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

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

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

RIEPE: Merv Riepe, District 12, which is metro Omaha and the good city of Ralston.

HANSEN: Also assisting the committee is our research analyst Bryson Bartels, our committee clerk Christina Campbell, and our committee pages for today are Maggie and Molly. A few notes about our policy and procedures. Please turn off or silence your cell phones. We will be hearing 5 bills and we'll take them in the order listed on the agenda outside of the room. On each of the tables near the doors to the hearing room, you will find green testifier sheets. If you are planning to testify today, please fill one out and hand it to Christina when you come up to testify. This will help us keep an accurate record of the hearing. If you're not testifying at the microphone but want to go on record as having a position on a bill being heard today, there are yellow sign-in sheets at each entrance where you, you may leave your name and other pertinent information. Also, I would note if you are not testifying but have an online position comment to submit, the Legislature's policy is that you-- is that all comments for the record must be received by the committee by 8 a.m. the day of the hearing. Any handouts submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring 10 copies and give them to the page. We use a light system for testifying. Each testifier will have 3 to 5 minutes to testify depending on the number of testifiers per bill. When you begin, the light system will be green. When the light turns yellow, that means you have 1 minute left. When the light turns red, it is time to end your testimony and we will ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone and then spell both your first and last name. The hearing on each bill will

begin with the introducer's opening statement. After the opening statement we will hear from supporters of the bill, and then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make a closing statement if they wish to do so. On a side note, the reading of testimony that is not your own is not allowed unless previously approved. And we do have a strict no-prop policy in this committee. With that, we'll begin today's hearing with LB1387, which is my bill, and I'll come up here and then hand it over to Senator Cavanaugh to take over.

M. CAVANAUGH: Thank you, Chairman Hansen. Chairman, you're welcome to open on your bill, LB1387.

HANSEN: All right. Good afternoon, members of the Health and Human Services Committee. My name is Ben Hansen. That's B-e-n H-a-n-s-e-n, and I represent Legislative District 16. Today's bill, LB1387, is going to address an issue that has caught recent attention on a national level. The subject: the fluoridation of public water. In 2008, the Legislature passed a bill to mandate fluoride in all public water systems in cities with populations over 1,000. Certain cities had an option to opt out before 2010, and of the 61 communities who brought the question of fluoridation on their ballot, 49 decided to refuse fluoridation. In fact, more individuals have voted to get rid of fluoride than to add it in Nebraska and I'm here to address this. Of these communities, over 227,000 Nebraskans voted against fluoride, while only 31,000 voted for it. These numbers lead me to believe that we are not currently listening to the majority of Nebraska when we implement-- when we-- when we implemented this mandate. LB1387 does two things: first, state statute would limit fluoride levels to 0.7 milligrams per liter of water. And second, after January of 2025, each city and village will be required to pass an ordinance through the vote of the people in a general election to-- in order to fluoridate their water. If no ordinance is passed, the water will not be fluoridated. If the ordinance is passed, the water will be fluoridated. Instead of the mandate, we would expand local control and community input. Fluoride as a naturally occurring element, which you will hear probably from the opposition saying fluoride is found in the soil and in the water, which is true, however, the fluoride that we add to our water systems is anything but natural. The main fluoride chemical that we use is a corrosive acid called hydrofluorosilicic acid and is captured in the air pollution control devices of the phosphate fertilizer industry. And let me say all of the chemicals added to the water are supposed to treat water. You know, a lot of us kind of have an idea of maybe how we treat water. I was on the city

council at one point, I got a chance to go to a water treatment facility and see how they add the chemicals, which ones they do. And almost all of them made sense. There's a reason why we add chlorine to water. I mean, to help prevent bacteria from spreading so we don't get sick when we drink the water. But fluoride is the only element we add in water that is used for medicinal purpose and not to treat the water. The only one. All the other stuff we add to the water is used to treat the water, which makes sense, but we add fluoride to the water as a medicinal reason why and not to treat the water. You know, for some reason we have decided that we will only add one drug and impose a digestion of fluoride on most Nebraskan citizens whether they like it or not. In fact, 97% of Europe refuses to fluoridate their water as they view the water supply as an inappropriate method to deliver medicine. 97% of Europe. Another thing you might hear today from the opposition is you will hear that fluoridation is one of the top 10 public health achievements of the 20th century. However, I would contend to say it is actually one of the most widely rejected health interventions in the world. 95% of the world's population is fluoride-free. Let me say fluoridation-free in their water, not fluoride. But we must fluoridate to prevent tooth decay is what I have been hearing from some of the dental communities. Yet, recent CDC surveys of dental fluorosis, known as NHANES, have found that 70% of teenagers now have dental fluorosis, 70% of teenagers, up from 41% in the early 2000s. Fluorosis is a tooth enamel defect and a visible side effect of overexposure to ingested fluoride during early development. One of the things you might also hear is that fluorosis of the teeth is, is not a concern, it's just some white spots on the teeth, but it's actually an indication that your body is actually, you know, not able to excrete fluoride and it's in the system too much. A lot of you might have kids or you might know sometimes people have white spots in their teeth, that's fluorosis. Another thing you might hear is tooth decay has declined rapidly since implementation of fluoride. Yet, numbers from the WHO show that Europe, who refuses fluoridation, has seen the same decline at the same rate. There are dentists across the world who have realized this and started speaking out about the hesitations they have with fluoride in the water. Also, the largest study ever conducted on the effectiveness of water fluoridation was just published last week called the LOTUS study out of the United Kingdom. It looked at 6.4 million residents over 10 years and found that decay was only, quote, 2% lower in the optimally fluoridated group. And there had-- and that there was, quote, no compelling evidence that water fluoridation reduced social inequities, inequalities in dental health. End quote. Authors ultimately concluded, quote, fluoridation resulted in very small positive health

effects which may not be meaningful for individuals. When digested, fluoride is no longer just influencing the teeth-- the health of the teeth. The whole body must be considered. What we find is an astonishing connection between slower brain development in children and fluoride. During utero, fluoride is able to cross the blood, blood brain barrier affecting development. The harm continues when babies who are on formula receive an overwhelming amount of fluoride. The fact that their kidneys aren't able to excrete fluoride efficiently adds to the problem. So much so that New Hampshire passed a law requiring that water confidence reports in fluoridated communities recommend that infant formula not be reconstituted with fluoridated tap water, so as to reduce the chance of overexposure. Also in recent years, New Hampshire passed a bill out of the House Committee to prohibit fluoridation with an almost unanimous vote and recently-- and recently passed a bill to specifically study fluoridation and neurotoxicity out of their health committee with a unanimous vote and out of the House with a voice vote. The National Toxicology Program, which is actually under the NIH, the National Toxicology Program's recent scientific review just reported that 52 out of 55 studies-- 52 out of 55 studies linked higher fluoride levels with lower IQs. This is a government-run program that's doing these studies. Of the highest quality studies, they found that 18 out of 19 stated the lower IQs even took place even in the optimal level of 0.7 milligram liters per water. 18 out of 19. Holistic and biological dentist associations have found that fluoride is being considered as endocrine disruptors and can affect the bones, brain, the thyroid gland, the pineal gland, and blood sugar levels. They aren't the only ones who are questioning the 1940's belief that fluoride needs to be ingested. Dr. Lanphear, the principal investigator for a study examining fetal and early childhood exposures to prevalent environmental neurotoxins, including lead, pesticides, mercury, alcohol, PCBs, and environmental tobacco smoke, has influence among modern medicine. He has recently testified that there are similarities between lead as a neurotoxin and fluoride. He's seeing a commonality between those two, and this is one of the main doctors in the United States who knows all about lead. He states, quote, fluoride exposure during early brain development diminishes the intellectual ability in young children. A current Toxic Substances Control Act trial is looking to see if fluoride poses an unreasonable risk. Both CDC representatives and Dr. Stanley Barone, Jr., an EPA neurotoxicologist, agree that fluoride has the ability to interfere with the functions of the brain and body by both direct and indirect means. Almost done. Members of the Department of-- members of the Department of Environmental Medicine and Public Health, along with the Department of Pediatrics, released a study stating that 60% of

fluoride is excreted in urine by kidneys in adults and 45% in adolescents. The kidneys, followed by the liver, liver accumulate-- accumulate more fluoride than any other organ systems in the body. This makes them especially vulnerable to the effects of fluoride. Additionally, it is absorbed in calcified tissues such as bones, teeth, and calcium-containing glands such as the pineal gland. Exposure in adulthood has been associated with kidney, kidney damage and damage to the liver. Notice the mention of teeth in the study. Yes, fluoride can affect teeth. But let me be clear this is much more than a discussion about tooth decay. This is about mandating a drug into our water system that is ingested affecting the entire body. It is not common practice for doctors to prescribe fluoride. The reality is that the only fluoride supplements the FDA has reviewed have been rejected. We are adding to the water a prescription-strength dose of a drug that has never been approved by the FDA. Both the CDC representative Casey Hannan and Dr. Edward Ohanian with the EPA have reported that the predominant benefit of fluoride in dental health is through topical application. That's one thing we're going to hear a lot of. So it's not so much about the topical application of the teeth, right, we talk about fluoride in toothpaste or when we go to the dentist they apply fluoride to our teeth. We're not talking about that at all. We're talking about the ingestion of fluoride that they're seeing a lot of problems with. And recent data and research, especially tons of it done by typically government-run agencies, have found neurotoxic effects in children. Let's not confuse the issue or be held back by concepts implemented in the 1940s. This is much more than a dental issue. Let's keep advancing dental services, implementing dental education in our communities, and promoting healthy diets for dental health. Our water systems are not to be used for drug distribution. Most importantly, let's give Nebraskans the ability to be part of the discussion. I actually just received a phone call from the utility supervisor who is a state certified water operator. The city of Gordon has asked for the removal of the chemical from their water. The city manager, with the support of the members of the council, submitted a letter. Their constituents are being forced to ingest a chemical without their consent. I don't see this as a practice Nebraska should continue. If communities want to fluoridate, they will be able to do, do so through a vote of the people. If not, they can have their voice heard through the voice-- vote of the people. I ask you to, to consider the concepts I presented today and join me in a conversation in the next couple of weeks. This is something we need to discuss further. I'm thankful for Dr. Cole, who will be testifying after me. If you have any questions, I will do my

best to answer them or suggest you ask him. I appreciate your time today and ask that you support LB1387. Thank you.

M. CAVANAUGH: Thank you, Chairman Hansen. Are there any questions from the committee? I have a question.

HANSEN: Um-hum.

M. CAVANAUGH: So I was looking at-- there's a CDC website that you can sort. There's a lot of communities in Nebraska that don't have fluoride in the water and there's a lot that do have fluoride in the water. Can you tell me a little bit, if LB1387 were enacted, would that remove the fluoride from the water? Because you said a community conversation,--

HANSEN: Yeah.

M. CAVANAUGH: --so it's clearly not a statewide issue.

HANSEN: Yeah, this would be after January 1 of 2025. The village, the locality has to-- during their next general election so we're not forcing them to hold a special election or anything like that, they have to put it on the ballot, the people then can choose to fluoridate their water or not fluoride their water. The other part of the bill is just saying not more than 0.7 milligrams.

M. CAVANAUGH: And would it put on the ballot even in communities that currently don't fluoridate, fluoridate their water?

HANSEN: For both, I believe.

M. CAVANAUGH: And so everybody would vote--

HANSEN: We don't discriminate.

M. CAVANAUGH: --whether or not to have fluoride in their water?

HANSEN: Yes.

M. CAVANAUGH: OK. Thank you.

HANSEN: Yep.

M. CAVANAUGH: Any other questions? Will you be staying to close?

HANSEN: Yeah, I'll stick around.

M. CAVANAUGH: OK.

HANSEN: All right.

M. CAVANAUGH: All right. Thank you, Chairman Hansen. And we'll bring up our first proponent testifier. Welcome.

GRIFFIN COLE: Thank you. Appreciate it.

M. CAVANAUGH: I didn't ask, actually, if we're doing a 3 minute or a 5 minute? We're doing a 5-minute clock. All right.

GRIFFIN COLE: OK. I'm Dr. Griffin Cole, G-r-i-f-f-i-n C-o-l-e, and I've practiced dentistry in Austin, Texas for 28 years. I've also spent 31 years studying, lecturing, and testifying on fluoride and the practice of water fluoridation. I'm also a parent of 2 college-age children who were afforded the opportunity to avoid ingesting fluoridated water or prescription fluoride tablets their entire lives. Like me, they have very good dental health. Thank you for this opportunity to testify today and for considering this important bill that will return the decision-making regarding the ingestion of fluoridation chemicals back to the public. Fluoride supplementation ought to be an informed decision between a patient and his practitioner, rather than a political mandate as it currently stands in Nebraska. This bill will also restore local control, giving communities the flexibility to redirect fluoridation funds to safer and more effective oral health strategies, such as school-based programs or to water infrastructure improvements. There's no reason to swallow fluoride. Modern studies clearly show that consuming fluoridated water is not necessary for good dental health. Most peer-reviewed research and even the CDC now acknowledge that any benefit from fluoride is derived through topical use. Toothpaste, mouthwash, and dental treatments. While swallowing fluoridation chemicals brings only risk by exposing all your organs and tissues to levels of fluoride that accumulate in your bodies for years. Moreover, there's no shortage of topical fluoride available to the public anymore. Toothpaste and mouthwash are inexpensive and readily available at every store and online with a several months' supply costing just a few dollars. Government data shows that tens of millions of U.S. residents have visible signs of fluorosis, as was just mentioned, which is overexposure to fluoride during child development. The U.S. CDC's National Health and Nutrition Examination Survey, NHANES, which was also mentioned, has consistently found increasing rates of dental fluorosis. It's actually now between 65 and 87% according to the last two surveys of 2012 and 2015. This is an

over 600% increase since the mid 1960s. Although fluorosis can be cosmetically treated, the damage to the enamel is permanent and the repairs are typically very costly. More importantly, fluorosis is a biomarker of overexposure to fluoride during a very critical time of development, particularly for the brain. Ingesting fluoridated water, especially in reconstituted baby formula, is recognized as the primary source of exposure. Plus, public health alternatives exist presently that are more effective, safer, noncontroversial, such as school-based programs including screenings, sealants, rinse and brush, and nutritional education. It's time we move away from this 80-year-old practice, and instead give communities the choice to focus their resources on something besides 20th century solutions to dental decay. Nebraska first mandated water fluoridation in 1973. That's 51 years ago. Thousands of fluoride studies have since been published and the weight of the science, along with government data, now shows that there are serious side effects associated with the practice, most notably brain and parents and lower IQs in children. Nebraska's mandate also makes it an outlier. It's one of only 12 states that mandates fluoridation, and most of those states have less compliance due to lack of funding since state laws often require that funds for such programs come from the state budget and not from local taxpayers. I'm sure most of you have heard about the current ongoing federal fluoride trial that will finally conclude next Tuesday after 7 years. Judge Edward Chen, who's presiding over the trial, will then deliberate and hopefully give his decision soon. And to anyone who watched the trial, it was very obvious that the plaintiffs had more than enough evidence to prove their point that the EPA needs to end water fluoridation, or at the very least, require them to promulgate rules that protect pregnant women and children. The trial was based on the large volume of recent peer-reviewed science, much of it government funded, linking maternal and infant fluoride exposures in fluoridated communities to lowered IQ and cognitive impairment. After conducting a 7-year systematic review of fluoride's neurotoxic effects, the National Toxicology Program, which is a part of Health and Human Services, reported that 52 of 55 fluoride brain studies found decreases in child IQ with an incredible 95% consistency. These were all low bias studies. The meta analysis could not detect any state of exposure, including at levels found in artificially fluoridated water. It is important that the state of Nebraska prepares to react to this emerging health concern, and likely ruling against fluoridation. NHANES data has been used in recent peer-reviewed studies to link fluoridated water with a number of systemic side effects, including earlier onset of menstruation in black teens, increased uric acid levels in the blood, sleep disorders in

adolescents, and kidney and liver impairment in adolescents. Additional studies have also found higher rates of hip fractures, disruption of the endocrine system, and increased rates of hypothyroidism. I will provide you guys with all the documentation here. Lastly, the disturbing part of this is that the CDC, along with the other promoters of fluoridation, know this. They are fully aware and yet not only have failed to warn consumers about these side effects, but rather have continued to push for the expansion of this practice all over the country. Thank you for your time and interest.

WALZ: Thank you. Questions from the committee? Senator Ballard.

BALLARD: Thank you, Senator Walz. First of all, you mentioned the federal case. Can you expand on that a little more? I know it's tough to do in 5 minutes, but that's a 7-year case.

GRIFFIN COLE: I'll do it briefly. So about 7 years ago, there were several plaintiffs, including the Fluoride Action Network, Food and Water Watch, Mothers Against Fluoridation, and some other advocacy groups that petitioned the EPA to look at these numbers and all the science and stop doing this. They refused. So about a year later, they actually filed a suit. And it's in San Francisco right now at trial, but it's gone on 7 years. They took about a 3- to 4-year hiatus to have the National Toxicology Program, a part of our government, look at all the science and come to a conclusion on what they could all agree on. So they came out with the first report back in, like, 2021. And the defendants, the EPA, said, no, we want it done again because it, it didn't look very good. They did it again. They said we'd like it a third time. So finally, a third time it was done and the plaintiffs were, like, we don't even care what it says, can we just release it? So it was held back by Health and Human Services, they didn't want this report released, literally, for almost a year. So the judge finally did a court subpoena. It was released. And, of course, all the information showed what we both discussed, that the majority of the studies, the lion's share of them, show that it is absolutely affecting children's IQ and their brain-- their actual brain development. So it's-- and they-- they are, literally, finishing this coming Tuesday with the closing statements. So Judge Chen is hopefully going to rule in the next weeks, months, hopefully,--

BALLARD: All right. Thank you.

GRIFFIN COLE: --and get a final ruling.

BALLARD: Perfect. And one more question if I may?

WALZ: Yeah.

BALLARD: I've received a lot of emails about-- and even Senator Hansen mentioned about tooth decay, cavities, without the fluoride use. And I'm looking at maybe a rural-urban divide. Have you seen-- have you seen anything from that lack of fluoride would cause tooth decay?

GRIFFIN COLE: No. And, in fact, if you look at, I think Senator Hansen mentioned it, if you look at the World Health Organization's chart, they look at all the countries that are doing it, all the area cities and everything. There is a declining rate in decay anyway happening, you can't differentiate between the areas. Now, there has never been a study-- a, a, a clinical randomized trial to prove that this practice ever worked. Honestly, it was never done. There's never been a follow-up, a long-term follow-up to prove that it worked. And, again, as he mentioned, too, you can apply this topically. There's, there's no shortage of topical fluoride. You don't drink it. It has no beneficial effect to the teeth whatsoever. And, in fact, if you look at the science, it actually has a very deleterious effect on the teeth. It makes it more brittle and weak. So you can argue that if I apply it topically, do I have some kind of antibacterial effect? Absolutely. But if I drink it, do I get that effect? No, the answer is no.

