MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Seventh Session
May 7, 2013

The Senate Committee on Health and Human Services was called to order by Chair Justin C. Jones at 3:42 p.m. on Tuesday, May 7, 2013, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Justin C. Jones, Chair
Senator Debbie Smith, Vice Chair
Senator Tick Segerblom
Senator Joseph P. Hardy
Senator Ben Kieckhefer

GUEST LEGISLATORS PRESENT:

Assemblywoman Irene Bustamante Adams, Assembly District No. 42
Assemblyman Richard Carrillo, Assembly District No. 18
Assemblyman William C. Horne, Assembly District No. 34
Assemblyman Randy Kirner, Assembly District No. 26
Assemblyman Peter Livermore, Assembly District No. 40
Assemblyman James Ohrenschall, Assembly District No. 12

STAFF MEMBERS PRESENT:

Marsheilah D. Lyons, Policy Analyst
Risa Lang, Counsel
Paul V. Townsend, Legislative Auditor
Jackie Cheney, Committee Secretary

OTHERS PRESENT:

Brittany Shipp, Assembly Leadership Attaché
Steven Yeager, Deputy Public Defender, Office of the Public Defender, Clark County
Christopher Frey, Deputy Public Defender, Washoe County Public Defender's Office
Brett Kandt, Special Deputy Attorney General, Office of the Attorney General; Executive Director, Advisory Council for Prosecuting Attorneys
John T. Jones, Jr., Nevada District Attorneys' Association
Brian Rutledge, Chief Deputy District Attorney, Clark County District Attorney's Office
Chuck Callaway, Las Vegas Metropolitan Police Department
Todd Raybuck, Sergeant, Traffic Bureau, Las Vegas Metropolitan Police Department
Sandy Heverly, Executive Director, Stop DUI, Inc.
D. Eric Spratley, Lieutenant, Washoe County Sheriff's Office
Laurel Stadler, Rural Coordinator, Northern Nevada DUI Task Force
Jacky Eddy
Gerard Mager
Illona Mager
Jim Holmes, Chairman, Northern Nevada DUI Task Force
Nancy M. Cappello, Ph.D; Are you Dense, Inc.; Are You Dense Advocacy, Inc.
Richard Reitherman, M.D., Breast Radiology Specialist, Orange County, California
Wendy Damonte, KTVN News Anchor
John Sande IV, International Game Technology
Cheryl Blomstrom, Nevada Nurses Association
Jane L. Kakkis, M.D., Breast Cancer Surgeon, Orange County, California
Janette Dean, Intern for Assemblyman James Ohrenschall
Michael Hackett, Nevada State Medical Association
John A. Ellerton, M.D., Oncologist
Lesley Pittman, Reno Diagnostic Centers
Elisa Cafferata, President & CEO, Nevada Advocates for Planned Parenthood Affiliates
Rebecca Gasca, National Research Center for Women and Families; Cancer Prevention and Treatment Fund

Denise Selleck Davis, CAE, Executive Director, Nevada Osteopathic Medical Association; Executive Director, Nevada Chapter of the American College of Osteopathic Family Physicians
Rachel Bowe

Chair Jones:
We will begin with Assembly Bill (A.B.) 351.

ASSEMBLY BILL 351: Revises provisions governing the medical use of marijuana. (BDR 40-733)

Assemblyman William C. Horne (Assembly District No. 34):
I will be presenting the background of A.B. 351. Existing law allows persons who suffer from certain chronic or debilitating medical conditions to use marijuana when they have a marijuana prescription and registry card from the Department of Health and Human Services (DHHS).

Assembly Bill 351 provides that persons allowed by law to use marijuana in Nevada may not be prosecuted for driving a vehicle or vessel solely for reasons of having a per se level of marijuana in their bloodstream or urine. *Nevada Revised Statutes* (NRS) defines these per se levels as 10 nanograms of tetrahydrocannabinol (THC) per milliliter of urine, 2 nanograms per milliliter of blood, 15 nanograms of THC metabolite per milliliter of urine and 5 nanograms of THC metabolite per milliliter of blood. Persons are not exempt from prosecution if they are determined to be impaired while driving under the influence of marijuana.

I have submitted the "Drug and Human Performance Fact Sheet" provided to the public by the National Highway and Traffic Safety Administration (Exhibit C). According to their findings, "It is difficult to establish a relationship between a person's THC blood or plasma concentration and performance impairing effects. Concentrations of parent drug and metabolite are very dependent on pattern of use as well as dose." This fact sheet demonstrates the difficulty associated with establishing causal relationship between marijuana use and impaired driving. Some marijuana users may be impaired with undetectable levels of THC in their system. Others may have high levels of THC in their system even though they have not used the substance in several hours or even days. As medical marijuana cardholders are legally able to ingest marijuana, THC

will be in their system. This does not mean they will be impaired for driving purposes.

Nevada's illegal per se limits were put in place in 1999, 10 years before Nevada voters ratified the amendment to the *Nevada Constitution* allowing the medical use of marijuana. Any detectable amount of a schedule I or schedule II narcotic could be used as evidence in the prosecution of driving under the influence (DUI). Unless there is a change in State law, a patient could be found guilty of a DUI solely based upon the level of THC in the blood.

Assembly Bill 351 holds medical marijuana users to the same standard as those who use other potentially impairing prescription drugs. When patients are prescribed antianxiety or pain medications, it is the responsibility of the patients to avoid driving while impaired by those medications. The State should not prosecute individuals who show no signs of impairment but have traces of prescribed medication in their bloodstream or urine.

Medical marijuana should not be treated differently than any other prescribed medication, particularly those medications that are far more dangerous. Since traces of marijuana can stay in a user's system for more than 5 weeks, it is crucial the State use better indicators for determining impairment.

Earlier today, I sent an email to the members of this Committee containing a video presentation done by the Cable News Network (CNN). A driving demonstration was done with three individuals with varying levels of THC in their systems. Two of the drivers were casual users, and one was a medical marijuana cardholder. The drivers were deemed not impaired for purposes of driving even after they reached the legally determined per se limit. As they continued to ingest more marijuana, all drivers eventually became impaired.

Critics have said if A.B. 351 passes, we will lose the ability to prosecute those who are driving under the influence of marijuana. This is not true. Police officers can still write citations and prosecute the same as they do with any other drug. Marijuana is the only prescription drug with per se impairment limits that identify whether or not a person is impaired. All patients, whether they are on marijuana, OxyContin, Flexeril, Ambien or other prescription drugs, can be convicted for a DUI. The police officers will articulate in the arrest report how the person was conducting himself or herself behind the wheel and, if deemed appropriate, will administer a field sobriety test.

Nevada law was changed to allow marijuana as a medication. These patients should not be held to a standard that is not applied to those taking other prescription medications.

Chair Jones:
Does anything in A.B. 351 prevent law enforcement from charging someone who does not have a medical marijuana card for exceeding the per se limits?

Assemblyman Horne:
No. The per se limits apply if the person does not have a medical marijuana card.

Senator Segerblom:
What is the per se limit currently in the law?

Assemblyman Horne:
The limits vary per user. Some people are chronic users because of high pain levels. Each person is different regarding how the THC is retained or metabolized in the system.

Senator Segerblom:
What are the per se limits for marijuana in Nevada?

Assemblyman Horne:
It is five nanograms of metabolite per milliliter of blood. In the CNN video I sent to the Committee earlier today, the drivers exceeded that amount by five times before they were deemed impaired.

Medical marijuana patients are regular users as opposed to weekend recreation users. Regular users tend to show higher THC levels.

Senator Segerblom:
Is alcohol the only other drug that has a per se limit?

Assemblyman Horne:
That is correct; however, alcohol is not prescribed by a physician. Marijuana is the only prescribed drug that has per se limits.

Senator Segerblom:
The per se limits for alcohol are supported by studies that substantiate the effects. Such studies do not exist for marijuana.

Assemblyman Horne:
That is correct.

Senator Kieckhefer:
Do the per se limits not apply to persons with medical marijuana cards?

Assemblyman Horne:
That is correct. If a person has a medical marijuana card, the per se limits do not apply. If a person does not have a medical marijuana card, the per se limits apply.

Senator Kieckhefer:
Are you making a policy statement that being at per se limits do not impair your ability to drive?

