BOSN: --started here. Welcome to the Judiciary Committee. I'm Senator Carolyn Bosn from Lincoln, District 25, which is southeast Lincoln, Lancaster County, including Bennett. I am the chair of the Judiciary Committee. We will be taking up bills in the order posted outside of the room, with some potential for flexibility if needed. This public hearing is your opportunity to be part of the legislative process and to express your position on the proposed legislation before us. If you're planning to testify, please fill out a green testifier sheet from the back of the room. Print clearly and fill it out completely. When it is your turn to come forward, give the sheet to the page or the committee clerk. If you don't want to testify but would like to indicate your position on a bill, please choose a yellow sign-in sheet on the back table. These will be included as an exhibit in the official hearing record. When you come up to testify, speak clearly into the microphone, stating and spelling your first and last name to ensure that we get an accurate record. We will begin the hearings today with the introducer's opening, followed by proponents, then opponents, anyone wishing to speak in the neutral capacity, and we will finish with a closing statement by the introducer. We are using a 3-minute light system. When you begin your testimony, the light on the table will be green. When the light comes yellow, you have one minute remaining. And when the light indicates red, you need to wrap up your final thought and questions may follow. The committee members may be coming and going during today's hearing. This has nothing to do with the importance of the bills, just the process, as senators have bills to introduce in other committees. If you have handouts, please bring up 10 copies and give them to the page. Please silence 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 legislature.nebraska.gov. Written position letters to be included in the official hearing record-- will be included in the official hearing record, but only those testifying in person before the committee will be included on the committee statement. You may submit a position comment for the record or you may testify in person, but you may not do both. I will now have the committee members with us today introduce themselves, starting to my left.

STORM: Good afternoon. Jared Storm, District 23, which is Saunders, Butler, Colfax County.

STORER: Good afternoon. Senator Tanya Storer. I represent District 43, 11 counties, Dawes, Sheridan, Cherry, Keya Paha, Boyd, Brown, Rock, Blaine, Loup, Garfield, and Custer.

HOLDCROFT: Rick Holdcroft, District 36, west and south Sarpy County.

DeBOER: Good afternoon, everyone. My name is Wendy DeBoer, and I represent District 10 in vibrant northwest Omaha.

McKINNEY: Good afternoon. Terrell McKinney, District 11, north Omaha.

BOSN: Thank you. Also assisting the committee today to my left is one of our 2 legal counsels, Denny Vaggalis. The other counsel, Tim Young, may be joining us for different bills. To my far right is our committee clerk, Laurie Vollertsen. We have 3 pages with us today. They are Kyanne Casperson, Kleh Say, and Thomas, is it Guinan? OK. Thank you for being here. With that, we will begin today's hearings with our very own Vice Chair, LB985 from Senator DeBoer. While she's making her way up there, I will note that LB985-- excuse me-- received 4 proponent comments, no opponent, and 1 neutral comment for the record. Good afternoon and welcome.

DeBOER: Thank you very much. Good afternoon, Chair Bosn and members of the Judiciary Committee. My name is Wendy DeBoer, W-e-n-d-y D-e-B-o-e-r, and I represent the 10th Legislative District in vibrant, northwest Omaha. I'm here to introduce LB985. LB985 caps the amount of individuals a guardian or conservator can serve at 20. The cap mirrors the cap we have for guardians in the Office of Public Guardian, also known as OPG. Currently, there is no cap on the amount of individuals one guardian can serve. As we have seen multiple times, abuse-- and we have seen multiple times, abuse by private guardians. To be clear, it is just a very small number of guardians who abuse the system, but it does happen. The abuse by a private guardian a decade ago was so severe that we created the OPG. This December, we saw another instance of a guardian allegedly abusing the system. The alleged abuse and profiteering is made possible, in part, by our lack of a cap. The more individuals you serve as a guardian for, the more accounts you have access to, and the more you can bill for your services, the more money you can make or, God forbid, embezzle. So in order to limit the potential for this abuse, I believe a cap is necessary. I use the cap of 20, which is what we have for OPG as the guide. But I will be honest, I don't know if that is the right number. We started with 20 because that's what we do for the OPG. We know that we struggle to recruit guardians, and some guardians are limited. So maybe someone

could reasonably handle more than 20. And we also know that the OPG takes on the most complex cases, so maybe 20 is appropriate for them, but not for private guardians. And while I'm willing to engage in conversations with anyone about what the right number is, 20 seems like that would be the appropriate number. I can tell you that the judicial branch informed me last week, or maybe it was this week, that there are currently only 2 guardians in the state of Nebraska who serve more than 20 individuals, so this is not going to affect a huge swath of our guardians. Having more than 20 individuals under one's guardianship doesn't happen often, so this bill won't massively impact the guardianship ecosystem. But it will lessen the ability for fraud and abuse because we know that fraud and abuse happens. Guardians most always-- who are engaging in fraud almost always have more than 20 individuals under their guardianship. I have heard from the bar that there is a concern with regards to institutional guardianships and conservatorships, where an entity like a bank is serving as guardian or conservator. So I'm happy to work on language to make it clear that the cap applies to individuals and to individual human beings appointed as guardians, not as corporate entities. Simply put though, we need to do something. We need to be sure that our statutes protect individuals under guardianships. We're talking about a legal structure in which we are taking the rights away from individuals. The protections of those individuals requires our full attention and necessitates a high standard of care. So I ask for your support and attention. And of course, if there's an idea that a number like 25 is better than 20 or something like that, I'd be happy to work with people. Thank you.

BOSN: Thank you. Any questions for Senator DeBoer? Seeing none, thank you.

DeBOER: Thank you.

BOSN: First proponent. Anyone here to testify in support of LB985?

AMY MILLER: Ma'am, can I give you this as well? Thank you.

BOSN: Good afternoon and welcome.

AMY MILLER: Good afternoon, Senators. My name is Amy Miller. That's A-m-y M i-l-l-e-r. I'm a staff attorney with Disability Rights Nebraska. We're a nonprofit organization and the federally-designated protection advocacy organization for people with disabilities in Nebraska. For the last 3 years, we have been working, researching, and

examining thousands of court files in order to get a sense of what was happening with guardianships in the state of Nebraska. There are currently approximately 10,000 Nebraskans under guardianship. We don't have solid numbers, but the judiciary branch estimates that 90% of those are full guardianships, not limited, but full guardianships. If you're under a full guardianship, you lose almost all autonomy to make your own decisions. Your guardian gets to decide where you live, what type of medical care you receive, whether you're able to get a job or take classes, and all of the money matters related to your life. It is hard to imagine how one person with even 20 wards under their care could thoroughly represent all of those issues for so many people. The problem is that without a caseload cap, there's a financial incentive to keep taking on more clients and becoming stretched too thin, even if you cannot provide quality care any longer. That's why we support LB985 for setting a reasonable caseload limit. We've had scandals, as Senator DeBoer alluded to. We know that back in 2013, Judith Widener had over 200 clients before she was caught. We know in 2020, Carolyn Trujillo had 50-plus clients. She had even volunteered and served on the Nebraska Supreme Court Commission on Guardianships. But her theft was uncovered when a diligent guardian ad litem thoroughly went through her accounting, and she was convicted of theft in 2020. And now, in 2025, we have a guardian charged in York County. She had 30-plus clients, and those charges are still pending. The problem, of course, is not just one of fraud or theft. The guardian who's currently charged in York County, in the years prior to her charges, already was just not providing the basic necessary care. We saw in the court files, one client needed an emergency tetanus shot. The assisted living facility tried to reach her by phone, by email, by text. She didn't respond, so the staff had to rush to the court to get an emergency hearing to get medical consent. She also failed to pay rent for an 82-year-old man here in Lincoln. The court discovered the problem that she wasn't paying his bills when an eviction notice showed up, but it was too late. He'd already been evicted, and we still don't know where that 82-year-old man is. In order to prohibit the sort of scandals of busy guardians who are not adequately taking care of the vulnerable Nebraskans in their care, we need a caseload cap. This commonsense reform has zero fiscal note, and we really appreciate the co-sponsors of this bill, and hope that we're able to answer any questions that the committee has now or as the bill progresses. Thank you so much.

BOSN: Thank you. Let's see if there's any questions. Senator Storer.

STORER: Thank you, Chair Bosn, and thank you for being here. I guess my only question, really, it seems to be-- make some sense that, you know, to have that many people that you're responsible for, legitimately have time to do the job and, and oversee them properly. Will this-- my only question, and, and maybe a different bill, different time, but is this going to really protect from some of those bad actors that-- are there other provisions that maybe are in place or that could be in place to have a check and balance system for those instances where, you know, someone maybe has 10 people under their guardianship, but they just happen to be negligent in that responsibility or, or taking advantage of that responsibility.

AMY MILLER: Those are excellent questions, Senator. We have seen, unfortunately, even for an individual who only had one ward-- sometimes even a family member, sometimes even a lawyer-- where it's not always a caseload issue. It is just that they have stolen money or stopped taking care of their person. There are additional remedies that we proposed in our report that I handed out that we are suggesting. County court judges are so busy.

STORER: Mm-hmm.

AMY MILLER: They can't be expected to go line by line through those accounting, but when we have done that over our research the last few years, red flags jump off the page. Some states have used volunteer recruitment of retired accountants, who do core samples and take a look to see if things are being done properly. Some states have invested in paying for having a fiscal review. That would come with a price tag, potentially. So we've offered some other suggestions, remedies that could be brought forward with additional legislation. But the low-hanging fruit, at least, does seem to be, can we make sure that there is a reasonable number? One reason that we attached the maps, both for the guardian that was the research that we did last or 2024 to show the breadth of her cases and then the most recent one who's facing criminal charges, is it's hard to imagine how you can check on your person when you live a hundred miles from them. So I think, on the fraud side, caseload cap will not affect. We'll need more, more legislation in the future. On the providing quality care where you are really taking care of that person, a caseload cap, I think, will help.

STORER: Thank you.

BOSN: Any other questions? OK. Oh, Senator McKinney.

McKINNEY: Thank you. Is there no, like, database that tracks how many people somebody might be a guardian of?

AMY MILLER: I was surprised to hear from Senator DeBoer's opening comments that the judiciary branch was able to give us a number, because they've previously told us they don't track that, so I'm not sure if they did a manual search. As you may have heard with other bills, our current court filing system--

McKINNEY: Yeah.

AMY MILLER: --JUSTICE, does not collect a lot of data that is normal in other states. So for example, we know there's 10,000 Nebraskans, but we don't know the race. We don't know how many of those people are under guardianship for being age-related disability versus a young adult with an intellectual disability, someone who has a serious mental illness. So a reform of JUSTICE would down the road be gathering more information so that we can see-- and when I say reform of JUSTICE, I mean JUSTICE, the court system--

McKINNEY: Yeah.

AMY MILLER: --database, would provide a lot more rich data. Literally, the way that we did our study, after finding out from the Court Administrator's Office that no, they could not pull those numbers, we simply started talking to people in the field-- lawyers who work in this. When I go out and visit group homes and nursing homes, I would ask, who's your guardian? And then, we just started wading through one by one, and trying to do the research, which is why you currently only have 2 examples of a snapshot of guardians in Nebraska, because it is a very data-heavy project.

McKINNEY: OK. Thank you.

AMY MILLER: Yeah.

BOSN: I just have a question. Are other states also capping the number of guardians? I mean, this seems very common sense to me, but is this-- is that the norm?

AMY MILLER: It is the norm, and the other thing is that many states have moved away from full guardianship. The fact that Nebraska has 90% full guardianships has created this problem with a need for guardians. The majority of states use limited guardianship. So say that I'm great at managing my money, but I keep making bad choices about who I hang

out with. And my parents get guardianship for me and say, we're not allowing those bad people to hang out with you, but I'm mana-- I'm paying my own bills in my apartment. Or vice versa. Maybe I'm just terrible at managing money, and I just need help with that. Limited guardianships tailor-make to what that person's needs are. But that's a little complicated for the judge, so you have to have a conversation to figure out exactly how many powers will be granted, what will be retained-- it is easier just to sign a piece of paper, "guardianship." But we are reaping what we sowed by having now, so many full guardianships that are very labor-intensive. So yes, not only have other states provided caps, but they don't have the same pressing need because they've moved to supported decision-making, limited guardianships, and they reserve the full guardianship for the people that really, really can't manage any of their own affairs.

BOSN: And maybe something I can follow up with you later. Let's say you would do one of these limited guardianships, and it was limited to financial decisions, in your example. And then you determined that there was a need to expand it. Do they-- are they-- do they have the capability then, to go in and-- OK.

AMY MILLER: They do. It's-- it just seems-- and I'm not sure how this happened. The state statute says a guardianship should be as limited as possible, and a full guardianship should only be the last resort. So our state law is crystal clear and beautifully framed, but the practice of what's been happening in the field for decades does not reflect that. But yes, you can always go back with a full guardianship or limited guardianship and say, you know, the person's gotten better about X, the person's got worse about Y, and either have some powers returned to the person or taken away, as the judge sees fit.

BOSN: Thank you. Any questions in light of that? Thank you for being here.

AMY MILLER: Thank you very much for your work on this issue.

BOSN: Next proponent. Anyone else here to testify in support? Welcome.

JINA RAGLAND: Good afternoon, Chair Bosn and members of the Judiciary Committee. My name is Jina Ragland, J-i-n-a R-a-g-l-a-n-d. I'm here today testifying in support of LB985 on behalf of AARP Nebraska. Additionally, I am a member of the Commission on Guardianships and Conservatorships, but my comments today are not representative of the commission or any of its members. Nebraska's aging population includes

older adults who may face cognitive, cognitive decline, chronic health issues, mobility limitations, and social isolation. When they require a guardian or conservator, they depend heavily on that person's ability to make timely, attentive, and informed decisions. Without limits on caseloads, some guardians may oversee dozens of individuals, making it nearly impossible to provide the attention-- attentive monitoring and personal engagement older adults need. LB985 helps prevent this by ensuring caseloads remain manageable so older adults receive genuine protection, rather than paper guardianship. As individuals age, the risk of financial exploitation, unmet medical needs, and social isolation increases, and when guardians are stretched too thin, they may miss critical warning signs, unpaid bills, missing medications, unexplained financial transactions, or concerning changes in health. LB985 strengthens oversight by reducing the likelihood that a guardian becomes overwhelmed to the point where neglect, intentional or not, becomes possible. This supports the broader goal of improving systems that protect vulnerable Nebraskans. Older adults often rely on guardians for more than financial or legal decisions. They need someone who visits, listens, advocates, and ensures they are treated with respect. That level of support becomes impossible when a guardian carries an excessive caseload. By setting limits, LB985 increases that likelihood that guardians can visit older adults regularly, attend care plan meetings, monitor long-term care, assisted living, or any general housing conditions, as well as respond promptly to emergencies. These are basic expectations of guardianship, and LB985 ensures that they are met. Families should feel confident that when the state appoints a guardian for their loved one, that person has the capacity, time, and attention to truly serve them. LB985 helps restore trust by signaling that Nebraska recognizes the unique vulnerability of older adults and is committed to prioritizing quality of care over quantity of appointments. For older adults in Nebraska, many of whom cannot speak for themselves, LB985 is a vital safeguard and ensures that guardianship remains a tool of protection for our most vulnerable, against individuals failing to protect and act in their best interests. Thank you to Senator DeBoer for introducing the legislation, as well as co-sponsors Bosn, Hughes, and Rountree. We would ask the committee to support and advance the bill to General File, and I'd be happy to answer any questions.

BOSN: Thank you. Any questions for this testifier? Thank you for being here and the work you do. Next proponent. Anyone else here to testify in support? Opponents.

TIM HRUZA: Good afternoon, Chair Bosn, members of the Judiciary Committee. My name is Tim Hruza, last name spelled H-r-u-z-a. I'm appearing today on behalf of the Nebraska State Bar Association in opposition to LB985. I've had several conversations with Senator DeBoer, so I do want to thank her for engaging in the conversation. And let me start my comments by just saying that the first 2 testifiers in support of the legislation have echoed things that I've heard from attorneys throughout this conversation, since we first saw the bill introduced. I appear today in opposition because of the practical concerns that the lawyers and judges that I hear from have raised about placing a cap on how this operates. And I think the one piece missing from the conversation so far, everything that the previous testifier mentioned about taking time and care and being there for these folks is absolutely critical and number one, and I think the lawyers and judges that work in this area would tell you that that is absolutely important. The piece that we are most concerned with or that I hear from is the fact that there are just-- there are real difficulties in finding people even right now, with no limit to the number of cases. That would apply broadly to guardianships and conservatorships. Judges tell me stories about going months trying to find somebody willing to serve as guardian that might be a relative or that might fit the profile, have the qualities, and do those things, and so what you end up with is appointed counsel that ends up taking over these roles in many small communities. And even in large communities, like Douglas County, there are specific attorneys that serve as guardians when no one else can be found. They might not currently have 20 cases, but they do go above that while trying to find guardianships-- or, or guardians to be placed in those roles. Our concern is simply that a cap of 20, while well-intended and would serve all of the purposes that you've heard the proponents testify, may not get to the root cause, which is these are very intensive roles that people play when they serve as a guardian or a conservator for a person who needs the, the assistance, and using a cap may not be appropriate in all situations and under all conditions. So I've engaged in conversations with Senator DeBoer, about what it might look like in terms of what that number should be, and we'll continue those conversations with experts and people who see this on a regular basis. I also brought to her, her, her attention, the fact that you have, sometimes, corporate individuals who serve as guardians or conservators, and so we might be looking at language related to that, right, if a bank or something is serving as a, a professional guardian or conservator in that instance. And then, I, I guess maybe the last thing I would say, where I was in private practice, you know, out in

Grand Island, I, I ended up with 4 or 5 of these cases after-- there were 2 individuals that had hundreds of cases where they were serving as guardians out in the western part of the state. I ended up with 4 or 5 of these things. They are intensive, difficult cases for anybody to undertake, whether it be a lawyer who's appointed to a case, who has-- you know, these are people that I had never met before until I went and visited them at the VA, in the, in the hospital and had to undertake this stuff. This is-- there's a, there's a very serious and, and time-intensive work. I don't think lawyers are taking those when they take these appointments willy-nilly. But sometimes an appointed lawyer is about the only thing that is left available. And there are people who are good at doing this work, who love doing this work, and the concern from the lawyers and judges is just that a, that a cap may be one step, but it doesn't solve our larger issue of needing more people willing to serve as guardians. So with that, I thank you for your time, and thank Senator DeBoer for her engagement.

BOSN: Any questions? Senator Storer.

STORER: Thank you, Chair Bosn. I guess my only question is, so what happens in, in the, in the event that you can't find a guardian for-- that is willing to take guardianship on? What happens to that, that individual?

TIM HRUZA: In most of those cases, you, you turn to court-appointed counsel, I think. That's, that's how-- I mean, you can-- the court has to find a guardian. In the instances-- like, for example, when I was appointed as a guardian-- and maybe it's working a little bit differently now. But when I was appointed a guardian, I was appointed counsel, and I was given a directive from the judge to help find a person who could serve as a guardian permanently, right? You're appointed as a temporary guardian.

STORER: So would it be reasonable that the 20-person limit does not include, potentially-- I'm just thinking out loud here-- does not include those court-appointed? It's sort of the last ditch effort to-- I'm just--

TIM HRUZA: Maybe a-- yeah, maybe a temporary guardian or something like that. I mean, I, I would love to talk to Ms. Miller, who testified earlier, about maybe some of those solutions. I think-- the standpoint that I've heard from the judges and lawyers I hear from, is the, the solution should be a little bit broader than just a case cap that applies in all of those instances. So.

STORER: It seems like there, there's a pathway to solve across the [INAUDIBLE].

TIM HRUZA: I did, I did talk to Senator DeBoer about maybe an exception for attorneys serving in that role. I don't know if that's an appropriate conversation or direction to go-- as oppose-- as opposed to like, you know, some of these situations, like the one I was referring to earlier that I think was mentioned, you know, you have some professional guardian services that, you know, had at that time hundreds of cases out in western Nebraska that-- it's probably too much. And I don't think anybody would agree that was a good practice. But since then, we've put in lots of reporting, che-- regular court check-ins, more forms that are filed, those sorts of things, too, so it's part of the way this has developed over the years. It's, it's all been good. We just think that the [INAUDIBLE] the cap as the, the solution might not be taking into account the breadth of the problem, if that makes sense.

STORER: Thank you.

TIM HRUZA: Thank you.

BOSN: I realize you're just kind of thinking on the fly as you're sitting up here, but you would agree that having court-appointed counsel take more than 20 wouldn't alleviate the concerns of being able to visit someone 100 miles away in a timely manner, any better than if you were not an attorney. I mean, I know attorneys are great and special, just ask Senator Holdcroft, but we still drive the speed limit and have to get there and visit them and still respond. And if somebody's needing emergency medical care, our status as an attorney doesn't make us better qualified to-- you would agree?

TIM HRUZA: I certainly agree with that, Senator. I think the concern, the concern that I would, I would anticipate if I had a little more thought, I would tell you back, too, is that having someone is better than not having anyone. Right?

BOSN: Is it? I don't know. I-- do you really think that?

TIM HRUZA: For-- I mean, these are individuals who have been determined-- and you know, I, I would agree with, with Ms. Miller's comments earlier, too. Limited-- the limited guardianships is probably a much better way for us to be going, but we-- these are individuals who the court has determined do not have the capacity to make

financial decisions for themselves, or to make healthcare decisions for themselves. That's where you need that guardian. You need somebody to come in and make that-- otherwise, they can't go and get treatment, right? They can't-- nobody can sign off on what the nursing home is going to do for them. Or if something comes up, they need a doc-- to see a doctor, have-- you know, they fall-- have a fall at a nursing home and need to have X-rays taken. They can't get services without somebody signing off and approving those things. So I don't know what the answer-- the, the broader answer and the concern I have from, from everybody I hear from is we just-- we need to find a way to make the process easier for folks to take these roles who are well-equipped to serve in them. But it's-- it is a hard and it is a-- sometimes a very thankless, difficult job, too. So yes, you are-- it is not good-- it's not good if people are overwhelmed with the amount that they have. But at the same time, that individual needs someone to be able to step in when they need them.

BOSN: Maybe if-- whoever represents the judges could mention that in their-- you know, as their lobbyist, that maybe limited guardianships might be a good step to go forward-- if you see that lobbyist.

TIM HRUZA: I will mention it to their lobbyist.

BOSN: OK. Great.

TIM HRUZA: It's not me.

BOSN: You have some of them. All right. Any other questions in light of that? Thank you for being here.

TIM HRUZA: Thank you.

BOSN: Next opponent. Anyone else in opposition? Neutral testifiers. All right. Senator DeBoer to close.

DeBOER: Thank you, all, for your patience in listening to this. I will say that in answer to your question, Senator Storer, and kind of in contravention of, perhaps, what I heard in Mr. Hruza's testimony, if there isn't someone, the court will put them on the list for the Office of Public Guardian, which is the point of the Office for Public Guardian is to take those cases that no one else can or will take. And when I started working on these guardianship issues, there was a really big backlog. So it was essentially ineffective to be put on that list because you'd be waiting and waiting and waiting. But I can report, as this committee's member on the Supreme Court's Commission

on Guardianship and Conservatorship, that we have greatly reduced and there's only a very few number of people on that wait list. I think it was like-- it was 20 or less. I mean, it was not very many people. And that's just part of just, you know, sort of the static flow-- or, you know the dynamic flow of things. So we do have a mechanism for helping folks, which I think is important to remember. So it's not like folks are just going to not have someone. And it is, I think, our responsibility. And as I am leaving here this year, I will ask that the members of this committee who stay here keep an eye on the OPG and make sure that they're well-funded, and make sure that they have the resources that they need to continue to keep that wait list down, and to continue to provide that service to the folks who do not have guardians. This is an entirely separate issue. This issue here before us today in this bill is to say that we need to recognize that there is a potential, because of the relationships between a guardian and a ward that are so intimate that they are making these decisions for them, that if and when there is ever a bad actor again, at least we have limited that damage to a certain number of individuals and not a huge number of individuals. We need to recognize that even with the best intentions, trying to do 20, 30, 40, 50, you get to a point where you cannot do a good job, no matter how good intentioned, no matter how hard you're trying. So having a limit on this is important to just say, we recognize the difficulty of these kinds of guardianships and conservatorships. So I'm happy to talk about a different number if that's, if that's what the bar would like. I was heartened to find out that there are only 2 with more than-- in the state of Nebraska, currently, with more than 20. So I think this is a completely doable situation. And maybe the number isn't 20, maybe it's 25, but I think we can find the right number in this committee. So, yeah.

BOSN: Senator Storer.

STORER: I-- I'm obviously very interested in this topic. Sorry. But so reaching out to some other folks that, that understand the issues a little bit better than I do about guardianship, have we added more responsibilities or sort of further complicated the requirements to be a guardian, in the last 10, 15, 20 years?

DeBOER: So whenever-- and I actually don't remember when that was now. Whenever the, the really bad incident occurred, with the woman that had all of the wards that had-- I mean, that, that really put us in a position to create the Office of Public Guardian and all of that. What was your question again?

STORER: If we've added significantly.

DeBOER: Oh. Yes.

STORER: Some of the feedback I've gotten is that, you know, that job has just become more burdensome and more requirements over the last--

DeBOER: Yes.