BALLARD: Thank you doctor. Thank you.

WALZ: Senator Riepe.

RIEPE: Thank you. I have what may be obvious to many, but in terms of, like, using water in cooking, does the boiling eliminate the fluoride or does it stay with the water in that concept?

GRIFFIN COLE: That's a-- that's a great question. No, it does not eliminate it.

RIEPE: OK.

GRIFFIN COLE: It's a-- it's a very, very tenacious molecule, very small. And that's why most filters won't even filter it either. You have to get special filters for it. It's very costly to avoid it. You bring up a very good point in that, you know, we're trying to make this to where everybody can afford to do this. So if you just turn off the spigot at the city, problem solved. But if you don't, then people in the poorer communities have to figure out ways to avoid this. And you have to buy either bottled spring water, have it delivered, you got to put filters on your house. You got to avoid it in all forms.

And it's really hard because it's in a lot of beverages, too, that use for that water to make the beverages. So if we just turn off that spigot, it would solve all these problems.

WALZ: Yeah.

RIEPE: Second question, I guess. That with so many people drinking bottled water or flavored waters or everything else, are the majority of those with or without fluoride?

GRIFFIN COLE: So it depends on where they come from.

RIEPE: OK.

GRIFFIN COLE: So a lot of bottled water and sodas come from Chicago, which is fluoridated. You'd have to know where your actual solution is coming from, but a lion's share of them do have fluoride in them.

RIEPE: You're not saying Chicago water just to scare me, are you? [LAUGHTER]

GRIFFIN COLE: No. That should scare you.

RIEPE: Thank you.

GRIFFIN COLE: Thank you.

RIEPE: Thank you, Chair.

WALZ: Thanks. Other questions? All right. I have one. In your last couple paragraphs, you talked about how it affects brain development.

GRIFFIN COLE: Yes.

WALZ: Can you repeat that study?

GRIFFIN COLE: Just exactly what I said or just in general just answer your question?

WALZ: Just in general, I'm just kind of curious about how long that study was and who--

GRIFFIN COLE: OK. So, so, as I mentioned-- well, first of all, there were-- there, there have been 72 world studies. Of the 72, the NTP got down to 64 and said, you know, these other ones are outliers or they were poorly done, high bias, things like that. So then of the 62, then they got down to 55 and they thought these are very low bias, meaning

that the researchers don't have a, a, a side. They just want to figure out what they can do. So a lot of these studies, as he mentioned, are 10 years long, 5 years long, a few years long. They all vary. But you guys have copies of all of the them. OK? The 10 most highest quality studies were all done by the National Institute of Health, our government, NIH. All of this, NTP, our government, Health and Human Services, our government, CDC even is our gov-- so none of these studies are, are, you know, like the-- a lot of the propo-- or the opponents-- proponents for water fluoridation will say, oh, well, those are studies in China and Mexico and other places. We're not talking about those studies. We're talking about the government funded, the most recent last 10-year studies.

WALZ: OK. So my other-- I was going to ask how far the studies go back because--

GRIFFIN COLE: Some--

WALZ: --there are so many other things that,--

GRIFFIN COLE: Sure.

WALZ: --as we all know, affect a child's brain development--

GRIFFIN COLE: Sure.

WALZ: --in the last 10 years [INAUDIBLE].

GRIFFIN COLE: Absolutely.

WALZ: Do you have any studies that go back 50 years?

GRIFFIN COLE: Yeah, there, there, there-- as far as your IQ and brain and parents, no, I don't think they go back that far, about 30 years, probably, 25, 30 years. But in the last 10 years is what we're talking about the most, you know, low bias, an incredible scientific method followed, good controls, the way they looked at everything. That's what we're talking about. And please keep in mind that the NTP, the National Toxicology Program, their job is to vet everything, to look at everything. It's all scientists. They're looking to trying to tear apart studies. Really. And so for them to actually get down to say these are the ones, these things were vetted, they looked at them very carefully to make sure to rule out--

WALZ: When you say they were-- they were vetted,--

GRIFFIN COLE: --to rule out cofounders.

WALZ: --you took out all technology, kids who had no access to technology or social media or anything like that. Those things were taken out?

GRIFFIN COLE: Well, a lot of studies are different, right? So they look for cofounders is what you're talking about. What other things could do this? So you'll have to read each individual one, you know, to find out which one fits to what you're asking. But they did look at a lot of cofounders so this is like they're looking at children that are-- that are being raised-- or, or, or in utero by moms who are ingesting fluoridated water versus moms over here that are not ingesting fluoridated water, comparing IQ scores exactly. It was a pretty good apples to apples in the lion's share, the best studies that they picked out. So they kind of get rid of the cofounders just by that alone.

WALZ: All right. Any other questions? I don't see any. Thank you. Next--

GRIFFIN COLE: Thank you.

WALZ: --proponent. All right. We'll go onto opponents.

JOSHUA BASSAN: Oh, I'm sorry. I'm testifying. I'm proponent.

WALZ: Oh, I said proponent. OK, sorry. Yeah. Did I say--

JOSHUA BASSAN: Hi. Name is Joshua Bassan, J-o-s-h-u-a B-a-s-s-a-n. I support this bill for three reasons: first reason, roughly 10 years ago, between the age of 30 and 32, I started drinking purified water with the fluoride removed. As the doctor just mentioned, it was expensive. It cost me, like, $400 for this water purifier and the set of filters that I had to replace twice a year, I think, were, like, 100 bucks. I was married at the time and started drinking this water and my impotence disappeared. The effect was immediate and I avoided fluoride at all costs ever since. Second reason, this takes power away from the Department of Health and puts it back with the Unicameral. Regulation with the force of law should only be passed by our elected representatives. Thirdly, it makes a lot more sense to require a town or city, 1,000 or more, to pass an ordinance to fluoridate as opposed to the other way around. You have experts that say, hey, fluoride is good for the prevention of cavities. You have similarly credentialed experts saying, not only is it not good for your teeth, it has all these other adverse side effects. When it's that controversial, the

safe and moral thing for government to do is to do nothing. Anyone who wants to add fluoride to their bodies is free to do so and leave the rest of us alone. Thank you.

WALZ: Thank you. Any questions? I don't see any. Thank you.

JOSHUA BASSAN: Thanks.

WALZ: Any other proponents?

STACEY SKOLD: Hello, my name is Stacey Skold, S-t-a-c-e-y S-k-o-l-d. Thank you for this opportunity. And thank you, Senator Hansen, for proposing this bill. I wanted to share my experience learning about fluoride toxicity as a doctoral student in human sciences. I became aware of this issue while writing my dissertation. My research on the impact of chemical pollution on human health led me to multiple studies. And also to a textbook, the Textbook of Children's Environmental Health. This book was published in 2014 by Oxford University Press, edited by Landrigan and Etzel, who are both medical doctors and epidemiologists. It's considered a go-to for those involved with environmental toxicology and pediatrics and it does address the risk of fluorosis, as well as liver and kidney damage and diminished development of intelligence in children from fluoride exposure. Since the publication of this book, I have observed that what is being taught in the environmental toxicology realm is finding its way into the medical professional community and to the public at large. One example is the-- a statement from the Fluoride Action Network, which was a professionals' call to end water fluoridation, in which 4,800 signatures-- and this was in 2018, where they counted-- from both environmental, environmental toxicologists, as well-- as well as medical medical professionals have signed. So it's a combination of both. Since then, there's also-- actually since 2004, there's been 4 documentaries produced on this topic on the toxicity of fluoride. But in my studies, a course stands out that was called Environmental Toxicology Ecosystems and Human Health. And in that course we studied fluoride and other endocrine disrupting chemicals. And they were addressed in the context of water pollution, as well as Dr. Bruce Lanphear's work on maternal fluoride levels and fetal exposure. His work highlighted the decrease in children's IQs and while to some a few points might not seem like a lot, he really focused on the implications in terms of school interventions needed for students and really presented that in a, a sobering light you might say. Also in the course, the synergistic qualities of fluoride were addressed. For instance, when combined with aluminum exposure, which is also prevalent in our environment, the toxicity of fluoride

is increased. This contributes to the complexities of fluoride dosing and is yet another reason to reconsider medical supplementation in the public water supply. In terms of fluoride studies, the meta analysis that has been addressed between fluoride ingestion and human intelligence, which is the National Toxicology Program's report on fluoride and neurotoxicity, it encompassed over 28,000 children and 689 adults. This report identified that 76 out of the 85, 85 studies on the subject have reported that elevated fluoride exposure is associated with reduced IQ in humans. The report also identified that there is no level of fluoride in drinking water that is considered safe. We need to pay attention to this meta analysis. We can also pay attention to toothpaste labels, because on fluoridated toothpaste, you will find it says you should not swallow the toothpaste for obvious reasons. We should also listen to the environmental toxicologists. Please carefully consider the significant risks versus benefits in terms of mandating fluoride in the Nebraska public water supply. Thank you.

WALZ: Thank you. Questions? I don't see any. Thank you very much.

STACEY SKOLD: Um-hum. Thank you.

WALZ: Next proponent.

DIANNE PLOCK: Good afternoon. My name is Dianne Plock, D-i-a-n-n-e, Plock, P-l-o-c-k. I live here in Lincoln and I grew up on a farm with, with well water. So until I graduated from high school, I didn't-- I wasn't really exposed to fluoride. I had braces when I was young. My dentist, I don't recall him saying anything to me about brushing my teeth with fluoride or anything like that, but that was years ago. I was diagnosed with hypothyroidism probably 20, 22 years ago, and I really didn't think too much about fluoride until then. But since then, I've been doing-- I've been on a journey, I guess, to find out about fluoride and that's led me down a rabbit hole, for whatever reason, and I have been to the point where I'm not a, a proponent of fluoride anymore, but rather an opponent. It's my belief that I don't have-- I shouldn't have to pay to have fluoride in my water system. Yet, because I live in Lincoln now, I get it whether I want it or not. So I have a filter on my water system now that takes it out, but it costs me over $300 a year just to do that. I have talked-- another matter, in February, Union, Union County, North Carolina voted fluoride out of their water system. Two days ago in Collie-- Collier County, Florida, they unanimously approved fluoride removal. I think it's time that we had the people's voice be known here rather than city or county administrators who think they're doing the best for us

and it's time for the people to speak rather than government authorities. I could go on and on about statistics and so forth, but everybody else kind of took their-- my, my voice away from that-- from that standpoint. But I'll go on a little farther. I have a dentist who grew up in Croatia. She became a dentist. They didn't have fluoride in Croatia and she lives here now in Lincoln with her husband, of course. And I asked her last summer about fluoride, and she called me after work and I was kind of, frankly, surprised that she did. But she did tell me, she said that's a touchy subject. And I said I knew it would be because she's on one fence with the Dental Association promoting fluoride. However, she came in to the end saying, I have a 20-year-old son, he's going to college in Omaha, he never-- I, I did not provide him with fluoridated water. That spoke volumes for me. That put me on another mission to contact my orthodontist, who I used about-- again, about 10 years ago, and I asked her this week what her thoughts were about it. And, again, she said it's a touchy situation. But she said, I think the people need to vote on it. It should be their choice. I also have a periodontist and I called her office and she's a proponent of fluoride, which makes me wonder if I'm going to keep that same periodontist. And, in addition, I called my own doctor and I got an email back from him yesterday. And if I could, I'd like to read it.

WALZ: You have a minute.

DIANNE PLOCK: Thank you. I've never dreamed that something like-- that should be the good health of a society would become so politicized by both sides. I've been following LB1387. I hope the Legislature does the right thing with regard to the bill. However, I do not have any faith that they will. I used to take time to testify at Legislature hearings, but over the last year or so I have quit wasting my time because at the end of the day most have their minds made up already. The state and federal governments are completely broken and the majority of decisions are entirely based on whether the money is flowing for election purposes, not facts, science, expert opinions, etcetera. Our healthcare systems in America are completely broken and the average citizen has no idea how close we are to complete collapse of the healthcare system and, yet, neither side is doing anything to fix the problems. I could go on about some of the personal health issues, fluoride affects kidneys, the pineal gland, any endocrine system. And I've had personal experience with those as well.

WALZ: Thank you. Do we have questions? I don't see anything. Thank you for being--

DIANNE PLOCK: Thank you.

WALZ: --here today. Next proponent.

TRACY AKSAMIT: Good afternoon. I'm-- thank you for considering this bill. I appreciate that. My name is Tracy, T-r-a-c-y, Aksamit, A-k-s-a-m-i-t, 7201 Willow Avenue in Lincoln, Nebraska. I support eliminating fluoride from our drinking water. The fluoride community has rightly focused on the pain, disease, and cost to society of tooth decay as there are plenty, as we've heard, detailed arguments on both sides of the debate. I would like to briefly remind us of the unseen, long-term costs to Nebraskans from mandates like fluoride programs and touch on how we got here, where we are today, and where we go from here. Last February, I shared with my county commissioner, as I will share with you-- as I share with you now how I believe we got here on a different mandate, a history that applies to fluoride as well. Of course, we understand some mandates are necessary for health, safety, and welfare. As a licensed architect, I regularly study these topics. However, more frequently than ever before, stories are not in sync, they don't make sense. As I've observed this inconsistency growing over the last 40 years, I've experienced glimpses into what I call simply a wonderful hidden world. We have this wonderful hidden world that for various reasons we, as a society, marginalize, even outlaw while we build up a government model with partners as be-all, do-all caretakers. We medicate our water while denaturing our milk, we increase toxic exposures, and continue to limit access to a wide range of healing arts. The long-term costs of these mandates and caretaker model can never be determined, and many of us instinctively know the government can't and shouldn't do so much. The limitations of this model are evident in my findings from an ongoing investigation into Nebraska's fluoride program, Title 179 fluoride regulations and program operations by the city of Lincoln and Lancaster County. I want to emphasize how much I appreciate the people who have helped me with my investigation and I leave with you a draft update of my findings showing, among other things, that there may be opportunity for Lincoln to lower the fluoride treatment level, currently, while maintaining compliance. This small adjustment, as you've heard before, could positively impact the health of pregnant women and infants, especially in the heat of summer. So going forward, I ask that we look to minimizing the needs for mandates by increasing access to this wonderful hidden world and advocate for a balance between the world of wise traditions and the best of today's advanced technologies. There are great opportunities waiting to improve lives with a secondary benefit of reducing the long-term costs. Thank you very much. And I wanted to add, if I have a moment, Senator Cavanaugh asked about the CDC website, and you'll notice in the handout that I provided, my

update findings, the Department of Energy-- Environment and Energy confirmed this week that CDC-- the requirement to update the CDC website is not mandatory and the state doesn't have a chance to update that very regularly. And to-- the quote is on, on the sheet there, but they-- it's not accurate. It doesn't match with what the city of Lincoln is reporting and I, I didn't check other cities, but you can be sure that there are some of that information on the CDC website that is not accurate. So I just wanted to-- and there's other points, updates on that handout that I provided. So thank you.

WALZ: Thank you. Questions? Thank you. Next proponent.

EDWARD F. FOGARTY III: Senators, hello, and, and thank you for allowing me to testify. My name is for the record, Edward Francis Fogarty III. That's Edward, E-d-w-a-r-d, F. Fogarty, F-o-g-a-r-t-y, III. I am an emergency radiologist and also integrative medicine physician who has had a, a, a sidebar practice of environmental medicine over the last 15 years coming out of my chairmanship at the University of North Dakota School of Medicine where I was the Chair of radiology. And as radiologists, we are-- we are dealing in the public health realm with, actually, one of the most toxic forms of medicine: CTs, X-rays, gamma rays, for medical good, of course. But we have in our culture and our professional society of radiologists, the concept of ALARA, which is as low as reasonably achievable, as a guide stone for our public health situation with, you know, giving known waveform toxicants to, you know, children as young as, you know, like 6 months old who have come in through our emergency rooms in the state of Nebraska. I read-- I read films at night. From Ogallala to, to Omaha, there's probably a 1 in 20 chance that if anyone in this room gets into a car accident, I might be the reading radiologist for your trauma images. But, you know, we do have children who come into the emergency rooms and have to get a CT for trauma purposes and, and so our, our mantra is we've got to do this with the lowest reasonable efficiency of radiation to get a diagnostic study done. And so that's a guideline and principle that I've taken into the research ranks of our nation's physicians. And working with Dr. Paul Harch, who's-- he's the emergency medicine hyperbaric fellowship director at, at LSU in New Orleans, and we have designed multiple protocols employing hyperbaric medicine to help detoxify patients and children from neurolog-- neurodevelopmental toxins. And so as Dr. Hansen, a chiropractic physician here in Nebraska, alluded to initially, there are-- there's a synergism of toxicities with all of these neurobehavioral effects of, of fluoride in addition to the metals that it combines with. One of the most important toxicity matters is the formation of aluminum tetrahydro fluoride which, which confuses the

cellular energetic mechanism through, through its mimic of phosphate. And so Stacey Skold, I think, also reiterated the Landrigan and Grandjean paper and research and that's just kind of a Daubert bar of, of, of my testimony as an environmental researcher. In, in 20-- in 2007, I published the first medical images of lead in the food supply. These are CT images of lead, lead inside of venison donated to North Dakota food pantries that my colleague at UND, Dr. Cornatzer, and I published with his son, who was a medical student of mine at the time. And so, so we have these fluoride-related synergisms with lead in the environment, aluminum in the environment, and it's hurting the IQs of our children. I am technically more on the side of neutral because I do think the language of this bill is, is-- needs to be amended to what is really the World Health Organization's published threshold for neurotoxicity is 3/10 of a part per million. It's not 7/10 of a part per million. And so I would advocate that the-- that if we're going to really protect Nebraska children and fetuses, in particular, we're going to want to come in right above-- actually, the World Health Organization has stated it's, it's 0.29 parts per million, which is the, the safety index level. And so, so that's an amendment that I would propose down the line for the good senators to consider. There might be-- in the municipal water supply of Lincoln, in particular, we might have a baseline of extra fluoride in the water anyway. I did-- at the-- when I was in college at the University of Chicago doing molecular genetics, I had-- my summer job was at MUD, the north Omaha water plant. So I'm very familiar with water science and just put myself out here for you guys to have as a resource as this bill moves forward and thank you for your time.

WALZ: Thank you. Any questions from the committee? Thank you so much. Other proponents? OK, we'll move onto opponents.