Assemblyman Horne:
The policy statement I would like to make is patients who are prescribed marijuana as a drug to treat an ailment should not be treated differently than people who are prescribed OxyContin. Marijuana is the only prescribed drug that has a per se limit.

Senator Kieckhefer:
Should we eliminate the per se limit altogether?

Assemblyman Horne:
Assembly Bill 351 proposes to do that for medical marijuana cardholders.

Senator Kieckhefer:
Why have a marijuana per se limit for anyone if the intent is not to hold persons accountable for driving under the influence when the THC metabolites exceed a certain threshold?

Assemblyman Horne:
Under A.B. 351, people will still be held accountable. The officer could conduct a field sobriety test and make a determination that the driver is impaired. The

driver could then be prosecuted under the law for impaired driving. The only difference is the medical marijuana cardholder could not be determined to be impaired for exceeding the per se limit. He or she could still be prosecuted for a DUI if found to be impaired while driving. The current standard presumes persons are impaired if the per se limit is exceeded.

Senator Kieckhefer:
You did not answer my question. If marijuana is recognized as a prescription medication, why have the per se limit at all? Perhaps it should be left to the discretion of an officer and the court whether to prosecute someone for operating a vehicle while impaired.

Assemblyman Horne:
Marijuana is illegal for those who do not have a medical marijuana card. I do not have a problem with the per se limits being imposed for illegal marijuana users. The per se limits should not apply to patients who are prescribed marijuana. The rationale is that per se limits are not applied to any other prescription drugs.

Senator Hardy:
Assembly Bill 351 would enact a double standard. The per se limits would not apply to marijuana users who have a medical marijuana card. The per se limits would apply to those who do not have a medical marijuana card. This is a complicated matter. Many factors come into play. There are unanswered questions regarding the potency and limitations for impairment on a given individual. Mixing alcohol with marijuana causes a greater effect. In addition, regardless of what we do as a State, marijuana is still illegal federally. I understand the challenge law enforcement would have if the per se limit were eliminated or if a double standard were implemented. I am not convinced this bill is a good solution for marijuana.

Chair Jones:
Page 2 of the study provided by Assemblyman Horne (Exhibit D) mentions 15 states that have per se legal limits for blood cannabinoid concentrations. Do the other 35 states have no per se limits?

Brittany Shipp (Assembly Leadership Attaché):
I do not know if only 15 states have the per se limits. I would need to research that. I can tell you 16 states and the District of Columbia have medical marijuana laws. Ten of those states do not have any per se limits.

Chair Jones:
Is Nevada one of six states where medical marijuana users might be prosecuted using the per se limits?

Ms. Shipp:
That is correct.

Steven Yeager (Deputy Public Defender, Office of the Public Defender, Clark County):
The Office of the Public Defender, Clark County, supports A.B. 351. I submitted a letter (Exhibit E) to the Committee describing a typical DUI prosecution and the impact A.B. 351 would have on the process. This bill will not prevent a prosecutor from charging someone with a DUI. An officer is free to arrest impaired drivers. It does not matter what the impairing substance is or whether it is legal or illegal.

Assembly Bill 351 is a nice complement to the voter-approved access to medical marijuana legislation enacted a decade ago. The science behind what levels mean related to impairment is inconsistent. Almost everyone agrees marijuana metabolite in and of itself has no impairing effect on someone's ability to drive. It is in our statute, but the science is not there. Metabolites can remain in someone's body for a long time. Generally speaking, metabolites do not contain any active drug. Under the current law, a person could be prosecuted 3 or 4 days after smoking marijuana when there is no impairment effect. Under the existing law, one is presumed impaired if the per se limits are exceeded. Consequently, there is no defense. The National Highway Traffic Safety Administration (NHTSA), U.S. Department of Transportation, has done studies on this topic. A quote from one of those studies, Exhibit C, says, "It is inadvisable to try and predict effects based on blood THC concentrations alone, and currently impossible to predict impairment effects based on THC-COOH concentrations."

Senator Kieckhefer asked why we have any per se limits in the law for marijuana impairment. This should be considered at some point by the Legislature. The question before the Committee today is whether it makes sense to treat persons with a medical marijuana card the same as other persons' prescribed drugs.

Prosecutions have occurred for driving under the influence of prescription drugs. I defended a case recently where a woman was in an accident while driving under the influence of Xanax. Xanax does not have a per se limit specified in the statute. The prosecution went forward, and we went to trial. The officer testified about his observations at the scene regarding the defendant's behavior, observations about his interactions with the defendant and her performance on the field sobriety test. A chemist provided a report showing the level of Xanax in her blood. A discussion ensued about what significance the level in her blood may have had on her behavior. She testified about her Xanax use. The judge decided whether her driving was impaired based upon the facts of the case and the testimonies given during the trial. I would foresee a prosecution against someone driving under the influence of marijuana to proceed in a similar fashion.

Senator Kieckhefer:
Is there any research that shows how long the metabolites remain in the system following ingestion?

Mr. Yeager:
The studies are inconsistent in their findings. Based upon what I have seen, the metabolites can remain in the body for days. The THC is the active ingredient that spikes around the time the marijuana is ingested; it stays in the body for several hours.

Senator Kieckhefer:
Are there tests for levels of THC?

Mr. Yeager:
Yes. There are blood and urine tests.

Senator Hardy:
Regarding DUIs, people are being stopped because they have been observed doing something wrong, not because the per se level is suspected to be too high. The test for per se limits helps confirm the observations. If the per se limits are removed, a helpful tool for analyzing impairment would be lost.

Mr. Yeager:
Prosecutions are easier using a per se level because it takes an element that has to be proved out of the case. The other per se levels in statute are for substances that are illegal such as methamphetamine, cocaine and heroin. When

the per se limit for marijuana was initially established in statute, marijuana was an illegal drug—there were no legal users. Now a segment of the population is authorized to use marijuana for medical purposes, and it is time to revisit this.

Senator Hardy:
I understand you want to do away with the per se levels for marijuana. I do not believe that is the right thing to do.

Christopher Frey (Deputy Public Defender, Washoe County Public Defender's Office):
The Washoe County Public Defender's Office is testifying in support of A.B. 351. I want to respond to Senator Hardy's concern. It is not the intent of the bill to exclude the per se test as a piece of the prosecution. If the prosecutor wants to proceed on an impairment theory, he or she can use the nanogram count as a complement to other pieces of evidence. It would not be the exclusive basis for a conviction.

Senator Hardy:
This is true unless that person is not a medical marijuana cardholder.

Mr. Frey:
That is correct.

Senator Hardy:
As previously mentioned, a double standard exists.

Mr. Frey:
I was not speaking to your concern about the double standard issue. I was clarifying that in the case of medical marijuana cardholders, the prosecution would proceed under an impairment theory not a per se theory. The nanogram count would be a piece of evidence the prosecution could use.

Senator Hardy:
I understand your point. There is a multiplicity of factors to be considered in the passage of this bill. The bill is not as simple as it may seem. One of my main concerns is a double standard would be imposed for marijuana users by applying the per se limits only to those who do not possess a medical marijuana card.

Brett Kandt (Special Deputy Attorney General, Office of the Attorney General; Executive Director, Advisory Council for Prosecuting Attorneys):
A car operated by an impaired driver is a lethal weapon. It does not matter if the driver is impaired by alcohol, cocaine, Xanax, Percocet, some other prescription drug or marijuana. The purpose of Nevada's per se law is public safety specifically to protect the public from an impaired driver. It does not make the public any safer if the driver impaired by marijuana happens to be carrying a medical marijuana card. The card does not make the impaired driver less likely to kill someone.

Among all states that have enacted medical marijuana laws or those that have fully legalized marijuana, only one state, Georgia, has enacted a law similar to A.B. 351. The Georgia law was ruled unconstitutional by the Georgia Supreme Court. I have provided the Committee with a copy of that court's opinion, *Love v. State*, 271 Ga. 398, 517 S.E.2d 53 (Exhibit F). On page 6 of the opinion, Exhibit F, the analysis turns to the issue of whether treating drivers with medical marijuana cards differently from all other drivers under the Georgia per se law violated the equal protection clause. The court concluded that "given the rational relationship between the statute and the legitimate state purpose of public safety, the distinction is arbitrarily drawn, and the statute is an unconstitutional denial of equal protection."

