HARDIN: Welcome to the Health and Human Services Committee. I'm Senator Brian Hardin, District 48, and I serve as chair of the committee. The committee will take up the bills in the order posted. There's one, one today. And so we're going to do them in that order. 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. Today's hearing will operate differently than a regular public hearing as noted in the notification of hearings and the agenda. This hearing will utilize annotated committee hearing guidelines in order to streamline the hearing process and provide consistency for all who wish to testify. Individuals who have the opportunity to testify are guaranteed 3 minutes to present their testimony, questions do not count towards the overall time. Testimony will alternate between 1 hour of proponent testimony, followed by 1 hour of opponent testimony, and there will be some time provided for neutral testimony as needed. What I'm going to do is I'm going to get a little squishy on this, guys. For example, yesterday we had an annotated hearing across the hall, and they went through an hour. I think there was, like, one or two people more on the proponent or opponent side, they got to stick around another hour before they got their chance to speak. So if we have something kind of like that that comes up, I'll fudge and just keep going so those folks can go on. So, anyway, that's how we're going to be flexible with me. And we'll, we'll figure it out to, you know, hopefully not keep you here too, too long. After the 2 hours are complete, the committee will recycle back through the proponents and opponents, alternating every hour again as needed. To make the process as smooth as possible, seating in the hearing room will be divided, one side proponent, one side opponent testimony to avoid the need to fully clear the room when changing to the next hour of debate. Sergeant at Arms will serve as an usher to indicate the next testifier. Overflow attendants will be seated in Room 1200 near the south door, that's that way. Admittance to this hearing room as testifiers exit the room will be managed by the Sergeant at Arms. And so are we going to be exiting that door, that door? That door over there. OK. Thank you. Green testifier sign-in sheets and yellow nontestifier attendee sign-in sheets are located near the hearing room entrances. If you intend to testify, please fill out a green sheet. If you want to indicate your position but not testify on the microphone, please sign the yellow sheet. Signing in on the yellow sheets is a way to express your position without repeating testimony that's already been heard. And I think we're not going to be doing yellow sheets in here, is that right?

JOHN DUGGAR: No, sir.

HARDIN: No, sir. OK. When you come up to testify, please speak clearly in the mic, tell us your name and spell your first and last name.

JOHN DUGGAR: [INAUDIBLE]

HARDIN: OK. And we'll hit that here in just a sec. Spell your first and last name so we can make sure we get an accurate record. We'll begin each bill hearing today with the introducer's opening statement followed by an hour for the proponents, 1 hour for the opponents, finally by anyone speaking in the neutral. As I indicated earlier, we'll continue this pattern until all who wish to testify have had the opportunity to do so. We'll finish with a closing statement by the introducer if they wish to do so. We'll be using a 3-minute light system for all testifiers. When you're-- you begin your testimony, the light on the table will be green. When the yellow light comes on, you have 1 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. The senators may have bills to introduce in other committees. We have to do the same thing in other places in the building while this is all going on. So it's just popcorn in and out of here. And so a few final items to facilitate today's hearing. If you have handouts or copies of your testimony, please bring up at least 12 and give those to the page. Props, charts, other visual aids, cannot be used simply because they cannot be transcribed. Please note that thumb drives, CDs, DVDs, oversized documents, books, lists, signatures, pets, small animals, large animals cannot be accepted as exhibits for the record simply because we don't know how to transcribe those. And so 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.com [SIC]. Written position letters will be included in the official hearing record, but only those testifying in person before the committee will be included on the committee statement. I will now have the committee members with us today introduce themselves starting on my left with that senator just now sitting down. Senator Riepe.

RIEPE: It's in the concept of just in time. I'm Merv Riepe, I represent District 12, which is the fine town of Ralston, but also Millard and Omaha as well. Thank you.

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

G. MEYER: Good afternoon, I'm Senator Glen Meyer, District 17, and that would be Dakota, Thurston, Wayne, and the southern part of Dixon County.

QUICK: Good afternoon, I'm Dan Quick, District 35, Grand Island.

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

HARDIN: Also assisting the committee today to my left is our legal counsel, John Duggar, and to my far left is our committee clerk, Barb Dorn. Our pages for the committee today are Sydney, who does not like to introduce herself, but go ahead and do it anyway, Sydney.

SYDNEY COCHRAN: Outstanding. Hi, my name is Sydney. I'm a sophomore at UNL and I study history.

HARDIN: And DeMet who likes to introduce herself and she is--

DeMET GEDIK: Hi, my name is DeMet Gedik. I study poli sci at UNL.

HARDIN: The agenda is posted outside, and with that, we're going to get rolling. Senator Kauth, welcome.

KAUTH: Thank you very much, Senator Hardin. Thank you very much, Health and Human Services Committee. My name is Kathleen Kauth, K-a-t-h-l-e-e-n K-a-u-t-h, and I represent LD 31, which is the Millard area of Omaha. LB732 discusses a full ban on puberty blockers and cross-sex hormones. In 2023, the Let Them Grow bill was able to fully ban surgical procedures on children dealing with gender dysphoria, but was only able to get a partial ban on the experimental use of puberty blockers and across-sex-hormones. More and more states have recognized that these drugs are experimental and detrimental to growing youth. This summer, the Supreme Court weighed in with the Skrmetti decision. In U.S. v. Skrmetti, the Supreme Court upheld Tennessee's law that protects children from gender transition drugs and surgeries that the Tennessee Legislature concluded were harmful and not worth the potential risk imposed on vulnerable children. First, the court

concluded that the law only focuses on two classifications, age and medical use. On its face, SB1 incorporates two classifiers: First, SB1 classifies on the basis of age. Health care providers may administer certain medical treatments to individuals ages 18 and older, but not to minors. Second, SB1 classifies on the basis of medical use. Health care providers may administer puberty blockers or hormones to minors to treat certain conditions, but not to treat gender dysphoria, gender identity disorder, or gender incongruence. Second, the court rejected the argument that the law targets any population based on sex. The court concluded that when properly understood from the perspective of the indications that puberty blockers and hormones treat, SB1 clearly does not classify on the basis of sex. SB1, in turn, restricts which of these medical treatments are available to minors. Under SB1, a health care provider may administer puberty blockers or hormones to any minor to treat a congenital defect, precocious puberty, disease, or physical injury. A health care provider may not administer puberty blockers or hormones to any minor to treat gender dysphoria, gender identity disorder, or gender incongruence. The application-- pardon me-- the application of that prohibition does not turn on sex. Third, the court also rejected the argument that Tennessee's law targets people based on their transgender identity. The plaintiff separately argued that SB1 warrants heightened scrutiny because it discriminates against transgender individuals. This case, in any event, does not raise that question, because SB1 does not classify on the basis of transgender status. The court emphasized that the law focuses solely on limiting certain medical procedures for children. SB1 does not exclude any individual from medical treatments on the basis of transgender status, but rather removes one set of diagnoses, gender dysphoria, gender identity disorder, and gender incongruence, from the range of treatable conditions. Under these circumstances, we decline to find that SB1's prohibitions on the use of puberty blockers and hormones exclude any individuals on the basis of transgender status. In his concurrence, Justice Alito summarized the court's holding. SB1 targets only the experimental medical procedures that the Legislature found to be unsupported and dangerous. It does not regulate any other behavior in which minors might engage for the purpose of expressing their gender identity. It says nothing at all about names, pronouns, hairstyles, attire, recreational activities or hobbies or career interests. And the law's restrictions apply only to the treatment available to minors. Takeaways from this ruling: number one, the U.S. Supreme Court has clearly held that it does not violate the constitution for a state to prohibit giving puberty blotches, cross-sex hormones, or transition surgeries to minors; 27 states have

passed laws that prohibit gender transition drugs and or surgeries for minors, almost all of those laws are now fully in effect after Skrmetti; the evidence continues to grow that these drugs and surgeries are harmful to miners. The concept of gender identity is increasingly used to gender reassign children who do not conform to sex stereotypes or who are diagnosed with gender dysphoria. Medical interventions that carry a high risk of long-term adverse consequences on the physical or psychological health of a child, such as the use of puberty-suppressing hormones, cross-sex hormones, and surgery, are used on children who are not developmentally competent to give full, free, and informed consent. Such medical interventions can cause a range of permanent adverse physical health effects, including sterility, as well as negative effects on psychological health. Per a Williams Institute study in August of 2025, Nebraska's trans population could be in the range of 20,000 people, including 4,800 minors and 6,500 young adults aged 18 to 25. Survey estimates are that 50% of trans identifying people access hormone therapy and 29% will have at least one surgery. This translates to thousands, maybe as many as 10,000 medicalized trans people in Nebraska. I want to talk about the 2025 Health and Human Services Gender Dysphoria Report. Over the past decade, the number of children and adolescents who question their sex and identity as transgender or nonbinary has grown significantly. Many have been diagnosed with a condition known as gender dysphoria and offered a treatment approach known as gender-affirming care. This approach emphasizes social affirmation of a child's self-reported identity, puberty-suppressing drugs to prevent the onset of puberty, cross-sex hormones to spur the secondary sex characteristics of the opposite sex, and surgeries, including mastectomy and, in rare cases, vaginoplasty. Thousands of American children and adolescents have received these interventions. While sex-role nonconformity itself is not pathological and does not require treatment, the use of pharmacological and surgical interventions as treatments for pediatric gender dysphoria has been called medically necessary and even lifesaving. Motivated by a desire to ensure their children's health and well-being, parents of transgender identified children and adolescents often struggle with how best to support them. Many of these children and adolescents have co-occurring psychiatric or neurodevelopmental conditions rendering them especially vulnerable. When they seek professional help, they and their families should receive compassionate, evidence-based care tailored to their specific needs. Society has a special responsibility to safeguard the well-being of children. Given that the challenges faced by these patients intersect with deeply contested issues of moral and social

significance, including social identity, sex and reproduction, bodily integrity, and sex-based norms of expression and behavior, the medical practices that have recently emerged to address their needs have become a focus of significant controversy. This review by HHS is published against the backdrop of growing international concern about pediatric medical transition. Having recognized the experimental nature of these medical interventions and their potential for harm, which has been inadequately studied, especially with respect to long-term outcomes, health authorities in a number of countries have imposed restrictions. For example, the UK has banned the routine use of puberty blockers as an intervention for pediatric gender dysphoria. Health authorities have also recognized the exceptional nature of this area of medicine. That exceptionalism is due to convergence of factors. One is that the diagnosis of gender dysphoria is based entirely on subjective self-reports and behavioral observations without any objective physical imaging or laboratory markers. The diagnosis centers on attitudes, feelings, and behaviors that are known to fluctuate during adolescence. Additionally, the natural history of pediatric gender dysphoria is poorly understood, though existing research suggests it will remit without intervention in most cases. Medical professionals have no way to know which patients may continue to experience gender dysphoria and which will come to terms with their bodies. Nevertheless, the gender-affirming model of care includes irreversible endocrine and surgical interventions on minors with no physical pathology. These interventions carry risk of significant harms, including infertility and sterility, sexual dysfunction, impaired bone density accrual, adverse cognitive impacts, cardiovascular disease and metabolic disorders, psychiatric disorders, surgical complications, and regret. And there has been inadequate research into the frequency and severity of these harms. Meanwhile, systematic reviews of the evidence have revealed deep uncertainty about the purported benefits of these interventions. The controversy surrounding the medical transition of minors extend beyond scientific debate. They are deeply cultural and political. Public discourse is dominated by intensely polarizing narratives. Some view the medical transition of minors as a pressing civil rights issue, while others regard it as a profound medical failure and a sobering reminder that even modern medicine is vulnerable to serious error. In the midst of this highly charged debate, children and adolescents and their families who seek only to support their flourishing have found themselves caught between competing perspectives. They require and are entitled to accurate, evidence-based information to guide their decisions. The risk of pediatric medical transition, including

fertility and sterility, sexual dysfunction, impaired bone density accrual, adverse cognitive impacts, cardiovascular disease, and metabolic disorders, psychiatric disorders, surgical complications, and regret. The existing systematic reviews of the evidence, including several that have informed health authorities in Europe were assessed for methodological quality. The umbrella review found that the overall quality of evidence concerning the effects of any intervention or psychological outcomes, the quality of life, regret, or long-term health is very low. This indicates that the beneficial effects reported in the literature are likely to differ substantially from the true effects of the interventions. In the U.S., the most influential clinical guidelines for the treatment of pediatric gender dysphoria are published by WPATH, which is the World Professional Association for Trans Health, and the Endocrine Society. A recent systematic review of international guideline quality did not recommend either guideline for clinical use after determining they lacked developmental rigor and transparency. Problems with the development of WPATH standards of care, Version 8, which is otherwise known as SOC-8, extend beyond those identified in the systematic review of international guidelines. In the process of developing SOC-8, WPATH suppressed systematic reviews, its leaders believed would undermine its favored treatment approach. SOC-8 developers also violated conflict of interest management requirements and eliminated nearly all recommended age minimums for medical and surgical interventions in response to political pressures. Although SOC-8 relax the eligibility criteria for access to puberty blockers, cross-sex hormones, and surgeries, there is compelling evidence that U.S. gender clinics are not adhering even to those more permissive criteria. The gender-affirming model of care as practiced in U.S. clinics is characterized by a child-led process in which comprehensive mental health assessments are often minimized or omitted, and the patient's embodiment goals serve as a primary guide for treatment decisions. In some of the nation's leading pediatric gender clinics, assessments are conducted in a single session lasting 2 hours. The voices of whistleblowers and detransitioners have played a critical role in drawing public attention to the risks and harms associated with pediatric medical transition. Their concerns have been discounted, dismissed, or ignored by prominent advocates and practitioners of pediatric medical transition. U.S. medical associations played a key role in creating a perception that there is professional consensus in support of pediatric medical transition. This apparent consensus, however, is driven primarily by a small number of specialized committees influenced by WPATH. It is not clear that the official

views of these associations are shared by the wider medical community or even by most of their members. There's evidence that some medical and mental health associations have suppressed dissent and stifled debate about this issue amongst their members. The evidence for benefit of pediatric medical transition is very uncertain, while the evidence for harm is less uncertain. When medical interventions pose unnecessary, disproportionate risks of harm, health care providers should refuse to offer them even when they are preferred, requested, or demanded by patients. Failure to do so increases the risk of iatrogenic harm and reduces medicine to consumerism, threatening the integrity of the profession and undermining trust in medical authority. Proponents of pediatric medical transition claim that regret is vanishingly rare, while critics assert that regret is increasingly common. The true rate of regret is not known, and better data collection is needed. That some patients report profound regret after undergoing invasive, life-changing medical interventions is clearly of importance. However, regret alone, just like satisfaction alone, is not a valid indicator of whether an intervention is medically justified. Patients may regret medically justified treatments or feel satisfied with unjustified ones. When we look at some of the studies in depth that are used to promote these, these treatments, I want to examine some of the flaws. Jack Turban, who is a researcher, medical journalist, and assistant professor of child and adolescent psychiatry at University of California, San Francisco, is the lead author on the following four studies, which are widely cited as evidence to justify sex-trait modification interventions. Each study is based on responses to the 2015 United States Transgender Survey, which recruited respondents aged 18 to 36 years old online via transgender advocacy organizations. All four of the studies have the following clause: A biased selection of study participants or cohorts. Only those who identified as transgender, trans, gender queer, and nonbinary at the time of the survey were allowed to participate. Therefore, those who were given puberty blockers and/or who took hormones or had surgery and later stopped identifying as transgender did not qualify to participate in the study, eliminating the people most likely to have been harmed by medical interventions. Of course, people who committed suicide after transitioning would not have been included either. Nearly 40% of the participants had not transitioned medically or socially at the time of the survey, and a significant number reported no intention to transition in the future, so their responses are not even relevant to the study's claims. Respondents to this type of survey tend to skew young and are likely to be more politically engaged, so the survey results do not represent the entire

trans-identifying population. The survey did not include any questions about gender dysphoria, which is typically the justification for medical intervention. And the survey explicitly stated its goals to highlight the injustices suffered by transgender people during the recruitment stage and in the introduction of the survey instrument itself. This could have encouraged respondents to overreport bad experiences. When you look at correlation versus causation, Turban acknowledges that survey design did not allow for determination of causation. This means that the studies can only show associations, but they can't provide actual proof for any of the claims. Nonetheless, all four studies treat the results as a valid basis for major policy recommendations. I have listed in your handout 12 systematic reviews that examine outcomes from puberty blockers and/or cross-sex hormones for individuals up to age 26. Note that the systematic reviews have varying levels of methodological quality. The highest quality ones, which are the Miroshnychenko SRs, also find very low quality of evidence for benefit. Note also that the Endocrine Society, in a guideline developed by WPATH clinicians, acknowledged in 2017 the very low quality of evidence from mental health benefits. Its recommendations are based on a values and preferences statement that explicitly ranks achieving desired cosmetic outcomes above avoiding harm. And I won't read through all of the studies, I'll let you do that. The group the Women's Liberation Front has done some research and what they-- their statement is as follows: Women and girls, especially those who are same-sex attracted, often take on a gender identity in the mistaken belief that they will be treated better if they were not female or that their same-sex attraction would be more socially appropriate if they transition to men and boys. As a result, the surge of youth going to gender clinics and seeking to change their sex are predominantly female, which makes this issue especially relevant to the welfare of girls and women. Between 2017 to 2021, 18,000 minors in the U.S. were taking puberty blockers and hormones, and the numbers have been increasing ever since. In 2017, only 2% of teenagers identified as transgender, but that percentage has grown to 3.3% with 724,000 youth now identifying as transgender. All this despite rigorous systematic reviews in the UK, Germany, and now the United States that reveal the evidence to support these treatments are incredibly poor. Even before such reviews were conducted, a cautionary approach should have been implemented from the very beginning. The list of health effects-- health risks to women and girls from taking supraphysiologic doses of testosterone alone include, but are not limited to, heart attack, adverse lipid profile, erythrocytosis, which is a dangerously high red blood cell count, blood clots, high blood

pressure, subclinical atherosclerosis, which is hardening of the arteries, ovarian damage, uterine and endometrial pathology, infertility, endometrial breast and liver cancers, vaginal atrophy, prostatic metaplasia, pelvic pain and pelvic floor dysfunction, neurological disorders such as idiopathic intracranial hypertension, which is characterized by high pressure around the brain, which can result in headaches and vision loss, psychiatric and behavioral disorders, vaginal cuff dehiscence, and increased mortality. If a woman or girl has her ovaries removed as part of gender-affirming care, she may suffer loss of bone density. Many have denied that there is even such a thing as detransitioning, or else claim that those who come to regret gender transition are incredibly rare, but the truth is that transition regret is under researched and poorly understood. However, 2023 meta-analysts reviewed the available research and found rates of discontinuation of care, medical treatment, regret, and detransition were up to almost 30 percent, and many patients do not inform their clinicians if they regret transition. The situation that has been created will undoubtedly come with a high cost to patients who are searching for something that is not based on either science or evidence, that one may change sex, or that attempting to live as such will resolve distress associated with wanting to be the opposite sex. LB732 protects minors from irreversible experimental medical interventions that carry significant unresolved risks and lack high-quality, long-term evidence of benefit. Children and adolescents are developmentally incapable of providing informed consent to procedures that permanently alter sexual function, fertility, and healthy bodily development. Medical interventions promoted as transition care, including puberty blockers, cross-sex hormones, and surgical procedures, are not neutral or reversible. Puberty blockers disrupt normal bone development, neurological maturation, and sexual function. Cross-sex hormones cause permanent changes, such as infertility, sexual dysfunction, and altered cardiovascular risk. Surgeries permanently remove healthy, necessary organs. Claims that these interventions are well established or lifesaving are not supported by robust evidence. Multiple systematic reviews have found the quality of evidence for these pediatric interventions to be low or very low. Countries including the UK, Sweden, and Finland have moved away from routine medicalization of minors in favor of psychological support and watchful waiting. LB732 does not deny care to children experiencing distress. It prioritizes noninvasive therapeutic approaches that allow time for development, reflection, and exploration without permanent bodily harm. Research consistently shows that the majority of children with gender-related distress do not

persist into adolescence or adulthood when allowed to progress through natural puberty. The Center for Bioethics and Culture has documented the real-life consequences of these interventions. Protecting children from irreversible experimental medical procedures is a fundamental duty of lawmakers. LB732 establishes a clear legal boundary that prioritizes child welfare over ideology, commercial pressures, or unproven medical trends. It ensures that minors receive care that is ethical, evidence-based, and truly focused on their long-term well-being. I was contacted 2 days ago by the Nebraska Board of Health, and for those of you who don't know, our Nebraska Board of Health is a 17-member board appointed by the Governor with the consent of a majority of the members of the Legislature. Those members include two individuals licensed to practice medicine and surgery, one dentist, one optometrist, one veterinarian, one pharmacist, two nurses, one osteopath or osteopathic surgeon, one podiatrist, one chiropractor, one physical therapist, one professional engineer, one hospital administrator, one credentialed mental health professional, and two laypersons interested in the health of the people of the state of Nebraska. I received this letter in support from the Board of Health of the Nebraska Legislature for LB732. Dear members of the Nebraska Legislature, on behalf of the Board of Health, we write to express our support for LB732, legislation that builds upon Nebraska's original Let Them Grow Act and reinforces a cautious, evidence-based approach to medical interventions for minors. Our position is grounded in our statutory responsibility to protect public health, particularly when interventions involve vulnerable populations and carry the potential for irreversible harm. In 2023, this board submitted a letter of support for the original act after careful review of the available medical evidence and ethical considerations. At the time, our conclusion was driven by uncertainty in the evidence base and concern about the long-term implications of medical gender transition interventions in children and adolescents. Since then, the critical question has been whether subsequent research has strengthened the case for these treatments. Based on our review, including the recent comprehensive federal analysis conducted by the U.S. Department of Health and Human Services, the evidence has not become more robust. Rather, it is now clear that earlier confidence in these interventions was overstated. The federal DHHS review evaluated studies examining puberty blockers, cross-sex hormones, and related interventions in pediatric populations. Its findings highlight the persistent and significant limitations across the literature, including low or very low quality of evidence for claimed mental health benefits, short duration of follow-up, high rates of loss to follow-up, and an

inability to adequately control for confounding factors, such as concurrent psychotherapy and natural developmental changes. These limitations substantially restrict our ability to draw reliable conclusions about long-term benefit. At the same time, the review identified a range of known and plausible risks associated with these interventions, including effects on fertility, sexual function, bone density development, and cardiometabolic health, as well as the likelihood that early medicalization leads to lifelong dependence on medical treatment. When such risks are coupled with unresolved uncertainty regarding benefit, particularly in minors who lack full decisional capacity, the public health imperative is one of caution. The legislation before you reflects that principle. It does not prohibit compassionate care, mental health support, or thorough clinical evaluation for children and adolescents experiencing distress. Instead, it establishes reasonable guardrails around irreversible medical interventions in the absence of high-quality evidence demonstrating clear and durable benefit. This approach aligns with long-standing public health ethics. When evidence is weak and potential harms are serious, restraint is warranted. By advancing this legislation, the Legislature affirms that policy affecting minors should be guided by rigorous evidence, humility in the face of scientific uncertainty, and a commitment to protecting children from unavoidable iatrogenic harm. Our board's support today is consistent with the position we took in 2023 and reflects an ongoing assessment of the evolving scientific record. We appreciate your thoughtful consideration of this issue and respectfully urge you to continue prioritizing evidence-based, child-centered public health policy for the people of Nebraska. Respectfully, the Nebraska Board of Health. And on that note, I would ask that you vote yes on LB732.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. My question, my lead question is, did you introduce LB732 as a successor to LB574 because you didn't feel that that was enough coverage?

KAUTH: The Skrmetti decision this summer really influenced my decision, because, yes, I, I did not feel it was enough coverage. We were able to put restrictions in, but not the full ban. The Skrmetti decision upheld other states' ability to do the full ban, and when the opposition was testifying before the Supreme Court, they admitted to the Supreme Court the low quality of evidence and the fact that there is nothing saying that these treatments actually work, that's what brought me to this.

RIEPE: Did we have any information data out of LB574 because it was-- was it 2 years ago time [INAUDIBLE]?

KAUTH: 2 years. What year-- '23. No, not specifically, so. The, the HIPAA stuff gets in the way of, of asking these questions.

RIEPE: OK. OK, thank you, Chairman.

HARDIN: Other questions? Do you know how puberty blockers are currently being prescribed within the telehealth space?

KAUTH: Within the telehealth, I believe that they're allowed to do it. And I know Planned Parenthood does the puberty blockers. They're supposed to follow the procedures in Nebraska. I don't know if we have restrictions to guard against it from doctors outside of the state prescribing it over state lines.

HARDIN: OK.

KAUTH: That's a very good question. And I'm hearing behind me that someone can answer that, so.

HARDIN: OK. Do you have a sense what a practitioner who would violate this new law would be facing in the way of disciplinary processes?

KAUTH: I would assume it would go before the state medical licensing board.

HARDIN: OK, very good. Other questions? If not, I'll keep going. Do you have a sense in terms of what new rules, regs would need to support this or come along as well?

KAUTH: I think the rules and regs would just be a full ban on the puberty blockers and cross-sex hormones up to age 19.

HARDIN: OK. Very good. Any other questions? Senator Riepe.

RIEPE: Thank you. I have a follow-up question please. In your Section 6, it talks about the Attorney General may bring action within 20 years. Is that kind of a national standard? That's a fairly long period of time.

KAUTH: It is. It is. And part of that reflects the fact that these are children and it's happening very young so they may not experience, they may not understand what has happened for quite a, a long time.

RIEPE: I'm just-- I'm concerned, I know in cold case murder trials they go back 10 years to make sure that people will tell the same story. 20 years is a long time out for anyone to remember particularly when it's maybe a traumatic situation that they've been able to live with and like all of us probably press some of our more troubling issues that we've had in life if we've had some. Anyway, I was just curious whether 20--

KAUTH: I'm, I'm happy to discuss that with you, and if, if that needs to be tweaked, we absolutely can look at that.

RIEPE: I was just, I was just curious [INAUDIBLE]. Thank you, Chairman.

HARDIN: It's about 2:08, so we're going to go till about 3:08 with our proponents. I'm assuming you will stick around until we're done at 1:30 this morning.

KAUTH: I will, however, I will be also presenting LB731 in Judiciary, so I will be stepping out to open in there. I'll be going back and forth.

HARDIN: Very well, thank you.

KAUTH: Thank you.

HARDIN: Appreciate that. We're on the proponent side of life on my list. Nate Grasz, you signed up first. Welcome.

NATE GRASZ: Thank you. Good afternoon, Chairman Hardin and members of the committee. My name is Nate Grasz, N-a-t-e G-r-a-s-z. I'm the Executive Director of Nebraska Family Alliance and I'm testifying on behalf of the thousands of families we represent who share our desire to see every child cherished, protected, and given the opportunity to reach their full potential. Children cannot consent to lifelong consequences. We know this and it is reflected everywhere in law and in medicine. That's why children can't buy alcohol, sign contracts, or get a tattoo. And, yet, today we are being told that a child can consent to medical interventions that may permanently alter their body, their fertility, and their future. This bill does not deny care. It denies the lie that children are born in the wrong body and must be medically altered to be whole. Sex is a biological reality written into every cell of the human body. Hormones can alter appearance, but they cannot change biological sex. And attempting to do so in children carries serious, often irreversible, consequences. Puberty blockers

and cross-sex hormones are not neutral. They interrupt normal physical development and can impair bone growth, cause infertility and sexual dysfunction, and create lifelong dependence on hormones because the organs responsible for natural hormone production were never allowed to fully develop. And the research is clear, the overwhelming majority of children who experience gender-related distress will resolve that distress naturally if they are given time and not medically intervened on. What does not resolve with time is infertility, impaired development, or lifelong medical dependence. These are not hypothetical concerns, they are documented outcomes. Countries that have conducted systematic reviews of the evidence have imposed severe restrictions on gender-altering drugs for minors, including Sweden, Finland, and the United Kingdom. Our laws should follow biology, not ideology, and they should follow the first principle of medicine: do no harm. If a child cannot consent to a tattoo, they cannot consent to infertility. We urge the committee to advance LB732 so that Nebraska's children receive help and not harm while preserving every child's future choices. Thank you.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you. Thank you for being here. I think I heard, correct me if I'm wrong, you said that it can be dependent-- dependence on hormones?

NATE GRASZ: Correct.

RIEPE: Is that will they or they might? I'm, I'm not-- I'm not-- don't know enough about various hormones that they might have an addictive nature or a dependency nature.

NATE GRASZ: Yeah, that's a good question. Thank you for the question, Senator. There'll be some people behind me, I think, who can testify very specifically to, to that. But one of the issues is oftentimes when you're putting someone at a young age on puberty-blocking drugs and cross-sex hormones, those can be very powerful drugs that interrupt a, a natural process of, of human development that has a, a ripple effect of, of consequences. When you're stopping, again, at the natural development, something the body is doing naturally through artificial means, in order then to continue on that path, it, it keeps them on those drugs for an extended period of time, especially if they're continuing to try to alter their, their sex or identify as the opposite sex. It creates a dependence on those drug and hormones in order to continue to try to do so.

RIEPE: One of my concerns gets to be is, you know, we haven't lived long enough with some of the transition, you know, issues and how that, how that will play out in 20 years or 30 or whatever.

NATE GRASZ: Yeah.

RIEPE: Either way, I don't know.

NATE GRASZ: Yeah, that's a good question.

RIEPE: And I don't think medicine knows just yet.

NATE GRASZ: Yeah, I think we do know that, that there's no child born in the wrong body. And I think when you look again at, at some of the countries who are actually some of the earliest adopters of gender-affirming care and, and prescribing puberty blockers and cross-sex hormones to children, including some very progressive Western European countries, they have done an about-face on this issue and completely stopped recommending that, that type of treatment or path for children due to the harms that they're seeing after years of, of following and documenting those cases.

RIEPE: OK. Thank you for being here.

NATE GRASZ: Thank you.

RIEPE: Thank you, Chairman.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chairman Hardin. Part of your testimony indicates the essential age of consent. What would be the age of consent in the state of Nebraska considering as an adult to be able to make those determinations?

NATE GRASZ: Yeah, thank you for the question, Senator. So the bill is, is very specific, that what would be limited or, or prohibited is prescribing or providing puberty blockers or cross-sex hormones to minors, so those under 19, intentionally to try to alter their gender. That's what would be prohibited under the bill, so it would be those under 19.

G. MEYER: Are you comfortable with that number personally?

NATE GRASZ: We think-- so I, I think that this bill is, is doing a lot of important things because it's protecting children, again who, who are young, who, who are vulnerable. I think that's where the focus needs to start. I think potentially there are conversations worth, worth having on whether that type of medical treatment is advisable for anyone, but certainly when you're talking about children who are vulnerable and don't have necessarily the, the life experience or the maturity to make the types of, of decisions, it's important that we have those protections in place.

G. MEYER: Thank you.

NATE GRASZ: Thank you.

HARDIN: Other questions? Thanks for being here.

NATE GRASZ: All right. Thank you.

HARDIN: Next, we have Marion Miner. Welcome.

MARION MINER: Thank you, and good afternoon Chairman Hardin and members of the Health and Human Services Committee. My name is Marion Miner, M-a-r-i-o-n M-i-n-e-r. I'm here on behalf of the Nebraska Catholic Conference, which advocates for the public policy interests of the Catholic Church and advances the gospel of life through engaging, educating, and empowering public officials, Catholic laity, and the general public. I'm here to express the Conference's support for LB732. It is important to repeat at the outset that the Catholic faith recognizes the supreme dignity of every person as made in the image and likeness of God. The only appropriate response to this reality is charity, which is to say, love. For this reason, the Catholic faith also recognizes that everyone, including those experiencing interior conflict about gender identity, those seeking gender transition, and those who have desisted and are seeking healing must be treated with respect and dignity. When the Let Them Grow Act passed in 2023, it included something of a grandfather clause that allowed people working in medical gender industries to continue providing nonmedically necessary puberty blockers and cross-sex hormones to minors who had already begun these interventions. LB732 phases out this practice requiring that anyone still providing these drugs for nonmedically necessary purposes to people who are still minors must cease doing so in 2027. Most who are taking these drugs by 2023 will have aged out and will no longer be minors by 2027, but a few will still be younger than 19. Ending or at least pausing a

profitable industry's exploitation of these remaining vulnerable people before they become adults might seem like a small achievement, but it would nevertheless, in our view, be an important one. Others have touched on this, I will do it too, because I think it bears repeating and it's important. The injuries that can result from so-called transitioning are devastating. Loss of sexual function and fertility are perhaps the most well-known. But these are not the only injuries that result from these interventions. Medicalized transition evolves at a minimum the prescription of hormones that must be taken continuously for life if the person receiving them wishes to persevere in maintaining a surface-level appearance of the opposite sex. Every level down to the last cell a person is naturally coded male or female and no amount of drugs or hormones can decode that built-in biology. The body constantly tries to heal itself and the hormones battle back against the body. A person eventually realizes that this battle cannot be won, and the psychological devastation that often takes place can be staggering, and so can the financial costs, both already incurred. Again, this is a very, very profitable industry. And for those that might be necessary to try and do your best to try and bring the body back to healing, back to as normal as possible. And it is our position that performance of medicalized so-called gender transition, whether by drugs, hormones, or surgery is always and everywhere malpractice, an intentional wounding of the body that must be repeated ad infinitum over a lifetime to preserve appearances. Just to wrap up, children, young-- and young men and women subjected to these interventions at the hands of an industry that profits lavishly from them ought to have a chance to heal which ought to begin as soon as possible. We'll close there.

HARDIN: Thank you, Mr. Miner. Questions? When we say an industry that profits lavishly, do you have a sense in terms of the lavish profits?

MARION MINER: I don't, perhaps others do. The reason I say that is because this is, this is sort of like a never-ending income stream, right, if, if you are a person who wants to present yourself as the opposite sex to the extent that you're willing to take drugs and hormones, perhaps solicit surgeries to persevere in maintaining that appearance. Because the body recognizes these interventions as wounds, it is constantly trying to heal from them and so to persist in presenting this appearance you have to continuously re-wound yourself and that continual need for intervention means continual-- a continual source of income for those inflicting the intervention. So that's what I'm talking about. If, if you do a number of these, this becomes a

very lucrative, permanent source of income, which is why there's such an incentive for people to provide it.

HARDIN: Seeing no other questions, thank you.

MARION MINER: Thank you.

HARDIN: We're in the proponent list and Kathy Wilmot is next. Welcome.

KATHY WILMOT: Thank you very much, and I appreciate this opportunity to come before you today. And I would like to just mention some of the things that, that are of a concern to me. I think it's very important that we prohibit the use of the cross-sex hormones and, and the blockers on the individuals younger than 19. It's common sense.

HARDIN: Ms. Wilmot, would you be, be so kind as to spell your name?

KATHY WILMOT: I did the same thing yesterday. I don't want you guys to know who I am. Sorry about that. Kathy Wilmot, K-a-t-h-y W-i-l-m-o-t.

HARDIN: Thank you.

KATHY WILMOT: You'd think I'd be relaxed enough to remember those things, but I don't.

HARDIN: I forget it myself. I, I, I do.

KATHY WILMOT: Anyway, I believe that it's only common sense that we protect our youth. And we know from science that brain maturity is a gradual process, and typically it isn't even completed till you're in your mid-20s or late 20s, and we're talking about individuals that aren't quite there yet. And that's as they, they make judgments and things we-- and that's why you heard some of the prohibitions of signing contracts, etcetera, and that's why we do that. Yesterday and today we've heard a lot from individuals who have admitted, admitted that youth are often facing confusing situations maybe in their life. They may be depressed. There's stress in their life and that's causing them to think that things aren't right with them, that they're not fitting in and that they need to be the one that changes. And we also know that there are times that they are fearful of their, their time to reach puberty. They're not sure they're living up to their other classmates and things that they see and this is what sometimes causes them to think that they need to seek some kind of counseling and often at that counseling they're misled and that's what's going on with them. It's common for all of this to happen, I don't know if you

remember back to when you were a teenager, I'm, I'm getting up there over age, but I can still remember that. It wasn't comfortable. I was a country girl. We didn't come to town a lot. And that was another thing that I felt seemed like the town girls were way advanced for me. I didn't quite fit in. But thank goodness this is not something that I faced as, as a question in my own mind. But kids do that, they think of those things, they're worried about fitting in with their peers. And so these are some of the common causes. They clearly exhibit the need for this bill, and I would ask you, you know, our youth as a whole would benefit from allowing this bill to pass, giving them time to grow up, to make some decision on their own. And so I would just ask you if you would take the time to protect our kids. I think it's very clear that the research now is showing there's many questions, things that, you know, people thought maybe were great has turned out not to be so.

HARDIN: Thank you.

KATHY WILMOT: Thank you.

HARDIN: Questions? Seeing none, we appreciate it, thank you.

KATHY WILMOT: Thank you.