STORER: 15, 20 years, which may be part of the challenge of, to Mr. Hruza's point, of finding people that are willing to [INAUDIBLE].

DeBOER: Absolutely. And at that time, we did. We added a lot. Because we wanted to make sure that, you know, care was being taken, that meetings were being attended, that checkups were happening, all of those sorts of things. And some could and have argued that we've gone too far, and so we have made some sort of adjustments on that, as well, and maybe there's more to be done. And you know, so that's something that this committee can continue to work on in future years. But I don't think that really has that much bearing on the-- I think we need to set a number and say, you know, this is what we think can meaningfully be done by an individual. And then, I think if we need to adjust reporting requirements or things like that, that's a separate question, and kind of related to the next thing I'm going to talk about.

STORER: OK. Thank you.

BOSN: All right. That will conclude our hearing for LB985. Next up, we have LB1178, also with Senator DeBoer. Before she gets started, I will note there was one proponent, no opponent, and no neutral comments submitted for the record. Thank you for being here, and welcome back.

DeBOER: Thank you. Good afternoon, Chair Bosn and members of the Judiciary Committee. My name is Wendy DeBoer, W-e-n-d-y D-e-B-o-e-r, and I represent the 10th Legislative District in vibrant, northwest Omaha. Today, I'm introducing LB1-- LB1178, which makes various changes to the requirements for individuals appointed as guardians. First, the bill makes clear that the person under guardianship has the right to attend all hearings relating to their guardianship-- related to their guardianship. Of course, in-person attendance of someone under guardianship may not always be possible due to mobility issues, health concerns, or perhaps they live in facilities far from the courthouse. As such, the bill ensures a virtual option is an acceptable way to fulfill this obligation. The bill will not require

attendance at hear-- hearings. It simply makes a virtual appearance possible as an option for those individuals who are ready and willing to participate in their own case. And I know senator-- I know I've talked with Mr. Hruza about this. And there's maybe some language that needs to clarify that this ability to appear virtually is limited to the ward and that the guardian, unless the judge specifically indicates, must appear in person. So there might be some cleanup language necessary to make that clear. Second, the bill will require that guardians visit the wards under their care once a month. This addresses a critical oversight gap. Guardianship gives someone substantial control over another person's life and assets. Yet without regular contact, the guardian may be unaware of any abuse, neglect, or mismanagement by daily caregivers that the ward is facing. Monthly visits ensure guardians actually know their ward's current condition, living situation, and needs, not just managing their affairs on paper. I understand that not every protected person is even going to be aware of the visit. But even if someone is nonverbal, a guardian needs to physically see them to detect things like bed sores, weight loss, medication issues, facility neglect. It's a reasonable expectation given the guardian's legal responsibilities, and it mirrors what we already require of our state employees at the Office of Public Guardian. Third, is Section 6 of LB1178. This was brought to me by the Nebraska State Bar Association to address a commun-- a continuity issue in terms of how challenges to guardianships and conservatorships are handled when compared to things like trusts and estates. The provision copies language from the section on trusts and estates to ensure consistency under similar circumstances. The bar will be testifying and can answer any questions about this specific session-- section. Since introducing the bill, multiple parties have offered thoughts on the bill, opportunities for refinements and rec-- recommendations to clean up language. Of course, as always, I will work with any interested party to be sure the language is as strong as possible, and I'll let the committee know if we have amendments that would reflect those kinds of comprehensive changes. But like I said before and as you heard in the last bill, the time is now. We need to do better as a state to protect those under guardianship.

BOSN: Thank you. Questions? All right. Thank you. Anyone here to testify in support of LB1178? Let's begin with proponents.

AMY MILLER: Good afternoon. My name is Amy Miller. It's A-m-y M-i-l-l-e-r. I'm an attorney with the nonprofit Disability Rights Nebraska. We're the federally-designated protection advocacy organization for people with disabilities in the state. I am going to

start with the section relating to monthly visits, because it touches on a good question that was raised by Senator Storer. How much reporting and what must a guardian do once they've got control over someone's life? By looking at the court records, what we have been primarily relying upon for our data is the annual report that's filed by a guardian. It's one report per year. I've attached an example at the back of my testimony. It's 2 pages of questions. Have you visited the person? Has their condition changed? Should the guardianship continue? Now, I only printed off 2 pages of a redacted sample so that you would get an idea of what a guardian is telling the judge about what he or she sees in the field. There are more pages when someone is managing money because they have to show all the money that came in and all the money that went out, but that's just an Excel spreadsheet for most guardians. This is the entirety of the burdensome reporting that guardians currently go through and you'll see that there's a question, how often do you visit the ward? Daily? Weekly? Monthly? Other? You'll see in the redacted one that this guardian is very honest. I don't visit her. That guardian lives approximately-- has his law office approximately 8 miles away from the individual who's under guardianship, and she's been his ward for 10-plus years. If he doesn't visit or any guardian doesn't visit, how do they know the condition of their ward? Many of the guardians write in, I speak with the staff at the facility. Well, if the staff at the facility are abusing, neglecting, or financially taking advantage of the ward, of course they're going to say, everything's great, nothing to see here. It makes common sense to go lay eyes on a person. Monthly makes sense, because that's what we require currently of our state Office of Public Guardian. And to the extent that we think that it can't happen for a professional, I've given you a couple of examples on the second page of my testimony, including an Omaha attorney who filed 6 years' worth of annual reports, faithfully reporting on how his ward was doing. Turns out he had not visited the man once. The elderly gentleman was actually transferred to another nursing home, someone noticed, and that attorney had to face sanctions as a result. Guardians of all stripes and colors are capable of phoning it in. Requiring monthly visits ensures that the person is actually being taken care of. I know my time is running out, so I'll simply say virtual attendance means judges can more easily talk to the person, if the ward is able or willing to talk. When the person's hearings are set, many wards who are under guardianship would not be able to physically travel to the courtroom unless their guardian made the arrangements. My time is up, so I will stop.Thank you.

BOSN: Any questions for this testifier? All right. Thank you very much for being here.

AMY MILLER: Thank you.

BOSN: Good afternoon. Welcome back.

JINA RAGLAND: Thanks, Chair Bosn and members of the Judiciary Committee. Excuse me. My name is Jina Ragland again, J-i-n-a R-a-g-l-a-n-d, testifying in support of LB1178 today, on behalf of AARP Nebraska. Again, I am a member of the Commission on Guardianship and Conservatorship, but my comments are not representative of the commission or any of its members. As advocates for older adults, we are aware how aging, disability, chronic illness, and cognitive changes can influence a person's ability to navigate complex court processes. LB1178 takes steps to modernize, increase transparency, and provide more direct focus on the rights and wellbeing of older individuals who rely on guardianships, which can further allow them to age in place and live independently as possible. LB1178 explicitly provides that an incapacitated person, whether an older adult, ward, or protected person, has the right to attend guardianship and conservatorship hearings, virtually or in person. This removes mobility, transportation, and health-related barriers that too often prevent older adults from being heard in proceedings that shape their autonomy and care. We feel it is essential to preserving their right to participate in these decisions that affect their lives, preferences, and independence. LB1178 also updates responsibilities by requiring monthly monitoring visits and written documentation on these contacts. These accountability measures are critically important for older adults who rely on guardians as their primary advocates. By requiring consistent visits and documentation, we feel that guardians will be better able to maintain real visibility in an older adult's living situation, identify earlier signs of neglect, abuse, or unmet needs, and intervene as well as provide better information to evaluate guardian performance and the older adult's well-being. While we do support the [INAUDIBLE] legislation, we have been in-- had a few discussions with Senator DeBoer's office. And so I would offer 4 things for maybe consideration as you move the bill forward. Section 4: this section adds a subsection to 30-2627, mandating that a guardian monitor a ward or protected person. This is the statute that lists the priorities for the appointment process for guardians. And we would recommend this section also be added to 30-2628, which is a section that lays out a guardian's powers and duties. Number two, this new subsection only refers to guardian, but then states the guardian

shall monitor the ward or protected person. A ward is defined earlier in statute as someone for whom a guardian is appointed. A protected person is someone whom a protective order has been issued. If the intent is that-- if that is what the intent is, that it should apply to both guardians and conservators. And so we would recommend a similar section be added to 30-2647, so it's not unintentionally dropping the protected person. Then the last 2 items, page 8, lines 5-10, both apply. We would recommend that the word monitor or the monitor in general be defined so it's clearly stated of what the requirement for visitation might be in that monthly requirement. And then we would also recommend that periodic contact also be defined more specifically. And our concern there is the section is vague and could potentially lead to litigation, which would take away the guardians time and ability to perform their duties. In closing, then, for older adults in Nebraska, many of whom cannot speak for themselves, this is a vital safeguard and ensures that guardianship remains a tool of protection for them. Thank you, again, to Senator DeBoer, for introducing the legislation. Thank you for the committee, for your time, and I would be happy to answer any questions.

BOSN: Thank you, any questions for this testifier? Seeing none, thank you very much. Next proponent, anyone else here in support? Opponents? Opponents. Neutral? Now you're on your way up.

TIM HRUZA: Good afternoon, Chair Bosn, members of the Judiciary Committee. My name is Tim Hruza, last name spelled H-r-u-z-a, appearing today on behalf of the Nebraska State Bar Association, in a neutral capacity on LB1178. Let me first start by saying, as you heard Senator DeBoer in her introduction, Section 6 of the bill is language that the Bar Association was working on a separate bill for. I talked with Senator DeBoer, who was working on the guardianship issue, and she wrapped that up into this, so we are thankful for her for that. Very much support Section 6. All that piece does is take provisions about when a court may award attorney's fees and costs to a party if, if you have continued challenges or things like that that happen in a guardianship or conservatorship in a similar fashion to how we handle trusts or estate situations, but mostly in trust context. So the language is copy-pasted from the trust code and put into here. Appreciate Senator DeBoer, for including this in the bill. I appear in a neutral capacity. Senator De Boer also mentioned some of the virtual language. We very much support wards being able to attend, having the right to appear, or a protected person, as well. I've heard from many attorneys and judges that even getting a person there virtually can make the hearing go a lot smoother and make for a much more, you know,

good experience for all involved. I have talked to Senator DeBoer. I think we have some questions about the, the language re-- regarding rights. And there is some concerns about, you know, what if virtual appearance isn't available as a result of technology in the courtroom, or for other instances. So we're going to work with her on some language, but very much support the aim there. The, the reason I'm neutral is because of the language in Section 4 of the bill, sub (f). The language "monitor" we think maybe needs to be defined, in terms of what that actually requires. I do think that there are several attorneys who think a monthly visit may be a lot to ask, not that it's necessarily-- there are certain cases in which that is necessary and a great thing to do. But maybe in all cases, it might not be the best. So I think the question is what, what the intent of the language monitor is. And then, the second piece, too, is-- deals with that second sentence, so the-- they must have a record of each visit and shall have periodic contact with all public or private individuals and agencies. There are oftentimes when caregivers and nurses, you know, nurses assistants or something like that, that are seeing an individual that a guardian would not necessarily be in a position to talk to every one of those. So I think we just need to tweak some language things, which we will do. If not for those reservations, I would definitely be in support of the legislation, and thank Senator DeBoer for bringing it. So we'll work on language, and hopefully, we'll come to a position of support on this bill.

BOSN: Thank you. Any questions for this testifier? Seeing none, thanks for being here.

TIM HRUZA: Thank you.

BOSN: Any other neutral testifiers? All right. Senator DeBoer, back to close.

DeBOER: Thank you. I appreciate the committee's time. And obviously, there are a few little pieces of language that we need to work out, which I am very apologetic that I didn't get done before the hearing, but I will get those done as soon as possible and then get back to the committee about them.

BOSN: Thank you. Any questions? Seeing none, thank you. That will conclude our hearing for LB1178. Next up, so fresh, we have Senator DeBoer on LB984. While she's getting ready to start, I will note for the record that on LB984, there were 9 proponent, 2 opponent, and no neutral comments submitted for the record. Thank you and welcome.

DeBOER: I was just noting LB984. I think I've had that bill number before. Good afternoon, Chair Bosn and members of the Judiciary Committee. My name is Wendy DeBoer, W-e-n-d-y D-e-B-o-e-r, and I represent the 10th Legislative District in vibrant, northwest Omaha. Today, I'm introducing LB984, a bill to increase the minimum age of consent from marr-- for marriage from 17 to 18. So I think this is a really simple bill. As long as you're a minor, your rights are limited, which means if you're being forced into marriage, you have limited ways to get out of the situation. Forced marriage are a common tactic of human traffickers and even something like a cult to the extent full-- to exert full control over others. To be clear, forced marriage is not the same thing as an arranged marriage. Forced marriage is where one or both parties do not give full and free consent. Typically, forced marriages occur through violence, threats, grooming, fraud, or other similar methods. And children are more likely to be victims of forced marriages, as they cannot file for protection orders against those forcing them to, to marry. Take this scenario. Sophia is 17. Her parents are addicted to meth and short on money constantly. Jimmy is friends with the parents' drug dealers, and it's known that the parents do anything for meth and money. Jimmy proposes giving Sophie's parents $5,000 for Sophie's hand in marriage. If they don't accept, Jimmy will call the cops on them for their drug use. Sophie, facing the pressure from her parents, is forced to marry Jimmy, and then they move across the country. And now, Sophie is being abused and trafficked. So this is something which is possible under the current law, and it does happen. Now, I start off by saying this is a simple bill, but there is a slight complication. I think 18 is the correct age for us to have as the minimum age to get married. It would align with 15 other states, and 18 is when you can vote and fight for your country. So it seems right that you should be able to marry at 18. But if you're 18 in Nebraska, because of-- because our age of majority is still 19, it still means you cannot access our court system to protect yourself against a forced marriage. Nevertheless, the way the bill is drafted, what it says is at 18, you can consent to your own marriage. And when you think about it, we really--like, marriage is a pretty big commitment. We want people to be in a position where they're able to make that, that commitment. 18, we've recognized if you're able to vote, you're to go and fight for your country, that sort of thing. We're recognizing that there's at least a certain level of maturity by the time you get to 18. So recognizing that, I chose 18 as the, the age, rather than 19, as the age that I would like to, to fix this bill for. LB984 strengthens our statutes to protect kids from forced marriage. It changes the minimum

age of consent for marriage from 17 to 18, which is an improvement on our current statute. Maybe some folks will say that's not perfect. I will tell you that there was a national group that originally was talking to me about this bill and they were not pleased that I had chosen 18 instead of 19, but it just seems like a better fit to me. So I'm happy to work on anything or have conversations with you about why I chose that particular number, but it does seem like that will help, at least in many situations, to move from 17 to 18.

BOSN: Questions for Senator DeBoer? Seeing none. Thank you very much. Anyone here to testify in support? Opposition? Neutral? Closing waived. OK. Next up, we have my bill, which is LB788. And I will pass it over to Senator DeBoer.

DeBOER: Thank you very much, Senator Bosn. While Senator Bosn is approaching, I will note for the record that there was one proponent testimony comment and zero opponent or neutral comments. So whenever you're ready, welcome Senator Bosn.

BOSN: Thank you. Thank you, Vice Chair DeBoer and members of the Judiciary Committee. For the record, my name is Carolyn Bosn, C-a-r-o-l-y-n B-o-s-n, and I represent District 25, which is southeast Lincoln, Lancaster County, including Bennett. LB788 is a cleanup bill. So this was introduced to change the administration of the Financial Fraud Victims Fund from the Attorney General's Office to the Nebraska State Patrol. So last year, we passed LB559, which was the-- we kind of called it the skimmers bill, which was a bill I passed. We had put in the Attorney General's Office as the distributor of those victims' funds, and they are not able to do that. It has to go through the Nebraska State Patrol. It was an oversight and was brought to our attention shortly after we passed the legislation. The Nebraska State Patrol does have the authority and capacity to administer this fund. They currently work with forfeited assets in other capacities and is better suited to administer this fund. We did do some work with them. But I'm happy to answer any questions if you have, because initially there was a fiscal note, so I don't think that's reflected. I think we worked it out before that actually came out. But there is no fiscal note on this. And I would certainly ask your continued support, as we had last year for the LB559, on this year's LB788, cleanup bill.

DeBOER: Thank you. Are there questions for Senator Bosn? Thank you, Senator Bosn. First, we'll take proponents. Are there proponents for this bill? Is there anyone who would like to testify in opposition to this bill? Is there anyone who would like to testify in a neutral

capacity? Senator Bosn, then, would you like to close? Senator Bosn waives her closing, and that will end our hearing on LB788. And I think we'll take just a minute to get reset to go to our next hearing.

BOSN: It's an annotated hearing on LB731. So you're welcome to come back in. We just have to have everybody go through the metal detectors at this point, in compliance with the annotated hearings.

[BREAK]

BOSN: While the introducer is getting herself situated, we are back on the record for LB731, with Senator Kauth. Before she begins, I will note there were 151 proponent comments submitted, 388 comments submitted, and 3 neutral comments submitted online. With that, we are doing an annotated hearing today, so there's going to be a little bit of unique shuffling as individuals are coming from one hearing room into the other, and we'll just try and be as flexible as we can. With a little bit of grace, we'll get through everything. Welcome.

KAUTH: Thank you very much, Chairwoman Bosn. And congratulations to the Judiciary Committee for whipping through 4 other bills before this. I was shocked to get the text that I was needed down here. LB731-- oh, sorry. My name is Kathleen Kauth, K-a-t-h-l-e-e-n K-a-u-t-h. LB731 focuses on the needs of those individuals who have engaged in medicalized treatments of their gender dysphoria and who experience regret. It provides for insurance coverage to reestablish, as close as possible, their physical health reflecting their actual sex. Individuals who engage in sex rejection procedures and medications may not recognize the full extent of the physical, psychological, or reproductive harm until they are well into adulthood. Extending the statute of limitations and creating a private right of action protects patients, promotes accountability, and upholds the integrity of medical practices. LB731 also protects the individual patient who has had these procedures and requires insurance companies to pay for sex-rejection procedures, otherwise called gender-affirming care, to then also pay for procedures to attempt to correct the damage. Insurance companies in Nebraska provide extensive coverage for procedures designed to reject natal sex In the Blue Cross-- gesundheit-- in the Blue Cross/Blue Shield Policy, Gender Reassignment Surgery, dated January of 2025, United Healthcare's Gender Dysphoria Treatment, there's a growing body of evidence of the short and long-term effects of these treatments. Patients deserve coverage of their health-- healthcare needs, including reconstructive surgeries and ongoing screening tests to monitor side effects

downstream of the covered transition services, no matter their transition status. The insurance industry needs adequate and legitimate diagnostic and billing codes for detransition. If there is no billing or diagnostic code for a condition, it does not exist for doctors. This is one of the reasons regret is extremely difficult to track. Without billing and diagnostic codes, insurance companies cannot evaluate the actuarial costs of long-term treatment. Physicians cannot adequately treat patients, report the care they provide, or crucially, get paid for providing care. Patients struggle to receive necessary care, and patients harmed by gender medicine need a longer statute of limitations because it takes much longer to come to terms with regret for these procedures. Children are not able to consent to these treatments, which means their parents or guardians are accepting radical, unsupported medical procedures on their behalf, but the children are the ones who have to live with the long-term ramifications. When you look at the scale of harm and the detransition rates, the number of patients of the medical-- of the gender medical procedures is unknown. There's been no effort to count adult patients, and efforts to track pediatric patients have vastly undercounted due to exclusion of private pay and documented cases of billing fraud. Since claim tracking is not accurate, we must rely on surveys and estimates. Per the Williams Institute study in August of 2025, Nebraska's trans population could be in the range of 20,000 people, including 4,800 minors, which is 13-18, and 6,500 young adults, 18-25. Survey estimates are that 50% of trans-identifying people access hormone therapy, and 29% will have at least one surgery. This translates to thousands, many-- maybe as many as 10,000 medicalized trans-identified people in Nebraska. Rates of detransition are unknown and poorly studied. The low end estimate of 1% often reported by gender doctors is from studies that are decades old, they only examined adults who transitioned under old protocols involving significant gatekeeping, and they had strict definitions of detransition, requiring affirmative statements to the original caregiver. 30% rates of detransition or more can be inferred from loss to followup-- patients dropping out of gender care. The time to regret may be as long as 11 years for gender-affirming care. Post-transition patient testimony. Insurance will cover nothing. These are comments from detransitioners. Over $35,000 and 3 surgeries needed-- from Prisha Mosley. Forced to have surgery without anesthesia due to denial of coverage-- Forrest Smith. Breast reduction is not covered for males. Costs $6,000 to $10,000-- two male detransitioners from Tennessee and Alabama, respectively. The documented medical complications. Some physical health impacts from cross-sex hormones:

4.9 times higher heart attack risk in female-to-male patients, 6% develop blood clots in male-to-female patients, 11% develop erythrocytosis in female-to-male patients, 25% develop osteoporosis in male-to-female patients, 94.1% on testosterone experience pelvic dysfunction, there's a 5 times higher risk of pulmonary embolism, as compared to patients with gender dysphoria who do not take cross-sex hormones, vaginal atrophy, atrophy in 52% of female-to-male study subjects. Some known complications for genital surgery: it's a 100% surgical failure rate, as it is impossible to change sex, and that's how it's being billed. Female-to-male: 76.5% overall complication rate, with the most common being a urethral fistula or urethral stricture. Male-to-female: up to 70% complication rates; tissue death, up to 25%; fistulas, up to 17%; prolapse, up to 10%; synosis and strictures, 10-13%-- pardon me-- 10-18%; tissue granulation, up to 26%; incontinence, up to 16%; urination issues, up to 33%; and infection, up to 27%. Some of the long-- some of the known long-term health risk-- risks? There's a 19.1 times higher post-surgery suicide risk. That is from a study, it's called Dhejne, in 2011. Endocrine and stability disorders are also part of this. In 2025, so just last year, our Department of Health and Human Services at the federal level wrote this gender dysphoria report. This is their executive summary. 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 sexual 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 life-saving. 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 is published against a 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 a 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 suggest-- 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's 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 risks of pediatric medical transition include infertility and sterility, sexual dysfunction, impaired bone density accrual, adverse cognitive impacts, cardiovascular disease, and metabolic disorders, psychiatric disorders, surgical complications, and regret. Existing systematic reviews of 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 on psychological outcomes, 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 a 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 [INAUDIBLE] determining they lack developmental rigor and transparency. Problems with the development of WPATH Standards of Care, Version 8, which is called 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 relaxed 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 a 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 is evidence that some medical and mental health associations have suppressed dissent and stifled debate about this issue among 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, healthcare 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 as 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 that inform how U.S. gender clinics work, there are flaws. Jack Turban, a researcher, medical journalist, and assistant professor of child and adolescent psychiatry at the University of California-San Francisco is the lead author on the following 4 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 18-36 years old, online via transgender advocacy organizations. All 4 of the studies have the following flaws: they have biased selection of study participants or their cohort. Only those who identified as transgender, trans, genderqueer, 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 survey, eliminating the people most likely to have been harmed by medical interventions. 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 the responses were not relevant to the 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 interventions and the survey explicitly stated 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 we look at correlation versus causation, Turban acknowledges that the survey design did not allow for determination of causation. This means that the studies can only show associations but can't provide actual proof for any of the claims. Nonetheless, all 4 studies treat the results as a valid basis for major policy recommendations. There are the 12 systematic reviews that examine outcomes from puberty blockers and/or cross-sex hormones for individuals up to age 26. The systematic reviews have varying levels of methodological quality, and the highest quality ones, the Miroshnychenko SRs, also find very low quality of evidence for, for benefit. Note also that the Endocrine Society, in a guideline developed by WPATH clinicians, acknowledged, in 2017, the very low quality of evidence for mental health benefits. Its recommendations are based on a "values and preferences" statement that explicitly ranks achieving desired cosmetic outcomes above avoiding harm. I won't go through all of the studies, but they're there if you'd like to research them. One of the groups that I worked with in researching this was the Women's Liberation Front. 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 transitioned to boys and men. 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 7,000-- or 724,000 youth now identifying as transgender. All of 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 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-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 (blood) pressure around the brain, which can result in headaches and vision loss; psyche--psychiatric and behavioral disorders; vaginal cuff dehiscence; and increased mortality; and if a woman or girl has her ovaries removed as part of gender-affirming care, she may suffer loss of bone density. Many deny that there is 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-analysis reviewed the available research and found rates of discontinuation of care, medical treatment regret, and detransition were up to almost 30%, 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. With all the health risks women and girls face from taking high doses of testosterone alone, it stands to reason that any insurance company that covers such care cannot then leave an individual to pay out-of-pocket the cost of everything else that might come along with it, including the likelihood of transition regret and the lifelong health complications that were caused by such treatment. Currently, professional negligence claims, including those involving complex and increasingly experimental medical interventions, are constrained by a fixed statute of limitations that may expire before the full consequences of certain procedures become known. Interventions that alter the physical sex characteristics, particularly for minors and young adults, often involve irreversible surgeries or lifelong hormone therapy, whose long-term effects are not yet fully understood. LB731 addresses this legal gap by providing an exemption to the standard time limitation for filing claims related to professional negligence in this context. By extending the window, the bill recognizes that harms from these experimental procedures may only emerge years later, ensuring that patients who are adversely affected have a fair opportunity to seek redress. A cornerstone of malpractice law is informed consent. LB731 holds clinicians accountable for failing to fully disclose the experimental nature and potential long-term risks of interventions. This reinforces ethical obligations and protects patients considering irreversible procedures. Providing care for detransitioning patients, LB731 also addresses a serious and

growing gap in healthcare equity. Individuals who later seek to detransition often discover that their insurance will not cover medically necessary care to address the consequences of prior interventions, including hormone management, reconstructive surgery, fertility-related care, or long-term mental health support. Detransition care is not elective or experimental. It is a standard medical treatment responding to prior interventions. LB731 ensures that patients are not financially penalized for seeking to restore health, promoting fairness, consistency, and ethical responsibility. LB731 aligns with the Judiciary Committee's mandate to ensure fair remedies for professional negligence. Insurance coverage and accountability should follow medical need, not ideology. All patients, regardless of current identity or treatment path, deserve comprehensive, ongoing care. This legislation does not restrict medical care. It ensures that harms or changing needs do not leave individuals without necessary treatment. And I wanted to add one thing. Two days ago, I received a letter from the Nebraska Board of Health, fully in support of LB732, which is the bill banning cross-sex hormones and puberty blockers for minors. And I want to read that because it does tap into this. There are people who are, are being harmed and have been harmed by the use of these drugs when they were minors, and for our State Board of Health to acknowledge that harm is really pertinent to this discussion. 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, 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 that time, our conclusion was driven by an 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 re-- 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 clearer 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

persistent and significant limitations across the literature, including low or very low quality of evidence for claimed mental health benefits, short duration of followup, high rates of loss of followup, 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 cardio-metabolic 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 avoiding iatrogenic harm. Our board's support today is consistent with the position we took in 2023, reflects an ongoing assessment of the evolving scientific record. So again, our State Board of Medicine believes that these are harmful, re-states the fact that there are no good studies proving that they are helpful. LB731 will help those people who have been harmed by these decisions. So, thank you.