Other states have expressly rejected what A.B. 351 proposes. For example, Connecticut legalized marijuana but specifically prohibited operation of a motor vehicle while under the influence of marijuana. The drafters of the marijuana initiative in Michigan argued after its enactment that by its approval, the voters had, by implication, intended to exempt drivers with medical marijuana cards from prosecution under Michigan's illegal per se law. That argument was rejected by the Michigan Court of Appeals in *People v. Koon*, 296 Mich App 223; 818 NW2d473 (2012). Likewise, there is no evidence that when enacting medical marijuana use, the voters of Nevada ever intended marijuana users to be immune from prosecution under our per se law.

Chair Jones:
It appears there are constraints for marijuana users to operate a vehicle because a certain quantity remains in the blood much longer than alcohol.

Mr. Kandt:
I am not a scientist or a subject matter expert suitable to talk about the levels and effects of marijuana upon humans. It may make sense to have the experts do a study and provide testimony about the results.

Senator Segerblom:
Nevada law presumes persons driving with the per se levels are guilty of driving under the influence.

Mr. Kandt:
That is correct. The Legislature made that determination some time ago when they listened to the experts and evidence supporting those per se levels. It is possible those per se levels need to be revisited and experts consulted so the Legislature can make informed decisions regarding the per se levels.

Senator Kieckhefer:
I will not vote for a bill that would reduce the threshold upon which we can prosecute impaired drivers. Do you believe the metabolite we test for is a direct indicator of impairment?

Mr. Kandt:
I am not a subject matter expert on the metabolite levels. The per se levels were established in the law by the Legislature based upon testimony and available scientific evidence provided. Law enforcement officials simply follow and enforce the laws.

John T. Jones, Jr. (Nevada District Attorneys' Association):
I oppose A.B. 351. The vast majority of convictions for DUIs occur under the per se statutes. The per se statutes are the major mechanism used to keep our streets safe from DUIs. The second way to secure a conviction is to show beyond a reasonable doubt that the driver was impaired. This is much more difficult to prove than the per se violation. Eyewitness accounts, the field sobriety test and any other evidence that demonstrates impairment are used.

Assembly Bill 351 takes away the use of the per se statute for medical marijuana cardholders. We have per se statutes because sometimes chronic and habitual marijuana users do not show signs of impairment. Yet, they are still dangerous, if not deadly, on the road. It is fundamentally unfair for one person to be prosecuted for a DUI, while another person who has the exact same level

of marijuana in the blood escapes prosecution. The case mentioned by Mr. Kandt, *Love v. State*, Exhibit F, specifically addressed that issue. Using the lowest standard, rational basis for equal protection scrutiny, it found that a law similar to A.B. 351 was in violation of the equal protection laws. Ironically, the prosecutors and law enforcement officials opposing the bill will be the same ones in court defending the bill should it pass and be challenged by a defense attorney.

Brian Rutledge (Chief Deputy District Attorney, Clark County District Attorney's Office):

Marijuana is different from other drugs. Marijuana has psychoactive qualities that result in neurological effects. Alcohol is a psychomotor impairment affecting one's movements. The standard field sobriety tests do not work as well for detecting driving impairments for persons under the influence of marijuana. Marijuana DUIs are approximately 5 percent of the misdemeanor DUI cases but represent a high percentage of the DUI death and substantial bodily harm cases. Marijuana was the causative substance in four of the last five death cases I have handled.

Studies show people under the influence of marijuana can concentrate on simple tasks for brief periods. Difficulties in concentration, higher-level thinking and decision making can last for 24 hours after marijuana ingestion. That cognitive thinking impairment causes the death cases. I had a case where a person under the influence of marijuana drove through a bus station at 100 miles an hour, killing four people and injuring multiple others. In all these felony cases, the driver is injured. The fire department comes, straps the injured driver to a backboard and takes him or her to a hospital. When injuries occur, field sobriety tests are not done. When field sobriety tests are done, the level of problems marijuana causes is not always apparent. The National Institutes of Health Study, U.S. Department of Health and Human Services, reported marijuana impairs perceptual motor speed and accuracy and the ability to do complex divided attention tasks. No field test can determine the ability to do complex divided-attention tasks necessary to be a safe driver.

When considering how long metabolites stay in the system, more scientific evidence is needed about the longevity and seriousness of the impairments. The National Institutes of Health cited two studies that show the THC concentrations in the blood from one marijuana cigarette will drop below 0.25 within 2 hours of smoking it, but the effects on visual tracking last up to

5.5 hours and the effects on complex divided-attention tasks last up to 24 hours. The science is not exact for determining impairments caused by marijuana. The NHTSA study referenced earlier concluded low doses of THC impair cognitive and psychomotor tasks associated with driving, while severe driving impairment is observed with high doses or chronic use. Passing A.B. 351 would remove the per se limits for the most chronic users, i.e., those with a medical marijuana card.

The National Institutes of Health studies noted THC has significant effects on cognitive and psychomotor tasks associated with driving concluding "any situation in which safety of both self and others depends upon alertness and capability of control of man-machine interaction precludes the use of marijuana." According to the National Institutes of Health, it would make more sense to ban people who use marijuana entirely from driving.

The World Health Organization agrees that cannabis acutely impairs cognitive development and psychomotor performance, increasing the risk of motor vehicle accidents by the intoxicated driver.

Assembly Bill 351 would effectively be a get out of jail free card for the most serious cases. This bill will severely damage our ability to prosecute cases. The worst of the worst is who would benefit the most from this bill.

Chuck Callaway (Las Vegas Metropolitan Police Department):
The Las Vegas Metropolitan Police Department opposes A.B. 351. I echo the comments already stated in opposition of this bill.

Senator Segerblom:
When someone is stopped, is it difficult to determine if he or she is under the influence of marijuana?

Todd Raybuck (Sergeant, Traffic Bureau, Las Vegas Metropolitan Police Department):
It is extremely difficult to identify characteristics of intoxicating levels caused by marijuana. Unlike other prescription drugs, marijuana has no instructions about a safe dosage in relation to driving a vehicle. Marijuana is a self-induced and self-medicated drug.

Senator Segerblom:
If you cannot tell if a person is intoxicated, why would a blood test ever be ordered?

Sgt. Raybuck:
We can use drug recognition experts to help identify persons who are under the influence of drugs such as marijuana. The Las Vegas Metropolitan Police Department only has 22 drug recognition experts serving approximately 2,500 police officers in the field. Consequently, officers must rely largely on the field observations and the per se requirements to validate those observations.

Senator Segerblom:
What is the typical observation that prompts a blood test? Does the driver's license identify whether the person has a medical marijuana card?

Sgt. Raybuck:
The driver's license does not indicate whether the person has a medical marijuana card. An accident or irresponsible driving is the first indicator of a problem. The officers are trained to look for evidence at the scene such as the odor of marijuana, drug paraphernalia and bloodshot eyes or other physical characteristics. As mentioned by Mr. Rutledge, the standard field sobriety tests are not adequate by themselves.

Sandy Heverly (Executive Director, Stop DUI, Inc.):
Stop DUI, Inc. opposes A.B. 351. Voting no on this bill will allow the DUI statute regarding marijuana THC levels to remain intact and do the job it was crafted to do. Those endangering public safety must continue to be held accountable.

Nearly every DUI law was written on the backs of innocent victims. The prohibitive substance section establishing the per se levels of marijuana is no exception. The impetus for this statute was the death of a husband and father of three children who was killed by a marijuana-impaired driver. At that time, Nevada did not have any per se levels for marijuana, and the perpetrator received a mere slap on the hand. The victim's family was devastated by these events and brought these concerns and frustrations to me and former State Senator Jon Porter. After the Legislature was educated about the effects of marijuana specific to driving, the per se levels were incorporated into the DUI statute. Since then, the law has performed the way it was intended,

providing some semblance of justice for the innocent victims of this crime. It has helped protect the motoring public.

As a victim advocate for the past 30 years, I have seen firsthand the horrific carnage and devastation caused by legal drugs and alcohol when combined with driving. There has been death, injury and destruction to tens of thousands of innocent victims in Nevada and across the Nation. I have also witnessed the same by those who have been victims of marijuana-impaired driving. With all the empirical data collected over the past two decades, we know marijuana use adversely effects a person's concentration, coordination and perception. These are all important skills for safe driving. The most frightening study reveals regular cannabis users were 9 1/2 times more likely to be involved in a motor vehicle crash than those who were not regular cannabis users. Considering those with medical marijuana cards are using the drug for medicinal purposes, one could conclude the drug would be used consistently. These are then included in the category of a regular user who is 9 1/2 times more likely to be involved in a motor vehicle accident.