JESSICA MEESKE: Chairman Hansen and members of the committee, nice to be back again this week. My name is Jessica Meeske, spelled J-e-s-s-i-c-a M-e-e-s-k-e. I'm a pediatric dentist from Hastings and president-elect of the Nebraska Dental Association. I'm speaking in opposition to this bill. While the NDA applauds Senator Hansen for wanting to adjust community water fluoride levels to 0.7 parts per million, which does reflect the CDCP's national guidelines. According to Doctor Fritz Craft, who's our state dental director, it's already being done across the state. So this is good news. So then we must address, does it make sense to require communities to reaffirm keeping fluoride in the water? I don't think it does, any more than it makes sense to allow communities to reaffirm the Clean Indoor Air Act or wearing seatbelts. Tooth decay is the most common chronic disease in children and adults. And, in fact, we have 75 years of scientific

evidence to support its safety and its effectiveness. It is one of the top 10 public health accomplishments of the 20th century, along with advances in infectious disease. So other things on the list are things that rise to the level of the polio vaccine and motor vehicle safety, things like seatbelts. Fluoridation is highly associated with about 25 to 30% lower rates of tooth decay, and it's a simple mineral. You could equate it with fortifying milk with vitamin D, vitamin C in orange juice, or even iodine in salt. They make us healthier if they're in the proper amounts. Lower decay rates mean lower Medicaid expenditures. And you've heard us talk a little bit about dental Medicaid this session. Financially, it's a good public investment. There are more than 100 organizations and government agencies that support water fluoridation. I'm just going to mention a few: the CDCP, American Dental Association, American Medical Association, American Academy of Pediatrics, U.S. Public Health Service, and the World Health Organization. Now if this bill would pass, instead of my focus being on helping children alleviating their dental pain, my time would be consumed with defending water fluoridation in all the communities for whom the patients that I serve. And this is because the effects of community water fluoridation far outweigh any preventive measures that I can provide in my practice. Also, we've had communities fight water fluoridation. We fought this in Hastings. Hastings still doesn't have water fluoridation. So communities can vote it out. But my first city council meeting was in York, Nebraska, with then former Senator Adams, who was the mayor at that time. And after I testified on the safety and benefits of water fluoridation, a community member who opposed fluoridation came over and addressed me "Heil Hitler." I'd like to address some of the comments that were made about the government studies, and this would be a summarizing statement. The National Academies of Science, Engineering, and Medicine conducted a peer review of the draft report that was mentioned earlier by the National Toxicology Program. And these national academies found that this report failed to make a clear and convincing argument to support its conclusions about the negative effects of fluoride. The National Academies added that the National Toxicology Program's draft report cannot be used at this time to draw any conclusions about the levels of fluoride used in water fluoridation. Finally, if dentists are forced to spend our efforts reaffirming water fluoridation, who will provide dental care to Nebraskans? We already have a dental workforce issue in the state. We have a dental hygiene workforce in the state. And as you already have learned, we have an access to dental care issue. Most groups come supporting or opposing fluoride-- or opposing bills that support their businesses and their livelihoods. But community fluoridation actually decreases tooth decay and, therefore,

the need of dentistry. So all the dentists that are coming today are speaking about an issue that we know is detrimental to our livelihood. That's how strongly we feel about the science and the benefits. But, yet, we're here to do what's in the best interests of the public, which is to keep our water systems fluoridated, to keep Nebraskans healthy, and to keep more money in patients' pockets and not spent on a preventable disease. Thank you.

WALZ: Thank you. Questions from the committee? Senator Ballard.

BALLARD: Thank you, Senator Walz. Thank you for being here doctor. Can, can you address the, the, the point from the proponents about ingesting fluoride versus the topical use of their toothpaste and mouthwash?

JESSICA MEESKE: Yeah, they're, they're actually correct that you get benefits from both. But science is definitely showing that you do get greater benefits from the topical fluoride. But that does not negate the fact that community water fluoridation is still beneficial for preventing tooth decay. But, but the point is, is that you're still getting exposed to the topical water when you swallow it, when it's in your mouth, etcetera. But there, there are greater benefits from the topical use. I will also mention that a lot of the fluorosis that I see from kids in my practice, these are kids that grew up in Mexico and not where the water was over fluoridated. It's just where the mineral happened to be naturally high in the soil and the water. And so I do see fluorosis, but I don't-- I only see severe fluorosis typically in immigrant children that grow up in, in those areas. So it is not a major concern in our practice.

BALLARD: OK. Thank you.

JESSICA MEESKE: Um-hum.

WALZ: Other questions? I, I want to go back to the question I had about brain development and do you have any feedback on that one?

JESSICA MEESKE: Yeah, I'm, I'm not surprised you asked that question as a former school teacher and I'm a former school board member for Hastings Public. So, obviously, dentists care about the development of children's brains. We would not recommend anything that we think would be harmful to the neurodevelopment of children. But there is just no evidence yet that suggests that. Dentistry is open to new research and new science. We're not closing the door on looking at what's coming out. It's just that what's coming out, the studies haven't been

designed well. They've been found to have biases and so there is just no evidence yet that it shows that.

WALZ: All right. Thank you.

JESSICA MEESKE: Um-hum.

WALZ: Senator Riepe.

RIEPE: Thank you. Thank you for being here.

JESSICA MEESKE: Thank you.

RIEPE: Good to see you again. The question I have, and I think this is in a conversation we had one time about a comparison with Lexington, Nebraska, where they do have fluoride in the water and Hastings where they do not. Do you recall that conversation?

JESSICA MEESKE: I'm not sure if Lexington has fluoride in the water.

RIEPE: Oh, OK.

JESSICA MEESKE: But I can-- I can speak-- if you have a question related to--

RIEPE: I, I thought it was Lexington, maybe I had the wrong one.

JESSICA MEESKE: --communities-- so Hastings-- for example, Hastings does not, Superior does. Superior was--

RIEPE: Well, maybe it was Superior.

JESSICA MEESKE: --was the first town that fluoridated back in the '70s.

RIEPE: What's the comparison then of-- or are there statistics that show the advantages of fluoride versus non-fluoride?

JESSICA MEESKE: There, there is-- there is--

RIEPE: OK.

JESSICA MEESKE: --good science that shows that. And it goes right down to the level of what do you want to spend on Medicaid for these kids and adults? I think we'll have another testifier come up and if you want to address this question to her. Medicaid expenditures, there have been studies that show that children that live in community--

water fluoridated areas have lower expenditures for dental Medicaid. So you can pay for it on the front end with a dollar or you can pay for it on the back end at $38. That's kind of the comparison.

RIEPE: Do you see a great discrepancy in terms of probably, maybe, income between-- for those that (a) brush their teeth, possibly floss--

JESSICA MEESKE: Of course.

RIEPE: Yeah. OK.

JESSICA MEESKE: Yeah, social, economic status plays a huge role in dental disease.

RIEPE: So fluoride in the water does expose all of them.

JESSICA MEESKE: It does. And so it's a great point you make that it is one of the few public health measures that we have that has equity amongst all members of our population so you can be rich, you can be poor, you can be of any race. But as long as you have some exposure to community water fluoridation, whether it be in your home, whether it be at school, etcetera, you're going to benefit from that.

RIEPE: Do you think we should outlaw bottled, bottled water then?

JESSICA MEESKE: You know, I don't think I'm going to get into that debate.

RIEPE: OK.

JESSICA MEESKE: The question did come up and the one doctor who said it, it does matter where it is bottled, he's absolutely right. But I believe what the majority of bottled water has is it, it doesn't have the fluoride in it. So, yeah.

RIEPE: OK. Thank you.

JESSICA MEESKE: Thank you.

RIEPE: Thank you for being here.

JESSICA MEESKE: Yeah.

WALZ: Thank you. Next opponent.

KENT ROGERT: Senator Walz, members of the Health and Human Services Committee, my name is Kent Rogert, K-e-n-t R-o-g-e-r-t, and I'm here today to testify in opposition on behalf of the Nebraska Dental Hygienists' Association. Senator Hansen, we respectfully disagree with you on this issue, but we thank you for bringing it for the discussion. Senator Riepe, I have a-- I have a, a data point for you here. School children living in fluoridated communities on average have 2.25 fewer decayed teeth compared with children living in fluoridated-- non-fluoridated communities. So there's, there's a number you can point to. I don't have a lot but the CDC does say that because of its contribution of the dramatic decline in tooth decay over the past 70 years, they named community water fluoridation as one of the 10 great public health achievements of the 20th century. So I think that's something we can look to. Mentioned topical treatments. We-- we've been before this committee for years and Appropriations Committee for just as many years. We have such a shortage of Medicaid dental delivery in Nebraska. And for those folks that aren't on Medicaid, they can go to the dentist and get fluoride treatments. There's no problem. Those kids and adults that don't-- that, that are on Medicaid and don't have the money to pay for a dentist, dentist, there's just so few places to go get a treatment now. Dr. Meeske has testified to, there are thousands of people on waiting lists to, to get treatment across the state. So this is the cheapest and easiest way to get it to as many people as possible and I'll answer any questions if I can.

WALZ: Thank you. Questions? I don't see any. Thanks.

KENT ROGERT: Thanks.

WALZ: Next opponent.

CHARLES CONE: OK. Good afternoon, Chairman Hansen and Health and Human Services Committee members. My name is Charles Cone, C-h-a-r-l-e-s C-o-n-e, like an ice cream cone and half of you'll get that and the other half won't so it doesn't make any difference. That's just the way it goes. I'm the retired director of Loup Basin Public Health Department. I also served two terms as mayor of the city of Burwell. I'm testifying today in my personal capacity. I'm here to oppose LB1387. Public health is focused on prevention as opposed to treatment. Results can be different-- difficult to measure, certainly in oral health. How can a decline in tooth decay be determined after implementing the community fluoridation program? That can be challenging, but still possible. I'll demonstrate that in a moment. The first-- in 2002, I became the first public health director of the

9-county Loup Basin Public Health Department. It's located in central Nebraska and it's based in Burwell. There's 9 counties. And shortly thereafter, the department began a dental health program which continues today. The program's objective is to biannually screen all preschool and K-6th grade children in the district, and an oral health screening is performed for each student. Records are kept, including the number who need an immediate referral. An immediate referral means they have a dental concern that needs a dentist's attention before their next scheduled visit, or in some cases, a child has never been to a dentist. Then in 2009, that was my first year as mayor of Burwell. Burwell began fluoridation of the city water. After 6 years, a decrease of immediate referrals transpired in Burwell's student population from 14% to less than 3%, where it still consistently remains. In comparison, other communities in the health district average about 12% needing immediate referral. None of the other communities in the district utilize water fluoridation, and coincidentally and unfortunately, none of the other district students attain results comparable to Burwell's students since water fluoridation began there. Fluoridation can be a contentious issue. If you want to dispute any of the facts or any things you heard here, you can go look at a reliable Internet article and get whichever side you want to explain your position. And so it's really tough to decide what's right and what's not right, but I think my facts speak for themselves. Most people who've grown up with fluoridated water support it or don't even think about it at all. And, conversely, people who didn't grow up with it are more likely not to be in favor of it, regardless of the unmistakable data that proves its effectiveness. Today, water fluoridation projects benefit over 200 million Americans that, in turn, experience 20 to 40% less tooth decay. There's one of those Internet article numbers. If Burwell or any other community that fluoridates their water supply would discontinue the practice, in all probability, the number of dental caries would migrate back up to pre-fluoridation levels. Fluoride continues to be dental science's main weapon in the battle against tooth decay. Adding it in city water systems makes sense because it makes fluoride available to everyone. It saves our healthcare system money and it saves kids and adults from the pain and inconvenience that comes with cavities and other dental problems. And I've been to schools before where-- especially when I was mayor and the children were supposed to do something, there'd be a kid in the back of the room that couldn't participate in it and what's the matter with that child? Toothache. I've never seen a kid learn anything with, with a toothache. And so-- I'm not a teacher, so maybe they do learn, but it doesn't look to me like that kid was-- that poor kid was learning very much that day. Anyway, this bill would open

debates that have been decided in Nebraska for over a decade now. That's why, as mayor of Burwell, we began fluoridating the water in 2009. The Legislature passed that bill in 2008 that any community over 1,000 had to bring their fluoridation levels up to one part per million and Burwell had a 3/10 of a part per million before fluoridation levels. And that was part of one, I don't know exactly where, I'm no longer mayor, but we did get it towards one. And so community water fluoridation has given us great public health gains. This would put a jeopardy-- put those gains into jeopardy. I stand opposed. Thank you. Charles Cone. Questions?

WALZ: Questions? Senator Riepe.

RIEPE: Burwell is a big cattle and horse country isn't it?

CHARLES CONE: Yes, it is.

RIEPE: And I think to look at the age of a horse we check their teeth. Right?

CHARLES CONE: Yep.

RIEPE: You've been drinking this fluoride, has it helped?

CHARLES CONE: Well, actually, actually, we don't let very many horses live in town where we have community fluoridation. The humans actually outnumber them 3 to 1 inside the city limits.

RIEPE: OK. OK. OK. I assumed that maybe this was extended beyond city limits, but it doesn't, so.

CHARLES CONE: No.

RIEPE: Thank you, sir. Thank you for being here. Thanks for making the journey here.

CHARLES CONE: Oh, yeah. It was my pleasure.

RIEPE: Thank you.

WALZ: Any other questions? I do have a question. During your time as mayor-- I got to read back here for a second. You had 6 years in which you tracked the, the, the changes in-- from 14% to 3%. That changed since you fluoridated water. Was that the time when you were the mayor?

CHARLES CONE: Yes.

WALZ: OK.

CHARLES CONE: Before that, when, when I first became public health department director and we started that dental program and we would do the 9 counties, all the-- every, every community, school district, or school and, and preschool, we do the dental health program and we'd track that. And we, actually, do the fluoride varnish treatment with the children's parents' blessing. And we would give them a tooth brush and do the best we could, and we'd track that. And our, our results came down gradually. It seemed like when we first started, we averaged districtwide about 19% of, of immediate referrals. And it came down to like 16% or 15%. I don't have those numbers, but I know it did come down and they're kind of-- it's kind of leveled off from there except for Burwell when we started to fluoridate the water. And we started graphing that every year on where the number of immediate referrals went, and it was a straight line down until it got down to where it's at now and then just kind of leveled off. Some of the kids who go to school there don't live in the city, they drink municipal water anyway. And, and so, you know, it's understandable that it's not down to zero. In fact, it's amazing that it is. But if you really want to get rid of, of, of dental caries, fluoridation is the second best way. Elimination of sugar is the very best way and I don't think that's going to--

WALZ: For a lot of things.

CHARLES CONE: --I don't think we have a chance to do that here today,--

WALZ: Right.

CHARLES CONE: --but that-- there's where your real problem lies.

WALZ: Right. OK. All right. Thank you.

CHARLES CONE: Yeah.

RIEPE: Thank you.

CHARLES CONE: Yep. Thank you.

JORDAN BROZEK: Good afternoon. My name is Jordan Brozek. That's spelled J-o-r-d-a-n, Brozek, B-r-o-z-e-k, and I'm currently a pediatric dental resident at UNMC based inside Children's Nebraska. And I'm speaking on my own behalf today in opposition of LB1387. Community water fluoridation is vital for the oral health of

Nebraskans across the state. Throughout my years of dental school and pediatric residency, we've been taught the importance of fluoride in our public water systems. First, fluoride acts to stop the formation of cavities. The Centers for Disease Control and Prevention found that fluoridated water has significantly reduced the rates of dental caries by greater than 25%. When the CDC looked at this monumental decrease, they deemed it as one of the last nation's most significant public health successes. Secondly, fluoride acts to help remineralize or repair teeth that have small cavities present on them. Thus, fluoride acts as a powerful agent that both prevents and protects our teeth from the development of cavities. From day one, dental students across the United States are taught the importance of water fluoridation in the primary prevention of dental cavities. I sat through many lectures throughout my dental education learning its mechanism of action and its countless benefits. There were even questions about water fluoridation on my National Dental Board Exams. Water fluoridation is a part of every dental school curriculum and is strongly supported by the American Dental Education Association. The reason water fluoridation is taught in every accredited dental school throughout the United States is because it is safe and effective. It is imperative that Nebraskans, especially children, maintain access to fluoridated water. As a pediatric dental resident based inside the only children's hospital in Nebraska, a majority of the patients I see daily are of low socioeconomic status and many children with special healthcare needs. Some of these patients are not able to brush their teeth regularly or correctly, but they do have access to the benefits of fluoride by simply drinking from their public water supply. This access to fluoridated water helps prevent tooth decay and save these children from unnecessary tooth pain regardless of age, income level, or access to routine dental care. We must safeguard these protections from fluoridated water for our most vulnerable Nebraskans. The safety and efficacy of fluoride has been well-established with over 70 years of extensive experience in the United States. The support for community water fluoridation not only includes the American Dental Association, but the American Medical Association, the American Academy of Pediatrics, and the World Health Organization. These medical and dental associations see the overwhelming benefit of fluoride and we should follow the recommendations of experts in these fields. I'm calling on the State Legislature to oppose LB1387 and maintain public access to fluoridated water. Thank you for your time.

WALZ: Thank you. Questions? Yes, Senator Riepe.

RIEPE: I have a curiosity question. Your residency, is that in a subspecialty within PD-- or pediatric dentistry?

JORDAN BROZEK: Pediatric dentistry. Yes.

RIEPE: OK, but is not in, like, periodontist or--

JORDAN BROZEK: Pediatric. It is like periodontists. It's a-- that's what we do, pediatric dental residency. Yes.

RIEPE: OK. So you could be a practicing dentist at this point in time,--

JORDAN BROZEK: Yes.

RIEPE: --you just like to go to school.

JORDAN BROZEK: I, I guess so.

RIEPE: Well, God bless you for it. Thank you. Thank you for being here.

WALZ: Thank you.

JORDAN BROZEK: Thank you.

WALZ: Next opponent.

DEBRA ESSER: Good afternoon, Chairman Hansen and members of the Health Committee. My name is Debra Esser, D-e-b-r-a E-s-s-e-r. I'm a family practice doc who is also chief medical officer for Molina Healthcare of Nebraska. I've been involved in helping the Medicaid population improve their health for many years. Dental has just been integrated into the Managed Care Organizations' purview beginning in January of 2024. And I'm very excited about tackling dental issues for the Medicaid membership. It's well known, but seldom thought of, that dental caries or cavities is the most common chronic medical condition. Not everyone has diabetes or high blood pressure, but there are very few of us who can say we have never had a cavity. Fluoride in water is known to help prevent this cavity formation, especially in those in underserved or impoverished populations. While certain tools are available like a fluoride varnish for teeth, if children aren't coming in for that preventive care, the fluoride in water at least gives them some protection. A recent article published in 2015 looked at 155 studies that showed a decrease in cavities in children. It was noted that there was about a 25% decrease in the dental cavities or caries in both deciduous or baby teeth and permanent teeth. Many other studies show similar results. I would hate to see Nebraska take a step backward in cavity prevention and remove fluoride in community water

supplies. Controlling mental and now dental costs for the Medicaid population is one of my top priorities. I don't want small children to have cavities in all their teeth, and I don't want to see kids go to the operating room to have their cavities repaired because there are too many to do comfortably in an office setting. I want our children to have smiles that they are proud of, and Nebraska's water fluoridation program helps with that. Thank you.