HARDIN: Wes Wilmot. On deck is Merlin Wehling. We're creating a at the plate, at on deck. You see how that's working?

WES WILMOT: OK.

HARDIN: OK. Very good.

WES WILMOT: Hi, my name is Wes Wilmot, W-e-s W-i-l-m-o-t. I'm from Beaver City, Nebraska, and I am here to speak in support of LB732, if I can get on the right page in here. And by the way, thank you, Senators, for all this work you do. It's not fun a lot of days. I guess we've heard a lot of facts and the lack of facts concerning this, this issue, and my story's a little more personal, my testimony today. I was privileged to meet and hear the story of a young woman who at the age of 13 began to question her sexuality. She was a tomboy and she looked on the Internet and looked around and found that, wow, this is really a real thing and I need to do something. She discussed it with her parents and they were naturally alarmed, so they decided to seek the help of a therapist. And in session, she states that they were not allowed to be in session together. She was in session by herself and her parents were in session by themselves. They were never

in session together, which seems like an issue to me. And as things progressed, unbeknownst to her, her parents were asked, not in her presence, if they preferred to have a dead daughter or a live son, because she was going to commit suicide if she didn't transition. And she was diagnosed, treatment started. They never discussed the possibilities of side effects or the dangers involved with the drugs or the surgeries. And as a 13-year-old, without information from her adult-- her parents who were fed misinformation, her life was subjected to-- she was subjected to puberty blockers, cross-sex hormones, and finally surgery to remove perfectly healthy body parts. This was all before she was 16. And I think the diagnosis and the recommended treatment, neither one settles medical practice. I think we've heard enough about that here today that it's all questionable. And just the fact that the adults involved were lied to and not allowed to be involved in the process says quite a bit. Involving a minor in itself is malpractice, I think, and not to mention that the 13-year-old became an uninformed participant in a barbaric experiment. And I think that's what this has been, leaving her physically and emotionally scarred for life. This practice needs to be stopped, and serious consequences need to be in place for anyone who continues these practices. Thank you.

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

WES WILMOT: Mm-hmm.

HARDIN: Merlin Wehling. On deck, Jamie Reed. Welcome.

MERLIN WEHLING: Yes, thanks, committee, for allowing me to be here. Thanks for your work. I know it's kind of long on days like today, but. My name is Merlin Wehling, M-e-r-l-i-n W-e-h-l-i-n-g. I am a physician from Kearney, Nebraska. As a lifelong Nebraskan, this gives me great pause to see the children that are being abused, the children that are being subject to these hormones and, and, quite frankly, there's a lot of misinformation that's out there that is basically been hijacked by the activists that, you know, they misrepresent the data to support their opinions and the Nebraska Legislature did do the right thing back in '23, but there's still the loophole where quite a few kids are still being harmed by these gender-blocking drugs and hormones. I feel for the parents that are out there, like the testimony we just heard, who their child has multiple psychiatric problems, whether that be anxiety, depression, gender dysphoria, etcetera. And then sometimes these parents or the children, they latch onto this idea that it's all related to their sex, and it would all go

away if they just changed their sex. And then they find some health care person who says, hey, we can, we can fix that for you. We'll just give you some of these drugs and it'll all be great. But suicide is a terrible thing, it is very misrepresented and represented in this literature and this data. Frankly, we just don't have enough long-term studies to say whether this is a mitigating factor for suicide or not. Since this bill in '23 where the Nebraska State Legislature passed the Let Them Grow, there's been quite a bit of research and analysis. You've heard quite a bit of that. I'm not going to go through that again. You know, we've looked already at the Cass study in Europe, the HHS study that has already been talked about. But what I'd really like to focus on is what I see. I see patients in the ICU with blood clots. I see patients with chronic pain. I see patients with urinary sepsis, patients with ureteral stenosis. All of the problems and issues that we normally have are multiplied because the body is not designed to transition, especially at this early age. So when you look at these studies, you look at these tests, no other field of medicine would plow into this area without any real clear benefit, but, yet, that's what we're asked to do as physicians. We see the suffering from anorexia, but we don't do liposuction. We see mania in schizophrenia, but, yet, we try to help that mitigate the, the psychosis. It would be unimaginable for a physician to do a hysterectomy on a 12-year-old because they don't have-- they don't like having periods. But, yet, that's what we're being asked to do as physicians. So I would ask and urge you to put your support behind this bill and protect our kids. So questions?

HARDIN: Thank you. Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Doctor, I appreciate you coming in today and sharing, sharing your, your insight. So you're primarily dealing with some of the medical issues of, of young people, intensive care, serious enough to be in intensive care. Are you familiar, you know, with the, like, psychology and the, the medical expertise of the people that are making these recommendations for, for the hormone therapy and the surgical interventions? Do you have any background in that or anything to share along those lines?

MERLIN WEHLING: You know, that's not primarily what I deal with in my practice, but, you know, in looking back through the history of medicine we don't always get it right. You know, you don't have to look too far back and see that. You know, the American Psychiatric Association has said you know that this is not necessary, most kids will figure this out within a couple of years. If you go back a little

farther, you see what we used to do, which is terribly atrocious, which is frontal lobotomies. We thought that was the cure for everything that was psychiatric in nature. And, obviously, the American Psychiatric Association has reversed their opinion on that. So some of these, like the American Academy of Pediatrics, they're being influenced with bad data to make these recommendations, essentially.

G. MEYER: If I may, just, just one more--

HARDIN: Sure.

G. MEYER: --brief question. Are you seeing more or less, or are we fairly static with regard to the recommendations for questioning youth to begin transition procedures? Is this, is this static? Has this run its course? Are we seeing just a consistent recommendation or are you seeing a, a substantial increase in, in the recommendations for young people that are questioning to go through these procedures and take these hormones?

MERLIN WEHLING: Yeah, good question. You know, when these first kind of came out, these recommendations, most of the physicians, I believe, took pause and they're like, whoa, you know, are we sure we want to do this? Is this something that we should be diving into? But a lot of people did get on board with this. A lot of people thought this was helpful. And then these kind of long-term data came out, the HHS study, all 400-and-some pages of it, basically, was, was very questioning whether these were even beneficial at, at, at any, at any stage, let alone in the pediatric stage. You know, the Cass study is the same way. And so what I have seen is the tide is turning to more questioning and more reluctance to actually do these blockers and drugs.

G. MEYER: Thank you.

HARDIN: Senator Quick.

QUICK: Yeah, thank you, Chairman. So I have a, a granddaughter, she's, she's 8 now, but at 6 years old she started going through puberty. And the doctor recommended a puberty blocker because if she didn't get on that, it could stunt her growth. It would-- she-- her bones wouldn't grow anymore. And so are you saying that that's harmful or not or that's--

MERLIN WEHLING: No, these drugs-- just to know, these drugs are not new. These have been around for 30, 40 years. You know, they're to treat, you know, prostate cancer, uterine, and cervical cancer. I mean, they are just being used in a different form right now. This bill would not block that. This bill will not prohibit correct usage, so to speak, or, or nonsexual transition usage of these drugs.

QUICK: OK. All right, thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. Did-- have you-- are you a psychiatrist [INAUDIBLE]?

MERLIN WEHLING: No, I'm an anesthesiologist and intensivist.

RIEPE: OK, so this particular topic is an, an avocation for you?

MERLIN WEHLING: What do you mean by that?

RIEPE: I mean, it's a hobby or something, or a special interest or--

MERLIN WEHLING: No, I'm just here because I see these patients in the OR. They have problems. And I had a particular patient about a year and a half ago, and, you know, as an anesthesiologist, we see everybody before surgery. And, you know, why are you here and how this happened and how long has this problem been going on? And this particular patient was transitioned in her youth. I can't remember exactly he, she when. But this was mid to late 20s, maybe, deeply regretted it, deeply regretted it because there was chronic pain, there was problems, there was sexual dis-- I mean, you name it. All the medical complications and side effects, they were definitely regretting.

RIEPE: My experience is that-- well, I do understand that anesthesiologists make visits with patients. It's not an extended visit or an in-depth history. The history is usually completed by the attending, so.

MERLIN WEHLING: Well, that's incorrect, sorry. We do a complete history and physical on every patient.

RIEPE: Maybe that's medicine in Kearney, it's not in Omaha, necessarily. But I was just-- you know, you said that there are-- or I

think said limited studies to mitigate the propensity for suicide. Is that what-- is that a correct statement that you said that?

MERLIN WEHLING: Yes.

RIEPE: OK.

MERLIN WEHLING: Yeah, the, the, the data is just not there. And in medicine, the gold standard would be a double blind placebo controlled clinical trial. Now, you know, obviously, you can't have a double blind trial with suicide risk, you know, you're going to unblind that very quickly. And the amount of people that you're selecting for, you know, the pediatric population who wants to transition, who has done the, the hormone blockers and then has this terrible, you know, suicide or whatever, that's a very, very small number. HIPAA would also prevent us from really collaborating, you know, widely with, with that study. And so it's very unlikely that that study would ever be done and, thus, any conclusions about whether or not these drugs increase or decrease long-term suicide risk, I think is, is, is not robust.

RIEPE: You know, I'd be, not today, but I'd be very interested. I think that-- I don't know-- I have grandchildren, but I'm not sure that sometimes the threat of suicide is the first response they have, they don't how else to express their anxiety--

MERLIN WEHLING: Correct.

RIEPE: --or something that would be very attentive getting, getting from their parents or whatever. So the difference to me between is varying degrees of how, how-- and one cannot overlook it, but a threat of suicide, I'd, I'd turn to one of my colleagues who knows a lot more about this on this committee, who knows a lot about how frequently does someone that threatens suicide actually commit suicide? I don't know.

MERLIN WEHLING: Yeah, I don't know either. I do know that, you know, the suicide patients or attempted suicide patients that I take care of in the ICU, they all regret it. It, it wasn't-- it was a cry for help. And suicide is terrible, it is absolutely devastating. You know, talking to some of these parents and things, this, this is a very bad disease, I don't want to decrease that, that conversation, but transgender hormone blockers is not a good treatment for suicide ideation.

RIEPE: OK, well, thank you for being here. Thanks for coming from Kearney.

MERLIN WEHLING: Yeah.

HARDIN: Other questions? Senator Hansen.

HANSEN: Thank you. I know one of the things we always try to control for in your double blind placebo controlled randomized trials is bias,--

MERLIN WEHLING: Right.

HANSEN: --bias of the people, you know, doing the study. In your professional opinion, do you think, like, a lot of-- I can only imagine, I'm assuming, but I just kind of want to get your opinion-- a lot of studies may be in favor of the use of these hormones for gender dysphoria? Do you think bias would be a appropriate factor in some of these studies? Like, like we-- how, how do we control for bias, I mean, like, in some of these studies that maybe they might view in, in favor of the use of some of these hormones in your opinion?

MERLIN WEHLING: Yeah, yeah, good question. And, you know, you read enough of these studies and you look at a lot of this, and like I said, I am not a psychiatrist, but I read studies all the time, and one of the biggest things is exactly what you were talking about. How do you actually get at the data and come to some conclusions that may be different than what is written in the summary statement? And so when you analyze the data, if you just look at the facts, you know, some of these studies they, they-- that they draw conclusions, specifically, around that suicide risk, is only in the first 3 months or the first 6 months. Well, I mean, that is bad. I mean, having a suicide in the first 3 months or 6 months starting on hormone blockers, but, you know, I'm more interested in, you know, the longevity of those because they're going to be on these for life. And then, you know-- and so maybe extend that study out a little farther. So the bias would be is I found my results, I found conclusion that I'm after, I'm stopping the study. If that makes sense.

HANSEN: Yes.

MERLIN WEHLING: So, yeah, I do agree that it's, it's hard to look at these-- look at this data with an unbiased opinion if, if, if you find what you're looking for and then you stop the study.

HANSEN: OK. And this might be some similar questions I might ask of those people in opposition to this bill because I'm curious, studies that they cite, how do they control for bias? I think that's kind of a big thing. Maybe when it comes to just this topic especially, as opposed to we're studying rheumatoid arthritis, you know, there's usually not a lot of, I think, maybe opinions or emotion involved with that, maybe when it comes to children and, and how people kind of view this.

MERLIN WEHLING: Yeah, and, and psychiatric disease is also very difficult to study. You know, when, when you're studying, let's just say glucose control, either the blood sugar is high or it's low. You know, it's, it's not ambiguous, but how do you ask a transgender person how serious they are when they want to take these hormone drugs? Are they really serious, or are they not so serious, and how serious are they with the suicide risk? Are they just seeking attention, or are they not? And so it is very hard with psychiatric studies to get the, the conclusion without bias.

HANSEN: And you, you brought this-- if I can keep asking?

HARDIN: Sure.

HANSEN: Just because I, I, I appreciate your opinion. The correlation of suicidality to, like, the lack of some of this medical treatment and the hormone treatment to those who view themselves in different gender, children especially, are there a lot of studies? I think you kind of touched on that a little bit, it seems like there's a lack of evidence when it comes to-- because that's, that's one of the biggest things we typically hear is, like, if we don't do this, my child is going to commit suicide. So that's how we are harming the children, right? I've tried to find it on my own, like, like studies or maybe some kind of specific hard data about suicidality and the, and the lack of treatment for children especially, and I personally couldn't find a whole lot. And if there was, maybe some of them were a little bit skewed or kind of maybe, again, a little bit of bias--

MERLIN WEHLING: Correct.

HANSEN: --of where they're coming from, maybe one side and both the other. I just couldn't find anything, maybe, more, like, from a nonbias perspective about, about that topic. I don't know if you have any or--

MERLIN WEHLING: And, and, and, and you're asking the right question because it's not there. That's what it is told to me as a physician, you need to prescribe these drugs because it'll mitigate the suicide risk. So I go look for these studies to see how much mitigation is going to happen because I know the downstream effects of this and the data is terrible. It's just not robust. And like we, like we were talking about before, the, the, the inherent bias of that is really tough to get away from. And so I guess my testimony is, is that, you know, without robust data, why are we accepting this risk? Why are we taking on all of these known complications for a potential not well-studied benefit?

HANSEN: Can I ask one more? This might come down to more, like, from your perspective being a medical professional, parental rights or parental autonomy.

MERLIN WEHLING: Yeah.

HANSEN: Would this affect that at all? Like-- or does this affect that if this is not, not past or currently maybe what's happening? Like, the ability for a child to say I am this way, and the parent says, no, you're not going to do this. Like, how does that affect parental autonomy?

MERLIN WEHLING: Yeah, that's a great question because, you know, you, you look at this and you say, well, in this-- in the, the medical community we have said that children as minors do not have the mental capacity to sign the consent forms for things like surgeries and procedures. So, therefore, the parents must be that surrogate for them or the guardian, whoever that is. At the age of 19, then they can sign their own consent, right? That's a big deal for me going into surgery. And so if you, if you say, well, OK, these parents are now in charge of making this decision, most parents I know are dealing with a, a very difficult situation with children. They got depression, they got anxiety, and then all of a sudden we put on there this gender-- gender-identity dysphoria and they're looking for any answers. They may be swayed without knowing all of the information. The kids will not know, the kids will not understand what they're getting into. And so when we say that, OK, this is the parent's responsibility to make this choice, me as a physician, I'm having struggles looking through the data and making a good, you know, judgment. How can I say that parents can do that? So, yeah, as a kid, how can you make that determination at 10 or 12 to saying I'm OK with the blood clots, I'm OK with the myocarditis, I'm OK with the, you know, urinary

infections, I'm OK with, you know, all of the scar tissues and the pains and all of that stuff when I'm 40 and 50 years old. You can't.

HANSEN: OK. Thank you.

HARDIN: I have another question for you before you run away.

MERLIN WEHLING: Oh, sorry.

HARDIN: I try to let them ask questions--

MERLIN WEHLING: Yeah, sorry.

HARDIN: --and then I come in and occupy some of that time, too. What's the best possible outcome, if 18, for example, physiologically gets on, what's, in your opinion as a doctor, what's the best possible physiological outcome from getting on puberty blockers? What's the human body do, best possible outcome?

MERLIN WEHLING: I, I guess I don't understand the question.

HARDIN: Well, I'm, I'm just saying if we were to get on these hormones,--

MERLIN WEHLING: Yeah.

HARDIN: --what's best possible outcome in your opinion as a doctor?

MERLIN WEHLING: Oh, what is the desired effect? Yeah, the desired effect would be, you know, that person who is basically transitioned in their youth and then the puberty blockers or hormone blockers will basically make that person look like they were before puberty. Well, nobody's going to stop there. They're either going to, going to be male or they're going to want to be female. So then that says, OK, now we're signing ourselves up for a lifetime of testosterone or estrogen. And the best possible outcome is somebody that's OK with that and is perfectly happy with that and their body image is something that they want. However, the number of people that are OK with that is very small, usually there's surgery involved, you know, top surgery or bottom surgery or, or reconstructive surgery of, of, of all of that. When you are on lifelong testosterone, when you're on lifelong estrogen, you still have, you know, all of those risks of chronic urinary infections, the blood clots, and all of that. So the best possible outcome, I guess, I've never seen that, because the patients that I see are not just OK with puberty blockers and, you know, the,

the, the hormone therapy. There, there's always something involved with a procedure, which it really makes me pause to do surgeries and procedures on normal healthy organs.

HARDIN: You're saying this is a step, and you're saying that it doesn't stop with this step. How is this different than a gateway drug in the illicit drug world? Because in the illicit drug world, we'll say, for example, marijuana is a gateway drug, and eventually it doesn't become enough, there's another thing beyond that thing. And I'm asking that question, what's beyond this thing?

MERLIN WEHLING: Yeah, what's beyond this thing is a lifetime of paying for testosterone, paying for estrogen, being OK with having to take drugs and medicines to prevent the blood clot and, you know, knowing very well that your sexual dysfunction is lifelong, that you will be sterile and you'll never have a family. You know, I-- like I said, I've seen some of these people who are down the road a ways a few years and it's not universal that they're happy with this decision.

HARDIN: Our legal counsel just shared with me the answer to a question I asked a little bit earlier and we'll see if it sounds right to you. And the question was, how much money do they--does the drug industry make from selling these drugs? And it's $2 billion a year. Does that sound about right?

MERLIN WEHLING: Yep.

HARDIN: I see.

MERLIN WEHLING: Yep.

HARDIN: OK. Thank you.

MERLIN WEHLING: And so, so to answer a question about bias with studies, this is a well-known problem. I mean, if a, if a, if a company who makes the drug is going to get a study, they're going to get a positive outcome.

HARDIN: Senator Hansen has another question.

HANSEN: Yeah, I just thought of this and I want to ask you maybe while you're up here, it has to do with malpractice. So I know we have malpractice standards, maybe, for medications that are prescribed to, to children. How, how does this fit in? Like, have there been any

malpractice suits that you know of that have been brought? I'm trying to think if I'm a prescribing physician--

MERLIN WEHLING: Right.

HANSEN: --giving somebody this. Since you're saying that there's not a lot of long-term, maybe, studies that show outcomes because I know a lot of times when we talk about reviews of cancer studies like to really show that a cancer has been resolved or, you know, they usually go at least out 5 years, right? And so I always thought 5 years was the minimum when we look at, like, any kind of typical study when it comes to medications or long-term study and you're saying there hasn't been any like that. So how does that fit with malpractice? So say, like, 5 or 6 years down the road you're starting to find a lot of harmful side effects that maybe weren't described or we didn't know about because there's not been a whole lot of studies, how does that fit in with malpractice for physicians?

MERLIN WEHLING: Yeah. Yeah. And so from a physician's standpoint, I would be, I would be really-- I'd, I'd take a step back and I look at what am I doing that's going to cause me risk, not today or tomorrow or the next day, but, you know, you start down this path, you're the one who wrote it in the chart, gender identity, gender identity dysmorphia, that all of a sudden now we're having this downstream effects. And somehow you're the one that initiated that. So from a malpractice standpoint, that would give me pause, absolutely.

HANSEN: OK. All right. Thanks.

MERLIN WEHLING: Yeah.

HARDIN: Senator Meyer.

G. MEYER: Just very briefly. Thank you, Chairman. And I, I don't-- piggyback a little bit on what Senator Hansen was saying. I'm a simple man, I have simple ears. Is ideation of suicide suggested to the child, in general, or is that part of the child's reveal in analysis? And I know that's not your area of expertise but, you know, the, the suggestion of a, a malady is not out of the question, so.

MERLIN WEHLING: Correct. Yeah. And suicide ideation like we have talked about before is a cry for help, it's not a cry for hormones or transgenderism. And, and I feel really bad for these parents, I really do, because I've consoled with these parents in the ICU and, and hugged them and cried with them when their adolescent or teenager has

an attempt. Now I think the question you're asking is, is that suggested or is that actually innate? And, you know, the answer is, is I don't know. It's probably both.

G. MEYER: Thank you. Appreciate it.

HARDIN: Seeing no other questions, thank you.

MERLIN WEHLING: All right. Thank you.

HARDIN: Jamie Reed. Erin Friday is on deck. Welcome.

JAMIE REED: Thank you. Good afternoon, members of the committee. My name is Jamie Reed, spelled J-a-m-i-e R-e-e-d. I am a Missouri resident, a lifelong midwesterner, a lesbian, and a clinical researcher who spent nearly 5 years working inside of a pediatric gender center at St. Louis Children's Hospital. I am the region's whistleblower. I treated nearly 1,500 pediatric patients within a pediatric gender center. I am here because Nebraska's policies do not exist in isolation. When a state adopts different medical standards for children, we know that interstate medical travel follows. My home state of Missouri has concluded, after my whistle blow, to ban completely the use of puberty blockers, cross-sex hormones, and surgery for minors. Lawmakers reached that conclusion, in part, after reviewing internal clinical data and outcome information that I provided from inside this medical system. Kansas then reached the same conclusion after examining similar evidence. South Dakota and Iowa has also since enacted comparable protections for children. When one state maintains a looser standard than its neighbor, it becomes the place for those to travel for harmful interventions that the home states have determined are not medically justified for minors. This is placing Nebraska now in the position of impacting the health care policies of the rest of the midwestern region. I also want to address why your earlier law included these so-called extreme case exceptions. At that time, policy was relying on two assumptions, that there was a distinct category of a true trans child, that this kind of child existed, for whom medical transition was necessary, and that withholding these interventions placed children at a uniquely high risk of suicide. Both of these assumptions have now since been undermined by long-term better data. Long-term follow-up has not confirmed a discrete diagnosticable category of child who benefits from a medical transition. And in the recent Supreme Court argument, the United States v. Skrmetti, even the ACLU acknowledged that claims of inevitable suicide risk are not supported by reliable evidence.

Other states had similar laws and loopholes like you have like West Virginia. I traveled to West Virginia and testified. They have now removed that loophole. There's another reason why this matters. Children are more likely to identify under this true trans model are those with long-standing gender nonconformity. Decades of developmental research shows that most of those children, if left alone, would grow up to be gay or lesbian. I now run an organization that exists to protect these children for what we consider a new kind of conversion practice, one that teaches children their bodies are wrong rather than allowing them to grow into healthy gay or lesbians adults. I would like to conclude by saying, Senator Hardin, I can answer your questions regarding puberty blockers and the questions regarding profit and the cascade effects. Senator Riepe, I can answer the cross-sex hormone question if it requires that hormones are medically necessary for the future and also the questions regarding suicide risk. Senator Quick, I can answer your question regarding puberty blockers when it's used in precocious puberty versus used in trans care. And, Senator Meyer, I also discuss suicidal ideations whether or not they're coming from the patient. Thank you.

HARDIN: I saw you earlier, you kind of looked like Horshack on Welcome Back, Kotter, because you were over there going, ooh, ooh, I think I know the answers to those.

JAMIE REED: I can answer all of these questions.

HARDIN: I welcome that. So, sure, start with mine, because I like my question the best, so.

JAMIE REED: Perfect. So your first question regarded the use of telehealth for a puberty blocker.

HARDIN: Yes.

JAMIE REED: That is an inappropriate use of telehealth because in order to determine if a puberty blocker is necessary, the first thing in this model of care is to determine what tanner stage the patient is in. There are 5 tanner stages. The model of care said you should start this at Tanner Stage 2. In order for a clinician to decide or determine if a child is in Tanner Stage 2, they actually have to do a physical exam. They have to examine the breast tissue development. And in boys, they have to determine the testicular size. They have to physically examine a child in order to properly determine if the puberty blocker is time if you're following the model of the care. In

addition, the way that puberty blockers are actually given are either an implant in the arm. So this is a same-day surgical procedure. So you can't do something like that through telehealth to actually implant the device or it's given as an injectable. That injectable is so expensive that it is not even worth the risk for most clinics to let that injectable go home with the patient. The single injectable is about $60,000 in Missouri terms. And we would not even give that, it could be given at home, but it costs so much for that single-use shot, we would not send it home with a patient. It's just too much cost wise.

HARDIN: You would be responsible for that.

JAMIE REED: Correct.

HARDIN: OK. And then, let's see, you had a list of others, and I'm willing for them to have their questions answered, too. So, anyway, you mentioned Senator Riepe, you had something for him?

JAMIE REED: Yes, you had asked the question of cross-sex hormones creates a requirement that that hormone is medically necessary in the future. There's only one instance in trans care where that becomes true. If somebody has their gonads removed surgically, so if we have a male go through what is referred to as bottom surgery and we remove surgically their gonads, in order for their long-term health they require some kind of sex hormone. Usually, if we're in a trans patient, it would be an estrogen derivative. There's no reason why they could not go back onto testosterone, but because we have physically removed their gonads, they cannot produce sex hormone anymore. That's the only instance where somebody medically needs to remain on any type of cross-sex hormones. Since there's no surgical procedures allowed in this state in minors, there's absolutely no medical reason why somebody once put on a cross-sex hormone has to remain on it. We can easily take them off. One slight example of this is we had patients who would travel to go on vacation, say they go to Florida, we had put them on testosterone at 13, now they're 16. They forgot their medicine at home. They would call thinking it's an emergency, oh, my gosh, I have to have my shot, the endocrinologist was like this doesn't matter at all. You can stop these drugs at any time with zero medical complication in stopping it. There should be no concern in the state about stopping a minor who had been put on these interventions. The only risk of concern is once you have post-surgical gonad removal. That's the only time there's a medical risk.

RIEPE: OK. Thank you.

HARDIN: I had also asked about what's the best possible outcome if physiologically that could happen if someone were to get on the hormones, what's, what's the best thing that we're hoping for that can happen anatomically for someone when they're saying I want to, you know, cross the hormone bridge? What's the best possible medical outcome?

JAMIE REED: A purely cosmetic result.

HARDIN: OK.

JAMIE REED: There's nothing else to it besides cosmetic.

HARDIN: Very well. Other questions? Senator Hansen.

HANSEN: I had a couple questions. I think maybe you even raised your hand on them.

JAMIE REED: Yes.

HANSEN: And I think you touched on one of them, but, first, I'll ask this question. You mentioned your background a little bit on kind of where you worked. Can you explain that just a little bit more?

JAMIE REED: Yes.

HANSEN: Kind of curious about that. You have a unique, unique testimony, I think, that maybe lends itself some credibility to what you're saying, so I'm kind of curious about that part.

JAMIE REED: Correct. St. Louis Children's Hospital opened a pediatric gender center in 2017. I started working there in 2018 as the social worker and the clinical research coordinator. My background, I have a Master of Science in clinical research management. I was hired in 2018 and I worked on the multidisciplinary team in that center and I assisted on that team in medically transitioning almost 1,500 unique patients. We medically transitioned 80% of the kids that we saw. St. Louis Children's Hospital opened that center in 2017. It was completely closed by 2023 because I blew the whistle, because I came out as a public whistleblower. I went to the Missouri Attorney General's Office with troves of data, troves of research, and I showed Missouri Senate and the Legislature that this intervention not only was based on shoddy research to begin with, but that we were

significantly harming our patients. And I became a whistleblower out of that industry, so that hospital center has now been completely closed. Missouri has stopped all of their pediatric gender centers.

HANSEN: OK, and I think that might get to the heart of, like, my question about bias. So, like, would you-- is it reasonable to say that when you first started there, you maybe had, I would say a bias maybe towards some of these treatments or like because of a lack of what you saw or lack of knowledge, you're like, this sounds good, these kids need help, how can we help them, that kind of stuff, but then over the course of time, you started to-- your bias kind of started to change or your-- maybe your, your level of thinking about this subject changed because of what you saw. That would probably be correct, wouldn't it?

JAMIE REED: Absolutely. So when I started working in the center, I would be what you would refer to as a true believer. I not only believed that such a thing as a trans child existed, but I believed that the earlier we could intervene, the better in the long-term outcome. This is kind of what we talk about in autism services or other services with kids. If we start an intervention early, perhaps we'll make it better for their life. It wasn't necessarily that my bias changed, I'm still from the community. I'm still a lesbian. I was married to a trans-identified adult at the time. What changed was the actual evidence in front of me. So what I started to see, first of all, is that these patients were not getting better, so their mental health was not improving, although that's what's promised in the intervention, that their mental health will get better. It wasn't happening. But also what we saw, which we've seen internationally, is there has been a complete, absolute social contagion element that just tore through this industry. When I started in 2018, we had four new patients per month, and they were almost all pre-pubital boys who acted very feminine. When I left, we had 60 new patients per month, and almost every single one of them was a trans-identified adolescent girl who had multiple mental health comorbidities, who had been sucked into trans as an identity, who had be sucked into it from social media, from their COVID lockdowns, from their school. This completely tore through this industry in an unprecedented way. The reason why we talk about this at all is because there was one of the largest social contagions to ever happen in adolescent girls rip through this country over this. It's starting to wane a little bit, but the fallout is, is that we still have states that have kids who are still sucked into this contagion who are being medically harmed. But what I also came to understand is that there is no true trans kid. The little boys, those

four little boys when I first started that I thought, oh, they must be trans, what I've come to realize is those were little boys who most likely would grow up to be gay if we simply left them alone or if we simple gave them supports or if we simply didn't let them get beat up in the bathroom and be bullied. They probably would just grow up to be gays or lesbians like I am.

HANSEN: OK. Yeah, going to ask you another question, if I can, because I'm trying with my level of questioning, not just with you but others, and these are topics I think we run into all the time here in the HHS Committee is the idea of who can prescribe what, what can they prescribe and how. OK. We talk about psychologists versus psychiatrists and who can prescribe and who can't. And so-- but I think that we've always kind of tried to maintain a level of objectivity when it comes to a lot of that stuff and that's what I'm trying to maintain. This is where some of the questions are coming from. It's not like the subjective opinions of others don't matter,--

JAMIE REED: Sure.

HANSEN: --but with the objective approach with this bill, it's like who can prescribe, who can't, and what. And so I think you've talked about systematic reviews, I think, in the kind of studies before. Can you explain that a little bit further, maybe, like, and why does that matter? Because, because when you leave here, and the, and the people in support of this bill are going to leave, and we're going to have the opposition come in, and we're going to have medical professionals come in here as well, and they're going to cite other kinds of studies.

JAMIE REED: Correct.

HANSEN: And this is maybe where I, I have-- maybe, I haven't read them, and so I don't know, like, their kind of quality of evidence. And I didn't know, you kind of mentioned, I don't know if you could touch on that a little bit and what that means especially for the people who come in here and testify in opposition to this?

JAMIE REED: Yes. So systematic reviews of evidence are at the very top of a triangle. So if you think about what kind of research studies are done, there will be thousands of research studies down here at this low level. That means that I could have a study with 10 patients or I could have study with 100. When you talk about what a systematic review of evidence is, is essentially it is a ranking system where it

takes every single paper that's ever been written on this topic. And then first thing it does is it ranks. Is this a quality study? Was it laid out correctly? Is there inherent bias in it? Was there a large enough sample size? Did it last long enough? Was it longitudinal or short? It reviews every single aspect of that and it ranks the studies. And it says of every single study that's ever been done about trans kids, these are the quality studies, these are poor studies, then it reviews the quality studies and it basically gives a ranking. When we say something has low to no quality evidence behind it, it basically means if you go back to the bare basics of what science evidence is, is I have a hypothesis, I want to test it. Did the study test the hypothesis and prove one way or the other the outcome of the hypothesis? 17 systematic reviews of evidence have been done globally. These are huge projects. Every single one of those 17 systematic reviews of evidence has come to the unequivocal conclusion that there is no quality evidence to support the medical transition of a child. Period. Those were reviews that the country of Finland did, that the country of Sweden did, that Norway did, that the UK did. We're not talking about one person at a hospital writing a paper. We are talking about entire nations reviewed all of the evidence you could find. And there is not a single, single paper of systematic review that supports doing this. They do have a ton of low-level, low-quality papers that say I gave this to five kids. Oh, when I checked in on them 3 months later, they look better. That's not a quality robust study. I want to add one little caveat to this, too, from a question you had asked earlier about drug studies. Every single drug that is being used in pediatric gender transitions is being used off-label, which means no single drug company has ever put forward these drugs to say I really like this. I think this is a good drug. I want to test it for this reason. Not a single drug company has ever done this. No puberty blockers have ever been tested to be used this way. No cross-sex hormone has ever been tested to use this way. They don't support that, so everything is being used off-label, which means doctors have the ability to basically pick and choose whatever drugs they want without any evidence. We give doctors that ability, but no doctor can say that they are doing these procedures with these drugs based on a clinical drug trial. It's never occurred.

HANSEN: Now, along those lines-- if I can ask again, sorry. And if you don't know this, it's OK. Are, are these pharmaceutical companies, if they find out that these puberty-blocking hormones used for this purpose found out to be detrimental, are they liable?

JAMIE REED: No. They were never FDA approved for use, the drug company never went to the FDA and said I want to test this puberty blocker for this reason. The drug company that created it never put it forward to the FDA for that use. They're all off-label. They're all outside of that normative FDA-approval process.

HANSEN: OK. Which is odd. OK.

JAMIE REED: It is odd, but it's also dangerous and scary when you think about that we are using all of these drugs completely outside of our normative FDA-approval process or in any way shape or form in a clinical drug testing regimen that we would use for any other drug and we're using them on children.

HANSEN: Can I ask one more? Sorry.

HARDIN: Certainly.

HANSEN: Because this touches on what-- sorry-- this touches on the first thing that you said about the quality of evidence. So we're going to have people come in here in opposition to this, medical professionals saying I have treated children and I have seen outstanding results and this is-- those studies don't matter because this is what I see, right? So how-- in light of what we're going to hear, which I'm assuming, you know what I mean, and they may be legitimate, they may mean what they see or what they think they see, whatever. In light of that kind of testimony that we're going to hear, and, and you're saying all these studies are low quality, like how do, how do you justify, like, what, what they're going to say or--

JAMIE REED: Yeah, that's a very common occurrence, and that is not something that surprises me at all. So one of the ways that I think about this with the endocrinologist that I worked with, who was medically transitioning kids, we had Tuesday clinic, we saw a whole group of patients. Which patients did he remember a week out? Was it the patient who came in, didn't really say much, left, and then fell off his schedule and never saw again or was it the 1 patient out of 32 who brought him, and I kid you not, flowers, candies, and a photo album showing, oh, my gosh, look at this amazing transition you walked me through? That's the patient Dr. Lewis remembered, a month out, 2 months out. That is not data. I am a clinical researcher. I cannot care about the line-item patient because they brought me flowers. I have to care about what does the system of data tell me? And in that, what it told me in my clinic is we lost 30% of the kids that came in

and we put them on a treatment. They disappeared. And they didn't disappear because they moved or went to college and they were happy. They literally disappeared out of my epic trans care, they were still in St. Louis. They were still seeing their pediatrician. They were right there. We put them on something that they then determined was hurting them or they didn't want to do anymore and they disappeared. My clinicians have no recollection. They weren't looking at the data set. They're never going to remember, oh, that kid I saw once that I put on testosterone, I permanently destroyed her voice. I never saw her again. I don't remember her. That's how it works when you are a clinician. They're not wrong. They are going to say that there were patients who feel like this made them better. But adolescents, when given what they want, will tell you, it made me feel better in the short term. That doesn't make it safe and efficacious in the long term or across the whole data set.

HANSEN: Thank you.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here. I do have one question. Senator Kauth brought up something interesting about pediatric gender clinics and their assessments. Can you talk, in your experience, can you a little bit about that assessment process? What, what does it entail? How does it interplay with, with studies? Just a little about your experience in gender clinics.

JAMIE REED: Yes, that's an excellent question. When this protocol was first devised in the Netherlands, they had this very long, very intensive, what they called a biopsychosocial assessment. It would last sometimes for years and it would cover all of these aspects of the individual's life and often would include intensive psychotherapy. That model of care jumped to the U.S. It started here in Boston at the first gender center in 2007. Immediately, they realized they did not have the bandwidth, the time, we charge things differently, we don't have a nationalized health care system. They didn't have away to replicate that biopsychosocial assessment. What has happened since 2007 until now is that assessment has whittled itself down to the point where in my clinic we would medicalize a child after a single visit with a psychologist, one 1 hour visit, and the assessment process was that they were required to write a letter of support to say I met with this child, they meet criteria, you can medicalize them. We wrote the letter as a blank template. We handed it to the psychologists and said, hey, after you see this patient for an hour,

just fill this out. We only wrote one template. We didn't write a letter that said, I met with this patient, they don't meet criteria, or I met this patient they need more time. The only letter that we gave the mental health professionals was, I met with this patient, put them on a medical treatment pathway. The industry has become directly where essentially we've heard doctors say if a child says they're trans and wants this treatment, that is the full breadth of the assessment. And I'll add, I met with three psychologists from within your state about a week ago. I tried to ask them, what is your assessment process? Are you doing something different to figure out if these are extreme cases versus not? They directly said trans children tell us who they are. That was what they described as their assessment process. Your psychologists in this state still going through the loophole.