Would you feel comfortable allowing your children or your grandchildren to be a passenger with a driver who had any level of marijuana in his or her system, legal or not? Are you willing to allow transit drivers with medical marijuana cards to take their medicine before driving? If your answer is no, then your vote should be no. Assembly Bill 351 jeopardizes public safety, specifically the motoring public. Please have compassion for the citizens of Nevada, our community and State and reject this dangerous proposal.

D. Eric Spratley (Lieutenant, Washoe County Sheriff's Office):
The Washoe County Sheriff's Office opposes A.B. 351. Law enforcement is willing to take the time necessary to discuss key components to ensure a successful outcome is reached for all parties on the issue and the drivers in our State. As the medical marijuana topic unfolds at this Legislative Session, this legislative body has made great progress in meeting the desires of the voters and the provisions in the *Nevada Constitution*. Law enforcement, while in a quandary over the issue, has tried not to stifle that effort. I look forward to productive discussion on the matter to move us from opposing this bill.

Laurel Stadler (Rural Coordinator, Northern Nevada DUI Task Force):
The Northern Nevada DUI Task Force is opposed to A.B. 351. I submitted information to the Committee (Exhibit G) detailing the prior legislative hearings on the per se marijuana bills.

The per se levels became law in 1999 with the passing of S.B. No. 481 of the 70th Session. This bill was passed with only one nay in each chamber and was upheld by the Nevada Supreme Court. In 2003, A.B. No. 362 of the 72nd Session proposed to change the per se levels. This bill was dismissed after two hearings without a vote in committee.

My testimony today will focus on the reality of the medical marijuana user, the use thereof and the ramifications of A.B. 351. Medical marijuana is authorized by statute for persons who suffer from chronic or debilitating medical conditions. As of April 1, 2013, 3,753 patients held medical marijuana cards. Only 442 had documented debilitating medical conditions such as cancer, glaucoma, and HIV AIDS. The remaining 3,311 cardholders indicate severe pain as their condition.

I have been dealing with excruciating debilitating pain since January 2013. It became increasing unbearable until April 5, 2013, when I could not move and was transported by ambulance to the hospital. During my downward spiral, I learned what debilitating pain meant. It meant not wanting to get up in the morning. When I did get up, I could only do one small task like feeding the dog or emptying the dishwasher. After a short time, I had to go back to bed and try to sleep the pain away. In the afternoon, I might have another hour out of bed then have to go back to bed. On a day when the pain was a little less, I would venture out of the house to do grocery shopping or other errands. I would immediately return home for fear of the pain returning with unbearable intensity. I do not say all of this for you to feel sorry for me, but for you to understand the reality of this type of pain. I did not understand this until I was afflicted.

Imagine those 3,432 medical marijuana cardholders who are housebound with severe pain. This number is estimated to grow to over 10,000 cardholders in the near future. Directly after these persons smoke a joint, they may feel good enough to leave the house. This is when they are most impaired by the freshly smoked joint. They will be driving and could even be transporting children.

If A.B. 351 passes, you will be authorizing medical marijuana users to drive during their most impaired state. They will be exempt from the Nevada statute that has served us well since 1999. You will be taking away a tool for law enforcement, prosecutors and judges. The current law has been tested by the Nevada Supreme Court and validated as the compass to measure marijuana impairment.

Consider the situation where the medical marijuana user is a school bus driver, a teacher or someone else in a capacity that can endanger our children and others. This body will be sanctioning medical marijuana cardholders to drive impaired and in doing so be exempt from the DUI laws. The impairment is the same whether the marijuana enters the person by legal or illegal means. The levels and the danger are the same. Please vote no on A.B. 351.

Jacky Eddy:
I am a victim of DUI. My daughter was killed in 2007 by an impaired driver. If A.B. 351 is passed removing the repercussions for impaired driving, how many more deaths will there be? I do not want anyone else to go through what I have gone through by losing a child, parent or other loved one. Impaired is impaired. It does not matter if a doctor has authorized the drug that causes the impairment or not. It is not acceptable to drive under the influence of any drug. Allowing this injures and kills innocent people. Actions should be taken to stop this, not make it easier to do.

Gerard Mager:
I am a victim of DUI. Our 17-year-old son was killed in 1996 by a driver impaired by marijuana. In my son's case, the district attorney's office would not prosecute for a DUI because it was too difficult to prove, even though the driver tested positive for marijuana. Driving under the influence of marijuana should not be legalized; it would be like issuing a license to kill. The prescriptions for marijuana do not specify a dosage. The patient is simply told he or she can use marijuana. Medical marijuana cardholders will most likely use marijuana multiple times per day and then drive a car.

Assembly Bill 351 will exempt medical marijuana cardholders from the per se limit. Someone using marijuana recreationally who does not have a medical marijuana card and gets into an accident will automatically be issued a DUI. Those who possess a medical marijuana card will not. Why should there be a difference? When there were no per se laws, the person who killed our son

got an insignificant punishment and was free to go. Assembly Bill 351 is a bad law. It needs to be defeated. Please vote no.

Illona Mager:
I am a victim of DUI. This is a picture of my son. He was killed on Valentine's Day in 1996. He was born on Christmas. I sent letters to members of Nevada's Assembly and Senate with his picture the first Christmas after my son died. I asked if people can be fired for failing a drug test, why is it not possible to prosecute people with a positive drug test when they kill someone? My husband and I lobbied for the passage of S.B. No. 481 of the 70th Session that put the per se levels in place.

I was a nurse for 18 years in Washoe County. Medical marijuana is the first medication classified as legal that is not approved by the U.S. Food and Drug Administration. This is all new territory. No one should have to go through what I have in losing my only child. This is 17 years later, and I never thought I would be here again. I want you to see the face of my son who is not here anymore. Family members who have been lost do not come back. You cannot fix what has been taken away. The per se law was a way to try to make something good out of something horrific. Please do not pass A.B. 351 and take away the good.

Jim Holmes (Chairman, Northern Nevada DUI Task Force):
My wife and I lost our son 17 years ago to a DUI driver. Since then, we have spoken before 45,000 DUI offenders. I consider myself an expert on this subject. In recent years, the percentage of marijuana and drug users involved in deaths and accidents has increased. If A.B. 351 is passed, more impaired drivers will be on the road. The number of deaths, property damage and personal injuries will increase. A 3,000-pound vehicle moving at 60 or 70 miles an hour can do more damage than a .38 caliber revolver. Year after year, death statistics prove this. Please do not pass A.B. 351.

Assemblyman Horne:
Nothing in A.B. 351 will prohibit arrests and prosecution of those who are driving impaired. The intent is to treat those persons prescribed marijuana the same as any other patients who are prescribed a drug. Currently, medical marijuana cardholders are presumed to be impaired and receive a DUI if the per se limits are exceeded. Assembly Bill 351 will remove that presumption for the small percentage of the population who are medical marijuana cardholders.

Without the per se limits, the prosecutors will have to work harder to establish impairment.

Mr. Kandt referred to the Georgia Supreme Court case, *Love v. State*, where the Georgia law similar to A.B. 351 was ruled unconstitutional because it violated the equal protection clause. I have provided the Committee with an opinion from the Legislative Counsel Bureau about the impact of this case on A.B. 351 (Exhibit H). I will read excerpts from this exhibit:

> As an initial matter, it is important to note that the decision of the Supreme Court of Georgia in Love is not binding precedent in Nevada. We are also unaware of any similar decision that is binding precedent in Nevada. Generally, state courts will not follow a ruling of the courts of another state "if such ruling is based on undetermined reasoning, is against the forum state's public policy, or is based on reasoning that is ... unpersuasive."
>
> ... However, with respect to the medical use of marijuana, Nevada law is different from Georgia law.
>
> ... The Nevada Constitution requires the Nevada Legislature to provide by law for the medical use of marijuana. ... The Georgia Constitution contains no such provision providing for the medical use of marijuana. ... AB 351 is rationally related to the governmental interest of carrying out the Nevada Constitution's requirement that the Legislature provide by law for the use of medical marijuana. Thus, unlike the Georgia law at issue in Love, the provisions of AB 351 are rationally related to a legitimate governmental purpose.
>
> ... During its 2005-2006 session, the Rhode Island Legislature enacted House Bill No. 6052, which authorized the medical use of marijuana. The provisions of House Bill No. 6052 provide that a lawful medical marijuana user is subject to criminal penalties for operating, navigating, or being in actual physical control of any motor vehicle, aircraft, or motorboat while under the influence of marijuana, except that a lawful medical marijuana user must not be considered to be under the influence of marijuana solely because of the presence of metabolites in his or her system. ... In addition, the

> Arizona and Delaware laws authorizing the medical use of marijuana contain language substantially similar to Rhode Island law. ... The laws of Rhode Island, Arizona and Delaware exempt only lawful medical users of marijuana from the provisions of state law prohibiting a person from driving a vehicle with an amount of marijuana in his or her blood or urine that exceeds a certain amount.