WALZ: Thank you. Questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman. Are there pockets within the state of certain-- I'm trying to figure out, I don't have any idea of how many towns do or don't have fluoride. And so is it sort of sporadic? I mean, Hastings is not the only town that doesn't, is it?

DEBRA ESSER: No. No, there are many communities.

RIEPE: [INAUDIBLE]. Pardon?

DEBRA ESSER: As far as I know, there have not been studies that show the difference in the Medicaid population with dental caries or dental expenses related to cavities within fluoridated or non-fluoridated communities. I think that would be a really easy and wonderful study for the current Managed Care Organizations to do over the next probably 24 months. I think that it would be a, a very easy thing for us to do and bring that back.

RIEPE: Would they be inclined to do that without a cost to the state?

DEBRA ESSER: Oh, yeah, that would be very easy for us to do without any increased cost to the state.

RIEPE: Do you also feel on the flip side of this that there would be merit to mandating it across the state?

DEBRA ESSER: I think that-- you know, I don't like to take choice away from folks.

RIEPE: Sure.

DEBRA ESSER: But I think once that choice has been made, I don't want to revisit that, that decision.

RIEPE: OK.

DEBRA ESSER: I think that once the communities have the fluoride within their water supply and we have proven results, I don't want to see that taken away.

RIEPE: I hate to overstep on stuff, but we also need to deal with facts and not emotion, so.

DEBRA ESSER: Yes.

RIEPE: Thank you very much.

WALZ: Thank you.

DEBRA ESSER: Thank you.

WALZ: Next opponent.

HEIDI STARK: Good afternoon. My name is Heidi Stark. I'm a pediatric dentist in Lincoln. My name is H-e-i-d-i S-t-a-r-k. Thank you so much, Senators, and for Senator Hansen for allowing us to testify today. Pretty much everything I wrote to say today has been mentioned by previous testifiers and I'm actually fascinated by what has been said today. I would just like to highlight a few things from my professional experience. I've been going to Honduras for over 25 years and I would say that very rarely in Lincoln, Nebraska do I ever see fluorosis. And I would agree with Dr. Meeske, we take care of thousands of patients on Medicaid and the majority of the fluorosis spots that we would see would come from kids who have come from other countries, which are likely due to the fluoride minerals that are naturally occurring in their countries. I thought that you said something, Senator Riepe, that made a lot of sense to me. There is so much evidence for water fluoridation and the cost savings. And in my professional opinion, when I go to work every day, I don't want any kids to have cavities. And there are times where I'm skipping around my office because I'm so excited that kids are taking care of their teeth. The reduction of sugar absolutely matters more than the amount of fluoride. But for it to make sense, every time we eat bacteria in our mouth, take sugar, it creates acid and breaks our teeth down. We eat a lot of carbs in the United States. We snack on them. We eat them for breakfast, lunch, and dinner. So the acid attack that develops from that bacteria and combination of sugar is what breaks our teeth down. Then when we drink fluoride from our fluoridated beverages or foods that we're consuming that have fluoride in them, which no one in this room can avoid fluoride because of the foods and beverages that are manufactured in the fluoridated communities. That fluoride helps

remineralize the surface of your teeth and it helps reduce the acid attack on your teeth which is what we're all trying to avoid so that we don't get cavities. So I think it's important to understand the terminology, I think, Senator Ballard, that you were looking for is how does it affect your teeth? We know that at inappropriate levels, yeah, it's probably toxic. Just like I wouldn't take a whole bottle of Tylenol. But we know that all the professional organizations like the American Academy of Pediatrics, the American Academy of Pediatric Dentistry, the American Dental Association, the American Medical Association, they have all proven over 70 years that they still support this. And so the ingestion of the appropriate amounts of fluoride, it's the first pass effect, which is the term that you're looking for. So the first pass effect is what we're all going for when we are having appropriate levels of community water fluoridation. So I would-- I oppose this LB1387 because we don't want to spend more time and money taking care of cavities. I'm highlighting my hair now because I'm getting a lot of gray hair from taking care of kids who, you know, frankly, they shouldn't have the decay that they do. Parents and families are more broken up than they've ever been so the diets have gone down the tubes. I have no idea, because I'm not an expert in fluoride, I'm not an expert in IQ. I grew up in Lincoln, Nebraska. I had some cavities back then. The water was fluoridated. I know I take better care of my teeth now because I've gone to dental school. But there is no doubt that if we eliminate water fluoridation from this state, and if we give a bunch of people an opportunity to vote about it, and I am all for freedom, I just think we're headed for a significant increase in decay. We know the statistics and the information show that we will have more cavities. And we have spent all these hours spent talking to you all about increasing reimbursement so that we can afford to stay open and take care of these kids. If this passes, then we are going to have a larger increase in a problem of kids not being able to access dental care. We'll have more cavities, more missed school, more toothaches, more work missed. It's just not going to be good. So I don't want to go backwards from how far we are now finally getting to be. So please oppose this. It's absolutely something that we feel passionate about as dentists and physicians. And if the experts eventually come forward and say, hey, we know for sure there's not a shadow of a doubt that this reduces the IQ of my child and causes problems that for sure create kidney-- all this stuff, absolutely every dentist in here would say, boom, take it out. But until the evidence shows that it should be taken out for the state of Nebraska, we need to keep community water fluoridation in place, please. Thank you.

WALZ: Thanks. Questions?

RIEPE: Thank you for being here.

WALZ: Thank you.

HEIDI STARK: Yeah. Thanks.

SCOTT MORRISON: Good afternoon, Senator Hansen, Ballard, Walz, and Riepe. It's great to be here. My name is Scott Morrison, spelled S-c-o-t-t M-o-r-r-i-s-o-n. I'm a dentist from Omaha and I specialize in periodontics. I'm a past president of the Nebraska Dental Association and currently serve as Chair of the legislative committee of the Dental Association. I also serve as trustee to the board of the American Dental Association. I speak today in opposition of LB1387. As I interpret LB87 [SIC], the bill calls for communities to reestablish their support for water fluoridation. Legislating and requirement that communities reestablish their support for water fluoridation is unnecessary as communities currently have the right to revisit the issue of water fluoridation at any time. If this provision is an attempt to open the door for a discussion of the benefits versus the perceived detriments of water fluoridation, which it obviously has today, then it is important to understand that fluoride is a mineral that naturally exists in all water supplies, and I know that's been discussed thoroughly today. It is important to understand that water fluoridation is one of the best tools of reducing the risk of tooth decay, which has also been discussed well. The most contested aspect to water fluoridation is the claim that research shows fluoride to be toxic and can harm the cognitive development of children. The research which these claims are based comes from China, Mongolia, India, and Iran and involve levels of fluoride that were 3 to 4 times the amount of fluoride that is used for water fluoridation in the United States. These studies are irrelevant to the discussion of water fluoridation in the United States as the levels of water fluoridation are not comparable. Science teaches us that the dose of fluoride is the key factor. Almost anything including iron, vitamin E, and even water itself, can be harmful if it is consumed in extraordinary amounts. Decades of research show the safety of fluoridated water. The Centers for Disease Control and Prevention, as well as the National Academy of Sciences, monitor research on fluoride. Based on 70 years of research, these organizations have concluded that research studies have proven the safety and benefits of fluoridated water. LB1837 or LB1387 also calls for water fluoridation to be established at a level of 0.7 parts per million. Since the inception of community water fluoridation in Grand Rapids, Michigan in 1945, water fluoridation has been tightly

regulated. In 1962, the United States Public Health Service established a level for water fluoridation within a range of 0.7 to 1.2 parts per million. In 2015, the United States Public Health Service reset that level of water fluoridation at 0.7 parts per million. Water entities and water operators within the state of Nebraska should have been maintaining water fluoridation at a level of 0.7 parts per million for the past 9 years, thus legislating at 0.7 part per million level of water for fluoridation is unnecessary. In closing, I would urge this committee not to advance LB1387. Thank you, Senators.

WALZ: Thank you. Questions? Senator Riepe.

RIEPE: Dr. Morrison, good to see you. My question is this. And I, I go to the paragraph in here and you say dose of fluoride is the key factor. Do we have good monitoring systems that constantly in, I assume, every community to measure that to, to make sure that we don't--

SCOTT MORRISON: Yeah.

RIEPE: --either way?

SCOTT MORRISON: Yes, sir. That's the day-to-day operations of the water operators of those communities.

RIEPE: OK.

SCOTT MORRISON: But the EPA once a year, I believe, tests those, those fluoride levels and reports on that so we can get reports. You asked-- I think you asked about pockets in the-- in, in the state and there are pockets in the state. And each community should have some numbers or at least have access to numbers of those levels of naturally occurring fluoride.

RIEPE: I don't know anything about it. Do they have to report those up on a quarterly, semiannual basis to someone that puts them all together and looks at the big picture?

SCOTT MORRISON: The water operators or the--

RIEPE: Well, I, I, I--

SCOTT MORRISON: Well, the EPA--

RIEPE: Whoever this reporting would go to.

SCOTT MORRISON: That would be EPA reporting and I know it's done annually so I get annual numbers of that.

RIEPE: Sounds like they at least if they don't, they should.

SCOTT MORRISON: Yes.

RIEPE: OK. Great. Thank you very much. Thanks for being here.

SCOTT MORRISON: Thank you, Senator.

WALZ: I think that's all the questions. Just us two now.

SCOTT MORRISON: I enjoy that.

WALZ: Thank you so much for being here.

SCOTT MORRISON: All right. Thank you.

WALZ: Next opponent. Anybody in the neutral?

EDWARD F. FOGARTY III: Well, I, I would like to clarify a few things for the record.

WALZ: He's coming up. You can't do that, right?

TIMOTHY TESMER: Hi, Senator Walz.

WALZ: Hey, how are you?

TIMOTHY TESMER: Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. My name is Dr. Timothy Tesmer, T-i-m-o-t-h-y T-e-s-m-e-r, and I'm the chief medical officer for the Division of Public Health within the Department of Health and Human Services, DHHS. I'm here to testify in a neutral capacity to LB1387 which addresses the fluoridation of public water supplies. Adding fluoride to drinking water is one of the most successful public health interventions in history offering protection against tooth decay. This connection has been observed since the 1930s when the U.S. National Institutes of Health began investigating how fluoride works, whether it is safe, and if it could be used therapeutically. This large body of research has overwhelmingly shown that the benefits of fluoride in drinking water significantly outweigh any health risks. For over a century, fluoride has been present in community drinking water systems, and to date there has not been consistent and convincing evidence that links water fluoridation with any unwanted health effect other than dental fluorosis, a change in the appearance of tooth

enamel that can occur when the permanent teeth of young children are still developing. In addition, Nebraska currently has over 45 counties that are designated as state shortage areas for general dentistry. This means those counties are experiencing a shortage, shortage of healthcare professionals. Nebraskans without access to regular dental care are already facing challenges to maintaining good oral health which is necessary to maintain good overall physical health. For these reasons, DHHS recommends that communities fluoridate their water supplies. DHHS supports the suggested change in LB1387 to reduce the optimal level of fluoride in community water supplies, acknowledging that the U.S. Public Health Service adjusted its recommended optimal level of fluoride in drinking water in 2015 to 0.7 milligrams per liter. However, DHHS would prefer a range of acceptable levels for water operators to achieve, rather than a specific level of fluoride that would be difficult to maintain. It is important to note that requirements governing public water supplies in Nebraska are found with both DHHS and the Department of Environment and Energy, DEE, with the DEE responsible for the method and frequency of public water testing. Community water fluoridation is one of the most cost-effective, equitable, and safe measures that communities have to prevent cavities and improve oral health. Data indicates that for communities of 1,000 or more people, savings exceed costs, annually, annually averaging $20 in savings for every dollar invested. We respectfully request that the committee consider amending LB1387 to include a range of acceptable operational fluoride levels in a community water supply. Thank you for the opportunity to testify today. I would be happy to answer any questions on this bill.

WALZ: Thank you. Questions? I have one question. I'm just a little confused. Does the DEE-- are they responsible for the method and frequency of water testing currently or you're asking them?

TIMOTHY TESMER: No, I think currently.

WALZ: OK.

TIMOTHY TESMER: I believe currently.

WALZ: All right. Just wanted clarification on that.

TIMOTHY TESMER: Yeah. Um-hum.

WALZ: All right. Any other questions? I don't see any. Thanks for being here today.

TIMOTHY TESMER: Thank you.

WALZ: Anybody else in the neutral?

LASH CHAFFIN: Good afternoon, members of the Health and Human Services Committee. My name is Lash, L-a-s-h, Chaffin, C-h-a-f-f-i-n. I'm a staff member at the League of Nebraska municipalities. Today, I'd like to testify on behalf of the League in a neutral position. The-- in 2007 and 2008 when Senator Johnson put the initial mandate in, that there were many cities including cities that already fluoridated who were opposed to the 1,000 population. Well, didn't start off as 1,000 population mandate, but the, the mandate that he-- that he put in place because it was a mandate and the League is opposed to mandates, cities are opposed to mandates. Unfortunately, as currently drafted, LB1387 replaces that mandate with another mandate, the mandate to have the, the public vote. The position of the League of Municipalities is that these, these decisions are best made at the local level with the water purveyor and the elected officials who, who, who are best suited to, to deal with these issues. So the debate that you've heard today should be a debate that takes place at the city council level or the village board level. So thus today we are testifying neutral on, on, on this bill. Now the League is agnostic towards the science, but what we're not agnostic towards is the fact that we think that locally elected officials need to be active in these, these-- this decision-making process. And, Senator Riepe, before you go, I do have-- I have the answer to your question--

RIEPE: On the horses?

LASH CHAFFIN: --unrelated to-- no, the number of-- number of systems that do--

RIEPE: Oh, OK.

LASH CHAFFIN: --that do provide fluoridation.

RIEPE: Yes.

LASH CHAFFIN: Unrelated to my testimony, but I know the answer. There's, there's 528 municipalities. There's around 100 that provide some form of fluoridation. Now you're going to get a little different number depending on who you talk to because some cities and water systems serve multiple jurisdictions. So say the city of Plattsmouth serves several rural water districts at the same time. So how you count that rural water district is a part of the Plattsmouth fluoridation or it's at a separate [INAUDIBLE]. So-- but it's a-- it's

around, depending on who you talk to, it's going to be 90 to 100, I think, is the-- is,--

RIEPE: OK.

LASH CHAFFIN: --is, is the number. And, of course, that includes both Lincoln and Omaha which are larger populations. But, but we think that this, this issue needs to be decided in front of the water purveyors and, and the local cities, so. But I would certainly answer any questions.

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

LASH CHAFFIN: Glad I could help. You're welcome.

WALZ: All right. Thank you. Any other neutral? You can only testify once. Sorry.

EDWARD F. FOGARTY III: OK.

WALZ: Anybody else? All right. We had 30 proponent letters, 15 letters in opponent, and 2 neutrals.

M. CAVANAUGH: There were 39.

WALZ: Oh.

M. CAVANAUGH: Update on the system.

WALZ: OK.

M. CAVANAUGH: Yeah. 39 proponents.

WALZ: 39. Sorry.

HANSEN: So some of the stuff I mentioned in my opening you may have heard by the opposition which I was expecting. So one of the things that we did here, a common theme was this is the top 10, you know, healthiest achievements we have ever done. And actually where that quote comes from, it actually comes from the great, the great public health achievements, United States 1999. And this is a 1999 CDC report on fluoridation and was written by two members of the Oral Health Division of the CDC. One was Scott Tomar, who's actually a dentist who never published anything on fluoride before that. And the other one is Susan Griffin, who's an economist. They came up with that quote which you hear repeated all the time. Both are not toxicologists and are 2 of 30 people in the Oral Health Division, the CDC is compromised of

over 14,000 people. What irks me is when they say there is no evidence or data showing the effects of fluoride on people when ingested. I have a few here which I'm going to hand out and I hope you actually look at. This is from the National Toxicology Program Scientific Review, like I mentioned before, who's under the direction of NIH, who's under the direction of DHHS. This isn't Bob's research facility in his basement. This is the government we have some, you know, faith in and hopefully and, and research. 52 out of 55 studies linked higher fluoride levels with lower IQs. Of the highest quality studies, highest qualities-- and you heard before by some of the supporters, low bias, peer reviewed. They found that 18 out of 19 stated that lower IQs even took place in the optimal level of 0.7. There is research. I have a few notes I have to go through here first so apologize. And I have some on my phone too. So I first-- you know what-- and I first want to underscore the fact that I'm not trying to diminish anything that the dentists or dental hygienists do in our-- in our state. I think they do amazing work. And I've done-- especially a lot of them know over the course of my time being here to do what we can to encourage people to use their services, get proper reimbursement rates, expand their services. So this is not in no way a reflection on who they are as a profession. But I got to go back to the first testifier in opposition, Dr. Meeske, which I actually really respect, except we just differ on this one. All the endorsements that she mentions are decades old and they are not based on current science. The report by the toxicology-- make sure I get that right-- by the toxic-- National Toxicology Program isn't-- she referenced it as a draft. It's not a draft anymore. It has been finalized and submitted for publication. So her statement is outdated. Plus, the NTP had an independent working group of scientists examine if the NTP adequately responded to the NASEM, which is the National Academies of Sciences, Engineering, and Medicine called NASEM, if they adequately responded to NASEM's concerns, and that working group voted unanimously that they did. They had no concerns about the report about this stuff. And they voted to support publication, so NASEM didn't reject anything. Plus, NASEM didn't evaluate the science. They only evaluated and criticized the words used. They wanted more explanation of the science. And we hear again-- we heard from a few people about we've seen-- we've seen fluorosis in the teeth, but it's only been from people who've been out of the country. And CDC data shows fluorosis impacts all kids. CDC data. There's no data on immigrants versus residents from the CDC. She provided no data contradicting the CDC fluorosis data. It doesn't exist. And I have to go back to these studies were funded by the NIH. She referenced this would be very similar to getting rid of the Clean Air Act or seat belts. Seat belts