BALLARD: OK. Thank you.

HARDIN: Any other questions? Thank you for--

JAMIE REED: Thank you so much.

HARDIN: --making the trek here from the show-me state.

JAMIE REED: It's colder here.

HARDIN: Folks, it's been a little over an hour and we're going to transition over to the other side of this and part of the-- part of what we're going to do is, is if you've already testified, we'd ask you to go out, if you'd like to continue watching along, you can do that in Room 1200 on the south side of the building, and we will take up opponents. We're going to take about a, a 3-minute break to do a room transition here. And we'll pick it up with the opponents as soon as we all reconnoiter. And, and we'll allow, we'll allow about 20 people in because at 3-minute testimonies that'll be about an hour.

[BREAK]

HARDIN: LB732. We're going to hear opponents of LB732, and we're going to begin with Alexander Liu. Did I say that last name correctly?

ALEXANDER LIU: Yeah, that's correct.

HARDIN: And then on deck we have Dr. Elizabeth Constance, so I'll kind of toss out the on deck thing as we go along. We're doing this annotated experience here, which is a fancy way of saying we go about

an hour, so we're not going to hit the ejection button on you if we hit 60 minutes, but we'll kind finish that person up and then we do this fun transition over again to the neutral and then it all reverses and goes again. And so anyway, are we ready? We are ready.

ALEXANDER LIU: OK. My name is Alexander Liu, as you said. It's A-l-e-x-a-n-d-e-r. Last name is Liu, L-i-u. And this is Keigo, K-e-i-g-o. She's my service dog. Everybody asks so I try to invite her in. I'm here to oppose LB732, and, obviously, I am disabled. I have EDS, MCAS, tectal glioma, that's caused damage to my optic nerve and auditory cortex. It's also caused obstructive hydrocephalus, which translated means I have a connective tissue disorder, autoimmune disorder, and a benign brain tumor that's damaging the optic area of, like, the nerve, which is damaging my vision and has caused some hearing issues. And which is the reason that I have low vision and will eventually make me blind. My point of telling you all of this is that people who do not have a medical background and who are not actually treating patients should not be making legislation or making medical decisions for people. The reason that I'm even here today is because the doctors that are treating me were, you know, it was lucky that they actually figured out that I had the tumor in the first place because it would have killed me if they hadn't. They found it on accident on an MRI. And the obstructive hydrocephalus, what that means is it, like, actually blocks where the cerebral spinal fluid flows down your spine and it essentially makes your brain a pressure cooker because it causes like the-- it builds up a bunch of stuff and it, like, puts pressure literally all on your brain and, like, compresses it and squeezes it. And it's not fun, it causes migraines and all kinds of stuff. So if you are not, like, the actual person treating patients, you should not be making medical decisions for people because even if you have the same condition as somebody else even then your treatment could be vastly different than somebody else. It does not-- it's not like a one-size-fits-all kind of a thing. And that's more my point because if you did not understand the beginning of this and all of the terminology I just threw out, how are you going to then be able to make medical decisions or somebody by creating legislation about this, right? Like, you're not the doctor of these kids. It should be between the parents, if they're minors, and these kids, and then their doctors. Or if they are adults, it should be between those adults and their doctors. Now, again, I understand that it may come from a good place, but, again, if, if you don't understand that, and you don't have that background, how can you possibly make decisions for these people? Because you could accidentally create legislation

that would then affect somebody like me, who then won't have access to the necessary health care. And it may not even be related to something that is, you know, related to trans health care, because I will also point out, a lot of, a lot of the gender-affirming care that is stuff affecting the hormones is actually used on a lot people who are cisgender. So, like, males that get something called gynecomastia, which makes you-- would grow what you would say like our breasts, it's just like a hormonal thing, and then they have to get, they have to get hormone treatments. So there's lots of other uses for these conditions, but, but like kids have to get them, right? So if you pass this legislation, those kids would not be able to get those treatments, which, again, is why doctors should be making this decision. It should not be up to legislatures who do not have medical degrees.

HARDIN: Thank you. Questions? Senator Hansen.

HANSEN: I think you make a good point. I think a lot of us may not understand, like, a lot of the medical parts of the bill and how it pertains to patients, but I think our job is to ask questions so we can understand so we can make better decisions, which is why it's important to hear from you just as much as people in favor of the bill.

ALEXANDER LIU: Yeah, absolutely.

HANSEN: And I think one of the things you brought up, which I think is in the bill, that those children who are receiving hormone treatment for something other than gender dysphoria, like gynecomastia, like you mentioned, or early puberty, like Senator Quick mentioned, I think in the bill that's not-- they specifically mention in the bill that says that can still be provided.

ALEXANDER LIU: The problem is, is that if you create any kind of legislation that is meant to punish people, doctors are going to be very hesitant to prescribe and treat conditions like that. You have to-- so look at it as like-- so there's a lot of doctors who, because as somebody who's on SSDI, who do not take Medicaid and Medicare patients because they hate having to deal with the state. Because it is a huge hassle, and then they get punished financially for having to deal and jump through all these hoops. So you're just creating a bunch of problems for doctors, and then they're going to be, like, very hesitant and reluctant to not only, not only treat them, but to also diagnose these conditions, because they know that, oh, I'm going to

have to go through all-- it's like a lot of problems and trouble, and it just makes it very difficult for then these kids to get even a diagnosis. Like, there's also a lot of, like, chronic conditions and, quote unquote, rare conditions that don't get diagnosed very often because it's really difficult for the doctors to have to, like, jump through hoops to get the condition diagnosed. Like, there's a lot of testing that they have to get approval from, like, the insurance companies for, and they just don't want to do the work. So by creating legislation that makes it difficult for them to get that stuff done, you're making it harder on these kids. It's like understanding the health care system and how, like, you know, like the steps and layers that are in it already, you're just adding another layer of difficulty to it.

HANSEN: OK. All right. Thanks.

ALEXANDER LIU: And, of course.

HARDIN: Questions? Seeing none, thank you.

ALEXANDER LIU: Yeah, thank you.

HARDIN: Dr. Elizabeth Constance is next. Julie [SIC], and forgive me if I get your last name wrong, Keown is next, K-e-o-w-n. Welcome.

ELIZABETH CONSTANCE: Hi, Chair Hardin and members of the committee. I'm Dr. Elizabeth Constance, E-l-i-z-a-b-e-t-h C-o-n-s-t-a-n-c-e. I'm a double-board certified reproductive endocrinologist and a board member of the Nebraska Medical Association. I'm testifying on behalf of the Nebraska Medical Association, NMA, in opposition to LB732. The NMA's opposition to this bill is rooted in a fundamental principle of our profession, the sanctity of the physician-patient relationship. In medicine, there is no one-size-fits-all solution. Every patient is a unique individual with unique needs. As physicians, we have an ethical duty to act in the best interest of our patients, tailoring treatments to their specific needs. LB732 is a blunt instrument approach to a deeply nuanced and complex area of health care. It replaces the expertise of medical professionals and the intuition of parents with a government mandate. It is important to recognize that the medical community already operates under rigorous evidence-based standards of care that prioritize caution. Before any medical intervention is even considered, patients undergo thorough clinical screening, extensive mental health evaluations, and ongoing counseling. This process allows and follows accepted evidence-based standards of care aimed at

reducing the significant distress associated with gender dysphoria. Distress that, if left untreated, leads to high rates of depression and suicidality. Furthermore, current Nebraska regulations have codified extensive prerequisites requiring a mandatory waiting period and a minimum number of therapy hours. In practice, this means care is already delivered through a slow, staged, and multidisciplinary process involving pediatricians, mental health experts, and specialists. By the time a family reaches the point of medical intervention, they have already navigated an exhaustive gauntlet of professional oversight. LB732 would not protect this process, it would simply dismantle it, leaving families with no path forward regardless of the needs of the patient and the clinical evidence. While we understand and share the desire to protect children, the NMA believes that medical decisions are best made within the exam room, not in state statute. When the government legislates that certain evidence-based treatments are never appropriate, it sets a dangerous precedent for all of medicine. It limits the options families can consider and prevents doctors from following the most current research and clinical findings. The field of medicine requires flexibility to adapt to the unique needs of each patient, a flexibility that legislative bans like LB732 would completely eliminate. In addition to the barriers this would create, the NMA also has strong concerns about Section 6 of the bill, which would allow the Attorney General to pursue civil penalties against providers within 20 years of an alleged violation. This sets an unprecedented standard for civil penalty against physicians and other providers. The NMA respectfully urges you to not advance LB732. Thank you for your time, and I'm happy to answer any questions.

HARDIN: Thank you. Senator Riepe.

RIEPE: Thank you, Chairman. Thank you for being here. I'm always interested in what the physician side of it has to say. And the physicians in working with a person that's in transition, is that done, and I'm hoping it is, is that done with a team approach, a physician, a psychologist, and whoever else needs to be involved in this so that you don't get this silo effect and, and, and their own-- we all have biases. Is that how they work?

ELIZABETH CONSTANCE: Absolutely, so it--

RIEPE: And, and, and-- excuse me.

ELIZABETH CONSTANCE: Yeah.

RIEPE: What are the-- what's the training of that, say, a physician? I mean, it's not necessarily an emergency doctor or an anesthesiologist.

ELIZABETH CONSTANCE: Correct. Right. So they, they are multidisciplinary care teams. It may be a little bit different. The care team may look a little different from patient to patient. There's always a mental health therapist as part of that, especially under our current statute. There's that required hours of therapy prior to being able to initiate any treatment. So there certainly is a mental health therapist, psychologist, psychiatrist involved. There's then the prescribing provider, maybe a pediatrician, maybe a family practice physician, maybe an endocrinologist who has both training, you know, during their residency and/or fellowship, as well as usually continuing medical education. So ongoing training to stay up to date with the most recent advances in medical care and research.

RIEPE: Is there anything that goes on with the certified, you get a-- you know, in medicine, in health care, we all have certifications and registrations and license and certificates and everything else. Is there any of that that says, you know, by some national group that you are-- have proven that you know what you're doing?

ELIZABETH CONSTANCE: There's not a specific certification that I'm aware of as it relates to gender-affirming care, gender dysphoria. The, the Association-- I know the, the, the Psychological, Psychiatric Association is going to be speaking behind me, so they may know more about that from their perspective. But certainly there are a number of different specialties where that would be considered within the scope of practice of that profession and well within their training and expertise.

RIEPE: So someone doesn't self-declare that they're an expert in the area and then start trying to take care of people that have serious issues. May I ask one more question?

HARDIN: Sure.

RIEPE: Thank you. My question is to LB574, the bill that we had before that, that limited to, to youth younger and more restrictive and more flexibility. Is-- I mean, that's not a very long period of time to evaluate in Nebraska whether it has or has been effective or destructive or anything else. Do you have an opinion on that?

ELIZABETH CONSTANCE: I don't have an opinion. I don't have any data to your point that it's been a relatively short amount of time. I, I don't provide-- I'm not a pediatrician, so I take care of adults, so I don 't have personal, professional experience. My colleagues who do take care of children with gender dysphoria are seeing a lot of families leave the state for care because the, the, the law in place is already so burdensome that it's, it's hard enough to get care as it is and a lot of families are leaving the state to, to receive that care.

RIEPE: Excuse me. Are some pediatricians doing a subspecialty and, and becoming concentrating to try to become experts because they have a particular interest?

ELIZABETH CONSTANCE: I'm not aware of any particular like fellow-- that would be like a fellowship training or sort of like to your point a certification within pediatrics. I'm not a pediatrician so I may not be the most up-to-date on that but I think, you know, certainly that requires, you know, funding and, and kind of the ability to do that as well, but I'm--

RIEPE: Well, families may tell us, too, that--

ELIZABETH CONSTANCE: Mm-hmm.

RIEPE: --go to Dr. X or Y because they understand the, the issue's better than others. And so they-- you don't want to necessarily go to a pediatrician that sees one patient of this particular diagnoses or issue once a year. They won't, they won't have the background for it.

ELIZABETH CONSTANCE: Correct. But even without, I would say, you know, without a specific certification, we have-- you know, our national medical organizations and societies have standard of care practice guidelines that any physician can look at and follow. So the American Academy of Pediatrics has guidelines for pediatricians. The Endocrine Society has guidelines for endocrinologists. So within the scope, you know, there's multiple specialties. Family Practice has, has guidelines for gender-affirming care as well. So all of these subspecialties in which gender-affirming care would be part of the training and scope of practice of that physician, there are, you know, well-researched society guidelines that kind of help guide that care as well.

RIEPE: Is that part of a residency now?

ELIZABETH CONSTANCE: It, it would be a lot of residencies in those kind of particular areas are going to have exposure and then have that as part of their curriculum to, to put out a well-trained pediatrician or endocrinologist or whatever.

RIEPE: Well, I appreciate being-- you being here. And thank you, Chairman.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chairman. Thank you for being here and testifying. I, I, I, I had a couple questions. I mean, so we had a previous testifier who discussed kind of when maybe this type of care was initially provided to refer to places in Europe, for example, where there would be sort of extensive evaluations of a patient before, like, a hormone was prescribed, for example, and then seemed to sort of imply that we're now at a stage where that assessment process has been really reduced and that hormones are prescribed kind of after a really brief assessment. I was a little confused by that because with LB574, in particular, we've codified a minimum of-- I don't know an exact amount-- but we codified into statute an amount of assessment needed prior to receiving a prescription. So can you help me understand a little bit more about if a minor were to get to the stage of a prescription or, or a, a medical intervention, what, in the state of Nebraska, what level of assessment occurs before that would happen?

ELIZABETH CONSTANCE: Yeah. My understanding with the current statute is that it requires 40 hours of therapy, which, you know, it's hard to find therapists. So, I mean, that's, that's, that's going to take at least a year to get, you know, in 1-hour sessions, right, to get to 40 hours of therapy. These are not decisions that either families or physicians are rushing into quickly or lightly. As with most things, you know, there's, there's a due diligence. We have to eliminate other, you know, confounding factors. And, and so, right now, my understanding is 40 hours of therapy, even before that statute, a letter of, of recommendation from the therapist was generally required before starting any kind of puberty blockers or hormones, confirming that, you know, the, the therapist had put in their due diligence and time and really had sussed out that this was truly gender dysphoria that would potentially benefit from, from treatment. And then these are physicians that have relationships with these families and these children as well. So, oftentimes, it's, you know, their pediatrician

or their family practice physician or somebody who's seen them over the course of their lifetime and has watched them grow and develop.

FREDRICKSON: OK. So just to clarify-- so, I mean, so 40 hours-- so, so before a prescription can be given to a minor they would require potentially a year of assessment.

ELIZABETH CONSTANCE: Yes, and my understanding of the way the statute is written is, like, so if we're starting at puberty blockers, there's a year of assessment and then puberty blockers and then another year of assessment before prescribing hormones. So we're going through 2 whole years of assessment before we're getting to the prescription of hormones.

FREDRICKSON: OK. Thank you.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Thank you for coming today. I appreciate that. I see you're a board certified OB/GYN and reproductive endocrinologist. Are-- do you personally treat any minors that are transitioning?

ELIZABETH CONSTANCE: No, I'm an, I'm an adult specialist, so I don't treat minors for the most part with rare exceptions but not as it relates to gender dysphoria.

G. MEYER: And I thought I heard you say that, and I thank you. So are you involved with any treatment with those that have regretted transition or having difficulties with the, the hormone therapy or the gender-altering surgeries? Are you involved with any treatment with people that regret their transitioning?

ELIZABETH CONSTANCE: I have not yet-- I have not as a physician had that instance presented to me, no.

G. MEYER: OK. Thank you.

HARDIN: Senator Quick.

QUICK: Yeah, thank you, Chairman. So I'd asked this to a testifer earlier, but I have a granddaughter, and she is 8 now, but when she was turning 6 she was going through some difficulty, and they discovered that she was starting to go through puberty. So they were going to have her get on a puberty blocker. Now, one of the things

that they were really worried about, and my daughter was, is that she would start menstruating before that happened and that would cause a lot of problems. So they had to wait, it seemed like forever for her to be able to get on that puberty blocker, so. Do you have any knowledge or things or anything you want to say or--

ELIZABETH CONSTANCE: Yeah, no, I mean, I think that's a really great point. And, certainly, treatment of differences of sexual differentiation and precocious puberty are in my wheelhouse and my scope of practice as a reproductive endocrinologist. And I with-- I know there was, there was questions about that earlier about, you know, with-- in my professional reading of the current bill as somebody who it is within my scope to treat precocious puberty, I don't see that-- I don't read the exception as actually including that. So I-- that is a personal concern as a, as a clinician that I have. But, certainly, you know, we've been using puberty blockers for the treatment of precocious puberty safely since the 1980s and it's been on label or it's been FDA approved for that use since 1991, I believe. And so I think, you know, if it's, it's safe in, in young children for that purpose-- the purpose for giving the medication is not what makes it safe or not in a child. You know, we have well established that, that these medications are, are safe and children have no long-term detrimental effects to their development.

QUICK: And I'm not sure what their reason for why it took so long, if it was insurance approval or if it was because of the previous bill or they had to wait to make sure it was for proper use, but I don't know what--

ELIZABETH CONSTANCE: No, I think there are a lot of-- you know, we can, we can try to write exceptions into bills as much as we want, but I think that's the reality that we as clinicians then are, are left to deal with in the examinations with our patients, which is whether it's insurance or a pharmacy bulking at a prescription because they don't understand the difference. They just see the age of the child and the medication that's being prescribed. And so we-- you know, then the pharmacies refuse to fill things. So it, it does actually impact care to people who are using these for other purposes as well as making it harder for people who have, you know, this particular legitimate reason for using it as well.

QUICK: Yeah, thank you.

HARDIN: Other questions? Senator Hansen.

HANSEN: I had that question earlier about the section of the bill that allows the prescription for cases like Senator Quick was talking about.

ELIZABETH CONSTANCE: Yeah.

HANSEN: Do you have the bill in front of you?

ELIZABETH CONSTANCE: I do, actually.

HANSEN: I'm just curious to get your opinion on this. I, I feel like this covers it, but unless there's some other language we, we need to put in here or that you recommend, it's on page 7, starts on line 10: A health care practitioner does not violate this subsection if: The cross-sex hormones or puberty-blocking drugs were prescribed for or provided to an individual in this state younger than 19 years of age to treat the individual's congenital defect, precocious puberty, disease, or physical injury.

ELIZABETH CONSTANCE: I'm sorry, I missed what page you're on because I was looking at--

HANSEN: Page 7, line 10.

ELIZABETH CONSTANCE: --congenital defects. Sorry.

HANSEN: Yeah. Basically, saying they're not violating this, because if they prescribe them for those--

ELIZABETH CONSTANCE: Yeah, no, I have been looking at a previous section where it just mentioned congenital defect.

HANSEN: Yep.

ELIZABETH CONSTANCE: And I would not call precocious puberty a congenital defect.

HANSEN: OK.

ELIZABETH CONSTANCE: That it can be acquired.

HANSEN: And they're, and they're not saying that they defined-- they're defining, I think, congenital defect in a previous section.

ELIZABETH CONSTANCE: Sure.

HANSEN: But they're not defining precocious puberty. So I think they're just listing off different instances of where these might need to be prescribed. Does that sound appropriate?

ELIZABETH CONSTANCE: I mean, it, it, it, it includes the words precocious puberty, but I think the, the issue still stands, that that-- that when these bills get put into place, we still see the after effects of insurance questioning things and, and pharmacists questioning things that puts delays in care. So we-- you know, even when there's an exception. I have, you know, in my personal practice with miscarriage management had pharmacies send back medications prescribed, you know, for miscarriages thinking they're prescribed for abortion that then delays care for patients for days or weeks. So, I mean, just in, in practice, we see that it's not quite as, as smooth as just having an exception in there and then everything's copacetic.

HANSEN: If you have-- like, if this bill does pass one way or the other, if it does, if it doesn't, but if it does, is there better language to use than this to protect those individuals, those children who actually do need hormones for other purposes besides gender-affirming care?

ELIZABETH CONSTANCE: I don't-- I think this is the problem with legislating medical care, is that it is so nuanced and it's so complex and every single patient that sits across the desk from me is slightly different than the one that sat there before them. There's no, there's no amount of legal language we can, we can formulate that's going to address every unique situation.

HANSEN: OK. All right. You mentioned in your opening this is a deeply nuanced and complex area of health care. And I think-- based on that, I think we, a lot of times, especially as legislators, who may not be as experienced in this, this realm rely on a preponderance of evidence to determine whether something is appropriate and something whether isn't without trying to micromanage too much, but to saying this is appropriate, this is not. Previous testifiers have, have lifted off-- listed off quite a bit of evidence to show that this type of care is not appropriate or does not help. And they're listing off-- one of the gals listed off 17 systematic reviews, global systematic reviews, and all of them showed no evidence that this type of care was appropriate or helped. What's your response to that?

ELIZABETH CONSTANCE: Well, without having heard that testimony or, or being able to see the studies that are being referenced, it's hard to,

it's hard to comment on those particular studies. But I can tell you I'm also happy to email you the preponderance of data that does show a difference. There's meta-analyses. There's all kinds of trials that, that do show benefits in terms of decreasing depression, anxiety, suicidality with this care. So--

HANSEN: Can you expound on some of those, like, who does them and what are they?

ELIZABETH CONSTANCE: Who does what? So, I mean, any-- all of the, all of the society guidelines, the American Academy of Pediatrics, American Academy of Family Medicine [SIC], the Endocrine Society, all of their evidence-based guidelines cite the data that those recommendations come from. So I'd be happy to send you all, you know, those particular citations. I don't have them. I have a lot of things in my mind, my, my brain, but I don't have space for everything,--

HANSEN: That's fine.

ELIZABETH CONSTANCE: --but, you know, there was a study just this last year in 2025, it was a meta-analysis in JAMA Pediatrics, which is a well respected medical journal. That was a review of 137 separate studies encompassing 131,000 young people who identified as transgender and gender diverse. It showed the rates of suicidal ideation were 48%, suicide attempts 26%, and nonsuicidal self-injury of 46%. And so there's, there's a preponderance of data on-- in, in that realm as well.

HANSEN: OK. I'm not going to get the weeds too much about the study because I'd be kind of curious about those who are listed as transgender versus not, you know what I mean, when you, when you talk about percentages, I'd be kind of be curious, is it 48% versus 45%, you know what I mean, or is it 48% versus 10%, you know what I mean, that makes kind of a difference, so.

ELIZABETH CONSTANCE: And I know I have colleagues from the Psychological Association coming up behind me, too, so they, they will probably even know that data even better, but I'm happy to, I'm happy to forward you those references.

HANSEN: Yeah, yeah, I'd take anything you got.

ELIZABETH CONSTANCE: For sure.

HANSEN: And you mentioned guidelines that you typically follow the NMA typically recommends, what are those guidelines?

ELIZABETH CONSTANCE: So each medical society has its own set of guidelines. The American Academy of Pediatrics has guidelines specific to provision of gender-affirming care for children. The Endocrine Society has guidelines for both minors and for youth and adults. And then the American Academy of Family Practice [SIC] has guidelines as well. And all of those have references to peer-reviewed journal articles that those guidelines are based on.

HANSEN: OK. Thank you.

HARDIN: Senator Riepe.

RIEPE: Thank you. At JAMA publication, do you have a, do you have a reference, a date, maybe a volume?

ELIZABETH CONSTANCE: I can send that to you. I thought I had it up here. Hold on.

RIEPE: I think at times we always look for what we consider one good, credible--

ELIZABETH CONSTANCE: Absolutely.

RIEPE: --document that we can go to and learn about.

ELIZABETH CONSTANCE: Let me get that date for you, I've got it. They don't have great service in here, but if I can't get it to pull up, I'm happy to, to email that to you as well.

RIEPE: I can probably get it, maybe, through the, the library, too, down at the med center.

ELIZABETH CONSTANCE: It looks like published December 22, 2025 in JAMA Pediatrics.

RIEPE: 12-25--

ELIZABETH CONSTANCE: 12-22-25.

RIEPE: 12-22-25. OK.

ELIZABETH CONSTANCE: It doesn't get much more up to date than that.

RIEPE: That, that-- that's a good start. That's a fraction of the library, so thank you.

ELIZABETH CONSTANCE: You're welcome.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here, Doctor. In previous testimony, they talked about other states that have passed similar legislation. In your-- do you see any studies, any, any accounts of an increase in suicide rates by, by children undergoing gender dysphoria into this process?

ELIZABETH CONSTANCE: So-- and I know the-- and, again, you know, I have colleagues coming up behind me who, who may have even more data. I know The Trevor Project is one organization that does a lot of tracking, specifically, you know, mental health and rates of suicidality in transgender youth. And they have seen over the last 3 years since these bills became kind of a hot topic across the country, the rates of depression, anxiety, and suicidality in children in youth in these states have gone up. I don't know that I have that specifically for Nebraska, but as this becomes a national trend, it is impacting our youth across the country.

BALLARD: OK. Yeah. Yeah, anything you have, I'd like to see, so I appreciate that.

ELIZABETH CONSTANCE: Absolutely.

HARDIN: I have a question for you. So Big Pharma provides about $2 billion in hormone treatment a year in this category. That's a lot. And my understanding is it's all being used off-label. I've been sitting here ChatGBTing and Grokking it and all other kinds of things to see if there's an exception to that. It's being used off-label. My question is, that's a lot, $2 billion worth of anything is a lot, fly swatters, kitty litter, $2 billion is a lot of money. Why don't the big pharmaceutical companies say, OK, it's time to make this on-label instead of off-label?

ELIZABETH CONSTANCE: Yeah. I mean, that's a, that's a fantastic question. I, I work in the realm of reproductive medicine, where the vast majority of things we use are off-label because the, the time and the, the money and the will isn't there--

HARDIN: I see.

ELIZABETH CONSTANCE: --to make it on-label. So, I mean-- so there's, there's a lot we do in medicine that is well established and data-driven, but still off-label.

HARDIN: Can you give me an example that would be as big?

ELIZABETH CONSTANCE: So like letrozole is a medication, it's considered first-line therapy for ovulation induction in women with polycystic ovary syndrome, or PCOS. It is well established as, as the first-line treatment, but it is an off-label use of that medication. Misoprostol is a common medication used in induction of labor. It's, it's considered standard of care. It is an off-label use when used for, for induction of labor, but, but it is used widely and in a well-- very accepted way.

HARDIN: OK. Thank you. Any other questions? Thank you for being here.

ELIZABETH CONSTANCE: Thank you.

HARDIN: Next, we have Julie [SIC] Keown and I apologize if I got your last name incorrect.

JULIA KEOWN: That's OK, everybody does.

HARDIN: Oh, no.

JULIA KEOWN: It's not a problem.

HARDIN: We are ready when you are ready and I'm about to learn how to pronounce your last name.

JULIA KEOWN: Dear Chairperson Hardin and members of the Health and Human Services Committee, my name is Julia Keown, J-u-l-i-a K-e-o-w-n. I am a Critical Care and Sexual Assault and Interpersonal Violence Forensic Examiner and Vice President of the Nebraska Nurses Association, or the NNA. I am here today on behalf of the Nebraskan Nurses Association, which represents the more than 30,000 nurses in our state. NNA opposes LB732 as it threatens the provision of evidence-based care, limits scope of practice, and undermines the ethical obligation of nurses to support and advocate for our patients. LB732 restricts nurses and other health care professions-- professionals from providing evidence-based care, particularly the gender-affirming treatment. By introducing legal risk, the bill creates a chilling effect that undermines clinical judgment and limits nurses' ability to practice within their scope, ultimately,

compromising patient care. LB732 would significantly reduce access to essential health care services by imposing legal barriers to gender-affirming care. The Nebraska Nurses Association aligns with the American Nurses Association, or the ANA, in recognizing gender-affirming care as essential to positive mental and physical health outcomes. Limiting access to scientifically validated care harms patients. The NNA legislative platform affirms access to health care as a fundamental human right and opposes barriers that inappropriately restrict nursing practice. LB732 contradicts these principles by prohibiting evidence-based treatment, curtailing nursing scope of practice, and increasing the risk of adverse health, health outcomes for patients seeking gender-affirming care. We humbly ask this committee to oppose LB732 and prioritize the health and well-being of all Nebraskans.

HARDIN: Thank you. Questions? Senator Meyer.

G. MEYER: Thank you, Chair. Thank you for coming in today. I appreciate that. I imagine it was a little slick coming out of dangers. Are you involved in any of the transitional care of youth? Are you practicing in that in any fashion?

JULIA KEOWN: Currently, no.

G. MEYER: Do you have experience in that?

JULIA KEOWN: No. We are here on behalf of-- there aren't many nurse practitioners in Nebraska who do actually practice in gender-affirming care. And, certainly, there are several nurses, especially nurses in clinics that are going to be a part of providing care to individuals. So we're here on the behalf of them.

G. MEYER: OK, thank you very much.

JULIA KEOWN: Yep.

HARDIN: Other questions? Senator Hansen.

HANSEN: I want to go back to the threat to evidence-based care. Can you--

JULIA KEOWN: Yeah.

HANSEN: I asked this earlier about evidence-based care.

JULIA KEOWN: Of course. Yes.

HANSEN: And like I mentioned before, previous testifiers have listed off a litany of studies--

JULIA KEOWN: Yes.

HANSEN: --saying the opposite of what you're saying in a pretty compelling fashion, they had, you know, some pretty large data sets. And, and previously it was listed off a December 22 JAMA study. It didn't show, it didn't-- that study wasn't even-- wasn't about care, like the care of those children with gender-identity dysphoria or gender-affirming care. It was about suicidality or, or suicide ideation, suicide attempts. And actually found it actually in younger groups that they-- there was less instances of suicide ideations. But as they got older, they went all the way up to 25. This bill goes to 19. It went above the age of 17 or 19, that's when they started seeing it creeping up higher. So, again, I'm trying to find a preponderance of evidence that shows the justification of why we, we should or should not pass this bill.

JULIA KEOWN: That's going to be quite difficult. I will tell you that people in my situation and physicians-- I know that I have taken multiple, multiple courses on, on just how to read scientific and scholarly articles. And I will tell you that a lot of people who haven't taken those courses or don't have experience in reading those, they, they don't necessarily know how to, how to read them appropriately is what I'm going to say. There are things like confounding variables, right, that a lot of people aren't going to necessarily be able to think about, I need to be looking for this and, and really critically assessing these articles. So, honestly, I would have to have access to all of those articles that the, the previous proponents were talking about and access to the JAMA Pediatrics and really go through all those and figure out really which ones are legitimate for this circumstance.

HANSEN: OK. I ask this because as a medical association--

JULIA KEOWN: Yes.

HANSEN: --and the NMA, I would expect here's a giant pile of evidence that we have shown, you know, proving what we're saying.

JULIA KEOWN: And we do have that.

HANSEN: The other side had that. They didn't provide it, but, you know-- but they cited some pretty relevant studies, and so I'm looking for that from the other side here, as well, to show that there is evidence on why we should make a decision one way or another. Because this is typically the questions we ask anybody coming here, determining whether we should allow for somebody to prescribe something or not, or to even have prescriptive authority or not. And so usually it's, like, we need more-- I need some objective, I think, reasoning on why we should make a decision.

JULIA KEOWN: Yeah, and that's fair enough.

HANSEN: And if you can't, it's fine. I'm not going to pick on you,--

JULIA KEOWN: We do have--

HANSEN: --but even if somebody behind you,--

JULIA KEOWN: Yeah.

HANSEN: --they, they might be able to cite some other stuff, too, which would be good.

JULIA KEOWN: I can assure you we do have that in nursing and medicine and everything, you, you really don't do anything unless you have that litany of evidence behind it. I know that Dr. Constance said that she was going to send you those clinical guidelines. Those are kind of, I don't want to say Bible or whatever, but that's-- those are really what we go to in health care because they, they take all of the preponderance of evidence, as you say, and they put it in a, a big amalgamation and just make those clinical guidelines, right? So we do have the evidence if you are asking for it, which is totally a legitimate thing to ask for. Are there specific things that you want covered or just whether this is a legitimate practice, like, what specific guidelines?

HANSEN: Whether it's appropriate to do gender-affirming care on children. And then what's the evidence the long term showing that it actually works.

JULIA KEOWN: Yep.

HANSEN: Stuff like that.

JULIA KEOWN: Yep. So long-term effects--

HANSEN: Yep.

JULIA KEOWN: --and what else?

HANSEN: Mainly that.

JULIA KEOWN: OK.

HANSEN: Thank you.

JULIA KEOWN: Absolutely.

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

JULIA KEOWN: Thank you.

HARDIN: Sheri Shuler. Kris Docherty is on deck.

SHERI SHULER: Thank you for the opportunity to speak. My name is Sheri Shuler, S-h-e-r-i S-h-u-l-e-r, and I'm speaking on behalf of Rainbow Parents of Nebraska. We are a parent-formed organization that fights for the rights and well-being of LGBTQ+ youth, including their access to health care. I know most of you on this committee are parents, and I want you to think back, maybe a ways back, to your earliest preparations for parenthood, maybe you researched the safest car seats and strollers. You probably asked the pediatrician, how often should they poop or what to do about a fever? Later, when they get a little older, it's about what's the best school or how to restrict their phones or keeping them safe as they learn how to drive. Especially with each new stage, parenting involves research to stave off anxiety because we all want to keep our kids safe. When one of our babies had an ear infection, my husband and I would write in a notebook when's the last time we gave Tylenol so that we wouldn't inadvertently give a dose too soon. This is how careful parents are when they care for their children. So when a child announces that they're a girl on the outside but they feel like a boy on the inside, do most parents say, OK, sweetie, let's run to the doctor and get you some testosterone? Obviously, that's absurd. When faced with a new issue like this, good and careful parents get to work. We read articles, we talk to therapists and doctors. In my family, that meant professionals from Children's, Boys Town, UNMC, CHI, and private practice. All parents contemplate risks, but also the very real risks of not pursuing gender-affirming care or not allowing your child to be who they are. I guarantee that none of you has spent more time thinking about gender-affirming care medicine than the parents that you will hear from

today. It's scary to contemplate any medical treatment and they all have risks, but ultimately parents have to have faith. That when we seek gender-affirming care or if we decide to hold off based on our research, we're making the best decision for our child with the information we have at the time. And if in the future it turns out to no longer be the right path, we will continue to get our kids whatever help they need with the assistance of their doctors and their mental health practitioners, not politicians. The past 4 years, Senator Kauth has brought bill after bill to scapegoat the transgender community, chip away at our kids' rights and well-being, and disrupt our families. Gender-affirming care is already severely curtailed, as we've just talked about, and make no mistake, she has already signaled that she doesn't intend to stop here and has a study for the interim that will look at whether supporting your transgender child with gender-affirming care equates to child abuse. Where is the line where we say no and stop this persecution of Nebraska children and families? Believe me, those of us speaking here today would rather be at work, spending time with our kids, doing almost anything else, but we're here because Nebraska is our home and we think it's worth fighting for. We also think our kids' access to health care is a basic right and they deserve to thrive and be themselves. We at Rainbow Parents of Nebraska urge you to stop LB732 in committee and allow our kids to enjoy the good life.

HARDIN: Thank you. Questions? Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Thank you for coming in today and I have the greatest respect for every parent. They want what's best for their children. I had that as, as a parent and especially-- it's especially true of grandchildren. If you're fortunate to have them, sometimes we say it'd be nice to skip over the children and go to the grandchildren and maybe some of you experience that. We hear it frequently, in fact a great deal that children's minds, children's brains aren't developed until early, mid, late 20s. They can know right from wrong, but don't understand the consequences of their actions. And, yet, we think at 6 or 7 or 8 years old, they can make the decision who they are sexually for the rest of their life. I have a problem with that balance. It just simply does not equate for me. Can, can you, can you share with me your view on that, please?

SHERI SHULER: First of all, I want to point out that we're not talking about sexuality, we're talking about gender identity, and they're, they're two different things. But as far as children deciding at 6 or 7, I mean, some children say at 2 that they know that they're a girl

on the inside and a boy on the outside or whatever. I don't think that par-- while children may say that, no parent is jumping immediately right into doing anything to change the medical situation of that child. So children also at young ages experience things like anxiety or depression and they have to describe these symptoms to us and we have to trust that they're not making it up or wrong about how they're feeling and we treat those things and this is-- to me, this is no different.