This opinion indicates that Nevada will not be treading on any new legal ground with the passage of A.B. 351. I urge you to pass this bill.

Senator Jones:
There were two letters submitted to the Committee in opposition to A.B. 351: Save Our Society From Drugs (Exhibit I) and a letter from Oregonians Against the Legalization of Marijuana (Exhibit J).

The hearing is closed on A.B. 351. The hearing is now open for A.B. 147.

ASSEMBLY BILL 147 (1st Reprint): Requires the notification of patients regarding breast density and supplementary mammographic screening tests. (BDR 40-172)

Assemblyman James Ohrenschall (Assembly District No. 12):
Women with increased breast density have increased risk for cancer and have increased risk for getting false negative mammograms. A false negative mammogram reports everything is fine when it is not.

At least 40 percent of women have either dense breast tissue or extremely dense tissue. Breast density is one of the strongest predictors of the failure of mammography to detect cancer. Breast density is a greater risk factor for breast cancer than having two first-degree relatives with breast cancer. Today, the vast majority of women in our Country are unaware of their breast density. Statistics tell us that one in ten women with dense breast tissue learn about their dense breast tissue from their doctors.

Several states have passed laws similar to A.B. 147. Those states include California, Connecticut, Texas, Virginia and New York. Seventeen other states are considering laws that resemble A.B. 147.

Assembly 147 requires a notice be incorporated into the mammogram report as shown in section 1, subsection 1 informing the patient about her breast density. She can then talk to her health care provider and decide what is best for her.

Today you will hear emotional testimony from families who have lost loved ones. Assembly Bill 147 is dedicated to Diane Wyness and Carolyn Graham Lambert who have been lost and have a lot to do with this issue. In both cases, the doctors believed dense breast tissue to be the culprit.

I have provided the Committee with a number of informational items regarding Breast Density (Exhibit K, Exhibit L, Exhibit M, Exhibit N, Exhibit O and Exhibit P) containing information regarding mammograms, dense breast tissue and cancer risks.

The pictures on page 1 of Exhibit K show comparisons of regular breast tissue, dense breast tissue and extremely dense breast tissue. Even the layperson can see how the whiteout effect of dense breast tissue can mask a tumor or growth. At times, additional testing is appropriate and necessary and may save lives.

You will hear a fair amount of opposition to this bill. I have not spoken to one woman who has told me she would not want to know whether she has dense breast tissue. This bill has the potential to help our mothers, wives, daughters and sisters.

Assemblyman Randy Kirner (Assembly District No. 26):
This is not a Democratic issue or Republican issue. There is no partisanship whatsoever on this issue. This bill is about saving lives.

I have been married for almost 47 years. Ten years ago, my wife was diagnosed with breast cancer. If it had not been for advanced testing, she might not be here today. I support this bill.

Nancy M. Cappello, Ph.D. (Are you Dense, Inc.; Are You Dense Advocacy, Inc.):
I support A.B. 147. When I was diagnosed in 2004 with advanced stage breast cancer which had metastasized to 13 lymph nodes, I was baffled because 6 weeks prior, I had received a normal mammography report, which I now call the "Happy Gram." I had received a decade of normal mammography reports preceding this devastating news. How could my mammogram not find

a suspicious 3-centimeter lesion the same day that the ultrasound discovered it? I questioned my doctor. For the first time, I was told that my dense breast tissue prevented my mammogram from finding my cancer. My radiologist knew I had dense breasts. My gynecologist knew I had dense breasts. I was the only one who did not know—the woman with the dense tissue breasts.

At the most vulnerable time in my life, I uncovered over a decade of studies which led me to conclude 40 percent of women have dense breast tissue; breast density is one of the strongest predictors of the failure of mammography to detect cancer; there is a direct correlation to tumor size at discovery and long-term survivability; women with dense breasts are at greater risk of having a cancer found right after a normal mammogram; there are additional tests that can significantly detect early stage invasive cancers in dense breasts. Armed with this knowledge, I went back to my doctors and asked them to consider informing patients about dense tissue. They said this would not be possible.

I went to the Connecticut Legislature and worked with legislators to change the law. Connecticut became the first state in the Nation to standardize the communication of breast density to women through mammography reports. I founded two organizations: Are You Dense, Inc., and Are You Dense Advocacy, Inc. These organizations have fueled a grassroots movement across the Country. This confirms there is no shortage of women harmed by dense breast tissue.

Following Connecticut's lead, Texas enacted legislation in 2011; Virginia, New York and California in 2012; and Hawaii in 2013. Presently, 17 states, including Nevada, have introduced notification bills in 2013. As Assemblyman James Ohrenschall mentioned, less than one in ten women learn about their dense breast tissue from a physician. This is why legislative efforts are needed. Assembly Bill 147 is about informing women about their dense tissue composition and its impact on their breast health. With this knowledge, women are informed and able to participate meaningfully in conservations with health care providers about their personal screening surveillance.

Richard Reitherman, M.D. (Breast Radiology Specialist, Orange County, California):

Dense breast tissue and its consequences have been scientifically demonstrated. This information has been available for decades to physicians but not to patients. Assembly Bill 147 is about informed consent and symmetry of

information which is vital to decision-making. If people do not have proper information, they will make poor decisions.

As a radiologist for over 20 years, I believe it is critical for women, as the patients who have the most at risk, to know about their breast density. The rest of the system needs to be worked out. The physicians, insurance companies and equipment suppliers need to do whatever is necessary to make this work. Informed consent is under the authority of the State. I highly recommend passage of A.B. 147.

Wendy Damonte (KTVN News Anchor):I support A.B. 147. I lost my mother to breast cancer; at least I thought so until I did further research. Now, I believe she died of dense breast tissue. I work for KTVN, a Reno television news station. My mother authorized cameras to follow her fight because she wanted women to see the horrors of breast cancer. She also wanted women to understand the need to detect breast cancer earlier to increase chances for survival. I aired a 30-minute special on my mother in December 2012. I reduced this video to 4 minutes for presentation to this Committee (Exhibit Q). The full version can be viewed on my Website at <http://www.wendydamonte.com>.

Six months prior to my mother being diagnosed with cancer, she had a mammogram showing no problems. It was not until I started researching this story and began talking to doctors that the dense breast tissue issue kept coming up. I could not understand why I had never heard of this before. I called my mother's doctor and asked what type of breast tissue she had. He responded, "Heterogeneously dense breasts." Considering she had 6 months of recent mammograms, I asked the doctor whether it was possible that her cancer suddenly progressed to where it was. She had three tumors in her breasts, a cancerous tumor in her neck and cancer in 38 of the 54 lymph nodes that were removed. The doctor responded, "Only God knows, but the science tells me that it is not possible." A tumor takes between 5 and 7 years to grow 1 centimeter. My mother had mammograms every year. The tumors growing inside were undetected. My mother died of dense breast tissue. If she had known, she would have obtained additional screenings.

You will hear opposition today. There are two sides to every story. Some of the opposition will say this bill will cause increased biopsies. They may say it will increase the anxiety level in women, cost more and cause more problems because women have this knowledge.

Because of my mother's story, a dear friend of mine had a mammogram. After learning she had dense breast tissue, she went back and had a SonoCine done. Two tumors were found. She had to have a surgical biopsy. The biopsy came back negative. She went through much anxiety and a surgery that turned out to be unnecessary. I asked if she was upset for knowing about the dense breast tissue. She responded, "Absolutely not." She could be the poster child for the opposition.

