology if-- I'm going to try my best at my auctioneer voice. But if it-- if-- I'm going to try to keep within the three-minute time limit. But if I extend myself, I apologize and I can stop. And I'll do my best, so. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Dr. Timothy Tesmer, T-i-m-o-t-h-y T-e-s-m-e-r. And I'm the Chief Medical Officer of the Division of Public Health in the Department of Health and Human Services, DHHS. I am here to testify in opposition to LB147. Adding fluoride to drinking water to protect against tooth decay is one of the most successful public health interventions in history. This connection has been observed since the 1930s when the U.S. National Institutes of Health began investigating how fluoride works, whether it is safe, and if it could be used therapeutically. This large body of research has overwhelmly-- overwhelmingly shown the benefits of adding fluoride to drinking water significantly outweigh any health risks. Fluoridation reduces dental decay rates by approximately 25% and reduces absenteeism. Children living in areas with a fluoridated water supply are more likely to attend school due to fewer dental-related illnesses, and adults miss fewer workdays for dental treatment. In addition, Nebraska currently has over 45 counties designated as state shortage areas for general dentistry. Nebraskans without access to

regular dental care are already facing challenges to maintaining good oral health, which is necessary to maintain good overall physical health. Fluoridated water provides health benefits to Nebraskans regardless of whether-- where they live or their socioeconomic status. Recent attention in the media has raised concerns about water fluoridation and its possible link to health issues. A recent monograph by the National Toxicology Program claimed a possible association between very high fluoride levels and lower IQ. However, this was based primarily on studies in non-U.S. countries, where some individuals received total fluoride exposure amounts at least twice as high as those often seen in the United States. The NTP itself indicates that an association does not prove a causal relationship and that more research would be needed to better describe any health risks associated with low fluoride exposures. It is important to base public health policy on sound evidence. For over a century, fluoride has been present in community drinking water systems. To date, there has not been consistent and convincing evidence linking water fluoridation with any unwanted health effect other than dental fluorosis, a change in the appearance of tooth enamel that can occur when the permanent teeth of young children are still developing. Currently, there is no reason to dispute the overwhelming evidence supporting fluoridation's safety and effectiveness in promoting public dental health. Pursuant to Nebraska Revised Statute 77-3306, DHHS has recently revised regulation Title 179, Chapter 1, Fluoridation of Public Water Supplies to set a target level of fluoride in drinking water at 0.7 milligrams per liter, consistent recommendations from both the Centers for Disease Control and Prevention and the U.S. Public Health Service. Community water fluoridation is one of the most cost-effective, accessible, and safe measures communities have to prevent cavities and improve oral health. Data indicates for communities of 1,000 or more people, savings exceed costs, annually averaging $20 in savings for every dollar invested. I see the red light is on.

HARDIN: You do, but I can also see you're nearly done, so keep going, please. And you're doing a marvelous auctioneering job. I'm very impressed.

TIMOTHY TESMER: Yeah. I'm gonna-- I need to-- I need a couple breaths of air here. We respectfully request that the committee not advance the bill to General File. Thank you for your time. I would be happy to answer any questions on this bill. Thank you.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. That was actually a very impressive speed-read as well. I agree with the chair. So just to kind of piggyback over-- I, I know the chair asked this of the last testifier, but do you-- are you able to shed any light-- because I-- the-- I, I'm kind of hearing a similar dynamic at play here. On the one hand, I'm hearing-- obviously, fluoride on teeth, it seems like very helpful, very beneficial. The concerns I've been hearing from proponents of the bill is the ingestion piece there. Can you shed any light on that? I mean, it sounds like what I'm hearing is that, at the recommended levels, it's completely safe. But are you able to say more?

TIMOTHY TESMER: Well, I-- yes. And thank you very much for the question, Senator. One of the honors that I have in this position is to, on topics like this, be able to try to review as much of the literature as I can, knowing that I can't look at every report that's out there. But I really try my best to look at the pros and the cons-- however you want to weigh those terms, anyway. And doing that and then applying what I'm supposed to do-- reasonable medical judgment-- on, on this-- yes, at the recommended levels of 0.7 parts per million or milligrams per liter-- which, if you think of it, three drops of that liquid in a 55-gallon barrel is what we're talking about here. OK? At that level, yes, it is safe. I have not seen any studies that point towards the recommended level of 0.7 causing any health risks.

FREDRICKSON: OK. And my, my other question to follow up on that is, are there any parts of our state that are outside of that level or nearing the high end of that level that might be at risk for overfluorinating? Am I-- is that the right word, fluorinating?

TIMOTHY TESMER: Well, that-- there may be natural, natural levels of fluoride in water supplies in parts of the state that are above that level.

FREDRICKSON: OK.

TIMOTHY TESMER: OK?

FREDRICKSON: So well-- like well water or--

TIMOTHY TESMER: Well water could or may or may not be, I guess. But, I mean-- but for those community water systems that supply to the-- those people, the 0.7 milligrams per liter is a sa-- a recognized safe level.

FREDRICKSON: And they're not supplying it at a rate higher than that.

TIMOTHY TESMER: No. I mean, with-- when we-- when the regulations were changed last year, we worked very closely with the Nebraska Department of Environment and Energy, NDEE, because they have the-- they're tasked with maintaining those levels. Public health can set, can set the level, but NDEE and its components maintain that level. So there's a working functional capacity within their systems to try to stay within a very small margin one side or the other of that 0.7 level.

FREDRICKSON: OK. Thank you.

TIMOTHY TESMER: Mm-hmm.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. And I know-- Grand Island, we, we used to put fluoride in the water. I worked for the utilities, and that was one of our jobs, to go out and-- when the trucks came in. And then we would monitor to make sure that we were, you know, making sure that that meter was putting in the, the correct amounts. But can you talk a little bit about, you know, how that-- when the law changed. So Grand Island had it. And then I'm going to say at some point we decided not to do it. And I don't know if it was a city council or by the vote of the people. And then what it is now. So is it-- it's mandated now or can people still change it?

TIMOTHY TESMER: Well, I, I think on previous testimony-- and I would probably defer to that. There was an opt-out time period from 2008 to 2010 where-- when those-- when the regulations were first enacted, communities could opt out. After 2010, I-- there may be a process that a community could, could go through. I don't know what that would be, though. I know there are a number of communities in Nebraska that do not have fluoridated water systems, and there are num-- a number that do.

QUICK: And I have one other question. And then-- so now is it the public health that-- I know we take water samples and we take it to the Public Health Department. And then they would, they would test for-- maybe it was bacterias, but they also test for fluoride. Do you know-- do the public health districts, do they do that? Or through the state?

TIMOTHY TESMER: I don't know, but, Senator, I'd be happy to try to find the answer to that--

QUICK: OK.

TIMOTHY TESMER: --to you.

QUICK: Because I'm going to guess we had to set our rates by what was in the natural-- you know, if we had so much in our, in our water already, then we only set our rates according-- to stay within the limits.

TIMOTHY TESMER: Well, I do know that in the mid-2000s, 2015-ish-- give or take somewhat-- the, the range of fluoride was, like, about 0.8 to 1.5. There was a range there. Now we have narrowed that down with the target level of 0.7 with an operational functional capacity, depending on the equipment, of 0.2 milligrams one way or the other-- realizing that you cannot keep it at 0.7 24/7 but within the functional capabilities of the equipment, depending on water flow and that type of thing. If we can provide that range-- so that would go from 0.5 to at most 0.9.

QUICK: OK. All right. All right. Thank you.

TIMOTHY TESMER: Mm-hmm.

HARDIN: OK. Senator Meyer.

MEYER: Thank you, Chair Hardin. I appreciate you coming in today, sir. As I read: a recent monograph by the National Tex-- Toxicology Program claimed a possible association between very high fluoride levels and lower IQ. However, this was based primarily on studies in non-U.S. countries where some individuals received total fluoride exposure amounts at least twice as high as those often seen in the United States. We are looking at a 0.7 parts per million or a--

TIMOTHY TESMER: Milligrams per liter. Yeah. Mm-hmm.

MEYER: 0.7 milligrams per liter, but that's down from, like, 1.2, which was considered the max, if I understand, if I recall correctly from, from Senator Hansen's testimony. And so essentially at 1.2, which we had been at, is almost twice as much as the 0.7, which would be an indication of reduced IQs in other countries when they were exposed to twice what normally we're exposed to here in the United States. So-- OK. 0.7 is where we're at. Are we going to end up down at 0.4 or 0.5? It seems like we're lowering the bar at the level-- maximum level for toxicity when we were already at a higher level. And so-- we, we hear expert testimony that it does not affect IQ, and yet there is some anecdotal evidence that it has affected people-- IQ at-- almost at where we were maximum until we dropped it to 0.7. So it sounds like we've got a real inexact science here. A very inexact science. And we're exposed on a continual basis of this. Shouldn't we back away from

it until we get some better data? Or perhaps back totally away from it and then start adding it back in to see if it makes the difference?

TIMOTHY TESMER: I-- thank you for the question. I'm not sure what the trajectory over the next five to ten years will be--

MEYER: It's hard for any of us to know that.

TIMOTHY TESMER: --relative to what the CDC might recommend at an optimal target level. So I, I, I don't know-- I don't know what that's going to be. I don't think anybody does. I don't-- again, from a public health perspective-- if I can make-- if I can make an analogy: there are four pillars or four legs to a table, generally speaking. And let's say that table represents dental health, dental cavities. Those four legs of that table-- which are all critical in maintaining the stability of that table-- are, number one, routine, regular visits to your dentist, along with brushing your teeth regularly; two, periodic, topical fluoride treatments; three, sys-- fluoride sealants on your back teeth especially; and then the fourth one-- not in any order of importance-- but the fourth one is fluoridation of community water system. Each one of those legs, each one of those pillars is important to maintain the integrity of that table. You take one away, the table is unstable. It's been shown that removing fluoridated water from a community system will increase the dental cavity rate. It's been, it's been shown that time and time again. So that increases dental costs. That increases the absenteeism and time off of work for those people. And at most, perhaps 60% to 65% of people in general are going to see a dentist once a year, whereas the recommendation's usually twice a year. And the proper toothbrushing techniques that parents teach kids, that's suspect to some extent. Lack of dental insurance, lack of dental access-- all of that plays a role into those pillars, those legs of the support of the system. So I think from a public health standpoint, community water fluoridation is the most cost-effective way of providing a foundation or a basis of oral health. It's equal access regardless of age, income level, or anything like that. If that answers your question, anyway.

MEYER: I thank you for that analogy. Thank you.

HARDIN: Other questions? Does the dental industry make money off of this? Because here's my-- here, here's my suspicion. Anytime we sit up here as the folks going, hmm, great. Now we get to sort of make this 51/49 decision that falls in our laps. But that is why they pay us the big bucks up here. I look at it and go, hmm. Follow the money. Who's making money here? I'm just curious.

TIMOTHY TESMER: Senator, I'm not sure how to answer that question.

HARDIN: That's exactly--

TIMOTHY TESMER: [INAUDIBLE]. I can't answer that question.

HARDIN: --why I wanted to put it in your lap.

TIMOTHY TESMER: Yeah.

HARDIN: Yeah.

TIMOTHY TESMER: So I--

HARDIN: Because that's what we have to figure out, because I think it's an indicator that helps us shed light on these situations when we've got kind of a 50/50 going on. You know what I mean?

TIMOTHY TESMER: I understand.

HARDIN: And, and it doesn't mean that it's wrong. It just gives you aha moments when you kind of figure that part out. So I'll keep asking others too.

TIMOTHY TESMER: I acknowledge-- I, I acknowledge that, that question. I think I can safely speak for most-- probably about all--

HARDIN: OK.

TIMOTHY TESMER: --I know medical people, my dental colleagues, they're not in to make the money. They're in it to help people.

HARDIN: OK.

TIMOTHY TESMER: And in the ca-- and this case that we're discussing now--

HARDIN: Yeah.

TIMOTHY TESMER: --help reduce the dental decay rates, especially in the most vulnerable part of our population: kids.

HARDIN: And I don't-- and I'm not questioning the dentists so much in this situation. I guess what comes to mind for me is those companies that are providing the fluoride to the municipalities who are juicing the water. I'm, I'm just looking at where, where does the money go.

Someone's paying for that. They don't give it away for free. Is that right? To the municipalities? They have to pay that.

TIMOTHY TESMER: I would imagine.

HARDIN: Yeah. And I'm just curious where that goes, because follow the money is just usually a good idea. We have more than 40,000 FBI agents, and what most people don't realize is that about 37,000 of them are forensic accountants. Follow the money. So that's why I'm asking.

TIMOTHY TESMER: I'm not sure how to answer your question. I understand it, but I don't know how to answer that question.

HARDIN: Well, thanks for being here.

TIMOTHY TESMER: Thank you.

HARDIN: Opponents, LB147.

STACIE BLEICHER: Sorry I'm a little slower getting up here.

HARDIN: That's OK.

STACIE BLEICHER: Chairman Hardin, committee members. Thank you for--

HARDIN: Welcome.

STACIE BLEICHER: --allowing my testimony. My name is Stacie Bleicher. I'm a-- it's S-t-a-c-i-e; last name is B-l-e-i-c-h-e-r. I am a retired general pediatrician, practiced in Lincoln for 35 years, and have presented some information from the Nebraska Chapter of Pediatrics, which also is oppos-- in opposition of moving this bill to the floor. I guess I feel like maybe you-- rather than a few-- I want to be sure I reach the points that I want to cover, but I wanted to talk a little bit about the research regarding neurologic developmental effects, those sorts of things with children. In my training certainly, I was taught that studies that show an association with an item, with a given finding is just an association. It does not mean it's causative. It is very difficult to do a study where you'd look at all the things that could impact a child's emotional and mental development over a period of their first years-- six years of life that are there besides just fluoride in the water. I mean, the-- our society is changing. Social media, different stresses. COVID may be a big issue for kids in how they're doing educationally down the road. And so to assume that it is causative is an assumption. And I think that's why some of us-- yeah. Yes, I'm a strong believer in taking care of teeth because that's an

important part of taking care of children. But that's why I have some questions about the true implications of those research studies. So that's how I'm able to sit up here and say, no, we really need to do this. I would not want to emotionally and developmentally impair the children that I take care of. The important thing is not to minimize dental disease in children. It can cause chronic pain. It can cause nutritional deficiencies. Kids that are hurting in their mouths and not eating well do not do well in school. That's going to impair their progress through school and their future education and success with education. There is a risk of life-threatening infections, especially in those areas where they don't have access to dental care to take care of the problem of developing a life-threatening infection like meningitis, brain infections, things like that, that can be fatal. And the other thing is some kids come in with such extensive damage that they have to have general anesthesia to have the procedure. And the anesthesia itself, you know, probably has some risk. You don't want people to have to have repeated anesthesia if not needed. It's a quite refined art, but it's not foolproof. Bad things can happen. And so, you know, from the medical standpoint, that's-- as a pediatrician why I really push that-- you know, dental care is part of a child's medical care. It's very important.

HARDIN: We have you in the red. Questions? I, I have one. And just comment in general on it. 38 states do not require this. Nebraska's one of the dozen that does require this. What's the matter with those other 38 states?

STACIE BLEICHER: I guess they just have different levels of things that they feel--

HARDIN: Do they hate their children?

STACIE BLEICHER: --they can place on their proponents.

HARDIN: Is that what we're saying here?

STACIE BLEICHER: Well, no, not really. But sometimes that fierce individuality and wanting to be able to make all your choices-- I mean, it's the whole conflict of public health versus let people do whatever they want to do. That goes with law enforcement too.

HARDIN: You, you bring up-- that's a great-- that's a great summary, because that is, at essence, what we're talking about here.

STACIE BLEICHER: Yes.

HARDIN: Do we trust the person to make wise decisions or the community to make those decisions? Or do we somehow hand it down from on high?

STACIE BLEICHER: I'm not sure all the communities-- I mean, I certainly know a lot of people in the Lincoln community that are not aware of the level of poverty in portions of our city and the lack of access to medical and dental care. And so if those people who are voting and the parents of these kids who are working three jobs so they can feed the family don't go out and vote, then it's pretty hard for the, the other voters to look after the other people's needs and-- so on that-- from that standpoint, I think public health is-- it has its place. I mean, it helped Lincoln have the lowest COVID rates and COVID deaths in the nation because-- in the state-- excuse me-- because we had some very aggressive policies about that. That was not totally accepted well by everybody. But I think as a public health measure, it protected our community. And if people look back at some of those numbers and comparisons, it's very hard to understand what public health does for us. But, you know, they take care of our garbage disposal. The bacteria-free state of our water, managing sewage, toxic spills in the community-- you know, all these different things.

HARDIN: OK.

STACIE BLEICHER: Nobody knows they do that. So, yeah, I think they have a different level of science and understanding of some of these.

HARDIN: This is, this is not the first time we've had this aspect of this discussion this year. So each time it comes up, I like to sit and stare at my other committee members. And, and it's going to be an ongoing one, isn't it? But thank you so much for being here today. We really appreciate it.

STACIE BLEICHER: Thank you very much for having me.

HARDIN: Thanks. Those in opposition, LB147. Welcome.

SCOTT MORRISON: Thank you, Senator Hardin. I'm going to try to channel Dr. Tesmer's auctioneer voice here and make sure I get through my testimony too, so.

HARDIN: You've got a high bar. We'll see how you do.

SCOTT MORRISON: So senators of the Health and Human Services Committee, I am Dr. Scott Morrison. That's spelled S-c-o-t-t M-o-r-r-i-s-o-n. And I'm appearing on this from Omaha. Past President of Nebraska Dental Association and current legislative chairperson for the Nebraska Dental

Association. Tooth decay, as you've heard, is the most common noncommunicable disease in the world. It is also the most common chronic disease in the United States for adults and children. It-- in children, tooth decay is five times more common than asthma, just to give you a little bit of perspective. And tooth decay is largely preventable, and that's kind of what we're talking about today here, is being prevented-- preventive in nature. Studies prove that water fluoridation continues to be effective in reducing tooth decay by more than 25% in children and adults. Opponents to water fluoridation assert that adding fluoride to the water system continues-- the-- adding-- of the water system constitutes-- excuse me-- the adding of medicine as it treats the disease of tooth decay. However, fortifying water with fluoride is basically no different than fortifying salt with iodine, milk with vitamin D, and orange juice with vitamin C. None of these additives are considered the adding of medicine, although each additive is beneficial to the child and adult health. There is no credible evidence to support that fluoride is harmful when consumed at re-- requi-- recommended levels. We do agree there is the potential for harm if fluoride is consumed at extremely high levels. However, such high levels are not consumed anywhere in the United States. I'd like take a little bit of time to talk about cost savings. When compared to the cost of other prevent-- prevention programs, water fluoridation is the most cost-effective means of preventing tooth decay for both children and adults. The cost of water fluoridation for one person's lifetime is less than the cost of one dental filling. And I think you asked about cost of fluoridation and where the money goes, Senator. It's $0.50 per person to fluoridate for one person over the course of a year. Researchers from the Colorado School of Public Health created a model of fluoridation program costs, savings, net savings, and return on investment for the United States population with access to optimally fluoridated water systems that served 1,000 or more people. The researchers found that savings associated with individuals avoiding tooth decay as a result of fluoridation were estimated at $6.8 billion, or roughly $0.32 a person, for the more than 211 million people who had access to fluoridated water. Based on the estimated cost of the water systems to fluoridate, the estimated return on investment averaged 20 to 1 across water systems of all sizes. I think Dr. Tesmer talked about that. It is clear that water fluoridation-- community water fluoridation can be a cost savings to families and communities. In summary, I ask you to oppose LB147 and not move it out of committee.

HARDIN: Thank you. Questions? Specifically on the money, I appreciate you pointing out the $0.50 per person or whatever. I was focused a little bit more on who's benefiting from selling the fluoride.

SCOTT MORRISON: Yeah. So that would be the fertilizer companies.

HARDIN: Yeah.

SCOTT MORRISON: There was some discussion earlier, I think, that the ADA was involved in that. And as a former ADA trustee, I can tell you I never cashed that check. I'm still waiting for it, but I haven't seen that coming from any trade industry.

HARDIN: OK. So no trade industry moneys or-- the trade industry itself per se does not profit from that is what you're saying.

SCOTT MORRISON: Yeah. Not, not directly. Obviously, you know, companies like Crest and, and those that make toothpaste have fluoride in their, in their products, so. That's a, that's a whole different story, though.

HARDIN: OK. Very well. Other questions? Thank you.

SCOTT MORRISON: Thank you.

HARDIN: Opponents, LB147. Welcome.

ANN ANDERSON BERRY: Hello. Good afternoon, Chair Hardin and members of the Health and Human Services Committee. I am Dr. Ann Anderson Berry. For the record, A-n-n A-n-d-e-r-s-o-n B-e-r-r-y. I'm a faculty member of UNMC and the Medical Director of the Nebraska Perinatal Quality Improvement Collaborative. However, I am not speaking as a representative of the university today. I am here speaking as an individual and on behalf of the Nebraska Medical Association, as well as the Nebraska Perinatal Quality Improvement Collaborative in opposition to LB147. Development in early life is a critical period. The correct balance of nutrients, including vitamins and minerals, is essential for optimal health. As a pediatric scientist, I study nutrient intake and health outcomes, including neurodevelopmental outcomes. Reviewing scientific studies is a key part of my job, and I would like to review key points from the recent National Toxicology Program, NTP, publication, which should not be viewed as evidence to support ending community water fluoridation. The NTP review combined a number of different studies and evaluated associations using estimates of fluoride intake in water and urine levels with possible lower IQ in children. The majority of the studies examined IQ of children with higher estimates of fluoride exposure compared to children with lower estimates of fluoride exposure. These studies were performed in ten countries, including China, Mexico, and Canada. No studies evaluating IQ were conducted in the United States. This review found that higher

estimated fluoride exposures, more than twice the level of fluoride that-- than is recommended by the CDC, the EPA, and DHHS are consistently associated with lower IQ in children. Again, this level is over two times what is recommended for drinking water here in the U.S. Remember that dose matters for everything. Another way to look at this is while the right dose of a medication can save your life, doubling that dose can cause significant harm. That is what this study is showing: at double the recommended doses or higher, there may be an association with decreased IQ in children. This report did not show exposure to fluoride added to drinking water in the United States was associated with a measurable effect on IQ. In fact, other rev-- another review of this report by the National Academy of Sciences concluded that there was no evidence to support the claims in the NTP report. Scientists must choose their words carefully for this exact reason. Without clear language for more nuanced situations like this, there's risk of misinterpretation. One must evaluate the methods of the study and the statistical analysis and assess if they align with the conclusions of the report. This NTP study isn't in itself good or bad. It's simply a matter of understanding what the study looked at and then asking, does it apply to water fluoridation in the U.S.? Does fluoridation show risk to our children's IQ? The answer to both is a resounding no. The safest path forward for our kids and our community is continuing our current fluoridation practices. If fluoride is removed from public drinking water, dropping fluoride levels to below 0.7 milligrams per liter, both the ADA and the American Academy of Pediatrics would recommend oral fluoride supplements from 6 to-- months to 16 years of age. We do not want to remove fluoride dosed optimally for oral health and put this burden on the shoulders of parents. This increases parent costs for fluoride prescriptions, adds another daily task to remembering to dose fluoride, and leaves the kids at risk for increased dental caries. I see I'm in the red, so I'll pause.

HARDIN: Would you keep going, please?

