MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Ninth Session
May 29, 2017

The Committee on Health and Human Services was called to order by Chairman Michael C. Sprinkle at 4:03 p.m. on Monday, May 29, 2017, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/79th2017.

COMMITTEE MEMBERS PRESENT:

Assemblyman Michael C. Sprinkle, Chairman
Assemblywoman Amber Joiner, Vice Chair
Assemblyman Richard Carrillo
Assemblyman Chris Edwards
Assemblyman John Hambrick
Assemblyman William McCurdy II
Assemblywoman Brittney Miller
Assemblyman James Oscarson
Assemblyman Tyrone Thompson
Assemblywoman Robin L. Titus
Assemblyman Steve Yeager

COMMITTEE MEMBERS ABSENT:

Assemblywoman Teresa Benitez-Thompson (excused)

GUEST LEGISLATORS PRESENT:

Senator Pat Spearman, Senate District No. 1

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Committee Policy Analyst
Mike Morton, Committee Counsel
Kailey Taylor, Committee Secretary
Cheryl Williams, Committee Assistant

OTHERS PRESENT:

Kathleen A. Conaboy, representing Death with Dignity Political Fund
Geoff Sugerman, Policy Analyst, Death with Dignity National Center, Portland, Oregon
Carol A. Parrot, M.D., Private Citizen, Lopez Island, Washington
Frankie Sue Del Papa, Private Citizen, Reno, Nevada
Barbara Thornton, Private Citizen, Reno, Nevada
Kat West, National Director, Policy and Programs, Compassion and Choices, Portland, Oregon
Debbie Black, Private Citizen, Carson City, Nevada
Holly Welborn, Policy Director, American Civil Liberties Union of Nevada
Nick Vassiliadis, Private Citizen, Las Vegas, Nevada
Wendy Stolyarov, Legislative Director, Libertarian Party of Nevada
Jan Gilbert, Co-Founder and Director, Emerita, Progressive Leadership Alliance of Nevada
Marlene Lockard, representing Nevada Women's Lobby
Linda (Lindy) Bruzzone, Private Citizen, Laughlin, Nevada
T. Brian Callister, Coalition Spokesperson, Nevadans Against Doctor Prescribed Suicide
Kirk Bronander, Private Citizen, Reno, Nevada
Evan M. Klass, Governor, American College of Physicians, Nevada Chapter
Kathleen Rossi, Private Citizen, Reno, Nevada
Brianna Hammon, Private Citizen, Reno, Nevada
Deidre Hammon, Private Citizen, Reno, Nevada
Peter Fenwick, State Delegate, American Medical Association
Tadea France, Private Citizen, Reno, Nevada
Linda Buckart, Private Citizen, Henderson, Nevada
Jeremy McNeil, Private Citizen, Reno, Nevada
Melissa Clement, President, Nevada Right to Life
Keith M. Shonnard, President, Northern Nevada Guild, Catholic Medical Association
Janine Hansen, State President, Nevada Families for Freedom
John Fudenberg, Coroner, Office of the Coroner/Medical Examiner, Clark County
Kevin Burns, Chairman, United Veterans Legislative Council
Leandra Cartwright, representing Nevada Psychiatric Association
Nathan R. Ring, representing Laborers International Local 872; and Operating Engineers Local 12
Fran Almaraz, representing Teamsters Locals 631 and 986
Rusty McAllister, Executive Secretary-Treasurer, Nevada State AFL-CIO
Chase Wortham, representing Southwest Regional Council of Carpenters Local 971
Ryan Beaman, President, Clark County Firefighters, Union Local 1908
Mike Ramirez, Director of Governmental Affairs, Las Vegas Police Protective Association Metro, Inc.; and representing Nevada Law Enforcement Coalition
Todd Ingalsbee, Legislative Representative, Professional Fire Fighters of Nevada

Stacie Sasso, Executive Director, Southern Nevada Laborers Joint Trust Funds; and representing Health Services Coalition
James L. Wadhams, representing Anthem Inc.
Alfredo Alonso, representing UnitedHealth Group, Inc.
Keith L. Lee, representing the Nevada Association of Health Plans

Chairman Sprinkle:
[Roll was called. Committee rules and protocol were explained.] We always expect professionalism and courtesy from Committee members as well as those testifying. That being said, we are on a tight schedule. We will hear Senate Bill 261 (1st Reprint) first so that the majority of people in the audience have the opportunity to present to the most members of this Committee. Understand that some of us may have to leave early for the Assembly Committee on Ways and Means, but we will continue with the hearings. Please understand that is just a necessity. The Senate just started their floor session, so we are trying to arrange to have other people present these bills. We are within one week of being done with session, so we need to have these bills heard.