BOSN: Thank you. Any questions for Senator Kauth? Senator Holdcroft.

HOLDCROFT: Thank you, Chairwoman Bosn.

KAUTH: Yes, sir.

HOLDCROFT: I noticed in one of your handouts here that you got support from the-- from LGB Alliance.

DeBOER: Yes, the LGB Alliance. Mm-hmm.

HOLDCROFT: I thought that was interesting. And I mean, they recognize that there is an issue there--

KAUTH: Yeah.

HOLDCROFT: --for de-transitioning.

KAUTH: And, and I think what's really interesting about this whole process has been the support from an incredibly broad base of people-- yesterday, in the bathroom and locker room. And today, we have the Catholic Conference, the Nebraska Family Alliance, and we have the LGB Courage Coalition and Detransitioners. Yesterday, we had a, a woman from San Francisco, who was a Nebraska star volleyball and tennis player, who came to testify about being a very proud lesbian Democrat who is pushing back against the-- this issue, and saying it is harming young people and it's harming gay kids, mostly. So it's been a very, very wide ranging group of people who are saying this needs to stop.

HOLDCROFT: Thank you.

BOSN: All right. And I know you're kind of navigating between 2 rooms, so.

KAUTH: We're going back and forth, so I will be here to close. I don't know how much I'll be in here, so.

BOSN: That's all right.

KAUTH: Thank you very much.

BOSN: No problem, thank you. So we are going to begin with invited testimony. And so, I think most of you are-- in here are aware of that. But just for those who are watching from the overflow room, we're going to have invited proponents and invited opponents. And I know some of them are also coming back and forth from both rooms. So I want to be respectful of both sides of that so we give everybody the opportunity to be here. I know most of you weren't in here when I read the rules, and I am a stickler for the rules. And Senator Holdcroft will hold me accountable. You have 3 minutes. So when the light turns red, please respect the timer so that we can actually hear from everybody today. We're going to begin with, is it pronounced Hallie or Haley? Hallie Hamilton. Thank you. Welcome.

HALLIE HAMILTON: Thank you. Good afternoon, Chairwoman Bosn, Bosn and members of the committee. My name is Hallie Hamilton. It's H-a-l-l-i-e

H-a-m-i-l-t-o-n. I'm an attorney from Omaha, and I'm here today on behalf of Nebraska Family Alliance in support of LB731. This legislation is an important next step in protecting people from the adverse consequences of medical procedures to modify an individual's body to appear different from that person's biological sex. This bill focuses primarily on post-procedure rights, including extending the timeline to bring a civil suit and mandating insurance companies provide certain coverages. One of these required coverages is for any procedure, treatment, or therapy necessary to manage, reverse, reconstruct from, or recover from the covered individual's gender-altering procedure. This is especially timely. Anecdotal evidence related to detransitioning grows by the day, as people share their personal experiences with gender-affirming care and their subsequent decisions to embrace their biological sex. The first person I heard discuss trans regret was in 2014, a man named Walt Heyer, who had lived as a woman for 8 years. In 2014, Mr. Heyer was one of just a few people publicly discussing this issue. But today, a quick Google search will provide example after example of people who regret their gender-altering medical procedures. As just one example, a man who goes by Shape Shifter shared his story on a popular video series called Soft White Underbelly. Shape Shifter explained how he regretted his medical transition, which included, among other things, large breast implants. Although Shape Shifter is now in the process of detransitioning, he stated he had been unable to get insurance coverage to remove the breast implants. He indicated that difficulty getting insurance coverage of reversal surgeries is a common problem among detransitioners. On a podcast, another detransitioner, Luka Hein, said that detransitioners are, quote, desperately searching for something to hold onto, and that they are looking for, quote help out there, when the medical system is looking us in the eyes and telling us it doesn't want to help. Shape Shifter said something similar about his efforts to have his implants removed. He said, I can't get any help. LB731 would extend a hand of help to people who need it, and Nebraska Family Alliance urges the committee to advance LB731. Thank you.

BOSN: Thank you. Let's see if there's any questions from the committee. Any questions for this testifier? Seeing none, thank you for being here, and congratulations.

HALLIE HAMILTON: Thanks.

BOSN: Yes. All right. Next, we will hear from Tom Venzor. Good afternoon.

TOM VENZOR: Good afternoon, Chairwoman Bosin and members of the Judiciary Committee. My name is Tom Venzor, T-o-m V-e-n-z-o-r. Now, usually on this topic you'd hear from Marion and Minor, but today you get the B team. So it is important to repeat that the-- and I'm the Executive Director of the Catholic Conference if I didn't say that. It is. It's important to repeat 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. 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 in seeking healing must be treated with respect and dignity. The conference supports LB731 because it would provide some reasonable measures to seek redress for those who previously sought or have been steered into medicalized gender transition procedures and have been injured by those interventions. The injuries that result from transitioning are devastating. Loss of sexual function and loss of fertility are perhaps the most well-known, but these are not the only types of injuries that result from these interventions. Medicalized transition involves, at minimum, the prescription of cross-sex hormones that must be taken continuously for life, if the person receiving them wishes to preserve the surface-level appearance of the opposite sex. At 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. The same goes for surgery. When a person's body is subjected to the manufacture of new, artificial reproductive organs, often supplemented by skin grafts and other parts taken from elsewhere on the body, the body recognizes the manufactured part as a wound and attempts to heal it. To prevent this healing and preserve the appearances of cross-sex reproductive organs numerous and repeated surgeries take place to rewound the body. When a person realizes that this battle against a body cannot be finally won, often after years beginning-- of beginning this process, the psychological devastation that often takes place can be staggering. So can the financial costs already incurred and the new expenditures that are required to help the body's attempt to return, as far as possible, to normal. It is our position that the performance of medicalized gender transition is always and everywhere malpractice. It's an intentional wounding of the body that must be repeated many times over a lifetime to preserve appearances. Persons subjected to these injuries at the hands of an industry that profits, profits lavishly from them, ought to have the chance to heal, and the industry

that injured them ought to help. We respectfully urge you to advance LB731 to General File, and I thank you for your time and consideration. Happy to take any questions.

BOSN: Thank you. Any questions for this testifier? Thank you for being here.

TOM VENZOR: All right. Thank you.

BOSN: Yes. Next we will hear from, is it Jamie Reed, or?

KAUTH: She may still be in the other room.

BOSN: And that's fine. We'll come back. So I see Kathy is here. Kathy Wilmot. Good luck to you and welcome to you.

KATHY WILMOT: Thank you for this opportunity. Hope you're all having a good day. My name is Kathy Wilmot, K-A-T-H-Y-W-I-L-M-O-T, and I'm here on behalf of the National Eagle Forum. I serve on their board and also for Nebraska Eagle Forum members across the state. When I look at the Internet, I find that the ACLU site says that they are champions for transgender, nonbinary, and gender nonconforming people's rights to be themselves in any situation. When you're doing research, though, it seems to be pretty hard to find other organizations and legal entities that protect the rights of individuals who are wanting to detransition. They also, when they get to a certain point, often realize that they've been lied to. And a particular case that we know of-- more than one, but when they go back to their doctors or counselors, no one wants to recognize the fact that you can detransition. They think that that can't be done. They're often told that, well, maybe you're just transitioning now into something-- another category. And that can be really concerning for the individual, very confusing, they feel devalued, and they have nowhere to turn. Excuse my voice here. If they find that they want to pursue doing something about the body parts that's been destroyed or removed, they are looking at a lifetime of all these medications. They have infections, many things that they describe that they're having to live through that's a result of the procedures that was done. And I've personally visited with several transitioning individuals and a common thread that I first started hearing and then the more I hear it, it really concerns me. They're often, they can't be in counseling with their parents, a lot of times if they're younger and they find out at some point in time the parents have actually been told that the individuals are suicidal and the parents then are presented with you

can have a dead son, if it's a, a lady or girl, or you can have a live daughter. And you know, how many of us as parents-- we would walk over nails and glass to protect our children. And so, the parents are presented with quite a dilemma. And often, you'll find that these parents have agreed, maybe, to these procedures, when they didn't really want to. But someone needs to be held accountable. That's where we're at today. There's so much that needs to be done at that point, for them. They're facing all kinds of medical procedures, perhaps, to try and get back to what they were or know, now that they are. And they're faced with entities that don't want to cooperate with them, that won't help them, that will not help cover expenses, et cetera. And that's where you all come in, on behalf of, of the individuals, here in Nebraska. There needs to be some kind of a, a answering from these entities that have been untruthful with them, and they need those helps to recover from their damages.

BOSN: Thank you. Let's see if there's questions. Any questions for this testifier? Thank you for sharing.

KATHY WILMOT: Thank you.

BOSN: Yes. Next we'll move on to Wes, if that's OK, just since I see you sitting up there. Tough act to follow.

WES WILMOT: Yeah, I know. I think we should have looked our testimony over.

BOSN: Welcome.

WES WILMOT: I'm Wes Wilmot, W-e-s W-i-l-m-o-t. I'm from Beaver City. Thank you, Senators, for all the things you put up with here and for being here for us. I'm here in support of LB731. Several years ago, I was privileged to meet a young woman who, who was de-- detransitioning. After beginning hormone, hormone therapy and removal of healthy female body parts, upon the decision to detransition, she returned to the counselor who had recommended hormone therapy and sex reassignment surgery to ask for help. The counselor wrote her off as saying she just wasn't done transitioning yet, or she was binary, maybe she was gonna be both. But they just wrote her off, and gave her no help at all. So next, she consulted the endochronologist, who put her on the hormones and the puberty blockers. The doctor could not answer simple questions, as what are the long-term effects of the meds that you've given me? And would her body ever be healthy again? And would she ever have normal hormone levels? Could she ever have

children? The young lady requested regular blood tests to com-- to compare to the normal female-- and fema-- excuse me-- and to be compared to a female growth chart. They would not do that. They would only compare it to the male growth chart. And they even refused to recode her in their files and change her name back to her female name and change her gender back to female. The medical provider was Kaiser Medical, who-- they totally remained unhelpful. Basically, in the medical health system, a detransitioner does not exist. There's no medical basis for that. So therefore, it's a little hard to get help from anyone when you don't exist. The young lady has sued Kaiser in 2023, and a couple of the issues referenced in her suit is the failure to advise her of what she was facing, what the dangers were, what the side effects might be, and also, the manipulation that my wife talked about. She never-- she denies ever mentioning suicide in any of her sessions. And yet, her parents were told that, you know, would you rather have a live son or a dead daughter? And she did not know that at the time. She just thought her parents rec-- you know, thought this was the best thing to do. So she-- that's one of the reasons she's suing them. Yeah, again, she, she maintains she never said that. She just said, I'm uncomfortable and confused with my situation. That's what she told her counselor. And in conclusion, the medical profession has been experimenting on children for decades. This is a crime. In January 2025, the President signed an executive order to ban such experimentation on children, and we need to, to support that here in this state. We need to stop this practice and we need to get some help for the people that are already-- have been sucked into this grinder. Get them some help. If they want to stay in it or if they want to get out of it, they need help. The medical profession opened their doors wide open when you wanted to transition. And now all of a sudden, you're in there. You know, whatever. Take care of yourself. Thank you.

BOSN: That's your time. Let's see if there's any questions. Any questions? Senator Storm.

STORM: Thank you. And I have a quick one. So how old was the female you were talking about in your story?

WES WILMOT: Pardon?

STORM: What was her age?

WES WILMOT: 13.

STORM: 13.

WES WILMOT: When she started her hor-- her puberty blockers and her transsexual hormones, she was 13.

STORM: OK.

WES WILMOT: She had her surgery when she was 15. She's now in her 20s and wishing to return to being a female, and nobody wants to hear it.

STORM: OK. Thank you.

BOSN: Thank you for being here. All right. Next, we'll move to Merlin Wehling. And if I pronounce these wrong, my apologies. Good afternoon and welcome.

MERLIN WEHLING: Yes. Thank you. And thank you, guys, for allowing me to give a testimony. Yes, my name is Dr. Merlin Wehling, M-e-r-l-i-n W-e-h-l-i-n-g, and I practice as an anesthesiologist-intensivist in Kearney, a lifelong Nebraskan. Been-- my entire private practice has been in Kearney. I don't represent any organization, just the physicians in Nebraska that are concerned about what is happening to our youth and protecting their, their, their safety. I know it kind of seems a little odd for, you know, a physician to be in here talking about malpractice and extending that. You know, to me, it gives me a little pause, as well, because I'm like, do I really want to do this? And, and the answer is yes, because these patients have no help. These patients are, are, are left out there. I've seen these patients. And this bill would give them that financial help that they need, not just today or tomorrow or, you know, during that initial transition surgery, but, you know, a lot of times, for that inevitable complication and side effect down the road. So it's-- I want to tell you a little bit about this patient that I was taking care of in pre-op. I went to go see them for-- you know, I can't remember exactly the complication. It was a, a, a scarring, or a scar tissue, wound revision or something. The patient was in their early 30s, and they had transitioned using hormones and, and, and things-- procedures in their early teens. And now, they're dealing with these lifelong effects of the scarring and the pain and, and et cetera, et cetera. As I was kind of talking to her about the surgery and the anesthesia-- and, and she kind of confessed to me and, and her significant other that they wished this had never happened. They wished that this process or this procedure had never been done to them, you know, being young and, and not consenting age. I, I felt really bad for her, her, her-- him. And what do you do when, you know, you're, you're paying out of pocket to have some of these reversals and to deal with the

complications with it? The, the, the idea of the sex change procedure is not as-- you know, like other procedures, in the fact that we don't know what the long-term outcomes are. We don't know what these, you know, kind of initial things do. The, the, the reports you've heard about before, this Cass study and the HHS study that's done in America, all have recommended that we don't have these procedures and these drugs for kids. But what about the kids that have already been down that road? You know, it takes an average 8 years into this procedure to even figure out that you didn't want it, let alone deal with all the complications. So the payers today, you know, will not approve a procedure that's permanent sterilization unless you are, you know, above the age of 21, and you have to wait 30 days, you know, before you get that, you know, ligation, vasectomy, oophorectomy, or orchiectomy. So why would we allow the insurance companies not to be liable for this when such a long-term duration is, is at stake here? So, yes. Go ahead, for questions.

BOSN: Thank you. Any questions for this testifier? Seeing none, thank you very much for being here.

MERLIN WEHLING: All right. Thank you.

BOSN: You bet. Next, we'll move to Sarah Stockton. That's OK. Is Erin Friday here? All right. Good afternoon and welcome.

ERIN FRIDAY: Thank you. 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 group has parents with current trans-identified children and adults. I am also a mother of a daughter who used to believe that she was born in the wrong body. But luckily, before she was able to irreversibly harm her body, she accepted her female sex. I work with detransitioners. These are people who were promised relief for their distress over their bodies if they only altered themselves to reflect another sex or a nonnaturally-occurring body. But not surprisingly, the promised Nirvana wasn't reached. One such woman is Layla Jane. Despite the doctors knowing her severe mental health issues, they coerced her parents to consent to puberty blockers and testosterone at age 12 and removed her healthy breasts just as she turned 13. Her mental anguish only increased. She lost sexual organs, lives with an enlarged vocal cords that deepened her voice, she has male-like baldness, and abnormal hair growth. Her fertility is unknown. What is known is that her lawsuit against the male-- the medical providers who harmed her body are walking away scot-free. They will now continue to carve up healthy bodies because of a short statute of limitations.

Sadly, sometimes it takes lawsuits to stop people from profiteering off of other people's misery and desperation. Layla's story is hardly unique. Those harmed by the gender medical complex struggle to hold their doctors accountable. Take Abel Garcia. He thought he was a woman and was immediately approved for hormones, and later, with no gatekeeping, obtained fake breasts completely covered by insurance. When he stopped believing that he was a woman, he had difficulty getting approval to get those breasts removed. The medical providers questioned whether his childhood trauma was the reason he no longer wanted to be trans. Tragically, no one asked him that question before he started hormones and before he went under the knife. Abel finally received doctor approval to remove the fake breasts, but then his insurance carrier denied coverage. They ultimately-- he ultimately won the appeal, but for more than a year, he had to walk around with the shame of having female breasts or wear binders. If insurance is required to cover the diseasing of a perfectly healthy body, it must be required to cover consequences and the cost to try to repair it. I'm available for questions.

BOSN: Questions for this testifier? Senator Holdcroft.

HOLDCROFT: When typically does re-- regret set in for someone who's under-- undergone sex intervention, intervention?

ERIN FRIDAY: So, the studies show about 5-10 years, but, but the regret-- to, to understand what, what gender intervention is like, is first, the person is told that if you do X, first you socially transition, you're going to feel better. You don't feel better. OK, then let's move you on to puberty blockers. And then, they move them on to cross-sex hormones. And so there's a cascade, and it happens over years over years. And finally, when they get the surgeries, then the patient says, I still don't feel better. Actually, I haven't changed sex. You promised I would change sex, and you haven't. And that's when the wake-up and the regret hits. Also, children don't mature until they're 23 or 25. Long-term consequences. We have laws on the books, I think you do, too, in criminal cases, why we don't charge children as adults, because they are unable to understand long-term consequences. And it's not until they are hitting the age where they think, I do actually want to have relations, I do want to sex and it hurts, or I do actually want to have children that they realize they can't.

HOLDCROFT: What age is-- I mean, I can't imagine somebody in their 40s or 50s all of a sudden deciding they want to transition. I mean, is

this mostly an issue for our teenagers and, and young, young adults or does it, does it, does it, does it go all the way through age?

ERIN FRIDAY: No. We see the, the massive uptick, because it's a social contagion, in the under 18. Here in Nebraska, I think, over 7 years, it increased by 436%. The 18-24 in Nebraska, of people saying that they're trans-identified, increased by over 600%. And then you see a drop off.

HOLDCROFT: Thank you.

BOSN: Senator Storer, followed-- oh, Senator Storer.

STORER: Thank you, Chair Bosn. And thank you for being here. I'm going to ask a really perhaps ignorant question, but one that I think might be on some other people's mind. Currently, do you know, does every state require insurance to cover the transitioning surgeries or-- and medicine? The, the whole process to transition, is that a requirement?

ERIN FRIDAY: As far as I know, and I may not be correct, is Florida does not cover it, but yes. Transitional medicine is covered by-- certainly by my state. I'm in California, unfortunately. But yes, it's cov-- it's covered.

STORER: OK. So they're, they're required to cover their transition, but not their detransition.

ERIN FRIDAY: Correct. But they're not required to cover the fix. And in fact, the doctors flee. So these detransitioners go back to their original doctors, and they just raise their hands, and say, sorry. We don't know what to do for you. In fact, there are no ICD codes and those are the codes for insurance. That's how insurance carriers are paid-- for detransition. It's only a one-way street. And then they're kicked to the curb.

STORER: Thank you.

BOSN: Senator Storm.

STORM: Thank you. Thank you for being here. So what's the percentage-- and maybe somebody mentioned this already. What's the percentage of people who transition wanted to transition back? Was that mentioned? Is there--

ERIN FRIDAY: So we don't study that--

STORM: You don't know that?

ERIN FRIDAY: --which is malpractice in and of itself.

STORM: Right.

ERIN FRIDAY: Right? So we do these harms and we don t track what happens to these kids. I asked the, the doctor who brought pediatric gender medicine to the United States. I said, how many of those kids have you followed up on? The answer is zero. They don't follow up, so we don't know. The closest studies that we have shows at least a 30% regret rate. But again, we're not tracking it. And, you know, the doctors don't, don't track whether their patients stop coming to them for the drugs. They just-- they're gone. So they give the child testosterone for a year, she doesn't come back, they don't make note of that. They move on.

STORM: I got one more question. So this would be suicide question. And I kind of researched this a little bit before, but what's the percentage, in your research, of people who transition that attempt suicide?

ERIN FRIDAY: There, there are a couple studies on the suicidality post-transition. The Dutch-- or sorry, the-- Denmark did a study, and it's 3.5 times higher post-transition. Sweden did a study. It's 19% higher post-transition. And the gender clinics actually did their own study that's been nicely buried. So what happened was the NIH commissioned a study on pediatric gender transition. And in the first year, out of 315 patients, 2 children committed suicide. Those 2 children were being subjected to puberty blockers and cross-sex hormones, they had families that supported them, and they were at the biggest gender clinics in the United States. 2 out of 315. In a normal world, that would have ended that study, but they buried that data.

STORM: That's all I have. Thanks.

BOSN: Thank you very much for being here.

ERIN FRIDAY: Thank you.

BOSN: Yes. Next invited testimony comes from, is it Christina Vosilla, Vosilla? I apologize if I totally butchered that last name.

CHRISTINA MARIE: Don't worry about it. Everyone does it.

BOSN: Welcome.

CHRISTINA MARIE: Hi. Good afternoon, members of the committee. I thank you for the opportunity to testify here today. My name is Christina Marie, 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 have 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, just 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 of 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. 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 not about that. It is a slippery slope 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. 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 lobby's inner core. The vast majority of gender-nonconforming children grow up to be gay. The trans lobby is pushing for gay conversion therapy by medicalizing gay kids 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. This logic goes against everything the gay community has historically fought for, and being gay is not a choice and you cannot escape it. Attempting to escape it without consequence-- 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, pelvic dysfunction, vaginal atrophy, that can lead to eventual prolapse and early onset osteoporosis, and I haven't even gotten to the surgeries. Children cannot consent to harmful and irreversible procedures. The laws being proposed today are needed. Inducing physical disease in the body isn't healthcare, and having funded this without funding a resolution is just plain wrong. 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. I urge you to support these kids by giving them the time they need to come to terms with what has been done to them and by covering their needs so that there is a path forward to them, whether they identify as a detransitioner yet or not. I urge you to vote yes on LB731. Thank you.

BOSN: Thank you very much. Any questions for this testifier? Seeing none, thank you for being here and sharing your story. All right. Next, we have Pear Davis. Nope. Jess Raburn?

JESSICA RABURN: Yeah. My name is Jessica Raburn, J-e-s-s-i-c-a R-a-b-u-r-n. I'm here today as a member of the LGBT community in strong support of LB731. This bill would compel insurance companies that cover gender transition procedures to also cover treatment of the harm that so often results from these procedures and drugs. It would also extend the statute of limitations to recover damages when such harm is done. The harm is not trivial. Male-to-female bottom surgery has a 70% complication rate. Female-to-male bottom surgery has a 76% complication rate. No other area of surgery has or would tolerate this degree of post-surgical complication. Surgical patients are at high risk of fistulas, essentially a tunnel from one part of the body to the other, urethra strictures, narrowing, tissue death, incontinence, and infection. Nearly 95% of women who take cross-sex hormones develop pelvic floor dysfunction, which is difficulty emptying the bladder and the bowels. 52% experience vaginal atrophy, thinning of the walls, common in menopause. Vaginal atrophy can lead to vaginal tearing. The risk of heart attack increases nearly five-fold. Nearly a quarter of male patients develop osteoporosis and are at high risk-- a higher risk for pulmona-- pulmonary embolism and endocrine disorders. Contrary to the myth that tran-- that transitioning decreases suicide risk, multiple studies have found that it actually increases suicide risk, which is logical when you think of the chronic and never-ending pain that can result from these surgeries. People deserve coverage of their healthcare needs, including reconstructive surgeries and ongoing screenings to monitor side effects downstream of the covered transition services, no matter their transition status. Moreover, people don't always realize the extent of damage done until the dust settles and reality sets in. The current statute of limitations to sue for malpractice in this state is 2 years, and that is far too short. Someone who detransitions must come to understand that they have made a mistake, that the treatment givien to them has caused harm, and then

take steps which may cost them their entire social circle. We know from detransitioners that there can be a devastating social cost on top of the physical. I have trans friends and acquaintances. As I prepared for this testimony, one in particular came to mind. I have a friend who had bottom surgery to construct a neo-vagina. This is a surgery that can fail spectacularly. Often, it requires multiple revision surgeries. A common complication is an anal fissure. That leaks, that leaks feces into the neo-vagina. The treatment is very difficult and it's-- also can be very life-threatening. If such complications arise, will my friend be able to get treatment, and who is going to pay for it? Thank you.