do not cause harm like overexposure to fluoride can. You're comparing apples to oranges there. She references the important-- like the polio vaccine. If I came with a bill to say we should put the polio vaccine in our water supply, would any of you vote for it? I highly doubt it. Another thing, it's a simple-- it's a simple mineral. This is what I referenced in my opening. It is not a simple mineral. It's a corrosive acid used from fertilizer plants in the scrubbers that they have in the water that comes down, it's a corrosive acid. She talks about vitamin D, vitamin C, those are essential nutrients. Fluoride is not. Those are essential for life. Fluoride is not. And time and time again, they even admitted it, topical is by far the most beneficial and most widely used. Not ingesting it. I'm not debating topical, that is-- that is most widely used. And the states with the lowest rates of childhood decay according to the CDC are Vermont and New Hampshire. Both are among the least fluoridated in the nation. The 25% reduction in the case data is outdated. So the key message here is a cavity can be filled but damage to the brain is permanent and lifelong. I appreciate the mayor of Burwell coming out and his actually, you know, his investment in this topic and his, his, his concern for the children in his community. He also talked about how he saw a decline in the rate of tooth decay or not tooth decay but the report of tooth decay emergencies up, if I remember right. But in the same-- and he is attributing that to fluoride-- fluoridated water. But in the same breath, he also said that they use topical varnishes and gave a toothbrush to the kid, which I would contend, you know, led to a decrease in tooth decay or emergency visits. And he also mentions that fluoridation of water is the best way when actually it is not. It is the topical application. Another thing that we heard often was that it is safe and effective. Obviously, that is not true and if it is even "slightously" not safe and effective, it comes with reasonable risk which is a lack of informed consent for the people who are ingesting this water as a medicine. And fluoridated water doesn't make it available to everyone. It forces it on everyone. There's a big difference. And, again, I think we heard analogies about if we happened to take too much Tylenol, you know, linking fluoride to medicine, which is the point that I was making before. It is a medicine that we are putting in our water supply. It is used for medical purposes. It is not used to treat the water and I think that's unethical. There's an increase in cavities if we stop fluoridating the water. I didn't see anybody bring up any research about that. Nobody is-- nobody is handing you research papers like I am. And how old is that research if they do have it? Is it as extensive as what the NIH has done in the last 10 years? I don't see any evidence of that. And 70 years-- like I mentioned, 70 years of research is not current. If--

before, we were looking at, like, 1.5 parts per million, now we lowered it down and accept a range about-- a range, I think, 0.7. I think we have actually from our own department, 0.7 to 1 parts per million, which tells you why are they lowering it? Why was 1.5 acceptable before but now it's not. I'm telling you, like, over time research changes. I'm almost done. Sorry. I also want to address dosage. So we're talking about it and everybody should have the, you know, fluoridated water. But there's a huge difference between an infant drinking it as opposed to an adult. You cannot control dosage. And that's what we're talking about, the effects it has on infants, neurotoxicity to the brain, IQ, huge difference there. Dosage is a big thing. I'm not going to give an infant two Tylenol, the same I would an adult. But here we are with fluoride. The idea. I love this one too. Research for the lower IQ, which I'm talking about, comes from China, Iran, and Mexico. You know who those were funded by? The NIH. Those are government studies. The ones in here aren't, coming from Mexico and China. I forgot to also mention that recently Kentucky passed legislation to outlaw the mandation-- the mandating of fluoride in their water, too, or it's on-- it's on the docket to be passed pretty soon with certain-- current legislation, so. I will hand these out for everybody to read, and I hope you at least glance at them, but I just want you-- a parting gift to think about. Imagine we lived in a world where we did not fluoridate the water right now, right? There's no fluoridating of the water. And I come to you saying I want to fluoridate the water. And then somebody behind me gives you all the information I just gave you about possible neurological effects on children. Would you then choose to fluoridate the water? I highly, highly doubt it. Even if you have a shred of concern that this can cause any kind of damage to a child's brain, which this is not a shred. Even if you think it helps teeth completely, fine. All the stuff the opposition said about how it helps cavities in the teeth, I'll erase all that. I didn't hear too many people talking about the neurological effects on the brain very well and provide you with information and data about the contrary to what I have. So even if you think it causes a small little bit of damage to a child's brain, get it out of the water. There's no reason we should use the water for medicine. Thank you. I'll take any questions.

WALZ: Questions from the committee? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Senator Hansen. First, I just want to say I appreciate how you challenge traditional thinking. This is something that's been around for a long time and prior to you bringing this bill not something I really gave a lot of thought to. So thank

you for that. I would like to talk to you about some of the practical parts of your bill as far as how this would work.

HANSEN: Yep.

M. CAVANAUGH: So we talked about it a little bit after your opening, it's a-- it would be a vote of the people.

HANSEN: Yes.

M. CAVANAUGH: So here's my question. In reading your bill, it looks like it's just a vote once. It-- so if in 2025, the whole state in their various communities votes on whether or not they want fluoride in their water, is there-- what if they change their mind, I guess, is kind of the question.

HANSEN: Yeah, I believe we have it in the bill that--

M. CAVANAUGH: Do you? OK.

HANSEN: --the ability is there for them to do that. I think you have to give it a year, if I remember right, we have in the bill.

M. CAVANAUGH: OK.

HANSEN: It's in-- it's, it's in there.

M. CAVANAUGH: OK.

HANSEN: And also I think there's also a way for the-- by two-thirds vote, I believe, for the--

M. CAVANAUGH: Of the villages or the--

HANSEN: Yes.

M. CAVANAUGH: --elected bodies.

HANSEN: Yes. Yes.

M. CAVANAUGH: They can over--

HANSEN: We just didn't want to leave one vote and it's just that way forever, so in case--

M. CAVANAUGH: That's what I was wondering is because whether you vote for it or against it, is there any opportunity to change it? So this

is kind of a ballot initiative bill because we could pass this bill, but that doesn't actually do anything. It goes to the ballot.

HANSEN: Nope. The only thing it really ever mandates is we can't go above 0.7.

M. CAVANAUGH: OK.

HANSEN: Yeah.

M. CAVANAUGH: OK. Thank you. And, again, thank you. This has been very interesting for me. It's-- I, I equate things to like a, a snow globe and sometimes you just got to shake up the snow globe to see things differently.

HANSEN: And I never do that. You know that.

M. CAVANAUGH: You never-- I-- neither do I. I think the two of us are known for just letting the snow settle.

HANSEN: Yes.

M. CAVANAUGH: Thank you.

HANSEN: Um-hum.

WALZ: Other questions? I guess I have, maybe, a concern, question, concern. First of all, I just want to-- do you think that fluoride does help with tooth decay?

HANSEN: Yes. Well, is it topical or ingested? Topically, yes.

WALZ: OK.

HANSEN: Yes. And that is the--

WALZ: You're absolutely sure about that?

HANSEN: I think the evidence does not show the contrary. I think right now the topical use of it, like in toothpaste when you go to the dentist, they put it on your teeth. Yeah, that has been shown to be wildly effective. And I don't see a whole lot of evidence that shows different, the ingestion of it is different.

WALZ: Do you have any ideas on how we can make absolutely sure that every child receives topical fluoride in our state?

HANSEN: Yeah, I believe right now (a) I think it's the schools. I think sometimes they-- when they have a dentist come they provide some of that. But also, I think, Medicaid might cover that as well. I think--

WALZ: So my question was do you have any ideas on how we can make absolutely sure that every child in Nebraska receives topical fluoride?

HANSEN: I don't think you could do that with anything. Absolutely sure they all get it. You know what I mean? You can do your best to make it widely available through different, different means. Whether it is, say, Medicaid is going to cover it or you can have the school then provide it or you mean-- it's not terribly expensive. Toothpaste isn't. And a lot of stuff-- actually, when you go visit the dentist they give you this and that for free as well, a toothbrush. Sometimes cities like Burwell do that which I really appreciate though, so.

WALZ: Thank you, Senator Hansen.

HANSEN: Um-hum.

WALZ: Any other questions?

HANSEN: Thanks. I tried to keep it short. It didn't work. Thank you.

M. CAVANAUGH: I have an entire another hearing on water in Natural Resources.

HANSEN: It's about the children.

RIEPE: Chairman, I will say this. You did your homework.

HANSEN: Thanks.

WALZ: Yeah.

HANSEN: I'm pretty sure I don't have to go somewhere else, so. I have another bill in Revenue, but I don't think it's up yet. All right. So-- all right. So now we will open up the hearing for LB1016 and welcome Senator Walz to open.

WALZ: Super easy. Good afternoon, Chairman Hansen and members of the Health and Human Services Committee. For the record, my name is Lynne Walz, L-y-n-n-e W-a-l-z, and I represent Legislative District 15. I'm here today to introduce LB1016. LB1016 removes the sunset provision

under the state's Home and Community-Based Services waiver in the developmental disability system allowing for services to youth transitioning from the education system to maintain skills and receive day services necessary to pursue economic self-sufficiency. I introduced this same bill back in 2019, but as a body we decided to extend the termination date to 2025 instead of just removing it altogether. The Medicaid Home and Community-Based Services waiver program is authorized in 1915(c) of the Social Security Act. The program permits a state to furnish an array of, of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalism. The state has broad discretion to design its waiver programs to address the needs of the waivers' target population. Waiver services complement or supplement services that are available to participants through the Medicaid State Plan and other federal, state, and local programs, as well as the supports that families and communities provide. This program is another tool of the state that helps prevent the unnecessary institutionalism of individuals, a key component of the 1999 homestead ruling by the Supreme Court. The time when a child moves on from high school and into their adult life is already one of the hardest times in a parent's life. Believe me, I know. I had three. They have spent years preparing them for this advancement. This period of time is even more stressful for a parent whose child has a developmental disability. There's so much more to worry about when this happens but, generally, parents want them to be able to experience their independence and to be able to make it on their own. As you might already know, I worked in the developmental disabilities field for many years as a direct care staff sharing a home with three ladies who had developmental disabilities. I also worked as a supervisor managing residential facilities and eventually an executive director overseeing both residential and day services. Throughout this time, I had the pleasure to witness tremendous growth in the lives of the people we served. Some of these positive changes included increased independence and daily living, health maintenance, community engagement, employment, volunteer activities, and prevocational training, building positive social skills and just a greater awareness of their own personal choices. Many of these skills and opportunities would not be possible without the formalized training and the staff provided by day habilitation services. I honestly can't imagine how different the lives of so many people would be without the opportunity to maximize their independence through day hab services. The impact of not having the transition services would have been devastating for so many individuals and families. I would encourage this committee to advance this bill on to General File. This is a great program and I believe in

the work and the services the providers do. Removing the sunset is an important step in permanently supporting our developmental disability community instead of kicking the can further down the road or, even worse, denying services. With that, I'd be happy to try and answer any questions.

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

M. CAVANAUGH: So this just removes the sunset?

WALZ: Just removes the sunset.

M. CAVANAUGH: When was this first enacted, do you know?

WALZ: Oh, my goodness.

M. CAVANAUGH: 2018?

WALZ: I was going to say 2019.

M. CAVANAUGH: 2019?

WALZ: Yeah.

M. CAVANAUGH: OK. That was it. Thank you.

WALZ: Yep.

HANSEN: Any other questions? Seeing none, see you at close. All right, we'll take our next-- we'll take our first testifier in support of LB1016, please.

KRISTEN LARSEN: Well, good afternoon, senators. My name is Kristen Larsen, and it's spelled K-r-i-s-t-e-n L-a-r-s-e-n. I'm here on behalf of the Nebraska Council on Developmental Disabilities to testify in support of LB1016. Although the council is appointed by the Governor and administrated by DHHS, the council operates independently, and our comments do not necessarily reflect the views of the Governor's administration or the department. We are a federally mandated independent council. We're comprised of individuals and families of persons with developmental disabilities, community providers, and agency reps who advocate for systems change and quality services. We serve as a source of information and advice for state policymakers and senators, and when necessary, we take a nonpartisan approach to provide education and information on legislation that could

potentially impact people with DD. Council members support LB1016, which removes the sunset provision that keeps the entitlement for adult DD day waiver services in state statute. Eliminating the sunset provision provides some assurance that day services in some form for graduates will not disappear overnight, and protects state services for the near future. Once an adult day DD offer is made and received, the new graduate can access an array of waiver options such as pre-vocational, supported employment, habilitative community inclusion, or respite. Nebraska citizens with DD rely on these day vocational supports to live independently in their communities. It's important to share the history of this legislative language area within state statute. Historically, eligible new graduates were entitled to DD services when they graduated from high school and reached age 21. That's because of family grassroots advocacy that made it possible for the graduate entitlement language to pass into state statute in 1995. This legislation ensured that graduates transitioning into adulthood would not be sitting at home and lose valuable skills because of the waitlist, as a disruption of services and supports can be detrimental. Accessing the adult DD-- adult DD waiver also makes it possible for the graduates parents to remain in the workforce. Without this entitlement in place, parents of youth with IDD with significant needs would potentially have to leave the workforce to provide supervision and care for their adult children at home until a waiver slot was made available. When DHHS requested the legislative change in 2018 to remove entitlement language, advocacy efforts resulted in compromise language being added to LB793, and then later in 2022, LB540 to extend the sunset clause. Advocates considered the sunset provision as a compromise with the Division of DD to have a backup plan in case graduates who are listed as the fourth priority in the state statute to receive DD services were not accessing the services. Any potential threat to these services was and continues to be taken seriously. Currently, an eligible 21 year old graduate will not automatically receive funding if there's someone with a higher priority need. Graduates are offered funding for day services under the state's fourth funding priority. When the change was made in 2018, the department assured advocates and the Legislature that, based on historical data, the state would receive-- reserve enough funds to serve all new graduates. This has proven true, and the council appreciates the commitment to serving people with DD that the current administration and the leadership within the Division of DD demonstrate. However, we know that, and share concerns, that administrations and DD leadership change over time, as well as economic forecasts, and we want to ensure that graduates maintain access to these key waiver supports. If we have an administration in

the future that decided, like, to cap or cut services, then this entitlement is the only way to ensure that these young adults are brought into the system to have some sort of support. Gratefully, this has not been an issue in Nebraska in recent years, as the state has been serving graduates by building in reserve capacity. However, if the state faces an unforeseen economic downturn, unless funds are appropriated to support those receiving DD waiver services, then these graduating youth would be at risk of losing the seamless transition into these critical day supports. Keeping the entitlement in state statute is how Nebraska ensures that eligible individuals with developmental disabilities have a protected pathway to enter the DD services system. It guarantees that transitioning youth have continuity of support from special education to vital day support services, empowering them to live productive and meaningful lives. And speaking as a parent, it keeps the parents in the workforce. So I have had to cut it down, and I have a little bit more in the testimony that I handed out. But, that's all I have, and I appreciate you bringing this up.

HANSEN: Thank you for testifying. Are there any questions from the committee? I'm seeing none. Thank you very much.

KRISTEN LARSEN: Thank you.

HANSEN: Our next testifier in support, please?

EDISON McDONALD: Hello. My name is Edison McDonald, E-d-i-s-o-n M-c-D-o-n-a-l-d. I'm the executive director for the Arc of Nebraska. We are a nonprofit with 2,600 members advocating for people with intellectual and developmental disabilities. We're in strong support of this bill because ultimately, this is the best path for families to begin to access services, and it's the most cost efficient amongst our priority categories. I want to start off with a little bit of an overview of our developmental disability system structure. We have six priority categories. One is for emergencies. Two is to get people out of institutions. Three is to address foster care needs. And then we get to priority category four, which is designed to go and be kind of the entry ramp on to services following special education. After we've gone and invested years in special education, this is the next step to get people into community based services. Some of you all will remember, as we worked to pass the family support waiver, we talked about how there was an access point at the age of 21, but for children, there was not. This is basically that same portion that we see in the family support waiver, only for adults. This is the onramp in which they get access to services. As a new priority five is

dealing with veterans kids. And then priority six is what we refer to as the wait list or registry. Ultimately, this bill came-- when we originally implemented the sunset date, it was under a different administration, different DHHS leadership. And I think that the way their-- the current leadership is pair-- picturing the structure has really shifted, and realized that, this is not something that is problematic, not something that we need to set a sunset on. As you'll notice, I don't believe DHHS is here. So I'd urge you to support this bill and ensure that people with intellectual and developmental disabilities are able to access community based services. That, any questions?

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

EDISON McDONALD: [INAUDIBLE].

HANSEN: I scared him off. Anybody else wish to testify in support of LB1016? All right. Does anybody wish to testify in opposition to LB1016? Seeing none, is there anyone who wishes to testify in a neutral capacity to LB1016? Seeing none. Yes. Senator Walz will waive closing. And for the-- for the record, we did have-- we did have three letters of support for LB1016. With that, that'll close our hearing for LB1016 and we will open up now LB-- Are you ready?

BALLARD: I don't know if my testifier's here, but--

HANSEN: Let's do this.

BALLARD: --fine.

HANSEN: Just to make sure we get all our ducks in order. We're going to take like a five, five minute break and we'll come back. And so they can kind of get ready for the next testimony. Thank you very much.

[BREAK]

HANSEN: Just a little bit of a different order, so we can be mindful of everybody's time and rearranged, because Senator Bostar currently right now is in a [RECORDING MALFUNCTION] bill, we will move on to LB1144, and welcome Senator Ballard to open up on that.

BALLARD: Thank you. Thank you, Chair Hansen and members of the Health and Human Services Committee, Committee. My name is Beau Ballard, for the record, that is B-e-a-u B-a-l-l-a-r-d, and I represent District 21

in northwest Lincoln, northern Lancaster County. I come today to introduce LB1144. Care management services, like those of Area Agencies on Aging, provide an attempt to keep older Nebraskans in their home with a lower level of care for as long as possible. This goal is one the state should focus on as well, since the longer old-- older Nebraskans stay in their home, the fewer state resources are used. Currently, a Triple-A operates by billing their clients on a sliding fee scale used on their income. From 1987 to 2018, DHHS interpreted the law so a sliding fee was a voluntary system, with the department picking up the clients did not pay. However, in 2018, the department stopped reimbursing a Triple-A unpaid fees, leaving them with a budget shortfall. LB 1144 moves the sliding fees back to a voluntary system, and requires DHHS to pay what the client does not, a return to the system that was used for 30 years. This also matches our state managed care policy and other programs offered under the federal Older Americans Act. These are-- the testifiers behind me will be able to explain the technical-- technicalities of the change, but I'd be happy to answer any questions.

HANSEN: All right. Thank you. Are there any questions from the committee? Seeing none, we will take our first testifier in support of LB1144. Welcome.