Finally, I hope you all understand the time crunch we are in from what I just said. I am asking everyone to keep your comments short, concise, and to the point. I do not want to hear anyone making redundant comments from people who have spoken before you. It would be helpful if you simply said, "I agree" or "Ditto." I am asking you this nicely right now. If it does start occurring I will have to ask you to wrap it up because we do not have time to hear the same comments over and over again. Many of these issues have already been vetted on the other side, so we need to have the hearing and get comments on the record. If you intend to read any of your statements, I will ask you right now not to do so. We are more than happy to have you submit your written testimony. Much of it has already been submitted and is up on the Nevada Electronic Legislative Information System (NELIS), but at this point, I will not take any testimony that is read. I am more than happy to hear your individual thoughts, but we can always read your testimony on NELIS.

I will open the hearing on Senate Bill 261 (1st Reprint).

Senate Bill 261 (1st Reprint): Revises provisions governing prescribing, dispensing and administering controlled substances designed to end the life of a patient. (BDR 40-17)

Kathleen A. Conaboy, representing Death with Dignity Political Fund:
We have been working with Senator David Parks on this bill for two sessions. We are delighted to present it to you today. The Senator is bringing this bill on behalf of terminally ill patients who suffer unbearable pain and loss of physical control at the end of their lives. The policy in this bill proposes that suffering patients should have the right to a peaceful and dignified death under their own control.

The Senator had intended to walk through the bill so that you understand it section by section, so I will proceed in that regard. I will come back to section 1, which deals with death certificates. Sections 1 through 10 are simply definitions. Section 11 details the requirements for eligibility to participate in the death with dignity program. Patients must be able to self-determine that they would like assistance in dying. They must be 18 years of age, they must be a Nevada state resident, they must be diagnosed as terminally ill by both an attending physician and a consulting physician, and the prognosis must be that they have just six months left to live. They must make an informed and voluntary decision without coercion by others. The bill has protections so that the patients asking this assistance from their physicians must have a private meeting with no one else in the room, short of an interpreter if necessary, so that the physician can assure that this is a personal decision and not being prompted by others. They must be competent, meaning that they have the ability to make and understand the nature of this very important medical decision.

Section 12 details the process for requesting the assistance. The patient must make two verbal requests to an attending physician. The second may be no sooner than 15 days after the first request. The patient must also submit a written request to the attending physician signed by two witnesses not related to the patient and not standing to benefit in any way from their death. This also is submitted to the attending physician. Section 13 is a sample of what that request might look like.

Section 14 outlines the responsibilities of the physician and what the physician must check off before writing a life-ending prescription. The physician must first understand and verify that the patient understands the diagnosis and prognosis that has been given to them. They must refer the patient to a consulting physician for a confirmation of both the diagnosis and the prognosis. They must inform the patient that they may revoke the request at any time. If the patient revokes the request, that revocation is effective immediately. The physician must also review all other available methods to treat or manage the terminal condition, including comfort care, hospice, palliative care, and pain control. The attending physician must describe the probable effects of the prescribed substance. They must describe the importance of having another person present when they self-administer the prescription. They must instruct the patient against using the prescription in a public place. They must recommend that the patient notify their next of kin about the decision they are making.

Section 15 states that if either the attending or the consulting physician is concerned that the patient may not have the ability, the competence, or the mental stability to make this decision, they must be referred to an evaluation by either a psychiatrist or a psychologist. The prescription may not be written until after the report comes back from that consulting physician about whether the person has the capacity to make such a decision.

Section 16 gives the further responsibilities of the physician. These include that the physician must notify the pharmacist of the prescription they are writing. The physician transmits the prescription directly to the pharmacist. The prescription is not handed to the patient. It goes either electronically or by delivery directly from the physician's office. The prescription may only be dispensed to the person intended to take the medicine, or to an agent of the patient, which is identified as such by the patient to the pharmacist.

Section 16.5 provides a very important safeguard declaring that the drug shall not be prescribed on a basis of age or disability of the patient. This is very important. This bill does not condone or legalize end-of-life prescriptions for anyone other than terminally ill patients described in the previous sections. This does not apply to people who are tired of living, and this does not apply to people with a disability. It must be a terminal disease with a six-month prognosis.