BOSN: Thank you for being here. Let's see if there's any questions from the committee. Any questions for this testifier? All right.

JESSICA RABURN: Thank you.

BOSN: Thanks for being there. Yes. Next on the list is Lance Kinzer. Is Lance available?

LANCE KINZER: I am.

BOSN: Come on down.

LANCE KINZER: Thank you.

BOSN: Good afternoon and welcome.

LANCE KINZER: Thank you so much. My name is Lance Kinzer, K-i-n-z-e-r, and I'm here on behalf of First Amendment Partnership. I am an attorney, although a Kansas attorney, so if you want to hold that against me-- and I served in the Kansas Legislature for a decade and chaired the, the House Judiciary Committee there. What I want to focus on is the, the statute of limitations issue in particular, and why I think that that policy change is particularly reasonable under the circumstances. As we've already heard repeatedly, gender-altering treatments and procedures are fraught with risk and uncertainty, and the kind of, I think, big highlight of the HHS study that I think really clarifies it is that health authorities are increasingly recognizing and the exceptional nature of this area of medicine, and I think it is the exceptional nature of this area of the medicine that justifies a, a, a separate medical malpractice standard-- statute of limitations. State laws designed to protect citizens from medical harm and to compensate where harm has occurred should reflect the unique realities inherent to medical gender transitioning is basically the,

the core point. What I'd say in that regard, is that the, the structure of this bill is to supplement existing Nebraska law on malpractice and professional negligence via the gender transition malpractice accountability portion of this bill, which is basically Sections 1-6. And while persons under 19 years of age who receive a gender-altering procedure after October 1 of '23 in Nebraska have potential civil remedies pursuant to the Let Them Grow Act, this does not abrogate the applicability of Nebraska's general law regarding medical malpractice or professional negligence. And, indeed, for most Nebraskans, medical malpractice and professional negligence will remain the primary claims available to address adverse consequences from gender-altering treatments and procedures. And one of the things that I think is important to recognize is that while this bill changes the, the, the statute of limitations, it doesn't change the standard of care. And so as these claims are being brought forward, the same standard of care that applies right now will still apply. And I'll, I'll read that because I think it's worth-- it's kind of in the background of this, but it's a core point of, you know, what do you actually have to prove when you bring your case within the 12 years? And its malpractice or professional negligence shall mean that in rendering professional services, a healthcare provider has failed to use the ordinary and reasonable skill, care, or knowledge ordinarily possessed and used under like circumstances by members of profession engaged in similar practices in his or her similar locality. So my point is that the, the change, while the statute of limitations is important, it's not changing the fact that the plaintiff still has to show that there was a deviation from this standard of care. And so, this isn't just kind of wide-opening, allowing for doctors to have their past acts viewed under some unreasonable, new novel standard. The same standard's in place, and I think that's critical. The other thing I would note is that the bill would preclude professionals from seeking to use waivers to get around that standard of care, and it would codify some specific categories of required written disclosures by providers to ensure in-- "incent is conformed." And one of the common themes we've heard here is that maybe because of mental health comorbidities or age or other factors, oftentimes informed consent really is a key issue. And there are a number of areas of law where states have specified in statute that specific-- there have to be specific disclosures to have informed consent. I think it's reasonable to do so here. So thank you.

BOSN: Thank you. Let's see if there's any questions. Any questions for this testifier? All right. Thank you very much for being here.

LANCE KINZER: Thank you so much.

BOSN: Yes. Next proponent, I have-- well, let me go-- those are the list of proponents, but let me see if Jamie Reed is back. Is Jamie? OK.

JAMIE REED: Good afternoon, members of the committee. My name is Jamie Reed, J-a-m-i-e R-e-e-d. I am a lifelong Midwesterner, a lesbian, and a clinical research manager. For nearly 5 years, I served on a multidisciplinary medical team inside of a pediatric gender center at St. Louis Children's Hospital. I became the region's public whistleblower in 2003. My role required me to understand these interventions in depth. I attended urogynecological surgical conferences so I could educate medical staff on followup care. When the first vaginoplasty was performed at St. Louis Children's Hospital, I was part of the team responsible for preparing the nursing staff for care for that patient post-operatively. That patient was under the age of 22. I also fielded calls from patients who had undergone medical or surgical transitions and were experiencing serious complications-- infections, tissue damage, loss of function-- individuals who were often struggling to be taken seriously in emergency rooms. I had a patient who had bottom surgery out of state, could not refill a prescription for silver nitrate, which was being used to continuously cauterize the open post-operative wound. It was causing an intentional chemical burn to remove the unwanted scar tissue and to make sure that that bleeding eventually staunched. That patient could not seek care anywhere in my state. This patient was still trans-identified, still seeking care, and was still in pain. They deserved followup treatment. These are not abstract policy debates to me. I worked in a pediatric gender center. These were my patients. In medical malpractice law, we often assume that when something goes wrong, a patient will recognize it quickly. But real life, it's not that simple. Imagine that you are a patient who wakes up from surgery and was told everything went well. Months later, you develop unexplained pain, then infections, then loss of function. Years pass before the correct scan is finally ordered and it's only then that it is discovered that a surgical instrument was left behind inside the body. Those cases have occurred. In cases like this, the law recognizes that justice cannot depend on when the injury occurred. Now consider these different patients. Someone who sought out gender transition medical interventions in good faith, they were told that the treatment was necessary and evidence-based. And years later, they came to realize that that intervention caused them irreversible harm. Should that person be told that they are out of time before they even understood what happened to them, or should they

be afforded their day in court? These harms are not limited to surgery. Within professional settings, the long-term hormone and puberty blocker interventions risks were discussed openly. We discussed sometimes, though, how we could manage to make the number of patients returning with seriously complications go away. What troubled me most is that our conversations often focused on how we could get our injured patients to simply stop calling and stop complaining, rather than confronting the medical failure directly. This is not legislative overreach, overreach. When a profession departs so dramatically from established standards of evidence, disclosure, and patient protections, it risks undermining public trust in medicine itself. Elected bodies have a duty to restore guardrails, and this bill would be a course correction that would bring back calm, rational, evidence-based care to the public offering in your state. I respectfully urge your support. Thank you.

BOSN: Thank you. Let's see if there's any questions. Senator Storm followed by Senator Holdcroft.

STORM: Thank you. Thank you for testifying. So are you a nurse?

JAMIE REED: No, I hold a master's of science in clinical research--

STORM: OK.

JAMIE REED: --management and worked within the gender center as the clinical research coordinator.

STORM: OK. Do you think it's ever-- having this type of surgery is ever beneficial, or do you think they should-- does that make any sense at all? I mean-- or is it always a phys-- a physical risk to do this?

JAMIE REED: The benefits are essentially purely cosmetic. There-- are you asking if they're physical risk or what they are?

STORM: Well, I'm just trying to ask-- it's a tough topic. I mean, is it just-- I mean, these surgeries take place. Are you saying that the benefits are minuscule in these types of surgery, or they should never take place, or? I'm just curious.

JAMIE REED: I believe it was stated before that these are some of the surgeries that have the highest complication risks in any sort of surgical field. When I worked with the urogynecologists that were performing these surgeries--

STORM: Yeah.

JAMIE REED: --one of the things, going in, that they knew, was that these patients were almost guaranteed to require multiple revisions, and some of those required revisions were to just handle basic functions of life-- the ability to use the bathroom, the ability to defecate. We have patients who were put on colostomy bags and put on-- you know, things that had to be attached to their body to be able to just go through their daily functions. These are incredibly challenging procedures that have, not only high complication rates, but when we first started developing these surgeries, in the first 70 patients, one of the children died from this type of surgery. To go in to have a vaginoplasty, they died from a massive septic infection.

STORM: I got one last question. So you're in St. Louis, working in a clinic. So do they have specialized clinics that perform this, or does this happen in regular hospitals?

JAMIE REED: That's a really good question. So, I worked in the St. Louis Gender Center at St. Louis Children's Hospital. This was so new that we were actually pulling over the surgeons from the Differences of Sex Development Center. These were surgeons who were trained to care for patients who had intersex conditions. They were learning as we go. The first vaginoplasty was done in a children's hospital and it was done by two surgeons who had never done so before and had just learned how to do the procedure. We had nursing staff that were so uncomfortable that they were fighting with their management to not be a part of the case, because they were so worried about the harm and the complications.

STORM: So do they-- how many-- does this happen in every state, or is it in certain states where they're performing these type of surgeries?

JAMIE REED: For adults, surgical procedures are still legal in basically every state in the country, except for Puerto Rico recently passed a law going up to, I believe it was 21, that they're scaling this back.

STORM: OK.

JAMIE REED: But for minors, half of our country allows these procedures to occur and half no longer do.

STORM: OK. All right. Thank you.

BOSN: Thank you. Senator Holdcroft.

HOLDCROFT: I'll waive. Thank you.

BOSN: Oh, OK. Any other questions for this testifier? Thank you for being here.

JAMIE REED: Thank you.

BOSN: Yes. All right. So then we had-- is Sarah Stockton here yet? No? Oh, that's the one that you said didn't make it. And then, the last one is Pear Davis. No? OK. All right. Next, we will move to invited opponents. And I recognize some of them are still in the other room, so I'm going to try and get through the names that I have that are here, and then we may have to come back to them, if that's all right. We do have an ADA testifier, Alexander Liu.

ALEXANDER LIU: Are we waiting for people to come back in, or?

BOSN: I'm sorry. What?

ALEXANDER LIU: Are we waiting for people to like, come back in, or?

BOSN: You're welcome to go ahead and get started. The-- people may be coming and going as we're going, so.

ALEXANDER LIU: OK. So as you said, hi, my name is Alexander Liu. That is A-l-e-x-a-n-d-e-r, and Liu is L-i-u. And then, this is Keigo, K-e-i-g-o, because everybody asks. And I'm here to oppose LB731. As you can see, I'm obviously disabled. I actually have a tectal glioma. It's damaging my optic nerve and my auditory cortex, and caused something called obstructive hydrocephalus. So what that basically means is I have a benign brain tumor that is damaging my optic nerve and has caused some like, vision damage and some damage to my hearing. That's why I'm low vision and will actually lose my vision fully. I had to have a brain surgery to address the obstructive hydrocephalus, because what that does is it means that the tumor grew to the point where it blocked this flow of cerebral spinal fluid, and it caused, essentially, to my brain to become a pressure cooker, which is real fun. So they had to go in and make a little hole, create another drain. Obviously, that's kind of dangerous. So, I think, Senator Storm, you were asking the wrong question, about, you know, these surgeries and stuff. Because every surgery has risks, depending on what the surgery is. The more they do surgeries, obviously they're going to get more experience with it. My-- I was very lucky that I

did-- that my surgery happened at UNMC and my surgeon was one of the top in the country. He's very experienced. If they had happened to-- because they found my tumor on accident. They didn't know it was there for a long time. It caused problems, and if I had-- they had discovered it somewhere else, I may not have had, had an experienced surgeon, right? I'm not saying that malpractice is not a problem. It definitely is. But you cannot make legislation based on-- like, it cannot be disorder-specific. Because when you create disorder-specific legislation, you're going to cause it-- you're going to make it so like, doctors are not going to want to work on or diagnose and treat certain disorders. And this is not like a, just a trans-specific thing, because people forget that gender-affirming care is not only for trans people. There are plenty of cis people who have to get this care, too, especially kids. So there is a disorder called gynecomastia that affects like boys, which will cause them to develop breasts. It's a hormone disorder. They have to get HRT to deal with that. Women have to get-- they have endometri-- endometriosis. And that is also something that is treated with a evil hysterectomy, but they do try to use some HRT first to see if that alleviates it. But these are things that would be falling under gender-affirming care. So if you create legislation like this, people are not going to be able to get treatment. And again, those are not trans people. Those are what you would qualify as, like, normal people, and doctors are not going to want to treat that because they'll be worried about getting sued. Again, malpractice is a problem. As somebody who is chronically ill and has like, rare disorders doctors never want to deal with, it is really an issue when doctors do screw stuff up and you can't do anything about it, because they've created a system-- makes it really hard for accountability But that's something you would have to create legislation that is more broad and it's dealing with the malpractice itself and not specifically for a condition, so that you're actually addressing the problem and not just trying to target certain people. Otherwise, you're just kind of adding to the problem. Because then, doctors are not going to want to treat people. They'll just be worried about getting sued and not trying to do their jobs. But also, I will point out that if you didn't understand, like, what I said at the beginning of the speech, like my actual medical conditions, that you also shouldn't be creating legislation targeting medical conditions in general, because you don't understand the medical terms, and then you're likely to accidentally prevent medical treatment for somebody like me, who, again, would have died without that treatment. Right? So thank you for letting me speak.

BOSN: All right. That's your time. Yeah. Let's see if there's any questions. All right. Thank you very much--

ALEXANDER LIU: Oh, thank you.

BOSN: --for being here. Our next invited testifier is Robert Bell.

ROBERT M. BELL: Good afternoon, Chairperson Bosn and members of the Judiciary Committee. My name is Robert M. Bell, spelled R-o-b-e-r-t, middle initial M, last name spelled B-e-l-l. I'm the executive director and registered lobbyist for the Nebraska Insurance Federation. I am here today in respectful opposition to LB731. I have also been asked to add the Nebraska Chamber of Commerce and Industry to the record in opposition to this legislative bill. This is my first time before the Judiciary Committee this session. So as a reminder, the Nebraska Insurance Federation is a state trade association of Nebraska insurance companies. The federation has 50 insurance company members, which include companies that write all lines of insurance, including life, property, and casualty, and relevant to the health insurance mandate provisions of LB731, most of the health plans operating in the state, including Blue Cross Blue Shield of Nebraska, Medica, Nebraska Total Care, Aetna, United Health Group, and Cigna. The Nebraska Insurance Federation has historically opposed, opposed most health insurance mandates introduced in the Nebraska Legislature. Coverage mandates ultimately lead to higher costs for consumers of health insurance. This happens for a couple of different reasons. First, is the cost of the mandate itself. Over the years, I have found with health insurance mandates, most, if not all insurers are actually covering the service mandated in the legislation, but it may be a question of how that service is covered. However, if the insurer does not cover that service or covers it in some unique way, the new cost must be accounted for in premiums. Second, one of the costs of mandates are the ability-- relates to the ability of insurers to negotiate appropriate rates with healthcare providers. I call this a hidden cost. If an insurer is required to cover the service, it impedes the ability to negotiate a fair rate because it has an inability to say no. The committee should also be aware that health insurance mandates passed by the Nebraska Legislature have a limited scope. As a function of both federal and other state law, this provision-- the provisions of this mandate would not apply to ERISA plans. That's large group employers, Medicare plans, or agricultural organization plans. The burden of state mandates fall on the individual insurance market and the small employer market, as well as state and local governmental plans. The cost of these plans, without

either governmental or employer subsidies, are running from $25,000 to $35,000 annually for Nebraska families, depending on age, children, smoking status, et cetera. The specific coverage mandates in LB731 are admittedly, once, a first impression for Nebraska insurance companies. Section 7 contains the health insurance mandates and like many other mandate legislation that we encounter, we're actually not certain that we don't provide that coverage. So we believe we do provide care when medically necessary. Also, given the complex nature of federal law, policy language, et cetera, the federation at this point is not going to ensure what the correct language might be for a mandate to match current practice or achieve the results, either the supporters, opponents, or whoever may seek. Senator Kauth and I have had a couple of conversations on this issue in this past week. One final note, both liability insurers and healthcare provider members of the Nebraska Chamber have concerns about the increased liability exposure of healthcare providers. May I finish my statement?

BOSN: You may.

ROBERT M. BELL: Thank you. In LB731, increased liability exposure for healthcare providers lead to both higher insurance premiums for both liability and health insurance. For these reasons the Nebraska Insurance Federation respectfully opposes the passage of LB731. Appreciate the opportunity to testify.

BOSN: Thank you. Questions for this testifier? Senator Storm.

STORM: I have a quick question here. Thank you for being-- so one testifier testified that they will pay for-- insurance will pay to transition. They will not pay to detransition. Is that correct or do you know?

ROBERT M. BELL: That depends on the policy, what the policy provides for. So there may have been policies in the past that have paid for it. And the way this particular mandate is, is worded, if, if you had provided such policy language in the past, then you would have to provide for re-transitioning in the future or other types of care. So-- but it-- there, there-- things have happened, both at the federal level and, and-- there's been changes in administration and changes in rules and regulations related to health insurance and what insurers must cover and must not cover. I think there was an executive order that was mentioned earlier today. So it's a dynamic area of law with a, with a lot of change in it. But certainly, there have been policies

in the past-- insurance policies in the past that have covered sex transition services.

STORM: One last question. So-- but you will cover-- if someone has the transition surgery and then they have any complications, that would be covered under the [INAUDIBLE]?

ROBERT M. BELL: Absolutely. In fact, I was listening to complications from surgery that are emerging that are emergencies. Right. It doesn't matter what healthcare provider you go to in that situation. The insurance company must step up and, and provide coverage. Sometimes, when we use the word "coverage" and "health insurance," there's, there's a misunderstanding. They're like, if I go and I have a procedure done and it costs me $4,000, right, to have said procedure done, and I'm like, dang, then, my insurance doesn't cover it. Well, it is covering that service. It's just under my deductible, so I have to pay that $4,000 out-of-pocket. But yeah, certainly mental health resources, things like that, that are medically necessary would be, would be covered. I think it's an open question on, on another transition. That's why I say it's kind of been a, a question of first impression for us. It's not something that we run across a lot. And a-- you know, a lot of what I heard was from other states, so-- and I can't speak to what is happening in other states.

STORM: OK. Thank you.

BOSN: We don't currently mandate that you cover--

ROBERT M. BELL: No.

BOSN: --transitions, so this would be--

ROBERT M. BELL: And I would oppose that, as well.

BOSN: OK.

ROBERT M. BELL: So, just to be clear.

BOSN: You oppose all mandates on [INAUDIBLE].

ROBERT M. BELL: You got to have some principles at some point, right? So--

BOSN: I appreciate that.

ROBERT M. BELL: Yeah. We oppose mandates. All mandates. All opposed. There's, I don't know, 6-- gosh, I almost said 6-7. But there's--

BOSN: Oh, don't say 6-7.

ROBERT M. BELL: --a number of mandates pending before the Banking, Commerce, and Insurance Committee that Senator Hallstrom will get to hear from me about, later.

BOSN: Well, I won't want to steal that thunder from--

ROBERT M. BELL: Sure.

BOSN: --you getting to tell him in that room. So I have no further questions, unless that has sparred any other-- thank you for being here.

ROBERT M. BELL: You're welcome.

BOSN: Next, we have-- is it Carmen Skare or Skare? Skare. Sorry. Welcome.

CARMAN SKARE: Thank you, Senator and members of the Judiciary Committee. My name is Carmen Skare, C-a-r-m-e-n S-k-a-r-e, and I appear before you today in opposition of LB731, on behalf of the Nebraska Psychological Association. This bill would create a new, extraordinarily broad malpractice framework that dramatically expands legal liability for healthcare, redefines medical practice law, and threatens access to care for Nebraskans, all based on vague and overbroad definitions that are ripe for unintended and harmful application. Specifically, we are concerned with: 1) The extremely broad definition of provider. The bill defines provider to include any physician, mental health professional, clinic, hospital, or other entity involved in recommending, approving, or providing a gender-altering procedure. This definition is unbound and could logically include mental health professionals conducting standard diagnostic assessments in clinics where referrals are made. Such vagueness invites litigation against any health professional who even talks with a patient about gender-related care. 2) The broad scope of gender alteration and gender-altering procedures definition. Define-- the bill defines gender alteration as the process of moving from identifying with one's sex assigned at birth to identifying with a different gender, including, quote, social, legal, or physical changes. This definition is extremely broad and vague and lacks clear boundaries around who or what is covered. Terms like involved social,

legal, or physical changes are open-ended, creating the potential to include anything from changing a name or pronouns to medical or surgical interventions. Without specific limits, the language could be interpreted to encompass routine social or legal steps that are unrelated to clinical care. Further, it defines gender-altering procedures to include other mechanisms to promote the development of feminizing or masculinizing features in the opposite sex. This could encompass any mechanism to promote physical characteristics-- language that could be interpreted to cover procedures far beyond its intended scope. There's no clear boundary. Could this include voice therapy, feminization or masculinization surgery, laser treatments, orthodontics, hair transplants? 3) The expansion of malpractice liability without clear scientific basis; and 4) the unintended and broad consequences for healthcare in Nebraska. Taken as a whole, LB371 [SIC] would create extraordinary liability exposures for an extremely wide array of health professionals, increase insurance costs for all Nebraskans, chill medical advice and referrals, even when care is medically indicated, and undermine recruitment and retention of healthcare professionals at a time when Nebraska is already experiencing a workforce shortage. LB731 is not targeted patient protected-- protection. Excuse me. It is an overly broad, poorly defined, and legally unprecedented overhaul of malpractice law that would disproportionately burden providers and jeopardize access to healthcare across Nebraska. For these reasons, we respectfully urge the committee to oppose LB731.

BOSN: Thank you. Any questions for this testifier? Seeing none, thank you for being here. All right. Next, I have, is it Rachel Oxley? Good afternoon and welcome.

RACHEL OXLEY: Yes. Thank you, Chairperson and members of the committee. My name is Rachel Oxley, R-a-c-h-e-l O-x-l-e-y. I live in Lincoln and reside in District 2. I am a licensed clinical social worker who provides essential care to gay and transgender youth. I have been in practice for 11 years. I stand alongside my colleagues at Kindred Psychology in opposition of LB731. Today, I will share the bill's violations of existing Nebraska law, ways in which the bill will block healthcare access to Nebraska youth, how it will obscure regulations for providers, and recommendations for alternative evidence-informed policy. Nebraska's Hospital Medical Liability Act of 1976 covers all healthcare providers, not all but gender-affirming providers, all. The law can be summarized in the following points: to ensure accessible and affordable healthcare for Nebraskans, to preserve affordable liability costs for providers, to maintain growth

of providers in our state, and to protect Nebraskans from medical harm. The malpractice parts of this law include a review panel, comprehensive protections for the patient, and a negligent standard, whereby if the provider is found at 50% or more fault, the license cannot be recovered. Healthcare providers have multiple entities governing our practice. This includes codes of ethics, standards of care rooted in evidence-based research, and Nebraska DHHS regulating our license. Comprehensive degrees of scrutiny already exist. Let these systems do what they were thoughtfully and deliberately created by your former colleagues to do. The law maintains that all Nebraskans have access to healthcare, not all but trans youth, all. With a mandate that insurance covers only detransition, LB731 would remove competent and affordable healthcare from transgender youth. Multiple clients and families served at our practice have expressed that this bill could cause them to lose our support. This is another layer of inaccessible healthcare which only serves to exacerbate gender dysphoria in trans youth. The bill orders that providers neglect, compromise, and/or eliminate medically necessary treatment of gender dysphoria, that in and of itself is malpractice. Our understanding is that LB731 would expand the statute of limitations from 2 to 12 years, which would place providers in an impossible position to retrieve records which may not otherwise exist under the current 7-year guidelines. The liability insurance costs in response to the bill would deplete available providers amidst an existing provider shortage, a further violation of the existing law. The public policy research organization, Rand, determined through a systematic review, in 2024, that practices most consistent with harmful outcomes were those associated with conversion therapy. Numerous studies have shown that transgender youth are at high risk of suicide and additional negative mental health outcomes following exposure to conversion efforts. If the state of Nebraska were to pass an effective evidence-informed law specific to protect from practices of harm, we would be responsive and responsible to pass a full ban on the practice of conversion therapy. I urge you to vote against LB731 so that we can protect our healthcare providers and uphold access for our transgender youth. Thank you for your time, and I'll take any questions.

BOSN: Questions for this testifier? Senator Hallstrom.

HALLSTROM: In your opening remarks, and if you don't know this question-- answer, that's fine. You said, many cases in which this violates state law.

RACHEL OXLEY: Yeah.

HALLSTROM: Are, are we required to cover all healthcare providers under the malpractice, or would we be at liberty, if it was appropriate, to carve somebody out, as this bill, in some form or fashion, does?

RACHEL OXLEY: Required to cover all healthcare providers.

HALLSTROM: You, you said--

RACHEL OXLEY: That's, that's a fair question, and I, I can, I can certainly look at the, the terms and the definitions of that, but my understanding is that it would cover all healthcare providers.

HALLSTROM: Yeah. My point is we can make a change, whether this is the right change is a separate--

RACHEL OXLEY: Sure, sure.

HALLSTROM: --issue. We could make a change in the law not to cover all healthcare providers.

RACHEL OXLEY: You're, you're ask-- I'm sorry. I guess I'm confused, I''m confused by your questions.