Assembly Bill 147 provides information. Everyone in this room now would have the luxury of knowing about dense breast tissue. You will go home and share this information with your loved ones. The women in your life may ask what type of breast tissue they have. Every woman in the Nevada deserves that same luxury. Please pass this bill.

John Sande IV (International Game Technology):
International Game Technology employs over 1,000 women. We agree it is important all women have breast density information. It is highly probable that everyone has been affected in some way by breast cancer. I lost my grandmother to breast cancer. She passed away months before I was born. I missed a lot by never knowing my grandmother.

Cheryl Blomstrom (Nevada Nurses Association):
The Nevada Nurses Association supports A.B. 147 for all the reasons you have heard and because women are great advocates for themselves when they have information.

Jane L. Kakkis, M.D. (Breast Cancer Surgeon, Orange County, California):
I have been in full-time practice for 13 years. Women are not informed of breast density. Women do not understand if the mammogram is negative and dense breast tissue exists that a cancer can be missed. The original law requiring notification of the mammogram results was not intended to withhold information about breast density. It is almost unethical to give patients a mammography report saying everything is good without also notifying the patient of other items that may be of concern. Women need information early in the process to make informed health care decisions.

Senator Hardy:
When you say the patient is not getting the actual copy of the mammogram report, are you saying the radiologist sends one report to the doctor and a different one to the patient?

Dr. Kakkis:
The patient usually sees her primary care doctor or gynecologist for a yearly exam. At that time, the doctor may order a mammogram. The patient gets notification of the mammogram results in the mail indicating normal or abnormal. The physician gets the actual mammogram report containing much more information. Included in this information will be a statement regarding the breast density. The patient may not see her physician again for another year. It would be better if the patient were sent a copy of her actual mammogram rather than a negative result notification. The negative reports are not absolutely negative in the case of dense breast tissue.

Senator Hardy:
I am a doctor and where I work, the radiologists send the mammogram report to the patient. The radiologist calls and tells me about reports being sent to the patient and advises me of any concerns. I then have the opportunity to call and warn the patient of additional views and tests I may be ordering. This sounds different from how it is handled where you are. Where are you?

Dr. Kakkis:
I am in California. The federal law for mammography reporting applies to the entire United States. The only mandated report to the patient is the test results of normal or abnormal. Generally, patients do not receive a copy of the actual mammography report. Do your patients get the actual mammogram report or only in cases where there is a finding?

Senator Hardy:
My wife recently received a mammogram notification, and it contained the full mammogram report. It sounds like the practices for notifications are not consistent. The full report would be more helpful.

Dr. Kakkis:
I have had some patients who received a copy of the full report. The only problem is the patient may not understand the language. The informed consent language suggested by A.B. 147 is much clearer.

Senator Smith:
The provisions in A.B. 147 would make women aware of the existence of dense breast tissue. What happens after that? What are the implications of this new information being received?

Dr. Kakkis:
The purpose of informing women of dense breast tissue is to initiate the dialogue with the physician. The physician can review the family history and other items that may contribute to increased risk. Further testing may or may not be needed.

Janette Dean (Intern for Assemblyman James Ohrenschall):
The existing clinical practices are not being changed regarding what might be posed to patients with dense tissue. We are adding breast density as a factor to be considered along with age and family history regarding what existing screening options might be proposed. Because the mammogram has the limitation of not being able to see through the dense breast tissue, women can use that information to determine whether they would like to consider alternate screening options such as an ultrasound or an MRI. The patient and doctor can decide if further testing makes sense considering the risk level and the fact that the mammogram could not see the entire breast to detect abnormalities.

Michael Hackett (Nevada State Medical Association):
While the Nevada State Medical Association (NSMA) supports efforts to increase education, awareness and early detection of any type of cancer, we continue to oppose A.B. 147.

Our opposition is not intended to diminish the serious nature of breast cancer or any other type of cancer. Our opposition is because there is no consensus within the scientific community on the relationship between breast density and breast cancer deaths. There is no reliable standardized method for assessing breast density and no clinical guidelines that recommend additional screening based solely on high breast density.

Dr. Keith Brill is an Obstetrics and Gynecology (OBGYN) physician, an NSMA member, Vice Chair of the Nevada Section of the American College of Obstetricians and Gynecologists (ACOG) and is the President-elect of the Clark County Medical Society. Dr. Brill has provided written testimony (Exhibit R) that echoes our concerns and delineates the opposition of ACOG.

Because the science has not yet evolved to substantiate the concerns this bill proposes to address, NSMA believes this legislation is premature.

John A. Ellerton, M.D. (Oncologist):
I oppose A.B. 147. I take breast cancer seriously. I have been involved in clinical breast cancer research for many years. I am a member of the National Cancer Institute Breast Cancer Screening Committee, National Institutes of Health, U.S. Department of Health and Human Services. My colleagues and I are writing a manuscript analyzing the effects of the cholesterol drug, Lipitor, for women with dense breasts. This study has given me a special insight into breast density and the biology of breast cancer.

Assembly Bill 147 introduces practicing physicians to a new regulatory agency outside the Board of Medical Examiners. Specifically, it allows the Health Division, DHHS, to impose an administrative fine to owners, lessees or other persons responsible for the radiation machines for mammography. In many cases, particularly for patients in the outpatient setting, the physicians will be the ones paying the fines. I do not believe a new regulatory agency outside the Board of the Medical Examiners is appropriate.

This bill creates a standard of care because it creates an expectation that something can come after the information about breast density is provided. Standards of care should not be legislated. This is a bad idea because science and standards constantly change.

An entire session about breast cancer was included in the December 2012 San Antonio Breast Cancer Symposium where they tried to gain consensus on the best approaches for detection. Everyone agrees there is a relationship between an increased risk of breast cancer and increased breast density. It is unclear what causes the relationship. It is conceivable the cancers are hidden and cannot be seen. It is also conceivable some other biologic link exists that suggests dense breasts have a propensity to develop breast cancer independent of whether the mammogram is successful.

The real problem is what a woman does when she has information about dense breast tissue. Women should not be misled about what can happen next. A consensus does not exist for what the next best imaging study should be for dense breasts. The biggest concern is not the cost of additional tests or increased biopsies. The concern is none of these is 100 percent reliable. One

should not assume a second or third test such as an MRI or ultrasound will assure no cancer exists.

We do not have a complete understanding of what causes the relationship of dense breast tissue and breast cancer. Doctors can review with their patients the standard risk-assessment models developed over the years for breast cancer; however, none of those models includes breast density. Until those models are developed and tested, they will not exist. In the case of breast density, the doctors do not have any tools to calculate the risks or to suggest what to do next.

Lesley Pittman (Reno Diagnostic Centers):
Reno Diagnostic Centers opposes A.B. 147. As an entity tasked with carrying out the provisions of this bill, we worked with the bill's sponsor to modify the bill language to address our concerns. Unfortunately, we were unsuccessful.

Reno Diagnostic Centers sees no problems with providing patients with a copy of their mammogram along with additional information concerning breast density. We also have no problem encouraging patients to have greater dialogue with their physicians concerning breast density.

The language included in A.B. 147 is unnecessarily alarming to patients as it mandates the notification go out to all patients regardless of whether they have dense breast tissue. This will result in unnecessary anxiety of mammography patients, many unnecessary additional procedures and increased health care costs. We also object to attempts to place a standard of practice in statute, especially one that is not currently defined. This is an area where technological advances are changing the approach to how radiologists respond to dense breast tissue in their patients.

We join with the American College of Obstetricians and Gynecologists and American College of Radiology in our objection. We recognize this is an issue of great concern to many women and men. We encourage greater awareness for our patients concerning the limitations of mammography in detecting cancer. We believe this can be accomplished with a resolution. If you choose to process legislation, we strongly urge you to change the bill to include language passed in California. I have submitted a proposed amendment (Exhibit S) which I will read to the Committee. The notification proposed in this amendment would only be

sent to patients who have heterogeneously dense breasts or extremely dense breast tissue.

Chair Jones:
Are the amendments proposed to section 2(c) and section 2(d) of Exhibit S also included in the California legislation?

Ms. Pittman:
Yes.