Section 17 requires that the attending physician, consulting physician, and the mental health professional, if applicable, document in the patient record all of the steps that have been described in the above sections. This is not an easy process. This is a very difficult and time-consuming process where every step of the way is documented and all safeguards are taken. Both the attending physician and the dispensing pharmacist must then submit specific information to the Division of Public and Behavioral Health within certain time frames as they either write the prescription or dispense the prescription.

I have already referred to section 18. It clarifies the patient's right to revoke his or her decision at any time and it is effective immediately.

Section 19 specifies that only the patient who receives the prescription may self-administer the drug. This is very important. What you will hear from my colleagues, who are also here on behalf of the Senator, is that a significant number of people who have the prescription written for them actually never fill the prescription. It is voluntary.

Section 20 has more to do with the paperwork, and it gives the Division of Public and Behavioral Health the ability to adopt regulations about what information will be reported to the state. This is important as well. Oregon has had this law in effect for 20 years, so there is 20 years' worth of data about the numbers and types of people who use this option. The same thing has been happening in Washington now for nine years. Section 20.5 has the Division compile an annual report so that the state can track the implementation of this bill.

Section 21 states that the physicians, psychologists, and/or pharmacists who participate in the process as described in the bill are not subject to professional discipline and do not violate applicable standards of care.

Section 22 very importantly states that the death of a patient under this protocol described in this bill is not suicide or homicide and may not be reported as such. Section 1 requires that the underlying disease be reported on the death certificate as the cause of death.

Sections 23 and 24 provide further patient protections. Section 23 prohibits any person from requiring a patient to make or revoke their decision as a condition of that person providing health care to a person or as a condition of a will or any other legal document. Section 24 states that it is unlawful for a person to forge a request for the prescription, to exert undue influence on a person to request this, and/or to encourage an ill person to self-administer this life-ending drug.

We have been talking about patient protections until now. Section 25 is important because it provides important protections of conscience. This section states neither physicians nor pharmacists are required to participate in this option for treatment. If a physician feels that he or she does not want to be involved in helping a patient to exercise this option, they would refer them to someone else. Section 26 has the same protections for people who own or operate health care facilities like nursing homes, hospice, or hospitals.

Section 29 says that any provision in a will executed on or after the effective date of this act that requires a person to request or take this drug is unenforceable and void. Section 30 provides that a person who asks for this option is not automatically deemed to need a guardian to otherwise make decisions for them. You could not assign a guardian based solely on their request to take advantage of this option.

Section 31 addresses confidentiality of data. You will also notice that sections 32, 33, and 39 through 53 were deleted in the amendment that Senator Parks presented in the Senate Committee on Health and Human Services. That is to make the bill silent on the provisions of health care insurance products. There is neither a mandate nor a prohibition in this bill that would consider this type of service to be a covered service. It is, as with all benefits, up to an individual insurance company whether they will cover this benefit.

Section 34 limits the provisions of this bill to attending physicians. You all know that there are others in the state who have the authority to prescribe controlled substances, but this bill limits that option to physicians only. Section 35 reinforces that the prescriptions are not public records and may not be divulged by pharmacists except under certain circumstances, including the report to the Division of Public and Behavioral Health.

Sections 36 and 37 provide that the life insurance policies that may be in effect may not deny a claim or cancel a policy or impose additional charges or refuse to sell or issue a policy or charge a higher rate, solely because the person has requested such a prescription.

Finally, I will go back to section 1. I did briefly mention this. Section 1 requires that on the death certificate, the underlying terminal disease would be listed as the cause of death.

With me today are Geoff Sugerman, who is a policy analyst for the Death with Dignity National Center, and Dr. Carol Parrot, who is a consulting physician in Washington State and works with Death with Dignity on protocols for patient advocacy and educating physicians about how to best use this law.

Geoff Sugerman, Policy Analyst, Death with Dignity National Center, Portland, Oregon:

[Read from (Exhibit C).] In 1993, I was hired to run the original campaign to pass this law in Oregon. After Oregon's law was approved by voters in 1994, it faced three years of court challenges all the way up to the United States Supreme Court and a second, even more decisive, vote of Oregon citizens. The law went into effect 20 years ago this November. Since then, some 1,200 Oregonians have used this law safely and compassionately. This law has been passed in essentially the same form in Washington State, California, Colorado, Vermont, and Washington, D.C.

Despite the flawless implementation of this bill in every jurisdiction, you will hear the very same arguments from opponents today that we heard 20 years ago: threats of coercion, unscrupulous doctors and insurance companies conspiring to deny patients care, targeting the disabled. Not one of them is true. There is not a single case of coercion or forced participation anywhere; not one.