HALLSTROM: That was in the form-- that was in the form of a question.

RACHEL OXLEY: OK.

HALLSTROM: I, I think-- and I'll just make a statement. I think we can carve out an exception statutorily, if we wanted to.

RACHEL OXLEY: Yes.

HALLSTROM: Thank you.

RACHEL OXLEY: Yes.

BOSN: I just have one question, and, and perhaps I'm misunderstanding the legislation, as well. But when you say a mandate that insurance covers only detransition, it would remove healthcare for transgender youth.

RACHEL OXLEY: Well, yeah. Because if, if insurance-- if, if, if the, the bill is stating that-- so under the definitions of the bill, what insurance is able to cover is detransition. So if that's all their insurance will cover, how will they have access to healthcare? Trans

youth? How will they have access to gen-- the gender-affirmative care under the gender-affirmative model?

BOSN: But there's nothing in the bill that doesn't allow transgender youth to consent to consent.

RACHEL OXLEY: But do you see how it's confusing? It, it is confusing because on the one hand, we are to, we are to abide by the rules that came out of LB574. But it's also stating-- it's laying out very clearly, this is what insurance can cover. So these are really good questions, but this is part of what makes it so, so obscure and confusing at the same time.

BOSN: OK. So you're--

RACHEL OXLEY: Because it's making it very clear that what is to be covered by insurance--

BOSN: OK.

RACHEL OXLEY: --are procedures related to detransition.

BOSN: So you're not saying it definitively says that. You're just saying that's a concern that may exist when you start listing out what is covered, that all of a sudden insurance companies would use that as sort of a carte blanche ability to say, oh, we don't cover this anymore, because you didn't list it in there as covered.

RACHEL OXLEY: Yeah.

BOSN: OK.

RACHEL OXLEY: Yeah.

BOSN: Have you ever had a, a youth that you've worked with who is transgender, who has detransitioned?

RACHEL OXLEY: No.

BOSN: OK.

RACHEL OXLEY: No.

BOSN: If you had a youth under those circumstances, I assume you would perform what would, at that point, still be gender-affirming care.

RACHEL OXLEY: The gender-affirmative model does not push anything. So-- and I know that this is-- that would be a separate conversation for LB732. But certainly, if, if part of, part of that model is, what does this mean to you, not what does it mean to me?

BOSN: Correct. OK.

RACHEL OXLEY: Yes. Yeah.

BOSN: All right. Senator Holdcroft.

HOLDCROFT: Thank you, Chairwoman Bosn. You mentioned here at the end, if the state of Nebraska would pass an effective evidence-informed law. What kind of evidence? Can you give me some example of the evidence that we would use in this law?

RACHEL OXLEY: For, for the, the recommendations for--

HOLDCROFT: Well, what your statement said, evidence-informed. So what evidence?

RACHEL OXLEY: Evidence that shows the degree to which conversion therapy is extremely harmful for trans youth.

HOLDCROFT: Can you, can you give me-- I mean, what, what specific measurements, hormone levels-- I mean, evidence to me is some kind of-- something you can measure and capture and measure.

RACHEL OXLEY: OK, so the Trevor Project's 2021 National Survey on gay and transgender mental health revealed that 83% of those who reported exposure to conversion therapy were 18 years of age or younger at the time of the therapy. We also have research that shows high suicidality rates associated with conversion therapy. We have, we have the research there to suggest that if we were to have a bill in place that would protect from harm, that would be a bill to put in place.

HOLDCROFT: I'm still not see-- hearing the evidence.

RACHEL OXLEY: I can send you more. I am happy to send you more.

HOLDCROFT: Thank you.

BOSN: Senator Storer.

STORER: Thank you, Chair Bosn. I apologize. I didn't-- I walked in a little bit after you'd started your testimony, so maybe this was

addressed. But-- and it's not meant to be duplicative of what I think Senator Bosn maybe was asking. But I guess what I'm hearing is if, if there was a youth, or a young adult, or a 40-year-old, that at some point, had the same emotional reasons and-- the same reasons that maybe they wanted to transition manifested 10 years later and they wanted to detransition, would they not be just as deserving? Should they be denied that healthcare?

RACHEL OXLEY: No. I'm not saying that. I-- the-- if somebody wants to detransition, I'm not suggesting they should not do that.

STORER: So--

RACHEL OXLEY: I'm not saying that.

STORER: So to the question, I guess, earlier, as well, the suggestion that, that this bill, LB-- the provisions in LB731 would, would limit the access to those healthcare services for, for individuals that want to transition, which I don't see--

RACHEL OXLEY: Yes.

STORER: --either. I see no-- I, I am not following where-- what LB731 is-- what's included there would at all limit that. It's actually opening up the ability for additional services.

RACHEL OXLEY: OK, so where it lists what insurance companies are to do in response to this, it is listing out detransition. It is not saying detransition plus transition. It is listing out detransition. That is what is clear to me, as a healthcare provider who is looking through that bill. That is what feels clear to me, when I see that.

STORER: But how is that limiting-- how is that changing anything about what's available under today's statute, today's Nebraska laws?

RACHEL OXLEY: Because if that, if that changes, how is a youth able, under their, what covers-- what is covered under their insurance, how would they be able to access transition versus detransition?

STORER: But this bill doesn't change that one way or another. This doesn't impact that.

RACHEL OXLEY: I-- OK. I don't interpret it to be that way.

STORER: That would be a separate sort of-- yeah.

RACHEL OXLEY: OK.

STORER: Thank you.

BOSN: All right. Thank you for being here.

RACHEL OXLEY: Thank you.

BOSN: All right. The next invited testifier is Julie-- is it Keown?

JULIA KEOWN: You're fine.

BOSN: I'm sorry.

JULIA KEOWN: It's OK. Everybody [INAUDIBLE].

BOSN: Someone should have phonetically written these out for me.

JULIA KEOWN: It happens in literally every Chamber that I testify in.

BOSN: How do you pronounce it?

JULIA KEOWN: "Cow-an."

BOSN: "Cow-an." OK.

JULIA KEOWN: It's like Gaelic or something. It's, it's weird.

BOSN: All right. Welcome, and thank you for being here.

JULIA KEOWN: Dear Chairperson Bosn and members of the Judiciary Committee, my name is Julia Keown, J-u-l-i-a K-e-o-w-n. I am a critical care and sexual assault/interpersonal violence forensic examiner and vice president of the Nebraska Nurses Association, or the NNA. I come to you on behalf of the Nebraska Nurses Association, which represents the more than 30,000 nurses in Nebraska. We oppose LB731 and all legislation that undermines nurses' ability to provide evidence-based care. Our patients deserve full access to care, grounded in the best available medical evidence. All nurses in Nebraska and the United States of America are bound by our Code of Ethics delineated by our parent organization, the American Nurses Association, or the ANA. In the Code of Ethics, Provision 9.5 states that, quote, nurses and nursing organizations have an obligation to speak against legislation and social policy that undermines health, equity, human flourishing, and the common good, end quote. LB731 establishes an environment where medical providers may face heightened

risks of malpractice claims related to gender-affirming care. By extending the statute of limitations and creating a private right of action, the bill fosters a climate of fear among healthcare providers. This could lead to a chilling effect where practitioners may choose to avoid offering these evidence-based treatments, due to concerns over potential legal percussions. If healthcare providers feel threatened by increased legal liabilities, many will opt to stop offering gender-affirming care altogether. This withdrawal would drastically reduce access to essential services for patients who rely on these interventions for their well-being. The American Nurses Association and other healthcare bodies have consistently supported the provision of gender-affirming care, based on robust clinical evidence demonstrating its benefits for mental and physical health. LB731 undermines the principles of patient autonomy and informed consent that are foundational to medical ethics. Healthcare providers must be empowered to make decisions based on the best available evidence tailored to the needs of their individual patients. LB731's provisions risk prioritizing legal considerations over the well-being of individuals, seeking care leading to suboptimal health outcomes. As healthcare professionals, nurses are bound by ethical guidelines that advocate for equitable treatment and access to care for all individuals, regardless of their gender identity. LB731 contradicts these obligations by imposing unnecessary restrictions and liabilities that disproportionately affect marginalized populations. The Nebraska Nurses Association humbly and respectfully ask the committee to stop the advancement of this bill.

BOSN: Thank you. Any questions from this test-- for this testifier? Senator Storer.

STORER: Thank you, and thank you for being here. I'm still, I'm still trying to wrap my head around how LB731 is sort of providing an unbalanced-- the, the argument that I'm hearing is that this would limit care to one population. But I-- but what I'm not hearing is a concern for the availability of care for those individuals that would seek to be transitioned. Is one prioritized over another? Is--

JULIA KEOWN: No.

STORER: Are, are both not on equal consideration?

JULIA KEOWN: That's, that's a great question. I-- you know, if you strip this bill to absolutely nothing but ensuring coverage for detransitioning should patients want that, I very much doubt you would

have all of the medical and healthcare associations opposing this bill. Anytime we can increase access to care, we're going to be happy about it for our patients. Right? The problem with this bill is it's not just adding the insurance coverage for detransitioning. Right? It has all of these other pieces in it that are quite harmful.

STORER: And we've also heard testimony that the, the time from when someone transitions and those that have chosen to detransition is not typically 1 or 2 years, that it is not uncommon to be 5 or more years. Is that a fair assessment?

JULIA KEOWN: I don't have the, the literature review on that right in front of me at all, so I could not honestly speak to the typical amount of time that it takes for someone to decide to detransition.

STORER: So if we-- let's-- and that's fair, that you don't have that in front of you. I just-- everything that was presented earlier has indicated that that-- that's the case. So I-- I'm going to go with that understanding at the moment. And if that's the case, then the current provisions for the limitations for liability just wouldn't, wouldn't cover that. Like, it's not realistic for those individuals, given the-- what the studies and, and history is showing us. So I guess that's more of a statement than a question, but I appreciate your--

JULIA KEOWN: So-- if I may respond.

STORER: Go ahead.

JULIA KEOWN: My concern with holding providers legally liable for it-- for patients wanting to detransition, is a lot of the evidence that we're finding about regret after transitioning procedures has been just lumped into what we call regret. Right? So we are finding that that's actually a confounding variable. So a lot of the research, research is showing that OK, so we have this tiny subset of patients. It's about 0.3% of patients in like the first year that express regret, right. So-- but up until I think it was-- let's see-- it was 2025. Up until 2025, no one had actually sussed out what that regret was for, right, where it came from. So what we are finding is there's the true, the true gender regret, right which might be one of those situations that would open you up to a legitimate liable situation, and that's regret at having transitioned at all. There's a social regret, which they're finding is actually a quite large piece of that, so-- and that's regret caused by external pressure, often placed on

trans people by their families and wider society. Right? So that's obviously a situation that's not on the medical provider. Right. It's external pressure that these patients would be detransitioning due to. Right. So-- and then there's the medical regret, which, that is resulting from something like an unforeseen medical complication, which, again, is incredibly low in numbers, but it happens with any surgical procedure. I think this-- the latest statistic is approximately 14% regret for all-- like, the whole huge amalgamation of, of different surgical procedures that you can undergo. So given that, you know, regret for transitioning is about 0.3%, that's quite drastically lower than what we see for like hip replacements and things like that.

STORER: So if it's so-- one final question. If it-- if that's such, such a low number, then wouldn't doctors-- I-- I'm not sure I understand why that there would, there would be this perceived chilling effect and pullback of wanting to do those procedures at all. If that number is actually that low, then that says the, the odds of them ever having someone come back is also that low. It-- it's still not making sense to me, the argument that this is going to, to chill the, the doctors that-- the number of doctors who are willing to offer this healthcare.

JULIA KEOWN: It's-- you have to factor in that social regret. Right? So there's going to be a-- the, the 0.3%, a fairly large proportion of that is actually going to be that social regret. So why should doctors and nurse practitioners and medical providers be held legally accountable 12, 20 years later for something if a patient has decided to do something based on outward pressure, right, rather than poor outcome? Right. Medical malpractice is, is definitely an appropriate thing that we need to have to have patients have those resources if they need them. But this is not a situation where it would be appropriate to, to leave our medical "proctors"-- excuse me-- our medical practitioners out to dry, basically, if we're saying, well, you're going to have more liability for this than any other procedure you're doing, and it's based entirely on how the patient feels in response to their external environment.

STORER: One last question.

JULIA KEOWN: Yeah.

STORER: If I may. How would this-- from-- in your profession, how would this liability affect you or any of your, your colleagues?

JULIA KEOWN: It's going to be-- largely going to affect the nurse practitioners, who are providing the gender-affirming care.

STORER: Thank you.

JULIA KEOWN: Mm-hmm.

BOSN: Senator Hallstrom.

HALLSTROM: Yeah. Just maybe to clear the record. I don't know that you testified to this, but Senator Storer started to ask a question. On page 7, it says, any health insurance policy which provides coverage or has ever provided coverage for an individual's gender-altering procedure then must provide the reversal or the detransitioning. Would that be your interpretation of, of the bill, if you know?

JULIA KEOWN: That's a great question. I don't have the bill right in front of me, and I'm not an audiological processor, so.

HALLSTROM: That's fine. And I, I wanted to make sure that committee members knew that there was specific language--

JULIA KEOWN: Yes. Yeah.

HALLSTROM: --in there, so thank you.

BOSN: I just have some curiosity questions.

JULIA KEOWN: Yeah.

BOSN: OK. So your position is that on behalf of your association, you are not opposed to detransitioning coverage insurance.

JULIA KEOWN: I'm not going to say specifically detransitioning coverage insurance. What I'm going to say is any-- you know, increasing access to any healthcare by mandating insurance coverage is, is usually going to be a good thing.

BOSN: OK. Do you include detransitions in that?

JULIA KEOWN: I wouldn't be able to speak on behalf of my colleagues, but, I mean, if, if detransitioning is something that a person needs and it is a medical thing, then it should be covered.

BOSN: OK. So that's confusing, because your emphasis was on needs. Do you think they don't need it?

JULIA KEOWN: Each patient is going to be different. Right? Each patient and each situation is going to be drastically different, and they're going to have to decide in that moment, with their provider. And obviously, this is not an appropriate place for me to just make a blanket statement when I don't have these patients in front of me.

BOSN: OK. You also placed a significant amount of emphasis on individuals who detransition due to social-- what you considered or categorized as social regret.

JULIA KEOWN: Yes. Yes.

BOSN: And I guess what my question is, and you've now sort of said maybe you don't support all detransitioners receiving coverage, is that the category that isn't-- shouldn't be covered?

JULIA KEOWN: Again, every single patient is going to be different. Right? So what I am going to say is insurance should cover medical procedures.

BOSN: Even if it's for social regret detransitioners?

JULIA KEOWN: That's going to be between the patient and their provider. Right? Each patient and their medical provider need to, to make what we call informed decision-making, and decide what is best and most appropriate for that patient. If that medical person and that patient decide together that it's the most appropriate recourse for them, then they should absolutely have that procedure.

BOSN: OK. I also-- I don't-- were you in here when Mr. Lance Kizer [SIC] testified?

JULIA KEOWN: I wasn't. No. Sorry.

BOSN: OK. That's all right. He indicated-- and part of what his testimony was regarding was that the standard of care remains the same. And you also have indicated that this increases liability. But if the standard of care remains the same, it's the statute of limitations that's changed, but the standard of care is boom, boom, boom, the same, it's the time. Can you explain how this increases liability for nurse practitioners was your example?

JULIA KEOWN: That's a great question. I don't know the answer to that off the top of my head. I can definitely send you an email later about it, though.

BOSN: That'd be great.

JULIA KEOWN: Mm-hmm. Yeah.

BOSN: I appreciate that. Any other questions? All right, thank you very much, Ms. Keown. And I--

JULIA KEOWN: Thank you.

BOSN: --think I pronounced it right this time. All right.

JULIA KEOWN: You did great. Thanks.

BOSN: Next, we have Dr. Elizabeth Constance. That, I think I did pronounce correctly. My daughter's name is Elizabeth. If I screw that up, I'm in big trouble.

ELIZABETH CONSTANCE: It's a hard one to mess up. Thank you. Chair Bosn 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 am testifying on behalf of the Nebraska Medical Association, NMA, in opposition to LB731. The NMA has strong concerns about LB731 and its unprecedented and dangerous expansion of liability for medical providers. While this bill singles out one category of medical counseling and care, the precedent is deeply troubling. There are well-established principles of medical liability that have worked for decades by balancing the interests of patients with the ability of providers to fairly defend their care. Nebraska law provides a 2-year statute of limitations for medical liability claims with notable exceptions. First, current law tolls the statute of limitations for care received while the patient was a minor, already allowing minor patients to bring claims within 2 years after they turn 21. Additionally, Nebraska's discovery rule allows a plaintiff to bring a claim within one year of discovery if an injury could not have been reasonably discovered within the 2-year period. LB731 abandons these principles for one category of care and would create an extremely difficult liability environment which could be extended to any area of medical care by future lawmakers. First, it exposes physicians and other providers to lawsuits for up to 12 years after care was provided, recommended, or approved. This 12-year statute of limitations is staggering. LB731 invites this litigation more than a decade after the fact against any healthcare provider who is alleged to have provided, recommended, or approved the care. The NMA is

strongly opposed to measures that would force physicians to defend not only care they provided, but even recommendations they are alleged to have given more than decade later. Not only does LB731 extend the statute of limitations far beyond accepted boundaries, but it also provides for attorney's fees and creates a special cause of action untethered from traditional legal negligence standards. Section 2 of the bill says it creates a new private right of action. It is not clear whether this new cause of action requires a plaintiff to allege or prove negligence, or just that they have injury or damages arising out of the recommendation, approval, or provision of care. If proof of negligence is required, LB731 is still-- seemingly lowers the standard to prove a breach in the standard of care by imposing additional vaguely-worded requirements. This means more litigation and higher defense costs, even when a clinician has followed every precaution and standard of care. The scope of this bill is expansive. The definitions in the bill make it applicable to medications, as well as procedures. Additionally, it would apply to care received as an adult, as well as care provided to minors. Adults who legally consent to medical care have full access to the legal system when negligence occurs or is discovered. And as already discussed, Nebraska's existing law protects minors through tolling of the statute of limitations. In short, LB731 would fundamentally rewrite established liability law in a way that is destabilizing and unnecessary. The NMA respectfully urges the committee to not advance LB731. Thank you, and I'm happy to answer any questions.

BOSN: Thank you. Questions for this testifier? Well, I guess I'm going to ask you then, the same question that you've had the benefit of hearing. Your statement on the-- page 1 in paragraph 2 says, expands liability. If the standard of care is the same-- I guess, are you referring to expansion in time?

ELIZABETH CONSTANCE: Correct.

BOSN: OK. That's different. OK.

ELIZABETH CONSTANCE: Yeah. We're, we're extending it by a decade.

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

ELIZABETH CONSTANCE: Thank you.

BOSN: Next, we-- I think we did have all of the opponents in the room that were here. So we'll start now with our proponents. And I think

what the agreed upon was we would clear the room, bring in the oppon-- or the proponent testifiers, and then we'll take a break and bring in opponents.

HOLDCROFT: What happened to Hunter Traynor?

BOSN: He was testified to by Alexander [SIC] Bell on behalf of the Federation and Nebraska Chamber.

DeBOER: Yeah, he was unable to attend himself.

HOLDCROFT: Got it.

[BREAK]

BOSN: --spell your first and last name.

GLENN SIMONSEN: Yeah, I don't think I put the bIll number on it. LB731. Hello. Good afternoon. My name is Glenn Simonsen, and that's G-l-e-n-n S-i-m-o-n-s-e-n. I'm from Omaha. I was one time at Omaha Public School student, Omaha Public School parent, Omaha Public School educator for a long time. And so, I think I represent the Omaha Public Schools as much as the school board chairman does. Thank you, because she didn't ask the parents, nor students, nor anyone else, if we supported or did not support this bill. So I, I, I want to start out saying I'm, I'm very disturbed this afternoon to have been denied access to the previous presentations in this public forum. I was told it was because of death threats against Senator Kauth for bringing this legislation into this democratic institution. So I don't know. Perhaps the measures were warranted. I don't know. But I'm at a disadvantage to not know what has already been said this afternoon. But I'll just say there is a debate among scientists about how long the human species has existed on Earth. Some say 100,000 years, some say 200,000, some say 2 million years. Let's just say 200,000 years for the sake of argument. And I don't profess to be good at math, but I think it's reasonable that the claim that a human being who has a male appendage is said to be a woman is an entirely new fiction concocted in the past 15 seconds of all of human history. It is flatly absurd. And there is an 18th-century atheist French philosopher, Francois-Marie Voltaire, who said something like, if you can make them accept an absurdity, then you can make them commit violence. We cannot have it. We cannot accept absurd pseudoscience. We reject threats of violence against Senator Kauth and against every other human being, each one made in the image of God. We are Nebraskans. We stand for

rationality. We stand for science. We stand for peaceful dialogue. And we stand for the fierce protection of all of our precious children. And I thank you, Senators, for this very difficult job. I think you're underpaid. Thank you very much.

BOSN: Thank you. Are there any questions from the committee? Senator Hallstrom, followed by Senator Storer.

HALLSTROM: Sir, did I, did I understand you correctly, you didn't feel you had an opportunity to observe what went on earlier today in this hearing?

GLENN SIMONSEN: No. I was told I could not enter.

HALLSTROM: This room?

GLENN SIMONSEN: That's correct.

HALLSTROM: Did they, did they tell you of the opportunity to be in the overflow room where you could view--

GLENN SIMONSEN: No, they did not.

HALLSTROM: OK. Well, I'm sorry if that happened. And for future--

GLENN SIMONSEN: In fact, in fact, Senator Kauth tried to invite me in. She asked the police officers, and they denied me access. So I don't understand that. But I understand-- their problem, so you do the best we can.

HALLSTROM: OK. Thank you.

GLENN SIMONSEN: Yeah.

BOSN: Oh, we got one more question for you, sir.

STORER: I just was curious more than anything. So are you retired from teaching, or are you current?

GLENN SIMONSEN: I, I still teach part-time. Right now, I teach adult immigrants English at-- for OneWorld Health Systems, so.

STORER: And what was your subject matter when you were full-time?

GLENN SIMONSEN: I taught with the Migrant Education Program. So I tutored our immigrant children in-- sometimes in their homes,

sometimes in group settings after school. And I also taught their parents English and-- as well as cultural orientation subjects and other things like that. Yeah.

STORER: Thank you.

GLENN SIMONSEN: Yeah. Thank you.

BOSN: Thank you for being here. All right. Does that conclude our proponents? All right. Next we will have the opponents invited in.

HALLSTROM: Senator [INAUDIBLE], did you say we're going to take a break between this, or because we only had one, we're just going to keep going?

[BREAK]

BOSN: And so, if you're here to testify in opposition to LB731, you're welc-- we'll just take you one at a time. If you want to reiterate something you've heard someone else say, please don't feel like you have to repeat what somebody else has already said because we are all sitting here, as well, and can hear it. You can just say I'd like to confirm what someone said before me. And that, that's great. And we do follow a 3-minute light system in this room, as well. So whoever would like to come on up first. Good afternoon-- evening, and welcome.

ADRY SEITZ: Yeah, good evening. Good evening, Chairperson Bosn, and members of the Judiciary Committee. My name is Adry Seitz, spelled A-d-r-y S-e-i-t-z. I am testifying today on behalf of Heartland Family Service in opposition to LB731. As a nonprofit human services organization and behavioral health provider serving individuals and families across Nebraska, we are deeply concerned about the harmful impacts this legislation would have on healthcare access, workforce stability, and client outcomes. LB731 creates an unprecedented and punitive malpractice framework that singles out one category of medically necessary care. From a provider perspective, this legislation introduces excessive legal risk that will discourage clinicians from offering care to transgender Nebraskans or practicing in Nebraska altogether. At a time when our state is already experiencing significant shortages of healthcare and behavioral health professionals, particularly in rural and underserved communities, policies that further destabilize the workforce will only worsen access barriers to clients. Behavioral health professionals are already subject to rigorous licensure standards, clinical oversight,

ethical obligations, and existing malpractice law. LB733 [SIC] does not improve patient safety. Instead, it politicizes clinical decision-making by imposing special liability standards based on ideology rather than medical evidence. This undermines the trust-based relationship between providers and clients that is essential for effective treatment and long-term outcomes. From a behavioral health standpoint, reduced access to affirming medically appropriate care directly contributes to increased mental health distress, delayed treatment, and disengagement from healthcare systems. Heartland Family Service urges this committee to reject LB731, and instead, focus on policies that strengthen Nebraska's healthcare infrastructure, support workforce retention, and promote access to evidence-based care. Healthcare policy should be guided by medical expertise and client well-being. Thank you for your consideration of our perspective, and I'd be happy to answer any questions.

BOSN: Thank you. Any questions from the committee? I have one question here.

ADRY SEITZ: Sure.

BOSN: You're, it would be your third paragraph down, towards the middle. It says, this bill politicizes clinical decision-making by imposing special liability standards. You haven't probably been in here when we had some of these, or maybe you heard from the overflow room. What are the special liability standards?

ADRY SEITZ: I think that is referring to the providers that are going to have to increase malpractice or have to basically not be able to provide gender-affirming care.

BOSN: Can you tell me where in this bill that, that, that takes place? Because we've heard from other testifiers that maybe you didn't have the benefit of hearing--

ADRY SEITZ: Sure.