G. MEYER: If I may, just ask a brief one?

HARDIN: Yes.

G. MEYER: Thank you, Chair Hardin. So let's say we have a child that, that begins to transition, hormone therapy or whatever other medical recommendations are made at 8 or 9 years old and they get to be 16 and say you know what I made a mistake. What, what does that conversation look like, you know, and, and perhaps you haven't experienced that but I'm, I'm sure you probably talked this over with other parents or other people in, in a similar situation. What does that conversation look like? Is that, OK, all bets are off, we'll just stop what we're doing and we're, we're back to square one here. What, what does that conversation look like? And, and, and maybe that's an unfair question of you since you perhaps haven't experienced it, but, but could, could you share?

SHERI SHULER: Well, yes, so first of all, 8- or 9-year-olds don't undergo hormone therapy. They, they would be prescribed puberty blockers, which would delay puberty and allow there to be more time for everybody to figure out if this is the right course of action. That's actually, in my mind-- my child did not receive puberty blockers. They determined who they were a little bit later. But in my mind, that is the ideal situation because it gives everybody, doctors, parents, children, more time to develop, more time to figure out, like, what's the situation here? For a child that undergoes-- starts hormone therapy, maybe that's going to be, like, age 15. And so if they, if they realize after a year or something that they're not-- this isn't what they want to do, they simply go off the medication. Like, parents will still support and respect and get the health care that that child needs regardless.

G. MEYER: OK. Thank you.

HARDIN: Other questions? Senator Riepe.

RIEPE: Thank you, Chairman. It seems to me like LB722 [SIC] intends to kind of kick LB574 to the curb. And it's only been there 2 years. That's, that's a short, very short period of time. Has LB574 failed us?

SHERI SHULER: I mean, as far as Rainbow Parents of Nebraska, we, we don't support LB574 either, so.

RIEPE: OK. Oh.

SHERI SHULER: I mean, that was already bad enough. This is obviously a much more drastic step that-- and, yet, I don't think there is any data suggesting that there's been-- the restriction of gender-affirming care has harmed children. Let me rephrase that. It has harmed children who haven't been able to get the care. So I don't understand why actually LB732 has been proposed.

RIEPE: Yeah, I would like, I guess as I sit here today, I'd almost like to go back and talk with the state medical director who had responsibility for writing the policy in LB574 to say what's, what's, what have we seen? How many of these cases we've seen? What's the statistic? What's been the outcome? What's been-- have we had some things that were just dangerous and we shouldn't have done? I want to learn from that. I need to learn from that before I take a bigger bite to try to chew.

SHERI SHULER: To make it further restricted.

RIEPE: Yeah.

SHERI SHULER: Right. I mean, the initial bill, as I recall, from LB574 was a complete ban on all gender-affirming care, including puberty blockers and hormones. In the negotiation process and the amendment process, that was allowed with the narrow pathway that we've already talked about. In addition, one thing that made the bill more humane is that children who were already receiving those treatments were grandfathered in, and so they were not required to immediately go off the medications. My understanding of LB732 is that they will be required to go off of the medications, there's no grandfathering, so it will be much more harmful.

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

HARDIN: Senator Hansen.

HANSEN: One of the things you mentioned earlier was that children are allowed, and I want to make sure I get this right, too, puberty blockers while they're trying to discover or figure out the process of who they are. You mentioned that, you just said that earlier. That kind of contradicts the testimony we got from the NMA, who say they go through an exhaustive process of almost 2 years before any medical intervention is started. You're saying, we give them puberty blockers, but, not, not cross-sex hormones, we wait until later until they, they determine that's appropriate. But you're saying you give them puberty blockers as you go through that whole process to determine what the appropriate use of cross-sex hormones is because that kind of contradicts what the NMA says.

SHERI SHULER: I don't really understand your question, but I, I think possibly I misspoke. So an 8-year-old is not immediately going to get puberty blockers. I'm obviously not a medical professional, so I don't know exactly the terminology here, but I know that they wait until a child is within a certain stage of puberty before puberty blockers can be prescribed. And then it prevents puberty from, right, continuing, and so it gives more time before deciding whether hormones are the right course of action.

HANSEN: OK. OK, yeah, that's why I was confused, because NMA made it sound like we don't do any medical intervention prescribing medications until we know 100% for sure this is the right decision. You're kind of saying-- I'm, I'm, I'm getting, I'm getting conflicting information on this and so that's what I'm trying to figure out.

SHERI SHULER: OK, so what-- when we're talking about, like, an 8-year-old, the sort of transition that's happening is social transition. Children are using a different name or different pronouns or dressing differently, what have you. At the same time, there's assessment happening, there's other kinds of medical care happening, there's mental health care happening. And correct that nobody is just willy-nilly providing puberty blockers or anything else. I mean, I was presuming that period of assessment.

HANSEN: OK. All right. I was just trying to straighten that out.

SHERI SHULER: Yeah.

HANSEN: You mentioned that LB574 has harmed children if they don't get the care. You corrected yourself there.

SHERI SHULER: Right.

HANSEN: How? Like what evidence do we have to show that since we passed LB574 that that has harmed children from an objective standpoint?

SHERI SHULER: Right, I mean, as a parent, I can't-- I'm not going to be able to give you medical data, right? It's not my, it's not my area of expertise, but I will say that from parents that I've interacted with, it's very frustrating when they know, when they feel, and they-- maybe their doctors feel that-- and their therapists feel that their child needs this type of care, that this care is what is appropriate for their child, but there's 40 hours of therapy required, which in the ideal world means 40 weeks, but we all know with the mental health shortages in Nebraska, we're probably not talking about a year. We're probably talking about 2 years before those requirements can be met. Meanwhile, like time is marching on, the child is not able to begin the process of becoming who they truly feel they are.

HANSEN: OK. I just-- and I'm-- it's not so much a question, but I think something you brought up made a good point from maybe our perspective as legislators trying to figure out what to do here. I mean, your last paragraph, your, your first page: It's scary to contemplate any serious medical treatment and all drugs have risks. But, ultimately-- I'm going to change a couple words to make it relevant to us-- but, ultimately, parents have to have faith that whether we seek gender-affirming care or decide to hold off, we're making the best decision for the children of Nebraska with the information we have at the time. I think that's relevant from, like, our perspective as well. We're trying to get the best information we can at the time to make the best decision we feel is appropriate for the children of Nebraska. So I thought it was interesting that you brought that from a parent's perspective.

SHERI SHULER: Right.

HANSEN: So.

SHERI SHULER: I mean, from our perspective, politicians, no matter how well intended, are not the appropriate people to be making these decisions. It's doctors and parents who are close enough to know what their kids need.

HANSEN: OK.

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman. I'm trying to get some clarity here for myself. Is it fair to say that puberty blockers are not harmful, and so it would be, can I compare this to, like, holding a child back from third grade who can't read?

SHERI SHULER: I-- that kind of sounds like a decent analogy to me except for the social cost of holding children back, like that would be [INAUDIBLE].

RIEPE: But those would be social costs in both cases.

SHERI SHULER: Yeah.

RIEPE: OK. I'm a simple farm boy. I don't know. Thank you, Chairman.

HARDIN: Other questions? Seeing none, thank you.

SHERI SHULER: Thanks.

HARDIN: Kris Docherty. Welcome. How badly did I destroy your last name?

KRIS DOCHERTY: Actually, not too terribly. Kris Docherty, K-r-i-s D-o-c-h-e-r-t-y.

HARDIN: Very good. Thank you.

KRIS DOCHERTY: And I strongly oppose the passing of this bill, LB732. I'm a transgender woman. I am only 15, and I have been living as a woman for as long as I can remember. I have never even once majorly reconsidered my decision, and ever since that day that I came out, I have always received some form of pushback, whether from my peers or from, in this case, the government. I've always been prevented from living the life that would bring me the most joy. I have not been able to make significant progress in transitioning, especially because of the restrictments-- sorry-- restrictions that were placed previously with LB574 on queer children in Nebraska, including myself. Ever since the Let Them Grow-- sorry-- Let Them Grow Act, hormone replacement therapy has been severely limited already, and it's to a point where it's inaccessible for me and many others. There's already severe social "chastisation" faced by all queer youth in Nebraska, myself included, and the fact that the government is continuing to take part in this is, in my opinion, unacceptable. I've been hospitalized twice

for the mental strain put on me simply because I am trans. I was severely bullied and isolated at school, and day to day I was invalidated by my peers everywhere I went, and I couldn't further my social transition with voice training because I would get harassed every more every time-- or sorry-- even more every time I tried. And in combination with my voice deepening due to puberty, it led to my treatment being worsened regardless by my peers. And despite all of that, though, I still live happier as a woman than I ever did as a man. Around the time of my first hospitalization, the Let Them Grow Act was passed, and this led to far more damage in my immediate life, as I was restricted from accessing puberty blockers and currently HRT, and it is what inevitably led me down the path that got me so much "chastisation" for my identity. I directly mentioned LB574 in the writing I had initially left, and I directly blame it for getting me to the point of suicide. It is a serious consideration that you must make, as even if I have gotten better, I know there are others in Nebraska in the same situation I was in. If this bill passes, it will decimate the already dwindling mental of so many queer children in Nebraska, and I think the best way to represent this is by directly quoting the suicide note that I wrote when I was 13: Nebraska LB574 also extremely influenced me, and almost entirely was the reason for my decision. LB574, if you're unaware, severely limited all forms of gender-affirming care for anyone under 19. This made my gender dysphoria so much worse and hurt me so fucking much mentally, I wish I had died before I came-- this bill came into effect because it would have been better than having to live with it Almost single-handedly the single reason for our suicide is this god forsaken bill. End quote. I was young, and I did not know how to express my disappointment in the reality of the situation. I did use foul language easily back then, as I tended to reserve it only for the situations where it was severe enough to warrant it, and even if I may live, the damage is still done. If you pass this bill, then it is very likely that more queer children will resort to the option, that option that no child, child should ever be forced to even consider. You cannot put a value on a human life, and that goes for everyone, not just the people who fit society's mold of a person. My story is one of only many-- one of many others that have faced the same judgment by their peers, and it's certainly not going to be the last one if change does not start now. I understand you may not agree with our existence, but continuing to sabotage us and limit us societally will only lead to more lives lost. This bill will not-- it will not protect a single child. It will not yield any positive change. It will only lead for more suffering for every queer child in Nebraska. So please do not

pass this bill. Help me and other queer youth in Nebraska thrive. Work with us, not against us. I request that you oppose LB732, and I thank you for your time.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. I don't want this to be insensitive, but it relates over to our bathroom types of issues. Do you-- and if I don't get this right, please forgive me-- but do you personally then look for an individual bathroom as opposed to one that's a more of, like, quote unquote, women's multiple [INAUDIBLE]?

KRIS DOCHERTY: I had to go to the nurse's bathroom every time I would want to go, like, to the bathroom whenever I was in school and I tend to just have to avoid it in public anyway because I get chastised no matter which one I go into.

RIEPE: What would you do here in the Capitol?

KRIS DOCHERTY: I just wait till I'm home.

RIEPE: Good for you.

KRIS DOCHERTY: Yeah.

RIEPE: OK. Thank you.

HARDIN: Other questions?

RIEPE: Well, thank you. I, I hope I wasn't offensive. I didn't mean to be.

KRIS DOCHERTY: That's OK.

RIEPE: OK. Thank you.

HARDIN: Seeing no other questions, thank you. Folks, we are at an hour and so we need to switch over to neutral and so we will take about 2 minutes to switch the room over to neutral and then we'll be back over to the positive side and then we'll come back to the opposition side and then back to neutral again. Do we have any neutral testifiers here?

SERGEANT AT ARMS: We were just going to check now.

HARDIN: OK. Thank you.

SERGEANT AT ARMS: We'll go to positive if we don't have neutral, right?

HARDIN: Yes.

SERGEANT AT ARMS: So if you would exit through that door, and then we will call you for the next hour. No neutral.

HARDIN: All right. Thank you. We'll take a break for about 3 minutes.

[BREAK]

HARDIN: Welcome.

ERIN FRIDAY: Thank you. Shall I begin?

HARDIN: Please do.

ERIN FRIDAY: OK. Erin Friday, E-r-i-n F-r-i-d-a-y, attorney and president of Our Duty, a group of parents and detransitioners. My daughter used to believe that she was born in the wrong body. Every doctor and therapist told me to accept my new son and transition her. They tried to coerce me by lying that if I did not poison her with hormones, that she would kill herself. Teachers even called child protective services on me when I refused to treat my daughter as a boy. But I would not be bullied. I held the line and my daughter returned to being comfortable in her female body. All it took was one graph from the Tavistock gender clinic to know that the whole transgender movement was manufactured. It showed a 5,000% uptick of children adopting a trans identity. Nothing increases to that extent organically. Nebraska-- in Nebraska the number of 13- to 17-year-olds claiming to be trans jumped 426% in 7 years. I read every study, I learned very quickly that they were "transing" autistic kids, kids with severe mental health conditions such as bipolar and multiple personality disorders, and kids who happened to not fit the stereotype for their sex. Girls who liked short hair, and boys who liked pink. Performing mutilating surgeries and pumping a child with wrong sex hormones does not prevent suicide. The pediatric gender clinics proved that themselves. The NIH study of 315 kids who were fully supported in their trans identity and treated by the so-called premier gender clinics resulted in two suicides in the first year of the experiment. Studies do not show that confused kids avoid-- who avoid gender medicine kill themselves. Even the ACLU admitted that in the Supreme Court case. But the opposite is not true. Suicidality does increase post-transition. The Swedes and the Danish provided-- proved that.

Marci Bowers, president of WPATH, the foundational basis of all trans medicine, admitted that males whose puberty is blocked just as it is starting and then goes on cross-sex hormones will never experience sexual pleasure and will have micro penises. WPATH's Dr. Metzger admitted that kids cannot consent to sterilizing treatments because they don't have the capacity to understand. And the later regret is real. WPATH clinicians were caught on video stating that they're just winging it. Winging it with children's health. I am from the state that started this hellscape. Stop following the insanity of California and protect Nebraskan kids. Thank you.

HARDIN: Thank you. Questions? So tell us about your experience as a mom.

ERIN FRIDAY: So my daughter went to her sex ed class in seventh grade, she was 11, they were about 11 and 12, and her last hour of sex ed class, which was 5 hours, was all about gender identity. She was told about all these various identities that she can adopt. She and her five friends all came to my house that afternoon and they all chose something on the LGBTQ alphabet. Some of it stuck. Half of her Girl Scout troop came out as transgender. Fast forward when she started to go through puberty and she didn't like the changes in her body and she's, COVID, and she is living on a computer through a screen, she found transgenderism and that's when she told me she was a boy. Actually, I heard it through the school because I heard them calling her a male name through the wall. So I called the school, I am a Democrat of 30 years, I never thought for an instant that a school would change my daughter's name and her identity without picking up the phone. They had never met my daughter. She had never stepped foot in that classroom. It was COVID. It was her ninth grade. I asked those teachers, name one thing you know about my kid. One thing. What's her favorite ice cream? How tall is she? Is she fat? Is she skinny? One thing, but they changed her name. And they said they needed to be safe. I asked them to define the word safe for me because I'm a lawyer. What does it mean? Well, I learned what it meant. It meant that I was unsafe because child protective services showed up at my house followed by the police. And that was my opening to gender ideology is that if I didn't submit to this garbage that I would lose custody of my child. And every doctor I took her to, everyone told me that she would commit suicide. And that is false. She is now a 19-year-old, beautiful, young woman with all of her body parts intact because I held the line. I said, no, to the doctors. I said I don't believe you, and I read the studies myself.

HARDIN: When they threatened you, did you end up in court?

ERIN FRIDAY: Well, I might have thrown the fact that I was a lawyer around about 17 times and they stopped knocking on my door. But I am one of the lucky ones. What I do now is I help parents across the country, both in red states and blue states, who are losing custody of their children merely because they want to raise their child as the sex that they were born. It is happening across, across everywhere, in Georgia, Maine, Washington, California, Arizona, where you'd least expect it, is parents, because they want to raise their child with their full bodies intact, are told that they are not fit parents.

HARDIN: Did you have any Nebraska clients?

ERIN FRIDAY: Not yet.

HARDIN: I'm curious, did you have any in Missouri?

ERIN FRIDAY: In Missouri, no.

HARDIN: OK. We just had a testifier earlier from there, so.

ERIN FRIDAY: Yeah.

HARDIN: Other questions? Senator Hansen.

HANSEN: Do you have any information on typically when youth tend to regret some of these interventions that are being put on them?

ERIN FRIDAY: Well, I mean, I think it's a moving target. It depends on what the child had done to their body and when they had it done. But I have a, a member, she was 12 years old when she was transitioned and she was-- she just turned 13. It was her 13-year-old birthday present. She had her breasts cut off. No, she regretted that at age 17. So sometimes it's longer and sometimes it's shorter. But the maturation of the brain doesn't really happen until 23, 25. And these young girls are asked, like, do you care about having your breasts before they even have been kissed? They don't even know what they're for. And they're getting them removed. And then when they realize that they're sexual organs or that they provide life for a child that they weren't thinking about having when they're 12, that's when the regret sets in.

HANSEN: OK. Thanks.

HARDIN: Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Thank you for coming today. I appreciate your story. Could you kind of walk us through how the conversation went, at what point in time-- to piggyback a little bit on what Senator Hansen is asking, how did that conversation go? You've got a beautiful 19-year-old daughter now. When was that realization on her part and how did that conversation go? Was it thanks, Mom, or was it-- I mean, because there has to be, there has to be that defining moment, I would, I would imagine, where whether the light bulb went off or all of a sudden there was a, a revelation of some type, and, Mom, you were right. I know all parents just can't wait to hear their children say that at some point in time. You were right. But how did that go?

ERIN FRIDAY: Well, that's-- it, it took a year and a half, a long, very, very long year and a half of her actually telling me how much she hated me, calling me a bigot, because this is what they're taught, is that parents who don't go along are horrible humans. She was taught to emancipate. She actually served me with emancipation papers at the age of 13. Where did she get those? Well, she got them through the Internet and through the schools. So it was a terrible year and half. I would never want anybody to go through what I went through and that's why I've dedicated my life to stopping this. But there was a light bulb moment. I'll never forget it, because we were going on a vacation and it required her to wear a bathing suit, which, you know, in the trans-identified world, that's probably the most horrible thing that could happen is you have to wear a bathing suit. So I laid out all different variations of bathing suits, from boy shorts to bikinis to whatever, and she put the bikini on. And she looked in the mirror, and she liked what she saw. And that was the moment I knew she had come back. And there isn't a day now that goes by, literally a day, that I don't get a text or a phone call from her telling me that she loves me. So she went from hating me, wanting to flee from me, from telling me she loves every single day, and it warms my heart.

G. MEYER: Thank you.

HARDIN: With your legal clients, regardless of the state they're from, have you noticed that there is a repetitive theme between those clients? Is there a script? Is there a formula? Is there a process that you have noticed that happens over and over throughout the life cycle of this experience? What does that look like?

ERIN FRIDAY: Yeah, so the, so the process, and thank you for that question, there is a process and there are patterns and I don't

understand why the medical community doesn't see these patterns because I see them as clear as day. But these children are-- you know, once they feel that they are born in the wrong body and that is now solidified, they are taught how to trump up abuse claims. They are also taught at their schools, there are third parties that come in and teach students what their, quote unquote, rights are. And that if they run away, or if they make claims of abuse, they can get into foster care. Once they are in foster care, then, at least in my state, I don't know if in your state, but there's a foster care bill of rights, and this child gets to dictate their own transgender interventions. So this is their way to skirt their parents. If their parents won't consent, they go into foster care. I actually signed up for an online seller of cross-sex hormones, and I said I was 15. I signed up, I put in a birth date that said I was 15. I got an email from them saying things you'd like to know. If you run away to New York City, you don't need your parents' consent to get on cross-sex hormones. In my state, we are a trans-sanctuary state. Any of your children in Nebraska can run away to California and we take jurisdiction over them. That means the family has to fight for the custody of their child in my state where all the judges are being trained, and they have been trained for 10 years now, that parents who won't pollute their children's body with cross-sex hormones and puberty blockers are abusive. And so we take them. And then we put them into foster care, and we all know what happens in the best of times when a child goes into foster care. The results are not great.

HARDIN: How young can a child be and run away and declare sanctuary in California?

ERIN FRIDAY: Any age, no limitation. Same with Washington, same with New York.

HARDIN: So your 2-year-old can crawl there.

ERIN FRIDAY: A parent can actually abscond with a child. So if there's a custody decree in, in the state of Nebraska that says dad has no custody for the child, dad can steal the child, abscond with the child, go to California and then ask the California court for jurisdiction and to redo that custody agreement.

HARDIN: What happens next? Say a 15-year-old decides to go to California, then what?

ERIN FRIDAY: Without-- with parents or without parents?

HARDIN: Without parents.

ERIN FRIDAY: Without parents, they are put into foster care and then they are housed in a glitter family. This is a, a terminology that I, I, I hope that you will look up. This is a family who is willing to transition the child. And so they go into either state care, which incidentally they are housed based on gender identity. Think about this for a moment. You have a 15-year-old female body who can share a bedroom with a male body up, in California, up to the age of 24. So you have opposite sex children or and an adult sharing a bedroom in foster care and that does happen. I don't know what your, what your state laws are on foster care if it goes up beyond 18 and what--

HARDIN: They're different than that.

ERIN FRIDAY: Thank God.

HARDIN: Questions? Thank you.

ERIN FRIDAY: Thank you.

HARDIN: Christina, last name pronounced, Vosilla?

CHRISTINA MARIE: Vosilla, but--

HARDIN: Vosilla.

CHRISTINA MARIE: --close enough.

HARDIN: OK. Thank you.

CHRISTINA MARIE: Good afternoon, members of the committee. I thank you for the opportunity to testify here today. My name is Christina Marie, spelled C-h-r-i-s-t-i-n-a M-a-r-i-e. I'm a lifelong gender-nonconforming lesbian who believes that should I've been born just 5 years later than I was, I would have been medicalized. I knew I was attracted to girls as early as the age of 5. I didn't know what I was at that age. I just knew that my attractions made me different. Because of this, I experienced an identity crisis. I went from doing all of the boy things, thus, easily meeting the current criteria for gender dysphoria in childhood, to wanting to be a boy. And why wouldn't I when my childhood consisted of being bullied for looking and acting like a boy, as I simultaneously watched every girl I ever had a crush on only ever date boys. You can become a boy is the single cruelest lie that an adult can tell a young lesbian, and the reverse

is equally true for gay boys. The trans movement gives the impression that celebrating nonconformity is what the movement is about, but make no mistake, this movement is a slippery slope to, to conformity. Over the last decade, I have seen countless lesbians go down the path of trans by initially identifying as nonbinary only to later identify as men. And these nonconforming women and girls end up taking on the appearance and identity of straight men. The surface-level celebration of nonconformity masks the true intentions of the trans lobbies in our core. The vast majority of gender-nonconforming kids end up gay. And the trans lobby is pushing for gay conversion therapy by medicalizing these gay kids because-- or before they have a chance to accept who they are and grow up with their bodies intact, just as I did. Get them while they're young, as they say. If you can change your sex, as the trans lobby claims, then being gay is a choice, and this logic goes against everything the gay community has historically fought for. Being gay is not a choice and you cannot escape it. And attempting to escape it isn't without consequence. These kids aren't just rendering themselves infertile and sexually dysfunctional, they're increasing the risk of cancer and heart disease, which are already the leading causes of death in a healthy American population. They're experiencing severe developmental delays of pelvic dysfunction, vaginal atrophy, that can lead to eventual vaginal prolapse and early onset osteoporosis, and I haven't even gotten to the surgeries. Children cannot consent to harmful and irreversible procedures, and why should they be faced with these seeing as they are not proven to cure anything? The laws being proposed today are needed. Inducing physical disease in the body isn't health care. Misled compassion and ideology were used as justification to start this, and true compassion and evidence-based medicine is needed to end it. I urge you to vote on the right side of history by keeping kids that are like me safe, and I urge you to vote yes on LB732.

HARDIN: Thank you. Questions? Seeing none, thank you. Pear Davis. Welcome.

PEAR JOSEPH: Hi, my name is Pear Joseph, P-e-a-r J-o-s-e-p-h. I'm here today in support of bill LB732. Some of the earliest memories I have in my life are of confusion about my sex. Starting around age 4, I began displaying behaviors many people consider atypical for boys. I liked playing with dolls, wearing dresses, and I preferred playing with girls rather than boys. By preschool, other boys began commenting on my mannerisms and asking me why I acted like a girl. After a few years of confusion, I told my mom I felt like I was a girl trapped in a boy's body. My mom took me to a therapist, and after only a few

sessions, he reassured her that this was not unusual and that many boys who feel this way in childhood grow up to be gay. He was right. I did grow up to be a happily gender-nonconforming gay man. And I am now extremely grateful that my mom did not affirm my belief that I was a girl, socially transition me, or worse, lead me toward medical intervention. The DSM-5, diagnostic criteria for childhood gender dysphoria lists having a preference for toys and clothes traditionally associated with the opposite sex or preferring playmates of the opposite as supposed evidence that a child is gender dysphoric. The idea that certain personality traits or interests can be incongruent with someone's body is regressive, sexist, and also homophobic, considering many gays and lesbians do not conform to the stereotypes traditionally associated with their sex. As this issue has gained national attention, many people now recognize that there is indeed a trans-social contagion happening among children and teens. Yet, many continue to believe that there is at least a small group of, quote unquote, true trans children who do need puberty blockers and cross-sex hormones. Whenever I ask people to describe who these kids are or how we can identify them, they either describe a child who announced that they were the opposite sex despite no adult putting this idea in their head or they describe a little boy who is so unbelievably feminine from early childhood that he would surely make more sense living as a girl. In other words, they describe me. The Let Them Grow Act should be amended so that puberty blockers and cross-sex hormones are banned completely for all trans-identified minors. Allowing medical intervention only for the so-called true trans kids would result in a modern form of conversion therapy being done on kids who would otherwise likely grow up to be gay. There is no child whose personality requires their body to be altered. I urge you to pass this bill so that all the little versions of me living in this state can grow up healthy and whole. Thank you.

PEAR JOSEPH: Thank you. Questions? Thanks for being here.

PEAR JOSEPH: Thank you.

HARDIN: Jess Raburn. Welcome.

JESSICA RABURN: Hello. Pronounced it correctly. Good job. My name is Jessica Raburn, J-e-s-s-i-c-a R-a-b-u-r-n. I'm here today as a lesbian, a midwesterner, and your Kansas neighbor. I have close family in this state. I'm asking you to close the loophole allowing children to access dangerous cross-sex hormones and puberty blockers. I urge you to vote yes on LB732. I see Nebraskans as my neighbors, my

extended midwestern community. I ask this of you as someone who knows what it is like to not fit in, to know you are different from others of your sex. As a child, I did all the same things the boys did. Wrestling, making weapons out of stick. My pretend self was always the hero. My brother was my comrade in troublemaking. One of my first purchases at age 9 was a pocket knife. My best birthday present was a 410 shotgun. In the 1980s, a distant relative once asked my parents, who is that girl who thinks she's a boy? I was 12. If I was that same girl in 2026, I know I would believe myself to be a trans boy. I knew I was different from the other girls, always on the outside. If someone had told me that becoming a trans boy was an option, I know my younger self would have latched onto that as an explanation. I would have asked for the drugs and hormones even if somebody had told the risks. I wasn't capable of consenting at the onset of puberty, age 12, to osteoporosis, lifelong urinary incontinence, endorphin disorder, or a womb that shriveled due to estrogen deprivation. The girls, now women, who were given puberty blockers as children have sued the manufacturer repeatedly. You will easily find reports from a decade and longer ago warning of its danger before it was politically loaded to do so. We must give children time to explore who they are without being locked in by medication. I have a niece who lives south of Kansas City. At age 9, the same age I was buying my first pocket knife, she told my sister she was trans. When my sister doug deeper asking questions, she discovered my niece meant she was bisexual. The other kids at schools were using trans as a shorthand for everything LGBT. Children are limited in what they understand. You don't know the world at 9, 12, or 16. You haven't had enough time to learn. I don't want kids like my niece to be able to cross state lines and take toxic drugs to match an identity that can change in a heartbeat with a growing kid. She still identifies as bisexual at age 13. She may continue to do so or she may easily decide that she is going to be a straight adult as more than one of my nieces and nephews has done. Nebraska was among the first states to protect children from destructive and irreversible gender-related surgeries, yet harmful puberty blockers and cross-sex hormones remain legal and easily available. Please act again to close this dangerous loophole. Thank you.

HARDIN: Thank you. Questions? Senator Hansen.

HANSEN: Thank you. Did you say you're from Kansas?

JESSICA RABURN: Yes.

HANSEN: I think an earlier testifier said-- do they-- what's their regulation on puberty blockers and, and sex hormones for minors in Kansas? Do they ban it there?

JESSICA RABURN: Yeah. Yeah, I know it's in the Supreme Court, but I'm, I'm sorry, I haven't looked to see if they've made a decision on it [INAUDIBLE].

HANSEN: Yeah, I think somebody mentioned that earlier. So from your perspective, I get what your perspective-- I don't even know what you call it. We're a Nebraskan. What do you call somebody from Kansas?

JESSICA RABURN: That's-- oh, Kansan. Yeah.

HANSEN: OK.

JESSICA RABURN: Same.

HANSEN: A Kansan.

JESSICA RABURN: With a 'n' on the end. Yeah.

HANSEN: Since they have banned or maybe looking at what this bill is trying to accomplish, what's it like there? Like, like, have you heard, like, a surge in suicide rates or people fleeing the state or, like, has things extremely changed since then?

JESSICA RABURN: I have not. I did not look. I would say that my stepson goes to a small private school and it is mostly children who identify as trans. It's probably like 60% of them. It's all really, it's kind of a school for those who don't fit in. He's autistic and so, you know, there's no bullying, which is great. But I, I talk to my wife about this subject a lot and she talks to the other parents and I have not heard of any children suffering from it.

HANSEN: OK. And now some historical context, you're mentioning when you're 9, you know what I mean, your friends, all that kind of stuff, do you see that it's different back then than it is now?

JESSICA RABURN: Drastically.

HANSEN: Why do you think that is?

JESSICA RABURN: I think it is this spotlight on trans identities and that for some people they are so willing, they want so bad to be nice.

A lot of them, it's not that they want to be mean and they want to hurt kids, it's not. So they see a child like Pear or myself or Christina and they think the way, the, oh, look, you know, what if you are trans and if you had asked me that one simple question at 5 or 9 or 12, I would have said yes. Back then nobody even thought about that. I was a tomboy. Girls like me were tomboys. We were just different. We might grow up to be lesbians, or we might grow up to be straight women. There are a lot of straight women who were tomboys when they were kids, who were just like me and liked guns and knives and getting dirty. You know, it's not always going to lead to being a lesbian, but my, my family told me later that, like, yeah, we, we all knew.

HANSEN: OK. So you would say probably societal influences played a pretty big role in, maybe, I wouldn't say a surge, but a potential surge in transgender youth recently?

JESSICA RABURN: Yes, I mean, I think it, it kind of-- even just-- I'm not saying that nobody should ever ask the question, but even just asking the question of a child, do you think you might be trans, is leading a child to it. Because if I know myself, and that if I had been asked that question, I would have thought, well, I need to examine everything inside myself to find this answer. Am I or not? I would've obsessed over it. You know, as children, you obsess over things, especially your future identity. Like, what profession am I going to be in? If somebody had said, oh, I think you'd make a good engineer, that would have influenced me as a child.

HANSEN: OK. Thank you.

JESSICA RABURN: Mm-hmm.

HARDIN: Other questions? Seeing none, thank you.

JESSICA RABURN: Thank you.

HARDIN: Other proponents for LB732? Welcome.

SCOTT THOMAS: Good afternoon, Chairman Hardin and, and the Health and Human Services Committee. My name is Scott Thomas, S-c-o-t-t T-h-o-m-a-s, and I am the Nebraska Director for the U.S. Institute of Diplomacy and Human Rights and the founder of Village In Progress, who work on various sets of human rights related issues. I sit up in this chair all the time and make lofty claims, lofty, big ones. You know, nobody poses me any questions. It's almost like, you know, everything

I'm saying here is true, so let's just go a little bit further. How do we get to this point? A senator bringing a bill to stop experiments from being done on children in this state of sexual nature. Let's start with a baseline. There's no such thing as a homosexual. Sexual activity is defined by its potential yield for procreation. Same-sex activity has no such potential, making it something else. It's a temperament inversion. Now, last night the news ran a story about a girl who suddenly gave birth one day without ever knowing she was pregnant. And I guess I'm just not that charitable when I'm describing the reasonable expectations of people. And Senator Kauth is an American hero around our house, but I disagree with her assessment that the cause is toxic masculinity. It seems to be an outgrowth of these general attacks on traditional masculinity. In 2012, Janssen Pharmaceutical set up a claim with the state of Nebraska and 36 other states. The claim was that anti-psychotic medication for schizophrenics was being prescribed for its secondary benefits to children and adolescents. Boys who were perceived as aggressive for engaging in rough-and-tumble play were given a medication to alter their temperament and suffered gynecomastia. They developed female breast tissue, presumably as a side effect. These are little boys being forced to take estrogen for decades in this state. There is nothing wrong with being a boy. There is nothing wrong with being a girl. There is absolutely nothing wrong with being just as God has made you. And telling children that there is, is child abuse. Forcing children to take drugs in an effort to alter their bodies or their temperament is child abuse. Article 25, Section 2 of the 1948 Universal Declaration of Human Rights makes giving young children experimental drugs of a sexual nature a treaty violation. It is a blatant human rights violation. And I don't care if Europe does it, because I think that we're better than Europe when it comes to human rights issues. And that's why I don't live there. I don't vacation there. I don't even like to visit there. I also don't care who tells you anything differently and I'm willing to debate these issues publicly, so. Respectfully submitted, and then any questions from the senators, I'd be happy to accommodate.

HARDIN: Thank you.

SCOTT THOMAS: Thank you.

HARDIN: Questions? Senator Hansen.

HANSEN: I'm just going to ask you a question so you don't always think you're right.

SCOTT THOMAS: OK, thank you, man. I appreciate that. That way, that way--

HANSEN: Like you mentioned earlier.

SCOTT THOMAS: --that way I can question myself and wonder if there were questions that were just left on the table.

HANSEN: The, the, the section about Article 25, Section 2 of the Universal Declaration of Human Rights, so that's still in effect?

SCOTT THOMAS: Yes, sir, it says that children even born out of wedlock are entitled to a, a substantial amount of protection given by the state. They're entitled to the same protection as children born in marriage.

HANSEN: And this is one about experimental drugs of a sexual nature, a treaty violation.

SCOTT THOMAS: I guess you could say that's my interpretation of it.

HANSEN: OK, just curious, I just wanted to get your opinion on it.

SCOTT THOMAS: They don't have that in the, in the treaty. It's not actually in the text language.

HANSEN: Thanks.

SCOTT THOMAS: Appreciate it.

HARDIN: Other questions? Senator Meyer.

G. MEYER: Thank you, Chair Hardin. Scott, if I may call you Scott,--

SCOTT THOMAS: Yes, sir.

G. MEYER: --you have appeared before this committee a number of times when I have been sitting in this chair. You were in Education Committee very recently.

SCOTT THOMAS: Absolutely.

G. MEYER: And I, I, I guess I don't have a question for you, but I do want to share that I always appreciate your viewpoint. You're articulate. You, you-- you're, you're well researched and I think you've got some really good points. Whether I agree with you all the

time or not, I really respect the fact that you step up to the plate and, and make your opinion known, so I appreciate that very much.

SCOTT THOMAS: I appreciate that. I appreciate the discourse. Thank you for that.

HARDIN: Other questions? Seeing none, thank you.

SCOTT THOMAS: Thank you very much, gentlemen.

HARDIN: Proponents to LB732. No more proponents. One more proponent.

KEN HUGO: It will be short.

HARDIN: Welcome.

KEN HUGO: Yep. Last time I've been in one of these chairs was Ernie Chambers days. My name is Ken Hugo and that's K-e-n H-u-g-o from West Point, Nebraska. Fewer things to kind of bring up here because the last three people really answered the questions that I had that they put for you in the information and they handled it much better than I did, so I appreciate them for that. You know, we're supposed to let the children grow up naturally and we're supposed to follow the science. And every time there's something in science that doesn't go the right way, it's put in the shelf there. And I guess I've kind of been thinking about the, the children and the lady there mentioned California and somebody else did, you-- your hands, once you get that child away, you don't get that child back. And I was following a couple cases until I got a bad injury. But a couple of cases in California where, yeah, the dad, he did not want the, the-- I thought it was the son be turned into a daughter. The mom was opposite onto there and the father had to stay away from-- couldn't, couldn't go to church, couldn't do anything, whatever, under there. And I don't remember how that case went, but that is a pretty hard part. And then the other question that was answered about what is the dosage for the blockers on there, and that was answered onto there, too. And then the other thing is kind of what happens, and that's, that's more a legal question there, what happens to the child if parent A said, yes, we're going to do this, parent B says, no, we're not going to do it? Well, if you're in California, maybe Nebraska will rule that way, you don't have any say with what it is. So at that time, having a lawyer and it's too late, the deed has already been done. So that's-- well, that is all I really have under there. I probably have more, but I want to--

HARDIN: Thank you. Appreciate it.