ROD HORSLEY: Good afternoon, Senator Hansen, and members of the Health and Human Services Committee. Thank you for your time. My name is Rod Horsley, R-o-d H-o-r-s-l-e-y. I'm the director of South Central Nebraska Area Agency on Aging, located in Kearney. I'm testifying on behalf of the Nebraska Association of Area Agencies on Aging. In 1987, under LB42, care management services were established through the eight Area Agencies on Aging to aid in the coordination of services for older adults. Here, management staff meet with an older adult, complete a comprehensive assessment, help determine what needs the individual may have, and then set up services to meet those needs. This may include transportation, home delivered meals, chore services, to name a few. The purpose of care management is to provide services which will allow an older adult to stay in their own home and avoid premature institutionalization. Providing services in-home is much cheaper than in a long term care facility, and it helps control the rising costs of Medicaid. It's the right care at the right time. Since the inception of the care management program through 2018, there was not a cost per se to clients for the service. A sliding scale was used based upon the individual's income to determine the value of the service. The client was sent a statement, but was not required to pay for the service. In 2018, the Nebraska Department of Health and Human Services reviewed the care management statute, and determined that the

statute had been incorrectly interpreted and that the care management clients were required to pay for the service if their income was above 10% of poverty guidelines. When clients were told that they were required to pay for the service, many clients opted to no longer utilize that service. LB40-- excuse me, LB1144 adds language to Section 81-2234 to state that, quote, care management clients may contribute to the costs of receiving care management services as provided under section 81-2230. A client family income schedule, using the federal poverty guidelines [RECORDING MALFUNCTION]. End quote. [RECORDING MALFUNCTION] --under the Older Americans Act allow [RECORDING MALFUNCTION] The Nebraska Association of Area Agencies on Aging fully support LB1144 and would ask for your support as well. I appreciate your time and consideration.

M. CAVANAUGH: Thank you very much. I'll see if there are any questions from the committee. Are there any questions?

RIEPE: No. Thank you.

M. CAVANAUGH: OK. Thank you for your testimony.

ROD HORSLEY: Thank you very much.

M. CAVANAUGH: Are there any other proponents for LB1144? Seeing none, are there any opponents for LB1144? Seeing none, anyone in the neutral for LB1144? Senator Ballard, and he waives. There are nine proponents' letters in support of LB1144. This will close the hearing on LB1144, and we will welcome Senator Bostar to open on LB874. Welcome, Senator Bostar.

BOSTAR: Thank you.

M. CAVANAUGH: We're doing a little shuffle of our schedule today. Everybody has got a busy schedule.

BOSTAR: Yes. Certainly. Seems like we'll be in Revenue all night. That's exciting.

M. CAVANAUGH: Well, I hope this is a nice respite for you, then. You're welcome to open.

BOSTAR: Good afternoon and thank you, members of the Health and Human Services Committee. For the record, my name is Eliot Bostar, that's E-l-i-o-t B-o-s-t-a-r, and I represent Legislative District 29. I'm here today to present LB874, legislation to streamline, clarify, and standardize various state licensing requirements and local regulations

under the Child Care Licensing Act to enable child care programs to operate more efficiently and effectively. Access to affordable, quality child care is inextricably linked to Nebraska's economy. Without it, parents won't be fully engaged in the workforce, and our state will struggle to attract and retain new business and industry to our communities. Without meaningful change, hard working parents will continue to struggle to achieve financial stability for their families. According to a Harvard Business Review report released in 2021, nearly 20% of working parents had to leave work or reduce their work hours solely due to a lack of childcare, and only 30% of all working parents had any form of backup childcare. The Nebraska Chamber of Commerce estimates that Nebraska loses $731 million annually in business productivity due to gaps in childcare services. The most recent data emphasizes the challenges faced by Nebraska's struggling childcare industry. According to the licensed childcare roster released by the Nebraska Department of Health and Human Services on January 3rd, 2024, nine counties in Nebraska currently have no licensed childcare provider at all: Arthur, Banner, Blaine, Hayes, Keya Paha, Logan, McPherson, Sioux,and Thomas counties. Examining the Nebraska Department of Health and Human Services license roster over the past few years shows that in 2023 there were nearly 12% fewer licensed childcare programs serving children ages 0 to 5 than in 2029-- 2019, not 2029, statewide. According to childcare industry employment data received September of 2023 from the Nebraska Department of Labor, the child care workforce in our state currently experiences a 30% turnover rate. The Early Childhood Institute at the University of Nebraska reported in 2021 that 7 in 10 providers report staff members leaving the early childhood field entirely. That same report found that 9 in 10 providers employing staff have had difficulty hiring for open positions, citing both a general lack of applicants and an inability to offer sufficient pay. It's clear the demand for quality, safe, affordable childcare is extremely high. It's also clear that recent years have been an extremely difficult period to be a licensed childcare provider in Nebraska. It requires an enormous investment of time, focus, attention, and material resources to ensure children's safety and meet developmental needs while operating a financially viable childcare business. In addition to these challenges, excessive regulatory obligations place undue strain on already overburdened childcare providers. Much of current law and regulation effectively ensures the well-being of our children. However, some of these regulations are needlessly burdensome, unnecessarily complicated, and conflict with one another. Our current jumble of childcare licensing regulations makes an already difficult profession harder than necessary. LB874 is designed to mitigate some

of these challenges. Current regulatory demands come from all levels of government, federal, state ,and local. This includes state licensing requirements, separate federal childcare subsidy requirements, federal and state background checks, local zoning, building safety and fire code enforcement, and numerous inspections at each level. There are multiple provisions contained in LB874. I'll highlight the most substantive. In Section 3, LB874 allows dual licenses for childcare providers. Enrollment in childcare programs can fluctuate significantly through the year, increasing during the school year and decreasing over the summer. This legislation allows providers to obtain dual licenses that enable a program to operate under a lower capacity Family Home Childcare II license when enrollment is down, but return to a higher capacity child care center license when more children are enrolled. This provision will be particularly helpful in rural Nebraska, who rely primarily on family home childcare providers. Currently, the Department of Health and Human Services requires previously authorized childcare employees to reapply to the department for a background check when applying for a position with a new childcare provider. Under Section 5, LB874 allows for the results of a background check to be portable between employers. This does not compromise state and federal requirements for childcare background checks. It simply allows the results to be viewed by both a current employer and a prospective employer. This change does not allow background checks to be portable if they are not current. Sections 8 and 9 of this legislation creates a standard five year regulatory review that the Department of Health and Human Services and the State Fire Marshal's Office must conduct to evaluate and determine the-- that the current regulations are still valuable and necessary. This is similar to legislation passed by former Senator Laura Ebke for a regular review of small business regulations. This mechanism ensures a process for eliminating outdated regulations and clarifying any issues that arise with new rules. Regulatory compliance is essential and necessary for the safety of child care in Nebraska. We also want to ensure that the regulatory environment for child care is not needlessly burdensome on an industry already struggling to keep programs financially afloat. LB874 creates a safer and clearer regulatory environment in Nebraska for our child care providers. Speaking as a parent, safety is my top priority. Complexity and confusion in current law doesn't keep our children safe. The clarifications and streamlining of LB874 improve both safety and access to care. Several testifiers will speak after me in greater detail about these regulatory-- what these regulatory issues look like in practice. Some will share their insights on how other industries streamline regulatory processes and reinforce the case for broader

downstream benefits for our kids, families, communities, employers, and economy. Thank you for your time and consideration. I would encourage your support of LB874, and be happy to answer any initial questions you may have.

M. CAVANAUGH: Thank you, Senator Bostar. Are there any questions from the committee? Senator Riepe.

RIEPE: Thank you, Chairman Cavanaugh. Thank you for being here, Eliot, Senator. My question is this, is-- and I had to step out to, to make an important call, but how much-- I guess I didn't, at least in my information, I didn't have the fiscal note. And-- is there one or, or-- my-- And where I'm leading with that on this, I'm constantly trying to deal with what's the state, the government's accountability or responsibility in, in both providing child care for and providing housing. And so much of it seems to be focused on, on the rural side of the, of the equation. And at some point in time, business has to step up or individuals have to step up. Otherwise, we're running the whole thing.

BOSTAR: Yeah. There is no fiscal note--

RIEPE: OK.

BOSTAR: --for this.

RIEPE: I see it.

BOSTAR: This legislation simply removes and clarifies existing statutes and regulations in order to make the operation of the business easier.

RIEPE: OK. So it, it should lower their operating cost, you feel?

BOSTAR: Yes.

RIEPE: OK. Well, that, that appeals to me.

BOSTAR: I-- and I want to mention I'm-- and I'm sorry for not doing this before, AM2446, it looks like a monster amendment. It's just a white copy to add small things, but that's what it looks like. Section 7 adds language to clarify that political subdivisions are still allowed to regulate business use relating to outside appearance, nuisance, or public health and safety. Section 8 strikes zoning and ordinance reporting requirements for DHHS. The department does not have this information as it does not create nor enforce its own or any

political subdivision's enacted zoning or ordinances. And Section 10 outright strikes the section that would have required municipalities to report on local regulations to the Legislature. We struck that because local municipalities did not want to comply with that provision. And so in order to get them not to oppose the bill, we decided to take it out. However, if the committee pleases and you want to put that back in, please feel free.

M. CAVANAUGH: Any further questions?

RIEPE: I if I may?

M. CAVANAUGH: Yes.

RIEPE: I think my question would be is, is this simplify the operation for the childcare centers, or is it protect them, or does it make it one more regulation that they have to respond to?

BOSTAR: It's fewer regulations. We're removing regulations.

RIEPE: You're singing to my music.

BOSTAR: This-- I'll give a little bit more background since-- due to your interest. The, the Governor put together a-- two working groups over the la-- the previous interim. One was on taxes and one was on workforce. The workforce working group had a subgroup made up to look at childcare and childcare issues. So that brought all these different stakeholders to the table. And so this legislation is a process of bringing together childcare providers, the State Fire Marshal's office, the-- basically municipalities, different communities, and looking at ways of saying we have a lot of government and a lot of regulations around how childcare is provided in the state of Nebraska. With absolutely posing no risk to compromising anything that would enhance safety, what can we look at to ease that regulatory burden? And so this is the result of that work.

RIEPE: OK. If I may?

M. CAVANAUGH: You may.

RIEPE: Thank you. I-- from a personal perspective, when I was at Children's, I had a responsibility for overseeing eight child care centers. Hardest work I ever did. Hardest work. So my heart goes out to the people that do that business and the complexities that go with it, so--

BOSTAR: Yes. As someone who drops their own child off at childcare every day, I-- they saved my life.

RIEPE: Yeah. Yeah. Well, thank you, thank you for being here.

BOSTAR: Thank you.

M. CAVANAUGH: Any further questions from the committee? I have a question.

BOSTAR: Yeah.

M. CAVANAUGH: So, first of all, thank you. I did not realize that-- and this makes perfect sense that you-- on page 11, line 3, that you can have your background check be portable from childcare providers. So thank you. Because that seems like a very common sense thing.

BOSTAR: It's currently a really big problem that it isn't.

M. CAVANAUGH: I-- yeah, I can imagine, have-- also having my children go to childcare, and my husband works for a child care facility, I-- yeah, that's a big problem. My question to you was about the dual licenses?

BOSTAR: Yeah.

M. CAVANAUGH: So the lower capacity when enrollment is lower is-- I guess-- what does it mean then, when they have a higher capacity? Are-- is it harder for them then to go back up to it, or is this making it easier? And what are the benefits--

BOSTAR: Yeah.

M. CAVANAUGH: --if you know, to going back and forth between those levels?

BOSTAR: Absolutely. And there will be people that can like really give--

M. CAVANAUGH: Sure.

BOSTAR: A real life example of all this. But providers currently hold one license. And so that license comes with a lot of different requirements. And the licenses are related to how many children they serve. So they'll have different staffing requirements and positions required, depending on what kind of license is being held. By, by allowing for multiple licenses to be held, we can-- it's-- especially

in rural areas in the state, what we're seeing, I'm kind of taking a half step back, is that enrollment numbers vary pretty significantly between summer and winter. And so a lot of providers are, for example, required to hold a Childcare Center License year round when really they're only a Center for six months, and they could hold a Home II license for the other six months. And so being able to be dual licensed would allow them to kind of operate under the license that they're required to based on their enrollment at the time.

M. CAVANAUGH: OK. And then, a question or a proposal, I guess, to you--

BOSTAR: Yeah.

M. CAVANAUGH: --would be on page 12, on Section 8 at line 16, and section 9 on line 20. In the era of term limits in the Legislature and institutional knowledge, while I appreciate an every five year review, would you consider having it be a five year review where they brief the committee? Because I think not everyone is as nerdy as me and reads all the reports online. Is that something that you might entertain?

BOSTAR: Absolutely.

M. CAVANAUGH: OK. Any further questions? Will you be staying to close?

BOSTAR: I wouldn't miss it.

M. CAVANAUGH: OK. Thank you, Senator Bostar. And we will bring up our first proponent for LB874. Welcome.

MITCHELL CLARK: Thank you. Welcome. Welcome. Thank you, members of the Health and Human Services Committee. My name is Mitchell Clark, M-i-t-c-h-e-l-l C-l-a-r-k. And, just want to thank you for allowing me to testify today. I am a policy advisor for First Five Nebraska. We are a statewide public policy organization invested in the care, early learning, and well-being of Nebraska's youngest children. I'm here to testify in support of LB874, and would like to thank Senator Bostar for his efforts in streamlining the regulatory environment for child care in Nebraska. In Nebraska, anyone who operates a child care program with four or more children from families other than their own must be licensed and meet certain health and safety standards, staff qualifications, and training requirements. Providing quality and safe learning environments for our youngest Nebraskans, as Senator Bostar reiterated, must be our top priority. But we also know that child care businesses struggle financially to make ends meet. In fact, just to

break even, a child care program must operate consistently within the constraints of what child care business analysts call the iron triangle. In other words, a child care program must operate with full enrollment, collect tuition and fees on time and in full, and must cover the true cost of providing care to a child with their revenues. Despite their best efforts, most-- excuse me, very few child care providers manage to adhere to all three components of the iron triangle. And in fact, many providers in Nebraska are operating on a deficit on a regular basis. And that's why regulatory environment makes these factors highly sensitive to anything which might be overly burdensome, such as background check processes, local enforcements, and sometimes conflicting guidance from separate regulatory bodies. This is not only bad news for sustainability of childcare programs, but on a broader scale, the sustainability of Nebraska businesses and stability of our economy, which depends on child care. In closing, LB874 would be a great step towards streamlining regulations for Nebraska's childcare industry. By reducing administrative burdens and costs for providers, the outcome would free up resources for improved quality of care, increased capacity and a more stable industry. Additionally, regular regulatory review and enhanced legislative oversight will promote transparency and accountability within the system. Ultimately, LB874 strives to benefit Nebraska's children, families, and childcare providers alike. You'll see I've distributed a policy brief to the committee. On the backside of that policy brief, there's also highlighted a few of the key components of this bill. Senate Bostar, as well, did a great job walking through some of those provisions. If you have any technical questions on the bill, I worked with his office very closely to help craft that language, so I'd be happy to answer any of those questions. And thank you, members of the committee, for your time and attention today. I urge you to advance LB874 to General File. I'm happy to take any questions you may have.

M. CAVANAUGH: Thank you, Mr. Clark. Are there any questions from the committee? Seeing none, thank you very much. We'll take our next proponent for LB874. Welcome.

RACHEL SISSEL: Hi. Good afternoon, members of the Health and Human Services Committee. Thank you for allowing me to testify today. My name is Rachel Sissel, R-a-c-h-e-l S-i-s-s-e-l, and I currently serve on the Communities for Kids team at Nebraska Children and Families Foundation. The C for K team works with 67 communities across this state, focused on expanding child care capacity and enhancing quality of early child care systems. I am here today to testify in support of LB874, and would like to thank Senator Bostar for introducing this bill, bill to help strengthen early care and education. I've

highlighted four pieces of this bill in my written testimony, but would like to take time to touch specifically on two in today's hearing. First, the dual licensure provision would help smaller child care centers, especially those in rural areas. I spoke with a board member of a center in Bayard, and her exact words about this provision were, oh, that would be so helpful during our summer months. A child care center being able to hold both a Family Child Care Home II license allows the program to operate as both a child care center and a family home II, depending on attendance. This does not affect the quality of care, but rather allows them to adjust staffing. This provision allows the program to control expenses by requiring one or two staff members to care for a mixed age group. It's important to note that earlier regulations allowed child care centers to use family child care home staffing compositions, but the language was dropped somewhere in the process of updating regulations. A center in Potter was recently going to pursue dual licensure when it was allowed, but in its absence chose to close during the summer months because of lower numbers and a lack of staff. Another center in Kimball would eventually like to offer extended care, including overnights and weekends. While they wouldn't have as many kids enrolled during those times, there is still a need. A dual license would be instrumental in developing this possibility for families in their community. I would also like to express support for the portability of required background checks. We know that there's an issue with the workforce in early child care programs. Allowing early child care professionals to take the eligibility letter to new programs would accelerate the ability of the individual to secure a position and begin working within the program. This would also support the early childcare employer, as it would allow for the expansion of the staff more quickly. I discussed this process with the hiring-- of hiring with the former director of a center in Lincoln. She said that not having a delay with potential staff members would help the hiring process. She said that generally, eligibility letters were received within a week, but it definitely impeded their ability to hire because people wanted to get started working right away, especially if they were just moving to another program. Sometimes, because of the need to not disrupt their personal income, they would take jobs in other fields because they were able to start immediately. This provision ties the eligibility to the individual teacher, not the program that they're working for. Another impact would be the ability to potentially explore how this could affect developing a substitute pool for local areas. Communities for Kids offers sustainability planning for childcare programs across the state. Earlier this week, during a planning session, multiple communities expressed the need for a

substitute pool to support their local programs. It is a priority goal as it directly supports the current workforce. Programs face shortages of staff. Like public schools, they have teachers that need days off. Portable background checks-- and, and that information allows individuals that can move between programs, and it creates a ready made, eligible list of additional child-- early childhood substitutes. So once again, thank you for your time today. I would request that you advance LB874 to General File, and I'm happy to answer any questions.

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

RACHEL SISSEL: Thank you.