BOSN: --that there is no change in the standard of care from this legislation to any other standard of care. And so, when testifiers have come in and said that this changes that or it poses special liability standards, I'm very confused by what that enhanced or special liability standard is, if it doesn't change the standard of care.

ADRY SEITZ: That's, that's a good question. And I didn't hear what they had mentioned before.

BOSN: Fair enough.

ADRY SEITZ: I didn't have the opportunity to do that.

BOSN: I won't impose it on you to speculate as to their positions, but--

ADRY SEITZ: Sure. I, I think it's just an, an effort to, I guess, make sure that clinical oversight is not politicized, in the sense that it creates and implicates professionals into choosing between ideology versus providing care.

BOSN: OK. All right. Thank you for being here.

ADRY SEITZ: Thank you.

BOSN: Next opponent. Welcome.

JENNY OLANDER: Hello. My name is Jenny Olander, spelled J-e-n-n-y O-l-a-n-d-e-r. And I-- this bill seems quite scary to me in a lot of ways, mostly because the-- some of the precedent that it sets in some ways. From the way that I read the bill, the way that I understand the bill, it seems that healthcare providers could be sued for, not even committing malpractice, for having a-- for having an agreement with a patient, and then not being allowed to seek a waiver, in case of any regret. That seems to violate a lot of, like, patient and patient-doctor relationships. And for the government to be imposing that kind of restriction and that kind of-- having that kind of imposition on providers seems to be a massive overstretch of the government's ability and very un-American, in my opinion. I have a couple of other things, but most of what I've already said has been covered by previous speakers. So are there any questions?

BOSN: Any questions for this testifier? Thank you for being here.

JENNY OLANDER: Thank you.

BOSN: Yes. Next opponent. Good afternoon and welcome.

HAILEY GILLESPIE: Good afternoon. My name is Hailey Gillespie, Hailey is spelled H-a-i-l-e-y, Gillespie, G-i-l-l-e-s-p-i-e. I'm here from Omaha. I drove all the way here, and I came here because I'm pissed.

I'm not trans, but people I love are. My friends are, my family are, and they always will be. And I want you all to know that regular people who live in this red state are pissed. We see what this bill does. We know it's bad. And if-- I love our country, I love freedom, and I think if you don't support trans people, you don't support freedom. If you want to catch pedophiles, go to the White House or the Governor's Office. If you want to support healthcare, go support universal healthcare. It's not about those things. In my opinion, supporting this legislation is wholeheartedly un-American. Thank you.

BOSN: Any questions? Senator Storer.

STORER: Thank you for being here. And I certainly can sense your passion. I just-- I guess I just want some clarification on this specific-- and I know there's several bills--

HAILEY GILLESPIE: Yeah.

STORER: --that surround this issue. But on this very specific bill, how you view it as being offensive or, or anti-trans, from the standpoint that really, it's just trying to expand coverage for trans people that have decided to detransition.

HAILEY GILLESPIE: Yeah, I think that framing is ridiculous and intentionally misleading. Because this bill absolutely gives a doctor a fear when trying to treat a transgender patient. That is what it does. Yes, I support detransitioning healthcare for everyone. I support healthcare for all, regardless of what kind of healthcare that is.

STORER: Thank you.

BOSN: Thank you for being here. Next opponent. Good after-- evening and welcome. I keep switching back and forth. It's evening.

JESSIE DIGGINS: We're on that cusp. Thank you for having me. My name is Jesse Diggins, J-e-s-s-i-e D-i-g-g-i-n-s. I'm a lifelong Nebraska resident. I started my gender transition at 19 years old. I'm 34 years old today. I am here today to testify against LB731. This bill is not about patient protection, it's about making gender-affirming care legally impossible to provide in Nebraska. LB731 creates a 12-year statute of limitations for medical malpractice claims relating to gender-affirming care with no medical review panel, which means no professional oversight and no screening for frivolous lawsuits. Nebraska's standard is two years from discovery with a 10-year maximum

and mandatory medical view panel, regardless of severity. This is unprecedented for any malpractice claim in Nebraska. People who detransition already have robust legal recourse under existing malpractices law. Worse, this is retroactive punishment. Section 9 applies to any care provided after October 2023, which is before this bill will potentially even exist. Providers are going to be punished for obeying the law. Section 7 requires any insurance policy that has ever covered someone's gender-affirming care must cover all detransition related procedures forever, even if they're no longer on that plan. An insurer could potentially be on the hook to pay expenses for someone not on their plan 2 or even 3 decades in the future. No insurance company is going to accept this open-ended liability. They will categorically exclude gender-affirming care from all policies. Without insurance coverage, care becomes unaffordable and unavailable. This harms both trans people and detransitioners who won't be able to afford the care this bill claims to protect. Section 6 requires providers to warn about a, quote, lack of long-term data, and a, quote, potential for regret, unquote. This is false. WPATH's 2022 Standards of Care, based on systematic review by 119 global experts includes a 40-year follow-up study reporting high satisfaction, reduced mental health issues, and zero patient regret. If 40 years is not long term, I don't know what is. So let me be clear. This bill weaponizes the model of informed consent, requiring providers to create documents that will be used against them in lawsuits. I started transition at 19 years old. I am now 34. I represent the 92% who don't detransition. Research shows regret rates below 3%. When people do detransition, 82% cite external factors, including economic factors. This bill creates those economic factors by withdrawing insurers from our state. It is creating the problem that it claims to address. It's going to be a cascading effect. So in conclusion, this bill makes care legally uninsurable and economically impossible. It creates the problem it claims to address. And I just-- it, it, it just doesn't make sense to me. And thank you for your time. That's all I have.

BOSN: Thank you for being here. Let's see if there's any questions.

JESSIE DIGGINS: Sure.

BOSN: All right. Thank you very much.

JESSIE DIGGINS: All right. Thank you.

BOSN: Next opponent. Anyone else here to testify in opposition? Good evening and welcome.

HEATHER RHEA: Good evening to you. My name is Heather Rhea, H-e-a-t-h-e-r R-h-e-a. Thank you for the opportunity to speak to you today about my opposition to LB731. I'm a little different than some of the previous testifiers in that I am not a medical professional and I'm also not trans. I am the parent of a trans daughter. She has been receiving gender-affirming care about 8 years, and she is absolutely thriving. Due to bills like this, she's chosen to pursue her education in a safe state, which I'm really proud of her for thriving and a little bit upset that she had to go thrive somewhere else. My opposition to LB731 has to do with when my daughter first started receiving gender-affirming care. There was definitely a standard of care that was followed. And in Nebraska, there's further steps now that a child her age would have to take to receive the same care that she got. I do have a little bit of survivor's guilt about that, for the families that have a lot more difficult time receiving this care than my daughter did. I know the regret rate is really low for kids that transition. And I'm here to tell you that that care saved her life. Not a doubt in my mind. I know that this bill is about being able to go back further in a malpractice claim an extra 10 years. And I firmly believe that this bill is an attempt to bully the providers that still exist in Nebraska. The doctor-- one of the doctors that my daughter saw has already left the state. And with the restrictions that are already in place, and then the added fear of losing insurance providers to be able to even receive care is almost impossible. If we were to lose insurance backing this which I believe this bill would make insurance providers less likely to cover any sort of gender-affirming care. And so, based on my lived experience of providing such a better quality of life and understanding that other kids who are like my daughter aren't gonna have the same chance to survive and thrive that she did because of bills like this, makes me feel like I have to speak out. So I'm happy to answer any questions.

BOSN: Thank you. Any questions for this testifier? Senator Storm.

STORM: Thank you. Thank you for testifying. So your-- how old was your daughter when she started to transition?

HEATHER RHEA: So 12 when we first started seeing a therapist, 13 when she started puberty blockers, 14 for hormones.

STORM: How old is she now?

HEATHER RHEA: She's 20.

STORM: OK. So does she have to take those hormones for the rest of her life?

HEATHER RHEA: Yes, sir.

STORM: Does insurance cover that?

HEATHER RHEA: Currently, it does.

STORM: So the insurance will pay for that for the rest of her life?

HEATHER RHEA: Yes, but the insurance that I have through my employer currently does. So if my employer, I am employed here in the state of Nebraska, decides the insurance provider that we use decides that it's not worth the risk with the additional 10 years and they decide not. To cover my daughter's care because right now she's on my insurance, she's a full-time student who's 20, then my entire lifestyle has to change to be able to afford that medication for her.

STORM: That was my next question. What's the cost a month for those hormones?

HEATHER RHEA: So, I don't know off the top of my head what the uninsured amount is. Right now, it is affordable for us.

STORM: I didn't know if you knew what the insurance cost was for that.

HEATHER RHEA: Oh, I'm terrified to know what the uninsured cost is. Her cost right now is about $63 every three months.

STORM: OK, thank you.

HEATHER RHEA: Any other questions?

BOSN: Thank you for being here.

HEATHER RHEA: Thank you.

BOSN: Next opponent. Anyone else here to testify in opposition? Good evening and welcome.

VESPER LaTHARY: Good evening. Good evening. My name is Vesper LaThary. That's V-e-s-p-e-r L-a-T-h-a-r-y. I am a licensed mental health clinician in the state of Nebraska with 3,000 hours logged, working with people with severe and persistent mental illness, mostly in an inpatient hospital. I'm also a transgender woman. I'm here to oppose

LB731, on the fact that it is-- seems like a scare tactic to try and get providers to stop providing transitionary care for gender-diverse individuals, in the chance that people may regret transition later down the road. By making that a longer time to file charges, it just disincentivizes doing it at all, in case that someone regrets it. I do know that most people who transition don't regret it. Most people who do detransition, detransition for social reasons, not because they regret transitioning, but because family has cut them out because they've lost resources, because of their status as a transgender individual. There's a very small percentage of people who go through with transition and regret it, and there are detransition services available to them. But being able to consent with a doctor, there should be no extension of that statute for malpractice. Because if you transition and you consent at any age, even as a child with parents working with you, then down the road, detransition is still an option. There's no reason to make that a longer point. As a mental health therapist, I will say, I will continue to serve the trans community. I will continue to do what I do for the people that I work with, because it's important.

BOSN: Thank you. Any questions for this testifier? Seeing none, thank you for being here.

VESPER LaTHARY: I will-- sorry. In-- just one moment. To your question about trans medications, HRT, and the price of that a month-- or every 3 months or so, I'm paying between $150 and $200. And that is with insurance covering the cost. And there is still the risk that my insurance decides not to, under bills like this. So.

STORM: OK. One question. So do you know what the insurance pays for that? You pay $150, but what's it cost-- do you know what the insurance cost is?

VESPER LaTHARY: I do not know what the insurance covers.

STORM: Just curious. OK. Thanks.

BOSN: Thank you for being here.

VESPER LaTHARY: Thank you.

BOSN: Next opponent. Anyone else here to testify in opposition? Just in the interest of time, can I see how many individuals in the room are here to testify that have not yet testified? 2, 4-- OK. 2, 4, 6, 8, 10, 11. Got it. Thank you. If you guys want to come to the front

row, we are no longer reserved seating. So you might just kind of make things go a little bit quicker for all of you, and then we can kind of just go chair by chair, in order. So.

STORM: Yeah. There you go.

_____: Thank you.

BOSN: Good evening and welcome.

AMY BETTINGER: Hello. I say my name, yes? [INAUDIBLE] OK. My--

BOSN: State and spell your name. Yeah.

AMY BETTINGER: Amy Bettinger, A-m-y B-e-t-t-i-n-g-e-r. I'm here in opposition to LB731. I like to think, and I believe that you all, as senators, are intelligent individuals. I would hope so, anyway, to make it into office. I like things that make sense. And unfortunately, this bill just doesn't, to me. I've been researching multiple statistics, and I don't understand why this bill-- so I want to clarify who this bill is for. So there's been a lot of focus on detransitions, on the possible impact and complications of gender-affirming surgeries. I just want to be clear. We are talking, based on a study from the-- let's see-- Harvard T.H. Chan School of Public Health that I think was around 2019-- that is the most recent information I could really find-- that there are about 2.1 detransitions-- or excuse me. 2.1 out of every 1,000 people are going to get these surgeries that are-- you are talking about. So if I take that number nationally and condense it down to Nebraska, we are talking a population, as of last year, of about 2,000-- 270,500 minors in all of Nebraska. So if we're just talking about minors, in general, we don't even have the stats because such a small percentage are-- identify as transgender. You're talking legislation for 6.3 surgeries. I would like to know why the focus is on complications with these surgeries, when there's also statistics that say 97% of breast reductions are done on male teens for gynecomastia. Is that not gender-affirming care, as well, so does that fall under this legislation? Are those children also-- why are they being left out? And this is only focusing on the trans surgeries. It doesn't make sense, just because it's such a small number. On one hand, you're going to say that there isn't enough medical evidence to support these surgeries. But then, you're going to turn around and legislate on not even 10 surgeries in a year. Why? That seems like a waste of time, when you could-- if it, if it were focusing on all kids-- no more

surgeries for minors, period, then I'd understand it a little bit more, but I don't. We also focus on detransitioning. The detransition rate is roughly 4%, and as everyone else has told you, a lot of it is societal, not anything else. And 40%--

BOSN: That's your time, ma'am, so if you want to wrap up your last thought here.

AMY BETTINGER: 40% of those who detransition will go on to retransition again, later.

BOSN: All right. Thank you. Let's see if there's any questions from the committee. Any questions of this testifier? All right. Seeing none, thank you for being here. Next opponent. Good evening and 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 reside here in Lincoln, Nebraska. I'm here as a concerned citizen and a person of faith to offer testimony in opposition of LB731. My ethical obligation as a Christian is rooted in the law of love, as taught by Jesus Christ and his apostles. The standard dema-- the standard demands that we actively seek the welfare of others, and it is against this principle that LB731, LB731 must be measured. When asked about the greatest commandment, Jesus provided the fundamental-- foundational ethical principle, and a second is like it. You shall love your neighbor as yourself, Matthew 22:39. The apostle Paul further clarifies the legislative application of this love in Romans 13:10, love does no, does no wrong to a neighbor. Therefore, love is the, is the fulfilling of the law. My concern is LB731, by focusing on legal liability for healthcare providers who offer gender-altering procedures, fundamentally violates the spirit of "love does no wrong to a neighbor" for both the patient and the medical professional. The bill creates a legal framework that is designed to impose exceptional hardship, which is the definition of doing wrong to a neighbor. It in to-- it, it, it institutionalizes a burden of fear and sus-- suspicion upon ethical medical practice. Extended legal jeopardy, the creation of a longer timeframe statute of limitations for patients to sue doctors for malpractice related to gender transition procedures, singles out this specific field of medicine. This action goes beyond standard malpractices to subject dedicated medical professionals to exceptional and protracted legal risk. In fact, they're punishing them for providing medically-affirmed care. This is a clear act of doing wrong. Expansion of legal avenues: the provisions to expand the legal avenues for individuals who regret

their procedures to seek damages are designed to chill care and intimidate providers. It's suggested that compassionate, necessary care in this area is inherently a source of legal risk, forcing healthcare providers to choose between their professional livelihood and the well-being of their patients. Mandated coverage for detransition: while requirement for insurance coverage for treatments needed for detransition may appear helpful, on the surface, its inclusion within a bill whose primary function is to expand legal punishment, reveals the purpose to provide justification for a punitive, discriminatory legal structure. The moral principle of love requires comprehensive support for all medical needs, not the targeted singling out of a single procedure set to preserve a legislative attack on an entire field of medicine. To love your neighbor means to support and protect the entire community, including the dedicated healthcare professionals and the vulnerable patients they serve. LB731 fails to-- the moral mandate by creating a law that does wrong and legislates fear. I urge this committee to reject LB731, and instead, to legislate with a genuine commitment to ensure the welfare and dignity of every person in the state of Nebraska, including doctors and nurses who serve them. Thank you so much, everyone, for your, for your words and listening and consideration today.

BOSN: Thank you very much. Let's see if there's any questions from the committee. Any questions for this testifier? All right.

JASON SLAUGHTER: Thank you.

BOSN: Thank you for being here. Yes. Next opponent. Good evening and welcome.

SABRYNA CHRISTIANS: Good evening. My name is Sabryna Christians, S-a-b-r-y-n-a C-h-r-i-s-t-i-a-n-s. I'm here to testify against LB731 as a nearly lifelong citizen of Nebraska, a U.S. Navy veteran, and most relevantly, a trans woman who started her transition nearly 3 years ago, at the age of 29. I am now 32. This bill is, briefly, unnecessary at best. Multiple studies have shown that regret rates for any sort of gender-affirming care, including hormonal treatment and surgery, sits at about 1%. The primary source of this regret is not, despite what some would have you believe, based on complications or adverse effects of the care being discussed. Rather, it's typically sociopolitical pressures caused by such things as these bills. As someone who started her own transition later in life, expressly due to these pressures, I can speak to how intense they are and can safely assert that this kind of legislation does not help. Now, to put that

1% regret rate into perspective, the regret rate of life-saving heart surgeries sits at about 5% to 10%. And for elective, nontransition-related plastic surgeries, it is roughly 20%. Even the, even the decision to have children sits at a 7% regret rate. Given these apparently egregious regret rates, does the Unicameral plan on allowing parents to sue their children? This is not merely a rhetorical question. LB732 bans any sort of gender, gender-affirming care for anyone under the age of 19. The law currently allows minors to undergo such care with parental consent. This bill extends the window to sue a provider for malpractice related to gender-affirming care from 2 years to 12. If I'm understanding this bill correctly, anyone connected to that care is able to bring suit within this window, including parents who had provided consent to treatment. In effect, this allows parents, upset with the transition of their child, to use the legal apparatus of the state of Nebraska as a cudgel against the providers of this care, and by extension, their offspring, who pursued it in the first place. This is, to be blunt, state-sanctioned child abuse by proxy. Further, this abuse is very focused on a few select targets. Statistically, Only about 0.5% of the U.S. population is trans, which means when applied to the youth population of Nebraska, this would really only apply to about 2,500 people, excluding the providers themselves. Personally, I can't imagine a less effective use of government power than to so harshly legislate against such a meager number of young people. Thank you for your time.

BOSN: Thank you. Any questions for this testifier? All right. Thank you for being here and for your service.

SABRYNA CHRISTIANS: Thank you.

BOSN: Next opponent. Welcome.

JOSHUA GIRARD: Hi. My name is Joshua Gerard. That's J-o-s-h-u-a G-i-r-a-r-d. This is my first testimony, so I apologize if I appear a little bit nervous in front of all of you. I think one of my biggest concerns-- and I think I will preface that I am a mental health pract-- practitioner. I've only been practicing for a year, so I'm still very new to the field, but I have seen a lot of fear coming out from all these bills, maybe not so much specifically this one, but, you know, just the whole cascade of, of it all. And I can't help but draw parallels between this specific bill when it comes to the malprac-- practices and this creation of fear with the doctors not being able to perform surgeries, because they don't know if, you know,

10 years down the line, someone's going, going to sue them for malprac-- practice. And it reminds me a little bit of when, when more states were starting to adopt abortion, abortion bans. When they-- and a lot of doctors were becoming a lot more afraid, performing very routine procedures that has saved lives through many different medical, medical reasons. And yet, because of this legality, they had to hold off on a lot of these procedures. And I'm wondering if the same is not going to be applied into-- to this. The trans community here in Nebraska is very small. And I have worked with many wonderful individuals who identify as part of the LGBTQ-plus community. And I mean, that is primarily one of my reasons why I became a therapist, is to provide safe spaces for these individuals. And I just wonder if we're making a mess out of a molehill. I don't know if that's the right phrase for that. But I think we just need to acknowledge it. I hope that what my words-- maybe not so much the events on what position to be here on, on this specific bill, which is-- consider the amount of affect that passing a bill like this is going to, going to have on an already oppressed, marginalized community that constantly face pressure, not only from members of their own commun-- community, but of society at large. We're already seeing that across this coun-- country. And, you know, there was a documentary that came out, years ago, called Boys Don't Cry. And there was a young trans person, I'm pretty sure, that was beaten to death in Tecumseh, Nebraska. That was around 45 minutes away from where I grew, grew up. That this fear continues this cycle, and what I hope that you senators could help do is at least stop the cycle that keeps going. Thank you.

BOSN: Thank you. Let's see if there's any questions. Any questions for this testifier? Senator Hallstrom.

HALLSTROM: It may be a mountain out of a molehill, but you may have meant what you said.

JOSHUA GIRARD: Thank you. OK. Thank you.

HALLSTROM: You may have meant what you've said, though.

JOSHUA GIRARD: Yeah.Thank you.

BOSN: All right, thank you very much for being here.

JOSHUA GIRARD: Thank you.

BOSN: Next opponent. Good evening.

CLEO ZAGURSKI: Good evening, Chairwoman, Chairwoman-- good evening, Chairwoman Bosn and members of the Judiciary Committee. Thank you for the opportunity to testify today. My name is Cleo Zagurski, C-l-e-o Z-a-g-u-r-s-k-i, and I am the policy fellow and lobbyist for Reproductive Health Collaborative Nebraska. We work with a statewide network of 10 healthcare agencies to advance access to high-quality, reproductive healthcare for roughly 25,000 Nebraskans annually. We are here to express our opposition to LB731, a bill that will significantly undermine Nebraska's ability to retain and attract healthcare providers, especially in rural areas, which already struggle to attract providers. LB731 extends the statute of limitations on medical malpractice claims to allow lawsuits up to 12 years after care was pro-- provided. This is a sharp departure from Nebraska's existing malpractices statute, which generally requires claims within 2 years of the act or reasonable discovery, and limits all claims to within 10 years of care. Even providers who do not focus on care for transgender patients, including those who only sign for routine prescription refills, would be impacted by this bill. Extended risk in this way substantially increases providers' exposure to malpractice lawsuits and extends the period of legal risk. Rural Title 10 clinics already operate on thin margins with limited staff. This increased risk exposure translates directly into higher malpractice insurance premiums, added administrative costs, and intensified sphere of litigation, even when care is evidence-based and within standards established by professional medical associations. Higher costs and litigation anxiety are not abstract concerns. They directly shape provider behavior, including clinicians narrowing their practice scope, reducing patient volume, or opting to leave the state altogether to go where liability risks are lower or more predictable. In Nebraska, where we already have 19 counties without providers who can prescribe contraception, we cannot afford to lose more providers or make recruitment more difficult. Extending liability periods just as we are struggling to staff clinics threatens the access to essential care. But legislation should support a predictable legal environment that encourages clinicians to serve in our communities, especially those practicing within Title X clinics. LB731's malpractice framework will deter practitioners from establishing or maintaining practice in Nebraska, further worsening workforce shortages in rural areas, and ultimately reducing patient access to care. For these reasons, we urge this committee to oppose LB731 and ensure Nebraskans in every part of the state can obtain safe and comprehensive care. Thank you.

BOSN: Thank you. Questions for this testifier? Seeing none, thank you--

CLEO ZAGURSKI: Thank you.

BOSN: --for being here. Next opponent. Anyone else? Good evening and welcome.

LINDSAY SALEM: Hi. Dr. Lindsay Salem, L-i-n-d-s-a-y S-a-l-e-m. Dear Chair Bosn and committee members, my name is Dr. Lindsay 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 LB731. This bill is anti-science. As you've already heard, every medical and psychological organization supports gender-affirming care. 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. The language, individuals subjected to gender transition procedures, is not medically accurate. Sorry. The correct term is gender affirmation. The consent process for gender-affirming care is already rigorous and considered a conservative approach, but the process is consent. For trans and gender-diverse youth, their parents give consent and the youth then give assent. The terms instill or create are also medically inacc-- medically inaccurate. These interventions, this healthcare is affirming. I also have concerns about the wording of mental health professionals recommending. Again, not the term. There are referrals. There are letters of affirmation. That the process is described as if the patient is not driving the care is a problem with this bill. Historically, gender-affirming care has been difficult to get, due to excessive gatekeeping. This bill is not describing standards of practice or violations thereof, which we already have malpractice laws for. The process of consent involves reviewing risks and benefits of interventions and care. The effect will stigmatize gender-affirming care and risks providers and their malpractice insurers to decide such care is too risky. The detransition rate for gender-affirming care is one of the lowest of any type of healthcare, but there's more language in this bill implying that youth don't know what they want. Again, that's not consistent with the data we have about when youth detransition. Although rare, usually it's because they lack support for their gender identity. In my profession, one of our ethical principles is do no harm. This bill would do harm to trans folks. This

bill is an example of 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 LB731. We need legislation that provides access to care. Thank you.

BOSN: Thank you. Any questions for this testifier? Senator Storer.

STORER: Thank you, Chair Bosn. One just real quick question for clarification. You said the detransition rate for gender-affirming care is one of the lowest for any type of healthcare. What, what are we comparing that to, where you would--

LINDSAY SALEM: So oftentimes, as like, speakers earlier said, they're looking at surgeries. And someone, someone else said even like, the decision to have a child, so those regret rates are higher than regret rates or detransition rates. For gender-affirming care, the regret rate is 1%. Regret rate for like knee surgery is much higher. So to have such extreme legislation for procedures with tiny regret rates doesn't seem to make sense with, with the numbers that we have.

STORER: Thank you.

BOSN: Senator Hallstrom.