ANN ANDERSON BERRY: Oh, I'd be happy to. I trained as a neonatologist in Salt Lake City, Utah before I returned to Nebrak-- Nebra-- to Nebraska to practice. My first daughter was born there. And at six months, she was prescribed daily fluoride because they did not fluoridate their water. In my busy schedule as a doctor in training and with my husband running a busy dental practice, I can remember getting to the end of many days and chastising myself for forgetting the fluoride drops. We were two highly engaged parents who definitely understood the consequences of forgetting these drops. I can remember the relief I had when we moved back to Omaha and I could throw away the bottle of fluoride drops knowing that her needs would be met by the

city water. Another important reflection from our family's time living in a community that chose not to fluoridate the public water is the nature of my husband's work as a general dentist. He would often remark how frustrated he was that he had again spent the day putting steel crowns on the decaying teeth of young children unlike anything he had seen when he practiced in Omaha and currently practice here today. We don't want that for Nebraska children. I urge you to oppose LB147. Thank you. And happy to answer any questions.

HARDIN: Does-- I ask this because I've never figured out a question you don't know the answer to, so I'm just going to go ahead and ask it of you. Does fluoride helps children's teeth before they're exposed above the gum line? I mean, is it even helpful then?

ANN ANDERSON BERRY: Yes. Yeah.

HARDIN: OK.

ANN ANDERSON BERRY: Our teeth are developing early in life, well before they come in. Some kids are born with teeth. I bet you didn't maybe know that.

HARDIN: Interesting. I didn't know that.

ANN ANDERSON BERRY: Yeah. They're called natal teeth. They often fall out. They aren't part of the primary set of teeth. So I-- even in my practice as a neonatologist, I occasionally see a tooth or two.

HARDIN: OK.

ANN ANDERSON BERRY: Yeah. But-- yeah. Our bodies are forming based on what our mothers are exposed to during pregnancy and what we're exposed to early in life. And we have to get the dose right. And that's what this is all about. It's getting the dose right.

HARDIN: So you're saying that it's-- if it does affect the teeth then-- and forgive me because I'm just putting this together. So if it affects the teeth before they come above the gum line, it is beneficial even if it's not topical.

ANN ANDERSON BERRY: Yes.

HARDIN: I see. And lastly, how did your daughter's teeth turn out?

ANN ANDERSON BERRY: My daughter has beautiful teeth.

HARDIN: They're beautiful. OK.

ANN ANDERSON BERRY: She needed braces, but fluoride can't correct that.

HARDIN: So you're saying-- you moved to Omaha just in time is what you're saying.

ANN ANDERSON BERRY: Well, I wasn't great at giving those daily fluoride drops.

HARDIN: I see. OK. Well, appreciate that.

ANN ANDERSON BERRY: Yes.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and your testimony. I'm sorry I missed the first part of it, but that actually-- your-- the story-- your personal story and-- with the fluoride drops has kind of made me curious. For-- in communities where they do not put fluoride into drinking water, how often are these drops or fluoride supplements having to be prescribed? Is that pretty common or-- can you--

ANN ANDERSON BERRY: It's-- that's what's recommended by the American Academy of Pediatriti-- of Pediatrics and the ADA, is between 6 months and 16 years that we have additional fluoride if you have unfluorinated water. That's a hard thing for a family to commit to and do. And taking fluoride out of our community water puts the onus on the general public and everyday parents who just want to do what's right and what's recommended by public health officials. It puts the onus back on them. For the few that have a concern about fluoride, we're taking out the fluoride for the general population. We're increasing risk for everyone for the concerns of a few. When the con-- the concerns of a few can be addressed by changing their source of water. They can buy distilled water. They can find unfluorinated water if that is their, their true concern.

FREDRICKSON: OK. Thank you.

HARDIN: Other questions? Senator Ballard.

BALLARD: Thank you, Chair. Good to see you, Doctor. Earlier testimony, they, they cited that kids have more-- I know par-- or, adults drink more water than kids, just by quantity-- or at least should drink more water than kids. And there were some, some earlier thoughts that this

would cause overexposure for children. Is that, is that true, if they drink so much water in a day that their, their bodies can't handle the, the increased dosage of fluoride?

ANN ANDERSON BERRY: Certainly that can be true for early infancy. Yeah. So we don't think that infants between 0 and 6 six months of age need extra fluoride outside of what they would get in breast milk, right? So we don't recommend fluorinated water for use in formula up until six months of age if you're mixing your formula. Does that-- did that answer your question?

BALLARD: It does. So I'm just looking-- yes.

ANN ANDERSON BERRY: But, but kids drinking regular amounts of water once water is introduced to them later in the first year of life and through infant-- through toddlerhood and childhood, fluorinated water's perfectly safe in the amounts that most kids would drink.

BALLARD: OK. Thank you.

ANN ANDERSON BERRY: Mm-hmm.

FREDRICKSON: Other questions? Senator Riepe.

RIEPE: Thank you. I have a question. I'm looking for some education. Do you recommend then to parents that for newborns that-- when they're-- that they may need-- do not use bottled water, that they do get that exposure to the fluoride?

ANN ANDERSON BERRY: At six months of age, if water is not fluorinated, then they should have an extra supplement of fluoride. There are some locations where fluoride is so high in the water that recommendations are to use unfluoridated water to mix formula in the first six months of life.

RIEPE: How do people go to their community to find out what their-- and is there any evidence that would say it's at this 0.7 consistently? I mean, can one call the city?

ANN ANDERSON BERRY: That's the responsibility of a pediatrician to advise the family around that.

RIEPE: The pediatrician would know what the community's levels are?

ANN ANDERSON BERRY: Absolutely.

RIEPE: Oh, OK.

ANN ANDERSON BERRY: Yeah.

RIEPE: OK. I've learned something. Thank you.

ANN ANDERSON BERRY: Mm-hmm.

RIEPE: Thank you, Chair.

FREDRICKSON: Are there questions? Seeing none. Thank you for being here.

ANN ANDERSON BERRY: OK. Thank you very much.

FREDRICKSON: Next opponent to LB147. Welcome.

DEBRA ESSER: Well, good afternoon, committee members of the Health and Human Services Committee. My name is Debra Esser, D-e-b-r-a E-s-s-e-r. I'm the Chief Medical Officer for Molina Healthcare of Nebraska. And I've been involved with helping the Medicaid population improve their health for many years. Dental was integrated into the managed care organization purview beginning in January of 2024. And we've learned a lot about dental services and the dental health of our Medicaid members in that time. The American Dental Association estimates that 51 million school hours and 164 million work hours are lost to dental-related illnesses each year. Fluoride in the water gives protection to the fight against cavities. Many studies have shown that fluoride in the water is the key to prevention and control of tooth decay and periodontal disease. Worldwide, there are hundreds of articles that show the same outcomes. Fluoride in water works. Molina Healthcare is educating our parents about the importance of having their children see the dentist every year. Unfortunately, we know some of our children do not get in for their annual checkups. While certain tools are available, like fluoride varnish for the teeth, if the kids aren't coming in for that preventive care, the fluoride in the water does give them some protection. For our Medicaid membership-- and in truth, for all Nebraskans who may live in underserved or impoverished communities-- fluoride can protect against tooth decay and tooth loss. Last year, Molina Healthcare was new to the market; but in 2025, we have some data to share. This year, we looked at three rural communities with fluoride in the water and three rural communities without fluoride in the water. These were chosen randomly so that the communities would be about the same size. And we compared the rate of restorative services for children and adults, as well as dental extractions in the adult population. We found that for children up to

the age of 18, there were 6-- 67 dental restorations or cavities filled in the fluoridated communities and 141 cavities filled in children in the nonfluorinated communities in 2024. For adults 18 and over, there were 16 cavities filled in the fluorine-- fluorinated communities and 93 cavities filled in adults without fluoride. On occasion, when an adult tooth is too damaged, the teeth need to be removed instead of restored. For adults with fluori-- without fluoride in the water, 90 adults had extractions. In communities with fluoride in the water, there were zero. The difference in lower dental costs in fluoride communities is apparent, and an increase in Medicaid costs would be there if we remove fluoride from the water supply. I work with the Department of Health and Human Services and other MCOs, as well as our Molina team, to help control medical and dental costs and improve the health care for the citizens of Nebraska. We want to improve dental education and promote the dental home so children don't have cavities and never have to go to the OR because they have too many dental restorations to do in an office setting safely. Fluoride in the water helps our children have smiles to be proud of, and we should be proud to support fluoride in our water systems across Nebraska. Thank you.

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

MEYER: Thank you, Vice Chair Fredrickson. This is probably a totally unfair question for you. It just occurred to me sitting here. I, I know that-- do kids drink water anymore? I mean-- you know, with, with soda--

DEBRA ESSER: You know, I think there are a few rare kids out there who still drink water.

MEYER: --and, and everything else, and juice, juice boxes and everything else. Do-- and, and so my-- and, and that was not a facetious question, because I'm kind of curious whether they actually drink water. And also, when we cook, when we use tap water to cook, doe-- doe-- does the fluoride stay-- does it transfer to the food? Does it stay in the-- I make macaroni--

DEBRA ESSER: You know, that's, that's a great question that I don't know the answer to.

MEYER: And-- which is why I thought maybe it's unfair.

DEBRA ESSER: I don't know what happens when you boil fluor-- fluori-- the wat-- fluorinated water. Does it go out? I, I would have to do some

looking into the-- into what happens with fluoride when you cook with it.

MEYER: I, I put you on the spot there. I, I was curious.

DEBRA ESSER: Oh, that's OK. It's a great question.

MEYER: You're much more learned than I am. And I thought perhaps you knew that. Anyway. I, I, I guess I'm, I'm just trying to realize how much fluoride are our kids actually exposed to anymore with their drinking habits and, and, you know, the, the prepared meals and the fast food industry. How much are they actually truly exposed to on a daily basis? I'm just curious.

DEBRA ESSER: The one thing that I would say is that the 0.7 parts per million is a very low level. We know that to be safe. I think that there's some wiggle room to go up a little bit, you know, with that so that other supplementation that you get is still going to be safe for the, for the kids when they get the extra fluoride and other supplements. But fluoride in water I think is their primary source.

MEYER: OK. Thank you. I appreciate that.

FREDRICKSON: Other questions from the committee? Seeing none. Thank you for your testimony.

DEBRA ESSER: Thank you.

FREDRICKSON: Next opponent for LB147. Welcome.

CHARLES CONE: Welcome. Thank you. In my notes here, I'm supposed to say, good afternoon, Chairman Hardin, but it's--

FREDRICKSON: Vice chair.

CHARLES CONE: --vice chair. Good afternoon, and the rest of the committee members. My name's Charles Cone, C-h-a-r-l-e-s C-o-n-e. I'm the retired Director of Loup Basin Public Health Department. That's located in the central part of Nebraska, and it consists of nine counties. And I also served as the mayor of the city of Burwell for eight years. I'm testifying today in my personal capacity. Public health's focused on prevention as opposed to, to treatment, and results can be difficult to measure-- certainly in oral health. In 2002, I became the first health department of this nine-county Loup Basin Health Department district in central Nebraska. And it's based in Burwell. And Burwell's the only town in Garfield County. And shortly

thereafter, the department began a dental health program, which continues today. The program's objective is to biannually screen all preschool and K-6 grade children in the district. An oral health screening is performed for each student, and records are kept, including the number who need an immediate referral, which means they have a dental concern that needs a dentist's attention before their next scheduled visit, or, in some cases, they've never visited a, a dentist yet. Then we try to assign them to a dentist. In 2009, Burwell began fluoridation of the city water. And that was in respect to legislation that was passed in 2008. And Burwell's over a thousand, so we brought to la-- water fluoridated levels up to what was required at the time. After six years of fluoridating the water, a decrease of immediate referrals transpired in Burwell's student population from 14% to less than 3%, where it still consistently remains. In comparison, other communities in the health department average about 10% needing immediate referrals. None of the other communities in the district utilize water fluoridation, and coincidentally and unfortunately, none of the other districts attain results comparable to Burwell's students since water fluoridation began there. I-- my handout there, there's a chart on the back. And I took pleasure to go look at-- from last fall-- in the school semester of last fall in the nine-county area, we did a number-- all the schools are screened from kindergarten through sixth grade, as well as preschool. In the eight other counties that don't fluoridate their water-- we did 2,250 sup-- screenings. We had 219 immediate referrals, which is a percentage of referrals of 9.7%. In Garfield County-- the only one that we fluoridate-- we screened 106 children. We had three immediate referrals for 2.8%. These numbers have been consistent like that for the last eight years. And, and I check with them every year. I'm-- no longer work there, but I check with them. And so you guys wanted some data. There's the best data that probably any health department can give you because I had the oppor-- our health department had the opportunity to start one of those counties fluoridating the water. And just by coincidence, we had been gathering that data. And here we are. And that's why I'm presenting today. I would like to say that if Burwell or any other community that fluoridates their water supply discontinue the practice, in all probability the number of dental caries would migrate back up to precommunity water fluoride levels. And I thank you.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? I was going to ask you about differences you've seen in your work, and it seems like you were able to provide all that. So I appreciate that.

CHARLES CONE: Yep, yep. Well, thank you.

FREDRICKSON: Yep. Thank you. Next opponent to LB147. Welcome.

JIM JENKINS: Thank you. Go? Good afternoon, senators. My name is Dr. Jim Jenkins. That's spelled J-i-m J-e-n-k-i-n-s. I practiced general dentistry privately for 18 years. And now I'm on the faculty at the UNMC College of Dentistry, where I've taught for 22 more years, and I practiced at that time as well. I am also the past President of the Nebraska Dental Association. And today, I'm speaking on my behalf-- not the university's, but, but mine as a general dentist in Lincoln. I'm speaking in opposition to bill LB447. At the dental college, community water fluoridation is taught to our dental students as the cornerstone of prevention of tooth decay. It is covered in our cariology class-- and cariology is the study of dental decay-- as well as our dental public health course and standard of care for public health-- dental health programs that reduce the dental disease burden in our state. It also taught-- it is also taught to all the dental hygiene students we teach at the college. Part of the educational process is to review all relevant research for what is true science and what is flawed research. It is also teaching our students and future dentists how to evaluate sound research. They are taught to question authors for conflicts of interest, recognize which are legitimate peer-reviewed journals, if the appropriate study design was used, and how to interpret those results. Study after study describes the eff-- the efficacy of the appropriate levels of fluoride-- the appropriate levels. We talked about that today-- in drinking water in helping to reduce dental decay in patients. The only side effect that I have seen in children who live in areas where there's too much fluoride-- or, they get too much fluoride, would be the dental fluorosis. We talked about that, the little white spots that they can get on their teeth. We also teach students that their patients can have personal choices with the fluoride. These include whether to choose-- to use a toothpaste conturning-- containing fluoride in the first place, receive fluoride treatments after their cleanings, and drinking fluoridated water. On a personal note, my three children grew up in Lincoln and enjoyed the benefits of fluoridated water. And they all have excellent teeth, I'm happy to report. Now, my eight grandchildren live in Nebraska communities with fluoridated water, and I expect them to have excellent dental health as well. We all know there is a shortage of dentists in our state that accept Medicaid dental patients, and studies do show that 50% of children on Medicaid typically see the dentist. So many are being untreated. It is important to note that even people who have a poor diet and poor dental home care, they can still have a reduced decay rate with fluoridated water. To risk communities taking the fluoride out of their water would cause great harm to those in greatest need. It would also turn back the

clock of what I think is one of the greatest and most cost-effective public disease prevention modalities of our time. That's all I have, but I really thank you for letting me come and talk. And I urge you to vote against the bill. Thank you.

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

JIM JENKINS: Thank you.

FREDRICKSON: Next opponent. Welcome.

JOHNNY JOHNSON: Good afternoon. I am Johnny Johnson, J-o-h-n-n-y J-o-h-n-s-o-n. I am a pediatric dentist. And I happen to be the President of the American Fluoridation Society, a nonprofit organization of unpaid pre-- public health professionals that formed in 2014 to take on the conspiracy theories that you heard from the professional lobbyists at the Fluoride Action Network earlier. He and I know each other very well. We go up against each other. Until recently, when they were not able to com-- get communities not to stop fluoridation-- because he's not a scientist-- so he went to using lobbying techniques. And that's why Florida is having such major issues. It's a very effective method that we're going to turn that around. So, yes, I'm from Florida, and I'm interested to hear him say that Miami heard from Dr. Ladapo yesterday, and they did. One county commissioner, our-- city coun-- city commissioner wanted to stop fluoridation, so he asked Dr. Ladapo to come in and talk. And when he got done, the others looked at him and said, you presented one side of this, an opponent's side. He said, that's pure and simple. And they're not going to stop fluoridation. He went with my-- north Miami Beach. You may have seen the Wall Street Journal article-- somebody asked me about it today-- from a couple days ago. That was me going up against Dr. Ladapo and one of these researchers from the Canadian studies and the California study are-- that are claiming reduced IQ from the fluoride evaluation of urine samples from mothers that they did not go and do the research. They're using a convenient sample of tissues that had been brought together to be studied at a university. And they go and say, well, I want to see if there's fluoride in it related to ADHD or-- we're not looking-- we notice the ADHD, and we're going to go see if fluoride has something to do with it. We're going to go look for a relationship association between fluoride in the urine and ADHD and all other issues. I, I handed out two sheets of paper, two papers to you, one showing the high-quality studies that had been done around the world, which have stood the scrutiny of the evidence-based science community, and they have been shown to absolutely have no effects of

water fluoridation. Or in Sweden, at fluoride levels of 0.7 part per million-- they don't fluoridate their water. But two economists were looking at it and they said, we want to look from low levels of fluoride up to 1.5-- which is their maximum that they allow-- they're allowed to drink in their water systems. Because they knew all this inf-- information was going around. And what they found was, number one, there are no IQ changes at levels of optimal water fluoridation. The optimal level was 0.7 parts per million. And the third thing is, which is app-- applicable to everyone here, is that the low economic families had a 2% bump in their economic output for the country. So most people don't realize that exists, but-- that study exists because it was published in an economic journal. That is outstanding. So these kinds of studies have gone on, reviews by, by organizations, systematic reviews by several that I've given you in there. There was one-- there's one-- there's some from New Zealand, Ireland, and Australia that have done reviews of all health effects and all positive benefits. Well, in Ireland, they have to by law do one every few years where they don't even look at the benefits of fluoridation. They're only looking at the harms of water fluoridation, and they absolutely have found none. None. And they fluoridate at 1 part per million. They have as much water fluoridation in their country as we do. Now, the one in New Zealand just put theirs out. And they looked at these studies that were being touted from Canada and, and California, and they said, this is not appropriate. These studies are not done appropriately. They're using it--

FREDRICKSON: You're in the red zone here, so if you can wrap up your thoughts.

JOHNNY JOHNSON: OK. I'm the subject matter expert for this side. And if you would indulge me just a little bit, I'd appreciate it. I'll take on any questions that you have. These cessations absolutely show that water fluoridation makes a difference in Canada, in Israel, in Windsor, Ontario and, and Calgary and Juneau. I have data on all of this as well. They have started back. They have seen the re-- the harms of not having it, and they have started back. U.S. court cases-- you've heard of mass medication, forced medication, informed consent. There's been 109 U.S. court cases, and all of them have found that none of that applies to water fluoridation. They have never ordered it to be taken out of the water. I'll just quickly go through two last things. One is the countries around the world-- and they, they emphasized this to me: Johnny, when you talk about it, let people know that none of us, based on these studies-- or, this NTP review, none of us are stopping fluoridation. Because that's bogus junk that's out there. It just doesn't hold water-- not to be a little bit humorous. And the last

thing is that we did in, in Missouri and also in the Florida town where Dr. Ladapo and the-- one of the researchers were speaking, we took school data to look at was-- OK. What's the proof in the pudding that low levels of fluoride in water, or even up to 2 parts per million, which-- Missouri has areas that are up to 2. And we looked at school data in Bartow-- which has 0.7 parts per million fluoride in the water-- and Zephyrhills-- the bottled water-- there's a town next door to it-- their school grades theoretically should have been lower in these elementary schools in Zephyrhills. They should have been higher, I should say, because they didn't have fluoride added to their water. And Bartow should have been lower. Well, the Bartow school grades were higher and the el-- the Zephyrhills were lower. And I said, now, we're not saying that drinking fluoridated water's making you smarter, but it doesn't flow through at what you're saying that it's going to make you dumber. As well as in, in Missouri, we looked at it from SAT scores-- or, ACT scores, graduating seniors. Those with low levels of fluoride and those with above-- at water fluoridation levels up to over 2 parts per million-- zero differences. When you add them up and divide them by the number of cities, there were zero differences in the ACT scores. So we're talking about playing statist-- statistics and looking for things that you're trying to show an association and possibly causation, and in fact it's not there. It's not there.

FREDRICKSON: Thank you for your testimony. We'll see if there's any questions. Senator Ballard.

BALLARD: Thank you, Vice Chair. Thank you for being here--

JOHNNY JOHNSON: Thank you.

BALLARD: --coming all the way up. This Alaska study's new. Can you, can you detail the, the findings of the Alaska study between Juneau and the-- Anchorage?

JOHNNY JOHNSON: Actually, the Al-- Alaska study--

BALLARD: Not new, but new to the committee.

JOHNNY JOHNSON: Thank you. OK. OK. What happened in Alaska, a, a nurse moved there with her family, and she started seeing on the playgrounds these kids had black teeth. And she'd been in Anchorage, I think it was, before that. And she's like, what the heck's going on here? Well, she found out that they had stopped fluoridating in 2007. And so she was wanting to see what differences there were between a fluoridated community like Anchorage and nonfluoridated community. So she bought

da-- data sets, as researchers have to do. They get funded and they have to purchase stuff to study. She bought two sets of data from Medicaid: one before they stopped fluoridating and one after they stopped fluoridating. And one of the pages in there has, like, this stair-step in it. And what they found was that kids-- low-income kids that were born after fluoridation stopped had one more cavity-related procedure per year than those that had fluoridated water. So in other words, if you take a classroom with 30 kids in third-- and, and-- at the age of three in preschool and-- before fluoridation and after fluoridation stopped, this bunch of kids-- 30 of them-- will have 30 more cavities than that group that had fluoridated water. The next year, it was 60 more cavities. So it increased one cavity procedure more per year. Well, that's on a small scale. So that's why they were seeing what they saw as far as the amount of cavities that were occurring once it was stopped. And again, this is on hard Medicaid data. And it's the lowest income families. They compared it to the expens-- the cost expenditures between Anchorage, what had-- what, what went up and overall, as was being said earlier by Stuart Cooper, who he-- and I-- know each other very well-- that the incre-- increase in Medicaid was a big-- it was not. It was not a big part of this. The part is that there was more work to do, and it cost more in Juneau to get that amount of work done. And they were doing everything in a preventing way that they could. They did more sealants to try and stop some of this decay. I mean, it was a very conservative, underestimated increase in decay because she didn't count in records if that-- was an extraction in the record but it didn't say was for decay. Could have been for an orthodontic reason. She threw all that data out. So it was much greater. And we can look at your mouth too and tell whether you grew up in a fluoridated community or not simply by the number of cavities and the severity of them. And as the one picture shows of-- they could be my kids' pictures on the right-hand side with a little mild fluorosis, a little white spot on it if you can see it. And on the left-hand side is the same person that grows up in a nonfluoridated community. So the ones from Calgary and in Juneau were strong. Israel did as, as well. Their health minister in 2014, very antifluoridation, stopped it. And then the next one that came in in 2017 voted to have it back. They had a lot of pushback, and one of them came from the director of the NTP, who retired. She was antifluoridation, and she immediately joined up with the antifluoridationists. Went out and gave interviews and saying that fluoride is toxic and it's bad. And she set up a Zoom. And I know the folks there because I'm working with them in Israel. She set up a Zoom with their chief medical officer, their water engineer for the entire country, and their toxicologist. Well, our NTP group is looked at as the gold standard of toxicologist. People around

the world look at us as like, OK. You've got the answers. She called them up and said that these studies show that fluoride is toxic. Shame. And as they found out, they ask us, what are we seeing here? We convey it to them. And they're like, OK. And their toxicologist was OK. They saw the weaknesses in the NTP report and how the studies-- I mean, God, they had-- over half of their studies in that NTP report were not-- were low quality. They were published in low-quality journals. In fact, a lot of them were published in the journal that the opponents put together called Fluoride because those articles could not be published in credible journals. So they started their own. In the meta analysis that was, that was talk-- was talked about, they had over 70% of their studies that were low quality. 14 of them were from the journal Fluoride-- or, 17 were. 14 were in the Chinese language. Who translated some of those was FAN, Fluoride Action Network, and that group accepted them. They didn't even translate the other Chinese studies. So they were using things at face value. It's a very complex, deep subject. I've been involved in it. But I can tell you that my grandkids drink fluoridated water. And if there was anything physically wrong with it-- forget them if they got a mouthful of cavities. If there was anything physically harming to their bodies, I would never allow it. Never, ever allow it.