Throughout S.B. 261 (R1), you will see a series of safeguards and a well-defined process to protect the patient, the health care professional, and the family— all designed to ensure that the patient is in control, acting voluntarily, and is able to make his or her own health care decisions. The multiple safeguards in S.B. 261 (R1) include:

- A diagnosis that the patient is within six months of death, verified by a second opinion. That is the same standard used to determine participation in hospice care.

- A mandatory counseling referral if either the primary or attending physician believes the patient may not be competent to make this health care decision.

- There are two oral and one written request. The written request must be witnessed by at least two people, one of whom cannot be the physician, a family member, or someone who might receive an inheritance from the individual.

- Two waiting periods are required, 15 days between oral requests and at least 48 hours after the written request.

- The patient may opt out at any time and for any reason.

- The patient must self-administer the medication.

- Any health care professional may choose not to participate.

I really want to reiterate that last point. There is no requirement that any health care professional, any doctor, any nurse, any health care facility, or any pharmacist must participate in this law. We included that in the original version of the law back in 1994 because we felt it was critically important that every person involved in this process must do so voluntarily.

The Death with Dignity National Center recently commissioned a poll of Nevada voters and found that 72 percent of your citizens want this option. We have included the entire survey, cross tabs and all, in the legislative record (Exhibit D). Support for the bill is bipartisan, diverse, and broad-based, with majorities of women (69 percent), men (76 percent), Democrats (80 percent), Republicans (66 percent), Independents (67 percent), Catholics (66 percent), Protestants (65 percent), and voters of all ages and education levels in favor of expanding the rights of the terminally ill. Overall support rose to 75 percent when we presented arguments in favor and against.

Recently, Oregon was named by the *New England Journal of Medicine* as the state where the most people die at home or in hospice care, surrounded by loved ones and family. This law will not diminish our love and care of dying patients. It will enhance those efforts to make patients as comfortable as possible as they face the inevitable on their own terms. It will give these dying patients the knowledge that, at the end of their lives, they will have control. We urge your passage of S.B. 261 (R1). Thank you very much for the opportunity to testify today.

Carol A. Parrot, M.D., Private Citizen, Lopez Island, Washington:
I am a licensed physician in Washington State. After practicing anesthesiology for 30 years, I retired and now work as a volunteer physician for the State of Washington and practice with terminally ill patients only. I will omit a lot of what I wrote because it has been talked about already. You can find it on the Nevada Electronic Legislative Information System (NELIS) (Exhibit E).

I want to tell you about some things from a physician's standpoint. It has been argued that it is impossible to figure out when a patient is six months from death. That is not exactly true. Hospice does this all of the time. We use the functional assessment scale, we use the palliative performance scale, and we use the hospice eligibility scale. If there is a question, we call the specialty physicians who have done tests and studies on patients and ask them for the most recent information in their literature so that they can either confirm or deny that the patient is in the last six months of expected life span.

Our data from Washington is not out yet for 2016. In 2015, 142 different physicians participated in qualifying patients for Death with Dignity. It is not only three doctors who take care of all of the patients who want to use the law; doctors throughout the entire state are participating as their patients are asking more and more. The graphs from Oregon and Washington show that the number of patients in both states started out fairly low and it goes up only a little each year. The fraction of patients who are dying who use this is very small, but they are significant, and they really want this. Patients are always strongly encouraged to discuss the option of death with dignity with their families. We want the families involved. It has happened that with patients who have not communicated with their families for years, bridges have been rebuilt during this time and their families have joined them to participate in their death.

We are offering the patient a painless death of comfort and peace, or to quote a supporting family member, "an amazing experience of happiness and sadness for everyone there." It would be impossible for insurance companies to talk patients into this. No company could force the patients to go through this. It takes a lot of effort on the patient's part. There is at least a three-week span of which they have to do all of the requirements that have already been listed. Analysis of the yearly data for patients in Oregon and Washington who have used the Death with Dignity law since 1998 show no indication of the slippery slope that has been threatened with everyone for the past 20 years. In addition, in Washington State, our patients are required to pay for their own medications out of their own funds. Insurance does not pay, Medicaid does not pay, and because Medicare is a federal program, they refuse coverage.

For this reason, last summer, I worked with a team of physicians in Washington, organized by End of Life Washington (EOLWA) to offer new, effective, safe, reliable lower-cost medications to our Death with Dignity patients. After we completed trials and modifications, this new drug regimen is now being offered as an alternative to expensive secobarbital, in all states where physician–aided dying is legally available.