HALLSTROM: In your professional opinion, is there any element of the low rate for transitioning that may be attributable to the complexity or the risks that are associated with the transitioning surgery or reversal?

LINDSAY SALEM: The low rate. I, I think the rate is low, because, because the care is so affirming and important, and, and has been difficult to get. There are many hoops that people have to go through.

HALLSTROM: Yeah, absent artificial hoops, would you think there might be some element of that, that somebody looks at it and says, boy, that-- that's risky or that's complex that, that they may be hesitant to undertake the surgery?

LINDSAY SALEM: I mean, we also have access to care, you know. If it's not covered, if a person doesn't have support, there's lots of things that go into that. You know, and I--my profession, historically, has not-- has thrown up lots of barriers for people getting that care. I, I-- so I think, unfortunate-- it, it-- we want regret rates to be low.

HALLSTROM: Sure.

LINDSAY SALEM: You know, obviously, for all of the care that we get. But I think there are all kinds of factors that go in. And it was just-- has just been difficult to get. But I think, on the other side, we should look at, this is awesome. This is wonderful care. And we have, like, long lists of medical associations saying, this is great. So, you know, legislation like this, it has an absolutely chilling effect, and I don't think that helps folks in our state at all.

HALLSTROM: Thank you.

LINDSAY SALEM: Yeah, thank you very much.

BOSN: Senator Storer.

STORER: Just a followup question-- thank you-- that was prompted by something that Senator Hallstrom asked. Is it-- the, the one, maybe, unknown here-- I guess I'm asking this as a question. Is it fair to say maybe one of the unknowns in terms of those low rates could be also, because the, the rates of detransitioning are just based on those who have actually de-- detransitioned. Right. I mean, we don't know who may have want-- who may want to that's not able to, we only base that rate on people who have actually detransitioned. Is that where those numbers come from?

LINDSAY SALEM: You know, that's a good question. I think, depending on the study, there, you know, the scope of a study may look at, for instance, there are some, just in preparing for today, that looked at-- and, and they kind of called it an umbrella term, of drop-- like dropout rates, from a study. You could think of it as detransition, but it wasn't necessarily. This is for trans youth. And so sometimes, that could be changed healthcare companies and didn't have coverage, or maybe met the goal of what they wanted, let's say, for hormone therapy to do, and so stopped. So there's lots of reasons why. And it might hit-- might be labeled detransition. So, so there's-- there could be research out there, I am just not aware of the full scope of it, that also asks, you know, where are you, how did this process go? And-- because not, not everyone pursues every type of medical care. These are all individual decisions, if that answers your question.

STORER: Right. [INAUDIBLE] So I think what we're both saying is we're not sure what that number is really based on, if it's people that maybe completely de--

LINDSAY SALEM: Well, the 1% rate, I mean, is, is on like post-surgery, post-pharmac therapy. OK. So it is. Yes.

STORER: OK.

LINDSAY SALEM: And there's like mountains of research on that. You're asking like what for folks, you know, outside of getting those procedures, and that I'm not clear on, but there may be someone else who can answer that.

STORER: And I guess what's prompting, you know, that is just maybe some concern of if, if-- that there could be people that wish to detransition but simply can't afford it or that care is not available. Is that, is that a fair--

LINDSAY SALEM: I guess I'm not sure, like wish to detransition, meaning?

STORER: That, that have decided that they would like to detransition but don't have financial means to pay for it themselves and insurance doesn't cover it.

LINDSAY SALEM: Oh, like, like a medical?

STORER: Right.

LINDSAY SALEM: I mean, they could, then I-- but I think that would be a different issue of, you know, do we have healthcare that covers hormones and these kinds of things. I mean, in no way do I want to ever speak for someone else. You can detransition. It, it's, it's a personal thing.

STORER: Right, I guess what I'm asking is, is it possible there are people that, that would like to, but there's simply not the healthcare available or affordable healthcare without insurance coverage for them to do that? So the--

LINDSAY SALEM: Probably, probably. We, we all have a, I mean, healthcare system that could be better.

STORER: Which is, which is probably possible on the flip, as well.I mean, there's-- yeah.

LINDSAY SALEM: Yeah, I mean, I, I, I absolutely am here to-- we need access to healthcare.

STORER: Right.

LINDSAY SALEM: And-- for, for everyone, you know, just because-- but we just need better access to healthcare and to center the people and those voices who are getting this healthcare. Our-- you know, our trans youth and, and adults, and ask them these questions, too, about, like, what are these processes, and what is that like? You know? And, and having-- especially in our state, having those requirements that these, these procedures are covered, and not in encumbered ways, I think would be amazing.

STORER: Thank you.

LINDSAY SALEM: Yeah. Thank you.

BOSN: Thank you for being here.

LINDSAY SALEM: Thank you.

BOSN: Next, opponent. Hi.

RACHEL MURPHY: Hello. My name's Rachel Murphy. That's R-a-c-h-e-l M-u-r-p-h-y, and I'm here today representing the board of PFLAG Omaha, as well as my own family as the mother of a transgender teenager. I'm testifying in strong opposition to LB731. As a leader in PFLAG, an organization that's dedicated to supporting, educating, and advocating for LGBTQ-plus people and their families, I see firsthand how vital evidence-based, gender-affirming care is for the health and well-being of our youth. As a mother, I see it every single day in the face of my own child. LB731 is not about patient safety. It's about intimidation. This bill is a transparent attempt to target and intimidate healthcare providers by extending the statute of limitations to an unprecedented 12 years and creating a new specialized private right of action specifically for gender-affirming care. This legislation tells doctors that if they provide the gold standard of care for their patients, they'll face a decade-plus of legal vulnerability. I'm sure most doctors aren't worried about it. However, their insurance providers might be. In Nebraska, standard professional negligence actions typically have a two year limit. Singling out the specific field of medicine for a 12-year window is a clear tactic to instill fear. It forces providers to weigh the needs of their patients against the threat of litigation. By requiring providers to sign disclosures that emphasize the pen-- ten-- I'm sorry, I can't talk-- the potential for regret and lack of conclusive long-term data, the state is attempting

to force doctors to use political talking points instead of medical science. Furthermore, the bill's provisions that prevent providers from seeking contractual waivers of liability, which are standard in many medical contexts, further isolates and targets these professionals. Healthcare decision-- decisions should be made in consultation with doctors, parents, and patients, not by the Legislature through the threat of specialized lawsuits. LB731 seeks to dismantle the medical infrastructure for transgender Nebraskans by making it legally too risky for doctors to do their jobs. On behalf of PFLAG and my own family, I urge you to reject this bill and allow our doctors to continue providing the life-saving care our children deserve without the shadow of state-sponsored intimidation. Thank you for your time and for the opportunity to testify.

BOSN: Thank you. Any questions for this testifier? Seeing none, thank you for being here.

RACHEL MURPHY: Thank you.

BOSN: Next opponent. Good evening and welcome.

CHRISTY KNORR: My name is Christy Knorr, C-h-r-i-s-t-y K-n-o-r-r. I heard some questions about what would it cost insurance to pay for hormones. I can speak to that. Roughly, for testosterone, it is around $100 for a 3-month supply. And for estrogen, it is, I want to say roughly $60, if you're using generic medications, of course. Right. You're, you're more old term. Like, your newer medications are always going to cost you money until there's that generic version of it. But I just wanted to speak to that. It's not-- insurance companies-- I felt like the way that question was being asked was how much is our insurance companies paying? It's not that much. They're not covering that much. And I can say that insurance companies don't cover a whole lot. My wife died of cancer. We were billed $2 million within 19 months. I guarantee you my insurance didn't pay that much, so I just wanted to put that out there. I wanted to talk about detransitioning. And let-- let's talk about straight people who have surgery, who have regrets. I have a lap band. I haven't had a steak since I had my lap band. Do I regret my lap band? When I really want a good T-bone. But I know the health benefits that I received from that are worth it. They're, they're worth that steak, not-- me not eating that steak. You might not think it's the same thing, but you have women who have breast implants that then regret it and have those removed. Should their doctors be liable for that? For encouraging them to get breast implants or tummy tucks or any of that? 150 minors-- there was a study

where they showed-- back in 2019, actually 150 minors, and this includes cis and transgender minors, so. They received gender-affirming surgery. Of those 146, approximately 97 were chest surgeries on cisgender males. That's a lot. The rare few that were performed on 13- to 17-year-old transgender folks were exclusively chest, chest surgeries. So where all of this is coming from, that we're doing this and this is happening and that is happening, that's not true.

BOSN: Thank you.

CHRISTY KNORR: It's simply not true. Please have integrity and state facts when you're up here, and not opinions when you're using numbers.

BOSN: Let's see if there's any questions. All right. Thank you for being here.

CHRISTY KNORR: Mm-hmm.

BOSN: Next opponent. Good afternoon and welcome.

FAITH WALKER: Thanks for having me. My name is Faith Walker, F-a-i-t-h W-a-l-k-e-r. The first thing I want to say is on December 18, 2025, the American Academy of Pediatrics called restrictions to gender-affirming care a, quote, baseless intrusion into the patient-physician relationship. This also is a baseless intrusion into the patient-physician relationship. There's no need, there is no increased risk, and in fact, there's quite a decreased risk, considering the regret rate, regret rate when it comes to gender-affirming care, and instituting this is going to have a chilling effect, as many other testimonies have, have noted, where doctors won't feel safe conducting that care for their patients. This has 2 negative impacts like, that I care about very much that don't necessarily relate to the trans people who are going-- being denied care, which is injust in and of itself. The first one is brain drain, both for parents and for doctors. Doctors aren't going to want to work here if they are scared to follow advanced medical science, and if they're scared and if there is hostile anti-science lawmaking that is preventing them from utilizing guidelines from organizations like the American Academy of Pediatrics, the World Health Organization, and the American Assoc-- the American Medical Association. It's very important that are-- that we are an attractive place for doctors to be, and also parents. I don't want to raise my kids here if I am facing this blockage to appropriate medical care. If I have a child and that child

is trans, I want to be able to follow the advice of the American Pediatrics Association, the American Medical Association, and the World Health Organization, where all of this is very safe, very routine, expected, and like, highly effective and necessary medical care. So we're losing doctors, we're losing parents, and we don't want to do that. So let's, you know, just allow this to be a, a place of dignity in medical care. And then, the other thing that I want to address is what a regret rate is. We've had some questions and confusion about that I've noticed, from the committee. A regret rate is very specifically when you-- like when you have the procedure done, any medical procedure once it's done, they, they will wait a certain amount of time and then they'll essentially do a survey. And they'll ask you, did you regret having the medical procedure done? It doesn't require any action, it doesn't require a detransition, it doesn't require any money. There's no blockage to saying that you have a regret rate. So like the-- and the 1% statistic, additionally, is coming from a meta-analysis that was published by the National Institute of Health-- which I pulled together 33 different studies about regret, about trans people who had had a gender-affirming surgical procedure done. And, and across the 33 studies, the, the length of time that they waited in order to like, do that survey question, did you regret this procedure, ranged from 6 months to, to like 3 years, or something like that. And of almost 8,000 respondents, only 77 reported any sort of regret across 33 studies. And of those 77 who reported regret, only 32 reported severe regret, as in they would not do it if they had the chance again, though the majority of them did meet a standardized criteria for regret matrix. Does that make sense? Cool. That's all I got.

BOSN: Thank you. Any questions for this testifier? Seeing none, thank you for being here.

FAITH WALKER: Mm-hmm. Have a good one.

BOSN: Next opponent. Good evening and welcome.

DANI HADENFELDT: Hello, members of the committee. My name is Dani Hadenfeldt, D-a-n-i H-a-d-n-e-f-e-l-d-t. I'm currently studying nursing at the University of Nebraska-Lincoln. I'm a first-year. At a very service level, and most people should be able to understand this, this bill is essentially just punishing doctors for doing their job. So if we're going to do this for something in advance as doctors, what's next? What's next on the line? Are we going to be able to sue tattoo artists when they give you a tattoo that you end up regretting?

Are we going to be able to sue hairstylists if they dye your hair and you regret it later? I come from a place where many people think they know better than doctors, even when they have little knowledge on anything in medicine. Back in 2020, there were many people in my community that swore by ivermectin to treat COVID, or they thought that masks would harm their lungs, or that when the vaccine came out that the vaccine was toxic and the vaccine was going to hurt them. I've also heard many more stories from my mother, who is also a nurse, of people who get diagnosed with things and then they reject the treatments that the doctors give them, just because they think they know better or they think that something they read on the Internet knows better. And this bill is what happens when we put people like that in office, and we let people like that come and speak on this. This bill is anti-science and anti-intellectual. Nebraska already has a brain drain problem, and this bill will make it so much worse. As I said, I'm studying nursing, and I know many people as they are my fellow students who are also studying nursing or even going on to become doctors themselves. I would not want to practice in a state that is hostile to doctors and that will punish them for doing their job. And I know many people will also not want to practice in a state like this. Thank you.

BOSN: Thank you. Any questions for this testifier? Seeing none, thank you for being here. Next opponent. Good evening and welcome.

AMARA PACE: Hello, my name is Amara Pace. That's A-m-a-r-a and P-a c-e. I realized that I need to live the way I do now, when I was only 12, pretty consciously. Just, OK, file that away for later. I don't really have statistics or numbers to give, just kind of my life experience, to give you some context. By the time I was 14, my father knew, but he didn't care to do anything. I told him again at 17, and he forced me to drive myself to a suicide prevention clinic, outpatient. Mind you, he also knew at the time that my primary thought of harming myself was driving said car into a wall. When I was 19, I went to my GP, who had treated me since I was a young child, and he said, oh, I actually just got back from a conference about this. So obviously, he was an expert, right? He panicked pretty hard. I could tell that he was uncomfortable. And he typed up 12-point notepad of 4 names and phone numbers for therapists in the city, and said, go talk to them. And whatever you do, don't cut it off. I'd really like to know what happened at that conference, and I'd like to know where's the malpractice suit for that. I reached out to Nebraska Medicine when I was about 26, 27. I realized that if I had nothing to lose, nothing to live for, I might as well live for myself for once. So Nebraska

Medicine said, OK, but you have to wait 11 months just to be seen, just to talk to me, just for consultation before I even start anything, not to start anything, just to see me. So I went to Planned Parenthood instead. They saw me the next month. They didn't treat me the best, but they did treat me. They gave me the care I needed. They saved my life. There is a clinic in Omaha called NextGen Male Medical, I believe it's called. Its original name was Med 88. Same people who own Tactical 88 and Signal 88. They provide-- they say, feeling low on energy or focus? It's time to push back. We deliver advanced treatments that help men sharpen performance, refocus-- so it's-- cis men can receive gender-affirming care, but we can't. The hypocrisy is just exhausting, and I'm tired of it. Sorry, there is one last point that I need to mention really quickly. I have a nonbinary friend, who began transitioning and then stopped. They don't regret transitioning, but they're comfortable with where they're at now, and they're a good friend. I don't think there's anything wrong with detransitioning. Sometimes it's just not right for you. And we should provide those people with care, but we shouldn't provide a minority of a minority of people with care by harming everyone else. It just doesn't make sense.

BOSN: All right. Thank you for your testimony. Let's see if there's any questions. Any questions of this testifier? Seeing none, thank you for being here.

AMARA PACE: Thank you.

BOSN: Next opponent. Good evening.

HAP HAUSMAN: Good evening. My name is Hap Hausman, H-a-p H-a-u-s-m-a-n. I would also like to talk about what it's like being a person whose gender identity does not match the one that they were assigned at birth. I was assigned male at birth and eventually came to the conclusion that I am nonbinary. I never had to undergo medical procedures, but I certainly had to think about it. And what that feels like, imagine looking at yourself in the mirror every day and seeing someone staring back at you that is not you-- someone that you don't recognize and someone that's-- it scares you, seeing someone in your body when you do not recognize that it's you. Many people told me that I would grow out of it, that, that it was just a phase, that I would learn to fit in like everyone else. And each day, I could feel myself growing further and further away from the person that I wanted to be-- that the person that I saw in that mirror was fading into the background. I can even identify about what is wrong in the reflection that you see, the person that is not you. For me, it was my hair. It's

always made to cut it short, and it never felt true to who I am. That was the first thing. These kinds of scenarios, where you are looking at yourself in the mirror and seeing someone else, that is the stuff horror movies are made of. You see it all the time in them, and people are going through that in real life. For me, I found my first glimmer of hope when I was 9. I was in the bathroom, top of the stairs of my parents' house. It's horrible bright pink tile. I was brushing my teeth one night, and I looked at myself in the mirror, and the-- for the first time, thought of something-- thought, would it be better if I wasn't a boy? After that, I stole my mother's hand mirror so that I could take it back to my room and keep trying to find the person that I saw that day. It felt like my life had been saved. I didn't have the words at the time to say what exactly that feeling was. I don't have very many memories from when I was 9. But that feeling is one of the clearest memories that I have ever had, that feeling of finding myself again, that feeling of finding hope that I could be my own person and not-- and look in the mirror one day and see myself, instead of someone else. Thank you.

BOSN: Thank you very much for your test-- let's see if there's any questions. Any questions for this testifier? All right. Seeing none, thank you for being here and sharing your story. Next opponent. Anyone else here in opposition? Good evening and welcome.

JOAN DAUGHTON: Good evening. My name is Dr. Joan Daughton, J-o-a-n D-a-u-g-h-t-o-n. I'm a physician, a child psychiatrist practicing in Omaha since 2003. I am 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 LB731. 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 life-saving 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 healthcare remains guided by clinical expertise, not political ideology, end quote. The evidence base has been reviewed thoroughly in this State Legislature. 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 is 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. Youth sometimes think if they don't feel completely female, oh, then I must be completely male, or vice versa. I have some patients who initially thought they wanted to transition medically, and then with 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 improved considerably after transitioning. For youth and 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 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's actually more evidence showing these women have long-term serious health concerns. 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?

BOSN: Thank you. Let's see if there's any questions. Any questions for this testifier? Seeing none, thank you for being here.

JOAN DAUGHTON: Thank you.

BOSN: Next opponent. Good evening and welcome.

JANET MORTON: Hi, my name is Janet Morton. That's J-a-n-e-t M-o-r-t-o-n, and I am the parent of an 8-year-old transgender

daughter. I am here to oppose LB731 because this bill does not protect children like mine. It places them at serious risk of medical neglect. By creating a-- LB731 does not ban gender-affirming care on its own. Instead, it weaponizes malpractice law to make providing that care legally and financially dangerous. And when LB731 is considered alongside LB732, which would eliminate or severely restrict access to gender-affirming care altogether, the combined effect is a near-total ban. One bill removes access directly, the other ensures that any remaining providers are driven out by fear of liability. Together, they function as prohibit-- prohibition with-- without transparency. For my daughter, that means fewer doctors willing to treat her. But it also means something just as dangerous: fewer therapists willing to support her. LB731 explicitly and implicitly includes mental health professionals-- therapists who diagnose gender dysphoria, write let-- referral letters, recommend care, or even explore gender identity in good faith can be pulled into litigation years later. The message is clear. Don't document. Don't refer. Don't support. Protect yourself. That creates a chilling effect on therapy itself. Instead of safe, exploratory, affirming mental healthcare, providers are pushed towards defensive documentation or silence. When therapists are discouraged from doing their jobs, children lose access to the very support that helps reduce anxiety, depression, and suicide. LB731 also reframes care around the assumption of future regret, elevating hypothetical lawsuits over present medical need. It ignores informed consent, ignores established standards of care, and ignores the lived reality of families who are trying to keep their children healthy and alive. Most importantly, the bill offers no alternative of treatment. Being transgender is not something that can be cured or ignored. Gender-affirming care, medical and mental health, is the only evidence-based treatment recognized by major medical and psych-- psychological organizations. Deterring that care without providing a substitute is reckless. When the state knowingly creates conditions where providers withdraw from necessary care, that is not protection. That is state-encouraged medical neglect. As a parent, I am doing what every parent is expected to do: follow medical guidance, work with licensed professionals, and act in my child's best interest. LB731 punishes that, and tells providers that helping my daughter is too risky, tells families like mine that our children are liabilities, not patients. I just wanted to address a couple things additionally to that. My daughter has been in therapy for almost 3 years, almost every other week. She has still, in 3 years, and it's not even that we're at that point of talking about medical stuff. But even in 3 years' time, she has not met the current standards and the hours required to get

the medical care for hormones or blockers, even if we wanted to-- in 3 years. There is already a standard put in place that is challenging enough as it is, let alone to add more restrictions and/or make it even harder to get because providers will disappear or, or pull away. So I just wanted to speak to that and I also wanted to just make a quick comment about the regret and detransition that was brought up.

BOSN: That's your time.

JANET MORTON: OK. Sorry.

BOSN: Let's see if there's any questions. That's OK. We just have a lot of testifiers, and--

JANET MORTON: I, I, I understand. Thank you.

BOSN: --it's 5 after 6, so. OK. Any questions for this testifier? Senator de Boer,.

DeBOER: Can you-- you were starting to talk about something there just now about the regret?

JANET MORTON: Yeah Yeah.

DeBOER: Please, can you speak to that?

JANET MORTON: And the person pretty much nailed it with the studies and stuff, about the regret rate of being 1% or less. And those are the factual evidence. And I just wanted to bring up that detransition does not mean regret. You can't have the detransition rates provided in a way that you're looking for or that some people are asking for. Because detransition isn't-- people don't detransition just because of regret. They may detransition out of no other choice. So they may still want to be or proceed with, with gender-affirming care, but don't have an option to. It may be a lack of support, it may be bills that are in place, it may be because they didn't have the money, the funding, the insurance, no parent care. Like, we are familiar with other people that don't have support system in place. We know people that are basically in their homes that are afraid to do anything and they don't go to doctors and they don't go anywhere, because they don't have the means to do so and they may have started a process when they had funding and then they had to stop because they lost the funding or they had to stop because a bill comes into place. So you can't look at detransition rates the same as regret rates because

there are more reasons to detransition other than regret. So I just wanted to point that out.

BOSN: Thank you. All right. Thanks for your testimony. Next opponent. Good evening and welcome.

ANDI CURRY GRUBB: Good evening, Chair Bosn and members of the committee. My name is Andi Curry Grubb, A-n-d-i C-u-r-r-y G-r-u-b-b. I'm the State Executive Director for Planned Parenthood North Central States, here in Nebraska, and I'm here to state my opposition to LB731. PPNCS's mission is to affirm the human right to reproductive and sexual health and freedom for all by providing excellent care, trusted education, and advocacy. We offer LGBTQ-plus care and educational programming so that people can access medically accurate information, compassionate care, and support in living healthy, authentic lives. As an organization that prioritizes policies that advance health equity, we strongly oppose bills like LB731 that seek to reduce or eliminate healthcare. PPNCS opposes this bill because it is motivated by politics and not patients. LB731 is an attempt to eliminate access to essential care for transgender Nebraskans. It is aimed at instilling fear in the medical providers that care for transgender Nebraskans, and even ones that are tangentially involved in that care, like a, like a practice partner, mental health provider, or support staff. This is an effort to eliminate access to medically necessary care by making it too legally risky to provide. This is a similar tactic to ones that we have seen used for years to instill fear in doctors that provide abortion care. In addition, LB731 is an unnecessary solution in search of a problem. Standard medical practice already requires protections and safeguards for patients, including informing them of risks associated with treatment. In Nebraska, medical malpractice laws already permit lawsuits against negligent providers. When patients can receive the gender-affirming care they need, their outcomes are extremely positive. The vast and overwhelming majority of people who receive gender-affirming care do not regret, regret receiving that care. A review of 53 peer-reviewed studies found higher levels of life satisfaction, happiness, and quality of life after gender-affirming surgery, while a review of 7 other peer-reviewed studies found that hormone therapy was associated with improved quality of life, depression, and anxiety scores. Less than 1% of people that receive gender-affirming care surgery regret it, which is significantly lower than regret rates around other surgeries and around major life decisions, including having children. To claim that patients receiving gender-affirming care have high levels of regret is just not true. Doctors should never be afraid to rely on medical

expertise. They should not be afraid to provide compassionate care. They should never be afraid to simply do their jobs. LB731 is an unnecessary bill that causes harm and offers no protections or support to anyone. For these reasons, we urge you to oppose LB731 and not advance to General File.

BOSN: Thank you. Any questions for this testifier? Seeing none, thank you for being here. Next opponent. Welcome.