BALLARD: Thank you.

JOHNNY JOHNSON: You bet.

FREDRICKSON: Are there questions? Seeing none. Thank you for being here.

JOHNNY JOHNSON: Thank you all for having me. I appreciate it. And please keep what you have. Please do. Thank you.

FREDRICKSON: Next opponent to LB147. Welcome.

BEN ALDRIDGE: Good afternoon, members of the Health and Human Services Committee. My name is Ben Aldridge, spelled B-e-n A-l-d-r-i-d-g-e. And I am here to testify in opposition to LB147 on behalf of the Nebraska Dental Hygienists Association. The Nebraska Dental Hygienists Association supports community water fluoridation as a safe and effective method for reducing the incidence of dental cavities throughout the human lifespan. Optimal levels of fluoride in community water reduce dental decay and strengthen teeth in a safe, efficient, and co-- cost-effective manner. Research shows that fluoridated water helps prevent dooth dec-- tooth decay by at least 25% even for individuals who use fluoride toothpaste. In Nebraska, access to dental

care can be limited, especially in rural areas. Water fluoridation provides a simple, equitable, equitable solution for improving oral health for all residents regardless of income or geographic location. It saves families and the state millions of dollars annually in preventable dental treatment costs and reduces the burden of oral pain, missed school days, and lost productivity. We urge the Nebraska Legislature to continue supporting community water fluoridation as a vital investment in the health and well-being of our communities. Thank you for your time and consideration.

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

BEN ALDRIDGE: Thank you.

FREDRICKSON: Next opponent. Seeing none. We'll move on to testifiers in the neutral capacity. Seeing none. Senator Hansen, you're welcome to close. But first, I will read the online comments. For LB147, we had 53 proponents, 105 opponents, and 1 neutral comment. Senator Hansen.

HANSEN: Thank you, Vice Chair.

FREDRICKSON: Yes.

HANSEN: There was also one online comment, I think that was a little bit late, from Dr. Edward Fogarty as Nebraska's first physician of dementia recovery. He's full-- I am fully in support of Nebraska-- Senator Hansen's bill regarding the regulation of fluoride in our great state, where water is the life source of our economy and health and wellness. I'm reading this because it got in a little bit late and some people may not have gotten this. Please recognize the citizensry-- citizensry-- citizenry testifying in support of Senator Hansen's bill. The last time I was in Lincoln on this very matter, the lobbyists for fluoride got a D in bioethics in my book. Thank you for your time, attention, and service to our great state. Dr. Edward Fogarty, III, Omaha embedded medical bioware-- biowarf-- biowarfare correspondent. So I, I'm just reading that because that one kind of came in a little late. And so I thought it was-- you know, what he talks about or what he's discussing, I only heard-- and what I discussed in my opening, I only heard from pretty much one testifier in opposition. We're talking about neurotoxic effects on the brain of children, not their teeth. Even if you believed it helped with tooth decay-- maybe it does-- the evidence doesn't really show that very well. There's definitely doubt that it does, and to what degree. But obviously the evidence shows that it does or has a strong potential for causing neurotoxic effects and IQ

issues in infants and children and pregnant women. That's what we're talking about. One person I think mentioned that in, in opposition. Otherwise, everyone's talking about tooth decay. So I appreciate Dr. Berry for coming in here and actually talking about that. She actually addressed the NTP reports. And she is right. It is important to get the dose right. And I'm glad she mentioned that. And she also then mentioned not too long after that it's not appropriate to give children fluoride under the age of six months. They also don't recommend infants below the age of six months drink fluoridated water. If it's so safe, why do you not recommend it? If it's completely safe, no problems, drink it. That is, admitting there's a potential for harm. And even if it's in some [INAUDIBLE] age of six, we still legalize it to help people with tooth decay at the risk of lowering the IQ of our-- the children of Nebraska? And we think that's OK? I'm glad I kept the opposition testimony from last time we were here because it was pretty much the same as last time I was here from the testifiers in opposition. Except it was missing some stuff: recent data and research that is very relevant to what we're discussing now, and not poor quality research. This is the National Institute of Health. This is the Journal of American Medicine Pediatrics. These are the Cochrane studies, the gold standard of, of review of research. And we're blowing them off like it's nothing? I'm flabbergasted that people even came here in opposition saying, I have not seen any studies about the effects of IQ and fluoridated water. It's right in front of all of you right now. I handed it out. From the NIH, from JAMA, from Cochrane studies. And a lot of them said, oh, it just came from Mexico and China, so we should just forget about it. Actually, from the National Institutes of Health. Four of the most significant studies-- and again, 19 of the studies were highest quality studies. You, you can just go with those 19. Forget the rest of the other ones out of 72. Go with the 19. The NIH said were the highest quality. 18 linked higher fluoride with lower IQs. Several of these studies found this link at levels in fluoridated water at 0.7. Not two times or three times the limit. 0.7. That's what we currently recommend. Four of the most significant studies documenting the seriousness of, of fluoride's neurotoxicity are from Canada. Not India or Mexico or China. Canada. In 2020, babies fed formula mixed with fluoridated water averaged six IQ points less than those mixed with nonfluoridated water. Nonverbal IQ losses were even higher: an average of 13 points. 2019, every 1 milligram increase of fluoride in pregnant women's urine linked, linked to a 4.5 decrease in IQ in the male children. JAMA Pediatrics physician editor said, quote, I would not have my wife drink fluoridated water. And he also said-- Linda Birnbaum, PhD, also said it is time to protect kids' developing brains from fluoride. 2019, a, a nearly 300% higher risk of ADHD was

found for children living in fluoridated areas. 2018, iodine-deficient adults-- nearly 18% of the population-- with higher fluoride levels had a greater risk of hypothyroidism. Quote from author Ashley Mullen, PhD: I have grave concern about the health effects of fluoridated water. And there was also one study that was not included in TP-- the NTP report because it was a little bit too late. That one is actually from Los Angeles. On May 1, 2024, the first U.S. study on human neurotoxicity was published. Based in Los Angeles. It found that children of mothers with higher fluoride exposures during pregnancy had double the risk of severe neurobehavioral problems, including anxiety, depression, symptoms linked to autism. It was the tenth consecutive NI-- NIH-funded study linking higher fluoride to neurotoxic harm. Now, if that doesn't create a tiny, itsy bitsy piece of doubt in your brain, even if you have a 0.0001% doubt that this may cause harm, you never put it in the water supply. It does not treat the water. We're doing it to treat people? I don't even know if that's ethical without consent. NTP did not conclude that fluoridated water at 0.7 milligrams per liter was safe. Indeed, out of 19 studies-- were the highest quality-- 18 linked higher fluoride with lower IQs. Again, at 0.7. So not two times, not three times. They're just choosing not to say it. And they're cherry-picking. I'm reading as much research and giving you as much as I can that I handed out. Look at your emails. There's a lot in there too. Johnny Johnson, who came up here-- I always have kind of a problem with testifiers in opposition to something this serious when the first words out of his mouth are, oh, the people in support are just conspiracy theorists. So trying to defame somebody right off the bat with your testimony's not a good look. Hard to take your testimony seriously after something like that. He also says Florida just has issues. Didn't expand on that at all. Florida just has issues? Bogus junk he called NIH, JAMA Pediatrics studies. It's just bogus junk. However, he did look at schools in Florida and he looked at grades and then looked at SATs. And they found there might be some differences there. Not saying anything else about it. But that's not bogus. And again, the Calgary and Juneau studies-- I think Senator Ballard had a question about that-- were not included in the, in the NTP and NI-- NIH studies due to poor research methods. And re-- Israel is still banning fluoride. He was, he was talking about 2018, how their-- they wanted to reverse it. Even if they were showing a lot of harm, since they did ban it-- they're still banning it. So again, gentlemen, I hope you look at the evidence in front of you because it is overwhelming. A lot of times in the state of Nebraska, we tend to be the last thing in a lot of stuff. We should not be the last thing in this one. Again, if you have any doubt, this needs to move forward. There's no reason medicine should be in our water supply. Thank you, Mr. Chairman.

HARDIN: Questions? You mentioned at your opening, I think, that 38 states are not doing this. We're one of a dozen that are. And what have you seen-- would, would-- can-- do you have some examples of other states that are still doing this and some other states that recently changed their minds? And what are the trends that are going on with this? I'm just curious.

HANSEN: Not in front of me. I don't have any of that information. However, I know if we were to see some kind of detrimental public health crisis because we're not fluoridating the water anymore, I would see states do the opposite.

HARDIN: OK. OK. And-- Senator Riepe. Go ahead.

RIEPE: No.

HARDIN: I was just going to say, regarding that money question again, that always nags me. Who would be financially benefiting-- or is this purely about saving face from your perspective over the last 75 years in the narrative?

HANSEN: Again, I'm trying to keep this evidence based the best that I can. And I don't have any, any evidence that the American Dental Association is getting money. Some people might.

HARDIN: Yeah.

HANSEN: Like a, a previous testifier. I don't have that front of me, so I can't speculate on that.

HARDIN: OK.

HANSEN: However, I can-- I feel like I can speculate a little bit on the fact that if you've been saying something for a very long time and then all of a sudden recent research shows-- not even resear-- recent, but growing evidence and a greater magnitude showing that maybe what you've been purporting for decades is maybe not correct, it's difficult to walk from that-- walk away from that. I think that's-- I don't, I don't know. I, I can't-- I don't know what else-- what other reason there would be--

HARDIN: Flat Earth theory, difficult to walk away from.

HANSEN: Possibly.

HARDIN: OK. Senator Riepe.

RIEPE: [INAUDIBLE] today about Utah has long abandoned or not allowed fluoride. Do you have any information [INAUDIBLE] what their-- any indications as to problems that they've had if they continue to not allow fluoride? Or do they allow communities to vote in Utah? I don't know anything about it.

HANSEN: So-- again, not the approach I was looking for, is to ban fluoride. My approach was to give cities and municipalities the option to do what they want. We believe in local control. If they still want to fluoridate their water, they totally can. From my understanding, one previous testifier also said that, for a long time, half of Utah has been fluoridated and the other half hasn't.

RIEPE: Oh.

HANSEN: And then-- and from, and from-- previous testimony stated that there has not been much difference in issues with that. So right now they're banning it, and that's not really the direction I want to go with it, so.

RIEPE: OK. Thank you.

HARDIN: Other questions? Thank you.

HANSEN: Thank you.

HARDIN: We are done with LB147. We will transition the room. And we will move on to LB437. Senator Riepe, I believe we are ready if you are ready.

RIEPE: Good enough. Good afternoon, Chairperson Hardin and members of the Health and Human Services Committee. I am Merv Riepe, spelled M-e-r-v R-i-e-p-e. I represent District 12, which includes a portion of Omaha, Millard, and the town of Ralston. I want to comment: while I am an urban senator and a former hospital administrator, I do have a keen interest in the health care delivery model in our more rural communities because that's where we have numerous deserts. And this bill is intended to help and not injure what would be placement or be able to provide available services to-- particularly nursing homes in rural communities. I am here today to introduce 4-- LB437 on behalf of Americans for Prosperity, which imp-- proposes the full repeal of the Nebraska Health Care Certificate of Need Act. The certificate of need, called-- frequently called a CON, program was established in 1974 as a regulatory measure requiring health care providers to obtain state approval before expanding facilities, adding medical services, or purchasing certain types of equipment. The intent was to prevent

unnecessary duplication of services and control health care cost. However, over time, these regulations have been widely criticized for limiting competition, restricting access to care, and slowing health care infrastructure development. The federal government repealed its certifi-- certificate of need mandate in 1987, but Nebraska still maintains some form of these regulations. Recognizing the need for reform, the Nebraska Legislature passed LB1215 in 2024, which eliminated certificate of need requirements for rehabilitation hospitals-- beds in hospitals. This change acknowledged certificate of need laws acted as barriers to the timely expansion of critical health care services. LB437 builds upon this progress by fully repealing the Certificate of Need Act, removing outdated restrictions that hinder health care development across all sectors. A growing number of states have recognized the limits of certificate of need laws. As of May 2023, 12 states have repealed certificate of need programs entirely, with South Carolina being the most recent example. Research shows these regulations result in higher health care costs and reduce access to care. For example, a study by the Mercus [SIC] Center at George Ma-- Ma-- Mason University found states with certificate of need laws have fewer hospitals and hospital beds per capita, which led to health care shortages, especially during crises such as the COVID-19 panic-- pa-- panademic-- pandemic. Additionally, states without certificate of need laws have seen increased competition, lower prices, and improved services and availability, particularly in rural areas. The persistence of certificate of need laws in Nebraska may inadvertently protect existing providers from com-- competition at the expense of patient choices and affordability. By repealing the Certificate of Need Act, we can foster a more competitive health care environment that encourages innovation, improves access, and reduces cost. This legislative change would allow health care providers to respond more effectively to community needs without unnecessary regulatory delays. In conclusion, LB437 represents a critical step towards modernizing Nebraska's health care system by eliminating regulations that no longer serve their intended purposes. I surge-- urge the committee to support this bill and would note that Governor Pillen has lent his support. And I will be answering questions to the scope of my ability. Thank you, Mr. Chairman and committee members.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Riepe, for being here and, and introducing. So I'm, I'm reading this and I'm, I'm-- I appreciate your opening here. So I'm-- from, from what I understand from your opening, the, the, the concern here is that there's too much bureaucracy that's preventing hospitals from-- am I

understanding-- is that, is that, like, the problem that this is trying to identify or, or to solve or--

RIEPE: I think certificate of need is, is really kind of a once you've gotten there, you raise the fence to not allow other people to come into your marketplace, if you will.

FREDRICKSON: Got it.

RIEPE: And while that maybe works for the people that are in the marketplace, it isn't as good for the health care system in total. It's anti-marketplace. It's, it's, it's really just almost a central control type of me-- mechanism.

FREDRICKSON: OK.

RIEPE: In my closing, I am going to share at that time a personal experience that I had when I was a young administrator at Bergen Hospital and how I had to fight the certificate of need. Ultimately, we got rid of it for hospitals and we got rid of-- and that hasn't been an explosion of hospitals being built all over the state of Nebraska.

FREDRICKSON: Yeah. No, that, that, that's helpful. And are, are you find-- are we finding-- I know we've spoken a lot about health care deserts this year. It-- are we finding there's a lack of beds available in some of these rural areas? Is that your understanding, and, and that's kind of what this is trying to--

RIEPE: Well, one, one of the things and one of the reasons that Governor Pillen is very much involved in this is there is a, a hospital group out of South Dakota that wants to close a Nebraska nursing home because they have some other homes in Nebraska. And the-- that community will be raising money. And they want to purchase it, but they have to have a certificate of need. And time is working against them.

FREDRICKSON: Got it.

RIEPE: So the governor is interested in moving this so that this community, not-for-profit group can go in and purchase this nursing home and keep this nursing home viable in this small Nebraska-- almost on the border of South Dakota. And the governor's personally called the CEO of that group and obviously was not successful in his relenting on his wanting to close that one.

FREDRICKSON: Thank you.

HARDIN: Sometimes you have to be maybe an old hospital administrator or at least some sort of an insurance wonk to know some of these things. You said this got started in 1974. Is that right?

RIEPE: Yes.

HARDIN: So that was the same year that ERISA was started, the Employee Retirement Income Security Act. Right? And that's what oversees-- well, things like self-funded health care, pension-- some pension plans and that sort of thing. I know that was also around the time that managed care became fashionable. PPOs, EPOs, EIEIOs and all of the rest. And was this an idea in cost savings when the certificates of need began in the 1970s? That was a pretty good idea. Are you saying in essence that that was a good idea then but maybe not such a great idea in the 21st century?

RIEPE: Well, I think it was a situation that, while in concept was good, but in actuality didn't work.

HARDIN: OK.

RIEPE: The way that it worked was DHHS was the basis of it, and they would go in with some of their academicians and say, well, we need one of these for 200,000 people. Well-- and statistically, yes, that was probably correct. However, that doesn't work in relationship to what the market is doing, where the need is. I mean, it's, it's fine in theory, but in actuality it is destructive.

HARDIN: They came up with averages that sort of fit no one anywhere?

RIEPE: Ideally, it was perfect if you want a textbook model.

HARDIN: OK.

RIEPE: The other one I think that applies to here was when Richard Nixon as president put in price fixing.

HARDIN: OK.

RIEPE: That didn't work either.

HARDIN: Price controls usually don't work very well. OK.

RIEPE: And so this is just-- to me, I, I'm-- I was a little bit surprised. I thought when we ended it back in the '80s-- which I'll talk about a little bit later-- I thought it was gone for the entire

state. I didn't realize it was reserved. But we have a lot of work to do on, on rural health. And as I said before, I'm an urban senator, an urban hospital administrator, but I have a keen interest in terms of what we're going to do in our rural health care delivery model. And I'm doing some reading and research right now on the Australian model to see if there's some ideas there that we could bring here in a reasonable delivery manner without destroying health care, building health care in, in rural communities.

HARDIN: OK. I would imagine you'll stick around for closing, but let me ask you this as well.

RIEPE: Yes.

HARDIN: And, and that is just I've had a few people come up to me, tug on my jacket and say, what's going to happen to Madonna over this situation? And if you want to wait till later on to answer it as well. But, I mean, I thought I would give you first crack.

RIEPE: Well, I know Tabitha and Ma-- Madonna would probably have some concerns, but they're well-established. Excellent reputations. And quite frankly, with the federal funding going on, I can't imagine anyone wanting to bring in and, and put in what might be a $400 million capital investment into a marketplace with so much of your revenue coming from the feds or the state. That wouldn't seem to me like something that, that would be invitational. You know, most of these in-- opportunities comes-- come when there's a, a void. And I don't think there's a, a void. I know Madonna expanded. They have a-- now have a hospital in Omaha as well. And so-- and they didn't have to go through certificate of need to get that hospital in Omaha. So.

HARDIN: All right.

RIEPE: I hope I answered your question.

HARDIN: Will you be around for later?

RIEPE: Yes, I will. I did take note that you referred to me as an old administrator, Senator.

HARDIN: Yes. Yeah. And, and that was just merely from a million feet up.

RIEPE: Yeah. Sure, sure, sure.

HARDIN: Thank you. Proponents.

RIEPE: Thank you. Oh. Oh, OK.

HARDIN: Proponents, LB437. Welcome.

SOFIA HAMILTON: Hello. Chair Hardin, Vice Chair Fredrickson, and members of the Health and Human Services Committee. My name is Sofia Hamilton, S-o-f-i-a H-a-m-i-l-t-o-n. And I am a policy analyst at Americans for Prosperity, which is a nationwide grassroots advocacy organization that works to increase opportunities for all Americans. And I'm here to support LB437. Nebraska currently regulates long-term care and rehabilitation beds through its certificate of need, or CON, program. There are strict moratoriums on these bed types, only allowing additional beds to be established if highly specific conditions are met. This regulation specifically affects nursing homes, intermediate care facilities, and skilled nursing facilities by prohibiting these providers from expanding to meet the needs of their patients. Countless studies have shown that CON laws have been ineffective at their stated purpose: lowering health care costs, increasing access to services, and ensuring high quality of care. In practice, CON laws do the opposite. Available research shows that CON laws have a profoundly negative effect on nursing homes and their patients. CON restrictions on nursing homes lead to lower staffing levels of registered nurses, substituting these professionals with certified nursing assistant care. As a result, health survey scores for nursing homes in states with CON regulations are 18% to 24% lower. At the same time, costs are higher for nursing home patients in government payers in CON states. Medicare and Medicaid spending for nursing home care is higher per enrollee in CON states. Per patient variable costs in states with CON laws that affect nursing homes are also higher than in CON-free states. To complicate matters further, the population of Nebraskans aged 65 years and older is projected to increase about 30% by 2030. As the baby boomer generation ages, the older demographic is poised to comprise 20% of the total state population. The need for quality nursing homes and residential treatment in Nebraska will only be increasing over the coming years. Implementing LB437 to address this increasing need would not be an unprecedented move. During the 2025 general session, the Wyoming legislature moved to repeal their CON laws that regulate the nursing homes, citing these same concerns. There's no doubt that Nebraska's CON laws are keeping Nebraskans from accessing safe and affordable health care. As Nebraska's population inevitably increases and ages, the health care marketplace will only become further strained, inaccessible, and expensive, especially for the state's most vulnerable population. Americans for Prosperity is appreciative of the reforms proposed in LB437 and applaud Senator Riepe for his important work in introducing this bill. And we appreciate the Legislature opening the

subject up for comment and are hopeful that Nebraska's health care market will see these needed changes for the good of all Nebraskans and the state itself.

HARDIN: Thank you. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and for your testimony. So I'm just curious. So, you know, my understanding is part of the function of the CON laws initially was to kind of prevent overbuilding and expansion. Do you, do you have any information on, you know, if we were to eliminate this, like, what kind of safeguards might be in place to ensure that there's, you know, one, accessibility and affordability for access to health care, but not necessarily oversaturation? Can you talk a bit to, to that or no?

SOFIA HAMILTON: Yeah. So we can look at other states that have repealed their CON laws to see what has happened there. So Florida, which is my home state, is a great example. And we heard a lot about Florida today. In 2019, they repealed their CON laws, which were more restrictive than Nebraska's currently. And their CON laws that they repealed were affecting hospitals. And so between the period of 2016 to 2019, around 20 hospitals were built. And then from 2019 to 2022-- and these aren't exact numbers because I'm just getting it off the top of my head-- around 70 hospitals were built. So there's way more access. And I know-- my mom's a nurse in Florida. I know she had way more employment opportunities. We had more hospitals coming up that were closer to us. We could then shop around to different hospitals because we had different options. And so it's really about giving this choice back to patients and allowing them to have options and to have that competition on the market so then there can be price differences and price competition.

FREDRICKSON: And have those hospitals been able to-- do they have longevity? In other words, have they been-- you know, one concern we've heard about here is obviously medical facilities or long-term care facilities having, having to shutter or close down because of the lack of ability to maintain their-- so has that been an issue at all?

SOFIA HAMILTON: I can't speak to that, especially in the case of Florida, since that CON law was repealed in 2019. I don't think there's time yet to look at the data. And it-- South Carolina's also another great example because they repealed all of their CON laws. And that happened in 2023, so it's hard to look at the data there. But I would also just look back at CON states. We're here in Nebraska. Nursing

homes are being shuttered with this law and with the supposed protection. So it really isn't going to its stated purpose.

FREDRICKSON: Thank you.