KEN HUGO: --I want to thank the previous people under there that took it away, so.

HARDIN: Any questions? Seeing none, thank you. Any more proponents, LB732? Scott, you already went once.

SCOTT THOMAS: No, somebody different.

HARDIN: Oh, OK. Well, I'm going to have to say hmm on that one. We're going to take a break for just a couple of minutes. Let's take 20, the next 20 folks in opposition because I believe we're out of-- we don't have any in the neutral, is that correct?

SERGEANT AT ARMS: Correct.

HARDIN: Great. So we'll do a changeover with the room. Would you turn the mics off there, please?

[BREAK]

HARDIN: Thanks.

ASHLEIGH CLARKE: Go ahead and start?

HARDIN: We're ready.

ASHLEIGH CLARKE: All right. Chairperson and members of the committee, thank you for listening to me today. My name is Dr. Ashleigh Clarke. That's A-s-h-l-e-i-g-h, Clarke is C-l-a-r-k-e. I'm a licensed clinical psychologist in Nebraska, and I'm here today on behalf of the Nebraska Psychological Association, which represents psychologists practicing across the state in schools, medical, and integrated health care settings, higher education, private practice, and community mental health. The Nebraska Psychological Association opposes LB732 due to concerns about its impact on mental health, clinical decision-making, and health care governance in Nebraska. Before I continue, I want to clarify my professional role. My training and licensure are in behavioral mental health so my testimony today focuses on mental health risks, systems impact, and policy consequences of restricting access to care for youth and families. LB732 represents a shift from Nebraska's existing framework of regulated clinician-guided care to statutory restrictions enforced through legal penalties. Under Nebraska's current system, care for minors is governed through

professional licensure, ethical standards, informed consent, parental involvement, and regulatory oversight. This framework is designed to manage risk and support individualized evidence-based clinical decision-making. LB732 would replace that framework with categorical restriction, shifting decision- making authority away from qualified health care teams and families and towards statutory mandates that cannot account for individual clinical circumstances. Supporters of LB732 often point to uncertainty in medical literature as justification for restriction. It's true that evidence continues to develop. Importantly, this does not reflect findings of harm or ineffectiveness. From a behavioral health perspective, restriction is not a neutral act. Restricting access to care and introducing legal penalties into clinical decision-making are interventions in their own right. Psychological research consistently shows that stigma, loss of autonomy, and disruption of trusted care relationships, particularly when they result from restrictive or stigmatizing policies are associated with increased risks for anxiety, depression, and suicidality in youth. When the state intervenes for a restriction, it carries a responsibility to consider and justify the mental health harms that restrictive intervention may introduce. LB732 does not address or mitigate those risks. In closing, this bill replaces regulated clinical-- clinician-guided care with statutory restrictions and removes individualized decision-making from educated, trained health care providers and families. From a behavioral health perspective, this choice carries predictable mental health and systems consequences. For these reasons, the Nebraska Psychological Association urges the committee not to advance LB732. Thank you for your time, and I'm happy to answer some questions that are within my scope.

HARDIN: Thank you. Questions? Senator Hansen.

HANSEN: Thank you.

ASHLEIGH CLARKE: Yeah.

HANSEN: Can you elaborate a little bit more on some of the studies or evidence you were talking about, like, on what maybe you rely on?

ASHLEIGH CLARKE: Yeah, so one-- so, again, the ones that I primarily looked at from my specific testimony today has to do a lot with kind of the system impacts of kind of the impact of access to care creating some structural barriers for coming in like providers, like future providers who may deem that they don't want to work in a system that

restricts this and so they go elsewhere. Also as well as how when we put these policies into place, then it increases stigma and kind of the argument that there are reasons we can act against and, and maybe transform it homophobic ways within other people. I'm not saying that's here in this house, but also-- but, again, within schools, it's kind of a, a easy way for kids to fall back into. And when there's a lot of restriction, their interpretation is that it's due to stigma or that there's reasons that they should maybe bully or target.

HANSEN: OK. Have you been involved in care for minors?

ASHLEIGH CLARKE: Yes.

HANSEN: OK. All right.

ASHLEIGH CLARKE: Yes.

HANSEN: OK, just curious. Thanks.

ASHLEIGH CLARKE: Yes. And, and I've also been in the care of, of gender expansive minors. So, again, those who identify as trans, nonbinary, things like that. So I do work with youth who identify that way. Yes, Senator Ballard. Sorry.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here, Dr. Clarke. You said something interesting in, in your testimony. You said as evidence continues to develop.

ASHLEIGH CLARKE: Yes.

BALLARD: We hear all the time that, from other organizations that said put a pause, put a break as, as evidence develops. And you're saying the opposite in this sense.

ASHLEIGH CLARKE: I'm sorry?

BALLARD: Are you saying the other opposite in the sense? As, as evidence develops, supporters of this bill said maybe we should put some breaks on this. Can you kind of describe that push and pull you're thinking?

ASHLEIGH CLARKE: I'm kind of leaning back into what, like, Senator Riepe said earlier, is, like, we haven't given enough time for even

the previous bill to, to show substantial progress or not. Like, we, we have to give them time. So while evidence develops-- and, again, medical research is not my area of expertise, so I'd really have to, like, defer, or even like research as a whole, I am more of a practitioner. And so I know we have some evidence coming up behind me. We have some really great testifiers who are going to talk about the state of evidence at this time. And so I feel like immediately putting a stop-- again, the bill has no timeline of saying, like, let's put a pause on this for 2 years while we continue to do research, this bill would go into effect indefinitely. Correct? Does that--

BALLARD: That helps. Thank you. Appreciate it.

HARDIN: Other questions? Seeing none, thank you.

ASHLEIGH CLARKE: Thank you.

HARDIN: Camie Nitzel. Welcome.

CAMIE NITZEL: Thank you. Hello, my name is Dr. Camie Nitzel, C-a-m-i-e N-i-t-z-e-l. I am a licensed psychologist in the state of Nebraska, and your Internet is really wanting to join. And I provide a wide variety of mental health services to individuals and families in Nebraska. I submit this testimony today in fervent opposition to the proposed LB782. As I believe it to be a legislative bill that is harmful to youth experiencing gender dysphoria. It interferes with parental rights and creates untenable barriers and mental health and medical and therapeutic relationships. So, as you all are aware, last session LB574 was passed. I heard lots and lots of concern about legislators wanting to protect children, to let them grow. Even extending to the state's desire to protect the unborn. LB574 mandates 40 hours of mental health counseling prior to commencing any puberty blocking or hormone interventions for youth who identify as gender diverse or transgender, so in answer to your earlier question. LB574 prohibits surgical interventions for minors and it has a waiting list post prescription, or waiting list, waiting time, post prescription. It's important to note that this 40-hour mandate was decided upon by the Chief Medical Officer at Nebraska DHHS, Dr. Timothy Tesmer, who was appointed by Governor Pillen. LB574 was the outcome of hours and hours of people on all sides of the political spectrum working together to craft a middle path that could be workable for everyone. People with concerns about youth prematurely identifying as transgender and/or regretting a decision were satisfied that the 48 [SIC] hours of counseling protected youth. Parents, youth advocates

for parental rights, and advocates for protecting the physician-patient relationship were satisfied, that for a small number of children who completed the 40 hours and were still unsure about their gender identity, hormone blockers remained an option. For those youth who were insistent, consistent, and persistent that they needed hormone intervention, and all members of the treatment team agreed, and parents were on board, cross-sex hormones remained an option. By no means was this an easy year, but we worked together to craft a solution that maybe no one loved, but that everybody could live with. For a little bit there, I was proud of us as Nebraskans. But this bill, this bill does exactly the opposite of protecting children. Puberty blockers, which put a temporary, completely reversible pause on puberty, are actually a protective mechanism. Think about this for a moment. You are seeking to ban a completely reversible, temporary medical intervention that could prevent youth from prematurely beginning cross-sex hormones. So the use of puberty blockers is entirely consistent with LB574. You're seeking to provide protections against premature or incorrect transitions for kids. To be sure, puberty blocks are one way to do that. It buys time for engagement in a careful, developmentally appropriate, parent-involved, clinician-involved, medically-informed decision-making process. I see my red light on and I want to be respectful of it, but I do have more things to say.

HARDIN: Senator Hansen.

HANSEN: I'll just ask questions and it gives you more time to say some more stuff if you want to. But just a couple things you mentioned. You said LB732 is harmful for youth. Can you expound on that a little bit more and why?

CAMIE NITZEL: Yeah. So when we have youth, I'm not saying it's-- what I'm saying is that when we have youth who don't have access to hormones or puberty blockers, that is harmful to them. But, in particular, when youth are questioning and would benefit from another year to kind of figure things out before their body takes off, we're taking that opportunity away. And so that year could be a pause that gives them the time that they need to then figure out, oh, I'm not actually trans. I'm gender diverse in this way, and natal puberty can happen.

HANSEN: You're saying using puberty blockers to pause so you can figure things out. I had this--

CAMIE NITZEL: Removing that.

HANSEN: We had the same question from another testifier, because that contradicts what the NMA is saying. The NMA is saying they go through 2 years of the most extensive therapy, figuring this stuff out, and then medical intervention is performed.

CAMIE NITZEL: I think you are--

HANSEN: I'm confused by this.

CAMIE NITZEL: Yeah, so when Dr. Constance testified,--

HANSEN: Yeah.

CAMIE NITZEL: --what she said was the 2 years-- she understood that the bill had-- that LB574 had 1 year prior to a therapy, prior to commencement of puberty blockers, and then another year of therapy prior to cross-sex hormones. So if you start hormone blockers, you've got 12 to 18 months that a kid is on them before you would start cross-sex hormones.

HANSEN: OK, and you're saying puberty blockers are completely reversible.

CAMIE NITZEL: That is what I am understanding from the literature from Dr. Constance's testimonies, both this and last year, and other professionals that I've worked with.

HANSEN: OK. Because I've heard variations of the opposite, like, there's some instances people were put on puberty blockers, and it delays puberty, and they have issues with it later on down the road.

CAMIE NITZEL: Well, they're-- that is in the literature, the predominant thinking, as I understand it, is that they are completely reversible and that it just buys us time.

HANSEN: Yeah. OK. Thank you.

CAMIE NITZEL: You're welcome.

HARDIN: Other questions? I guess my concern is and I'm looking at the Mayo Clinic site and they're saying one prominent issue with puberty blockers is reduced bone mineral density, which may increase the risk of osteoporosis, fractures in adulthood. And it goes on to talk about

another, another challenge that, that can happen as well, alterations in final adult height and body composition may persist. So it does sound like there could be some challenges with puberty blockers, that they are not in fact like taking a vitamin C, just pointing that out.

CAMIE NITZEL: No, they're not like taking a vitamin C, but it does provide protective benefits.

HARDIN: OK.

CAMIE NITZEL: And if we just--

HARDIN: But that would be very different from what you said a little bit ago. So let's just not make sweeping observations, I guess is what I would caution you about. Other questions?

CAMIE NITZEL: That is outside of my scope as a psychologist and would encourage you to consult the medical professionals about that.

HARDIN: OK. We've been listening to them today. So thank you. Appreciate it.

CAMIE NITZEL: Mm-hmm.

HARDIN: Other folks in opposition. We've kind of worked through the list of folks who were-- had registered to come, now we can take others in opposition. Welcome.

BRADEN FOREMAN-BLACK: Welcome, or I guess, thank you for having me. Hi, everyone. My name is Braden Foreman-Black, B-r-a-d-e-n F-o-r-e-m-a-n-B-l-a-c-k. I'm a social worker and therapist at Kindred Psychology. So Camie is my boss. But if I ever say that, Camie will correct me as her colleague. So I work at Kindred Psychology and Kindred Psychology, in my expertise, I see folks across the spectrum of mental health diagnoses. Kindred Psychology is known for its excellent care with gender diverse and expansive people. So what I'm sending out to you today is I did some pre-work before these hearings to meet with Senator Kauth about the rationale behind her bill, because I work with these gender-diverse youth who might be seeking hormone replacement therapy or puberty blockers. And so I wanted to get to know, to know about her data, and she did share with me the systematic reviews that were a part of what a lot of the medical research is, right, being talked about in the session today. And what I want to also start out with was Senator Kauth did not really speak in this meeting. It was led by two of her medical team is what she's

phrasing it, which was Leor Sapir, which is from the Manhattan Institute, who is not a licensed mental health or medical professional, and Jamie Reed, who you heard earlier, who is also not a licensed medical or mental health professional. But they are providing the status saying, hey, this is what the medical reviews say. So you have a list of the systematic reviews that pertain to Nebraska, they're mentioning 17, but 12 really pertain in Nebraska based on the laws that are already established in LB574. Because we don't allow for surgeries under, under the age of 19, so the mastectomy systematic reviews were eliminated, so you had 12 there. But what I really want to talk about because I've heard questions about this from previous testimonies about, hey, these systematic reviews are proving that you-- that this is bad. And that's not true. As individuals who are social workers and therapists, it's our, our job to understand the literature. So a lot of my team and I went and did look at it. And so, you know, as we look through the literature, they're not saying definitively that these are bad treatments. One saying: Nevertheless, these interventions have not shown the serious risks of harm that would suggest the need for policies to restrict these interventions. So even the authors of these systematic reviews that Senator Kauth is saying prove that they're not ethical are actually not saying that. She's misrepresenting the data and her medical team who are not medical professionals are citing this as expert fact and that is just not true. And so we've, we've gone through all that work. And, you know, as, as for, for us, we have to be very careful as professionals who understand this work that in these studies, there are things where they say that there's just not enough data to support it. But what we do know, and when we talk about it, is you can't say that that is a justification for harm. And that is very clear from what these researchers and these statements are saying. And so we have, and Camie has, lists and lists and lists of data and literature that do support the ethical treatment of, of puberty blockers or hormones for children under 19. And it's hard for a lot of us to, I think, pull it out because the, the literature is so expansive. And it's, it's gone over multiple years, but when people say that we don't have it, that is also not true. We just need to work together to get that literature out there so that way you will have it, too.

HARDIN: OK. We have you in the red, so--

BRADEN FOREMAN-BLACK: Oh, so sorry.

HARDIN: --any questions?

HANSEN: I, I got one.

HARDIN: Senator Hansen.

HANSEN: What was, what was-- what did you say-- the quote you used from the research--

BRADEN FOREMAN-BLACK: Yes.

HANSEN: --provided saying the research doesn't-- like, I'm trying, I'm trying to figure out what-- remember what you said about it doesn't justify a ban.

BRADEN FOREMAN-BLACK: Yes, it does.

HANSEN: What was that, what was that quote?

BRADEN FOREMAN-BLACK: Yep, so it's on the back page of this one where it says Senator Kauth's medical team.

HANSEN: Oh, OK.

BRADEN FOREMAN-BLACK: Right before the first highlighted section it says: Nevertheless-- and this is just a direct quote from one of these articles.

HANSEN: It is a direct quote?

BRADEN FOREMAN-BLACK: It is a direct quote: Nevertheless, these interventions have not shown the serious risks of harm that would suggest the need for policies to restrict these interventions.

HANSEN: OK, so that was-- do you know which one that was?

BRADEN FOREMAN-BLACK: If you go to LB32 [SIC] opposition, that one is-- it's listed in there, too, somewhere.

HANSEN: OK, I can look for it.

BRADEN FOREMAN-BLACK: Yeah, yeah. We'll, we'll, yeah, get into the weeds of it, but, but multiple of them say something similar of the risks that we're seeing don't outweigh the harm, and so it would be very hard for legislatures to justify that these bills are effective because, right, like when we think about cancer research with kids, there are major side effects that happen from chemo treatment, but we-- because the risk of not treating them is so grave, we still treat

them, even through clinical trials. And so they're saying essentially that, too, of we do need more research to understand the long-term efficacy of things, but it doesn't justify a ban.

HANSEN: OK. So you're saying even if these do have the potential for harm long term, we can still justify using them on children?

BRADEN FOREMAN-BLACK: Absolutely, because, because what we're doing is we're saying what risks are people comfortable with? What are parents comfortable with? Right? So--

HANSEN: But we don't know the risks, like you just said, long term, [INAUDIBLE].

BRADEN FOREMAN-BLACK: They've, they've listed risks such as bone density or height velocity.

HANSEN: OK.

BRADEN FOREMAN-BLACK: We do know those. Now, long term, like bigger things, we have systematic reviews and meta-analyses that do talk about long-term effects and Dr. Constance talked about that also. But it's those things of we, we-- you know, and as a provider, I work with folks to understand, is it gender dysphoria? Are we thinking about sexuality instead? Are we really looking at anxiety, depression for other causes? And so we're trying to get a grasp of what the person is clinically showing up with. And as that happens then through the 40 hours, we can say, yes, this child is ready, and then they would go to the medical team to get those answers. And we might help them come back and process those risks of what are you comfortable with? What aren't you? But the parents have that full autonomy to say we are comfortable with this that we know of currently.

HANSEN: OK.

BRADEN FOREMAN-BLACK: But research is always expanding in every field and we still perform those medical interventions.

HANSEN: Is, is that what-- is that somebody's done that, that LB, is, is-- are these some of the studies--

BRADEN FOREMAN-BLACK: Yes.

HANSEN: --that you're, that you're saying, like--

BRADEN FOREMAN-BLACK: Well, these are the ones that Senator Kauth has all provided. It's hard because-- but we have plenty that we can actually get it to you. Yes.

HANSEN: Yeah, because I-- yeah, whenever you can, hopefully sooner than later because--

BRADEN FOREMAN-BLACK: Yep. They're in my inbox from Camie, multiple, multiple, multiple.

HANSEN: OK.

BRADEN FOREMAN-BLACK: And we have resources and resources.

HANSEN: Because I've heard that, I've heard that, you're, like, maybe, the fourth person to say that. We have an expansive, so much research, but nobody's providing it.

BRADEN FOREMAN-BLACK: So I think this is where we-- it's important to understand that this is years and years of research from the AMA, from the APA.

HANSEN: Where, where are the studies? Like, you got Senator Kauth's on here.

BRADEN FOREMAN-BLACK: Yeah, we'll get those to you.

HANSEN: Where, where are yours though? Like, would you have a piece of paper like this?

BRADEN FOREMAN-BLACK: We have, like, books and books of these things. We can't just pinpoint to, hey, here's one study that justifies everything. It's mountains of literature based on different systematic reviews and meta-analyses. There are so many things to sift through that it takes us providers a lot of researching based on what we're seeing individually to say, OK, what is actually happening? We can get you a list of the ones that we often go back to, but I'm just saying there's such a plethora of information out there.

HANSEN: OK. That would be good because I think one of the major things we're hearing from people in support of this bill is, like, there is no clinical evidence to show that these puberty blockers benefit these children and so I'm looking for something, but I haven't got anything yet.

BRADEN FOREMAN-BLACK: Well-- but, I mean, people have stated it, right? We often rely on these medical bodies like the APA to provide these justifications.

HANSEN: Yep. I'm sure somebody will send it to me, maybe Dr. Camie [SIC] will, and I can look at it, but just expressing my concern with that.

BRADEN FOREMAN-BLACK: Sure.

HARDIN: Senator Quick.

QUICK: Yeah, thank you. So-- and you can-- mine's more of a comment, but you can respond to it if you'd like. I'm going to talk about my granddaughter one more time. So she's on a puberty blocker right now because, because she was going through-- starting to go through puberty too soon. And the doctor said if she doesn't get the puberty blocker before she menstruates that her bone density would drop and she wouldn't, she wouldn't grow anymore, she-- you know, there could be other, other effects from that. So she's going to be on that puberty blocker until they determine that time when she can actually go off of it, which could be when she's 10, so that she could be on it for 4 years. I know every year they have to take an X-ray, they take an X-ray of her hand, and I'm sure that's to see what the bone density is, to see if maybe she can go off of them sooner. So I don't know if you have any comments to, to that, but I think the puberty blockers also have-- they're not a dangerous drug, but I'm sure they have some adverse effects, just like anything. I mean, I take blood pressure medicine, and there are side effects from that as well.

BRADEN FOREMAN-BLACK: Right.

QUICK: So I don't know if you want to make a comment.

BRADEN FOREMAN-BLACK: Again, that's outside the scope of my practice for that specific medical intervention. What I can talk about is the mental health effects of gender dysphoria that would lead to the need for these types of interventions.

QUICK: OK.

BRADEN FOREMAN-BLACK: Yeah.

QUICK: All right. Thank you.

BRADEN FOREMAN-BLACK: But I appreciate [INAUDIBLE].

HARDIN: Senator Riepe.

RIEPE: Thank you, Chairman Hardin. I don't mean to speak for the-- my fellow committee members, but I sense that what we get is a really slow-- what I feel that I get is, is it's either black or white. It's either suicide or not suicide if you don't do, if you don't-- aren't allowed to do these things and so we're left with this almost ultimatum of what are you going to do? Are you not going to it and maybe have the kids then be subject to suicide or what, you know? So it's-- that boils it down a little simplicity, but--

BRADEN FOREMAN-BLACK: Yeah.

RIEPE: --I, I don't know.

BRADEN FOREMAN-BLACK: Yeah, and I--

RIEPE: --I need help moving beyond that, I guess.

BRADEN FOREMAN-BLACK: For sure, and that's where I think this work is so misunderstood as a provider, right? And this is where the 40 hours of, of, of therapy is so critical, because our job is to assess for are we experiencing suicide because of gender ideation or because of gender identity or is it something different?

RIEPE: Is it important to get that 40 hours? I heard someone testify that says if you live particularly maybe in the rural.

BRADEN FOREMAN-BLACK: Yeah.

RIEPE: You might take it longer or too long, so my sense is, you know, does it need to say 40 hours within 100 days or 40 hours within X time or something?

BRADEN FOREMAN-BLACK: Yeah. So I think where, where clinicians and providers have always wondered from LB574 is why 40? And I don't think we know, I think that was with the Chief Medical Officer.

RIEPE: Was that Moses in the devil-- or desert or what?

BRADEN FOREMAN-BLACK: Maybe. But so we don't know, and it is case by case dependent, right, of, of being able to assess for readiness based on where the child is at. But the 40 hours currently does allow us

time to really work with the child and, you know, a lot of my work and, and of what I do is, sure, it's gender dysphoria but it's social anxiety, it's, it's other types of anxiety, we might be talking about OCD, and our work is to work with that child and that family to really understand what is impacting them. And I think that gets often misconstrued of gender-affirming care is just we're talking about gender. We are talking about so many important factors that affect school and education, family life, trauma, which is a big part of my training, is how trauma impacts people. And so this does-- the current structure of LB574 at least allows us an opportunity to get to know the rationale behind it. And we just don't see the impacts of LB574 yet because we haven't had time to play it out. And I will also say that for a lot of gender diverse youth, hormones are not something that they want. For some it is, and for some it isn't, and, and that's wonderful, and, and we work with people and all that. But there are moments where we might say, OK, a person isn't ready for this yet, based on what we're seeing. And so we have that clinical expertise to really create those safety guards that are needed before any type of medical intervention is, is, you know, recommended.

RIEPE: OK. Yeah, that's helpful, thank you.

BRADEN FOREMAN-BLACK: Yeah.

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

BRADEN FOREMAN-BLACK: Thank you.

FREDRICKSON: Next opponent for LB732. Welcome.

JESSIE McGRATH: Senator Fredrickson, members of the committee, my name is Jessie McGrath, J-e-s-s-i-e M-c-G-r-a-t-h. I am a post-op transgender woman who's been living as a trans person for the past 11 years. LB732 is a component part of anti-trans legislation that has been developed by nationalist "christus" organizations hellbent on making it impossible for a trans person to exist in America. I am at a loss as to why Kauth has such an incredible dislike of transgender Nebraskans. Perhaps, she sees these bills as a way to gain political power or some other reason, but we do know that she has a deep dislike of trans people. We have been paying the price for her unrelenting obsession for the last 4 years. And now we're faced with another bill that is specifically targeting transgender Nebraskans' access to health care. Creating a right of action by the Attorney General with a 20-year statute of limitations and a $25,000 civil penalty is a gross

violation of the, of the nature of what a state is supposed to do. This is-- there's no great governmental interest in having a $25,000 penalty for each instance of a, of a provider providing a, a prescription for puberty blockers or hormones. I've done consumer protection work for years, and even in California, which is liberal and you would think would want to go after people, their civil penalties are $2,500 per violation. So our state is faced with so many more important issues than, than the trans issues that we're facing. We passed LB574 as a part of a compromise and, yet, Senator Kauth is not satisfied enough until she totally prohibits anybody from being able to gain access. And, Senator Riepe, you're correct. We don't know if LB574 has been effective or not, because it hasn't been in existence that long. It took them months and months to even put forward the regulations. So it's, it's really only been like a year and a half at most that we've been doing under this. These bills aren't about protecting children. They're about eliminating transgender people from America. And it is-- something that I saw last night from a, a friend of mine who wrote researching the Holocaust and a quote by Theodore Adorno, and it's a wrong life cannot be lived rightly. And what does that mean? There are certain people who believe that transgender people don't deserve the right to exist and the only way that they will be able to do it is to eradicate them. And there are people on the far right who have said transgender people need to be eradicated. And I find that horribly offensive, and I find it horribly offensive that we are continually fighting about individuals' rights to gain access to health care. It's none of your damn business what a parent and a child want to do in relationship to their health. They are in charge, they are there, they know what is going on. And I have got to tell you that after all of these years, 4 years, of coming back here and testifying on these issues--

FREDRICKSON: Jessie, you're in the red so I'm going to have to ask you to wrap up your thoughts.

JESSIE McGRATH: Yeah. So I, I just say I, I do oppose this bill because I think it is horribly offensive to the trans kids of this state. They already have to go through incredible hurdles, and I would ask you to not vote this out of committee.

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

RIEPE: Thank you, Chairman. Do you still practice law?

JESSIE McGRATH: I do practice law. I retired from the DA's office in June of last year after 37 years, so I am not licensed to practice here in Nebraska, but I am still licensed to practice in California.

RIEPE: Oh, I was just curious whether you had a practice of transgender folks who wanted some expertise?

JESSIE McGRATH: I-- you know, I have thought about doing that now that I'm retired. For the entire 37 years that I was a prosecutor for LA County, I was prohibited from giving legal advice to anyone or practicing outside of the district attorney's office because the county of Los Angeles had a, a county code that prohibited that because they were paying our bar dues. And so I am looking at getting licensed in Nebraska and I probably will, I'm just not sure I want to work full time after, you know, 37 years of, of doing it every day.

RIEPE: Oh, you're just getting started.

JESSIE McGRATH: I know, I'm just a kid.

RIEPE: OK, thank you, Chairman.

FREDRICKSON: Thank you, Senator Riepe. Other questions from the committee? Seeing none, thank you for being here.

JESSIE McGRATH: Thank you, Senator Fredrickson.

FREDRICKSON: Next proponent for LB732, or I'm sorry, opponent. Yeah. Welcome.

JOAN DAUGHTON: Feel short. OK. My name is Dr. Joan Daughton, J-o-a-n D-a-u-g-h-t-o-n. I am a physician, a child psychiatrist practicing in Omaha since 2003. I'm here representing the Nebraska Regional Council of the American Academy of Child and Adolescent Psychiatry and the Nebraska Advocates for Child Health in opposition to LB732. You get a sense of my national organization's approach to gender care through my handout for this committee, which is the American Academy of Child and Adolescent Psychiatry's Facts for Families of Children who are Transgender or Gender Diverse. The Academy's acronym is AACAP, and their most recent statement on gender care is from June 2025, quote, Any legislation which denies access to evidence-based, developmentally appropriate and often lifesaving medical care for transgender and gender-diverse youth disregards clinical consensus and undermines the ability of families and physicians to make decisions in the best interest of their patients. AACAP urges policymakers to ensure that

health care remains guided by clinical expertise, not political ideology, unquote. The evidence base has been reviewed actually thoroughly in this State Legislature, but I'm happy to provide more. I'm here to help you question why this legislation is being pursued at all. It's my understanding that no other part of the practice of child psychiatry is being questioned. Why is this Legislature proposing that I should follow all of my national organization's recommendations for treating depression, anxiety, PTSD, autism, ADHD, bipolar disorder, but that all of the research and recommendations for gender-affirming care are incorrect? There's limited data which shows gender-affirming care could be detrimental to some youth. This type of data is not uncommon in medicine. Our evidence base evolves and over time experts in the field change recommendations based on robust research. Individual physicians have to weigh new evidence until there's a new consensus with our patients and allow them to make decisions appropriate for their lives and their bodies. There is a spectrum for how we each identify our gender and how we express it outwardly. Youths sometimes think, if I don't feel completely female, I must be completely male or vice versa. I have patients who initially thought they wanted to transition medically, and then within several months or years of conversations, realize they don't want to. The ongoing discussions about their overall mental health, goals for treatment, and open dialogue with family allows them to come to these conclusions. I have others who have transitioned socially and medically whose anxiety and depression have improved considerably after transitioning. For youth and their families to even ask for help regarding issues of gender nonconformity takes a lot of bravery. Do you want to tell all Nebraskans to not even bring this up to their trusted providers? This Legislature has already limited the ability for youth to receive puberty blockers for transgender health citing concerns with long-term side effects of Lupron. But this Legislature has not even introduced a bill to stop the prescription of the same medication to females being treated for precocious puberty or small stature. And there is actually more evidence showing these women have long-term serious health concerns, bone density loss, diabetes, etcetera. Does that make any sense under the guise of protecting our youth? Legislation to stop all care halts conversations with individual patients and the equally important broader conversations among experts. Do you really have a good reason to do that?

FREDRICKSON: You've got your red light, so I'll ask you to wrap up. Are there any questions from the committee? I just have one. So one of the questions that sort of kind of come up a little bit between both

proponents and opponents of the legislation has been the current state statute LB574. This has been, I think, discussed quite a bit. Do you feel as though, under current statue-- statute, adequate assessment occurs before an individual receives any medical intervention, whether it's a puberty blocker or hormone treatment?

JOAN DAUGHTON: Adequate assessment was occurring before LB574. Our, our national organizations, the AAP, the American Family Physicians Group, the American Academy of Child Psychiatrists, recommended a, a robust evaluation and ongoing conversations about risks and benefits and why these children were pursuing this at all, and we talked about the gender spectrum with them because some kids didn't understand if I don't feel totally male, there's a whole spectrum. I don't have to be on the very other end. Let's talk about what that means for you. That has been in place for 20 years. If you want to base things on a preponderance of evidence, the 40 hours is completely arbitrary. There is nothing in the literature that says that that's a helpful amount. That that's too little, too much. Sure, was it a nice compromise? In some ways, yes, but I have kids who are saying when do I start the therapy? Where do I access the therapy? How long is this going to take before we have actual conversations about treatment? I think it's limiting access to treatment.

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

JOAN DAUGHTON: Thank you.

FREDRICKSON: Next opponent to LB732.

LISA CARMICHAEL: Hello, my name is Lisa Carmichael, C-a-r-m-i-c-h-a-e-l, and I am here on behalf of the League of Women Voters of Nebraska. Dear Senator Hardin and members of the Health and Human Services Committee, the League of Women Voters of Nebraska is dedicated to ensuring equal rights and opportunities for all and stands firmly in opposition to any legislation that would deny rights or dignity to individuals in the LGBTQ+ community. The LWN-- sorry, the LWVNE also opposes legislation that restricts individuals' access to quality health care, including behavioral and mental health care, and undermines their right to privacy surrounding health care choices. LB732 does both and, therefore, we oppose this bill. Gender-affirming hormone therapy is a safe and effective way to improve quality of life and mental health outcomes for transgender adolescents. Access to this treatment is limited, with most vulnerable transgender people

experiencing the greatest gaps in care. In Nebraska, hormonal treatment for those under 19 years old is not common and has rigorous requirements to even consider it as a method of care. The extreme penalties proposed in, in LB732 are not simply meant to discourage, but to inflict reason-- beyond reasonable punishment on health care providers. This bill gives jurisdiction to the State Attorney General to penalize physicians and others for each violation at the rate of $25,000 per violation. This could, this could be in each instance they prescribe cross-sex hormones and/or puberty blocking drugs a separate violation. This bill is an infringement on individual rights, parental rights, and the right to privacy in a violation of the patient-provider relationship. This bill discredits doctors and discounts the reality of an extremely vulnerable group of Nebraskans. LB732 undermines and threatens health care providers, perpetuates transphobia, and is damaging to Nebraska's LGBTQ+ community and their families. We urge you to oppose LB732 and protect not only transgender and nonbinary individuals, but also health care providers who care for them and so many other Nebraskans. Please do not advance LB732 to General File. Thank you for considering our position and all you do for the state.

FREDRICKSON: Thank you for your testimony. Are there any questions from the committee? Seeing none, thank you for being here.

LISA CARMICHAEL: Yep.

FREDRICKSON: Next opponent to LB732. Welcome.

ERIC REITER: Thank you, Vice Chair Fredrickson and members of the Health and Human Services Committee. My name is Eric Reiter, spelled E-r-i-c R-e-i-t-e-r, and I'm here today on behalf of Voices for Children in Nebraska. Our organization works to elevate the voices of children and youth and to advance public policy that ensures all young people can grow up safe, healthy, and supported in their communities. And for those reasons, we oppose LB732. And I will spare you from repeating a lot of what you've already heard, which is the rest of my testimony. So I'll end a little bit early and ask if anyone has any questions.

FREDRICKSON: Thank you for your abridged testimony, I suppose.

ERIC REITER: Yes.

FREDRICKSON: Are there any questions from the committee? I'm seeing none, thank you for being here. Next opponent for LB732. Welcome.

MARY ENSZ: Hi. I'm Mary Ensz, that's M-a-r-y E-n-s-z. I'm from Omaha, Nebraska. And a lot of folks have talked about, like, the political, the, all the legalities, the medical stuff. And they've all done a really good job. They clearly shared that this is a discriminatory, harmful, unnecessary bill. I personally want to share how it affects my family. It's all in the writing, but I'll just share a little bit. So I'm a mother of three. I have a 17-year-old, I have a 10-year-old, and I have a 6-year-old. And the oldest, he is cisgender, my 10-year-old is nonbinary, and my 6-year-old is almost 7, but is trans. And she was assigned male at birth. She paints, she makes, like, dramatic scenes with her stuffed animals and dolls all the time and at the last legislative session that I was talking at, she was wearing dresses and sparkles but now she likes to wear jeans and anything that, like, has Hello Kitty or all the Hello Kitty and friends things now. You know they do-- they change, they evolve, they do all these things. I don't know what will happen with my children as far as their health care goes, we don't know that. I want to know that they have the same access and equal rights to health care going forward. And when I sit my kids down and I talk to them, I have different conversations with the 17-year-old than I do with the 10-year-old than I with the 6-year-old, because they all have different rights and access to different things based on what their lives look like moving forward, and what my family looks like moving forward, where we want to live moving forward. My dad, my brother, my sister-in-law, what access will they have to the medical care that they can provide for their loved ones for they work in rural health care? Are they going to have to refer people out to bigger towns outside of their small town altogether? These are a lot of things that are just not necessary whatsoever because, like people have said before, this was something that was already covered. Medical professionals were already doing their jobs. I was already doing my job as a parent and considering these things that people were already doing. And, well, we definitely need to look into things and make sure that, no, people aren't overstepping and doing a bad job with medical care, these are individual instances. And people are doing the research that they need to be doing. But, right now, Senators, you all are making choices on a systemic level that affect our families and how our children see themselves, whether or not they get to have the same health care as their sibling, whether they get to, you know-- and I guess to me, you all talk a lot about family values, and government overreach, and

bodily autonomy is something that I value a lot, and I just feel like that's something that we should all consider when we're making legislation that is pretty invasive with individuals, with our families, and our health care.

FREDRICKSON: Thank you for your testimony. Are there questions from the committee? Seeing none, thank you for being here.

MARY ENSZ: It's hard to argue with personal experience.

FREDRICKSON: Next opponent for LB732. Welcome.