Elisa Cafferata (President & CEO, Nevada Advocates for Planned Parenthood Affiliates)
Nevada Advocates for Planned Parenthood opposes A.B. 147 in its current version. I have submitted to the Committee written information (Exhibit T) regarding our concerns. We all agree on some things in A.B. 147. Nevada Advocates for Planned Parenthood Affiliates suggest a resolution or further study rather than legislation.

Planned Parenthood does not do mammograms but may see a patient after the notification required by A.B. 147 is received. Nevada Advocates for Planned Parenthood Affiliates requested that all women receiving a mammogram get the notice because tissue density can change over time for women.

Planned Parenthood believes women should be active partners with their health care providers and be more aware about their health issues. Professionals in the health care community can do more to help patients understand a range of issues. Dense breast tissue is an area where information is changing rapidly. During my research over the past few months, I have seen considerable information about the effectiveness of mammograms, ultrasounds and MRIs. At this point, a clear protocol does not exist that tells us how to move forward.

If this goes forward as a statute, we request the proper organization within the State government be tasked with updating the statute and notice language as the science evolves and a standard of care is developed at the national level.

We support the efforts to make women better consumers of health care and are committed to assist in the process.

Chair Jones:
Do you have any concerns about who is funding the Are You Dense organizations that have been pushing this legislation across the Country?

Ms. Cafferata:
I have heard Are You Dense gets funding from companies that provide some of the screening technologies. I have not done the research to confirm or deny whether that is true. Honestly, I do not know who funds those organizations.

Rebecca Gasca (National Research Center for Women and Families; Cancer Prevention and Treatment Fund):
The Cancer Prevention and Treatment Fund helps children and adults reduce the risks of cancer and assists them in choosing the safest and most effective treatments. We carefully analyze research by scientists around the world and draw conclusions about the best strategies for preventing and treating cancer.

Our organization revolves around proper treatment and response to cancer. While we applaud the intent of the bill to educate women about this important issue, we are concerned about the type of letter it requires radiologists to send. Similar legislation passed in other states has frightened and confused women. It caused a default for doctors to begin ordering additional tests when there has been no standard of care or protocol agreed to by medical professionals around the Nation.

The intent of the letter is to educate. It tells women they may be at risk, but it is not clear about that risk. Many times the additional tests are paid out of pocket by women. Radiation from a mammography and additional screening tests can increase the risk of developing cancer over a woman's lifetime. This is a risk not contemplated in A.B. 147. When women are frightened, they may pressure their doctors for additional tests.

The bill says many factors affect a person's risk of developing breast cancer including family history, personal medical history, smoking and increased breast density. This proposed language fails to mention breast implants. A large number of women in Nevada, particularly those in the service and entertainment industries, have breast implants. That number is increasing nationwide. Breast implants can obscure mammogram images, decreasing the ability of mammograms to reveal breast cancer. If this legislation moves forward, there

should be some mention of the effect breast implants can have on detecting breast cancer.

Denise Selleck Davis, CAE (Executive Director, Nevada Osteopathic Medical Association; Executive Director, Nevada Chapter of the American College of Osteopathic Family Physicians):
The Nevada Osteopathic Medical Association has some policy issues concerning A.B. 147. I have submitted written comments (Exhibit U).

I am a woman, and I have two daughters. After I had my first baseline mammogram, I asked the radiologist if I could see the results. I saw two walnut size images and asked if these were irregular. The radiologist asked me not to tell anyone that she had shown me the images. After my doctor reviewed the results, I was scheduled with a surgeon to do a biopsy. The surgeon went out of town for 2 weeks before he could do the biopsy. I spent those 2 weeks agonizing over it. He begged me not to plan my funeral before he could do the biopsy. I had two small daughters and this was not the news I was hoping to hear. This legislation is a very personal thing to me.

Policy is written as a guideline. Laws are to be followed exactly as they are written. When we include medicine in the law, we stop progress. I was born in the year Jonas Salk developed the polio vaccine. I am not that old. Aspirin is less than 120 years old. Medical knowledge changes daily. What we did routinely 10 years ago may not apply to today. We must be prepared to change policy quickly and to treat patients according to current medical knowledge. When we add things into law, the best we can hope for is a 2-year turnaround.

We have concerns about putting into law a provision requiring all patients to receive the same information. It can become one more warning label that people see all the time and, therefore, ignore, or it is something new to them and they panic. Neither of these leads to better medical care for patients. What does lead to better medical care is a conversation with the physician about personal care.

I have never received a full mammogram report directly from a radiologist. However, I do pick up my films, which belong to me according to Nevada law. I keep these for comparison purposes. Many women may not know this is available to them.

The Nevada Osteopathic Medical Association supports patients having the opportunity to meet with physicians about personal health care needs. We have concerns that mammograms are mandated for insurance coverage, but additional testing is not. Research shows varying differences in the outcomes of breast ultrasounds. It has to do with the varying degrees of pressure applied by the individual providing the test. The next step is the MRI. The MRI has a considerable dose of radiation and consequently should not be done on a regular basis. Additionally, MRIs are expensive. Most insurance companies will not cover MRI costs unless a specific need is demonstrated.

If this bill is passed, please consider a sunset date so the policy can be revisited sooner rather than later. The medical science is constantly being updated. In California, sunset language is already being used. Due to the amount of research being done on cancer in general, and breast cancer in particular, we suggest even a shorter sunset date than that used by California.

Senator Hardy:
For clarification purposes, MRIs use magnetic resonance imaging. They do not use radiation.

Assemblyman Ohrenschall:
Dr. John Ellerton stated A.B. 147 introduces a new regulatory agency, the Health Division, to impose fines. The NRS 457.187 already designates the Health Division as the regulatory agency to impose administrative fines for violation of the mammogram provisions of the law.

Ms. Selleck Davis stated that the patient having a conversation with his or her physician leads to better medical care. I agree this is important, but if the patient does not have the knowledge about the dense breast tissue, how will the discussion happen?

Ms. Gasca spoke about the dangers of radiation from additional testing. Dr. Hardy pointed out that there is no radiation with the magnetic resonance imaging tests. I am not a physician, but I believe the ultrasound test uses sound waves.

Dr. Kakkis:
I want to confirm that there is no radiation associated with an MRI or with ultrasound. The MRI and ultrasound are the primary additional screening methods used to detect breast cancer.

Policy already exists for sending a notification of mammography results. The problem is the notice does not include the complete details. Unintentionally, women are being deceived by receiving incomplete data. Women need to be treated as equal members of society. Women should not be considered weak fledgling people who cannot handle information about their own bodies.

Research shows both ultrasound and MRIs will detect additional cancers in dense breasted women more than mammography alone. Literature shows dense breast tissue increases chances for breast cancer. It is well documented that mammograms miss cancers in people with dense breasts. I know of no research that suggests women will have an inordinate amount of anxiety with the increased knowledge about breast density. It is pure speculation that A.B. 147 will result in the ordering of additional tests.

Ms. Gasca indicated that if this legislation moves forward there should be some mention of the effect breast implants can have on detecting breast cancer. When women undergo this elective cosmetic surgery for breast augmentation, they are informed of the increased cancer risks at the time of the surgery.

Women have a right to know the same information about their breasts that their doctors know. It is unethical to withhold information. There is no perfect solution, but A.B. 147 is a good step in the right direction.

Senator Hardy:
Do you agree with the proposal from Ms. Pittman to amend A.B. 147 to include the California language? Will that solve your ethical issue?

Dr. Kakkis:
I am okay with the California law. Each state may have unique concerns. My expertise is not in how laws are written, but rather is in the deliverance of good patient care.

Assemblyman Ohrenschall:
The original bill would have only informed women with heterogeneously dense breasts or extremely dense breast tissue. In response to concerns, the language was changed to inform every woman about her breast density.

Ms. Dean:
Comments were made suggesting A.B. 147 is driven by profit motives. That could not be further from the truth. National advocate, Dr. Nancy Cappello, founded the Are You Dense organizations solely for the purpose of helping women. Dr. Capello is not doing this for profit. The American Society of Breast Disease, behind many of the notification laws, was formed in 1976. This professional medical society advocates the multidisciplinary team approach to breast health care. They do not advocate any particular breast screening except when it is the best technology available.

Informed consent is letting women know limitations and risks of procedures. Assembly Bill 147 is about informed consent letting women know the limitations of mammography for detecting cancer in dense breast tissue.