SOFIA HAMILTON: Mm-hmm.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. So, you know, of course, Nebraska's a rural state and we have a lack of hair-- health care out in-- so it-- do you see another hospital that would be willing or a nursing home that we-- be willing to build out in rural Nebraska versus building in an urban area like an Omaha or Lincoln where they're going to have more-- a larger population?

SOFIA HAMILTON: I really can't speak to that. I'm not, I'm not an expert on west-- or-- sorry-- Nebraska's market. I do know that was a concern in Wyoming when they did pass their CON law. And that just happened this session a couple weeks ago, so we'll see what happens there with their marketplace. But I know there is a chilling effect with CON laws. And so states that do have these laws, entrepreneurs and health care providers that want to enter the market aren't even applying for these permission slips because of the high barrier to entry and the ability for them to be denied entry after paying the fees. I know in Nebraska, it's a fee of $1,000 for an application. So for a business, that's not too hard. But if you're a smaller nursing home or a smaller provider, that could be a reason as to not go towards that application.

QUICK: Thank you.

HARDIN: Senator Meyer.

MEYER: Thank you, Chair Hardin. In your estimation, does this improve the opportunity for us to provide health care in our rural communities, our underserved communities?

SOFIA HAMILTON: I, I 100% believe so. Getting rid of this barrier-- this bureaucratic barrier I think will really help increase businesses, and we've seen that in other states that have gotten rid of their CON laws. I think Wyoming will be a very good test case, but Nebraska can be another great test case as to getting rid of these nursing home, nursing home CON laws. And under the current system, we're not seeing those facilities open. And so I think we need to try something different because this is a huge barrier to entry.

MEYER: Given the great need we have in our rural communities, how would applying for a certificate of need and making a determination of need, how would that be detrimental to our underserved communities?

SOFIA HAMILTON: Well, they have to go through a process. In Nebraska, the process isn't as onerous as it is in other states, so that's good. The process takes about 60 days and is $1,000. Though, looking at the amount of applicants and those who are denied doesn't show you those applicants that aren't applying because they don't want to pay that fee or they're worried about going through that process. Typically, you have to also hire on an attorney to fill out that paperwork. That's another added fee that's not listed. And so there, you're just getting rid of another barrier. So you're allowing people to come in to the marketplace if they want to, like we do with any other business. I hear all the time that health care is different, that it needs to be regulated differently, but I have, I have to disagree. We don't do this with coffee shops. You're not seeing us go and saying a mom-and-pop coffee shop has to get permission from Starbucks or from the state government to open up and to compete in the market. We just allow those businesses to open and to compete and allow customers to come to them and patients to come to them as they see fit.

MEYER: Thank you.

HARDIN: What's the opposition about to get up and say?

SOFIA HAMILTON: I hear their arguments all the time. It really is about protectionism and protecting their bottom line and their, their money and their client base. And I'm sure as a former hospital ad-- administrator, Senator Riepe will be able to really talk about those positions. But they want to keep other individuals out of the market and get rid of competition, which-- that seems very anti-American to me. We're all about market freedom and market competition.

HARDIN: Do they have a legitimate point when they say, wait a minute. This could end up hurting Tabitha, Madonna. How would you respond to those kinds of concerns?

SOFIA HAMILTON: I think back in the '70s, when this law was first passed, that was a legitimate concern. Actually, the reasoning behind CON laws goes back to an academic from California whose name is escaping me at the moment. But his theory was if there is an open bed, it will be filled. That's just not the case. I think you saw that with the pandemic. We saw all these bed gets filled, and then there's no more for patients that are in need to go into. And so they'll say that

it's going to strain their bottom line, that these facilities won't be able to sustain themselves. But realistically, a business is not going to open if they're not going to have a client base. And they're going to be thinking economically before investing hundreds of thousands, millions of dollars into a community and opening up a facility.

HARDIN: You mentioned that our age 65 and older population is going to go up by 30% by 2030, five years from now. That's a pretty significant increase.

SOFIA HAMILTON: Yeah. That number came in 2022-- or, 2021 based on census data. So that's the most updated increase-- number I can give you for Nebraska. But we're seeing this trend throughout the United States. Our population is growing. It's aging, and it is becoming sicker. And so we need to increase our care capacity and get rid of these hurdles to increasing that.

HARDIN: So your contention is that, in part, this is a philosophical move that allows us to be more nimble because that's about to hockey stick up.

SOFIA HAMILTON: Exactly. We saw with the, the COVID pandemic, a lot of states repealed, for a time, their CON laws to allow hospitals to act in the moment and increase their capacity because these CON laws aren't allowing you to open up more beds if your population is increasing. They have to go through this process and they may be denied. Or they're spending $1,000 to get maybe ten more beds added to their facility. It's, it's not just opening up facilities. It's expanding the facilities that are already there. And even if you want to transfer beds from one facility to another, if it's owned by different providers, you again have to pay that fee to the state.

HARDIN: If they suspended their CON laws during the pandemic, were there any of them that suffered ill effects from having done that?

SOFIA HAMILTON: Not that I'm aware of.

HARDIN: Senator Meyer.

MEYER: Thank you, Chair Hardin, again. With the applications for certificate of needs, do you have any idea how often a need is denied?

SOFIA HAMILTON: That's a great question, Senator. I unfortunately don't have that data for Nebraska. Typically-- my, my team typically does get that information for different states when they do ask. And it comes from the state data. And so we have to go through a records request

process. I'd be happy to look into that for you. I-- but I know-- I, I'm not sure what the number would be, but I, I'd be happy to look into that after this meeting.

MEYER: It would seem with the substantial amount of need we have in this state that I would be shocked that there would be any denied, frankly, unless it's in a overdeveloped urban area. But, yeah. I, I appreciate that. Thank you.

SOFIA HAMILTON: No, that--

MEYER: You could-- you can elaborate on that if you care to, but.

SOFIA HAMILTON: I hear that thought process a lot. And unfortunately, that's not what happens in practice. In high-need areas all of the time throughout the United States in all of the states that I study, these needed facilities are having their applications denied. And I, I'm not sure that that's the case in Nebraska. I haven't looked at the data, but I, I know that that is happening despite the supposed purpose of this program.

MEYER: I'm not sure a $1,000 fee and a 60-day wait is that detrimental given the amount of money that's involved in developing something like this. We're facing pretty much a pandemic right now of nursing homes closing. Or-- we've only got 40 hospitals in the state that deliver babies. We, we have a, a health care pandemic, as far as I'm concerned. And I'm seeing a reduction in facilities and a reduction in providers. I don't want to do anything that's going to reduce that in any way, shape, or form. And, and I'd like to find a way to stop the hemorrhaging and start building back. To this point, we haven't really found anything positive. So. Anyway, I appreciate your time. Thank you.

SOFIA HAMILTON: Thank you, Senator. And I, I appreciate that comment. And we're seeing, we're seeing a lot of closures around the United States in CON states, and that's under the current system. And so I think that's what we really need to challenge here, is the thinking that, that the CON law will keep the health programs and keep the health facilities there. But they're, they're still closing and they're prohibiting-- or, they could be prohibiting new facilities from opening up as quickly as they'd like to.

MEYER: Thank you.

HARDIN: Thanks for being here.

SOFIA HAMILTON: Thank you.

HARDIN: Proponents, LB437. Welcome.

BRITANIE BREWSTER: Welcome. So before I get started, if you are not a broadcaster, you need to be. You have a wonderful voice.

HARDIN: Oh. Bless you.

BRITANIE BREWSTER: And, Senator Meyers [SIC], I am going to answer some of the questions that you asked her that she didn't have the actual facts on, but that I do. So if you will wait, I'll give those to you.

MEYER: I won't even ask those questions. I'll just let you answer them.

BRITANIE BREWSTER: OK. Well, they're not in this-- what I'm going to read, so I will-- I'll keep going if that's OK.

MEYER: Thank you.

BRITANIE BREWSTER: My name's Britanie Brewster. It's B-r-i-t-a-n-i-e B-r-e-w-s-t-e-r. And as Senator Riepe said, I'm from Butte, so our nursing home is closing and I don't have access to those beds. So I am here before you today not just as an individual but as the voice of our community, our counties, and our state. I'm from Butte, Nebraska, a small town of approximately 300 people. On February 10, residents and families of our local nursing home were informed that our facility would be closing in 60 days. This is not an isolated incident. Currently, 21 counties in Nebraska lack a nursing home, and 3 more will lose their facility by spring of 2025. The residents of these homes-- our parents, our grandparents, our teachers, coaches, and community members-- are being forcibly relocated to crowded care centers in urban areas, stripping them from rural communities they called their home for generations. Governor Pillen often speaks about the importance of considering the impact of policies on seven generations. Right now, we are forcing Nebraska's seventh generation out of their homes. Family farms and ranches are being sold, with widespread closures of rural nursing homes affects more than just displaced residents. It fractures entire communities. The closure of the Butte Senior Living Center alone eliminates 6% of the employment opportunities in Boyd County, reducing wages by $2.5 million, causing an overall economic impact of $7.5 to $9 million annually in our county. Statewide nursing homes employ 30,000 workers and contribute $3 billion to Nebraska's economy. Closing rural care centers forces employees to relocate, uproots their families, and weakens rural school systems as children are pulled from small districts and moved to urban settings. Our community worked tirelessly to prevent the closure of our nursing home. We had a plan to purchase

the building and secure a local management company to keep the facility open without ever having to close our doors. However, we were stonewalled, stopped by the certificate of need statute. Boyd County does not have another care facility within 25 miles radius, and there are no avairable-- available opens-- openings within 45 minutes of our town. My grandpa was forced to move 2.0-- 2.5 hours away. Just seven days after his lelo-- relocation, he passed away. He is the second resident we have lost since this closure announcement. The most of-- most-- to most of you, the 28 residents might seem like just a number-- but to us, they're everything. There are our history, our family, and our legacy. Currently, Nebraska holds 14,800 nursing home beds. With approximately 77,000 Nebraskans aged 80 and older, or 4.2% of Nebraska's population-- with only enough beds to support 0.78% of the population, this means that over 3.3% of Nebraskans aren't even able to access necessary care. Under the current certificate of need statute, once our nursing home closes, its licensed beds are permanently lost to the state. Boyd County can apply for a new certificate of need, but we cannot recover those 40 beds that were lost. Instead, we must attempt to buy beds from state-- from the state's remaining 189 nursing homes with no set pricing. The cost of one bed can range from $5 to $150,000, making the process financially unattainable to small rural communities that cannot compete with Lincoln or Omaha. I--

HARDIN: You're in the red, but keep going.

BRITANIE BREWSTER: I urge you to support our for-- a full repeal of the certificate of need statute to protect rural Nebraska from corporate control. Opponents will argue the statute preserves competition and maintains the integrity of our health care system. The reality is this outdated policy la-- favors large corporations at the rural expense. We cannot compete with large out-of-state corporations, leaving rural Nebraskans with abandoned facilities and no way to provide for our residents. When I reached out to the Neba-- Nebraska Health Care Association-- the organization who is behind the "Who Will Care for Nebraska's Seniors" flyer-- I was shocked to learn they opposed LB437, a bill that could provide a solution to the care desert crisis. This material emphasizes the importance of rural nursing homes, yet their stance prioritizes securing state funding rather than truly addressing the issue. A week ago, our fight changed forever. The man I was fighting so hard to bring home passed away. I texted my mom and I said, Mom, you know Dad and I fought with everything we could to bring grandpa home. I don't know if I can fight anymore. And she responded, Britanie, grandpa is home. Now you and your dad fight harder for him. And we will. We will fight for him. We will fight for all the grandpas and grandmas and parents and families and friends. We will fight for

the right to compete for the health care of our aging population. We are calling for a full repeal of the certificate of need statute because, without it, we don't even stand a chance to fight for our loved ones. This repeal is essential so that no family, community, or county has to struggle to keep their seventh generation at home. Let us protect the integrity of our state by allowing rural Nebraska the opportunity to compete, to fight for what is right, and provide care for our seniors near the people who they love. We are asking you to fight with us for the right to compete. With that being said, with your question before, there are only 14,863 nursing home beds in the state of Nebraska. We cannot get any of those beds without purchasing them. So there is no set price by the state. So even if we go and we fill out that $1,000 application and they approve it because we are without a nursing home facility within 25 miles of us, I still have to call every nursing home in the state and say, hey, can I buy a bed? They have the right to set that bed limit-- that cost at anything. I think my dad just heard this week that the average cost of a nursing home bed right now is $38,500. That will bankrupt us. We're not looking for the state to fund our nursing home. We're looking for the state to give us an option so we can compete with those that are from out of state. Because I have talked to people from across the state, and it's the same thing. The building is owned by somebody in a different state. The licensing is held by somebody from a different state. And the management company is from somewhere in a different state. And they're coming here and running our nursing homes into the ground and then closing them. And we can't compete against them. So I'm asking for a full repeal of this bill so as Nebraskans we can compete with those people who are coming in and ruining our rural health care system. And that is all I have for you. Are there any questions?

HARDIN: As she said, are there any questions? So paint a picture for us. Rural nursing home closes. There's 28 people in there. Maybe there's twice that many people in there. They have to go further away if they can find another open room someplace else. So the loved one is no longer close to their family, so on and so forth, in that, that home area. Paint the picture of kind of what happens next. I mean, what, what, what goes on next-- not just, just for families. What happens for communities in that situation? Just curious. If, if you had-- gosh, we just heard earlier, right, that 30% more will be turning 65 and older. Will those folks essentially be leaving those communities before they get to that nexus?

BRITANIE BREWSTER: The-- there's nowhere-- place for them to go. So what we found is-- so I'm going to paint this picture for you just so you understand where I'm coming from. My town is of 300 people. My

grandpa lived there for 88 years and never left. When he moved into the nursing home, it overlooks my garage. OK? So-- and he would call me every day if my car was not in the garage. I couldn't even let my garage door down because he would know. And so this way, he could see what I was doing. So as he had to leave, it was like, OK. He just stopped living. But the impact of this is there's 50 people that work at this nursing home. I'm in a town of 300 people and a county of 17,000-- or, 1,782 people. There are 861 available employment opportunities in our county as of the-- as of 2022. Well, I can't tell you-- Senator Fischer had put out this, this economic growth. There-- 861 jobs. So we lose 50 of those. That's over 6%. It's $2.5 million in wages. So if you want to know the economic impact, our county will-- there will be nothing left. The land will be sold, the school will be closed, and my community will die. Because this nursing home also supports the, the Short Stop, which is our gas station. It supports our-- they pay for water. They pay for electrical. They are putting money back into our community by the people that live there. Without this, we have nothing left. That's why we're fighting. That's why we are fighting so hard. Because I lose my community and my county if we don't fight for this.

HARDIN: So you're saying this is about a whole lot more than where you're from? This is basically--

BRITANIE BREWSTER: Oh, yes.

HARDIN: --most of the geography of Nebraska.

BRITANIE BREWSTER: Yes. There are 24, 24 counties in Nebraska that do not have a nursing home. And I have talked to people from across the spectrum. I talked to the-- his name is Doug, but he's from Tecumseh, and he is the head of their economic board. And I said, hey, Doug. I'm-- this is what I'm doing. He is like-- he goes, fight. He goes, fight with everything you have. Because he goes, we lost our nursing home. And it helped. It employed 139 people. He said the economic impact is insane. He said, right now, I have a building that I can't do anything with because they would not-- because I couldn't get the certificate of need because they wouldn't transfer us the beds and there was a no compete clause. He goes, so now I have a condemned building that I can do nothing with. And he goes, my hope is I can salvage the, the assisted living. That was his hope. Not that it was what he could do. It was his hope. The economic impact of this is, is beyond the certificate of need. The certificate of need is a hurdle for us. It is not going-- we don't need the state to fund our nursing home. We have plans in place to make sure that we can fund it in our county

and keep our people there. But what we can't do is we can't overcome when we can't afford to buy the beds and we have somebody who's unwilling to sell us those 40 beds. Because they're taking over care facilities across the state right now. So the people who are stonewalling us are taking over additional health cal-- care facilities and not allowing Nebraska rural communities to fight for their own choice of care.

HARDIN: OK. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for, for being here and for your advocacy for, for the work you're doing. One, one question I have is-- so approximately-- my understanding's around 70% of Nebraskans who, who need this service are, are on Medicaid. Would your facility be able to accept Medicaid? And can you--

BRITANIE BREWSTER: Yes. Yes, we have somebody who is willing to help us manage this facility, but we can't even get to that point until we get over this hurdle.

FREDRICKSON: Sure. Sure. OK. Thank you.

HARDIN: Other questions? Thanks for being here.

BRITANIE BREWSTER: Yeah. Thanks for listening.

HARDIN: Proponents, LB437. Welcome.

TANNER JONES: Thank you. My name's Tanner Jones, T-a-n-n-e-r J-o-n-e-s. I'm with Cicero Action. I just want to start by saying the previous testimony was very powerful and something I think you ought to keep in mind when the opponents get up here in, in a moment. The world we live in in Nebraska is the world of certificate of need. So any arguments about getting rid of CON exacerbates problems with access, quality, price, et cetera, should be deeply unpersuasive insofar as that data is happening in the world of certificate of need and is therefore the consequence of a certificate of need. In essence, CON results in a constraint on supply. It is an anticompetitive, someone else said anti-American measure that was put in place due to a federal mandate in 1974. And Nebraska is frozen in time in 1974 in these sets of facilities that still have CON. So just three quick arguments I want to make for you today. One is that CON increases prices. Two, it yields unnecessary suffering and preventable deaths. And third, stymies innovation. First on prices. A great American economist, George Stigler, won a Nobel Prize for this work several decades ago, finding that the regulated price of a good or service becomes, in just five

years, the oligopoly price of that good or service. That's because-- well, your constituents have access to you. It is only the most powerful, entrenched, incumbent, moneyed firms that have access to the unelected regulators. It should therefore be unsurprising that the bureaucracy and the regulations are wielded as a lever and as a weapon in order to stymie competition. Sadly, it's unsurprising that that nursing home closed elsewhere in Nebraska because that nursing home challenged the market share of the incumbent firms who controlled the CON board. There was a study actually focused on Nebraska in particular, finding that if you repealed CON laws, you would get a $235 per capita annualized savings in the set of facilities. And this is for a couple of reasons. It's-- competition, of course, yields price-setting behavior-- that's kind of economics 101-- but also bad business practices, meaning that the hospitals in CON states, several studies show us have the worst balance sheets. I see I'm running out of time, so I'll, I'll run through these next two points quickly. Second is unnecessary suffering. We have several A/B tests baked into the cake. You can compare CON states versus non-CON states and post-repeal versus pre-repeal. This is a, a, a, a very like-- a, a lot of data that you don't see in other policy areas. And what you find is that preventable deaths, heart attacks, pneumonia in these long-term care facilities are happening at a ridiculous rate, far more than any other developed nation only in the states with certificate of need, not in the states that have repealed it. And, you know, the-- kind of the, the great tell on this is if you look at COVID, when Governor Ricketts under Executive Order 2012 suspended all of the CON laws in Nebraska to increase access. So it, it's kind of nonsensical that you would only have that privilege during COVID but have to endure unnecessary death and suffering otherwise. The final point is on innovation. Wyoming just ended its session strong, doing away with the last vestiges of its CON. And your other neighbors here-- Kansas, Colorado, and South Dakota-- all have repealed their, their CON laws over the past several years and decades. And in these states, we are seeing is a new form of treatment, longevity-based care, using artificial intelligence, early disease detection and prevention. And these are innovative companies that want to scale into Nebraska and come here and change the way that we think about health care. But it's not possible for them to do that because incumbent actors who have captured the CON boards are standing in their way.

HARDIN: So you're in the red. You're saying that this is a turf war, and the war is-- it's basically between wealthy out-of-state conglomerates going up against a small town.

TANNER JONES: That's one way to put it. Yes, sir. I think that, that's a big piece of the story here.

HARDIN: I see. Questions? Senator Ballard.

BALLARD: Thank you. Thank you for being here. Is there any benefit to targeting CON law? So let's say-- we all-- most of us can agree up here it's-- nursing homes probably could do without CON laws or-- saying-- do away with those, but keep it for skilled nursing, rehabilitation, the ones that have more high capital cost. Is there any benefit to that?

TANNER JONES: Yeah. These are unprecedented powers of market intervention. I think that there's a difference between theory and practice. Well, in theory, you can say there's a desirable market equilibrium. We're worried about oversaturation. Over any reasonable X axis-- i.e. time-- you're going to find the market return to equilibrium. But the, the real problem is that when you implement this system, it gets captured right away. The only people who can talk to the regulators are the ones that are already in the market, and then use it as a lever to bulwark their, their monopoly or oligopoly and then engage in price-setting behavior. So to, to answer your question more directly, I think the answer is no. There's a way to do statutory changes that don't basically result in delegation to the executive branch and unelected regulators. I think, like, you could do statutory changes to deal with specific problems in nursing, for example. But the answer is not to defer to the incumbent players who control the market share.

BALLARD: So, so I guess my point-- so maybe most of these incumbent players are-- I, I don't know. They'll probably come up in-- later, but. 60%, 70%, 80% full. Isn't-- is there a need to keep a CON law just for those that are-- because you don't want them-- you don't want them dropping down to 40% or 30% full. I'm just--

TANNER JONES: Yeah, yeah.

BALLARD: --for the sake of argument.

TANNER JONES: No, I mean-- completely valid. My response to that is there's absolutely no evidence of this. It's so-- you know, in my role as a policy analyst, often what I'm doing, admittedly, is making a very tenuous set of arguments to explain that, downstream, if you pass this statute, this will happen, then this will happen, then this will happen, and it'll be good for your state over time. With CON, the story

is very simple because it's unambiguous. We have 40 years of data, and we have A/B tests baked into the American map-- CON versus non-CON, pre-repeal versus post-repeal. And there is no-- I mean, go on Google Scholar. These are some of the most highly cited papers over many decades. There's no evidence whatsoever that you're going to get any long-term utility along any dimension you would care about, whether it's quality, price, or access.

BALLARD: OK. And one, one final question, if I may. Is there any evidence to large, out-of-state comp-- companies coming in-- for the sake of the argument. So right now there's a liquor store coming into Nebraska. They use it as-- this store as a loss leader for the rest of their, of their business. So they're out of an East Coast town. Do Nebraska-- they don't care if they lose money. Is there any argument to nursing homes or skilled nursing-- or, skilled facilities coming in, using Nebraska as a loss leader, and to facilitate-- and so it's, it's not really benefiting anyone. Kind of back to that argument of the supply and demand. And then as soon as they kill the entire ecosystem, they raise their prices.

TANNER JONES: This is an interesting question. I'm, I'm-- and I have some research on this-- not at my fingertips, but I'd be happy to, to send you afterwards. So it-- if you are trying to build a nursing home or a health care facility, if you're putting your capital up, that's a risk. And you-- we, we heard about this, this case a moment ago. What's happening in the status quo is you have demand, but supply is unable to meet demand because it's threatening to the set of firms that are here. If you didn't have CON, that nursing home would, would be there still. And, I mean-- she explained. They're put-- they're putting their money up. They have a manager. Everything's lined up. To your question about out-of-state nursing homes coming in and using Nebraska as a, a hotbed of-- basically a loss leader, I have not seen any evidence of this. And it's, it's unclear to me why, as an investor, that would be advantageous for you elsewhere.

BALLARD: OK. Interesting. I appreciate it. Thank you.

HARDIN: So would CON be the perfect antidote to a free market economy?

TANNER JONES: It is in every way antithetical to free market principles.

HARDIN: Any other questions? Thanks for being here.

TANNER JONES: Yes, sir.

HARDIN: Proponents, LB437. Welcome.