GARY ENSZ: Glad to be here. My name is Gary Ensz, E-n-s-z. I'm not related to Mary Ensz. Joke. She's my daughter. Good afternoon, Senator Hardin, who is no longer here, and members of the Health and Human Services Committee. I am an actively practicing family physician in rural Nebraska. I am here to oppose LB732. I have been a registered Republican in Nebraska for all my voting life. I believe scientifically evidence-based medical care is a nonpartisan right for all Nebraskans, where we all can live, love, and learn without discrimination. Those reasons are some of why I oppose LB732, which further restricts access to hormone and puberty blockers for Nebraska under age 19. First of all, let me address an issue that seems to divide people on transgender care. Anyone can start with a preconceived notion or idea of how to care for transgender people. If you start with that idea that transgender youth and their families should be prohibited by policies from receiving certain nonsurgical medical care, you can find studies in the medical literature that support your positions. You can find a stack this high. On the other side, you can find a stack higher. And if you-- that's not high enough, you can go all the way. Evidence-based care guidelines on adolescent transgender care are rapidly evolving, as all medicine is rapidly evolving. And I agree that medical care regarding hormonal therapy and puberty blockers for trans kids is not black and white, as Senator Riepe said. Most studies done in the U.S. conclude that puberty blockers and hormone therapy improved mental health, decreasing depression and suicide. With every treatment, medical providers are forced to weigh risks versus benefits. Because of this, I believe care should be individualized, individualized with a focus on comprehensive support for the young trans person and the family with guidance from qualified health care professionals. The current law is a result of a bill passed last legislative session, Let Them Grow provides guidelines for medical care for transgender youth with adequate, many would argue overly strict, guidelines. I believe that

politicians should not dictate how I or other physicians compassionately care for youth in our state. I could provide many personal experiences from dealing with trans kids and their families, which support my views, but my time is limited. I would like to have a follow-up conversation. If you want to ask any questions, I'm able to provide additional information. Thank you.

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

HANSEN: So you mentioned about evidence-- people can provide evidence for whichever opinion they see fit, right, stack here, stack here, we can go higher.

GARY ENSZ: Yes, that's right.

HANSEN: But don't you believe there's at least some kind of gold standard to studies when we, when we talk about placebo-based, you know, gold standard studies?

GARY ENSZ: Sure, and I think you need to rely-- all I see here-- I don't see any-- is anybody an MD here? I think you need to rely on people that you can trust. You can trust me. And you can trust-- what I'm saying is, I don't think you have the qualifications to look at a study and understand it. I do not believe you have the ability to tease out what's a good study, what's a bad study. I think you all should rely on people that are your health care providers. People like me, who is a family physician, who's been to medical school, has evolved and has experience, has done a lot of research on this subject, more than you have ever done.

RIEPE: I was a hospital administrator, I'm sure you're not talking about me.

GARY ENSZ: No, I think you've done proper research. I'll go-- I'll take a bullet for you. But all I see here is-- I see somebody that is on this committee who has a preconceived and is cherry-picking studies and it is trying to be David deciding should I-- you know, what should I do? I don't think you have-- I think you should rely on professionals. I think you should rely on the Nebraska Medical Association. You should rely on my testimony, my daughter's testimony.

HANSEN: Well, we had physicians in here saying pretty much the same thing in favor of this bill.

GARY ENSZ: I'm saying you-- I know, that's why you have to rely on somebody you trust. Because I don't-- obviously, you trust them more than you trust me. I'm hearing that. I can read your face. I know what you're thinking.

HANSEN: That I don't-- I can't read research studies.

GARY ENSZ: I believe that, true, not as well as somebody else can that is making decisions. I don't think you have the background. You're a politician that is trying to interfere with people's lives.

HANSEN: OK.

GARY ENSZ: OK.

HARDIN: Questions? Thank you.

GARY ENSZ: You're welcome.

HARDIN: Next person, LB732.

MEGHAN OAKES: I feel like I need a booster seat.

HARDIN: Welcome.

MEGHAN OAKES: Thank you for allowing me to testify today. My name is Dr. Meghan Oakes, M-e-g-h-a-n O-a-k-e-s, and I'm a double boarded reproductive endocrinologist. I spent 7 years studying reproductive physiology, the mammalian hormonal axis, and the effects of exogenous hormones on the body and the brain. I'm an expert in human hormones, both those that are naturally produced and those that can be administered to optimize health and quality of life. Nebraska enacted the Let them Grow Act in 2023, severely restricting access to gender-affirming care for minors. The Legislature did so against the recommendations of virtually every medical body with a position statement on the topic. LB732 doubles down on the existing legislation, moving from extensive restrictions to a near total ban. I could spend this time discussing the many ways that this legislation harms Nebraska's children and families. Not only does it contradict best practices and endanger the well-being of our youth, it negates parental autonomy, taking medical decision-making out of the hands of parents and placing it in the hands of individuals who have no medical training or relationship to the child. LB732 aims to eliminate gender-affirming care for minors in Nebraska by creating so much red tape, by making the process so cumbersome that patients simply cannot

proceed. And it takes things one step further, allowing for civil charges and financial penalties to be levied against any provider in violation of the existing act or this new, more rigid doctrine. It extends the statute of limitations to 20 years, a statute of limitations that does not exist for any other medical procedure, and is unnecessary as current malpractice regulations already extend the statute for children. When penalties are levied, the money does not go to the child involved. The money goes to the state. It lines the pockets of our treasury. Gender-affirming care for minors has already been addressed by the Legislature. We have guidelines in place. By the same token, existing malpractice laws hold physicians liable for the care they provide, extending that statute when children are involved. LB732 is a waste of this Legislature's time and energy. We have real problems in this state. We have a $471 million budget shortfall. We have exorbitant and nonuniform property taxes. And we have increasing political polarization. The bill is simple pandering. It serves no purpose or benefit. And it is time to move on and do something more productive for the state of Nebraska. Thank you for letting me speak. I would be happy to take questions.

HARDIN: Questions? Senator Riepe.

RIEPE: Thank you, Chairman. You're quite accomplished in terms of your academic training. Are you associated with a, a larger group or are you an individual practitioner?

MEGHAN OAKES: So I'm in private practice with four other physicians and have privileges throughout Omaha at the CHI system, UNMC, and Methodist.

RIEPE: So they're all endocrinologists of your partners?

MEGHAN OAKES: Correct. Yes.

RIEPE: OK. Well, congratulations. Good for you. All right. Thank you.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here, Dr. Oakes. So you're, you're a physician.

MEGHAN OAKES: Correct.

FREDRICKSON: So one of the things that-- there's, there's kind of been a little bit of conversation about specifically puberty blockers,

hormone treatment. But I think one thing I've heard kind of repeatedly is this sort of idea of puberty blockers and the risks of those, whether it's reversible, whether there's long-term side effects, damage. Your expertise, it seems like, is in--

MEGHAN OAKES: I use them every day.

FREDRICKSON: You use them everyday. OK. So can you maybe shed some light on that?

MEGHAN OAKES: Yeah. So the most common puberty blockers prescribed are medications, two medications called Lupron and Zoladex. And what they do is temporarily shut down the hormonal axis. And they can be used for a wide variety of things. They are used to treat, for instance, endometriosis. Right? They are used in IVF. And they are used for precocious puberty. In the setting of precocious puberty, especially with females, one of the concerns is if these young girls enter into puberty too soon, if they start making estrogen too soon, their growth plates are going to close and they're going to have abnormally short stature, right? And so what the Lupron does is it prevents that and it allows them to obtain maximal height, right, where they, where they maybe should have been based on genetics and their parents and things like that. And it allows them to get to an age where it is more appropriate to be having breast development and menstrual cycles. We would prefer that to not be happening for a 6-year-old. It's temporary. It's absolutely temporary. When you stop it, it goes away. It's not there anymore. I know it was brought up that there could be long-term side effects with bone density. And children are laying down bone density until the age of 30. That's when human beings hit maximum bone density, and then after 30, unfortunately, we start going back down. And so using puberty blockers for a year or 2 years of time, the age of 12 to 14, the idea with all of this is that they come off those blockers and then they start building bone density again, right? They, they are not, they are not at a point where they're out of time to strengthen their bones. They still have it. If we were really worried about the effects of long-term Lupron use, we would ban it in endometriosis treatment, because that's when people are using it for a long time. If we were really worried about everybody's bone density, we would ban Depo-Provera, which is a very common birth control method. This is short-term use. And, and I say that meaning short term, a year or two, right? This is not something we're keeping people on for 15 years.

FREDRICKSON: If I could do a quick follow up to that? So, so let's say there was an individual who was on a puberty blocker because they were maybe exploring their gender and during that time period over a year they decided, hey, look, this is-- hormones are not for me or maybe I am, in fact, cisgender and they stopped taking the puberty blocker, that-- what happened?

MEGHAN OAKES: They would just enter into natural puberty at that point.

FREDRICKSON: Got it.

MEGHAN OAKES: Nothing, nothing would be different about it. The idea is that it would-- say, if you were a young girl thinking of transitioning, it would hold off breast development so that you could make a decision. And if you did, ultimately, decide to transition and start testosterone therapy, you might be able to avoid a mastectomy, like a painful, potentially complicated, long recovery surgery. Same would go for a male, right, if he is trying to decide should I transition to living as a female, as a girl? One of the things that's going to happen with puberty is he's going to develop an Adam's apple and the puberty blockers would prevent that so that if he did decide to transition he would not have to have the surgery to have his Adam's apple shaved down.

FREDRICKSON: Thank you.

HARDIN: Other questions? Thank you.

MEGHAN OAKES: Thank you.

HARDIN: Opposition, LB732. Welcome.

KATARYNA MORTON: Hi. My name is Kataryna Morton, K-a-t-a-r-y-n-a M-o-r-t-o-n. I graduated with my bachelor's degree in psychology and communication studies and I'm currently obtaining my master's in social work. So as a personal advocate for the community, I'm here to testify in opposition to LB732. I have an 8-year-old transgender sister. She's a child in every sense of the world. She loves to play with monster trucks and barbies. She goes to school, she laughs, she looks up to her family, and she deserves to grow up in a safe, supported, and valued community. And this bill directly threatens that. LB732 is framed as a protection measure, but in practice, it unfairly targets transgender health care and undermines established medical standards, patient autonomy, and the rights of transgender

individuals. First, this legislation would prohibit doctors from providing puberty blockers or hormone related care to individuals under the age of 19, even when that care is carefully prescribed, evidence-based, and supported by parents and medical professionals. For families like mine, this is not an abstract policy. It is whether our loved ones are allowed to access medically appropriate care that can significantly reduce distress and improve mental health when they are ready. Second, LB732 restricts access to care and sends the harmful message that the health needs of transgender youth are less deserving or valued than those of others. These kinds of restrictions are highly-- are strongly associated with increased mental health risks for transgender youth who already face high risks of depression, anxiety, and suicide. In addition, restricting access can lead to psychological distress that also affects sleep, eating, and overall health. Limiting access does not prevent gender dysphoria, but instead prolongs distress and induces risk-taking behaviors. This bill replaces medical judgments with political judgments when lawmakers are not even in exam rooms. You do not know our children, sisters, uncles, grandparents, or their medical history. Decisions this personal should never be dictated by transphobic government officials. As a sibling, I want my sister to grow up knowing that Nebraska values her health, her dignity, and her future, this bill does the opposite. I urge you to reject this bill and allow families and medical professionals to make decisions based on science, compassion, and the best interests of the trans community. Thank you for your time and consideration.

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

KATARYNA MORTON: Thank you.

HARDIN: Opposition to LB732.

KENNETH MORTON: I do not have any testimony printed out.

HARDIN: Welcome.

KENNETH MORTON: Thank you. My name is Kenneth Morton, K-e-n-n-e-t-h M-o-r-t-o-n. I, I decided to take a little bit different tact tonight. As Mary pointed out earlier, you're going to hear lots of experts. You're going to hear lots of stories. It was my daughter that just testified, so I do have an 8-year-old transgender daughter. So, you know, I'm definitely invested in this process. But what I wanted to talk about is sort of the underlying reason for why I think a lot of this is going on. I think it goes back to religion. I think that if

you look at the root of this, it's, it's based-- and, and as Jackie [PHONETIC] said, a lot of, of Christian ideas and that's where it comes down to. There may be things where, where people are able to make these arguments, but the end of it, this idea that we need to eliminate trans people from existence, which I think is Kathleen Kauth's goal, that really comes from, I think, a religious base. So I wanted to talk a little bit about that. And I know there are points in the Bible, you know, people bring up Genesis, things in Genesis, there are things in Leviticus, although, you know, not all the things in the Leviticus are necessarily followed by Christians all the time. There's, there's Romans, you know, Romans 1 we talk about, you know, all these sins that people do which I think also ignores Romans 2 where Paul very clearly says that those that judge those who sin are sinners themselves. So just by judging we are-- you're committing just as an egregious sin as those who are committing those sins. It's God's place to judge, not people. So I think that's important too. But what I really want to do-- it's Christianity, it's the teachings of Christ. So I wanted to look at the gospels and I just wanted to kind of go through and the things that-- I'm not an expert-- but the things that I think that Jesus said against trans people. So I'm just going to go through the gospels. I just want to talk, talk or I just want to sort of list all the things that Jesus had about transgender people. OK? So I start with Matthew. Let's move on to Mark. Let's try Luke. How about John? That's all I have, thank you for your time. If you have any questions, I'd be happy to take them.

HARDIN: Questions? Thank you.

KENNETH MORTON: Thanks.

HARDIN: Opposition, LB732. Welcome.

RENE DOCHERTY: Good evening, Senators. I am here opposing this bill. My name is Rene Docherty, R-e-n-e D-o-c-h-e-r-t-y, and, yes, you witnessed my child testify earlier on about her suicide attempts on the back of the situation she finds herself in. I'm here to testify against this. I could give you a thousand reasons why, but the main reason I want to present in front of you is that the reality is subjective that's going on. We have different bits of information saying different things. The best thing we can agree on is it's subjective, that is not absolute. And I disagree on the basis of this bill going forward because it seeks to make a situation that is not black and white, black and white, and, ultimately, leaves me in a worse position as a father to support my child. I have already lost

one child. I, I reach out to you as men, as fathers yourself. I don't want you to go through what I went through. And I beg you not to make it harder for me. Because this does not present an alternative, it removes an option. What am I to do? What am I to do? It doesn't matter politics, it doesn't matter religion, when you're standing over the grave of your child and the senator who brought this bill is she going to stand next to me? Is she going to put my hand-- her hand on my shoulder? Is she going to commit the sin of empathy? My heart broke. My heart broke again. I was unable to act. What am I meant to do if this is taken away from me? And that's, that's the basis on which I come to you. I plead with you, as fathers yourself, who I'm sure have been thrown curve balls in your life, how do you seek to empower me as a father if you take away my ability to be one? It's that simple. I'm sorry, very passionate about this. I invite you to get to know me as a father of a trans child. I invite you to experience vicariously through me what it means to accept and to love because, ultimately, it involves loving yourself first and having the confidence to move forward. You have to have the confidence to engage. You have the confidence to [INAUDIBLE]. The one thing you're not meant to have is a pigheaded attitude of I know the right way. It's subjective and I appeal to you on that basis.

HARDIN: Thank you. Questions? Thank you. Opposition, LB732. Everybody, just so you know, we're going to have a, a little bit of an interruption here in a moment because there's going to be a lot of folks joining us. We're kind of done with Room 1200 over there, so there's-- there are troopers are kind of moving folks in here, so we're going to have about 20 folks joining here in just a little bit, Russ [PHONETIC]. So, anyway, just a, a heads up, and so hopefully they won't do anything to interrupt what you have to share with us. And so, anyway, we'll try and do that, Russ, if we can, perhaps after the next testifier, so. OK, thanks. Sorry, go ahead.

A.T. MILLER: Thank you, Senator HardIn and senators of the Health and Human Services Committee. My name is A.T. Miller, A-T M-i-l-l-e-r. I am the Executive Director of OutNebraska, a statewide nonpartisan, nonprofit working to celebrate and empower LGBTQIA+ Nebraskans. Making sure Nebraska's young people grow to be healthy adults is important to us all. It is a shared value we all hold dear. Unfortunately, LB732 will actually endanger the health and happiness of transgender youth and their families. You will continue to hear from many more young people and from families that the decision to seek medically sound essential health care is extremely important to the well-being of young people. Medical experts tell us that many children explore and

have questions about gender and the role it plays in their lives. To be very clear, these are not the young people discussed here. Transgender youth and their parents who may seek the care of a medical professional do so when that child is insistent, consistent, and persistent in their gender identity for an extended period. Families do not enter into this medically sound essential health care lightly and additionally have to jump through many hoops and barriers to access it due to the Let Them Grow Act of 2023. I ask you to contemplate if the safety of youth in Nebraska is really the goal of this bill when we consider that this medical care is only banned from transgender youth, not their peers. Youth who are not transgender can still access these same treatments when deemed appropriate by their doctor for other health conditions. Withholding necessary medical care specifically from transgender youth is blatant discrimination and puts this already vulnerable group of young people at further risk of poorer mental and physical health. We all want what's best for our children, and families with transgender youth are no different. No parent should be denied the freedom to do what's best for their family, and that includes helping their transgender youth access the care that is right for them. I believe that parents know best how to protect and support their children, and we shouldn't be overruling their decisions about any kind of complex medical care. Parents who are working through tough conversations about what is best for their child should not have to worry about the government getting in the way. Furthermore, when it comes to remaining in the state they love and call home, or being able to pursue lifesaving care for their children we know what loving parents will choose. This bill will not prevent these procedures, it will merely add to the brain and talent drain away from Nebraska and harm employer and student recruitment to Nebraska. Even the introduction of this bill has caused panic and anxiety for youth and families. If you are a young person listening to today's testimony, please know that you are loved and valued for who you know yourself to be. OutNebraska continues to fight for full equality for all transgender people in our state. This equality cannot be realized if politicians insist on taking away medically sound health care options. We respectfully ask that this committee not advance LB732.

HARDIN: Questions? Thank you.

A.T. MILLER: Thank you.

HARDIN: Opposition, LB732. Senator.

JEN DAY: Good evening,--

HARDIN: Hi.

JEN DAY: --Chairman. Good evening, Chair Hardin and members of the Health and Human Services Committee. My name is Jen Day, that's J-e-n D-a-y, and I'm here on behalf of the Women's Fund of Omaha to state our strong opposition to LB732, which will negatively harm Nebraska youth's ability to receive proper care and eliminate their parents right to providing their children with the care they need. Additionally, LB732 will cause serious damage to the health care ecosystem that the Nebraska economy relies upon. When states place more medical restrictions on care, physicians are less likely to be willing to work in those states. A 2024 report by the Association of American Medical Colleges found that the United States will face a shortage of up to 86,000 physicians by 2036. This shortage is especially significant among pediatric physicians, with the American Academy of Pediatrics particularly concerned about a pediatric endocrinologist shortage. Pediatric endocrinologists serve children with diabetes, hormonal conditions, and growth problems in addition to gender-affirming care. Their treatment is necessary and important, and with an already alarming shortage, this bill will further exacerbate the strain on an already overloaded system of health care. When pediatric endocrinologists choose not to practice in states because of bills like LB732, children in need of treatment for things like diabetes and thyroid issues suffer. Additionally, it places strain on all physicians and makes Nebraska a less desirable state for physicians of any specialty to work in. Not only will this bill impact the availability of health care providers in Nebraska, it will also directly impact individuals seeking this care. Every major medi-- excuse me, every major U.S. medical association, including the American Medical Association, the American Academy of Pediatrics, and the American Psychological Association, recognizes the need for gender-affirming care. This bill would ask a physician to choose to adhere to the law over adhering to their own professional code of ethics. Outlawing gender-affirming care will make it almost impossible for physicians to provide the established standard of care, because this standard of care puts them at risk for committing medical malpractice. Blocking gender-affirming care does not protect youth as this bill absurdly purports. It actually increases harm and leads to higher rates of suicide and depression amongst youth. This harm is highly relevant and statistics show that when youth are denied the ability to receive gender-affirming care, they are more likely to experience depression and have a risk for suicide or suicidal

thoughts. Effective medical treatment for children is highly individualized and should only involve a physician, their patient, and, and their parents, not the government. Please consider the immense harm this will have on your local economy, the medical community, and across the state before passing legislation that is deeply destructive to necessary health care. The Women's Fund of Omaha respectfully asks that you do not advance this bill from committee in order to prevent further harm to both our Nebraska youth and to the medical professional communities. And with that, I'm happy to answer any questions.

HARDIN: Thank you. Senator Riepe.

RIEPE: Thank you, Chairman. Good to see you again.

JEN DAY: Good to see you too.

RIEPE: Welcome. Thanks for being here.

JEN DAY: Thank you.

RIEPE: You had talked about 86,000--

JEN DAY: Yes.

RIEPE: --physicians by-- what year was that?

JEN DAY: 2036.

RIEPE: 2036.

JEN DAY: So 10 years.

RIEPE: OK. I also noticed in your remarks what I picked up as being rather some conservative comments and I appreciate those.

JEN DAY: You know, I can provide all perspectives, Senator Riepe.

RIEPE: Thank you. I have no more, Chairman. Thank you.

HARDIN: Other questions? It's good to see you.

JEN DAY: Thank you, good to see you too.

HARDIN: Opposition, LB732. Welcome.

ALEX HAMRIC: Hi. Like all good teenagers, I'm reading off my phone. OK. Hi, I'm Alex Hamric, spelled A-l-e-x H-a-m-r-i-c. I'm 18 years old, a senior at Lincoln East. Don't tell my mom I skipped school to be here. And I have been on this stand more than five times over the last 6 years. I wrote LR294 in 2020. I testified on the poorly named Let Them Grow Act the first time around. I've been in this building a lot. And every time, I make a rule for myself that I will not get up here and beg. I will not allow this Legislature to force me to beg for my life, for my autonomy, for each of you to see me as a person. I made that promise to myself when I was 12 years old. And today I am breaking that promise. I am begging you, please do not pass this legislation. I help coach my debate team every year and my slam poetry team. And every year I have freshmen latch on to me because I'm older and I'm transgender and I am still alive and there aren't that many of us left. I watch these kids exist in agony, forced to live in a body that is trying to kill them and a world that is hoping that it does. And I tell them they have options. I tell them that this will not be the rest of their lives. I tell them that they can change the world, that they matter, that no one can take away their agency and their future. And I am begging you to not make me a liar. Do not tell these kids that there is no place for them in this state that we all love. We're all here because we love Nebraska. Do not make me attend another funeral. I refuse to plead with you for my own sake. I know no senator will take a trans teenager seriously no matter how hard I try, no matter how hard I have tried. No matter how many sources we cite, or anecdotes we give, or tears I shed on this stand, but I have nothing else I can do or say. So, fine, I am begging you. Listen to the professionals that have been before you today, to the parents, to the community you are policing. Listen to reason, god please for once in your lives listen to your constituency. Oppose this bill. And as the demographic, you are legislating right now, as a transgender teenager under the age of 19, I implore you, ask me some questions, get to know my experience, and defend yourselves then. Yield my time.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you. You asked for a question, I'll give you a question. Do you serve as a counselor to a lot of these-- your peers, if you will?

ALEX HAMRIC: More of--

RIEPE: And I see a head shaking over here, so that's a yes, I guess.

ALEX HAMRIC: --a, a coach, a mentor, somebody who's been through what they have, and, you know, I made it out to the other side of depression and gender dysphoria without hormones because I could not afford them. I made it out. Some kids are less optimistic about their ability to. So for them, I provide that maybe they can, and maybe they can access those hormones.

RIEPE: How do you take care of yourself mentally? I assume you've had loss of a friend or maybe more.

ALEX HAMRIC: It has been difficult, especially as this Legislature proves time and time again that they are not interested in the voices of the youth, they're not interested in the voice of transgender people, especially with the passage of LB-- what is it-- 574, yes, that I spoke on previously. It has been difficult to see the state that I love consistently throw away my testimony, throw away experience in favor of conforming to conservative ideals that I do not believe this Legislature is actually interested in upholding safety. I believe they are interested in upholding, you know, over policing of an individual's bodily autonomy. It has been difficult to maintain my faith in the state, my own mental health, my self-- my sense of self-worth in the face of all these things, but I've managed.

RIEPE: I assume you have a, a support group of some kind.

ALEX HAMRIC: I am often alone, as many of us are.

RIEPE: OK. I'm sorry for that, but you seem strong.

ALEX HAMRIC: I've had to be.

RIEPE: Or you wouldn't be sitting there if you weren't fairly strong.

ALEX HAMRIC: I would rather that I not be strong and I would rather to not have to sit here. So I would prefer for you each to vote this legislation down so I never have to be here again.

RIEPE: Oh, we wouldn't want that, but we [INAUDIBLE]. Thank you, Chairman.

HARDIN: Other questions? Thank you.

ALEX HAMRIC: Thank you, all.

HARDIN: LB732.

DEVIN CROZIER: I have, if not allowed, may I ask a quick question before my time starts?

HARDIN: Which would be?

DEVIN CROZIER: What birth year do you think the first American doctor that conducted gender-affirming care or HRT actually, specifically?

HARDIN: Well, I don't know, but I'll let you-- your, your, your time is going, so have at it.

DEVIN CROZIER: 1885, and I know a lot of people like to make this argument of-- well, actually, I apologize--

HARDIN: Can I have your name and spell it for me, please?

DEVIN CROZIER: Yep. My name is Devin Crozier, D-e-v-i-n C-r-o-z-i-e-r. So with that, I make the point that a lot of people that are for this bill say trans, trans people and trans care is a new thing. And it is not, clearly, I have a book, and I swear that I didn't make this book. It's not blank pages. There's words. It's a biography about this doctor. So it's not new. And, obviously, if it was as detrimental as so many people are making it out to seem, we would have a lot more evidence saying, oh, this-- these-- this care killed people. This care caused awful harm to people. And that is not the case. And, Senator Riepe, you had said, what about gray areas? Well, I am not a-- I was not born in Nebraska, and neither was my son. We decided to stay here to fight for trans youth, because I am a trans person who realized that they were trans at 14, or actually found the word for it. I had been saying that I knew something was wrong from a young, very young age, even though I had parents that said very negative things to me about it. I still knew, and at 14 I went, am I really going to do this? This is going to make my life a lot harder, not because I was trans, but because of the people that would treat me bad because of it. And I went, it is better to be hated and be who I am than to live a lie or to kill myself. And I have the uniquely awful position of being a parent of a trans kid, because they said, being trans is not enough, you also have to watch your child suffer the same things you did. And he-- I have had to take him out of state to get care because those 40 hours, they don't happen when your kid first says I'm gender nonconforming. It happens when they start showing signs of puberty. And even at an appointment a month, that is still 10 months forced to go through a puberty that he did not want and would make him upset. So how do these things make my son feel? He feels unsafe, unwanted, like

it's hard to be alive, and I felt those same things. I joined the army to save money for my care right as I became an adult because it was better to die trying to afford the care to live who I knew I am and I've always been. I'm 34 years old or I'm 33 years old. Next year, I'll have been out for that long. So please ask me any questions that you have. I'd love to answer them.

HARDIN: Questions? Seeing none, thank you.

DEVIN CROZIER: All right.

HARDIN: LB732. Welcome.

CECE CROZIER: Hello. I am Cece Crozier, C-e-c-e C-r-o-z-i-e-r. I am a transmasc, of course, the son of the person right, right before me, my dad, my very awesome dad. And I have interviewed other trans youth that I know. There's many of them. I did not get to actually say all of their opinions, because there were quite a few people that came up to me that overheard me talking to my friends and asked if they could also write their opinions in the book that I had taken. Right now, I am paraphrasing all the opinions on this bill. I also had some from last-- from the bill yesterday, but I got so legitimately angry that I had to miss school to talk about-- I had to miss school. I didn't get to learn how to divide or multiply fractions because I had to teach grown adults how to have empathy. So here is everybody's opinion that I talk-- talked about. And I'll just start, I'll start with Elliot [PHONETIC], a trans man who is my nonblood-related brother. Start quote: I know other people that want to get on, on HRT or trans health care, and I am one of those people. I want to be able to feel like me. To be honest, if that all around got banned where I live, where I was, was born and where I, I am growing up, I would honestly not be on this earth as someone who has already attempted suicide. End quote. Of course, from there. The next one I have is from Zoe [PHONETIC], my best friend, a demigirl or as known goes by she/it pronouns. Start quote. This is, is full proof that people want to kill trans people. No, not that they want to trans people, they want trans people to kill themselves. End quote. This one will be from Brooke [PHONETIC], one of my, one of my nonbinary friends. Start quote: I feel all that the amount of alienation for trans people and nonbinary people, all that they get is unfair, and everybody should be allowed to do what they want no matter what gender at birth, what gender they were given at birth and what gender that they have now. OK. End quote. The next one will be from Aspen [PHONETIC], one of my nonbinary friends. Start quote: Your disgust for human and children and adults is, is repulsing

and absurd. You don't care about kids. You only care about yourself. Often it makes me and others sick. End quote. The next will be from Tucker [PHONETIC], one of my nonbinary friends. Taking away any type of health care is stupid.

HARDIN: Cece, I got you in the red, so if you can summarize your thoughts.

CECE CROZIER: I don't think I can summarize, way more pages.

HARDIN: OK.

CECE CROZIER: But I do want to say that treat me as if I'm not a 12-year-old and, actually, ask me questions because I would love to talk more.

HARDIN: Are there questions? Senator Quick.

QUICK: Yeah, thank you, Chairman. I just want to thank you for being here and you did a very good job of, of testifying. So I just want to thank you for your testimony.

CECE CROZIER: Well, I don't feel like I should be thanked because I feel like this is a nonobligated thing for me to do since I know so many people that don't get to say their things. Because, one, these were on school days. I had to miss school to be here. And, two, a lot of my friends have homophobic parents and they don't actually get to be on the things that we're discussing yet, but they're trying to and they want and they are all in the age of about 11 to 13. So if this bill does get passed, they don't get to have it now, they will still have to wait, like, 7 to 9 years before they can actually change their body to the way that they want it to be.

QUICK: OK. Thank you.

HARDIN: Seeing no other questions, thank you. LB732. Welcome.

MELANIE KNIGHT: Hi. So I'm able to see here. My name is Melanie Knight. That's M-e-l-a-n-i-e K-n-i-g-h-t. I live in Clay Center, Nebraska, District 38. So I thought about what I could discuss today. There's lots of different ways that you can approach any given subject, right, and so one of the first ones that I thought about was that I'm a lifelong Nebraskan, lived here my entire life, and I've heard more than once that we are a conservative state, right? That being said, I am also old enough to remember that conservatism meant

small government. It meant staying out of our business, right, whether it be, you know, home, school, you know, the doctor's office, etcetera. It also meant parental rights, it meant individual liberty, and it meant self-autonomy. I'm not seeing any of that with this. So then I thought, OK, well, then I could approach it from the fact of I believe in experts, as we've talked about. I don't try to tell my mechanic how to fix my car. And if I have a heart condition, as much as I love my chiropractor or my podiatrist and/or, you know, maybe even my gynecologist, who are all doctors, I don't go to them for my heart condition. And I not only go to a heart specialist, I'm going to go to one-- if I need surgery, I'm going to go to a heart surgeon. I want the best expert that deals with that subject. But I won't talk about that either. So I could have talked about the harm that this will do to our friends and our families and our neighbors. But I think that you have enough people back here that can actually speak to that. So I won't talk to that even though it will harm them. I could talk about how weird this is, that we keep talking about other people's genitals or, you know, how they identify or their sexuality and all-- etcetera, etcetera, etcetera. It's just creepy. But I won't talk about that either. What I will talk about is how I've had the opportunity to be able to go and talk to a lot of people lately. I've been knocking doors and not once has this been an issue, not once. In District 38, people are talking about property tax relief, rural health care, the cost of living and rising prices, and why the government, the Governor, and you seem to refuse to honor the vote of the people in regards to medical cannabis and saying no to school vouchers. That's what's important. Not once has this ever come up. So just wanted to let you know. Thank you. Any questions?

HARDIN: Questions? Seeing none,--

MELANIE KNIGHT: Thank you.

HARDIN: --thank you. LB732. Welcome.

LESLIE DVORAK: Thank you, members of the Health and Human Services Committee. My name is Leslie Dvorak, L-e-s-l-i-e D-v-o-r-a-k. I'm an advanced practice nurse, and I'm board certified in women's health care. I'm a member of several professional organizations to include ACOG, AANP, WPATH, to name a few. And I'm here to oppose LB732. In 10 of '23, Nebraska enacted the Let Them Grow Act. This act conflicted with our medical evidence-based medication and put into place very restrictive regulations for nonsurgical gender care. Current rules require extensive therapy. An hour of 40 at least that is an arbitrary

number, there's no medical evidence that this is what people need. It has-- we've always insisted on parental consent. There's a waiting period. Right now, youth who are receiving gender-affirming care are not allowed to do subcutaneous injections at home for hormone therapy. Yet, we trust them and their parents to give Sub-Q injections for insulin, a drug that should they over or under dose is a true medical emergency. LB732 does not add safety. It overrides the careful clinician-led framework and replaces individualized medical decision-making. Families have always had the right to know what's best for their children. I ask you, we allow parents to make medical decisions every day, one of those being a medical decision to permanently change a baby's reproductive system without their consent and with no medical necessity. This procedure is called circumcision. How can we allow them to make that decision but not start hormone therapy? The state is not protecting children against things like hunger, gun violence. Why are we not working on those issues? The state doesn't have the knowledge or the expertise to make decisions for Nebraskans when it comes to gender-affirming care. We need to leave health care to the medical professionals, not junk science. I have over 30 years of nursing experience. I've been a nurse practitioner for over 24 years. This is a long time to see a lot of different things. I heard that people were talking about off-label use of medications. We use off-label use medications for things every day. Talking about regret rates, let's talk about the regret rate of someone having a knee procedure is 20%, the regret rate of having children is about 14%, and the rate-- regret rate is-- for gender-affirming surgery is 1%. Families need to make their decisions with their providers, their therapists, their psychiatrists and their children. Thank you. I welcome questions.

HARDIN: Any questions? Seeing none, thank you.

LESLIE DVORAK: Thank you.

HARDIN: Opposition, LB732. Welcome.

AMY ARNDT: Thank you. My name is Amy Arndt, A-m-y A-r-n-d-t. I oppose LB732. I was born and raised in Lincoln, attended Lincoln High School, SCC, Wesleyan, UNMC, and University of Missouri, Kansas City. I am a proud nurse. It is my honor to be trusted with the care of my patients for the last 32 years. My code of ethics guides me towards advocacy, respect for dignity, and justice for the people that I serve. I serve families, veterans, farmers, students, all backgrounds of Nebraskans that you can imagine. Gender-affirming care is, in essence, culturally

competent care. It is a respect that I show my patients that I took the time to learn more about you, that allows me more trust. Trust is key to a long-term primary care relationship with anyone. When my patients trust me, I can help them reach health care goals and move forward in their life journey, thriving, not just surviving in this world. Standards of care guide all principles of primary care. Gender-affirming care is no different. It is safe, nuanced, evidence-based care provided in a multidisciplinary team. I see it change my patient's lives for the better. And I think my experience in education as a clinician should be weighed more heavily than people without such experience. You trust me with complex health issues, care through the pandemic, anticoagulant therapy, cancer care, complex insulin regimens for diabetes, depression and anxiety, multi-system trauma, the wellness of people from infancy through the end-of-life care. Please trust me now to do what is best for my patients and families, do not move forward this harmful bill.

HARDIN: Questions? Thank you.

AMY ARNDT: Thank you.

HARDIN: LB732. Welcome.

DOMINIC GLIKO: Thank you for having me. My name is Dominic Gliko, D-o-m-i-n-i-c G-l-i-k-o. I am a psychiatric nurse practitioner here in Omaha. Well, I guess in Omaha, not here. But I am here today in opposition of LB732. And I want to emphasize that I am here testifying on my own behalf. I do not represent-- like not represented of my employer or affiliations. So in my professional role, I have the privilege of supporting families that are navigating some of the most, like, complex and emotionally charged situations they ever experience. And each patient I see has unique needs and concerns that really require a nuanced approach and holistic assessment. The individualized care plans I create are made cautiously, collaboratively, and prioritize safety with these considerations. Clinical judgment cannot nor should not be imitated by cookie-cutter legislation such as LB732 that jeopardizes optimal health outcomes. It is clear to me that LB732 aims to further strip Nebraskan parents of their rights to make medical decisions for their children, restrict practitioners of their ability to provide evidence-based medicine, and perpetuate the stigmatization of an increasingly marginalized community. Our current literature demonstrates time and time again that when access to this type of medically indicated care is restricted, it is-- it does not eliminate the real and palpable distress that the youth experience,

rather that it perpetuates it, exacerbates it. And I have seen this firsthand with the first passing of the Let Them Grow Act as I worked with Dr. Amoura in her clinic, helping those families navigate how they will get care for their kids. So the continued political infringement and blatant disregard for Nebraskan life that is affecting our medical care is utterly reprehensible. Parents deserve the right to maintain their authority to make medical decisions for their children in partnership with qualified licensed practitioners, not by politicians and practitioners be-- deserve to be able to practice to the fullest extent of their scope guided by evidence-based best practice and their ethical obligations to do no harm, not by politicians lacking specialized training. And for these reasons, I respectfully appeal to the committee to oppose LB732. Thank you for your time and consideration.

HARDIN: Thank you. Questions? Seeing none, thank you. LB732. Welcome.