End of Life Washington is a non-profit organization that offers information and support to physicians, pharmacists, and patients working with end-of-life issues. Trained client support volunteers are available to assist patients and their families throughout the state. Since 2009, EOLWA has been tracking data, and they routinely communicate with the participating physicians and pharmacists to ensure they have the most up-to-date information on the drug regimens available. This information is readily shared both nationally and internationally with physicians and appropriate organizations.

I would like to end with this thought: I truly hope that you consider allowing the diverse residents of the state of Nevada this human right and dignity. Most of your constituents will not choose it, but those who do, and their families, will thank you forever. I appreciate your time and attention today.

Chairman Sprinkle:
Thank you very much. Is there anyone else that is part of the initial presentation?

Kathleen Conaboy:
That was our official presentation; we have others here in support.

Chairman Sprinkle:
At this point, I will open up to questions from the Committee.

Assemblywoman Titus:
Thank you all for being here. I know this is emotional and everyone will have their story on either side. I have questions specific to the bill itself. In section 1, subsection 3, it talks about the certificate of death. It states the physician must sign it and shall specify that the terminal condition in which the patient was diagnosed is the cause of death of the patient. I am somewhat uncomfortable with that as a physician. I sign many death certificates. It is not like I want to, but in my course of practicing for 35 years, patients do go through life and they do die and I have to sign their death certificate, and there are multiple lines on that. A patient that I have diagnosed with prostate cancer may not die from that prostate cancer for ten years down the road. They might have a heart attack before they die of that prostate cancer. I am concerned that you are mandating that we say they die from that terminal disease, even though they may have a plethora of other diseases they could have died from before they die from that terminal disease. Does that happen very often in these other states? Is that a concern?

Carol Parrot:
That does not happen because the patients with prostate cancer who might live ten years, would not be considered terminal. Unless one of those other diseases was expected to kill that patient within six months, he would not qualify for the law. If his prostate cancer had metastasized to so many different organs that he was at risk for dying of, let us say, brain tumors and herniation, and his death was expected within six months, then his diagnosis would go down as prostate cancer with metastasis to his brain.

Assemblywoman Titus:
I have another question regarding section 36. Do all states mandate that an insurance company sell life insurance to someone who they know has a terminal illness? This says that insurance companies cannot refuse to sell, provide, or issue life insurance. So, they cannot refuse to sell life insurance to someone who has purchased or has plans to purchase this medication. Is that correct?

Geoff Sugerman:
The concept behind the life insurance policy portion was to ensure that policies could not be denied post a patient's death. That is the main intent of this portion of the legislation. What you are referring to here is really about denying claims and not denying coverage. I do not think it requires them to offer coverage to a person who was recently diagnosed with a terminal illness and does not already have life insurance. It is really designed for those people who have existing life insurance policies.

Assemblywoman Titus:
Thank you. I definitely think this would need a clarification because the way this is worded, it says that you cannot refuse to sell, provide, or issue a policy of life insurance to someone who has purchased or applied for this controlled substance. I am very concerned about that, and I think we need some clarification for the record on those. Finally, in the bill it states that no physician can be prosecuted or found to have committed malpractice for prescribing the medication. Where does that leave a family who perhaps felt as though they

were misguided? Is there a clarification that exempts any wrongdoing by a physician? Along that same question, have there been any complaints against doctors in other states who have these laws? Have there been any patients who sued the physician later?

Carol Parrot:
There have been no lawsuits from patients who have used the Death with Dignity drugs.

Assemblywoman Titus:
Have there been any complaints against any physicians who prescribe this medication in these states?

Carol Parrot:
The patient makes three requests. They are told over and over again by the doctors and everyone else they work with that they never have to take the medications. I strongly advise my patients to leave their prescriptions at the pharmacy and not fill them. It saves between $700 and $4,000 to leave the prescription in the pharmacy in case they change their mind, become sicker, or lose competency. I suggest they fill their prescription a day or two before they decide that their disease is so intolerable that it is time to take their medicine. At that time, I suggest they pay their money and pick up the prescription. However, if they never want to take it, they never have to. There is no coercion. It is up to the patient and the family. When I write the prescription, I do not call them again. I find out months later that they have died and whether they have taken it. Then I fill out five pages of forms in addition to the previous forms and send them into the state of Washington.

Assemblyman Hambrick:
You are talking to a prostate cancer survivor. If I may, how accurate are physicians in predicting life expectancy when giving a terminal diagnosis?