BO BOTELHO: Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Bo Botelho, B-o B-o-t-e-l-h-o. I'm the Chief Legal Officer for the Department of Health and Human Services. I'm here and testify in support of LB437. As Senator Riepe already stated, the Certificate of Need Act was created in the '70s and was intended to limit the number of health care resources in the state to control costs, prevent unnecessary expansion, encourage the use of alternate levels of health care. The act currently only places an moatur-- moratorium on the creation of new licensed nursing home beds and hospital rehabilitation beds. All the other restrictions have been removed by the Legislature in our act. Repealing the Certificate of Need Act would allow greater access to health care and provide more flexibility for facilities to meet the unique needs of the communities they serve. Currently, only 7 of the 26 health planning regions have hospital rehabilitation beds. Low occupancy rates for these beds make it difficult for a hospital to meet certificate of need requirements to create new rehab beds. Rural patients who require hospital rehabilitation services need to travel long distances to receive care. And it's important to note that the, the statute bases their certificate of need to create new beds on occupancy rates. It's not at the discretion of the department. There's tests in the statute that if you want to get a certificate of need to create a new bed, you have to meet the test. For long-term care facilities, it's 90% occupancy capacity for the three previous quarters in the 25-mile radius. And for rehab beds, it's 80% occupancy in the entire health plan region for the previous three quarters. And if you can't meet that test, you can't create a new bed. It is common for a rural community to want to keep nursing homes, as it can be one of the largest employers in the area. When the facility closes, the owner can sell or transfer the right to operate the licensed beds. But if the owner chooses not to, the right to operate those beds no longer exists when the facility closed. They don't go into a pool, a storage pool. They go away. If you don't sell them, you don't transfer them, they don't exist anymore. And then you're forced with trying to create them, which is difficult to do. Nursing homes have been closing in Nebraska at alarming rate. Since January 1, 2019, 37 nursing homes have closed for various reasons. Another two is set to close by April 10, 2025. These closures force residents to relocate to other facilities that are often farther away from their families. The Certificate of Need Act makes it difficult to create nursing-- to create nursing home or hospital rehabilitation beds. Repealing the act would eliminate these obstacles and allow nursing home residents and patients who require hospital rehabilitation

services to remain in their communities close to their families and friends. We respectfully request the committee to advance this bill to General File. I'm happy to try to answer any questions you may have.

HARDIN: Questions? You have a pretty good history-- understanding of history and health care in our state. When was certificate of need coming in Nebraska? When did it have its heyday if it's evidently not now? It was sometime between the 1970s and now. Was there a time when it was really, shall we say, hitting its stride?

BO BOTELHO: To be honest, Senator, not that I'm aware of. I, I think it was a concept, and I think it-- concept was to preserve resources. I know one of the issues that will be brought up, I'm sure, by the opposition is the concern that some of these facilities, especially the rehab facilities, that requires highly trained professionals to, to operate those beds, right? And if you start building more facilities, that, that will dilute the workforce. So you have--

HARDIN: Tax the supplier.

BO BOTELHO: Exactly. You won't have enough docs or, or, or skilled nurses. Right? And it puts a strain on the workforce. So by limiting the number of those beds, obviously you concentrate the workforce in fewer locations.

HARDIN: OK. Very well. This is just more evidence for my idea of small communities need to go out and forgive the property taxes for just a few years of these medical professionals. They need to attract them into their community just long enough for them to love it and stay there. Anyway. Just an idea. Just an idea. But, yeah, we have a need. And we have to balance that need, but it sounds once again like this was one of those things that maybe never-- it was like a bad suit. It touched us everywhere but fit us nowhere.

BO BOTELHO: Perhaps.

HARDIN: OK. Thanks for being here.

BO BOTELHO: Thank you, Senator.

HARDIN: Great. Other proponents to LB437? Senator, welcome.

LAURA EBKE: Chairman Hardin, members of the committee. My name is Laura Ebke. That's L-a-u-r-a E-b-k-e. I'm the senior fellow at the Platte Institute. Platte Institute is a free market think tank that focuses on removing barriers to individual and business opportunities. I come to

you today not to discuss the specific issues raised by some of this bill's proponents but rather to discuss the more generic principles that provide the foundation of our support for the bill. Proponents of free market economics generally oppose certificate of need laws because they prevent the free market from working. These laws give the government the power to manage industry competition through the allowance or disallowance of new providers, facility expansions, or other services defined by law. As we sometimes see with occupational licensing-- sort of my hobby horse-- certificate of need laws-- perhaps well-intentioned-- distort marketplace forces, protecting those already providing services from new competition. That in turn hurts consumers, whose services-- whose service options are unnecessarily limited. The government has an interest in protecting public health and safety and health care facilities, obviously. As with many licensed occupations, they have that, that interest. That can be done, though, through periodic facility inspections and reporting functions. It can be done by requiring standards of care, like providing minimum staff-to-patient ratios for all facilities and evidence of provider training. However, the government should not determine whether a business can compete while following those standards. In my community of Crete, we have a Subway sandwich shop-- this, this will make sense-- and a Pizza Hut. A new building is going up on the corner of town and-- on one of the corners in town, and the rumor is that it will contain a Jimmy John's and a Domino's Pizza. Now, one might reasonably ask if a city of around 7,000 really needs more sandwich and pizza places, but choice is good for the consumer, and the role of the government ought not to be decide where we can eat but rather ensuring that where we choose to eat is reasonably safe. Businesses come and go, but long-term success should be based on the business model and the quality of product-- the quality of product and service provided, not on protecting one company over another by government fiat. So that's the same case with long-term care facilities and other medical facilities. If a business owner believes that they can provide a service to consumers, then the government ought to let them try. Thank you to Senator Riepe for bringing the bill. And I'll be happy to try to answer any questions you have, keeping in mind that I am a political scientist, not an economist.

HARDIN: Thank you. Questions? Will you do your best crystal ball, looking ahead about seven minutes into the future?

LAURA EBKE: Seven minutes into the future?

HARDIN: That's right. What's the other side going to get up and say?

LAURA EBKE: Oh. They're going to-- they're, they're, they're, they're going to, I think, argue-- as they often do-- that, you know, this protects health and safety, that it, it, it-- as we've heard several others allude to, that it will--

HARDIN: And you seem unconvinced.

LAURA EBKE: Well, I mean, sure, it, it, it protects-- it, it, it protects from an over-- an oversaturation. I mean, there's no doubt about that. But the question is, does that stay-- or, do, do-- does the, the market stay oversaturated? You know, in, in, in my little town, is the market going to stay oversaturated with sandwich shops or will some of them decide to do something else? I mean, that's just the way business works. Things come and go. But you ought not prevent-- you know, there's a need out there. We've had nursing homes in my four-county area that have closed down in the last ten years and haven't been able to open back up. People have had to-- you know, we've had, had-- heard the same story where they've had to, you know, go 25 or 30 or 50 miles away to, to have their folks in a nursing home. So, I mean, I think that it's important for us to keep in mind the human element of this too. And if there are people out there who are willing to provide the service, who are willing to follow the rules that the state otherwise sets up in terms of, of, of public health and safety, then we ought to let them try. And if they can't make a go of it from a financial standpoint, then they can't make a go of it from a financial standpoint. I mean, it sounds, sounds cruel, but, but that's kind of the way it is. And competition is good. I'm a big believer that competition makes everybody better.

HARDIN: It does beg the question how much an outside group-- whether they're from outside the state, inside the state-- but if they don't know your community, how much do they care about that community? Those older people who were there, those families who would surround them?

LAURA EBKE: Sure. Well, I mean-- and that's where the market forces work, I think. If, if they aren't providing the service that you want, then some-- they'll-- people will go someplace else.

HARDIN: OK.

LAURA EBKE: That's, that's the way market-- the market works, right?

HARDIN: Because Platte measures various kinds of big trends, do some predicting for me. We don't pass this, what happens to the small communities and what happens to the older generations in these small

community connu-- communities across Nebraska in the coming 10 to 15 years?

LAURA EBKE: Well, in, in the coming 10 or 15 years, my, my parents will be of the age where they may need long-term care and they may not be able to have care. And they're in, in, in-- you know, in my hometown of Fairbury, because there's limited supply of, of beds there, that, that's going to happen. And, you know, that's a relatively urban area. You fur-- you go further west where there's a lot more space in between and, and there's a lot fewer beds, there's going to be a lot of people that are going to be-- you know, folks up in Burwell that are going to have to go to Grand Island for their nursing care or, you know-- I'm picking names out of a hat here. But I, I think that-- I think we're going to find it tougher and tougher for people to be closer to home and closer to family. And we know that that family support is important. You know, I-- my mother-in-law died last August, having been in a nursing home in the community where we live. But it was still 50 miles from where, you know, where she had-- what-- where she had lived most of her life. And so she missed out on a lot of that. While, while she had children and grandchildren around, she missed out on having, on having her, her own social network close by.

HARDIN: Thank you. Appreciate you being here.

LAURA EBKE: Thank you.

HARDIN: Proponents, LB437. Welcome.

JOHN GAGE: Thank you. Good afternoon. My name is John Gage. That's J-o-h-n G-a-g-e. And I'm the state director for Americans for Prosperity. I'm here on behalf of our thousands of activists across the state of Nebraska to testify in support of LB437, which will repeal Nebraska's remaining certificate of need requirements on hospitals and nursing homes. As noted earlier, in the 1970s, the federal government prodded states create certificate of need laws, leading to every state adopting some form of these laws, including Nebraska in 1975. Lawmakers believed at the time that certificate of need laws would help lower the cost of health care by preventing unnecessary expansion and duplati-- duplicative services, an argument I'm sure you'll hear in opponent testimony. The problem is these good intendants-- intentions did not end up with good results. Instead of lower health care costs, certificate of need laws have significantly increased health care costs wherever they've been implemented. A study bun-- done by the Mercatus Center found that in Nebraska, patients would save an average of $235 a year on health care spending if we repealed our certificate of need

laws. And the same study show that these laws are suppressing access to health care, especially for rural Nebraskans. I would like to note that if this hearing is anything like last year's, you will probably be hearing from some hospitals, nursing homes, and related associations telling you that repeal is going to hurt health care and lower quality of care. What you probably won't hear is the issues our state is already facing with low quality of care, which are a result of the certificate of need laws. Take, for example, Nebraska's nursing homes. Our state has 183 nursing homes across it. And of those, 22 had serious deficiencies, 168 had infection-related deficiencies that were reported for, resulting in $3 million in penalties. I believe our state's health care providers can do better but only if they're provided with proper incentives by allowing an open market to compete and give Nebraskans more options for their care. The federal government has seen the disaster that has resulted from these regressive laws and has reversed course. All seven of the latest presidential admen-- administrations, from Reagan and Clinton to Obama and Trump, all have recommended repealing these programs. And many states have heeded the call, from California and Texas to Colorado and Kansas, with over a dozen states repealing these harmful programs and more looking to follow suit. By passing this bill, Nebraska would join a growing number of states that have found that repea-- re-- repealing certificate of need laws lower costs and improve levels of care. We urge your support on LB437 to help create more opportunities for Nebraskans seeking care in our state. Thank you.

HARDIN: Thank you. Any questions? Obama and Trump agreed on something?

JOHN GAGE: Yes.

HARDIN: I see. All right. Well, thank you. I just needed that clarification on that point.

JOHN GAGE: Yeah.

HARDIN: All right.

JOHN GAGE: Thank you.

HARDIN: Appreciate it. Proponents, LB437. Any opponents? LB437. Welcome.

KORBY GILBERTSON: Good afternoon, Chairman Hardin, members of the committee. For the record, my name is Korby Gilbertson. That's spelled K-o-r-b-y G-i-l-b-e-r-t-s-o-n. I'm appearing today as a lobbyist on behalf of Nebraska Health Care Association in opposition to LB437. I

was asked to come up and give kind of a historical perspective because, interestingly enough, one of my first job-- one of my first assignments as a lobbyist-- well, it was a few years after I started-- but back in 1997, we did the first legislation that repealed the majority of the Certificate of Need Act. Let me tell you what happened with that. I will tell you-- I have many times since that said, I'm wondering if we made a mistake with this, because let me tell you what has happened. The group that hired us wanted to provide a, a specialized care, and they then were able to do that because we were successful in doing this. And they said the amount of care will balloon, people will be able to get care closer to their homes. This will be a great thing for the state of Nebraska. I'll tell you in less than ten years, they then merged with two other large entities and formed one location where people have to go to get care. So that did not improve care across the state and it did not reduce the cost. Another thing that has happened as a result of the, the repeal of certificate of need has to do with ambulatory surgical centers. If you look at ambulatory surgical centers-- and I know I'm going to upset some people, but I'm going to go through this. When you look at the cost of industry shifting the care to another facility that isn't necessarily have to be licensed in the same manner in which a hospital does, it changes their costs, what they can do. And in a sandwich situation, I guess, you can look at things because costs are pretty much the same. One isn't required to have an emergency room and the other one not. But what has happened in, in Nebraska, especially in this, the terms of workers' compensation costs, our costs for care have gone up even though the frequency and severity of injuries have continued to go down each year. The cost has gone up, and why is that? Because the care has been shifted to the facilities that are not hospitals and therefore not subject to the hospital fee schedules or the other costs that hospitals have to cover. So the cost to employers and insurance companies and others has increased because certificate of need was removed. Wanted to address a few other things that were said by the proponents. We need to support the free market. I think the problem with this is this is not a free market. I remember years ago once we were talking about nursing home closures and someone told the, the nursing home industry, you need to change your business model. You need to quit accepting so many Medicaid patients so that you can make money and not have to have so much state assistance. The problem with that is that when you look at the number of patients in the Nebraska system that are on Medicaid, these facilities don't have the chance. And I see my red light is on, so I won't continue.

HARDIN: Keep going.

KORBY GILBERTSON: OK. Thank you very much. What instead happens if you remove certificate of need, you will have companies come in and open facilities that don't accept Medicaid, that have different fee schedules, do things differently. Might provide the best care for people that can afford it, but what will happen to the people that are on Medicaid? They are the ones that will get transferred to Lincoln and Omaha that can still afford to have larger facilities that can house more Medicaid patients. They won't be in the communities. So that is a falsehood. I think Mr. Botelho said that the closures were for unknown reasons of the nursing homes that have closed. They aren't for unknown reasons. They're because of staffing issues and reimbursement issues. And I think it's unfortunate that the proponents of this bill aren't here supporting the nursing home industry in Nebraska, who's desperately trying to survive when they are asking to be reimbursed at a rate which will help them keep their doors open, instead of focusing on undoing the protections that currently exist. With that, I'd be happy to answer any questions.

HARDIN: Senator Meyer.

MEYER: Thank you, Chair. So what do you tell Butte, Nebraska-- talk-- given, given the, the current operational opportunities, they-- their hands are tied. And so you tell a rural community, hey. That's tough. These are the rules. Live with it. Is that what you tell them?

KORBY GILBERTSON: No, I don't tell-- I don't tell them that. But I tell them that--

MEYER: You tell them to spend $130,000 for a bed somewhere 150 miles away?

KORBY GILBERTSON: I, I would be willing to bet that they could-- I'll let other people talk about the availa-- availability. But, Senator, I think that we're ignoring the issue. That facility wouldn't have had to close but for shortages in staffing and funding. And I think it is extremely naive to think that someone else could come in and just open a new business and think it will be successful. There are many businesses, people who have been in this industry for decades, and it has been their life's work to try to keep these facilities open. And year after year after year, they come to the Legislature and explain what is going on. DHHS has done its own studies showing that lack of support for facilities and the shortcomings of our current rates. So I think if the state would listen to its own DHHS and facilitate those or make payments that would help them stay open, that's what needs to happen.

MEYER: Really? So what do we do in the short term?

KORBY GILBERTSON: What do we do in the short term?

MEYER: So your, your solution, if I'm hearing correctly, is we need to pay our Medicare providers in nursing homes more. Is that, is that what I'm hearing--

KORBY GILBERTSON: I think that's one--

MEYER: --as part of the solution?

KORBY GILBERTSON: I think that's definitely one of the biggest burdens or problems that we are facing right now.

MEYER: I look at a number-- the-- nursing homes have closed over the past four years on one of the handouts.

KORBY GILBERTSON: Mm-hmm.

MEYER: And my home town lost their 42 beds. I'm quite aware of that.

KORBY GILBERTSON: Absolutely.

MEYER: And so I'm not hearing any solution other than we need to pay more for Medicare reimbursement.

KORBY GILBERTSON: And so, and so my pushback on that is, how does releasing certificate of need and eliminating the ability for these facilities to maintain the required-- that they have to keep accepting the Medicaid patients? How do you accept that you would have facilities that come in and open and won't accept Medicaid or won't allow the others to compete? So they take the only paying patients out of those existing facilities, and then those other facilities will close. We'll have more closures.

MEYER: So what do we do with the Medicaid patients?

KORBY GILBERTSON: Well, I--

MEYER: I mean, I, I--

KORBY GILBERTSON: I have been told we don't care and they can go to Lincoln and Omaha.

MEYER: Well, it is the United-- it, it is the state of Nebraska, not the state of Omaha, not the state of Lincoln.

KORBY GILBERTSON: I couldn't agree more.

MEYER: And from my perspective, I see a lot of that, quite frankly, and, and--

KORBY GILBERTSON: And that's what I think is the-- that's what I agree with you is wrong. We need to be focusing on keeping people close to their families and where they live. And that's what the Health Care Association has been trying to do for decades. The problem with eliminating CON is you exacerbate the problem. You don't fix it because you create businesses that will be able to cherry-pick patients and then leave the patients that cost the money for the other facilities.

MEYER: It appears we have a quota system right now, and anything that's produced outside the quota, in all probability, if you, if you have a certificate of need, it's probably going to get rejected. And so we have a quota system, and we're losing part of that and no way to replace it. And, and it doesn't appear that the current system works at all. And so to perpetuate that and continue that looks like just perpetuating a very, very bad policy. Things have changed since it was initiated. And so we need to make a change to try to improve the situation.

KORBY GILBERTSON: And I, I agree that there-- changes could be made. I think the committee and the Legislature needs to be very careful of the unintended consequences of any changes you decide to make. And take the time to actually look at what could happen.

MEYER: Can it be changed within the context of the current certificate of need?

KORBY GILBERTSON: Absolutely.

MEYER: What are your suggestions?

KORBY GILBERTSON: I am not-- I do not operate nursing home, so I would recommend asking--

MEYER: So it can be fixed but--

KORBY GILBERTSON: --the people behind me.

MEYER: --you don't know how.

KORBY GILBERTSON: I don't operate nursing homes. I was here to give a little history about the different certificate of needs we've removed

and the impact of those. There are people-- other people that actually work in the industry that will answer those questions.

MEYER: I apologize if I've been too difficult with you.

KORBY GILBERTSON: Oh, not at all.

MEYER: It just seems like status quo is not an option.

KORBY GILBERTSON: And we couldn't agree more.

MEYER: And what I'm hearing is we need to stay with status quo. And, and I, I, I will not accept that.

KORBY GILBERTSON: And I don't think we're saying we need to keep with status quo. I think we're saying that something needs to be done to help facilities. And we have been staying level or doing very little to improve the ability for them to stay open. And we'd love to work on, work on it together.

MEYER: Going to have to have my hearing aids adjusted so they hear better. Thank you.

KORBY GILBERTSON: Oh, no.

MEYER: Appreciate it. Apologize if I was too difficult.

KORBY GILBERTSON: No, not at all. I understand.

HARDIN: When you say we need to improve Medicaid rates, do you have a sense in terms of how much?

KORBY GILBERTSON: Yes. And the people behind me could tell you specifically, but the Department of Health and Human Services did a study and recommended an amount that has been ignored for years, and we have nowhere close to it, so.

HARDIN: Which is to say that that amount must be--

KORBY GILBERTSON: Old.

HARDIN: --expired.

KORBY GILBERTSON: Yes.

HARDIN: OK. All right. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for, for being here. And I'm sorry I missed the beginning of your--

KORBY GILBERTSON: That's OK.

FREDRICKSON: But I, I, I-- just-- some of the questions you've been answering-- or, the way you've been answering questions got me thinking more. So what I'm hearing you say is-- and, and I certainly share this concern-- is by eliminating the certificate of need, we open up the risk of potentially having facilities open up where-- sure, if you are private pay, self-pay, you have means, you have access to that. But arguably the most vulnerable members of the community-- so those who might be on Medicaid-- they wouldn't necessarily have access to that facility.

KORBY GILBERTSON: Right.

FREDRICKSON: Is there-- well-- and this is probably complicating things, but I, I guess, like, is there a-- is there a world where we could look at the certificate of needs and then require acceptance of Medicaid if you forego the certificate of need process? Is that, like, a--

KORBY GILBERTSON: I think that we are open to any type of discussion. My fear-- and I think it's shared by the-- I know it's shared by the Health Care Association-- is that if it is eliminated, we know what will happen. And it won't make things better, but something has got to happen, because we want people to be able to stay where they live. We don't want people to have to come to Lincoln and Omaha. We don't want to have to change our business model so that we can make money, because their purpose is to help people in those communities.

FREDRICKSON: Thank you.

KORBY GILBERTSON: Thank you.

HARDIN: Senator Quick.

QUICK: Thank you, Chair. Did you say that we did change it or, or stop it for a time, certri-- certificate of need?

KORBY GILBERTSON: So back, so back in 1997, the Legislature passed LB798 that undid a number of different certificate of needs. So that was the fur-- further whittling down of what we have. And so now we just have nursing homes and skilled-- and the rehab beds. The language was done in a way so that it happened over kind of two years when this

bill was passed to protect some things. And we honestly-- you-- we did not think of the ramifications on the access to care. Obviously, if you live in a rural area, you realize there isn't an abundance of care opportunities. So it hasn't necessarily worked.

QUICK: Well-- and I, I know it during my time when I was in here before, I'd visited several nursing homes and talked about the percentage of Medicaid patients versus self-pay just so they could pay their employees and stay open. So I know that's a concern.

KORBY GILBERTSON: Yep.

HARDIN: Seeing no other questions. Thanks for being here.

KORBY GILBERTSON: Thank you.

HARDIN: Those in opposition. LB437. We're just getting warmed up. Welcome.

JALENE CARPENTER: Welcome. Good after-- evening.

HARDIN: Good "afterevening." OK.

JALENE CARPENTER: Chairman Hardin and members of the Health and Human Services Committee. My name is Jalene Carpenter, J-a-l-e-n-e C-a-r-p-e-n-t-e-r. I am the President and CEO of Nebraska Health Care Association. We represent over 170 nonprofit and proprietary nursing facilities across the state of Nebraska. I am going to attempt to answer a lot of the questions that have been asked and also understand that-- I'll, I'll get to where-- I think we're, we're trying to solve a problem by addressing the wrong solution. So to answer your question, Senator Meyer, it's my understanding from the Department of Health and Human Services' website there have only been 2 CON applications in the last five years. There was a comment made by the very first proponent testifier that certificate of need states have lower staffing ratios in their nursing homes than those that do not have CON. Nebraska ranks significantly higher than the nation for their staffing ratio. We are at a 4.5 where the rat-- the nation is at a 3.5. The comment around the barrier of accessing certificate of need. It is $1,000 and 60 days. There are also exemptions that can be applied for. So for example, if there is a medical necessity that is not being addressed in a mi-- in a 25-mile radius, an exemption can be granted by the Department of Health and Human Services to allow those beds without anybody having to purchase those beds. So I want to be clear on that point. It's an or. So an organization that would like to open a new nursing home, there are beds available to purchase. There are facilities who, due to very

low staffing and availability of staff, have beds that they could potentially sell. The alternative through the CON process for $1,000 and a 60-day approval, the department can grant an exemption for those beds to be issued. So I just want to make that point clear. I also just want to say I-- Indiana repealed their certificate of need program in 2001. And by 2006, they had to place a moratorium because the-- of the concerns that resulted. One, the development of new facilities of beds that ultimately went unfilled, putting a strain on the state's Medicaid budget. So in 2001, they implemented a repeal. In 2006, they put a moratorium. By 2017, they completely reinstated their certificate of need program. So I think that is a very stark example of the concerns that we have. I would, with most certainty, appreciate Britanie's testimony and passion. It is something I am wildly passionate about and have been doing for the past three years to try and save our nursing homes. I find it somewhat disingenuous in the governor's actions to support this bill but not to put additional funding into the state budgets to actually keep nursing homes open. There is a solution, Senator Meyers [SIC]. We can have a critical access nursing home. And I see my red light is on, so I will be respectful.