M. CAVANAUGH: And we will invite the next proponent for LB874. Welcome.

HEIDI PIEPER: Thank you. Members of the Health and Human Services Committee, my name is Heidi Pieper, H-e-i-d-i P-i-e-p-e-r. I'm a mom, a licensed foster parent, a rancher, and I'm on staff with Nebraska Farm Bureau. I live near Farnam, a small town in the southwest part of the state. And I'm here today in support of LB874 on behalf of the Ag Leaders Working Group, which represents 96% of all farmgate receipts in Nebraska, and consists of the following organizations: Nebraska Cattlemen, Nebraska Corn Growers Association, Nebraska Farm Bureau, Nebraska Pork Producers Association, Nebraska Sorghum Producers Association, Nebraska Soybean Association, Nebraska State Dairy Association, Nebraska Wheat Growers Association, and Renewable Fuels Nebraska. There is a massive shortage of childcare options across Nebraska, leaving families without the opportunity for parents to work, or requiring families to travel long distances for child care. There are many factors that contribute to this problem, and it's time to remove unnecessary regulatory burdens, elevate child care in Nebraska, and empower our workforce across the state. LB874 remedies this issue in multiple ways. It removes a mandate that requires child care providers to have insurance coverage 24/7. With this change, providers would only be required to have insurance coverage for the hours that they are open. Removing the 24/7 requirement will allow the insurance companies to assess the providers at lower risk, and hopefully offer more reasonable rates. It makes background checks portable. If a person has already passed approval by DHHS to work in child care, it makes sense that their background checks should be transferable between different childcare centers. This will also alleviate pressure on the system, in turn speeding up the process for other background checks. With substantial changes like this, there

must be checks and balances to ensure that the changes being made have a positive impact on the state. Providing the Legislature reports about outcomes will be helpful in improving the law moving forward. We appreciate the mandatory reporting that this bill creates. LB874 reinstates the ability for centers to operate under dual licenses. This is how Nebraska operated in the past. Though the intent was genuine in removing that ability, the results show that we are currently better situated if we allow the system to function as it did previously. Lastly, this bill helps childcare providers to be more financially sustainable by exempting some childcare facilities from property taxes. It's no secret that Nebraska's overreliance on property taxes is an impediment to operating viral-- viable businesses, including childcare facilities. Property taxes are far too high and need to be brought to reasonable levels. The change proposed in this bill kills two birds with one stone, offering incentives to a needed industry while moving towards decreasing the overreliance on property taxes. We hope that the market will correct and move away from the reliance on incentives. Until then, this is a solution to a dire problem. This bill implements many positive changes, and we appreciate Senator Bostar for bringing LB874, and encourage the Health and Human Services Committee to take our thoughts into consideration as you prepare LB874, to be advanced to General File. I'm happy to answer any questions that you may have.

M. CAVANAUGH: Thank you. Are there any questions? Senator Riepe.

RIEPE: Thank you. Thank you for being here. Thank you for traveling here to testify today. The question I have, it's a term that I'm not familiar with, it says farmgate receipts. What, what does that include?

HEIDI PIEPER: Yeah. So, the Ag Leaders Working Group, represents 96% of all agriculture in Nebraska.

RIEPE: That's the list underneath there, the bullet points?

HEIDI PIEPER: Yes, sir.

RIEPE: And they represent 96% of all the gross ag receipts?

HEIDI PIEPER: Yes.

RIEPE: OK. Thank you.

M. CAVANAUGH: Are there any other questions from the committee? I just-- wow. You're a mom, a licensed foster parent, a rancher, and

you're on staff at the Farm Bureau, and you're here today testifying. I am just blown away. Thank you for being here and taking time to share your expertise with us.

HEIDI PIEPER: Thank you. It's an important issue, and I appreciate the opportunity.

M. CAVANAUGH: Thank you. We'll take our next proponent for LB874. And I will turn things back over to our Chair.

HANSEN: Thank you. Welcome.

DAWSON BRUNSWICK: Welcome back.

HANSEN: Thanks.

DAWSON BRUNSWICK: Chairman Hansen and members of the Health and Human Services Committee, my name is Dawson Brunswick, spelled D-a-w-s-o-n B-r-u-n-s-w-i-c-k. I have the pleasure to serve as the president of the Columbus Area Chamber of Commerce, as well as Columbus Area Child Care. I'm here today on behalf of the Columbus Chamber, the Nebraska Chamber, the Nebraska Chambers Association, the Omaha Chamber, the Lincoln Chamber, and the Nebraska Economic Developers Association to testify in support of Senator Bostar's LB874. I want to start off by sharing that I recently had the opportunity to serve on a childcare panel at a conference up in Indianapolis last December, and my opening comments to them is child care is a lot like Nebraska football. In the '90s, we really have to worry about it, we were just good. Now we kind of all know the situation we're in. But just like Coach Rhule is working to improve the Huskers, bills like LB874 are working to provide regulatory relief and make operating in the childcare space slightly less burdensome. In all seriousness, in my role, workforce, housing and childcare drive every conversation, meeting, and planning session we're involved with in Columbus. My point is, just like workforce and housing, childcare or the lack thereof is a business issue. A recent study shows that Columbus families lost out over $7 million in payroll, and employers incurred $3.6 million in added costs due to lack of childcare. And that's annually. In the summer of 2022, we had two childcare centers close in Columbus, impacting over 150 childcare spots. That's on top of the roughly 700 spot gap that we'd already identified. This led the chamber to lead an effort to form a new 501(c)(3) nonprofit, Columbus Area Childcare, to purchase and operate one of the childcare centers that had announced it was closing. The chamber pledged its own funds, operational support, and secured commitments from public-- private businesses through our

community, and philanthropic partners to help stand up the organization. Today, the center is exempt from property taxes, participates in the state subsidy program, is enrolled in the USDA Food Program, and as of the past month, has achieved step two of Nebraska's Step Up to Quality program. I share all these because we're fortunate to have all these programs in our state, because it really does take all of them to help operate these childcare centers on the very tight budgets they're on. One of the main points-- pain points we encountered in our journey to start Columbus Area Childcare is addressed in LB874, and that is the permissive property tax exemption. We originally submitted our exemption under the charitable and educational exemption provisions, and were initially denied, as it's not clearly stated that nonprofit childcare centers qualify for either of those. Ultimately, we went back and forth with our assessor, our board of supervisors. Our good friends at First Five Nebraska assisted us in identifying another 501(c)(3) nonprofit that had gone back and forth with their county assessor to secure tax exempt status. Ultimately, we were granted, but I know that it is a process, and the permissive exemption is something that I'm very excited to see in the bill. As was mentioned earlier, the portability of fingerprints and background checks would be an amazing addition as well. With that, I'm happy to answer any questions and appreciate your consideration of LB874.

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

RIEPE: Thank you, Chairman Hansen. I guess in your discussions, you said in-- there in Columbus, I think it was, that, yeah, every discussion comes down to affordable childcare and affordable housing. In that same conversation, does the property tax relief, does that come into the conversation as well?

DAWSON BRUNSWICK: Not in the discussions we're to involve with, Senator Riepe. For us it's having the, the high wage jobs which Columbus is fortunate to have a, a higher average wage. But really for us, it's the availability of housing and childcare. Affordability doesn't matter when you have no availability, in my opinion. So, it, it's more on the availability of those services right now in our community.

RIEPE: Do you think in that group, whatever that gr-- whatever that group is or how big it is, do they connect the fact that taxes are related to support? I mean--

DAWSON BRUNSWICK: How so?

RIEPE: Well, somebody has to-- for affordable childcare and affordable housing, it's going to take tax money, right? Or that's my assumption. I don't know where else it comes from.

DAWSON BRUNSWICK: It, it, it's going to take money from somewhere else other than--

RIEPE: Bingo. That goes right back to sales tax, property tax, income tax, some kind of tax.

DAWSON BRUNSWICK: And, and that's where all-- you know, I mentioned the public-private philanthropic partnership that we did. So we have four major industries in Columbus, two Fortune 200 companies, two locally owned, family owned companies that are supporting this. We have our local Nebraska Community Foundation affiliate that is supporting it as well. Our city and county go through ARPA dollars as well as LB840 funds have supported it. And I, I'm not going to say it's necessarily take tax dollars, but it takes a new funding stack that we're not used to.

RIEPE: You said a magic word, philanthropy. If you-- if have some big companies there, you're uniquely positioned as opposed to many towns and villages across the state.

DAWSON BRUNSWICK: We are very fortunate.

RIEPE: Omaha's in a very much similar position. And Lincoln is or could be, so, thank you.

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

DAWSON BRUNSWICK: Thank you.

HANSEN: Anybody else wishing to testify in support of LB874? Is there anybody wishing to testify in opposition to LB874? Seeing none, is there anybody wish to testify in a neutral capacity? Welcome.

CHRISTY ABRAHAM: Hello, Senator Hansen and members of the Health Committee. [COUGHS] Excuse me. My name is Christy Abraham, spelled C-h-r-i-s-t-y A-b-r-a-h-a-m. I'm here representing the League of Nebraska Municipalities. I first want to start by just thanking both the First Five and Senator Bostar for introducing this amendment that you received. I believe it's AM2446. And as Senator Bostar indicated,

the League is neutral on this bill because of the provisions that are in that amendment. And Senator Bostar did a great job explaining what was in that amendment. I just want to go through it sort of briefly with you. The first concern that the League had was in Section 7, which prohibited municipalities from having residency requirements for their family home care centers. It's my indication that there are at least three municipalities that currently have those residency requirements. So there was some concern about taking away that authority. The language that is added in the amendment takes away many of those concerns, because it allows municipalities to continue to regulate on issues like public health and safety. Secondly, the amendment removes a requirement that the Department of Health and Human Services submit to this committee all zoning requirements and ordinances relating to child care. That would be quite a few regulations for you to sort through, so we appreciate that being removed. It does leave in place that HHS is going to provide to you all licensing requirements and regulations relating to child care. And then the final part of this amendment is it completely strikes Section 10. Section 10 is the part that required cities to submit codes, ordinances, fire, and building safety permits to the Urban Affairs Committee, to your dear friends over in that committee. Obviously, as you know, they deal a lot with municipal issues. It's my understanding from the municipalities I chatted with, this would literally be thousands of documents. The safety permits and building permits for a lot of our rural municipalities are not electronic. They're paper. So it would literally mean paper, paper, paper coming to the Urban Affairs Committee. So we, we appreciate that that entire section has been removed. So we appreciate your time on this bill, and we encourage you to advance this bill, again, with the amendment, and with the amendment the, the League will continue to be neutral. I appreciate your time.

HANSEN: Thank you. Are there any questions from the committee? I don't see any. Thank you very much.

CHRISTY ABRAHAM: Thanks so much.

HANSEN: We'll take our next testifier in neutral, please.

ELAINE MENZEL: Chairman Hansen and members of the Health and Human Services Committee, for the record, my name is Elaine Menzel. That's E-l-a-i-n-e M-e-n-z-e-l, here today on behalf of the Nebraska Association of County Officials. And I could almost say just ditto to the testimony that Ms. Abraham just testified to. We greatly appreciate Senator Bostar offering the amendment that you have seen.

There's just one additional comment that I'll make, and with that said, hopefully it doesn't create a lot of questions given I don't generally go to the Revenue Committee, but it relates to the, balancing of the property tax exemption with the public policy related to exempting that. We're not taking a position on that specifically at this time, but just to factoring into your consideration. With that said, I appreciate your time, and if there's any questions, I would be glad to attempt to answer them.

HANSEN: I'm sure there's going to be a lot of very difficult questions coming up, so. Are there any questions? Nope, I was wrong.

ELAINE MENZEL: Well.

HANSEN: Thank you.

ELAINE MENZEL: Gee, darn. Thank you very much.

HANSEN: Thanks. Is there anybody else wishing to testify in a neutral capacity? All right, seeing none, we'll welcome up, Senator. Bostar to close. And before that, we did have 15 letters in support of LB874, 2 in opposition and 1 in a neutral capacity. Welcome back.

BOSTAR: Thank you, Chair Hansen and members of the Health and Human Services Committee. I, I realize that actually this is my first time ever being in this committee. And so--

RIEPE: You just got lucky.

BOSTAR: It's very exciting.

M. CAVANAUGH: We're the best.

BOSTAR: So I, I think that this is kind of a common sense bill. It's a deregulatory bill. Its whole function is to remove governmental barriers to the ability to operate a childcare facility in most of the state profitably. And so I, I would really encourage the committee to look favorably, favorably upon this legislation. I understand that there are-- there's a debate about what role we should have in funding affordable housing, childcare, things like that. That's a worthwhile debate. I would say LB874 doesn't have anything to do with that. We're just trying to make the business easier. I want to speak a little bit to the neutral testimony. I gave you all the amendment that makes sure that no one opposed the bill, right? It takes out all the things that the municipalities and the counties wanted removed. But I, I do want the committee to think about it. And, and perhaps in the future, ask

more questions of the counties, the municipalities, about why it was required for the stuff to be removed. For example, residency requirements. The, the green copy of the bill says that municipalities can't establish residency requirements for the operators of child care facilities because, as they said, there are three cities that do, that say you can't run an, a home provider child care operation if you don't live in the structure that the care's being provided in. What does it matter where the provider lives when they're not operating the childcare business? But there are three communities that do require that. It is a regulatory burden placed upon childcare providers. I wanted to remove it, but that was a sticking point where if we kept that in, they would oppose the bill. So you have an amendment that takes it out. And then the piece on the bill requires the state to do a review of its own regulations every five years to make sure that we're not putting in burdensome regulations and statutes just to bog down the system. It gives us an opportunity to go through and clean it up. I appreciated Senator Cavanaugh's request of considering having it report to the committees of jurisdiction. I think that's really a, a good move. And in the green copy of the bill, it would require local governments to do the same thing, to go through their local laws, their local ordinances, and see, every five years, if they have unnecessary garbage bogging down the system. Things like residency requirements. But they talked about how that would be a burden. Could you imagine the thousands of documents? They use paper after all. That sounds like a burden, but it also sounds like a burdensome environment that we're putting our businesses through. I think the objection to that provision defines the reason why it's important. So the amendment removes the opposition. I would ask this committee to do with it what it wants. There are important parts of the amendment, the HHS stuff. That's good, you should definitely keep that. But I, I didn't understand why we needed to remove those provisions. But here we are. Anyway, happy to answer any final questions. And I would please, please, let's, let's try to get this bill done. It'll-- I think it'll help at least marginally make some service more accessible for folks across the state, particularly in rural areas. Thank you.

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

M. CAVANAUGH: Thank you. Thank you again, Senator Bostar. I apologize, I missed this in the opening about the, the property tax?

BOSTAR: Yeah.

M. CAVANAUGH: So-- and I appreciate the clarifying that a childcare facility can be considered a nonprofit. The childcare that my children, thankfully, are too old to attend now because that was expensive, was operated within a church. And so the church automatically, obviously, was a nonprofit. My question is, just seeing this one sentence, I'm not really clear. I guess it's more a concern if a, like, a large corporation had a childcare on site, and the childcare itself was a nonprofit sort of subsidy of the corporation, would the corporation then be considered tax exempt? Property tax exempt?

BOSTAR: So I think, First Five handed out a, like a one pager on the bill. On the back of that document, I think on the bottom, it talks about permissive exemption. I, I would say most counties in the state already treat these as exempt.

M. CAVANAUGH: OK.

BOSTAR: So what were-- I, I'm not sure-- the details of some of this, I'll get back to you on it.

M. CAVANAUGH: We-- Yeah, we can dig into it further. That was just something that, that rose for me, and, and just thinking through that like-- I represent Westside, which is a landlocked school district, can't expand at all. And I also represent Children's Hospital, and HDR used to be on that same campus, and HDR moved out of that campus onto OPS' school district, and so we lost that footprint. So I'm very cognizant of property taxes in my school district, and that's where this sort of question comes from. Not that I'm mad about Children's Hospital expanding in my district, it's a very lovely facility. So, but we can follow up.

BOSTAR: Yeah. And so I would just say is the purpose of that, of that section in the bill is to provide consistency across the state. It's not so much about giving some tax benefit that didn't exist. It's about-- really about saying the majority of counties are doing it this way. But as you heard in testimony, in some places, it's a fight to get them to do it that way that everyone else is. Ultimately, they end up getting there. But again, it's just another barrier that we have in place, so we're just trying to remove it.

M. CAVANAUGH: I really just wanted to point out to the former administrator of Children's Hospital that they--

RIEPE: Wow.

M. CAVANAUGH: Thank you for answering my question.

BOSTAR: Thank you.

HANSEN: Any other questions from the committee? I don't see any. Thank you very much.

BOSTAR: Thank you.

HANSEN: That'll conclude our hearing-- actually-- Yes, that'll conclude our hearing LB874, and then we will open it up for the last bill today, LB907. And welcome, Senator Riepe to open.

RIEPE: Thank you sir. Seeing if there's a packed house. Evidently not. OK.

HANSEN: It's all yours.

RIEPE: Good afternoon, Chairman Hansen and fellow members of the Health and Human Services Committee. My name is Merv Ruby, it's M-e-r-v R-i-e-p-e, Senator for District 12, which is Metropolitan Omaha and the fine city of Ralston. Today, I am introducing LB907, which will provide coverage for treatment of obesity for Medicaid recipients. Under the bill, covered treatment for this disease will include intensive behavioral therapy and anti-obesity medication. Most guidelines recommended that patients start with a 3 to 6 month of behavioral therapy, and if not successful with the intensive behavioral therapy alone, people with obesity should be prescribed an anti-obesity medication that is used in conjunction with diet and exercise changes. In Nebraska, Medicaid enrollees living with obesity have access to behavioral therapy and bar-- bar-- baricra-- I can't hardly say it here. I'm just going to say surgery to try to not stutter in it, but not medication. Which means that if a person is not successful in treating obesity with behavioral changes, the only other option is bariatric surgery, which is a serious surgical procedure with a rehabilitation requirement. These medications are not meant for a person who wants to lose a few extra pounds that they have put on over the holidays. Anti-obesity medications are approved by the Food and Drug Administration for patients with a body mass index over 30, and over 27 with one or more "co-midity"-- comorbidity conditions. I have distributed a letter from health and-- from health care providers across Nebraska endorsing LB907. I'd like to read from that letter, and I quote. The landscape of our understanding of obesity has evolved significantly over the past two decades. What was once received-- perceived as simply a matter of excess dietary fat or lack of

motivation, has now been established as a complex health challenge driven by genetics, environment, and a multitude of neural-hormonal pathways that affect individuals of all ages and backgrounds. Its prevalence not only leads to serious health issues such as diabetes, cardiovascular disease, hypertension, multiple cancers, and many other chronic diseases, but also places a considerable economic burden on our health care system. Including anti-obesity medications in Medicaid coverage is a proactive and necessary step in addressing this public health crisis. It is important to dispel the misconception that the availability of these medications on a formulary automatically leads to ubiquitous use. Exclusive criteria, tolerability, contraindications, and patient preference all play a significant role in determining their suitability, as well as good provider stewardship. However, denying coverage entirely prevents practitioners from even considering these medications as potential tools in obesity treatment, hindering their ability to make informed decisions with their patients. End of quote. As a committee, we need to consider that obesity is associated with over 200 comorbidity conditions that negatively impact quality of life and increase health care cost. Close to 32% of Nebraskans have hypertension, which on average increases health care costs by over $1,600 per year per patient. 10% of Nebraskans have diabetes, which on average increases health care costs by over $2,700 per year per patient. Obesity and associated comorbidities are chronic diseases that are impacting the quality of life of Nebraskans, their health care outcomes, and the cost of our-- to our health care system. I would like to address the fiscal note on the bill. An analysis of Medicaid data in other states when anti-obesity medications for a covered Medicaid benefit shows a very low utilization rate, the highest utiliza-- utilization rate-- utilization number we are aware of in any state with anti-obesity medication Medicaid coverage is Michigan, which has a utilization of 1.5% of the eligible patient population actually receiving prescriptions for these medications. In Nebraska, there are approximately 90,000 total adults on Medicaid who would be eligible. Applying an ambitious 33% utilization rate and using pricing that is based on federally mandated rebates yields a state cost of $3.6 million annually. And this is just a pure cost that does not account for the myriad of health savings expected from the health benefits that will accrue to that population. With that, I thank you, Mr. Chairman, and I would yield to questions. Me being a campaign for expanded Medicaid is probably a historic spot, but I am here.