Chair Jones:
Susan G. Komen for the Cure submitted a letter of support for A.B. 147 (Exhibit V). Barry Duncan submitted a document from the American College of Obstetricians and Gynecologists (Exhibit W) containing information about state legislative mandates on mammography and breast density.

The hearing is closed on A.B. 147. The hearing is now open on A.B. 144.

ASSEMBLY BILL 144 (1st Reprint): Revises certain provisions pertaining to anatomical gifts. (BDR 40-141)

Assemblyman Richard Carrillo (Assembly District No. 18):
Current law allows a person to make an anatomical gift at the time of death. This gift can be all or part of the body for medical education, scientific research or organ transplant. This is done by a signed document such as a will or driver's license. Additionally, an emancipated minor may make an anatomical gift if he or she is authorized under State law to apply for a driver's license and is at least 16 years old. However, existing law also provides that if the unemancipated minor dies, a parent of the donor may revoke or amend an anatomical gift of the donor's body.

Assembly Bill 144 proposes to change the law to prohibit revoking or amending an anatomical gift in cases where the donor is an emancipated minor who dies and at the time of his or her death was at least 16 years old, held a valid driver's license, and had both the donor and a parent or guardian execute a form authorizing the anatomical gift.

Rachel Bowe:
A few years ago, I began doing research on organ donation and tissue procurement as an awareness project for a Girl Scout gold award. I learned minors between the ages of 16 and 18 might have their organ donation revoked or changed at time of death by a parent or guardian. I disagreed with this law and started working with Assemblyman Richard Carrillo to get the law changed.

If minors are allowed to apply for driver's licenses and are trusted to drive, we should also trust them to make the decision to be organ donors. Assembly Bill 144 changes the law so once the minor signs the consent form and his or her parents sign the consent form, the decision is final. I will show a video presentation (Exhibit X) I prepared supporting this legislation.

Senator Hardy:
I like how you have amended this bill requiring parental consent for minors when signing the initial organ donor forms.

Chair Jones:
We will close the hearing for A.B. 144 and open the hearing on A.B. 255.

ASSEMBLY BILL 255: Provides for an audit concerning the use by the Department of Health and Human Services of certain assessments paid by counties to the Department. (BDR S-191)

Assemblyman Peter Livermore (Assembly District No. 40):
The intent of A.B. 255 is to make the DHHS more efficient, accountable and transparent. The DHHS provides critical services to Nevadans, some of which bring in State revenue. Assembly Bill 255 proposes an audit that will help determine the quality and efficiencies of assessments collected and will assure State funds are being used correctly and effectively.

Section 1 of A.B. 255 proposes to require the Legislative Auditor to conduct audits concerning DHHS's use of assessments paid by counties for the cost of

services provided in the individual counties. The Legislative Auditor would be required to present a final written report of the audit to the Audit Subcommittee of the Legislative Commission on or before January 31, 2015.

Senator Segerblom:
What prompted this bill? What do you intend to find with these audits?

Assemblyman Livermore:
I have provided a copy of a letter (Exhibit Y) sent to Senator Kieckhefer and me from the Carson City Board of Supervisors expressing concerns about the financial burden to the counties and the consequences it has caused. I am not expecting to find anything in particular. I would love to report back to the counties that the assessment charges were correct and appropriate.

I asked Paul Townsend, Legislative Auditor, how this would be funded. He responded that if A.B. 255 passes, it would simply become part of the Legislative Counsel Bureau (LCB) audit plan.

Paul V. Townsend (Legislative Auditor):
As a staff member of the LCB, I am neutral on A.B. 255. This audit would focus on certain assessments levied on counties by the DHHS. The audit would apply to certain detention facilities for children, the Youth Parole Program, Child Protective Services in rural counties and the Consumer Health Protection program services and community health services. The audit would review records to ensure the assessments were applied properly. This audit can be absorbed into our regular workload.

Chair Jones:
The hearing is closed on A.B. 255, and the hearing is opened on A.B. 495.

ASSEMBLY BILL 495: Abolishes the Committee on Co-Occurring Disorders. (BDR 40-571)

Assemblywoman Irene Bustamante Adams (Assembly District No. 42):
I had the honor of serving as chair of the Sunset Subcommittee of the Legislative Commission during the 2011-2012 legislative interim. This Subcommittee originated with the enactment of S.B. No 251 of the 76th Session. It was a bipartisan effort sponsored by then-Assemblywoman Debbie Smith and Senator Ben Kieckhefer.

Our mission was to review all boards and commissions in Nevada that are not provided for in the *Nevada Constitution* or established by an Executive Order of the Governor. We were tasked with reviewing over 170 entities over the next 10 years. This first year we completed reviews on 29 entities. The Subcommittee is charged with determining whether those entities should be terminated, modified, consolidated with another board or commission or continue unchanged.

I have provided this Committee with the findings (Exhibit Z). A summary of the findings and recommendations can be found on pages 15 and 16 of Exhibit Z. A letter from the Chair of the Governor's Committee on Co-Occurring Disorders (Exhibit AA) has been provided to the Committee explaining the reasons for its termination.

Chair Jones:
The hearing for A.B. 495 is closed. There being no further business before this Committee, the meeting is adjourned at 6:33 p.m.

RESPECTFULLY SUBMITTED:

_____
Jackie Cheney,
Committee Secretary

APPROVED BY:

_____
Senator Justin C. Jones, Chair

DATE: _____

EXHIBITS				
Bill	**Exhibit**		**Witness / Agency**	**Description**
	A	1		Agenda
	B	8		Attendance Roster
A.B. 351	C	7	Assemblyman William C. Horne	National Highway Traffic Safety Administration
A.B. 351	D	10	Assemblyman William C. Horne	THC Concentrations Study
A.B. 351	E	2	Steven Yeager	Letter from the Clark County Office of the Public Defender
A.B. 351	F	7	John T. Jones Jr.	Westlaw site of *Love v. State*
A.B. 351	G	11	Laurel Stadler	Letter from Northern Nevada DUI Task Force-Rurals
A.B. 351	H	4	Assemblyman William C. Horne	Legislative Counsel Bureau opinion
A.B. 351	I	2	Amy Ronshausen	Letter from Save Our Society From Drugs
A.B. 351	J	2	Shirley Morgan	Letter from Oregonians Against the Legalization of Marijuana
A.B. 147	K	17	Assemblyman James Ohrenschall	Several publications regarding mammograms and dense breast tissue.
A.B. 147	L	3	Assemblyman James Ohrenschall	American Society of Breast Disease publication
A.B. 147	M	2	Assemblyman James Ohrenschall	American Medical Association Informed Consent document.
A.B. 147	N	1	Assemblyman James Ohrenschall	Clinical Navigation Options Chart

A.B. 147	O	10	Assemblyman James Ohrenschall	DHHS Snapshot of Women's Health Nevada—2012
A.B. 147	P	2	Assemblyman James Ohrenschall	Argument: Mammographic Breast Density Stability and Assignment of Mammographic Breast Density
A.B. 147	Q		Wendy Damonte	Video on Mother Dying of Breast Cancer
A.B. 147	R	3	Michael Hackett	Letter of support from Dr. Keith Brill
A.B. 147	S	1	Lesley Pittman	Proposed Amendment
A.B. 147	T	1	Elisa Cafferata	Letter from Planned Parenthood outlining concerns
A.B. 147	U	1	Denise Selleck Davis	Letter from Nevada Osteopathic Medical Association requesting amendment.
A.B. 147	V	1	Chair Justin C. Jones	Susan G. Komen for the Cure letter regarding access to screening and increased education
A.B. 147	W	4	Chair Justin C. Jones	Publication from ACOG regarding state legislative mandates on mammography and breast density.
A.B. 144	X		Rachel Bowe	Video

A.B. 255	Y	6	Assemblyman Peter Livermore	Letter to Senator Kieckhefer and Assemblyman Livermore from the Carson City Board of Supervisors
A.B. 495	Z	38	Assemblywoman Irene Bustamante Adams	Sunset Subcommittee of the Legislative Commission Bulletin No. 13-17 January 2013
A.B. 495	AA	1	Assemblywoman Irene Bustamante Adams	Letter from chair of the Governor's Committee on Co-Occurring Disorders.