GRANT FRIEDMAN: Hello, Senator Hardin, members of the committee. My name is Grant Friedman, G-r-a-n-t F-r-i-e-d-m-a-n. I'm a staff attorney at the ACLU of Nebraska, and we are speaking in opposition to LB732. Gender-affirming care is lifesaving care that individuals take in consideration with their doctors, family, and community supports, not something that is able to be provided regularly or easily accessible, especially under the existing regulations that this state has invested time and money into putting into effect. Now, we opposed LB574 when it went into effect, when it was before this committee in years past, and we continue to oppose it. However, it is worth noting the time that this body spent into getting that law passed and that went into effect making regulations, the time and effort that the community has taken into account to continue to be able to access care under that existing model. Further regulating that not only harms the individuals that they are seeking to protect, but it deprives families of that independent relationship that they have with the medical professionals before them. Relationships that you've heard before you today talking about how that that decision is not a place for politicians to get between. Trans youth are still going to exist no matter the amount of regulation or laws that go into effect. But laws like this only go to further to make their lives harder and more difficult to work in. Because of the time and effort that goes into making these health care decisions, it is unnecessary for the state body to get in between that and intervene in a field that it is not an expert in. Because of this and the discriminatory impact and effect that this will have on the trans youth in this state, we ask that this body indefinitely postpone LB732. I welcome any questions.

HARDIN: Thank you. Questions? Seeing none, thank you. Opposition, LB732. Welcome.

RACHEL MURPHY: I was going to give you these as well. Don't need those all for myself, thank you. Hello, my name's Rachel Murphy. That's R-a-c-h-e-l M-u-r-p-h-y. I'm testifying today in strong opposition to LB732. I appear before you wearing two hats, as an unpaid board member of PFLAG Omaha and, more importantly, as a mother. PFLAG was founded over 50 years ago by a mother and teacher named Jeanne Manford. After her son was beaten for being gay, she did not hide in shame. Instead, she marched in the streets with him, carrying a sign that urged other parents to unite in support of their children. She founded the organization because she knew that parental love should be louder than hate, and I carry that same spirit with me today. The first time I visited our beautiful State Capitol was several years ago when this body had started targeting trans kids. I was the mother of a somewhat newly out trans child and I sat in front of this committee and sobbed, pleading with you to not take away the health care that had finally started making my child smile again. You passed the bill anyway. Thankfully, we found ourselves grandfathered in and my daughter was able to continue her care. I've been back up here every year since challenging these continued attacks on trans people, particularly children, and here we are again. But I won't sob this time. I'm past that. Frankly, I'm just pretty ticked off. Because this legislative body made me feel like a terrible mother with the talking points used to justify this bill or these bills, I would ask my daughter regularly, do you still want this? It's OK to stop if you want to. You don't have to do this. She always reassured me that she still wanted it. Finally, she put her foot down and told me to stop asking. She isn't going to change her mind and she still doesn't have any regrets. She knows who she is. She's now almost 19 and that fact remains the same. No regrets. This bill talks about cross-sex hormones as if they're toxic alien substances. But every single person in this room, barring a medical condition, produces estrogen, testosterone, and progesterone. None of them are foreign, and we just produce them at different rates. We are not introducing foreign substances to this body, we're just balancing them to meet each individual's needs. I'm running out of time, so I'm going to jump ahead. But there's also this talking point that this is just common sense. As a kid I, too, learned that the sky is blue, boys have a penis, and girls have a vagina. But there is more to it than that, if you actually look up, the sky can be beautiful shades of pink and orange, or deep shades of green and purple. With a scientific explanation for each shade, there's more to

humanity than just being born male or female if you're willing to look past the elementary understanding. If you're having a tough time understanding the complexity of this, please listen to the experts. Every major medical association supports this as a best practice health care for the rare scenario of being transgender. Do not pass this bill. Thank you.

HARDIN: Thank you. Questions?

RACHEL MURPHY: Any questions?

HARDIN: Senator Riepe.

RIEPE: Thank you for coming.

RACHEL MURPHY: Mm-hmm.

RIEPE: It says here, I think you said in about 4th paragraph in, she's now almost 19.

RACHEL MURPHY: Yep.

RIEPE: Has this been such a negative impact that she is eager to leave the state of Nebraska?

RACHEL MURPHY: She would love to leave the state, but she can't afford to. She's still living with mom. So she's exploring those opportunities. She's actually at this point looking to leave the country because she feels that the American population is, I'm sorry, the American government is working on a genocide of transgender people. I hate to say that, but it's legally occurring, and we're well within the steps now, and she's looking to flee this country.

RIEPE: Well, you're to be commended for picking up the gauntlet here and marching on because you don't have a direct impact, I don't believe, if your daughter is that age, but you still understand the issue.

RACHEL MURPHY: If I have to look my daughter in the eyes and know that my care of this topic stops with her, I feel like I'm a bad person and a bad mother because there are so many other children and mothers in the state who deserve the opportunity to get best practice medical care. And as a board member of PFLAG and, you know, just a, a human being with empathy, I, I want to show up and, and ask for our legislators to do the right thing.

RIEPE: Bully for you. Thank you, Chairman.

RACHEL MURPHY: Thank you.

HARDIN: Any other questions? Seeing none, thank you. LB732. Welcome.

EVELYNN FREEMAN: Welcome. My name is Evelynn Freeman. That's E-v-e-l-y-n-n F-r-e-e-m-a-n. I'm 29, a native Nebraskan, homeowner, psychotherapist, and trans woman. If there-- there are several points I would like to address today and time does not permit me to address all of them. If you'd like to discuss this further, I invite you to correspond for more in-depth discussion. I was fortunate to be one of the few who had the opportunity to speak in opposition to Senator Kauth's LB574, which initially restricted gender-affirming care for minors. I was grateful for that opportunity, though horrified by the, by the nature of it and now disappointed to see a referendum on it. Nebraska's State Legislature is uniquely nonpartisan, but it is no secret that this is a party-line Republican issue. Conservatives seem to have drifted from being the party of small government that I knew. Otherwise, we would surely hear some conservative voices decrying government overreach, as LB732 is proposing to make decisions for families in spite of incontrovertible evidence in support of gender-firming care from the AMA, the APA, the AAP, and additional guidance and support from the Chief Medical Officer. Currently, minors are required to have parental consent, receive 40 hours of therapy, and wait a week to access any sort of gender-affirming care. While I see these restrictions as something of a bureaucratic unnecessity, the regulations are in the, are in the spirit of the Nebraska I know. We're cautious, but we're also pragmatic and not a state to fall in line with others blindly. I can speak to this bill from two perspectives, as a provider who works with trans youth and as an individual. As a mental health provider, I can attest to the benefit my patients see as a result of access to this care. They rest more easily knowing they will not suffer harm that could have otherwise been prevented. They are less depressed, make more friends, and are less anxious. They found the confluence of access information and support necessary to avoid having to undergo trials I, and many others, have had to undergo due to not having access to this care at a younger age. I did not benefit from gender-affirming care until I was 21, but I often think about how much better my life would have been if I had access sooner. I had known I was trans since I was 10, but I was afraid my parents wouldn't be accepting. I was afraid I would never be able to live a normal life. I've done hundreds of hours of painful hair removal, undergone multiple surgeries, and worked on, and worked

on voice training for hundreds of hours, all to arrive at a place I would have started out if I had access to gender-affirming care as an adolescent. It has cost me an excess of $20,000 so far, but the thing I mourn the most is time. What could I have done with that time? Not just in receiving those treatments, but also time lost to depression from not treating my dysphoria earlier. Maybe I could have gotten into painting, made more friends, or just wouldn't have had to hurt so much. I want to protect other people from hurting like I did. This is something I will defend now and for always. The goal of this bill isn't to solve a problem. The goal is to score political points off the back of a vulnerable community. Vote no on LB732. I rest my time.

HARDIN: Thank you. Questions? Seeing none, thank you. LB732. Welcome.

MASON LUTTIG-LEAPLEY: Everyone, my name is Mason, M-a-s-o-n, Luttig-Leapley, L-u-t-t-i-g-L-e-a-p-l-e-y. I'm here to speak for a friend of mine, but I'd like to introduce myself just a little bit. I am myself a trans athlete and trans coach, and also a, a blue collar worker in Nebraska. I have my master's done at the University of South Dakota with a focus in criminal justice and working with LGBT and marginalized groups in the juvenile justice system, which also is backed by my bachelor's degree that I had at St. Anselm College in Manchester, New Hampshire, which was one of the first Benedictine campuses in the U.S., which has also signed on with Harvard to denounce the Trump administration. So just as a up there for the people that want to say that religion is an excuse to be a bigot. With that said: Dear Senator Kauth, my name is Blake [INAUDIBLE]. I'm a patient and representative of Pride Health Clinic. I am writing to you concerning LB732 and furthering the Let Them Grow Act and how this will affect families and friends within my community and ask you to oppose this bill with an understanding of who is at risk. I have a personal connection to this bill as I started my transition as a minor. I was 15 when I started my journey and I am now 24 as I write this. Almost 10 years of my life have been changed for the better because of my transition. I can honestly say that those beginning years in my adolescence made the biggest difference in who I am today. And had this bill been placed then I would not be sitting here writing this today. Please understand the adolescents who will be impacted by their choices being taken away are the same ones you argue to have a career and a dream picked, picked out at the same age the people who are saying they aren't able to make this decision to be who they feel and know where-- they are where-- they are when they want kids to make lifelong impacting decisions like join the military as early as 16 or have the right to vote as early as 17. These kids deserve to be their

full selves and those rights shouldn't be taken away because someone has opinions that don't align with theirs or the people or the families. Like me, these kids just want to feel comfortable in their own bodies. They want to feel at ease when they're, when they're at school or in public with friends. They have the option right now, even with the hoops and barriers that they must jump through. I have seen the kids at Pride Health Clinic come out of their shell within months or starting their transition because they finally begin to, to feel happy and comfortable with who they are. It's bad enough that most families and parents don't support it, so those kids have to wait till 19 with no support. That shouldn't have to extend to all kids. If your child comes to you and tells you that you feel differently than how they were born, how would you react? I hope that aside from all the worry of the transitional changes and experiences, you tell them you're by their side and will help them navigate the way to be the very best and confident version of themselves, that you should stand by your children in the most nerve-racking but exhilarating time of their life. I understand the concerns of people's mental well-being, but I think we're trying to please the wrong people. We should not take away from our-- almost done, promise-- away from the lives of our children to make adolescents-- adults comfortable. We need to be the change that helps them grow in the world that we, we built for them in their future. By taking this away, we will only be telling them that they shouldn't be who they are from the start of them finally figuring it out. We need to support them and staying with these kids, I worry that they won't, won't stick around to see what the future looks like. Say no. Any questions?

HARDIN: Thank you. Questions? Seeing none, thank you. Welcome.

ALYCIA LaMARCHE: Hi. My name is Alycia LaMarshe, A-l-y-c-i-a L-a-M-a-r-c-h-e, and I am a co-owner of Pride Health Clinic in Omaha, Nebraska. I am here today to respectfully request that you oppose LB732 and any further efforts to expand or strengthen the Let Them Grow Act in ways that would not only harm LGBTQ+ youth and families, but also the practitioners who have lawfully provided care by the guidelines that have already been agreed upon. Nebraska's current law already places extraordinary barriers on transgender minors and their families. Under existing regulations, access to puberty blockers or hormone therapy requires extensive hours of therapy, waiting periods, and ongoing monitoring. With these restrictions in place, families across our state are already struggling to access medically necessary evidence-based care recommended by their providers. The changes proposed with LB732 would mean that Nebraska families would see an

effective ban on puberty blockers and hormone therapy for anyone under 19, regardless of medical need, parental consent, or the patient's treatment history. This removes clinical judgment from doctors, strips parents of their ability to make informed decisions for their children, and creates a significant risk for youth who are already receiving care. I am particularly concerned about the minors who began treatment after October 1, 2023, and did so in full compliance with the state's requirements. These patients followed every guideline imposed by the Let Them Grow Act, yet would not be considered grandfathered in under LB732. As a result, they risk losing access to their medically necessary care. Medical experts warn that abruptly discontinuing care can cause significant physical and mental harm. No child should be penalized for following the law or lose access to care because of shifting political decisions. Families deserve compassion, stability, and the ability to work with qualified medical professionals, not laws that force them to leave the state or forgo care altogether. Nebraska should be focused on supporting young people and families and not creating policies that increase distress, isolation, and harm. So my question for Senator Kauth is why? Why are you attempting to change legislation that you and the state have already agreed upon and already set those guidelines rather than improving the well-being of the state of Nebraska as a whole and contributing to the overall American growth is being perceived that you are working on your own personal agenda and attacking your own people. In August of 2021, you posted a blog on your website, K.T. Beck Enterprises, titled: Misdirected Anger. In that post, you say, quote, Sometimes people are unwilling to deal with a situation that is upsetting them, and they redirect their anger in other ways. So Senator Kauth, what, what is so upsetting you that you redirected all your anger to the LGBTQ+ community? That is all.

HARDIN: Thank you. Questions? Thank you. LB732 opposition. Welcome.

KAREN MARKER: Hi, my name is Karen Marker, K-a-r-e-n M-a-r-k-e-r. I live in Legislative District 29 here in Lincoln and I am here both as a licensed independent mental health practitioner and a mom. As a therapist, I own a group practice here in Lincoln where we work with gender-diverse folks across the lifespan, including adolescents who are seeking gender-affirming mental health care. As a mom, I have a 12-year-old and a 9-year-old whose mental and physical health and well-being are my husband's and my responsibility. I'm an expert in providing mental health care to my clients, and along with their doctors, I'm expert in making sound medical decisions for my kids. I know from my training and experience as a therapist that the absolute

best care that we can give to a young person who identifies with a different gender than they were assigned at birth is to affirm that gender both in the therapy office and through medically necessary care decided by their doctor and parents. I know as a mom that if my child came to me saying that they are a different gender than they were assigned at birth, that I would seek out appropriate medical and mental health care. And because every major medical, psychological, and social work association in the U.S. has stated that gender affirming care, which can include medical interventions such as puberty blockers and hormone therapy, is the best care for gender-diverse youth, that is the care that I would seek. Every therapist and medical provider that I know who provides medically necessary care to gender-diverse youth has spent countless hours in training and consultation to make sure that they are providing the best care possible. Therapists, psychologists, and medical providers all take an oath to do no harm. And we are already forced to skirt that line with the restrictions that were put into place after the legislation that was passed in 2023. If medical providers are no longer able to provide necessary medication to their patients. They will be forced to go against their oath, because we know that gender-affirming care for young people is lifesaving care. We also now know that there is a correlation between an increase in suicidality for transgender and nonbinary youth and living in a state where anti-trans legislation has been passed. I am asking you to please allow medical and mental health providers and the parents of trans and nonbinary youth to make the best decision for their care, as they are the only ones with the expertise to do so. As a result of the legislation passed in 2023, there are already tough restrictions put on mental health and medical providers to provide this care, but we are still able to. Please do not force medical and mental health providers to cause harm and take away the option to provide medically and psychologically necessary care. As a mental health care provider and as a mom, I promise you that providers who are caring for gender-diverse youth and their parents only have the best interest of that child in mind. If this bill passes, it will cause irrevocable harm to trans and nonbinary youth in our state. Please allow Nebraska to remain a safe state for all of our young people and do not allow LB732 out of committee. Thank you.

HARDIN: Thank you. Questions? Thank you.

KAREN MARKER: Thank you

HARDIN: LB732. Welcome.

AMARA PACE: Hello. Thank you for taking the time to listen to me. My name is Amara Pace, that's A-m-a-r-a P-a-c-e. I don't really have numbers or stats to give you, just my experience, so. I realized that I, that I need to live the way that I do now when I was only 12. My father knew, by the time I was 14, he basically looked me in the eyes and said I know, and then walked out the door. We didn't talk about it again until I was 17, but all he did was force me to drive myself to a suicide prevention clinic and they didn't, they didn't help in care. I went to my GP, who had treated me since I was a young child, at 19, and he printed out about a 12-point font notepad that he jotted up really quick of four names and phone numbers in the city. He said go talk to them and whatever you do, don't cut it off. By the time I was an adult and I realized that I can actually live for myself for once, I went to Nebraska Medicine, but they wouldn't see me for almost a year just as a consultation. So I went to Planned Parenthood, and they didn't give me the best treatment, but they did help me, they saved me. These days I go to Pride Health Clinic, and they treat me like a person, which is amazing. I actually have a-- actually, before I touch on that, there is a clinic in Omaha that used to be called 88MED, owned by the same people who own 88 Tactical and Signal 88. They're now called NextGen Male Medical Clinic, and they know firsthand how devastating, reading from the website, how devastating low T can be. For years, they were misdiagnosed and treated for symptoms rather than the cause. After exploring several doctors and treatments, they found success through consistent therapy. Wow. The results were remarkable: improved energy, focus, mood, libido, and confidence. Now they're on a mission to enhance men's health for today and the future. Just cisgender men. Not us. I have a nonbinary friend who began transitioning and then stopped. They're a good friend. They're ultimately happy with what they did, they don't have regrets. But they're the way they want to be, and I think that's great. I think people should be allowed to detransition and receive care for that, but we shouldn't be harming so many people, so many vulnerable young people who don't know any better just to help them. It doesn't work, it doesn't make sense. Sorry, one last thing. When I was 14, my father needed to get healthy. So he hired himself a personal trainer and decided, hey, I'm going to hire one for you, too. So I had the, the lovely experience of him forcing me to strip in an office while he laughed at me and mocked me. And then he forced me to work myself until I built up muscles that I didn't want or need. I've received nothing but apathy and abuse. And I'm tired, and I don't want this to happen to anyone else, please say no.

HARDIN: Thank you. Questions? Thank you. LB732. Welcome.

JANET MORTON: Hi. My name is Janet Morton, J-a-n-e-t M-o-r-t-o-n. I'm here today as a parent and I'm here because LB732 turns medical neglect into state policy while claiming to protect children. LB732 eliminates the only evidence-based, medically recognized care available to transgender youth and it replaces it with nothing. No alternative treatment, no medical pathway, no safeguards, and no follow-up care. Being transgender is not a disease and there is no medical cure. Therapy alone is not substitute when medical care is clinically indicated. Treating enforced inaction as a solution is not neutral, it is harmful. And we already know how cautious this system is because we are living it. My daughter has been her authentic self, authentic self for 3 years. She has been in continuous therapy and even today she still does not meet the Nebraska's existing LB574 requirements to receive any medical treatment. That means the current law already imposes significant barriers, extensive oversight, and careful gatekeeping before medical care is even considered or ever considered. So the question is not whether there are safeguards, they already exist. The question is why the state would eliminate care entirely when it's already so rare, so regulated, and so deliberate. Denying medical-- medically recommended care is not neutral, it is an act of intervention. Medical and mental health experts consistently warn that withholding this care increases depression, anxiety, school avoidance, family stress, and suicide risk. When harm is foreseeable, documented and preventable, mandating inaction becomes a medical neglect. In every other area of medicine, refusing effective treatment would be considered neglect or abuse. If a child were denied insulin, asthma medication, antidepressants because lawmakers just disagreed with the condition, that would be unacceptable. LB732 requires that exact standard of care denial, but only for one group of children. LB732 also replaces doctors, parents, and patients with politicians, it strips licensed clinicians of professional judgment, it overrides parents who are otherwise trusted to consent to every other form of pediatric care, and it forces doctors to choose legal survival over patient well-being. What makes this even more troubling is that this bill is not grounded in any proven cause of why someone is transgender. There is no established medical determination that being transgender is caused by parenting, or trauma, or ideology, or social influence. Yet, this bill overrides parents, doctors, therapists, and world-recognized medical organizations based on a belief that being transgender is wrong. Belief is not a valid legal justification for banning medical care. Major medical authorities include the American

Academy of Pediatrics, American Medical Association, Endocrine Society, and World Professional Association for Transgender Health support the use of puberty blockers and hormone therapy for adolescents. For my daughter, this bill is not abstract. LB732 would force her to grow into a body that does not match who she knows herself to be while telling her that the care that could help her is illegal or dangerous. That doesn't protect children, it emotionally devastates them. LB732 does not protect children, it bans evidence-based care, offers no alternatives, and mandates harm through neglect. It bans care, not risk, and it replaces medicine with ideology. I urge you to oppose LB732.

HARDIN: Thank you. Questions? Seeing none, thank you. LB732. Hi.

TERESA LOMBARD: Hi. So good day, Chairman and Senators. My name is Teresa Lombard, T-e-r-e-s-a L-o-m-b-a-r-d. I oppose LB732 and ask you to indefinitely postpone it. Each of us have unique health challenges. It's best for us when our doctors aren't limited in what they can suggest to help. This is truth for youth and their families, too. Do you know why balding men with hair implants and youth with puberty blockers are the same? They both get gender-affirming care to help them feel comfortable with their looks. My oldest son told me that. Next year you can be hearing a bill that bans hair replacement therapy for men and barbers required to buy extra insurance to offer scalp massage. Yes, I'm poking fun, but, you know, sometimes you want to cry and have to find a way to laugh instead. A kid younger than 19 who's hurting and doesn't know how to fix it may try all kinds of things. My middle son didn't know why he was hurting. I didn't know why and didn't know what to do. I thought he wore long sleeve shirts because he was self-conscious about hair. Hair on his arms. Kids can be sensitive to all kinds of things, especially at that age when they think everyone is judging them. Well, and they're right, aren't they? You're judging. My son wore them to hide the cut marks on his arms. The cuts he put there because he didn't know what to do. Some kids hurt enough that they try to kill themselves. Sometimes they succeed. Back then, if I thought of trans at all, I was thinking of the Rocky Horror Picture Show or maybe Tootsie. If I'd known my son was hurting because his body was wrong for him, maybe I could've asked for help, and maybe a puberty blocker would've helped him get through school a little bit less miserably. But he did make it to adulthood, and when he figured out what he needed, I certainly didn't understand. I still don't completely, but I don't need to. I just needed to tell him, you're my child, and I'll always love and support you. Senators, respectfully, you don't need to fully understand it either. You just

need to support Nebraska children. All of them. Respect that they and their families need all the help they can get, all the health options possible because what helps one can't help all. Discrimination is bad. It's bullying. Bullying children and their families isn't a good look for the Legislature. Once my youngest son asked instead of thinking what's the worst that could happen, why not ask what's that best that could happen? So I'm here looking for the best that could happen. I'm looking for each of you and everyone listening and watching to get you don't have to fully understand people to accept them. Kids are just people learning who they are. For some, puberty blockers or cross-sex hormones may be all that get them safely to adulthood. Please indefinitely postpone LB732. Thank you for listening.

HARDIN: Thank you.

TERESA LOMBARD: Questions?

HARDIN: Questions? Thank you. LB732. Welcome.

JACLYN OLBERDING: Good evening. OK. My name is Jaclyn Olberding, J-a-c-l-y-n O-l-b-e-r-d-i-n-g, and I am a resident of Lincoln District 29. I am here to strongly urge you to vote no on LB732, which seeks to further restrict access to gender-affirming health care for minors in our state. My heart rate is through the roof. My watch keeps notifying me of that. As a parent of a transgender child, I know firsthand that gender-affirming care is not experimental. It is evidence-based, medically necessary, and lifesaving care that follows standards set by major medical associations, like the American Academy of Pediatrics and the American Medical Association. This bill does not protect children, it endangers them. Research consistently shows that denying this care increases risks of anxiety, depression, and suicide among transgender youth. Decisions about medical care belong between families, doctors, and patients, not politicians. If there was a decision you had to make for your child's health that reduced their suicide risk by up to 73%, 73, what would you do? This number was cited in the Journal of the American Medical Association published online February 25, 2022. So you say let them grow, kind of hard when they aren't here to do so. My child's health care should not be a political issue. Please protect the rights of families to make private health care decisions and oppose this bill. Thank you.

HARDIN: Questions?

HANSEN: One quick one.

HARDIN: Senator Hansen.

HANSEN: What was the date of that study? Sorry, I missed that.

JACLYN OLBERDING: February 25, 2022.

HANSEN: Cool. Thanks.

HARDIN: Any other questions? Thank you.

JACLYN OLBERDING: Yes. Thank you.

HARDIN: Welcome.

AMY BETTINGER: Hi. My name is Amy Bettinger, A-m-y B-e-t-t-i-n-g-e-r. I am here to oppose LB732 and ask all of you to do that as well. Thank you for your time. I am a lifelong Nebraska resident. I was born here. And you've heard a lot of testimony today about lived experiences of parents. You've heard from different associations and so on. And so one thing I wanted to talk about, because it keeps coming up, is evidence. I like evidence. And so I went on a whole spree getting ready for this. I wanted to know if there really was a lack of evidence for gender-affirming care. And one thing that really stuck out in all of this searching that I did is that the demand is for high-quality evidence. That is the reasoning being given for why studies are not acceptable. However, the highest quality of evidence is a random controlled trial. However, doing that kind of trial on minor youth for gender-affirming care would be patently unethical because it would require withholding care proven to help trans youth. I want to repeat that for you. It is unethical because it withholds care proven to help transgender youth. So if we're talking about an evidence-based study, the demand for that level of evidence is inherently unethical. You won't get it, so you're asking for an impossibility. We can't get you that information because it can't be done ethically. I looked over the studies that were available and in my research I found five separate institutions that completed studies. Cornell University analyzed a handful of studies. Out of the 55 they analyzed, 93% supported gender-affirming care, while only 7 found mixed or no findings. The study time frame was 1997 to 2018 that they were looking at. The only studies I could find against gender-affirming care were the Cass report or the HHS report, which heavily cites the Cass report. And the Cass report was a flawed study. They don't address any of the positive outcomes at all. Members of their focus groups included individuals who admit their knowledge of

gender questioning young people came from media and public discourse, 34%. And either agreed strongly or just agreed with the statement that there is no such thing as a trans child. That's bias. So I see I'm red now. What I want to finish with is just listen to the trans voices here. There's 30 people in this room alone right now who are telling you lived experiences. And listen to associations you've heard from. They've already been listed for you. I don't need to do it again. If we're truly talking about evidence, there isn't a lack of evidence.

HARDIN: OK, we're in and out of the red.

AMY BETTINGER: Thank you. If you have any questions, let me know.

HARDIN: Questions? Thank you. LB732. Welcome.

JILL DIBBERN MANHART: Thank you. Good evening, the members of the Health and Human Services Committee. My name is Jill Dibbern Manhart, J-i-l-l D-i-b-b-e-r-n M-a-n-h-a-r-t. Four years ago, we were blindsided by LB574, the first anti-transgender legislation to come to our state. We've been thrown into what has become a 4-year long fight for the rights of trans children in our state, 4 years of taking time off work, spending countless hours writing testimony, meeting with senators, not to mention the stress and worry caused by bills like this, as well as time taken away from families. Four years ago, we testified asking for the same rights afforded to other parents to make medical decisions with our medical providers without government overreach. This felt like a commonsense approach to trust one's medical professionals, but LB574 passed, albeit with a narrow path for families with extreme requirements to meet, but there was a path. Now, this is not enough, you sold LB574 under the guise of protecting trans children. Then we moved to LB89 stripping away the right of trans children to play sports with their peers. Suddenly those same children that you stated you were protecting from health care decisions, now you decided those children no longer needed or deserved your protection. It was their peers who needed protection from them. So the few trans children who were playing sports and having the childhood experience of being part of a team are no longer afforded the same rights as their classmates. And yesterday was LB730, now trans children should not have the basic dignity to use the bathroom without scrutiny by others. Now senators want to know what genitalia children have under their clothes. It appears that children need protection from you. Slowly and methodically you strip away piece by piece every right trans children have to live the same life as your children. This, my friends, is erasure, erasure of trans children, the

dehumanization of people who are just trying to live their lives. The senator has brought three bills this year as well as a study on whether affirming trans children is child abuse. Child abuse. You see it will never be enough when a society decides that it is OK to begin to slowly strip away, little by little, the rights of one population, the right to merely exist in this world, we have begun a genocide. I know that world-- that word may not be comfortable for you. Some here will call me an alarmist, but look up its meaning: an attempt to wipe out a specific group of people. First, they limit health care, then they take away their ability to play sports, next bathrooms, then full health care ban, then doctors threatened for even doing gender-affirming care, finally, accusations of child abuse and removal of children. You see, the pathway to erasure is all laid out. Bills like this pull at every fiber of every being until their existence vanishes. I know that many senators on the legislative floor like to tout religion or cite their favorite Bible passage to justify their decision to dehumanize a child. But I ask you, when will it be enough for you? At what point will you decide that your decisions have hit the tipping point for your conscience? Is that moment when trans children no longer exist in our state, our society? You each must ask yourself these questions. What kind of person are you comfortable being? I urge you to vote out-- I urge you to not vote out LB732.

HARDIN: Questions? Seeing none, thank you.

FREDRICKSON: Next opponent for LB732. Welcome.

TIFFANY WEISS: Thank you. Members of the Health and Human Services Committee, my name is Tiffany Weiss, spelled T-i-f-f-a-n-y W-e-i-s-s, and I live in Kearney, Nebraska, which is District 37. I'm here today to oppose LB732. This bill is very personal to me, as two of my five children are transgender. Today, I want to focus on my 13-year-old daughter. She's amazing. She plays trombone in her band. She has her first set of braces. And she loves her friends fiercely. And she just happens to be transgender. And that's the least interesting thing about her. And she was 9 years old when she told us that she wanted to be a girl. And she has never wavered on that fact. When she came out at age 9, we did not simply change everything overnight. Unlike what everyone on this panel seems to think, the process of transition is slow. First, we started with at home just calling her a girl's name and letting her wear girls' clothes at home. And then we started-- then we did that for an entire year to make sure she was insistent, persistent, and consistent with her identity. After a year of that, we talked to the school and we let her change her name and pronouns and

gender identity at school. We finally let her dress like a girl outside of our home and acknowledged to her friends and family that she was transgender. Then it was 2 years later that we got her a puberty blocker. This, too, was just to buy some more time to make sure she was ready. Then you all passed the Let Them Grow Act. So she was fathered in on her puberty blocker, but she was not fathered and on the cross hormones. So she had to do the therapy hours. And she did her hours and she waited and waited and waited. And finally she met the quota and she started her cross hormones and she's been on these hormones for 6 months now. And, personally, she's developing breasts and she's getting acne and she is going through puberty at the same rate as her peers. But she did exactly what you asked of her. When you, as a governing body, decided it was required, she jumped through your hoops. She did so much counseling that she didn't need because she's not mentally ill. She is not depressed, she is not going through trauma, but she did it anyway. We saw the providers, we got the signatures, and now after all of that, after she's already started cross hormones, you want to take them away. You want her to detransition because it makes you uncomfortable that there are trans youth, not because of anything she's done. Even when people asked her over and over again if she was sure, she has never ever faltered. It's not right and it's not fair to take away gender-affirming care, which is lifesaving care for any minor who needs it. It is doubly wrong to take away gender-affirming care of minors who have already jumped through the hoops and started their transitions based off of a law that you already passed. We are here again, again, for the second time, for the fourth time, depending on which bills you fought. But we've already passed the law, you've already passed the Let Them Grow Act. When is it enough? Thank you for your time.

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

TIFFANY WEISS: Thank you.

FREDRICKSON: Next opponent. Welcome.

ARIANA WEISS: Members of the Health and Human Services Committee, my name is Ariana Weiss, spelled A-r-i-a-n-a W-e-i-s-s, and I live in Kearney, Nebraska, District 37. I'm the kid that you just heard about from the mother that just spoke. I'm 13 years old and here to oppose LB732. I'm scared of speaking so publicly, but my fear of this bill passing has surpassed that and made me come to speak. I was scared of all the eyes watching me, and all the ears listening to me, but then I

realized that everyone here has the same fear of this passing. I am a normal kid. I live a normal life. I play trombone, I have a passion for math and Rubik's Cubes, and I love, love, love cats. I am a normal kid. What every kid wants is a good life: ice cream, park days, video games. For that-- no, for me, having a good life is being a girl, the person I feel most comfortable as. That means having medical care that affirms my identity. Getting to look like a girl makes me feel more like the person that I know I am. If you pass this bill, that means that me and countless other kids get to live a life of hell. That would mean that my life would essentially fall apart. That would make me have to, have to live life as a boy, and that would be a lie. A lie that I would have to live with for the rest of my adolescence. If they take my hormones, I will grow a beard. My shoulders would widen and my hips would stay the same. I would look like a person I wish-- I do not wish to become, and these changes would be permanent. Me being a girl is not a choice. It is who I am. Living as a girl has made me happier than I would be as a boy. Before my transition, I felt like a hollow shell of who I was, just trying to impress the teachers and make it through the day. As a girl, I can finally be outgoing and feel like a person, not just a shell. It was scary starting my social transition. I was worried that no one would accept me for who I am, except my parents. When I finally transitioned, I realized that I didn't have anything to fear and that everyone supported me for who I truly was. But with this bill, I am starting to feel that fear all over again, the fear of not being who I truly am. Thank you for your time. Do you have any questions?

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Thank you for being here. Next opponent.

DANIEL RICHIE: Hi, my name is Daniel Richie, D-a-n-i-e-l R-i-c-h-i-e. I don't think I'm alone here in this, but I'm tired. I'm tired of the anxiety. I'm tired of wondering what's coming next. I'm tired of reaching out to legislators that don't listen. I have had the, the chance to speak to a few of you in person, and I thank you for that. I'm tired of speaking publicly when I might as well be sitting here in silence. How many more hearings are there going to be going after trans people? Because that's, that's clear, that's what's happening. How many times can these people keep pouring out their hearts, pleading, trying anything for some way to make this legislative body see that trans people are people? Some of you think there are, are simple binary decisions in life, but look around, life is anything but. You are literally forcing a square peg in a circle hole. The message that these bills reinforce is there's an ideal and specific

way lives should be lived. That doesn't sound like freedom to me, definitely not equality above the law. It honestly sounds like a state that does not want somebody who looks, speaks, or acts differently. So I ask you, Senators, instead of bills like this, let's work on the ones that actually lift up the people and empower them to succeed or, hell, how about work on budget? But I want to leave you with this: I am angry. I am tired. I am so tired, just like all the rest of these people in here, we've been here many times. We know, we know each other now. But I'm not going to quit. Thank you.

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

DANIEL RICHIE: Thank you.

FREDRICKSON: Next opponent. Welcome.

JILL BROWN: Hi, thank you. Thanks, everybody. Yeah, I'm tired. My name is Jill Brown. It's J-i-l-l B-r-o-w-n. I'm a psychologist, a social scientist who's really read through the research pretty thoroughly around puberty blockers and around hormones. I'm also the mother of a trans 6-year-old. So I'm reading it not just as somebody who teaches a psychology of gender course, because I want to show my students and, and make sure that the research I'm presenting is real, but as a parent who's, like, really trying to understand what this is. Specifically, this research by Kristina Olson at the TransYouth Project. It's been a longitudinal study going on, and this recent article was published in 2024 in JAMA. So it was looking at exactly what you all are dealing with right now, which is the bans on puberty blockers and hormone treatment. So out of 220, 220 youth that they followed for 4 years, 9 out of 220 youth had regrets about being on puberty blockers at a 3-year marker, and 4 out of 220 youth regretted being on hormones at 4 years. So that's about a 1.8% regret rate. And we've heard the statistics on suicidality, right? Sometimes 220% odds ratio when blockers and hormones are presented. But I know you guys, you do have access to these numbers. And I'm not sure that they matter. You know, in 2023, when Senator Kauth introduced this, the opposition was 6 to 1, and that didn't seem to matter. Also, these vulnerable stories that you all are hearing don't really seem to matter much. These are people's lives. This is my life. I'm wondering if the photo that I put around, if anyone knows what that is, or if anybody would even just be willing to nod if you do or, you know, my students they just kind of look down when they don't know. OK. I know

you can't answer my questions, but can you just raise your hand if you know what it is?

HARDIN: This is not for you to ask questions.

JILL BROWN: Oh, OK. It's a clitoris. It's the life-size model of a clitoris. And my suspect is that no one knew that. And if you guys-- you're charged with the gender and sexuality making laws about Nebraskans, and you don't know what a clitoris looks like. Like, this is the problem, it doesn't mean that you don't have very, very good things that you contribute, but it's not making laws of gender and sexuality of my child and everybody's child when we don't know basic things. There's people that know this. The American Medical Association knows this. Right? Pediatricians know this. But my hunch is that you don't. So I guess I would just say we stay in our wheelhouse. I need to have access to this. It doesn't mean that my child will be on it, but I need to have access to this to have it be an option if, if that's what is needed. So please consider not advancing this out of committee. Thank you.

HARDIN: Questions? Thank you.

JILL BROWN: I saw one head shake, somebody shook their head up there.

HARDIN: LB732. Welcome.