HARDIN: Keep going.

JALENE CARPENTER: Thank you. There's a path forward. There is an o-- there is an opportunity to create a system where rural nursing homes can stay open. It does take investment by the state. I handed out in my handout the current 2024-- or, 2023 gap between the cost of care and the actual reimbursement from Medicaid. It has not kept up. So if we would like a solution, let's create critical access nursing homes. Let's, let's cover their cost. Let's reconcile to cost so that they can actually remain open. What I say, Senator, to Butte is what I would-- what I have said to the Governor's Office, and that is January 1 of this year, Butte had a nursing home. There was a budget proposed by, by the governor, and there has been consistent efforts to not fund nursing facilities. There is little hope for facilities in our rural area to remain open. And, and Butte is a terrib-- I, I hate that they have to move. I don't want them to. Like-- and I can tell you it is not just facilities that are owned by larger corporations. Trenton was a locally owned, community-owned facility that closed and was not able to sustain it even through efforts of the county. Greeley, locally owned, county-owned facility closed. Grant, owned by the local hospital. Couldn't maintain it, even with trying to use supp-- supplementation from the hospital to keep it open. Pender, same story. Like, I want to address this problem, but we're, we're looking at the wrong solution, in my very humble opinion, in my very passionate opinion, so I appreciate that. I don't mean to look at you, Senator Meyer. I just

wanted to answer your questions. So with that, I'm very much out of my time. And I appreciate it. And would-- happy to answer any questions.

HARDIN: Looking ahead-- again, similar question as to a little while ago. Convince me that in 5, 10, 15, 20 years, the best way to handle this onslaught of older folks coming our way-- because each day, we just get a day older, I noticed-- what's the best way to handle that? Are you saying certificate of need is the undeniable champion of how to handle that moving forward?

JALENE CARPENTER: I see certificate of need-- one of the-- one of the reasons around certificate of need was to ensure that we look for other pathways of care so that we don't overbill the highest level of care and we instead invest in home- and community-based services, which you can see across the state of Nebraska has happened. We advocate fiercely for the right level of care for the right time for those with or without resources. So simply saying that we should build more nursing homes is not potentially the solution. There is going to be a demand. And if that demand exist-- with the current CON, for $1,000 and 60 days, you prove that demand, you can open your nursing home. Somebody said to me today that when-- if there's a need, Valentine can't open a nursing home because of CON. That is factually inaccurate. They, they absolutely can do so either through purchasing of beds or qualifying through that exemption.

HARDIN: I guess I'm hearing you say if we remove certificate of need, more of these nursing homes will close than if we don't remove certificate of need.

JALENE CARPENTER: I am saying I think that-- you know, if we need to look at how to make a certificate of need in a better process, 100% we can look at that. I do not believe it is the problem of why these facilities are closing. I, I think if you repeal CON or not next week, next year there are going to be closures.

HARDIN: OK.

JALENE CARPENTER: We're not addressing the root cause of the issue.

HARDIN: OK. So we're addressing the wrong cause. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for your testimony and for being here. I, I was curious. You mentioned-- I took a note. You, you talked about Indiana's experience with this and sort of-- and shortly after they repealed, they actually reinstated this. Can you

shed any light on to what, what happened there? Why did they choose to reinstate this after they appealed it?

JALENE CARPENTER: They were seeing--

FREDRICKSON: Repealed it, excuse me.

JALENE CARPENTER: --a strain on the state's Medicaid budget because they were seeing an increase in their costs because there was more-- there was more facilities, lower level of occupancy. And so you were essentially having to take care of more people in-- with lower population. So if you're in a facility that's only half occupied and there's 20 people there versus a facility that's 50 people, it's more efficient when the facility is full versus when it's half full. And so costs go up exponentially. And so then you continue to need to increase that Medicaid funding for those facilities to remain viable. And I'm happy to send you more information in regards to Indiana in particular.

FREDRICKSON: And did they find that the new facilities that opened as a result of the CON being repealed, were, were they still accepting Medicaid? I know this is maybe apples and oranges because there's--

JALENE CARPENTER: I, I don't, I don't have the answer. I'm sorry.

FREDRICKSON: Thank you.

HARDIN: Senator Quick.

QUICK: Yeah. Thank you, Chairman. So like what-- I know in nursing when I went and visited, I know there's different levels of care. Do they have to meet those levels of care? Like, for-- say you have memory care in some facilities or you have, you know, maybe assisted living-side, but then the nursing home-side too. So how does that work? Does that fall into the certificate of need?

JALENE CARPENTER: It, it does. You have to be able to show that you have availability as far as demand for people to serve, but also the availability of workforce. And I can say unequivocally the closures have resulted due to workforce. I know that a recent closure was because that facility was cited at-- because it-- they were cited by the department of having insufficient staff. They then resulted in having to use additional agency staff, which eventually put them so far in the hole that they weren't able to sustain operations. So it does go into why certificate of needs exists, so that you can ensure that there is an adequate workforce and adequate supply of residents to serve as well.

QUICK: Is that also like-- do you have to have so many, like, maybe an RN or LPNs or--

JALENE CARPENTER: Correct. So a nursing home is required to have eight hours a day of RN coverage. And then there is 24/7 nursing coverage that is typically made up by an LPN.

QUICK: OK. OK. And then there are also-- are there, like, CNAs too that work there or they're--

JALENE CARPENTER: Yeah. Yeah. There is-- so we have a staffing requirement in the state of Nebraska that states that you have to staff to meet the needs of the residents. So that can vary. If you have a memory care facility, you may need more staff than if you have a facility that doesn't serve memory care or a lower level of care.

QUICK: And then my other-- last question would be, so if we didn't have the certificate, certificate of need, would that affect any of those levels of care?

JALENE CARPENTER: No. You still would have to meet all of the, the requirements of being a nursing home.

QUICK: OK. And one other question. Would they-- I know you talked about them maybe taking more of the self-pay. Is that just because of-- that's their policy what they would do? Or are they going to be required to take so many Medicaid patients?

JALENE CARPENTER: There's no re-- there is no requirement. I-- in, in theory-- it's interesting because certificate of need was originally created to insure to protect rural facilities so that people didn't overbuild in the metropolitan areas and stuck all of the business to that particular area. Now, I can say the closures have nothing to do with certificate of need that is happening, but the, the potential unintended consequences if you remove that, it would actually only expedite closures because it would only promote growth within those urban markets.

QUICK: All right. All right. Thank you.

FREDRICKSON: Other questions? Seeing none. Thank you for being here.

JALENE CARPENTER: Thank you.

FREDRICKSON: Next opponent for LB437. Welcome.

AIMEE MIDDLETON: Thank you. Thank you, Chairman and committee, for allowing me to be here today. My name is Aimee Middleton, A-i-m-e-e M-i-d-d-l-e-t-o-n. I'm the Chief Operating Officer for the Good Samaritan Society. And I'm here today to testify in opposition of LB437. Good Samaritan is the largest non-for-profit provider of senior care and services in the nation. We are privileged to provide skilled nursing care to 1,000 seniors across 14 Nebraska communities. My loved ones are some in those communities, and they receive long-term care services. So this bill matters to me not only professionally, but personally. Repealing the Nebraska Health Care Certificate of Need Act would have unintended negative consequences for seniors and health care providers all across Nebraska. The Certificate of Need Act is crucial to maintaining a healthy senior services landscape. First, it prevents overbuilding and ensures stability, including, most importantly, for our workforce. Certificate of need laws help match supply with actual demand, preventing unnecessary nursing home expansion that could lead to underutilized facilities across Nebraska, also financial instability and unfortunate closures. Unchecked, expansion will increase Medicaid and Medicare costs as more beds often lead to more utilization, whether needed or not. The certificate of need laws help ensure the availability of qualified caregivers that it matches the need. Health care, particularly long-term care, is experiencing staffing shortages. The shortages would be worsened if there is an oversupply of beds but not caregivers to staff them. Ultimately, this would drive up costs for consumers and providers. The Certificate of Need Act also protects quality of care. By regulating the number of facilities, the laws ensure resources are evenly distributed, allowing existing providers like the Good Samaritan to maintain high standards of care. The regulations prevent the entry of low-quality or financially unstable operators who may cut corners on staffing and care, and our seniors deserve better. Lastly, the certificate of need laws encourage thoughtful, need-based growth. The current process requires a demonstrated community need before approving a new nursing home development, ensuring facilities are open where they are most needed. It promotes the investment also in in-home and community services. I urge you and implore you to protect the Nebraska Health Care Certificate of Need Act, which helps our seniors and communities continue to have access to the services delivered by quality, mission-driven providers like the Good Samaritan Society. Thank you for your time and consideration today.

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

AIMEE MIDDLETON: Mm-hmm.

FREDRICKSON: Next opponent for LB437. Welcome.

JOHN WOODRICH: Thank you, members of the Health and Human Services Committee. My name's John Woodrich, J-o-h-n W-o-o-d-r-i-c-h. I'm the Chief Operating Officer and Executive Vice President for Bryan Health. And I do resemble Senator Hardin's earlier remark of being an old administrator. Just happened to have it in the age. I've been in health care for 48 years. We're one of the largest health systems in the state. We support patients, providers throughout the region. We care for hundreds of thousands of patients each year. A small subset of that is rehab patients. And to maybe put in perspective of all of Bryan Health, about 3.5% of our beds are rehab beds. And what we're talking about here is really the CON for rehab beds. I come to you representing Bryan Health, Nebraska Hospital Association to oppose LB437 on the grounds of protecting the certificate of need. As written in the bill, if we remove that certificate of need from the state, we are going to be destabilizing a high specialized workforce. I'm going to talk to you about-- Madonna Hospital is one of them. The, the, the technology they have and the skills and all that is really great. And, and so we have rehab too at, at Bryan Health. And I think you guys all know about the nursing shortage. We're trying to protect that. We were also trying to protect the rural and urban facilities. So protecting the high-quality, post-acute rehab care requires extensive training, leading edge technology, equipment, and a critical mass of patients. Nebraska has rehab beds positioned in Scottsbluff, North Platte, Lincoln, Omaha. This does not include all the ones that are within the critical access hospitals, which provide rehab care in their swing beds in all these small communities throughout the state. Within the current rehab certificate of need statute, it allows for any facility to increase their rehab beds by ten beds or 10% every two years, allowing for thoughtful growth to these communities. If the CON is removed entirely, there will be an influx of profit and non-for-profit entities that enter the market that's going to dilute that highly skilled workforce and the critical mass of patients for people to maintain that high quality of care and keep their competencies up. The current understanding around the removal of the certificate of need for rehab in Nebraska is that this is one way to remove an administrative burden for those wanting to expand their rehab beds, especially in rural Nebraska. In the last five years, we're not aware of any filings for rehab certificate of need beds. And when asked, rural facilities are also worried about the removal of what that would do to their swing-- rehab swing beds in their bed programs. You know, I-- one might argue that we are removing a process that isn't being used. Conversely, we are aiming to remove a process that isn't being used, therefore not

burdensome on the department or the facilities. That protects our workforce and the quality of rehab patients in Nebraska.

FREDRICKSON: And you're-- the red zone. But if you could just-- you could finish up your final thoughts here.

JOHN WOODRICH: OK. So LB437 would destabilize a highly specialized workforce, impact quality, and chip away at rural facilities' swing bed programs. We stand opposed to LB437 as written and would welcome the opportunity to work with Senator Riepe on this bill to protect the rehab beds portion in Nebraska. We urge you to consider this for rehab patients, the workforce, and providers that would be impacted should this bill move forward. Thank you. And I would take any questions.

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

HANSEN: Thank you, Vice Chair. I got a question about a sentence in your second paragraph, the last one. It str-- if the certificate of need is removed entirely, there will be an influx of for-profit and not-for-profit entities that enter the market. I got a couple of questions about that part right there. Is that a bad thing?

JOHN WOODRICH: I think so. When you have a, a specialized workforce that you're going to dilute--

HANSEN: Well, I'll talk about the specialized workforce in a second. But just the fact that we'll have for-profit and not-for-profit entities entering the market, wouldn't that actually make health care cheaper?

JOHN WOODRICH: No, I don't believe so. Because what you're going to do is have people replicate services. When we are-- if we were at capacity or close to capacity, I say that's a good thing. But if you're going to go ahead and take workforce and spread them out-- and I'm going to give you an example. I spent $52 million during one year of COVID on agency nurses. Did that not increase health care costs? We're going to do that again by diluting it. We're going to cause people to buy all this equipment. And then they're going to use-- lose the skill set of people having that repetition of just dealing with rehab patients. I, I think it's going to definitely increase cost of health care.

HANSEN: OK. And then-- how would it-- is-- so that-- is that the point you're making with diluting the highly skilled workforce, so the profit and not-for-profit people aren't going to have as skilled a workforce?

JOHN WOODRICH: Yeah. Because, because they're going to steal from the, the current facilities you have. And then where are you going to bring on these other nurses? I, I have a-- we have a program at Bryan Health College of Nursing. We're producing nurses every year, and they're getting-- taken into the system just due to what we're seeing by the increased census due to our baby boomers, which-- I'm one of them. And we're, we're watching not people go into the field. Because I'm gonna-- I'll be real honest with you: it wasn't a very attractive field during COVID when people are watching these nurses and what they had to go through. We're trying to rebuild that workforce again. Projections, 2030, state of Nebraska's going to be short 5,000 RNs.

HANSEN: OK. And when you say the critical mass of patients needed to maintain-- so that's the-- what you were talking about having a critical mass. OK. OK. Thanks.

JOHN WOODRICH: Thank you.

FREDRICKSON: Other questions? Senator Ballard.

BALLARD: Thank you for being here. What is your capacity right now for rehab beds? Where are you--

JOHN WOODRICH: I have up to 30 at, at Bryan Medical Center. Yeah.

BALLARD: And how many of those are, are filled on a given--

JOHN WOODRICH: I would say, if you had to take an average, about 22.

BALLARD: OK. So about 80-- trying to do math in my head-- 75%, 80%?

JOHN WOODRICH: Yep.

BALLARD: So-- and how much-- do you know how much a bed costs in the-- not cost, but for the certificate of need. I heard we-- there was some estimates, $30,000, to purchase a certificate of need.

JOHN WOODRICH: Well, I'll, I'll tell you what it costs for us to build the hospital bed. Today, if I was to add, it's between $1.2 to $1.5 million a bed.

BALLARD: So a pretty significant capital investment.

JOHN WOODRICH: Yeah.

BALLARD: OK. Thank you. I appreciate it.

FREDRICKSON: Other questions? Seeing none. Thank you for being here.

JOHN WOODRICH: Thank you very much.

FREDRICKSON: Next opponent to LB437. Welcome.

CHRIS LEE: Oh. Good evening, senators. Sorry to be keeping you from your dinner. My name is Chris Lee, C-h-r-i-s L-e-e. COO of Madonna Rehabilitation Hospitals. And Madonna is opposed specifically and only to the portions of LB437 which would repeal the Nebraska Certificate of Need Act for rehabilitation hospital level beds. Most arguments that I've heard so far tonight for repealing the CON focus on increasing access, decreasing regulatory burden and associated cost, and improving quality. However, Nebraska's hospitals have ample rehab beds to meet the needs of Nebraskans now and mechanisms for expansion in the future. Federal requirements dictating the very few who qualify for medical rehabilitation and how that care is delivered and how that care is reimbursed won't change. So increasing competition for the very small population that needs and qualifies for medical rehabilitation won't decrease cost or improve quality. It has the opposite effects. Nebraska, to add to the list that John gave you, has ten rehabilitation facilities in Omaha, Lincoln, Norfolk, Grand Island, Hastings, Kearney, and Scottsbluff. And they serve about 3,300 people a year but have capacity to serve many, many more than that, with occupancy in the state only running somewhere in the 60%-something range. All of these facilities have strong roots in their Nebraska communities and long histories of investing in Nebraska. It's far from certain that the out-of-state interest who would capitalize on a CON repeal for rehab would have the same commitment to reinvesting in our communities for the long term. The influx of beds from out of state concerns would also lower patient volumes in Nebraska's rehabilitation facilities, which would then, one, make it difficult for Nebraska facilities to create the capital necessary to obtain expensive rehab technologies that patients benefit from; and, two, spread patient volumes below levels needed to maintain high-quality services. In a very specialized field like this, quality patient outcomes are impaired when facilities don't have the critical mass of patients to develop and maintain expertise in complex diagnoses such as brain injury and spinal cord injury. More unneeded beds would further strain an already inadequate health care workforce and further drive up cost. Nebraska's hospitals are threatened by a statewide nursing shortage that-- the latest numbers I saw there are about 5,400 more nursing jobs than we have nurses in this state. This has contributed to Madonna's labor cost increasing by 28% over the pre-pandemic baseline. Spreading a scarce workforce across more facilities and beds will drive cost even higher as wages are

further inflated and facilities are forced to rely heavily on contracted labor to meet patient needs. So Ma-- Madonna believes that repealing the portions of the CON dealing with medical rehab will negatively impact Nebraskans who need medical rehabilitation and Nebraska hospitals that provide this relatively low volume but essential type of medical care. We urge the committee not to advance the portions of LB437 that would end this critical piece of managing Madonna's health care and Nebraska's health care. So thank you for your consideration for this opportunity to testify on behalf of Madonna. And I'm happy to take questions, although with the indulgence of the committee, I would like to also add that-- to clarify that Madonna built a brand new rehabilitation facility in Omaha, Nebraska. And we did work within the existing CON statutes. There-- have the flexibility for us to be able to add new beds and start new facilities already. So with that--

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

HANSEN: Thank you. I don't know if this question was asked earlier of somebody in opposition, but maybe more specifically for rehabilitation beds, do you know how many states currently have certificate of need for rehabilitation beds?

CHRIS LEE: No, sir. I don't know the number.

HANSEN: OK. That's all right. I can find out later, so.

CHRIS LEE: I, I, I do-- I can tell you this, though, because I looked up some federal data, the, the latest federal data over the last five federal years that are available going up through 2022, and I do know that CON has been removed in several states. And as that has happened, what we've seen is a dramatic increase in the types of hospitals that are not necessarily always invested in their communities, a 50% increase. And we've seen a 21% decrease in the types of units that are represented in all of those towns in Nebraska that I just named off. So all ten of those towns would be the type of, type of facilities that would likely be harmed based upon the latest federal data.

HANSEN: That's what I'd be kind of curious about, is a little comparative analysis and see what states have changed theirs and the direction of health care, I think, in those regions.

CHRIS LEE: Well, you know, one thing I would say is that I do think Nebraska is somewhat unique, as is our CON statute. This has a lot of

flexibility built into it. It's-- not every CON is the same. And, you know, as I said, we've added beds over the years and expanded greatly over time. And there are plenty of mechanisms to continue to do that. Now, you know, we're probably running somewhere in the 70s for capacity. So we still have quite a bit of capacity. But if we start getting more full than that, I know that I can get beds easily and actually pretty quickly under the current statutes.

HANSEN: Thank you.

FREDRICKSON: Other questions? Seeing none. Thank you for being here.

CHRIS LEE: Thank you.

FREDRICKSON: Other opponents to LB437? Seeing none. Anyone here to testify in the neutral capacity for LB437? Seeing none. Senator Riepe, I see-- you are welcome to come close. But when you come, we had some online comments: 5 proponents, 1 opponent, and 1 in the neutral capacity. Floor is yours.

RIEPE: Thank you, Acting Chairman. There's a lot to wrap our heads around. And I will try to be brief. First of all, there's a correction that my staff pointed out and that-- I think it was in 2024. I stated my-- that there was a citation about LB1215. And I think that at the time Senator Hansen pulled that particular piece out of that certificate of need. So I want to get that correction on record. I want to talk about-- I think we've invoked about three different issues or subjects on this particular CON bill, and one of those is the issue of workforce development. Regardless of workforce development, it's a problem. It's a major problem in the urban areas. And it's a major problem-- a real major problem in the rural markets. Second, we've talked about beds and filled, and I can assure you that I know enough about this business that it's, it's not so much your occupancy, it's your payer mix. It's what makes a hospital run. The third piece is-- and then I will get down to some more specifics. But from the cost reimbursement, as this committee, we meet with a lot of agencies. Our ability now and probably in the near future to pay cost reimbursement is absolutely out of order. It's not going to happen because we're currently dealing with a $200 million budget hole. So I think that that's irrelevant. I was going to tell my own story, but I'll be very brief about it. I was a young administrator. I was at Bergan Mercy Hospital in, in Omaha. I had been on the administrative staff at Lutheran-- small hospital: 209 beds. They came forward to CON and asked for a CT scanner. I testified at the hearing and said, CT scanner's state of the art. The problem with the state looking at it said, well,

we only need one for every 300,000 or 200,000, not recognizing that it was a state-of-the-art technology. I've-- spoke in favor of their-- getting their CON approval. They got it. I went back six weeks later from a 420-bed, very active hospital, and was denied. In today's dollars, I spent $75,000 in a lawsuit against the state to get that certificate of need. And that's how unfriendly the market was and how very unresponsive certificate of need can be. It protects those that have and keeps anyone else away. I'd also like to point out Nebraska grew, what, 2,000 people in the last census? Anybody with a lot of pile of money-- and as was noted-- to build a hospital bed is, like, $1 million. That's why the new hospital proposed at the med center in Omaha is talked about being a $2 billion hospital. So there aren't going to be a lot of people out there that run into Nebraska that want to build multimillion dollar facilities here. We're lucky we have what we have. I think we have good facilities. I don't want to go on on that, but I want to close with this because I think it's more important than anything I've said or maybe anything that I could say. And I want to go to Ms. Brewer, who told the story better, quite frankly, than I possibly ever could. And I'm going to-- I'm not going to quote, but I'm going to try to come close to paraphrase here. We have a community that wants to save its nursing home for its neighbors to keep them close to home. They also want to save the jobs of their friends and their neighbors. We have a community that wants to save its nursing home, but the certificate of need says no. That's all I have.

FREDRICKSON: Thank you, Senator Riepe. Any questions from the committee? Seeing none.

RIEPE: Thank you.

FREDRICKSON: Thank you.

RIEPE: Thank you very much. I, I would also like to thank everyone who testified for or against. It's part of democracy. I respect that. And I appreciate it. Thank you.

FREDRICKSON: Thank you, Senator Riepe. That'll close our hearing for LB437. We will now transition to-- give folks a minute to clear out. All right. If we can continue to transition out of the room so we can continue with hearings. OK. We are now going to move on to LB48. Senator McKinney, you're recognized to open.