HANSEN: Thank you. Are there any questions from the committee? The committee has a question. Senator Cavanaugh?

M. CAVANAUGH: I missed the last thing you said about expanded Medicaid. Could you repeat that?

RIEPE: I say I-- you know, my opposition to expanded Medicaid is probably historic. And so, for me to be in this chair at this time is, I find, unique. I would hope that it's something that-- and again, I know I argue at times about in the long run, world we're all dead with Keynesian economic theory, but my interest is to say, can we make this a cost savings by doing more preventive and doing more aggressive health care to this particular population?

M. CAVANAUGH: Well, thank you for, for sharing that. I would say that you bringing this bill just shows the human capacity to evolve and change their views and opinions and constantly learn.

RIEPE: I'm going to find a compliment in there someplace.

M. CAVANAUGH: That is 100% a compliment.

RIEPE: Thank you. Well--

HANSEN: I'm not going to--

RIEPE: I do consider myself a compassionate conservative. So that's where I find myself. Yes, sir.

M. CAVANAUGH: I wouldn't go that far.

M. CAVANAUGH: Well--

M. CAVANAUGH: I'm teasing. For the record, I am teasing.

RIEPE: All right. That's fine.

HANSEN: OK. I'm assuming you're staying to close?

RIEPE: Yes, sir.

HANSEN: All right. OK. So with that, we will take our first testifier in support of LB907. Welcome.

BRIANNA JOHNSON-RABBETT: Hi. Thank you. Good afternoon, Chairperson Hansen and members of the Health and Human Services Committee. Thank you for holding this hearing, and thank you to Senator Riepe for introducing LB907. My name is Doctor Brianna Johnson-Rabbett. That is B-r-i-a-n-n-a J-o-h-n-s-o-n hyphen Rabbett, R-a-b-b-e-t-t. I am board certified in internal medicine, endocrinology, diabetes and

metabolism, as well as obesity medicine. I'm an endocrinologist at UNMC as well as medical director of obesity medicine at the Nebraska Medicine Bariatric Center. However, I am testifying in support of LB907 today on behalf of the Nebraska Medical Association. Very clear evidence has shown that having excess weight is not simply due to a failure of willpower. Obesity is a disease per institution such as the National Institutes of Health, USFDA, Veterans Health Administration, and the Department of Defense. The chronic disease of obesity had clear biological underpinnings and clear health consequences. Of note, having a BMI of 35 is associated with double the risk of sudden cardiac death. Having a BMI of 40 is associated with triple the risk of sudden cardiac death. Obesity affects Nebraskans in significant numbers. Per the 2022 CDC adult obesity prevalence maps, 35.3% of adults in Nebraska are affected by obesity. Obesity also results in significant costs. Obesity related medical care costs in 2019 dollars are estimated at almost $173 billion for the United States. Obesity not only leads to direct health care costs. Obesity is also associated with significant productivity losses estimated in additional billions of dollars. An article published in 2021 estimated the national cost of estimated productivity losses due to only missing work at $13.6 billion to $26.8 billion in 2016, and these figures would be expected to continually increase. These numbers also do not include projected losses from reduced productivity while at work, disability payments, or workers compensation payments. However, obesity is a disease for which there are effective treatment options. Similar to many other chronic diseases such as diabetes or high blood pressure, if lifestyle interventions alone are insufficient to support adequate weight loss, intensification of therapy to medication therapy is indicated. There are multiple medications that are FDA approved for treatment of obesity. Excluding anti-obesity medications for Medicaid coverage only serves to widen healthcare disparities that already exist. I see countless patients that are struggling with their weight. The difference between those that have anti-obesity medication coverage, or the wealth to cover medications out of pocket if needed, and those that lack the ability to obtain medications is stark. Of note, it is not unusual in my practice to assist patients with diabetes in transitioning completely off insulin, and those with high blood pressure come completely off anti-hypertensives due to drastic improvements in blood sugar and blood pressure with improvement in the disease of obesity. A surprising number of patients no longer are pursuing joint replacement surgeries that would have cost many thousands of dollars. These medications can be catalysts for true transformation. It is essential for treatment of obesity to be covered by insurance, including through Medicaid. For some patients, effective

treatment requires medication. Eligibility criteria for use of the anti-obesity medications would be expected to apply. Of note, anti-obesity medications are only indicated for use in those with a BMI of 30 or above, or a BMI of 27 or above with a weight related comorbidity. Historically, only an extremely small percentage of people eligible for an anti-obesity medications are treated. There are also additional ways to build in cost containment if needed, such as institution of step therapy or more narrow eligibility criteria. On that note, I'd like to also address the fiscal note. I would point out some factors that may significantly inflate the cost estimates provided. It's noted that 42,000 people with a BMI of 25 to 29 would qualify for nine months of medication after three months of nutrition therapy. However, as I noted, only those with a BMI of 27 or above plus a weight related comorbidity would qualify for treatment. Estimates also include a range that includes medication utilization rates up to 60%. This utilization rate is approximately 40 times greater than utilization rates published in the literature. In sum, recognizing obesity as a chronic disease that should be treated accordingly will allow patients to access treatments that can drastically improve outcomes and reduce other costs. FDA approved medications are one valuable tool for managing this disease. Thank you.

HANSEN: Thank you. Are there any questions from the committee? OK. I have maybe some. Yeah. I was looking at the fiscal note, and I think. Yeah, they said if we do not put best practice standards in the bill, you're looking at about-- it might likely exceed $500 million per year. So. which is pretty significant.

BRIANNA JOHNSON-RABBETT: Yeah. I, I would be curious to know how that number was achieved, or reached.

HANSEN: I think that's-- yeah, if we don't, like, put any-- some recommendations or some guardrails on this, it could kind of turn into something like this, so. Are anti-obesity medications currently being prescribed with people with a BMI less than 30? Or 27 with weight related comorbidity?

BRIANNA JOHNSON-RABBETT: So I certainly do not. Unless there are extenuating circumstances that would make that makes sense. That would be extremely, extremely rare. For example, someone who has a, a very rare disease where their ability to function is significantly impacted by, you know, a slightly lower BMI, but very significant adiposity with a high body fat percentage or things of that nature. I would expect that these medications would be associated with prior

authorizations that would require that it is demonstrated that people have a BMI of at least 30 or 27 and above with a weight related comorbidity.

HANSEN: OK. Is one of those medications I-- it starts with an "O", I got [INAUDIBLE]

BRIANNA JOHNSON-RABBETT: Ozempic?

HANSEN: Ozempic. Yes.

BRIANNA JOHNSON-RABBETT: Yeah.

HANSEN: Would that be included in that? Because we've been hearing on the news, obviously there's some issues we're starting to see with that.

BRIANNA JOHNSON-RABBETT: Yeah. So that is not actually FDA approved for, for obesity, so that wouldn't be included here.

HANSEN: OK.

BRIANNA JOHNSON-RABBETT: Semaglutide-- the confusion is semaglutide. The medication semaglutide is labeled as ozempic for diabetes. Semaglutide is labeled as Wegovy for weight loss. They come in different pens, they have different indications. If there's any issues that you've heard in general with ozempic, I'm happy to speak to that.

HANSEN: I was just kind of curious if that was one of them. So I didn't think it would be. Are there other conservative treatments that could be used before using medications?

BRIANNA JOHNSON-RABBETT: As-- yeah, as a-- as a, a basis, you know, just like, say, hypertension or diabetes, the first line is lifestyle interventions. I talk to patients when I treat them that, you know, we do these things. Obesity medications, any obesity medications, are solely a tool to help support the significant lifestyle changes, on the changes in what we eat and, and to a lesser degree, our activities and so much more of the, the equation is related to what we eat. They're only meant as a tool. It is all based on changes in, in intake and activity.

HANSEN: OK. Thank you.

BRIANNA JOHNSON-RABBETT: Yes. Of course.

HANSEN: Senator Cavanaugh.

M. CAVANAUGH: Yeah. Thank you. On the fiscal note, I was kind of looking at it a little bit more while you were talking, and, yeah, the 60% utilization feels high. So I appreciate you speaking to Senator Hansen's questions about other interventions. I, I know that this is-- these types of medications are a significant step and do have some side effects that are-- can, in certain patients, be concerning. So it would be unusual for that large of a population to utilize that. And I have had people in my life who have gone through different interventions, and that have worked well other than this. So, this does seem a little bit high. So thank you for speaking to that.

BRIANNA JOHNSON-RABBETT: Yeah, of course. And I will say that, that a lot of the, you know, the things that we hear in the, the media, I would be concerned that are related to compounded medications that are not FDA approved, that are being managed inappropriately and, and all kinds of other things. So-- and I think it's important to kind of weigh the, you know, the, the risks of intervention with the benefits of intervention. You know, as I noted, a BMI of 40, 3 times the risk of sudden cardiac death, like that is very significant, so just, you know, weighing that.

M. CAVANAUGH: And this covers nutrition counseling in addition to, which would be the the first--

BRIANNA JOHNSON-RABBETT: Right. Right. You know, it's, it's sort of a tiered approach. Like any chronic disease, it's, it's always the basis of the lifestyle, essentially always. And then, if needed, if that is insufficient, then adding medications if appropriate clinically. So.

M. CAVANAUGH: OK. Thank you.

BRIANNA JOHNSON-RABBETT: Yeah.

HANSEN: All right. Thank you for your testimony.

BRIANNA JOHNSON-RABBETT: Thank you.

HANSEN: We'll take our next testifier in support LB907. Welcome.

SAMANTHA PEDERSON: Thank you. Thank you for having me. My name is Samantha Pederson, S-a-m-a-n-t-h-a P-e-d-e-r-s-o-n. I'm a physician assistant working in family practice for the past two and a half years, with prior experience as a sub investigator in clinical research. My patient population is almost exclusively adults with

weight related diseases. I'm a board member of the Nebraska Obesity Society and a member of Nebraska Academy of Physician Assistants, and I'm here to express support for LB907. As a medical practitioner, my purpose is to always do what is best for my patients. And I have seen in practice the significant benefits associated with weight loss. However, as a Nebraskan and fellow taxpayer, I understand expanding Medicaid coverage for obesity treatment is not solely about what is best for each patient, which is why I would like to address this from an economical standpoint today. A robust economic analysis conducted by the University of Southern California in 2023 demonstrated the massive savings that could be associated with Medicare and private insurance coverage of weight loss medications. The research simulated a population of 68 million Medicare patients with obesity and weight related diseases, and analyzed savings associated with a 20% sustained weight loss, which is consistent with current performance of leading weight loss medications. Findings showed direct medical savings of $175.6 billion after ten years of Medicare coverage, and $704.3 billion by 30 years. 60% of the savings were associated with Medicare Part A. This represents a substantial decrease in hospitalizations and need for skilled nursing care. The researchers then factored in private insurance coverage for anti-obesity medications, and found the population would enter Medicare in a healthier state, which would increase savings to $1.5 trillion after 30 years. In addition to this, Medicare and private insurance coverage would result in $4.6 trillion of savings related to quality of life, longevity, and disability improvements. Interestingly, the analysis also found that weight loss in younger, less educated minority populations with a BMI specifically between 30 and 40 resulted in the greatest economic benefit, which is what we are primarily discussing with LB907. According to the CDC, 35 to 40% of Nebraskans are considered obese. Although no economic analysis specific to Nebraska exists to my knowledge, I still believe national data can be representative of what kind of cost savings could be associated with Medicaid expansion in our state. The main downside of the USC analysis is the cost of treatment itself was not factored in. So we must ask the question of whether or not newer, more effective, but more expensive therapies are still cost effective. Analysis of all commonly used anti-obesity medications have shown the potential to be cost effective. Although cost analyses for semaglutide vary, one analysis considered it to be cost effective when taking weight related conditions into, into account. This is unsurprising to me, given research showing semaglutide achieves a 20% reduction in major cardiovascular events such as death, heart attack, and stroke. To my knowledge, no analysis has been conducted for semaglutide at the much lower prices that can be negotiated between Medicaid and the drug

manufacturer, which, which would improve cost effectiveness data. Data is lacking for cost effectiveness of tirzepatide, which is likely due to its very recent FDA approval, but I expect it to be-- perform similarly to semaglutide. Please refer to the supplemental material provided to see comparisons of current front running weight loss medications. Considering all of this, I encourage you to add an amendment to clarify LB907 and define obesity as a documented BMI greater or equal to 30. I also encourage you to work with economists to determine an appropriate value to negotiate with drug manufacturers for newer, more expensive therapies such as semaglutide and tirzepatide, which have conflicting cost effectiveness data at current market prices. Luckily, in this circumstance, my duties as a provider align with my views in the role in the duty of our government. I believe an investment in obesity treatment would benefit patients, taxpayers, and society in the long run, and it is because of this I encourage you to pass LB907.

HANSEN: Thank you for your testimony. Are there any questions from the committee? Seeing none, thank you very much. We'll take our next testifier in support of LB907. Maybe? Anybody else wishing to testify in support. One of these days, we're going to get you up here first.

MARCIA MUETING: Well, that way I keep my testimony short.

HANSEN: Welcome.

MARCIA MUETING: Chairman, Chairman Hansen, members of the Health and Human Services Committee, my name is Marcia Mueting, M-a-r-c-i-a M-u-e-t-i-n-g. I'm a pharmacist, the CEO of the Nebraska Pharmacists Association, and a registered lobbyist. The Nebraska Pharmacists Association supports LB907. I'm not going to read my testimony that's in front of you. I'm just going to say that we recognize, the pharmacists recognize, that LB907 will impact public health, it'll provide preventative care, and the, the pharmacists of Nebraska support evidence based interventions. There's a couple of points I do want to bring forward that are not on my testimony. It's important to know that Nebraska Medicaid cannot knowingly pay for a drug that is being used off label. So if these drugs are only approved in patients with a BMI greater than 30 and-- or greater than 27 with another condition, they cannot be used outside of that. And how does Medicaid achieve that? They do that by putting a prior authorization on the drug itself, making sure that the patient is a candidate for therapy. The other thing I think is important to know is that these are a whole new class of drugs. Medicaid probably shouldn't have paid for obesity drugs before these drugs came out. They really weren't very effective.

I mean, I-- as a pharmacist, a practicing pharmacist, I never knew anybody who successfully lost, lost weight and didn't gain it back on meridia, fen-phen, you know, whatever the stimulant of choice is. So, I respectfully urge you to consider advancing LB907. I'm happy to answer any questions.

HANSEN: Thank you. The term prior authorization is like a dirty word here.

MARCIA MUETING: I know. I know.

HANSEN: Please be careful when you use that one.

MARCIA MUETING: Yeah.

HANSEN: There's a lot of emotion surrounding that one.

MARCIA MUETING: I get it. I get it. But the-- a nicer way to say that is clinical criteria.

HANSEN: There you go.

MARCIA MUETING: There you go.

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

MARCIA MUETING: Thanks for the opportunity.

HANSEN: Thank you. Anyone else wishing to testify in support of LB907? Welcome.

WYATT LANIK: Thank you. Good afternoon, Chairman Hansen, and members of the Health and Human Services Committee. My name is Wyatt Lanik, Wyatt Lanik. I'm a fourth year medical student at the University of Nebraska College of Medicine, and a member of the Nebraska Medical Association. My testimony does not represent UNMC, however, I am testifying on behalf of the Nebraska Medical Association, which supports LB907. Much of what I was going to say has already been said by a lot of people, so I'll be brief. Unfortunately, obesity rates in Nebraska continue to rise. As such, obesity in Nebraska is an epidemic. It's a multifactorial, chronic disease with many intermingling causes ranging from psychosocial, genetic, environmental, socioeconomic and other health conditions, and more. There's many comorbidities, over 200 as previously stated, including cancer, cardiovascular disease, gastrointestinal problems, fertility

issues. And these comorbid, comorbid disease processes come with a high cost in quality of life, shortened life expectancy, and health care related expenses. As discussed, first line intervention as lifestyle therapy, as behavioral with healthy meal plan, physical activity, and behavioral interventions for all patients who, who are overweight or obese seeking to lose weight. As an adjunct to behavioral therapy, initiation of pharmacotherapy is recommended for those with a BMI greater than 30, or greater than 27 with a comorbid condition. Anti-obesity medications promote long term weight loss, ameliorate comorbidities, amplify adherence to behavioral changes, and improve physical functioning, allowing for greater physical activity. Weight loss in those with obesity significantly increases quality of life and can prevent or reduce many of those comorbid medical conditions and the downstream consequences of which would have significant health care cost savings. As such, the language in LB907 will provide Nebraskans on Medicaid the ability to receive guideline recommended management for obesity. The NMA-- the NMA appreciates, appreciates Senator Riepe for introducing LB907 and we encourage your support for the bill. Thank you for your time. I'm happy to answer any questions.

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

WYATT LANIK: Thank you.

HANSEN: Is there anybody else wishing to testify in support of LB907? All right, seeing none, is there anybody who wishes to testify in opposition to LB907? Seeing none, is there anybody who wishes to testify in a neutral capacity? Seeing none, Senator Riepe, we'll wel-- welcome you back up to close. And before he does, we did have 15 letters in support of LB907, 1 in opposition, and 2 in the neutral capacity.

RIEPE: Thank you, Chairman. I appreciate the opportunity of-- my interest is giving physicians an additional tool in caring for patients who are dealing with chronic obesity. You know, it's just one more tool in their toolbox, if you will. Regarding the Medicaid pre-approval, I would think that we would be able to work that out through the three managed care organizations. Also, I want to thank everyone who showed up to testify. I know they have-- some of them have to travel, and they took time out of their day, and I very, very much appreciate that. I also wanted to, to air-- add a little bit. A driving force for me was that it was six years ago when I met a senator from Vermont who gave me a little slogan shield, and the

slogan said "do hard things." And clearly this particular piece of legislation with its fiscal note is a very hard thing because it changes the way that we address the health care, it basically goes to the root cause of these problems, as opposed to simply throwing more money at it for-- and repeating the same problems that we seem to be able to not get fixed. So with that, I would invite questions or comments if you have them.

HANSEN: All right. Thank you. Are there any questions? OK. There are none. Thank you very much.

RIEPE: Thank you much. Have a great week.