JESSIE McGRATH: Good afternoon, Senators. My name is Jessie McGrath, J-e-s-s-i-e M-c-G-r-a-t-h, and I'm a retired criminal prosecutor from the Los Angeles County District Attorney's Office, now living here in Lincoln, Nebraska. Let's cut through the BS on this, and let's get to the point of what this really is. This is another one of a series of anti-trans legislation developed by nationalist Christian organizations hell-bent on making it impossible for transgender people to live in this state and in this country. It is groups such as the Family Research Council, which, the same time as I transitioned, back in 2015, produced a report on understanding and responding to the transgender movement. And what they said is that biological sex is the most important, fundamental, accurate measure of a person's intrinsic identity, rather than the purely subjective and often-shifted concept of gender identity. Ideally, the law would forbid government recognition in any way, whether it be on birth certificates, driver's licenses, passports, and other governmental-issued identification of any change iniden-- an individual's identical-- biological sex identified at birth. They have been working on this for the past 11 years. This is not something that just suddenly came up. This is the fundamentalist Christian view that you have to accept how you were born. And frankly, it, it's, it's really upsetting to have to keep coming back here, time and time again, because somebody's religious beliefs believes that I don't have a right to exist. Make no mistake, this bill is, is not necessarily about malpractice. This bill is about making it impossible for healthcare providers who provide gender-affirming care to get malpracticing insurance. It is one of a cog that is in place to try to prevent individuals from being able to transition. All of these things work together. Senator Kauth has introduced 3 bills this year-- this, this session, and they all attack trans folks, and all of them relate to being able to get medical care. And frankly, it's frustrating, because they want us to only go through mental health counseling that forces us to be able to accept our birth gender. Well, I'm sorry. I've lived as a trans person for the last 11 years. There's no way in hell I'm going back. You can't do that to me. You can force me to do that, and I won't do it. And frankly, it is

frustrating as hell to have to sit here and listen to people talk about their concern when their concern is, I want my religious views to be the ones that take place. Well, I am not ashamed of being transgender. I was created by my, my creator, by God, as a trans person. And one thing I want to ask all of those people who have these views that, in Christianity, that you have to accept your birth gender. I've accepted that God created me as trans. What if you're wrong? What if you guys are wrong? If I'm wrong, it's only on me. If you're wrong, you're forcing your religious views on a whole group of people, and you're going to have to answer to your maker. I'm very comfortable answering to mine for my choices in my life, but don't force your stuff down my throat. Thank you.

BOSN: That's your time. Thank you. Any questions for this testifier? Thank you for--

JESSIE McGRATH: Thanks.

BOSN: --being here. Yes. Next opponent.

DeBOER: Welcome.

GRACE JACOBSON: Hello. My name is Grace Jacobson, G-r-a-c-e J-a-c-o-b-s-o-n. I'm going to be frank with you. I don't even have what I was going to testify today, because I have spent the last day and all of last night with a transgender young woman who is in crisis. I have been in the ER with someone who tried to walk out into traffic, because what was said yesterday while she was trying to watch the virtual hearing was so distressing and so triggering, and it reminded her of the fact that she was raped in a bathroom because she was a trans girl just trying to go pee. And this legislation is just another part of Senator Kauth's obsessive vendetta against transgender people, and especially transgender youth. I am exhausted. I am so tired of fighting this. I have been coming here for years, specifically testifying against Senator Kauth's extreme policies. I know families who have had to leave the state. I know children who are now suicidal, who are now anxious, who are now afraid to be who they are because of this legislation and because of the hate that it just spreads throughout our communities. My friend needs a therapist. She needs to actually be able to get gender-affirming care. She fled from an abusive family, a father who tried to break into her hospital room last night that we had to call the police to remove her-- remove him. Sorry. LB731 will just make it harder for her to get the care she needs. She has identified as a girl at least since she was a-- 9 years

old. She fled to Canada and had to come back because she couldn't get work and she couldn't get asylum, because apparently, it's not dangerous enough yet. I'm tired. I'm sick of this. I should not have to be here. My friend shouldn't have been so traumatized by what happened to her and then so re-traumatized by hearing what was said yesterday that she had to go to the hospital. And she doesn't feel safe staying at a psych ward because they're going to misgender her. They're gonna put her with men. She's terrified. And I'm sorry for yelling and being angry, but I'm just done. Like, I can't do this anymore. This legislation is doing immediate and direct harm just by being put here, out in front. So please table it. Don't bring it to a vote.

DeBOER: Thank you. Let's see if there are any questions. Are there questions for this testifier? Thank you for being here.

GRACE JACOBSON: Thanks.

DeBOER: Let's take our next opponent. Welcome.

TERESA LOMBARD: So my name is Teresa Lombard, T-e-r-e-s-a L-o-m-b-a-r-d. You know, this bill is obviously designed just to discourage health professionals be-- from being able to help the people that they want to help, that they need to help, the people who need their help, right? It's-- that's very clear. There's no reason to pretend anything else. You know, it's discriminatory. You know, you're not targeting everybody with this bill. You're targeting a subgroup of people that I suppose you think aren't going to have as many people protecting them, and so you can get away with it. Well, that's just immoral, and I, I really question how you guys can live with yourself sometimes, by, by even considering these kinds of things. Nebraska has big budget challenges, right? Why are we spending our time on this? Aren't there lots and lots and lots of other things that we could be spending our tax dollars on that would improve things for all of us? And instead, instead, we are bullying at-risk youth and their families and pretending that it's because, well, no, you know, we need to have more insurance, no they're gonna regret it, no we're gonna protect them. Wrong. That's bullshit. OK. You know it. I know it. Everybody out there knows it. Everybody watching and listening knows it. So I have one more thing to say, which is that when my son was under 19 years old, he was very unhappy. He did not know what was wrong. I did not know what was wrong. We did not have a resource to go to that we knew of that even understood what might be happening to him, you know, what he was seeing. He would wear long-sleeve shirts to school, no

matter what the weather was. All right. Well, I thought maybe he just was concerned about hairy arms, right. Kids are sensitive at that age. They worry about being judged. Guess what? You are judging. Right. It's not kind. It's not adult. In many ways, these trans kids are more mature than the adults in this country who are trying to make decisions for them, but they're not making decisions for them. They're making decisions against them. So the reason that my son was wearing these long-sleeve shirts, was because he was in so much pain-- he was cutting his arms. OK? Thankfully, my son matured to be an adult. And as an adult, he figured out what it was that was wrong, and he transitioned to being a man. He is now happy. He is now successful. He's married. He's living the life of the person he needed to be, the person that is him, right? So I want you guys to think about this. There are some children out there who do not--

DeBOER: Ma'am, I'm sorry. I'm going to have to--

TERESA LOMBARD: OK. I'm sorry.

DeBOER: The red light. Sorry.

TERESA LOMBARD: I wasn't even paying attention.

DeBOER: That's OK.

TERESA LOMBARD: My apologies.

DeBOER: Let's see if there are any questions. Are there any questions for this testifier? I don't see any. Thank you for coming and telling your story.

TERESA LOMBARD: Thank you.

DeBOER: Let's have our next opponent, please. Welcome.

JENNIFER CATLETT: Good afternoon. Vice Chair and members of the Judiciary Committee, my name is Jennifer Catlett. That is J-e-n-n-i-f-e-r C-a-t-l-e-t-t, and I am here in opposition of LB731. I oppose this bill because this act-- this opens up physicians to an extended period and retroactive period of frivolous lawsuits because people have changed their mind about what is mostly a cosmetic-- well, deeply personal procedure that they have elected with their physician, psychiatrist, and much counseling, to do at a particular time. In the end, what these frivolous lawsuits and the opening up this would do is make it very difficult and you know, emotionally distraught, even for

physicians themselves to go forward in providing care. And it would effectively, effectively end transgender and gender-affirming care within Nebraska. I am a long-term Nebraska resident. I mean, I was born and raised in Hastings. I have lived in Nebraska the majority of my life and then stayed in the Midwest for all of it-- Iowa, live in Minnesota. And I-- have lost my transcript-- but I was raised in Hastings, my father was a physician, and he spent his entire life trying to expand care for everyone. He always would say that the most revelatory experience that he had with his patients was when they finally got on Medicare or Medicaid, after having years of being farmers, with no actual ability to receive care. He spent his entire life providing care to the homeless, providing care to the die-- to the dying, and trying to work and vote to expand care for everyone in this country. And he opposed any, any efforts to restrict care, which is what this does. I understand that it sounds like it's trying to provide additional care, that it's written in such a way to make us support it, to make it sound like it is a good idea and it's harmless, but it is not. Anything that makes it harder for anyone to get care is bad. It hurts people. It's going to hurt people. It's gonna kill people when they can't get it. And it's driving people away from Nebraska. 4 friends, 4 friends of mine, from my Ph.D. work, from just my life, in general, have left Nebraska, left this country already, because of this bill, and they need to protect themselves and their family. And it is going to continue. We lost social workers, scientists, physicians. We're going to lose more, and Nebraska can't afford to lose these people. And it's not who we are. As Nebraskans, we help each other. We support each other, even when we don't understand. I'm not trans, no one in my family is trans, but I can see this bill, and I can look at it, and I know this is bad for us, as a state. We should not be passing this. Thank you for your time, and I'm-- I hope that I give you some new information. I-- once again, I am here to oppose LB731, and I hope it does not go to the floor.

DeBOER: Thank you, let's see if there are any questions. Any questions? Thank you for being here.

JENNIFER CATLETT: All right. Thank you.

DeBOER: Next opponent. Welcome.

MEGHAN OAKES: Thank you. I appreciate everybody still being here. I know it's getting late. Thank you for allowing me to testify today. My name is Dr. Meghan Oakes. It's 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 access, and the effects of 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 recommendation of virtually every medical body with a position statement on the topic. LB731 attempts to double down on the existing legislation, with the goal of effectively eliminating gender-affirming care for all Nebraskans through fear-mongering and financial penalty. Regret after surgical procedures has been extensively studied. The rate after-- the rate of regret after a breast augmentation is 5-9%. The rate after prostatectomy, 30%. I myself see patients on a weekly basis who are interested in IVF because they regret their vasectomy or tubal ligation. This equates to 3-7% of men that have a vasectomy, and five to 5-7% percent of tubal-ligation patients. 16% of people that get a tattoo regret getting one. 7% percent of people who have a child regret having that child. This is all in comparison to gender-affirming care, which has an incident of regret equal to 1%. People do not make the decision to start gender-affirming care on a whim. It's not an easy decision, nor is it an easy path. Truth be told, it might be easier to keep living the lie. When patients are brave enough to seek treatment, the standard of care that must be met to initiate treatment is high, so high that regret is almost non-existent. Existing malpractice laws hold physicians liable for the care they provide, extending the statute of limitations when children are involved. Patients that elect to proceed with gender-affirming care already receive equal protection under these regulations. And if we feel that an extra layer of protection is necessary when it comes to gender-altering surgery, say breast reduction, shouldn't the same rights be provided to women undergoing breast reduction for other reasons? It is, after all, the same surgery performed by the same surgeon. The different lies in the patient's motivation, not in the inherent danger of the surgery, or the potential for regret, and that is the definition of discrimination. LB731 is a waste of this Legislature's time and energy. The state of Nebraska has real problems. This bill is a solution in search of a problem that doesn't exist. It's time to move on and do something more productive for the state and the people that elected you. Thank you for letting me speak. I would be happy to take questions.

DeBOER: Let's see if there are any questions. Senator Storm.

STORM: I actually do. Thank you. Thank you for testifying. So you're a fertility doctor, basically?

MEGHAN OAKES: Correct.

STORM: In Omaha?

MEGHAN OAKES: Correct

STORM: And I keep hearing this statement of, you know, several percent of people regret having children. Is that-- where does that come from? I'm curious.

MEGHAN OAKES: So that comes out of a study-- UCL-- UCLA Law School has a-- my understanding is, and I'm, I'm not a lawyer. But my understanding is the Williams Institute is a facet of UCLA's law school, and they do quite a bit of research on trans, the trans population, and incidence, and, and population and things like that. And it comes from, it comes from the Williams Institute.

STORM: OK. How many people regret having an abortion? Do you know that?

MEGHAN OAKES: I do not have da-- I do not have data on that. I imagine my colleagues who provide abortions and work at Planned Parenthood--

STORM: Well, I just was curious because we talk about 7% regret in having children, so I was curious if you knew the stats on abortion.

MEGHAN OAKES: I think the, the greater point is that people have regret in life--

STORM: Right.

MEGHAN OAKES: --that cannot always be accounted for and there are many medical procedures that have significantly higher rates of regret than gender-affirming care.

STORM: Abortion would be way up there on that, probably.

MEGHAN OAKES: I don't know that I would say it would be way up there. I understand you would think it would be way up there, but I'm not sure that the data actually supports that. Again, that is not my area of expertise, and I didn't prepare to testify on abortion, because we're not talking about abortion. But we are singling out this

procedure that has a known, much lower rate of regret than many other procedures.

STORM: OK, thank you.

BOSN: Thank you. Any other questions? Thank you for being here.

MEGHAN OAKES: Thank you.

BOSN: Next opponent. Good evening.

LISA CARMICHAEL: Hello. Thank you, again, for being here so late this evening, as others have said. I know it's getting, getting-- well, very dark out there. 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. And Dear Senator Bosn and members of the Judiciary 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-plus community. The LW-- the L-- the League of Women Voters of Nebraska also opposes legislation that restricts individuals' access to quality healthcare, including behavioral and mental health, and undermines their right to privacy surrounding healthcare choices. 7-- LB731 does both, and therefore we oppose this bill. Gender-affirming care is a supportive form of healthcare. It consists of an array of services that may include medical, surgical, mental health, and nonmedical services for transgender and nonbinary people. For transgender and nonbi-- nonbinary youth, this-- early gender-affirming care is crucial to overall health and well-being, as it allows the individual to focus on social transitions and can increase their confidence while navigating the healthcare system. According to the Kaiser Family Foundation, Nebraska has 0.7% of the trans youth in the United States. Even with this tiny population, gender- affirming care for those under 19 years old is rarely, if ever, provided. In the state of Nebraska, surgical gender-affirming care is not an option for those under the age of 19. Hormonal treatment for those under 19 is not common. It has rigorous requirements to even consider it as a method of care. Yet, this bill would have an outside negative-- an outsized negative effect on the ability to practice medicine. It creates a significant conflict between physicians' adherence to the law and adherence to the professional code of ethics and civil law tort duty not to commit medical malpractice. The traditional standard of care with regard to medical malpractice requires that medical care for a given patient in healthcare provider is the quality of care that

would provide to any patient in a similar clinical situation by the average provider in a similar situation-- or similar location. Additionally, the bill forces physicians to hold extra malpractice insurance, extending the statute of limitations for trans patients. Instead of the current 2-year statute of limitations, this bill implements a 12-year statute of limitations, specific to this type of care. This would require doctors to carry tail coverage once they've stopped practicing. Additionally, LB731 targets not only the physicians and mental health professionals, but the clinics, hospitals, and any other entity involved in the gender-altering procedure. This could lead to medical systems refusing to provide care to a special subset of patients due to the legislative creat-- created potential risk liability issues.

BOSN: That's your time. Let's see if there's any questions. Any questions for this testifier? All right. Thank you for being here.

LISA CARMICHAEL: All right. Thank you.

BOSN: Next opponent . Anyone else here to, to testify in opposition? Good evening and welcome.

KATARYNA MORTON: Hi. It's really loud. My name is Kataryna Morton, K-a-t-a-r-y-n-a M-o-r-t-o-n. I graduated with a bachelor's degree in psychology and communication studies, and I'm currently obtaining my master's in social work. As a personal advocate for the community, I'm here to testify in opposition to LB731. While you claim this bill would prioritize the safety, health, and well-being of children and other patients, it will actually create a harmful, unequal legal standard that targets transgender individuals and their healthcare providers. So first off, the bill's requirement that providers and insurers cover treatments and procedures arising from regret or dissatisfaction with gender-affirming care is both misleading and harmful. Gender-affirming care is widely recognized as medically appropriate and beneficial for transgender individuals and is supported by many U.S. and international medical organizations. And LB731 ignores this medical consensus and treats gender-affirming care as dangerous, without scientific justification. Secondly, this bill creates a separate and unequal legal standard by allowing extended malpractice claims for only gender-affirming treatments. No other form of medical care is subject to this level of retroactive liability. This sing-- sing-- singling out reinforces stigma by implying that transgender patients' needs are less legitimate than other patients' needs. LB731 sends a societal message that gender-affirming care is

inherently harmful, thereby increasing discrimination and discouraging youth from seeking medically necessary care. Frankly, there's just no need for this law. And finally, LB731 offers no alternative solutions or forms of care for transgender individuals. If you all claim that child and patient safety is your priority, then you must have some sort of evidence-based treatment you propose instead. Currently, gender-affirming care is the only evidence-based treatment shown to improve mental health outcomes for many transgender individuals, so removing access or restricting access without offering a reliable replacement does not protect these individuals. It puts them at greater risk. Rather than improving medical oversight or patient outcomes, LB731 politicizes healthcare, undermines the doctor-patient relationship, and imposes, imposes unnecessary legal burdens that will harm patients, families, and providers. I urge the committee to oppose LB731, and to instead, prioritize legislation that is grounded in data and contributes to the well-being of all kids and community members. Thank you for your time today, and your consideration.

BOSN: Thank you for your testimony. Any questions for this testifier? All right. Seeing none, thank you for being here.

KATARYNA MORTON: Thank you.

BOSN: Next opponent. Good evening and welcome.

KENNETH MORTON: My name is Kenneth Morton, K-e-n-n-e-t-h M-o-r-t-o-n. I feel like we've been here so often, I should get like a punch card to the cafeteria or something. I hope, I hope this doesn't continue, but I guess we'll see what happens. A lot of the people you've probably seen here tonight have been here before. A lot of us were here last night, some of us until after 8 or 8:30. We're spending our evenings fighting for our kids and our loved ones' just the right to exist, instead of making meaningful memories with them. Most of us will or will have testified in front of HHS regarding LB732, as well. That's just where I came from. I spoke yesterday in front of the Government Committee, opposing LB730. And I really wanted to make the point that this isn't, in my opinion, about protecting anyone. You have 3 bills and that pesky research commissioned in this very committee, LR301. She's not going to stop unless you stop her. She tries to get up there and act like these bills aren't related, but I think LR301 really is the glue that holds her plan together. I'll get back to that in a second. But with regards to LB731, I'm wondering why it's only gender-affirming care. Why not all childhood procedures? Why not something like circumcision? I can guarantee you nearly every

single one has a higher regret rate than gender-affirming care, and we heard that a little bit earlier, as well. I think the why is obvious, and, and Kauth, Kauth really isn't trying to hide it anymore, I don't think. We've known all along what her end goal is. This and LR301 are scare tactics, scare tactics, where providing care, whether it be by a medical professional or simply a parent loving and supporting their child, as LR301 threatens, will be deemed both "litigatable" and criminal. It's just another rung on the ladder towards her ultimate goal: the eradication of trans people from this state and, ultimately, this country. As you know, if this committee has an open hearing to LR301, we'll all be here to-- we'll all be here to oppose it, taking more time away from our families, more sleepless nights and time off work, and, and spending time, just trying to figure out what we're going to do next. I think one thing I would love is, I would love, when I finish my testimony, ask me questions. I have an 8-year-old transgender daughter. Senator Bosn, we just moved into your district, so we are constituents of yours, as well. Or just take the time to talk to somebody who is living this day by day. I know some of you already do this, and I really do appreciate those who do. I mean, thank you for taking your time. I think most of you are on the wrong side of history. You may feel like you're winning, but history will not look kindly what is happening in this state or nationally. And what happens if Senator Kauth gets her way? Which group is next? Fascism always needs a target. Are you going to be complicit in that, as well? If I know one thing from watching the debate at LB89 last year, is that a lot of you have granddaughters. Heard a lot about granddaugters, especially into debate. Scared granddaughters that you would rather tell to continue to be scared, rather than teach them empathy and that diversity is what enriches us and makes this country great. I paraphrase the immortal words of Pastor Martin Niebohler. First they came for the trans people, and I spoke up because I read the rest of the damn poem. Thank you.

BOSN: Thank you. Any questions for this testifier? Seeing none, thank you for being here.

KENNETH MORTON: Thanks.

BOSN: Next opponent. Anyone else here in opposition? All right. Anyone here to test-- are you here in opposition?

AUBREE JACOX: I'm neutral.

BOSN: OK. Yep. I was just, just moving on to neutral testifiers. All right. Come on up. Looks like you're the, the lone neutral testifier. Thank you for being here.

AUBREE JACOX: My name is Aubree Jacox, A-u-b-r-e-e J-a-c-o-x. I come to speak neutrally on this bill. And part of the reason of that is because I think like, some of the things in the bill that it is trying to address are like good, but the problem that is happening and like why you have all this opposition against this, is kind of like the person who happens to be proposing this bill seems to act in bad faith towards the transgender community. And so, when we look at like this bill, a lot of these people come with that sense of this is a bad faith act. But there's a lot of things in this bill that are very valuable. And I think like, some of you senators have asked these tough questions, like yourself and yourself, unlike there are things in here that are very good, like shouldn't we be expanding healthcare for people that want to transition. Isn't that something that we should strive for, and I think that that's a very valuable thing that we should do. Shouldn't we be holding doctors, in general, liable for malpractice? I generally believe that that's something that we should be doing. And yeah. Anyway. Sorry. I got a little-- but one thing that disappoints me, I think, regularly, about this legislation as a whole, is that we hear all this opposition, and I just like, don't see a lot of like, trying to like come together in a way that's like, OK, well, we do want to meet these needs of helping these people that do want to transition, while trying to understand where the opposition is coming from. And so, I've kind of like tried to put together a few things that I think would help like maybe just change the bill, that might kind of alleviate both sides and kind of like come to more of like a, a neutral, like, let's help those people that want to transition while not hurting transgender people at the same time. And so, one of the things in the bill is that it specifically ties insurance providers to, if, if they provide care for trans-- people who transition, they must also provide for detransitioners. But I think you should just change that part to just say if you're an insurance company, you should always provide for detransitioners. Why tie the two together? And that's where I think like, a lot of opposition comes from and where like, the hesitation of like, is this a bad-faith bill. But if you take it away, any insurance company that I have, if transit-- detransitioning is truly important to us, should cover it. It shouldn't be tied to that aspect. The other thing I would just suggest in this bill is that the, the legal-- you know, like we're expanding the range of-- sorry-- liability for doctors, but why don't we also

make it extra liable for doctors that detransition, as well, because that's equally as invasive. Correct? So like should they not also be in this bill as having the same amount of legal burden when they detransition? And then, I would just generally say you should probably make therapists exempt from this, because they're not the ones that are providing the physical care. And then, one last thing is I would just generally recommend that you reduce the time for liability. 10 years is an exceptionally long amount of time. You know, like I'm still getting care today. I like-- you know, like, so if I regretted it in 2 years from now, even though I started transitioning a really long time ago, you know, like, I would-- anyway. That was my time. I'm kind of rambling a little, so I'll just leave it there.

BOSN: Thank you very much for your testimony.

AUBREE JACOX: Yeah. Of course.

BOSN: Any questions? Senator Storm, followed by Senator Storer.

STORM: Thank you. Thank you. I appreciate the fact that you thought this through, came in neutral, didn't yell at all of us, and that you, you made some good points. Really good on that, so I appreciate that. Thank you.

BOSN: Senator Storer.

STORER: Yeah. Thank you, Chair Bosn. And thank you for coming tonight. Yeah, I just also wanted to commend you and your thoughtfulness in terms of-- you might have a future in politics, being able to, to come and say, hey, you know,can we, can we think this through, and what might work, what's good about this, what's not good about this. But I appreciate your thoughtful comments. Thank you.

BOSN: All right. Thank you. Anyone else here to testify in the neutral capacity? I stepped out for a minute, so I, I, I believe I saw everyone in the room last that testified, but OK. All right. With that, we will welcome back Senator Kauth to close on LB731. Thank you very much. Thank you very much. Senator Kauth.

HOLDCROFT: Are you waiving?

STORER: I don't know if she's heard you.

DeBOER: Why don't you do it again?

BOSN: Senator Kauth, can we have you come up and close really quick? That's OK. OK. So apparently, I misspoke when I said the comments that were submitted. There were 151 proponent comments, 388 opponent comments, and 3 neutral comments submitted for the record. Welcome back.

KAUTH: Thank you very much and thank you to the Judiciary Committee for taking a lot of really good, thoughtful time with this. I was talking with Aubree when I came in. Those were some interesting points. So I'm going to get some information, sit down and talk about those. I think they were very-- the-- very well-made points. LB731 is about providing care for people who are-- if they are-- if they have had transitions and they need to detransition, to make sure that they have the insurance coverage available for that, and to provide an extension on the malpractice, just in case they feel that at the end of it, if it didn't do what they thought it was going to do, what they were promised it was going to do, that they have to ability to go back and sue, because it does take a very, very long time to get through these processes, and it takes a while to figure out what you have missed out on. You also, in any sort of malpractice, you actually have to prove that there was malpractice. So it doesn't mean that if you get to the end and then you don't like how it turns out, you can go back and sue your doctor. If the doctor did everything right, gave you all the information, has proof that you were given full, informed consent, then that's, that's up to the courts to decide. So I appreciate everybody taking the time to listen tonight.

BOSN: Awesome. Any questions for Senator Kauth?

HALLSTROM: Just one quick question, Senator Kauth.

BOSN: Senator Hallstrom.

HALLSTROM: The expansion to 12 years. It says after the later of the date of the provider's recommendation, approval, or procedure, which outlines that there's different types of providers, one may take a provider recommendation, but it doesn't necessarily say after the date of the final. Is that the intention, that it's after the day of the final provision of services?

KAUTH: Well, it really depends on what the procedure is. Because you could have a mastectomy, and then going to have other procedures, but that mastectomy might, might be what you're upset about. So it, it-- it's specific to the procedure.

HALLSTROM: So it would be tied to that?

KAUTH: Yeah.

HALLSTROM: OK. Thank you.

KAUTH: Thank you.

BOSN: All right. Thank you very much.

KAUTH: Thank you very much.

BOSN: That will conclude our hearing on LB731, as well as our hearings for today. Thank you to those who joined us.