McKINNEY: Good afternoon, Vice Chair Fredrickson and members of the Health and Human Services Committee. My-- I am Senator Terrell McKinney, T-e-r-r-e-l-l M-c-K-i-n-n-e-y. I represent District 11 in the

Legislature, which is in north Omaha. I am here to discuss LB48, a bill that helps families and prevent young people from getting caught up in the juvenile justice system. This bill creates the Family Resource and Juvenile Assessment Center Pilot Program, which will provide immediate, 24/7 support to youth and families before their challenges turn up-- turn into bigger problems. The centers will offer services like counseling, mentoring, job training, mental health support, and other resources to keep kids from entering the system unnecessarily. We all know that when families struggle, kids are first to feel the impact. If there's no help available, small issues like school absences, family conflicts, or mental, mental health struggles can quickly turn into bigger ones. Without intervention, many young people end up in the juvenile justice system not because they are criminals but because they've lacked the, the right support at the right time. LB48 aims to change that pro-- by providing a safe place for families to turn, turn to before the begin-- before the situations worsen. This bill also focuses on culturally relevant and community-driven solutions. Families in crisis are more likely to seek help from places they trust by partnering with local grassroot organizations and leaders with lived experiences. These ceature-- these centers will be built around the needs of the, of the people they serve. They will increase trust, improve access to services, and ensure families get real, practical help that make differences. I, I also gave you guys an amendment that makes some important adjustments. Originally, the plan was to open four centers, centers, but the amendment scales this down to two centers to start, allowing us to test and refine the program before expanding it. Additionally, the funding structure has changed. Instead of drawing from the General Fund, the program will now be funded by the Medicaid Managed Care Excess Profit Fund, ensuring the money comes from existing resources and does not require new taxes or additional spending. The amendment also limits administrative costs, making sure most of the funding goes directly to the services for families. This bill isn't just-- isn't just good for families. It's also a smarter financial decision for the state of Nebraska. The cost of jailing a kid is far higher than providing supp-- support services. Every dollar spent on prevention saves taxpayers money by reducing future, future court, incarceration, and social services costs. With a clear goal and built-in accountability measures such as data tracking and program evaluations, we can make sure these centers are delivering real results and adjust them as needed. Other states, like Nev-- Nevada, have already seen success with these programs. And Nebraska has a chance to lead the way in creating a more effective and compassionate approach to juvenile justice. This bill is about giving kids and family a fair shot at success rather than letting them slip through the cracks. Supporting

LB48 means choosing prevention over punishment, community support over crisis intervention, and opportunity over adversity. I urge your support for this bill. And with that, I'd answer any questions.

HARDIN: Thank you. Questions? Senator Quick.

QUICK: Yeah. Yeah. Thank you, Chairman. So does this work anywhere in the state, or is it more towards maybe metropolitan areas. Or do you know?

McKINNEY: Right now, I'm just trying to pilot it in a metropolitan area. Douglas County has the highest population of juveniles that are kind of in the system. So that's what it's kind of tailored to.

QUICK: OK. Yeah. Thank you.

McKINNEY: Yeah. Thank you.

HARDIN: Other questions? Senator Hansen.

HANSEN: Thank you. So-- OK. These are existing facilities that offer these services or--

McKINNEY: No.

HANSEN: --you're going to transform them into these?

McKINNEY: So it would-- so we got different, like, entities in the community that are involved in juvenile services. And what this would do would allow for people to apply to DHHS to get the designation. But they would have to offer the services that's in the bill to get the designation. So if they're not offering the services that's in the bill in order to comply with-- to get the designation, they would have to start offering those services.

HANSEN: Are, are there facilities already that offer these services?

McKINNEY: There's some facilities that offer some, some of these services, but not all.

HANSEN: But they would have to bring it in and--

McKINNEY: Right. Yeah.

HANSEN: Would a church be eligible for this?

McKINNEY: It's possible. If they start off-- offering services.

HANSEN: If they decide to--

McKINNEY: Yeah

HANSEN: --offer these services and--

McKINNEY: Yep.

HANSEN: OK. All right.

HARDIN: Other questions? Will you stick around?

McKINNEY: Yes. And I, and I brought the amendment because I thought, you know, trying to do a pilot program and in a budget deficit, two center's more, you know, palatable than four. And just decreasing the fiscal note made more sense as well. So that's why, why, why I brought the amendment.

HARDIN: OK. Very good.

McKINNEY: Thank you.

HARDIN: Thank you. Proponents, LB48. Welcome.

COREY STEEL: Good evening. Good evening, Chairman Hansen and members of the-- or, Hardin and me-- that was last year. My apologies.

HARDIN: I've been called worse. That's OK.

HANSEN: Don't worry. I'm not offended.

COREY STEEL: That was a-- that was a year back. I haven't been in front of the committee this year. Chairman Hardin, members of the Health and Human Services Committee. My name is Corey Steel, C-o-r-e-y S-t-e-e-l. And I am the Nebraska State Court Administrator. I am here before you today testifying in support of LB48. I want to thank Senator McKinney for bringing this bill forward. The Administrative Office of the Courts and Probation is in support of the pilot program created by LB48, which would establish a family resource center-- or, family resource and juvenile assessment center. These services and supports that will provide-- provided by the centers are best practice models, which will positively impact youth and families. The judicial branch will be an active partner in planning the creation of the pilot and bring valuable experience regarding essential services. Currently, court and probation staff often work with youth and families who stress they cannot access the necessary services and supports they need without becoming system

involved. They also report that the services are not in their local communities, and accessing those, accessing those services and supports are difficult. This, this could result in youth not receiving essential services at the right time and becoming system involved. A family resource and juvenile assessment center model removes those barriers and creates a local, community-based facility which provides behavioral health services, mentoring, family support, and educational services. The center provides services at a no cost to the families, again removing those barriers to accessing needed services of a lot of the families that we see. Additionally, court and probation staff report challenges in locating services due to waitlists or limited availability. They also report difficulty locating culturally diverse services and supports for youth and families. The creation of the centers can both build services in the community and support targeted, culturally focused services and local organizations. Finally, creating a center based on national standards and require data collected-- collection to prove effectiveness is essential. This will ensure the services are-- and supports are being implemented with fidelity, as well as ensuring the services provided are truly focused on juvenile justice system prevention. In closing, the Administrative Office of the Courts and Probation is testifying in support of LB48, and we support this pilot and creation of family resource juvenile assessment centers, which will directly impact youth and families, provided them necessary services and supports to avoid system involvement or shorten the time frame within the system. I thank you. And I'm happy to answer any questions you may have.

HARDIN: Thank you. Questions? Senator Hansen.

HANSEN: Thank you. I think the more you explain this, this sounds like what the YMCA used to do. Except for cognitive behavioral therapy. Like, I'm reading through the list of all the stuff it's supposed to do. Mentorship, you know, conflict resolution, anger management, you know, drug-- substance abuse, intervention, food and clothing assistance. So-- I don't know. What, what happened to those? Like--

COREY STEEL: A lot of those resources have dried up over the years. We don't see those resources collected in one area. What we know in probation, we get the juveniles in the families that weren't able to access these types of services early on that may have addressed their issue and their reasons for coming into the system. So it's exacerbated their problems. And so if we have-- this is true prevention. This is early, upfront prevention for families to go and get some of their needs met so that they can address the use issues so they don't come into the juvenile justice system. That's why we're in support of this.

We want anything that can assist a family, the youth prior to juvenile justice involvement so we don't see them on the probation end.

HANSEN: OK. And, and so-- I mean, you probably have the most insight, like, I would say why it's dried up. But, I, I-- it seems like we used to have social, church, community, family-driven, you know, ways to address a lot of these issues. Now we're moving more towards a, a government approach for these issues. So, so why do they dry up? Why do we have to-- why do we have to rely on this now?

COREY STEEL: A couple, a couple different reasons that we see. One is funding, lack of funding to be able to provide these services. Or fragmented services, where they're spread out through a community and you can't go to one place to get all of those issues and all of those problems addressed in one, in one area.

HANSEN: OK. All right. Thanks.

HARDIN: With-- this is potentially four different ones. Is that right?

COREY STEEL: In, in the current bill. I haven't seen the amendment that Senator McKinney introduced.

HARDIN: I guess my question is, would this be AAAA, four of the same thing, or is this ABCD, kind of tailored for the, the given community? And-- I mean, do they all do essentially the same thing or do they-- are they slightly different?

COREY STEEL: Well, I think in my brief conversation with Senator McKinney in reading the legislation, it would be four different centers and different, different areas-- or, different areas of the state.

HARDIN: Programmatically, I guess.

COREY STEEL: But programmatically, I think they would include the majority, if not all, of those services that's based on the need within the community.

HARDIN: I see. OK. Thank you. Let's see. And then-- go ahead, Senator Quick. I'm looking at a question.

QUICK: Yeah. Yeah. Thank you, Chair. So-- and one other thing I-- you know, I see, like, in Grand Island sometimes it's a variance for the families too that maybe they don't have-- it's a, a single parent home and they have the kids there and they don't really maybe have access to something like this. And I see, you know, you know, he-- Senator Hansen

had mentioned maybe more family resources, but sometimes they don't have that. What-- what they need-- and I don't-- if, if you see that as well.

COREY STEEL: We do. And that's the, the, the fragmenting of the system-- of the juvenile justice system that we have seen. We don't have what we call, I, I'll say, a one-stop shop. Like you had mentioned, the YMCA used to do all of these things. Now, the local YMCA doesn't do a lot of those programs and services. We see fragmented, where they may do one or two of those services. They may do mentoring. They may do, you know, some of those others. One of the examples and what this reminds us of on the probation side is, on the adult side, we have, we have what we call reporting centers. And in our larger communities, they're run by probation, and we have all services in one location. So if you're an adult and you get placed on probation and you need, you need pre-treatment-- you're going into treatment but there's a waitlist-- you can go get education classes there. We do domestic violence classes there. We do cognitive behavioral treatment in those centers. Some of our centers have become clothing hubs where they have racks and racks of clothing. They've partnered with the Salvation Army or whomever, and they bring clothes in as well. They have a food pantry right there. So it's really-- they can come get their service needs met if they need an evaluation. They can meet the evaluator there and, and get that evaluation done. They can go through group programming and services. We have financial resources where we have banks come and they help them open up accounts and do a lot of financial resources and what have you, as well as-- then they can walk through, grab some food, grab some clothes as they walk out and what have you. It's a one-stop shop. It's, it's something that they know they can go to and they can get their needs met. Now, obviously, if there's long-term treatment, mental health, substance abuse, those may have to be done off-site, but they can start all that process there and then they can refer out and work with the family to refer out. We look at this as kind of that same concept of, where can somebody go prior to juvenile justice involvement where they can get a lot of those early interventions addressed and their needs met? It may not be they provide 100% of everything, but they know where to go. Because a lot of the families we deal with just don't know where to go. They don't know who to ask. They don't know what type of counseling they need or what have you. And we can-- you can come into a shop and then they can do a warm handoff referral to some other type of service need met within the community.

QUICK: One more other question. You, you probably know the-- maybe have the idea of what the cost is for a juvenile who's sent-- goes through

the courts and ends up in detention. I mean, the cost per day has got to be quite--

COREY STEEL: It is high. Correct. And, and we look at our detention costs. Today, our detention for one day in juvenile detention is $345 a day.

QUICK: All right. Thank you.

HARDIN: Senator Riepe.

RIEPE: The way that-- and good to see you. Thanks for being here. The way you've described it, it sounds like there's one center, and one center won't work in an urban area like Omaha. I mean-- and you're going to have-- so you're going to ha-- because you're going to have to be on bus lines. You're going to have to be on-- if we can say this in Omaha, you're going to have to be on the streetcar line, someplace close. Little pun there. But, you know-- I mean, it's pretty comprehensive. And I don't know how far-- whether you-- or is-- are we just starting to get into the research part-side of this thing? Did-- because the devil's in the detail, and it would cost maybe a million bucks just to get this thing planned out in great detail if you-- because you're probably going to have to build something new.

COREY STEEL: I'll tell you on our adult side, like in Omaha, we have multiple reporting centers. So we have one in north Omaha. We have one in Midtown. And then we have one out in Sarpy County. So we have three reporting centers. Lancaster County at one point in time, we had two north and south Lancaster County on the adult side. Again, we make sure those are by bus terminals so that people can get there. They provide bus vouchers. You know, different things to make sure you eliminate those barriers for those, for those people that are coming. So, yes, you may need in a, in a big metro area maybe, you know, throughout. But again, when it-- when somebody can go and they know they can get their service needs met or a referral and a warm handoff to a service and you eliminate those barriers for those youth and families to get there-- we see a lot of families, when they come to probation, they're still in crisis because their needs haven't been met early on. And if we could have addressed their needs earlier on, they may not have committed that law violation. They may not have come into the court system. And I think that's the intent, as we read this, is this is early intervention to get needs met so that they don't come into the juvenile justice system.

RIEPE: But all the services you've described to me, mentally I can't match it up with probably the square footage and space that you have at those three. And I'm talking about Omaha. You know. So you probably have to have a different loc-- not the-- or expand where you're at or-- I don't know how you can get all those services into that. And I don't even-- I've never been there. I don't know what size it is.

COREY STEEL: Well, we'll invite you, Senator. You can come to any of one of our reporting centers and we'll give you a tour.

RIEPE: Do you serve lunch?

COREY STEEL: I'll, I'll make sure there's lunch provided.

RIEPE: But-- I mean, wouldn't you have to expand, though?

COREY STEEL: Well, these are the adult reporting centers. You know, this would be-- yes, you would have to have a facility and you would have to have, you know, rooms so that these meetings can occur and, and those types of things. But we started small. In probation, we started really small with our adult reporting centers, which were a couple offices and a couple of meeting rooms. And then as we've grown and added more services, we've been able to expand the, the footprint of the facility to take on all the-- and meet all those needs.

RIEPE: Going to where Senator Hansen was talking about: the YMCA. You're going to need about three, quote unquote, YMCAs if you're going to put in all those services. It seems to me-- and that's limited knowledge just from--

COREY STEEL: Right.

RIEPE: --what we've been talking for a few minutes.

COREY STEEL: Yeah. How do we do it on the adult side-- which I think that kind of concept would work here-- is, again, you coordinate services so they're not there all at the same time. And again, when somebody comes in and they-- they'll meet with somebody to say, here's the crisis we're having or here's the issue we're having with our juvenile. We need help with X. They can help link them to those services. So it's not-- you don't have to have every single service there. But if you have-- they're going to somebody because they don't know what to do. They need help navigating the services-- the community-based services they have. So it's not necessarily they have to be there, but it's-- they're coming to somebody that can help them navigate that and do that warm handoff or have that service provider

meet there one time with them and say, here's our location. Here's where we are. Here's how we can get you there. It, it's really a coordinated effort.

HARDIN: And hence, it, it's, it's a pilot program. And, and correct my earlier statement from the record. We just scanned the amendment, and it's two locations for the pilot center in there as opposed to what's on the fiscal, which said four, so.

RIEPE: May I do-- call-- a follow-up?

HARDIN: Sure. Yeah.

RIEPE: Yeah. My other piece would be is if you've-- and because-- we're a little short on cash here. OK? So I-- and, and, quite frankly, you know, there's philanthropic money and very generous people. At least-- I can't speak for Lincoln, but I can speak for Omaha. And, you know, like the Peter Kiewits, $500 million that they're going to determine to give away by the 3-- they're-- people there that want to be helpful and want to help, you know, individuals get back on their feet. We need that, if for no other reason, workforce, and to get their families. So I don't know. I, I just-- and maybe I, maybe I should wait and--

COREY STEEL: I think those are things that Senator McKinney can-- and, and we're more than willing to, to--

RIEPE: He can hustle money faster than you can, right?

COREY STEEL: --to assist, assist with this concept. We're here in support because, you know, I'm in the Judiciary Committee the majority of the time, and, and so is Senator McKinney. And we hear any juvenile justice bill that comes: lack of resources, lack of intervention. We see these kids get into the system. And if they would have had something upfront that could have addressed their issue, it would have saved them coming through the court system, them potentially being placed out of the home and down the road. And I think that's the concept here, is this is true intervention at the community level to try and address and, and, and stop those issues so we're not going further down the line and getting involved in the system. That's the way I see it as we read the bill.

HARDIN: Other questions? Thank you.

COREY STEEL: Thank you.

HARDIN: Proponents, LB48. Welcome.

JASON WITMER: Thank you. Chair Hardin and members of this committee. I'm Jason Witmer, J-a-s-o-n W-i-t-m-e-r. I'm here representing the ACLU in support of LB48. First, I want to say that we have heard arguments about ju-- juveniles labeled high risk. We will have bills talking about this tomorrow quite a bit. And we have not seen data solution-- data-driven solutions that did not involve incarceration when nil-- with these arguments. Also, we've listened to a proposal just recently about juvenile probation being moved to another branch of the government, with the repeated, repeated declaration that we need to try something different. So I'd like to start out here by saying LB48 offers something different with data-driven solutions based on proven models like the communities that care, CTC. Research in this, this particular program I've found has, has shown-- they had research on 4,000 students in 24 communities that showed youth in the CTC-supported areas were 27% less likely to engage in delinquency by seventh grade. CD-- CTC interventions also reduce key risk factors that increase the likelihood of the legal system involvement, such as family management issue, low school attendance, academic failure. Multisystemic therapy is a proven, family-based intervention for high-risk youth that has significant redu-- has significantly reduced recidivism rates and improved family functioning. So while this bill does not explicitly talk about multisystemic therapy, when you read through the list, those are a list of many of the things that say-- many evidence-based strategies such as youth counseling, mental health services, conflict resolution, mentorship, and trauma-informed care. So as the ACLU, I'm saying this is something different. We are saying this is something different. This is something that has evidence about it. This is something that we need at this time when we have what's going on that's going on. As a person who's worked in adult system of the-- this side of this as well as a peer support-- so that's a baseline grassroots. I worked with the Mental Health Association-- and I know I'm limited on time-- but very limited resources. People coming out of the correctional system have a lot of issues. I have been one of them, as I think I have, have showed to this system. But in this time, we worked with the police. The police had problems. They would contact us. We would go meet the people. We would be the resource. We would be find-- making the connections. And the police have shown at that time that we brought down their mental health calls through our services. I coordinated the Keya House, which is a hospital diversion house, so that people wouldn't end up at the crisis center. They could have us as an alternative. And what that did-- Region V funded us. And what that did was brought down the amount of people that had to also go-- that had to go there, but also the cost, because most of the people could

not afford this. I see the same effects coming from this. I see my time. And I'll take any questions if there is any.

HARDIN: Are there questions? Senator Hansen.

HANSEN: Thank you. Thank you for coming, by the way. Was this the Family Resource Center? Was that what-- the one you were talking about? Was that one on one of the handouts? Do you know?

JASON WITMER: No, I have not seen those handouts.

HANSEN: So I-- it's more about the funding of the-- of what you were talking about before. Do-- so do they have, like--

JASON WITMER: So the Keya House that I coordinated was funded by the Regional V.

HANSEN: OK.

JASON WITMER: And the, the end goal was, such as with juveniles, rather than moving to where this is not going to get-- they're not going to pay for ambulance that are $6,000, crisis center that is thousands-- so we was able to save the county thousands of dollars a year. This-- I can see the same right here.

HANSEN: OK. All right. Thank you.

HARDIN: OK. Other questions? Thank you for being here.

JASON WITMER: Thank you.

HARDIN: Proponents, LB48. Opponents, LB48. Those in the neutral, LB48. Senator McKinney. We had online 20 proponents, 12 opponents, 0 in the neutral.

McKINNEY: Thank you, Chair Hardin and members of the Health and Human Services Committee. Again, I introduced LB48 honestly as my solution or part of my solution to address the concerns I've heard from community and, and families about juvenile justice in this state. I believe if we swim further upstream and address the issue, we can start solving a lot of these i-- a lot of these issues. I think, you know, growing up in a community like north Omaha, the lack of these services and the lack of these facilities is why, you know, things have occurred and, and, and, and why, you know, people are advocating for increases in penalties. I think when you give people services and resources, there will be different outcomes. I know people talk about the cost, but think about

the cost to incarcerate those young people when you increase penalties. That's a big cost too. We should consider that. I think we should invest in these families and these young people because I think that is a better return on investment than locking them up and, you know, creating a, a life of, you know, system involvement. Because when you go through our, our adult institutions, a huge percentage of the men and women that are in our adult institutions were either in a child welfare system or in a juvenile justice system. So I would rather prevent that cycle and swim further upstream and then we wouldn't be building prisons. So think about the costs when you talk about costs. No matter if we're in a deficit, we're going to have to ask ourselves, what is our priorities? What are we going to invest in as a state? Are we going to invest in further incarceration, or are we going to invest into the future and our families? And this is a pilot for two centers that would be in, in Omaha. Anybody that apply, apply would have to have a facility. I don't think it's asking too much. Because we're not asking philanthropy when we bring bills to increase penalties to pay for the incarceration of those young people. We're not asking philanthropy that. And I just, I just-- you know, I spent my whole interim talking to kids and asking them what did they need. And they said, we just need opportunity and resources. And that's why I brought this bill. And honestly, I'm considering prioritizing it because of that. And I understand we're in a-- whatever our budget is. And depending on who you talk to, some people tell me we got money. I, I said something to Senator von Gillern. We're going broke. He said we ain't broke. So I guess it, it, it depends on who you talk to. But my, my whole thing is we have to set our priorities. And I understand it's tough times, but our, our alternative cannot be we don't do the intervention, but we do the punitive side. Because the punitive side cost. And if that's $345 a day and if you lock up ten of those kids, that's 1.0-- that's, that's millions of dollars. That's, that's $1.2 million or something. I forget the calculation. But that's more than this bill. And that's just ten kids. So we have to think about that. So-- and I'm just saying let's do this pilot. Let's, let's try it out and see if it works just to at least show families and youth that we're trying. We're trying to help them, and we're not just trying to just say, you know, what-- whatever's happening, happening in your communities, we're not going to try to help you regardless of it. And with that, I'd answer any questions.

HARDIN: Thank you. Questions? Senator Quick.

QUICK: It's probably more of a comment, but I want to thank you for bringing the bill. These are the same type of things I've been trying to work on in Grand Island. You know, [INAUDIBLE] we're, we're affected

by some of the same things. So I really appreciate you bringing this bill. So thank you.

McKINNEY: Thank you.

HARDIN: Senator Hansen.

HANSEN: I'm not against what you're trying to accomplish here. It makes sense. And I think the more healthy and positive outlets and outreach we can give to youth I think will always help prevent them from going the wrong direction. The funding part is what I'm curious about. So will there be volunteers too? Because it's-- because the, the list that you have here about what we-- that what it-- what it shall do?

McKINNEY: Yeah. So, so people could volunteer. So somebody applies, get the designation. Those organizations could have volunteers. And people can volunteer services. So that, that could happen as well.

HANSEN: Yeah. I'm trying to think because you have-- I think it's just the word "shall" that you've mentioned many times in here.

McKINNEY: Yeah.

HANSEN: If they don't have the volunteer there or they can't find the employment but you're saying they shall do that in order to get this money but they can't-- either because they don't have the employment or the volunteers do it-- like, like-- how it-- I don't know how that work-- like, you're, you're mandating they do something to get the money, but they can't. It's-- so it should be-- would it be better to have a "may" instead of a "shall?"

McKINNEY: I put the "shall" because a lot of times what I've seen, you have organizations and communities that say they're doing something, but when you dig into it, they're never doing it. And, and that's why.

HANSEN: OK. And a little bit on the data collection system.

McKINNEY: Mm-hmm.

HANSEN: Is that just-- is there any specific-- what, what kind of data collection system you would--

McKINNEY: Just, just collecting on, like, what's going on. Just, just so-- because it's a pilot, I want to-- I think we need something to say, like, what's been going on? Has this been working?

HANSEN: I agree.

McKINNEY: Yeah.

HANSEN: I'm just trying to figure-- I just didn't know if there's some specific. And then one other thing-- if I can quick. This will be coming from the Heal-- the Medicaid, Medicaid Managed Care Excess Profit Fund.