MARILOU KILIAN: Hello. My name is Marilou Kilian, M-a-r-i-l-o-u K-i-l-i-a-n. I am a student at Creighton University. Dr. Brown is one of my professors. I'm studying psychology and international relations, and I strongly oppose LB732. Across history and cultures, extensive diversity in the expression of gender and gender identity has always existed. Many Native American cultures recognize two-spirited people as individuals who possess distinct social, cultural, and spiritual roles. In Thailand, trans women have an extensive history of being largely accepted and valued within Thai society. These examples and the surplus of others that you have heard today demonstrate that variation in gender expression is not new, unnatural, nor dangerous. It is a reoccurring and genuine part of human experience. LB732 fails at its conceptual goal of improving the well-being of children. Protecting the innate right of expression, a liberty foundational to our nation, does not put children at risk. What does put children in danger is ignoring the profuse consensus of major medical and psychological organizations that recognize gender dysphoria as a legitimate medical concern requiring-- condition requiring

evidence-based care. Research in pediatric and adolescent health consistently shows that access to affirming medical care is associated with improved mental health outcomes. If the goal is to maintain the health of the children, this bill does the opposite. Section 4 of LB732 gives the Chief Medical Officer broad authority over the regulation of puberty-blocking drugs and/or cross-sex hormones that determines whether care is legally allowed. This directly removes medical responsibility, standards, and decision-making from medical associations with pre-established medical guidelines to a politically appointed official. Primarily, this creates the risk that care will be restricted based on ideology, rather than medical evidence. This also raises considerable legal concerns, namely regarding nondelegation. Clear standards is what is expected of the legislator, not the outsourcing of core policy decisions and definitions to executive officials without appropriate guardrails. The use of vague and undefined terms, including long-lasting, intense, and pattern of gender nonconformity, invites arbitrary enforcement by a single entity. As seen in Montana, Alabama, Missouri, Texas, and Maine, laws such as LB732 lead to costly litigation, constitutional challenges, and even interstate legal battles, all the while worsening medical provider shortages and further politicizing medical care. By empowering a single state official to redefine diagnostic legitimacy and punishing doctors with lawsuits and fines, this bill represents a dangerous shift from medical governance to unchecked political control. To protect the health, well-being, and constitutional rights of Nebraska's children and families, I urge you to reject LB732. Thank you.

HARDIN: Thank you. Questions? Seeing none, thank you. LB732. Welcome.

ELLEN HAZELS: Hi, my name is Ellen Hazels, E-l-l-e-n H-a-z-e-l-s, and I'm a sophomore at Creighton University, getting a degree in psychology and sociology. And I'm also one of Dr. Brown's students. And I am here in strong opposition of LB732. Often the argument against gender beyond the binary rests upon the Christian tradition, rooting itself in the belief that God made two sexes, and we should live within that frame of creation. However, the popular Christian culture is not the only lens that gender is seen throughout the world, nor is it the only lens that gender has been viewed through historically. Goddesses of Mesopotamia, for instance, were commonly portrayed crossing traditional western gender lines, showcasing ambiguous features and traits such as passion, love, and strength within the same deity. This can be further seen within their religious practices where priests that had been assigned male at birth wore

traditionally feminine clothing and spoke in a feminine dialect during worship. Similar patterns can be seen across the ocean, such as in pre-colonial Peru, more shamans and priests were almost exclusively self-identified men, women since childhood and given a place with [INAUDIBLE] social structure. The ways in which gender is viewed today is not the only answer. It is not the only correct way to understand identity. From these brief examples, it can be seen that the cultural politics surrounding transgender individuals, including children, is one that is not based on morality-- or on morality or biology, but rather what is socially constructed. Gender has meant different things to different people for thousands of years. To constrain it to a binary definition is to erase the history and futures of entire communities. Understanding gender is my life's work. And I do not intend on staying in a state that reduces that work and those communities to nothing but a harmful stereotype and restrictive binaries. I will not get my doctorate in a state that won't teach and value the stories outside of what is currently culturally acceptable. I will not teach in a state that actively harms children, children and their families. I will not raise my kids in a state that won't grant them access to health care. To make trans health care political is to remove trust from the individual, children, their parents, and their doctors to make informed decisions designed to meet individual needs and save trans lives, trans lives and children. Thank you.

HARDIN: Thank you. Questions? Thank you. LB732. Welcome.

HOLLY RICHIE: Good evening. My name is Holly Richie, and-- H-o-l-l-y R-i-c-h-i-e, and I stand in opposition to LB732. Transgender people have always existed, but let's remember what started this. The 2020 election cycle, the GOP began to test the water by spreading fear towards transgender people and found that it worked. They were able to rile up their base and latch on to the strategy that dominated the recent election cycle. You fed the public something to fear and it worked and so you ran with it. So why wasn't this common sense to pass legislation here in Nebraska in 2018? Senator Kauth has admitted people were not asking her about this issue when she started knocking on doors. No one cared until she made it an issue until she started teaching her constituents that we need to be discriminating against their neighbors. That doing so is just common sense. And, sadly, this is disgraceful human behavior. You are spreading fear and the real risk of violence towards humans, just trying to live their lives and it is truly shameful. People do a lot of talking about transgender people, but don't talk much to them. Excuse me. You have not lived our experiences. Not every story is the same. Just because something

worked or didn't work for one doesn't mean that it is the same for everyone else. Every situation is different. In 2023, we provided you study after study after study. Now, not even 3 years later, after LB574 passed with a narrow path, you are willing to completely pull the rug out from underneath the people that you allowed to seek transgender care for and forcibly detransition kids without their consent or the consent of parents providing them zero path for help, given even further-- going even further to float the idea of charging parents with abuse. I will end with this: are you saying that you-- you are saying that you want to make the best decision for our kids, but would you be OK with politicians making medical decisions for you? What if it was something to do with vaccines? Would you be OK with them requiring vaccines? This isn't a social contagion, as some like to say, acceptance allows kids to feel comfortable letting us in and telling us their truth. Thank you.

HARDIN: Thank you. Questions? Thank you.

FAITH WALKER: Hello.

HARDIN: Hi.

FAITH WALKER: My name is Faith Walker. I am here in opposition of this bill, F-a-i-t-h W-a-l-k-e-r. On December 18, 2025, the American Academy of Pediatrics called restrictions to gender-affirming care a, quote, baseless intrusion into the patient-physician relationship. The American Medical Association, as well, as well as the World Health Organization, share this stance and have released their own statements and studies confirming the medical science and the efficacy and necessity of gender-affirming medical care. Proponents of this bill claim to care about the well-being of children. And if that is, in fact, true, ignoring the recommendations of three of the most reputable medical organizations in the world isn't really a strong start. I do not see care for children here. I see belligerent ignorance and hatred. The World Health Organization, American Medical Association, and American Academy of Pediatrics have made these recommendations based on rigorous medical research. And I deserve to follow the most accurate and up-to-date medical advice if I have children in this state. Hostile anti-science lawmaking is contributing to brain drain of Nebraska. I will not have children here if I cannot provide appropriate medical care up to best practices according to reputable medical organizations. And I know-- and parents I know are already planning to leave due to this overstep. To this point, I ask you what you think freedom means. To me, it rather obviously includes

the right to follow the medical advice of the World Health Organization, American Medical Association, and American Academy of Pediatrics, and my doctor as well, without interference. Proponents of this bill clearly would not follow their advice, but those who would reject medical science have no right to enforce their opinions on the rest of us or on credentialed medical professionals. It is horrifying to have medical care held hostage and to have the statements of 20 random people and one anesthesiologist who is not even qualified to provide pediatric care above the conclusions and clear guidance of, again, the World Health Organization, the American Medical Association, and the American Academy of Pediatrics. Respectfully, not a single one of you standing-- sitting in front of me is a pediatric clinician trained in gender-based medical care. And every single Nebraska resident combined cannot compete with the medical expertise of the organizations that I've named. So what value do you have to this discussion? It's time to butt out. Thank you.

HARDIN: Questions? Thank you. LB732. Welcome.

HAP HAUSMAN: Hello, my name is Hap Hausman, H-a-p H-a-u-s-m-a-n, and I am speaking in opposition to this bill. As you have heard from a couple other people now, bringing up the, the rate at which people that undergo gender-affirming care regret doing so, it's about 1%. I'm going to read you some other statistics about things that you are also allowed to do under the age of 18 or under the age of 19, which is when this bill is proposed to push gender-affirming care back to. At 17-year-old-- at 17 years old, you are old enough to join the military, a decision that can lead to the end of your life as well as other people's and as well as lifelong trauma as a result of that. At 17 years old, you can, you can also decide to take out tens of thousands of dollars in student loans, a decision that will affect your finances for at least the next 10 years. 16-year-olds are allowed to risk bodily harm to themselves and everyone around them by getting their driver's license and getting behind the wheel of a 2-ton motor vehicle. In a quote from the National Safety Council, motor vehicle crashes continue to be the number one cause of preventable deaths for U.S. teens, totaling 2,027 deaths in 2013-- or in 2023, and the number of people, teenagers-- or the number of people, teenage or otherwise, that died in crashes involving at least one teen, were 5,588. When comparing these statistics to the less than 1% regret rate for seeking gender-affirming care, it does not make any sense to me why we would need to push that to 19 while allowing all of these other major life decisions to be made younger than that. I would also like to talk a little bit about my experience with gender. The best way that I can

explain it to you for anyone that has not had any sort of experience with questioning their gender, imagine you are looking at yourself in the mirror, but the person that's looking back at you is not you. You have no idea what you can do to pull that-- to, to make yourself into the person that you see in that mirror. It is not your goal to make yourself into the person that you see. It is your goal to make that person become more like what you want to see. For tran-- for many trans youths, that does involve gender-affirming care. Taking that option away, away from them relegates them to a life of looking in the mirror at a stranger rather than themselves. Thank you.

HARDIN: Thank you. Questions? Thanks. LB732. Hi.

JOSHUA GIRARD: Hi. My name is Joshua Girard. That's J-o-s-h-u-a G-i-r-a-r-d. I am a mental health practitioner, a business owner, still relatively new to this field, but I at least have, like, 300 hours and a year's worth of working underneath-- private practice underneath my belt. I am here to stand opposed of LB732, but before I go into my reasons why, I'm wanting to introduce myself a little bit more. To say that I'm a full-blooded Nebraskan I think is a little bit of an understatement. I was born in Columbus, Nebraska, and I grew up in a small town called Peru, Nebraska, and I hope you have heard of us. I am the son of educators. My father has been teaching high school since 1992. My mother moved to Nebraska when she was 5 in 1972. I'm the grandson of immigrants. I went to Peru State College, our very first college here in Nebraska, where I got my undergrad in biological science with a minor in psychology. Then I went to get my master's through the University of Nebraska-Lincoln in educational psychology to become a, become a therapist. And I had the great privilege to work in the interpersonal violence research lab. And I know that there was some questions earlier today about some of the guidelines and research. So if you have any questions, we can discuss that more at the end. And another thing to know about me is that I am queer. I know what it's like to grow up in a community, in a community that doesn't see you as a human being. I've spent the last 9 years dedicating my life to provide safe spaces for LGBTQ+ youth and adults in this state. To provide something that I never had growing up. And these bills that are being presented here in the Senate is making it really hard to do so. I have lost friends. I have lost clients. I have lost business. I have lost training opportunities all because of bigotry. And, yes, I'm a cis gay male. But if you attack one of us in the community, you attack all of them, all of us. And I guess I just want to add, you know, we are here, we've always been here, and we're always going to be forever here. Thank you.

HARDIN: Thank you. Questions? Thanks.

JOSHUA GIRARD: Thanks.

HARDIN: LB732. Welcome.

JASON SLAUGHTER: Good evening. My name is Jason Slaughter, J-a-s-o-n S-l-a-u-g-h-t-e-r. I'm here today as a concerned citizen and a person of faith to offer testimony in, in opposition of LB732. As a Christian, my moral framework is centered on two-- on the two greatest commands given by Jesus Christ. When asked which commandment was most important Jesus responded in Matthew 22:37-40: You shall love your God with all your heart and with all of your soul and with your mind. This is the greatest and first commandment. And the second is like it: You shall love your neighbor as yourself. On these two commandments hang all the law and the prophets. My concern with LB732 is that it, fundamentally, violates the spirit and command of the second and great commandment: You shall love your neighbor as yourself. This commandment-- this command to love one another is not an optional suggestion. It is the core ethical mandate for those who follow Christ. Love, in the context, is not defined by warm feelings, but by seeking the welfare, dignity, and flourishing of all people, especially those who are marginalized and vulnerable. Apostle Paul further instructs, instructs us in Romans 13:10 stating: Love does no wrong to a neighbor, therefore love is fulfilling of the law. When I examine the context and foreseeable impact of LB732, I cannot in good conscience find that it is rooted in the principle of a Christ-like love of one, of one another. The bill, in my view, is morally wrong because it, it proposes a law that does harm to a specific segment of Nebraska's population. It creates an environment of fear, exclusion, and institutionalized discrimination, rather than one of acceptance, care, and neighborly support. To love your neighbor means to protect them, not to subject them to legislative action that undermines their well-being, their identity, or their basic human dignity. LB732 sends a message that certain members of our community are not worthy of the same consideration, safety, and respect afforded to others. This is the opposite of Christ's example, who consistently reach out to those who are ostracized by society. It is a proposed law-- if a proposed law does harm, it's not an act of love. If the proposed law divides and singles out vulnerable group for differential treatment, it is not an active love. Legislative action should aim to uplift, to protect, and to ensure justice for all Nebraskans. LB732 fails to meet this standard. It represents a turning away from their clear biblical mandate to do not wrong to a neighbor. And, instead, embraces policies

of exclusion that stand in direct opposition to the gospel of love. I urge this committee to, to remember the profound simplicity to the command to love your neighbor. I ask you to reject LB732, instead to legislate with compassion, dignity, and a genuine commitment to the welfare of every single person in the state of, of Nebraska. Thank you so much for your time and consideration.

HARDIN: Thank you. Questions? Seeing none.

JASON SLAUGHTER: Thank you. Have a good evening.

HARDIN: LB732. Welcome.

LINDSAY SALEM: Hi. Dr. Lindsay Salem, L-i-n-d-s-a-y S-a-l-e-m. Dear Chair Hardin and committee members, my name is Dr. Lindsey Salem, my pronouns are she, her. I'm a licensed psychologist in Nebraska. I treat adolescents and adults. I was born and raised in Lincoln. I'm speaking to you today in opposition to LB732. LB732 is an anti-science bill. Every major medical and psychological organization supports gender-affirming care for transgender youth. I'm a member of APA, the American Psychological Association. APA has established empirically supported practice guidelines that encourage clinicians to use gender-affirming practices. Such practices have enormous benefits for clients, including improved psychological functioning, quality of life, and reductions in psychological distress and gender dysphoria. In a 2024 policy, quote, APA opposes state bans on gender-affirming care, which are contrary to the principles of evidence-based health care, human rights, and social justice. They also say that the imposition of such bans poses a direct threat to the mental health and emotional well-being of transgender, gender-diverse, and nonbinary youth, exacerbating the already high rates of depression, anxiety, and suicide attempts among this vulnerable population. This bill would force youth have been take-- who have been taking puberty blockers or hormones to go off their medications. For youth who've been navigating the cumbersome process to get hormones in our state, they'll be cut off from care. That is contrary to evidence-based care. Dr. Gordon Guyatt, distinguished professor of medicine who helped pioneer the framework of GRADE, a method of assessing clinical recommendations, seen as a trans health care skeptic, made a reversal this past fall. Dr. Guyatt said in a September 2025 article in Mother Jones: It is an unconscionable use of our work to deny people gender-affirming care. He went on to say: To deny it to people, to make people suffer unnecessarily, that's another type of harm. The terminology in this bill is a philosophy, inconsistent with science and standard practice.

Examples include the term gender altering which isn't a medically appropriate term. The appropriate term is gender affirming. The bill removes diagnostic codes used only by trans and gender-diverse people. That is ideology, it's not science, or, most importantly, the lived experiences of trans youth and adults. The definitions of who gets care, what care is, are removed. But the people who provide care would be in trouble if they provide it. That is a discriminatory ban. In my profession, one of our ethical principles is do no harm. This bill would harm trans youth in our state. It's an example of dangerous legislative overreach. I'm urging you to listen to the scientists, medical providers, families, and, most importantly, trans youth and adults in our state. Please oppose LB732. Instead, we need legislation that ensures access to care. Thank you.

HARDIN: Questions? Thank you. LB732. Welcome.

DANI HADENFELDT: Good evening members of the committee. My name is Dani Hadenfeldt, D-a-n-i H-a-d-e-n-f-e-l-d-t. I'm currently a university student at the Nebraska-Lincoln studying nursing. I would be prohibited under this law. I was born on March 16, 2007, which makes me 18 years old. I have been in university for over a semester, and I'm currently partway through my current-- my second semester. This law is trying to say that people like me shouldn't be able-- aren't able to make their own medical decisions or make decisions for themselves, despite the fact that I have been living on my own for over 6 months. I also have many friends that are in the same boat as me. I know people who have been here on the presidential scholarship, which means they received a 36 on their ACT, and that would pretty much make them some of the smartest people in the state, even if they're young. And they still had to wait until the age of 19 to get treatment because of LB574. And this bill would further restrict it. There's no point in making, making anybody wait until 19. And there's no point in making people wait at all. If you would open a book, specifically the DSM-5 by the American Psychiatric Association, gender dysphoria is in there. And it is stated by many psychiatrists that the symptoms can appear in early childhood or adolescence. There are many examples of this. I have a friend who knew when she was 13. Another friend, she knew as young as 7 years old. In the former case, this was before 2023, so she was able to get the health care that she needed at the age of 16. The latter case, my friend was denied care by her parents. But this still opens up many cases in which the child consents, the parent consents, and the medical institutions will even consent. But the doctors will have their hands tied because of this law because this law was motivated by hate and attack on an already

marginalized community. This bill targets children, a minority of a minority. And I would like to say that supporting this bill would make you evil and that you're going to go to hell, but I don't believe God sends people to hell. They send themselves. Thank you.

HARDIN: Thanks. Questions? Thank you. Welcome.

ALMA CERRETTA: Thank you. Hello, my name is Alma Cerretta, A-l-m-a C-e-r-r-e-t-t-a. I'm here to express my opposition to LB732. You have heard today many people explain the benefits of gender-affirming care. People that I know and love have benefited greatly from gender-affirming care. I believe that trans Nebraskans deserve access to the health care that is determined to be best for them and I realize that many people in this legislative body do not. It's really OK if we personally disagree on this matter. If you'd like to sit down and discuss our perspectives, I know a lot of people here are ready and willing to do so. But my testimony today is not to change your mind on transgender people. Informed parents or guardians and the minors' medical care team should be the ones making medical decisions for minors, not the Nebraska Legislature. As we have seen from abortion laws across the country, I know it's another touchy subject. Whenever lawmakers attempt to restrict doctors' ability to do their job, there are unintended consequences that end in death. The maternal mortality rate in Texas went up 56% in 2022, the first year of their 6-week abortion ban compared to the national increase of 11%. I commend you, Senator Riepe, for choosing to listen to medical professionals when opposing a similar ban here in Nebraska and refusing to legislate morality, as you put it. It's clear that Senator Riepe can delineate his personal feelings from his responsibility as a state representative, and I really hope that everyone else on this committee follows his lead there. LB732, as introduced, prohibits, among other things, hysterectomies and ovariectomies for biological females under 19. While rare, there are many documented cases of these surgeries being medically necessary for conditions such as cancer, endometriosis, and for disabled girls for their safety and comfort. There are already policies in place to ensure that these surgeries are medically necessary, including ethics committee reviews. Under LB732, what happens if a cisgender girl is denied treatment and dies because her physician is afraid of a medical malpractice suit if she decides to come out as trans later in life. That situation is a very real possibility between LB732 and LB731 that was currently heard down the hall today. Committee members, I'm asking you to trust the processes and procedures already in place between medical care teams and

patients. I ask today that you decline to vote this bill out of committee. Thank you.

HARDIN: Thank you. Questions? Thanks. LB732.

VESPER LaTHARY: Good evening, members of the committee. My name is Vesper LaThary, that's V-e-s-p-e-r L-a-T-h-a-r-y, and I'm here to speak in opposition of LB732. I'm a licensed mental health therapist in the state of Nebraska, having done 3,000 hours of direct client contact with people with severe and persistent mental illness, mostly in inpatient settings. So as of this morning, I'm an applicant to be an LIMHP in this state. But I'm not here to talk to you as a therapist today. I'm here to talk you as a trans woman. A trans woman who started her transition at the age of 30. Just because I waited until I was an adult does not mean I didn't know as a child. And that's what this bill is trying to say, is children don't know better. So from a young age, the men in my mom's life knew that I wasn't right. They knew that my mom wasn't raising a boy, a boy's boy, a man's man, whatever they wanted me to be. And they were worried about that. At 6, I was called names in school. At 7, I knew that something was different about me, that I was not a boy like the other boys in my class. Didn't say anything about it. I didn't have words for it at the time. Around 12, or sorry, around 6, my mom married my stepdad, and he tried to straighten me out with his fists, with his belts, with a ping-pong paddle. Just about anything he could hit me with he did. So that didn't work, clearly, or I wouldn't be sitting here. At 12, my stepdad died. At 12, my sister went to boarding school. At 12, I had access to the Internet, and I found community. I found people who felt like me. I found the word transgender, and I came out to the one person that I trusted would accept me, my 9-year-old cousin at the time and he did. We'll sit on that information for a second. But in the following years, I explored in my sister's clothes while she was at boarding school and felt a level of freedom that I'd never felt in my body before as I went into adolescence in a body that felt like a betrayal every morning I woke up. A body that I knew wasn't mine, a body I hated, and, and so many people like me, their story ends here. The story ends here at the bottom of a pill bottle or a gun or a knife. They take their own life. My story did not end here. Instead, I got fat. I ate. I ate my feelings and I hid everything that I felt behind food, behind weight, and I became the person that I was supposed to be because I lived in Alabama, a very bigoted state, which Kathleen Kauth wants to copy in Legislature. But I grew, I grew and grew. I was 450 pounds a year ago. I hated my body for so many reasons. And in all those years as a kid, I never had access to mental

health. I never-- we were in the poverty line. Doctors were a last resort. So I didn't have anyone to talk to about it. And I see that I'm in red. So I'm just here to tell you, I'm not a trans woman because I was bullied. I'm a trans woman, because I was a woman the whole time. This bill isn't about letting kids grow. It's about eliminating transgender people by denying access to care for trans youth under the idea that they aren't old enough to know better. If I wasn't old enough at 7, if I wasn't old enough at 12, 16, 18 or 19, and at 30, I come out and people say, you can't be trans, you would have known when you were young. There were no signs. Those are the things I faced as an adult transitioning. So I'm asking you, when do we trust people to know who they are? Please trust medical and mental health professionals to help people. That's our job. Trust people to who they are as opposed to assuming that senators like Kathleen Kauth know what's best for anyone. That's all. I'm open to any questions.

HARDIN: Questions? Thank you.

VESPER LaTHARY: Thank you.

HARDIN: LB732. Welcome.

HEATHER RHEA: Thank you so much for having me. My name is Heather Rhea. That's H-e-a-t-h-e-r R-h-e-a. I am so glad that we could gather again for my annual update on my trans daughter. I think we bring a new bill every year, just so you can have the update. You could just email me or follow her on Insta instead, but here we are. I want to tell you, my daughter Nola [PHONETIC] is trans. And she also has been obsessed with politics from a young age. Do you remember Pete Ricketts' commercials? I'm Pete and I'm bald. Yeah, my daughter fell in love with politics that year. We watched all the commercials and when she figured out that it was the primaries and they were all Republican, she was horrified. They're saying all these terrible things that's on the same team. And it's been love ever since. When she was in the fourth grade, she was-- my daughter's brilliant and funny, in the fourth grade she got in trouble, not a perfect kid. She started a petition to get her teacher fired. She disagreed with how her teacher was teaching one of her classmates, and so she started a position and not enough kids signed her petition so she made a new petition to fire the teacher and have more hat days so that more kids would sign her petition. OK? So in the sixth grade, I got a call from the school and said they wanted to discuss Nola, and I was thinking here we go again, LPS isn't a democracy. And, instead, they told me that my daughter had told her friends that she was thinking about

killing herself. My brilliant daughter, my, my kid. And so we started seeing a therapist and she had been self-harming and hiding it from me. And it came out that she is trans and I was terrified for my kid because I knew her life was going to be harder because of this and I was, I was wrong and then I was right. So after gender-affirming care, starting in middle school, she's never self-harmed. She has become more herself. Because of LB574, she is thriving in college in Minnesota so I'll probably never forgive all-- you all for not allowing her to thrive here in Nebraska. She is halfway done with college a year and a half in. She went-- graduated from the IB program at Lincoln High within an ACT score in the 30s. Thanks brain drain. And she has started a club at the university. She's on the exec committee of their chapter of college dems. And she recently was elected a senator in their student senate. I asked her if she had a message for you, and she did. She said think about if you had to watch your child suffer every single day for being how they are and how long it would take you to do something to help them. I have a success story from gender-affirming care. It, it absolutely guts me to think that we would rob other kids of the care that saved my daughter's life. I'm happy to answer any questions that you have.

HARDIN: Thank you. Questions? Thank you. LB732. Welcome.

CHRISTY KNORR: Hello, everyone. My name is Christy Knorr, C-h-r-i-s-t-y K-n-o-r-r. I am a registered nurse in the state of Nebraska. Earlier today you had Jamie Reed up here talking about the work that she had done and the research and the whistleblowing. I just didn't hear anybody mention that that had been unfounded and unsubstantiated. So I just wanted to be sure that I let everybody know that, that her whistleblowing did not go anywhere. OK? I also want you all to realize that 39% of LGBTQ youth in this state, in our beautiful state, great state of Nebraska, right, only 39% of them feel safe in their home and at school. 39%. I also heard Jamie say-- there were just a few things that as a nurse and as a wound specialist that I heard her say, we're not using silver nitrate on women's genitals, OK, that's, that's contraindicated. We don't do that. And I'm a wound specialist, hospice nurse as well. I wanted to talk to you about a study that was published earlier this month. It's titled: Few U.S. Adolescents Receive Gender-Affirming Medications and Surgeries. Key takeaways: An average of eight youths start puberty blockers and four start hormones per day from 2018 to 2022. No child aged 12 or younger receive hormones or gender-affirming surgery. Everyone is certainly entitled to their personal feelings about things, but when you're coming and quoting things, make sure you're speaking truth to it. One

thing that I always believe with my patients when I'm talking to them is telling them the full honest unadulterated truth. Why? Because they deserve a choice about the kind of health care and what choice they make with their body, whether that be that they're dying, cancer treatment, wound care. Some people don't want to off-load their diabetic foot wound and they're OK completely losing it. These concerns are unwarranted. There was a similar study that has also said the majority of-- so there was also in 2019, there were 150 minors that received gender-affirming surgery that year. 100 of those-- 146, which is approximately 97%, were chest surgeries on cisgender males, so. I see my red light is on. Please do not vote this out of committee. I really hope that Senator Kauth can move on from terrorizing trans people and being worried about children's genitals. It's starting to really be a concern for me that we bring this back year after year after year after year after year when we've already said no.

HARDIN: Questions? Thank you.

CHRISTY KNORR: Thank you.

HARDIN: LB732.

CHRISTY KNORR: Oh, and, Senator Riepe, you are my hero to this [INAUDIBLE].

RIEPE: Oh, aren't you a sweetheart.

CHRISTY KNORR: Or about the anesthesiologist. Thank you.

HARDIN: Welcome.

GRACE JACOBSON: My name is Grace Jacobson and I'm here in opposition to LB732. I'm a fifth-generation Nebraskan on one side--

HARDIN: Can I have you spell your name, please?

GRACE JACOBSON: Oh, sorry, G-r-a-c-e J-a-c-o-b-s-o-n. I'm a fifth-generation Nebraskan on the one side and likely a seventh-generation Nebraskan on the other. I have been coming here and testifying against the constant stream of anti-trans legislation since the first bill was introduced in, I think, 2022. I frankly have lost faith in this body's ability to do its job of listening and uplifting Nebraskans. Senator Kauth has repeatedly and obsessively introduced legislation that has a clear vendetta against, against trans people,

especially trans youth. I find it disturbing that someone has such fixation on the gender presentation and especially the genitals of children. This is not normal. Others before me have given you proper scientific evidence. Transgender children who should have been in school have come here to beg you to stop harming them, their friends have come here to stop-- to beg you to stop harming them, their parents have come here to beg you to stop, their doctors and therapists have come here to beg you to stop. I doubt my testimony against LB732 will do anything considering the overwhelming opposition to the Let Them Grow Act that was blatantly ignored. What I want to know is, where will this stop? LB730 and LB731 make it clear that adults aren't safe and that their care and rights are in direct danger as well. Will it really end with just the harassment, erasure, and potential genocide of trans people or will you turn against women who do not conform to state mandated gender expression and medical requirements? Will you eventually start legislating if I can wear pants? Will you require me to keep my hair long? Will you legislate away my access to the hormone blocker that keeps my endometriosis from gluing my internal organs together and making me wholly infertile? I'm asking you to do your jobs and prove you actually care about Nebraskans as a whole. Let this bill end here, and let's focus on doing things that actually help and uplift, uplift the citizens and other members of Nebraska. This is my home. I want to be proud. I want to tell people that I love the state that I was born in, that I've lived in, and that I stayed in. I had the opportunity to go and live in France. I stayed here because I love Nebraska. But every year that this is brought up, I lose more faith in the fact that we, as the people of Nebraska, have any say or any control over our own destinies and fates. Thank you for your time.

HARDIN: Thank you. Questions? Thank you. LB732. Welcome.

LORI ASHMORE: Hi, my name is Lori Ashmore, L-o-r-i A-s-h-m-o-r-e. So here we go again for the fourth straight year in a row with anti-trans legislation. In 2023, the legislator attempted to take away health care from trans folks, but we instead got a very narrow pathway. In 2024, the legislation attempted to ban trans folks from the bathrooms and playing sports that aligned with their identity, which did not pass. In 2025, legislation came back for bathrooms and playing sports, but only got sports. So now here we are in 2026 with not just one bill, but three. We're going to try to take bathrooms away again. Oh, now we're going to add malpractice rules for providers. And now we want to completely take away the narrow pathway for health care. These legislative bills are aimed at erasing trans existence from public

life. It's a group of people that make up 1% of the population. This goes beyond discrimination. These legislative bills meet the early to mid-warning indicators of genocide process against transgender folks. Genocide is not mass killing. The definition of genocide is the eradication of a group of people from existence. The United States is using a systemic process to eliminate trans folks as a recognized group of people by law, illegal genocide. Laws that make trans folks not exist on paper and then use that paper to control their lives. IDs that no longer reflect their transgender marker, limiting access to health care. School policies that affect their names, pronouns, what bathrooms they use, and if they're even able to play sports. And narrowing the definition of sex to male and female invalidating their testimony. All of these things are pushing trans folks out of employment situations, housing, education, health care, travel safety and family stability, all without a single act of violence. But last year, on the floor during the debate at LB89, a senator asked another senator about the receipts for increased suicide attempts that was going to happen from the passage of L-- or LB574. It was callous, and it showed how much you respect the trans community. So I'm asking you, when is enough enough? When Kauth brings her LR301 and makes it's a bill to charge parents with child abuse or when you finally have erased all transgender people from public life? Thank you.

HARDIN: Questions? Thank you. LB732. Those in opposition, LB732? Proponents, LB732? Those in the neutral? If there's no one else, this concludes-- oh, yeah, we've got our close. Oh, thank you. Senator Kauth, while you're returning, online comments: proponents, 155; opponents, 426; neutral, 2. Welcome back.

KAUTH: Thank you very much. And thank you, committee, for all of your attention tonight. And thank you for everybody who came to testify. A lot of emotion going on here and I want to talk about how this has to be a logical fact-based decision. The emotional responses that this is going to kill these kids, it's not factual. The, the thought that we are doing this for anything other than protecting kids from experimental and irreversible drugs is ludicrous. We listened to a lot of, of testimony, again, very emotional, discrediting medical professionals who I brought. So each side seems to be kind of digging into, well, my medical professional is better than your medical professional. There was a lot of talk about reliance on the associations, but, yet, I presented evidence that these associations have suppressed evidence. They are deliberately doing this for ideology. Around the world, these drugs are being banned for children because other countries who have been doing this for far longer have

seen the harms and realized that there is no research, there's nothing that says that these are positive for kids. When you have kids who go on the puberty blockers, 98% of them go on to cross-sex hormones. This isn't a pause. This is just the first step in a progression. You don't pause puberty. You don't just stop it, think about things for a while, and pick up right where you left off. It's impossible. This is part of how your body develops and grows, and there are no studies showing that this is safe and effective. Lupron that was mentioned quite a few times is used for precocious puberty. Well, the people who were given Lupron for precocious puberty a decade ago are now suing the maker because of the devastating physical effects on their bodies from that drug. That is what we use to chemically castrate sex offenders. It is not safe for a developing child. The systematic reviews prove that there are no studies that show that this is safe. The Supreme Court listened to testimony, listened to the opposition have to admit that there are no study showing that this was safe, and they accepted that fact. The Skrmetti decision is very, very interesting. We cannot allow a motion to dictate this type of decision. And, again, the Skrmetti decision is why this got brought back. Because we do have a narrow pathway, but what it means is kids are able to say, if I just do these few steps, and that was actually my concern when we put those regulations in place, that people would say, OK, all I have to do is follow this path, rather than getting real therapy and thinking about how they can live with their actual reality. It says I can just keep doing these things until I get to the end of this path. These drugs are still extremely dangerous. Watchful waiting and psychotherapy is what is being recommended around the world. I hate that the United States, which I like to think of as being pretty good at the medical profession, is the one that is saying, you know what, let's keep doing this. Let's keep pushing this. Do you know that this is, I think by 2030, supposed to be a $7 billion industry? There's a lot of money to be made by medicalizing children. You start them out young, you get them hooked on these drugs, and by hooked, I mean they can't stop taking them, because then the effects that they're going for stop. The ones who do stop taking them are in agonizing pain. I went through all the list of the things that, that these drugs can make happen. So to say that it is in their best interest to let them choose what to do as a child, child-directed care is not found in any other area of medicine. Why on earth would we let kids decide that they should be able to change their sex? You cannot change your sex. It is an impossibility. It doesn't work. Every chromosome, every DNA, every part of your body is coded to be either male or female. Some of the comments about we have other things to do, lawmakers can't possibly

know what to do. We make these decisions all the time by bringing in experts, by talking with people about it. The number of people trans, gay and lesbian, doctors, doctors who don't agree with me, the AMA, other groups that I have talked to around the country and around the globe about this topic give me a lot of insight into it. And that's why I bring experts to talk. And that's why I will have experts discuss these things with people because they understand how to read those studies. They understand how to analyze these claims. As our job as lawmakers is to do the best we can to find out facts and to legislate from facts and not feelings. I wanted-- a couple previous testifiers were talking about the number of pediatric patients who were getting these drugs. For the analysis, this is from Reuters, for the analysis of pediatric patients initiating puberty blockers or hormones, Komodo searched for patients with a prior gender dysphoria diagnosis. Patients with the diagnosis of central precocious puberty were removed. A total of 17,683 patients ages 6 through 17 with a prior gender dysphoria diagnosis initiated either puberty blockers or hormones or both during the 5-year period studied. That's a lot of kids. 6 to 15. The analysis of insurance claims found 56 genital surgeries among patients aged 13 through 17 with prior gender dysphoria diagnosis. And among teens, top surgery, which is to remove breasts, is much more common than genital surgery. In the 3 years ending in 2021, at least 776 mastectomies were performed in the United States on patients aged 13 to 17 with a gender dysphoria diagnosis. When you talk to the young men and women who have gone through these procedures, started these drugs, and then decided that they still weren't happy, that they didn't feel right, 85% of kids who are dealing with gender dysphoria or gender disorders will revert. They will just grow out of it. There is no diagnostic test. You can't take a blood draw and say, oh, look, you're trans. You can't do a scan and say this proves you're a trans. There is nothing you can do to prove, you have to allow them to grow, because as many people have pointed out, kids change their minds frequently. One of the testifiers was talking about, she said Kristina Olson, but it was Johanna Olson-Kennedy, who is one of the leaders in giving this kind of care to kids, and I refuse to call this gender-affirming care. You are not caring for a kid by telling them that they are the wrong sex and that everything will be fine if you just take drugs or cut off your body parts. Johanna Kennedy-Olson [SIC] suppressed the study that she had-- the NIH-- pardon me, the NIH, National Institutes of Health, commissioned her to do this study and she suppressed it for 9 years because it did not reflect what she wanted. She thought the opposition could use it because it proved that these don't help. So when we look

at this, and I'll have more handouts for you discussing some of the other comments that were made, and I'll talk with you all individually. This is something that is important for us to protect kids from getting these irreversible and experimental drugs. They can wait the watchful waiting, the psychotherapy to help them deal with who they are and how they feel about who they are is important. That's all I have.

HARDIN: Questions? Thank you.

KAUTH: Thank you very much. Appreciate it.

HARDIN: This concludes LB732.