McKINNEY: Yup. I talked to Fiscal. There is money in there.

HANSEN: It's like a-- the honey pot, or whoever gets to it first kind of almost. So what hap-- so if there is no money in, in the Ma-- Managed Care Excess Profit Fund, are-- will we be taking it from general funds at all?

McKINNEY: No. That's why-- no.

HANSEN: OK.

McKINNEY: Not, not how it's written.

HANSEN: I know some people are saying, if unable to take it from the Excess Profit Fund, general funds shall not be used. They're saying that's specifically in the bill. To know if we're going to fund something and there's no money left in the Managed Care Excess Profit Fund--

McKINNEY: Oh. I could amend it to say that, so.

HANSEN: And I-- I just know it's-- that's what some are doing because we're starting to see that Managed Care Profit Fund kind of-- a whole bunch of people are getting-- going after it now, so.

McKINNEY: I didn't know that.

HANSEN: Yeah. Just-- OK. Something to think about.

McKINNEY: All right.

HARDIN: Other questions? Seeing none. Thank you.

McKINNEY: No problem. Thank you.

HARDIN: This concludes the testimony for LB48. And we will move on to LB275. Oh. I'm sorry. I think I did, but I can read them again. 20 proponents, 12 opponents, and 0 in the neutral. Senator Hunt. Welcome.

HUNT: Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. I'm Megan Hunt, M-e-g-a-n H-u-n-t. And I represent District 8 in the northern part of midtown Omaha. This bill is the next phase in a long-term project my office began several years ago with an interim study, LR198, back in 2021 to examine the state's practice of intercepting Social Security benefits intended for foster children. I learned about this from a national investigation from the Marshall Project and NPR. Literally, colleagues, I was driving into work here to Lincoln from Omaha. Heard a bit about it on NPR. And I became fascinated. I became really curious. And the study revealed that a majority of states were quietly using state's wards' Social Security benefits to pay for the cost of their care. So my office and I got curious, is this happening in Nebraska? Yes, it is. What these states have been doing is identifying children in their care-- foster youth-- who might be eligible for Social Security funds, applying for money on their behalf, and then keeping the money and using it to pay for the cost of their care. These are kids who can be eligible for Social Security money, averaging somewhere around $700 to $800 a month, for two reasons. One, because they have a parent that's died, or, two, because they have a disability. So this is a group of some of the most vulnerable-- of the vulnerable children in our state. State child welfare agencies-- DHHS here in Nebraska-- have mostly contracted with private companies-- and in Nebraska, we use a company called Maximus-- to screen kids for Social Security benefit eligibility and to apply to become the child's, quote, representative payee. This is permitted by federal law, and the state's ability to retain Social Security assets of children in their care has been upheld by the Supreme Court. Per federal law and Social Security regulations, minor children cannot service their own payee or receive the benefit money directly because they are legally recognized as not capable of responsibly managing the funds on their own. So the kids that are eligible have to have a representative payee manage the money in an account for them, whether that's a parent, another relative or guardian, or the state. So in most cases in Nebraska, the state becomes the representative payee, and all the kid's money goes to the state. And then the state uses that Social Security money to reimburse itself for the cost of the kid's care. There's a lot wrong with this. The overarching problem I see with this is that foster kids should not be funding their own care. They should not be seen as a revenue stream to the state to fulfill their obligations to these kids. But at a more pragmatic level, whether or not we think any of the kids' money should be kept by the state, we could all agree that if the state is going to do this-- intercept money from vulnerable children-- at a minimum, they need to do that making sure those kids have full knowledge, full consent, full transparency,

communication with the children and their legal representatives and their parents or guardians. This is just a government transparency issue. And I think that if this was happening to any other group by any state agency, people would be making a much bigger deal about it. People would be up in arms about it. But due to the nature of this practice, that the affected population is vulnerable and disabled kids, the families might not necessarily realize that this is going on. So once I learned this was happening, we started working on various types of legislation to shine a light on the practice and then try to get some of those money back to the kids who are entitled to it. The interim study that we did in 2021 revealed that this was indeed happening in Nebraska to something, like, 400 kids a month, generating nearly $3 million a year for the state. I used the findings from that study and extensive collaboration with stakeholders to bring LB932 in 2022. And we got a portion of that bill passed in the Health and Human Services Committee bill, LB1173, that year. And what it did was require the Department of Health and Human Services to notify youth and their guardian ad litems if they were benefit eligible and if the state was going to serve as a payee and retain their funds, and to keep a regular accounting of the youth's assets. So the bill got really watered down, but it did get passed in that form in a committee bill. This was an important step forward, and we wanted to see it take effect and watch for a couple years to see what other kind of action could be needed. I've been working with child welfare advocates on the language in this bill to bring it up to speed with changes and progress that other states have made since we advanced our bill to bring more transparency, fairness, and opportunities for engagement in the process for foster youth with their guardians and attorneys. What this bill does in summary, it strengthens department communication with youth and their guardians about eligibility screening for Social Security, its application to serve as the child's representative payee, any benefit determinations, and the right to appeal or request a different representative payee. It requires the Department to hold the youth's benefit funds in a trust account separate from the department's funds and provide that the youth may request access to the funds for personal use or that funds be used or conserved in a specific manner. It improves access to more detailed accounting information about the funds for the youth, courts, guardians, and youth's attorneys. It requires that funds are used in the child's best interest only when other funding is not available and are conserved for the child's reasonably foreseeable future needs. It requires the department to conserve a minimum amount of funds, beginning at 40% when the child is 14, increasing at a sliding scale percentage as the child grows older. And it ensures that the child is informed about the process to receive and

manage their Social Security benefits as they prepare to exit state care. Of these provisions, one of the most important to me is that we save at least some portion of these funds for the kids. If I had it my way, I would say that all the funds should be set aside for them. But I think what we have here, we-- it's a compromise that we came to in consultation with national child welfare advocates and-- that kind of brings Nebraska in alignment with other states' laws. When a child turns 14, that's the age at which the department starts working with youth on their plan to transition into adulthood in regard to finances. And that's in Nebraska state statute. So in theory, this is when a youth gets to gain some education and some sense of autonomy regarding their financial planning. And that's when the state would have to start conserving a minimum amount of funds at 40% when they turn 14. My intent here is to take some steps toward being better stewards of our vulnerable state wards and their assets by involving them and their adults in this process, giving them rights to information about what's happening to their money and how to provide input on how it's spent, and to save a portion of it for the youth's future that could be used for college or technical education or a car or rent for their first apartment-- whatever they might need. For youth in foster care, this money matters a lot. Many exit the system to lead successful lives, but they are also more likely to face challenges like increased rates of homelessness, substance addiction, increased health care needs, and difficulty finding work. There's all kinds of data about how youth aging out of the foster care system without permanent families are more likely to experience homelessness, unemployment, and incarceration. With LB275, the Legislature can help better prepare these youth for transitions to independence. In closing, I would like to emphasize that child welfare agencies exist to protect and serve the interests of vulnerable kids. Federal law already requires that states pay for the cost of foster care, not the children. Federal-- or, by intercepting foster youth's Social Security benefits, the state of Nebraska is forcing abused and neglected youth to self-fund their own care. We all know that that's not right. Foster children should not be used as a funding source for their own care, and this bill just provides more transparency around how the state does that. Thank you.

HARDIN: Questions? Senator Hansen.

HANSEN: Thank you. You mentioned earlier about the Supreme Court upheld the decision, the-- given the state's rights ability to use this money or take it.

HUNT: Mm-hmm.

HANSEN: Right? Correct?

HUNT: Yeah.

HANSEN: So would there be any issue with this bill and that decision?

HUNT: Nope.

HANSEN: Then-- OK. Just want to get your opinion. Thanks.

HUNT: No. The Supreme Court ruling was in 2003-- it was Washington v. Keffeler-- and it found that agencies did not violate the Social Security Act by using foster children's benefits to subsidize their care. But the ruling left room for states to successfully challenge it and for due process and the kid's rights to be treated equally to other foster children who aren't being required to pay for their care.

HANSEN: All right. Thanks.

HUNT: Also, a lot of other states already do this.

HANSEN: OK.

HARDIN: Do we have a sense-- you-- it says on the fiscal note here the amount's about $3.5 million annually. And you were talking-- it says $2,000 per child versus $1,000 per child. Do we have a sense in terms just what it is the state is hanging on to per child?

HUNT: I'm not sure per child. It affects about 400 kids--

HARDIN: OK.

HUNT: --per year. And so I would just do that mental math--

HARDIN: Do that math? OK.

HUNT: --real quick, but.

HARDIN: About 400 kids into $3.5 million.

HUNT: Mm-hmm.

HARDIN: OK.

HUNT: That's how much they're pulling in from these kids' Social Security benefits they're getting because they're disabled or their parents died.

HARDIN: I see. OK. Senator Quick.

QUICK: Yeah. And thank you, Chair. And maybe you already addressed this, but what happens to the money? I mean, what do they do with the money if it's not-- if it's not spent on the kids and-- they just keep it, or what do they do with it-- or, those dollars?

HUNT: I don't know. I'm thinking about that. I've been working on this for so many years. I don't remember, Senator Quick, but I'll, I'll get back to you on my closing.

QUICK: OK. All right. Thank you.

HUNT: Thank you. Or maybe someone will readdress it, but I'll make sure to if no one does.

QUICK: OK. All right. Thank you.

HARDIN: Short math on that's about $8,750, $8,750 per child. So. Questions? Will you stick around?

HUNT: Yes.

HARDIN: OK.

HUNT: Thank you.

HARDIN: Proponents.

HUNT: Thanks for your attention too.

HARDIN: LB275. Welcome.

ALLISON DERR: Thank you. Good evening. Chairperson Hardin, members of the committee. My name is Allison Derr, A-l-l-i-s-o-n D-e-r-r. And I'm an attorney at Nebraska Appleseed, which is an advocacy organization that works in part to improve Nebraska's child welfare system. And we support LB275. As Senator Hunt already discussed, many youth in foster care are eligible for Social Security benefits, frequently due to a deceased parent or a disability, and these benefits are meant to cover their current and future needs that aren't otherwise funded. But instead for Nebraska's foster youth, the state intercepts these benefits, applying to receive them on their behalf, and then using them to pay for their foster care without the opportunity for the youth to object or say no. And this is despite state and federal child welfare funding already existing to pay for their foster care and other youth

in foster care not having to pay for their care. And for perspective-- and you have a chart in your handout showing this. But in fiscal year '24, Nebraska received about $4.2 million in foster youth Social Security benefits. It paid itself $3.5 million of those benefits. And even though it's supposed to save benefits for youth to have when they leave care, it only gave each youth leaving care an average of $911 to support themself, which is less than one month benefit and less than 10% of benefits received that year. There is no legal question that these benefits are these youths' money and property. And in any other context, before the government takes a person's property, they are owed due process. That process does not exist here because the state automatically intercepts and takes these benefits. LB275 attempts to mitigate this while balancing the state and youth's interest, allowing the state to still collect and use these benefits but adding protections for youth when the state chooses to do that. Senator Hunt addressed this, but I did want to briefly just remind that the Legislature did take some initial steps to address this with LB1173 in 2022, primarily requiring the department to tell youth this was happening to them and how. But what we have heard from attorneys and families since is that that didn't quite solve the issue because they had no opportunity or power to use that knowledge or to push back. And also, while Nebraska was one of the first states to act on this with LB1173, many states have gone much farther since, putting us a bit behind on this practice, with other states even going so far as to allow youth to keep all of their benefits, deciding this practice was just too ethically and legally suspect. So LB275 allows us to catch up with other states and better protect youth. In conclusion, just as a reminder, the best interest of children is the North Star of child welfare law and policy. And it's really hard to see how the state's current practice follows that, especially with so much research showing how transformative these benefits are for youth and families to come out of poverty. That the state is taking youth within its care's benefits without question should be really shocking to you all and addressed. So we thank Senator Hunt for her continued work on this issue and ask you all to advance LB275. And I know my light is on, but I have an answer to Senator Quick's question, if that's helpful, and also Senator Hardin's question about money. So happy to address or readdress--

HARDIN: Go ahead.

ALLISON DERR: --whatever. OK. Maybe starting with your question, Senator Hardin, about the money per youth. I provided as a handout to you all-- I believe it's the second handout-- a bit of a breakdown of the money that the state is receiving for youth. You'll see on the

first page that green chart is how many youth that this affected-- so how many youth they screened for benefits, received benefits on behalf of. So that just gives you an idea of fiscal year 2024, but we do have research going back many, many years. So if you want more years, we can provide that. And then if you see-- the blue and red chart is the spending of those benefits and how many youth that affected per month. So-- as well as a percentage of how much was spent per-- or, compared to what was received. And so there's some math you all would have to do. But those numbers are there for you if you're willing. And then that red chart is 2021 through 2024-- so if it's helpful to see a longer look at the amount of benefits. And then the other thing I'll say just to clarify, Senator Hardin, is it depends on the type of Social Security benefit you're receiving how much the check or the benefit would be. So it-- yeah. It-- that-- but there certainly could be some average math done there. And then to your question, Senator Quick, if these funds aren't spent on foster care, what happens to them? So I think there's a bit of a misunderstanding here and maybe a misconception about this practice that youth cannot save their Social Security benefits because it is an in-- for SSI benefits, those are income-based benefits. So you have to be low income in order to receive them, as well as many other public benefits. So I think the department is under the belief that if they save these benefits, the youth will become ineligible. And that is just not true. There are savings accounts that exist for youth and even youth not in foster care to save their Social Security benefits to have for future needs. And that does not count against their eligibility for Social Security benefits. And those benefits can be used for anything else that the young person would need currently or their reasonably foreseeable future needs so long as in their best interests. That could be saving for college. That could be extracurricular activities, things the department isn't already covering or Medicaid is not covering. That is what they are meant for, things that are not otherwise covered. So hope that helps.

HARDIN: Questions? Senator Hansen.

HANSEN: I, I thought with-- because I remember having this conversation in 2022 with Senator Hunt's previous bill, LB1173. The idea that we're not providing informed consent, I think, in a way, for these youth. But you're saying that wasn't enough. Has there been any challenge to that court at all, or is that just kind of a growing concern that you're hearing?

ALLISON DERR: There has not been a challenge in court in Nebraska that I'm aware of-- and I could be wrong on that. There has been challenges in other states that have been successful on this idea of a lack of due

process. All LB1173 was able to accomplish in the end was just notification at the very beginning of the case this was happening. And it wasn't an opportunity to push back or to say you have the option. It was, this is happening to you. We will be using the benefits in this way. So it wasn't a true opportunity to contest like due process would require, which is again what has been challenged in other states, and in some states successfully.

HANSEN: OK. What would be the option they would have?

ALLISON DERR: Well, I think it depends who you ask. In my opinion, it would be-- and what LB275 provides is, option one, is the young person can request to use these benefits in a different way from the department. That is a practice that already exist. The issue: it is the department's discretion to grant that request as they see fit. The better and different option that this bill clarifies exist is they can go to the juvenile court, who always has the jurisdiction to make orders in the youth's best interest, including over folks in the juvenile court case like the department. And so to say, juvenile court, please order my benefits be used in this way, in a different way, please order they be saved for this reason. And we-- frankly, we would say that that is an option that already exists, but parents don't know about that. And there is no weight to that if it doesn't say that in statute, because the statute kind of has-- the default right now is what you-- use youth assets to pay for their foster care services. And so this bill would clarify that that should not be the rule for Social Security benefits as to comply with federal law. So just kind of gives more teeth to, to that idea and clarifies.

HANSEN: OK. All right. Thank you.

ALLISON DERR: Yep. You're welcome.

HARDIN: Other questions? Seeing none. Thank you.

ALLISON DERR: Thank you.

HARDIN: Proponents, LB275. Welcome.

TONJA NIEVEEN: Good evening, Chairperson Hardin and members of the committee. My name is Tonja Nieveen, T-o-n-j-a N-i-e-v-e-e-n. And I support LB275 because my daughter, Raina Svoboda, had her Social Security survivor's benefits taken while she was in foster care. Raina received survivor's benefits because her father was killed by her stepmother. The benefits were meant to replace the money Raina's father would have been giving to support her everyday needs if he was still

alive. Instead, DHHS took them to pay for her foster care without asking our permission. More specifically, they took them to pay for foster care services that had already been provided and paid for. And while Raina was already being moved back into my home full time. In fact, they wiped out almost all of the trust holding her benefits the day before the judge signed physical custody of Raina back to me after her caseworker assured me the money was being safely kept for Raina. In the end, DHHS took $10,251, leaving just $1,000 to support Raina. After finding out about this, we have done everything we could to get the benefits back. Before the end of Raina's foster care case, her attorney pleaded to the juvenile court, quote, Nebraska had confiscated a large portion of Social Security Raina is supposed to receive due to her father's untimely death. Clearly, it would be in Raina's best interest to have access to those funds to maintain her mental and physical health, end quote. The court did nothing. Did not return the benefits. I also opened an investigation and appeal with the federal Social Security Administration, which has been pending for a long time. I filed a grievance through DHHS, a complaint to the Inspector General of Nebraska Child Welfare, and a report to the Nebraska Ombudsman, among many other things. Nothing has been successful in getting her benefits back because, according to most, current Nebraska law allows this. If the money had been saved for Raina, she says she would have used it for food, clothes, daily needs, and college. I also would have used it for medical care, therapy, a car, and housing that would allow her emotional support pet, which used to help Raina recover from her traumatic past few years but we can't currently afford. Instead, DHHS used the money to pay for foster care we did not ask for, which was by no means in her best interest. LB275 would it help-- would have helped us by giving us the opportunity to keep up to date on her benefits, request they be used in different ways, and save some for Raina's future needs once she left care. In closing, I ask you this: other kids in foster care don't have to pay for their care, so why should Raina? If you want to know more about our experience, I provided a handout with our full story. Please read it if you have time. And thank you for your time. And please advance LB275.

HARDIN: Thanks for being here. Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and for sharing your story. You mentioned something in your testimony that struck me. And I don't know if this is kind of typical practice or common practice or if this was just kind of unique, but you mentioned that-- almost, like, the day before the custody was-- the agreement was signed, the funds were all swept all at once as opposed to the-- being,

like, a monthly payment that were taken from the funds. Did I understand that correctly?

TONJA NIEVEEN: It was three separate payments in the amount of six weeks while she was being reunified into my home. And the very last payment that they took was the day before the judge signed physical custody over to me.

FREDRICKSON: OK. So before that process was in place, they were not using these funds.

TONJA NIEVEEN: They had applied on her behalf when I mentioned it to the caseworker as she was being reunified home. And she said, I'll look into that. And then I got a letter from the Social Security Administration that she-- they were going to be her beneficiary. And I contested that. And so I was just so-- supposed to pro-- provide proof that she was coming home when the judge signed the papers. But within that amount of time, they, they put-- for every month that her dad had died, since-- from when they applied into a trust account. And then within the six weeks, that's when they, they emptied the trust account. Except for $1,000.

FREDRICKSON: OK. Thank you.

TONJA NIEVEEN: Mm-hmm.

HARDIN: Other questions? Thanks for being here. Proponents, LB275. Welcome.

KENDRA JACKSON: Good evening. Good, good, good evening-- instead of good afternoon. Senators, thank you for taking the time to hear all of us speak today. My name is Kendra Jackson. That's K-e-n-d-r-a J-a-c-k-s-o-n. I reside in Omaha, Nebraska. And I have been involved in the foster care program for over 30 years. From placement to adoption, I've done it all. Today, I am speaking in support of LB275. Kids in foster care deserve the financial support of Social Security benefits that are given whether in care or not. My daughter, Aziana, came to us at the young age of four years old. At that time, Aziana was not receiving any benefits, and her birth mother knew nothing of them and how to receive them to support her. Aziana from birth was completely disabled, nonverbal, low functioning IQ, and wheelchair bound and was not supposed to live past the age of five. She gave us 19 beautiful years in the end. While in foster care system, she only received foster care benefits. These benefits were supportive, but truly I paid the most of her food, clothing, and medical equipment not covered by

Medicaid out of pocket. Upon speaking to a caseworker and deciding adoption was the best route, we in turn found out she was receiving Social Security benefits after the adoption process took place. It took some time to begin to receive those benefits, which helped provide for much more. But again, that took time to receive. I am grateful for the financial help I was given for Aziana. She was able to truly live out her life as happy and careless-- and carefree as possible-- as possibly could. She went everywhere with us. She was at every family event. If Aziana had not received the extra help, we wouldn't have had the opportunity to do as much with her as we did. We truly are grateful for the memories and life who were able to give her due to the Social Security benefits. Finally, LB275 would greatly impact many others like Aziana in a positive way. I want to thank Senator Hunt for introducing this bill and again want to thank you all for taking the time to listen to our experience.

HARDIN: Thank you. Questions? Thank you for 30 years.

KENDRA JACKSON: Yes.

HARDIN: When you say you've seen it all--

KENDRA JACKSON: Oh, yes.

HARDIN: --tell me about seeing it all.

KENDRA JACKSON: I've had over 300 children come through my home.

HARDIN: 300.

KENDRA JACKSON: Yes. I've done respite. I have adopted four, four girls. I have in total seven children: three biological, four that I adopted. And it's so funny because you would think they were all mine's. Well, they are mine's. And Aziana, she was the baby. She would be 24 years old today. She passed away December 15 of '22. She was my world. She was 24-hour care. And the children that I foster parent, they all came and didn't leave. I had them all up until they age out the system. My last one, she left at 25. I never put them out.

HARDIN: You have an amazing capacity for love.

KENDRA JACKSON: Oh, yes. I'm from a big family.

HARDIN: Thanks for being here.

KENDRA JACKSON: Thank you.

HARDIN: Proponents, LB275. Opponents, LB275. Those in the neutral, LB275. Senator Hunt. We have online 31 proponents, 0 opponents, 1 in the neutral.

HUNT: Thanks again, everybody. You know, I appreciate the proponents who have helped me with this process over the last several years. The Nebraska Chapter of the National Association of Social Workers, the National Center for Youth Law, foster parents and former youth, and-- especially the ones who were able to be here today. Nebraska Apple-- Appleseed, Children's Advocacy Institute, Voices for Children. I'm very proud and happy that we had no opposition to this bill, whether online or in person. And DHHS is neutral, and I'm happy to work with them in any way. Colleagues, I would like to prioritize this bill. So I know you guys are execing tonight. If any of you want to talk about moving this bill out with my, you know, good faith promise to work with you guys before the priority bill deadline so that I can have something to work on this session, I would appreciate that. And if you have any other questions for me, I'd be happy to take them.

HARDIN: Any questions? Senator Hansen.

HANSEN: I got a cup of coffee because I thought you'd have opposition. I'm surprised.

HUNT: I'm surprised you thought I would. You've, you've heard this bill before.

HANSEN: So, so what'd the department say about--

HUNT: The department has some technical concerns, but they are-- they understand the spirit of the bill. And I'm happy to work with them.

HANSEN: The fiscal note, they-- did they mention that at all? Like, the-- how-- now the state has to absorb the cost of the money going elsewhere. [INAUDIBLE] the General Fund of, like, $3.5 million. Did they-- are-- is the department able to absorb that or are they expecting to come from general funds?

HUNT: It, it wasn't a part of the conversation about their opposition or-- they don't have opposition, so.

HANSEN: OK. Cool. Thanks.

HARDIN: OK. Any other questions? Seeing none. Thank you.

HUNT: Thank you, Senator.

HARDIN: This concludes the testimony on LB275 and our hearings for today. We will be going in to exec. So we'll ask everyone but the press to dismiss as soon as you are able. Thank you for today.