Carol Parrot:
Because there are scales available that have been published by Medicare that are used to allow patients to be put in hospice, hospice has the same exact requirement that the patient should be within six months of expected death. Those scales cover both general characteristics of patient weight loss, eating, being able to walk, and they cover disease-specific characteristics. Medicare has published these. They are used to putting patients in hospice because they expect patients to die. Those are exactly the same scales and judgments we use.

Assemblyman Yeager:
You have indicated that Oregon has had this for some time now and some other states have come online. Is there any data to know how many people have essentially relocated from states they lived in where this was not an option to those states in order to take advantage of this opportunity? I do not know if that data is out there, but if it is, I would like to know about it, and if you have anything in writing you could share, I would appreciate that as well.

Geoff Sugerman:
It is a very rare occurrence. You probably know of Brittany Maynard from California, who moved to Oregon to take advantage of the law several years ago. Her mom was able to testify during the hearing in the Senate. I would encourage you to look at that if you have a chance to do it. We do not specifically record that data in Oregon, but we do know that there are very few incidents of people who have not actually been in the state for some time. It is not a common practice. That was one of those things we heard would happen, but it never really materialized except in a rare case. Incidentally, you will hear from someone from Carson City who does not want to have to make that choice.

Assemblyman Thompson:
In your opening comments you talked about how there has to be a private meeting and it has to be the patient, the doctor, and maybe an interpreter. I have asked this question in my office, and I have asked it twice to two different groups. I just want to see where in the bill it specifically states that. The reason is, many times when people are terminally ill they look to the family for support. Sometimes families make decisions together. A person may feel scared to have to be in that room with the doctor and to have to make that decision on their own.

My second question is in section 19. It talks about the fact that the patient can be the only person to administer the controlled substance. What if the person always needs a caregiver and needs assistance with taking their regular everyday pills? Also, it talks about discarding the medicine. I would think that would be something that is very time-sensitive. We would need to remove that drug as soon as possible. Is that correct? We would not want it to get in the hands of anyone else.

Carol Parrot:
The medicine is dispensed as a powder in a small vial or a glass jar. It is mixed with about a half a cup of liquid right before the patient is to take it. That liquid can either be water, clear juice, or alcohol if the patient so chooses. It needs to be drunk in a minute or two. I tell my patients in advance there are two important things, no matter how much they want to take this medicine, to be aware of. They have to be able to drink a half cup of liquid in one to two minutes because if they do not get it all down, it may not work. The other thing is they have to be competent. The patient has to be of sound mind and know what that medicine is for the day they take it. If someone walks in with it and the patient asks what it is for, he or she is no longer competent and is no longer eligible to take the medicine. The volunteers in Washington State know that and check that out. When volunteers are not present, for instance in California where physicians are sometimes present, if only a family member is there, we send detailed instructions to the family member about how to mix the substance and how to have the patient drink it, as well as other information that they need to report to the state.

Geoff Sugerman:
The answer to your first question is in section 14, subsection 3. The situation we are talking about here is an additional safeguard that was added in some states after the Oregon law was originally written in order to address concerns of people that there might be coercion at work in this situation. It is not that the patient can only meet privately with the physician, but it is required that at least on one occasion, the physician meet privately with that patient to make sure there is no coercion happening. In most cases, you would find that the family is intimately involved and a part of the process, but this is an added safeguard to make sure the patient is acting completely voluntarily.

Assemblywoman Miller:
We know that when we talk about terminal diseases, in the six months before what would be predicted as the end of their life, there are many diseases where dementia eventually will become a huge part of that disease. Are there no cases or states that accommodate that, knowing that dementia is going to occur?

Carol Parrot:
Unfortunately—and this is really sad for Alzheimer's patients and their families—they do not ever qualify for the law because they have lost their decision-making capabilities. You cannot use your advanced directive saying, "Can I use this if I develop dementia?" The answer is no. This is to be used only in patients of sound mind. If, as in a brain tumor patient, someone may become very confused and lose their competency, while they are still competent and making their requests, I tell them that as soon as they start to become confused their families need to watch because it is now or never. They take their medicine or they lose their window. Once they develop dementia, they are no longer a candidate for this law. That is unfortunate. It is the same situation for someone who cannot self-administer the medicine. If they cannot lift up a glass, sip through a straw, or they are too weak to swallow more than a teaspoon at a time, unfortunately, they are no longer candidates for this law.

Assemblyman McCurdy:
Thank you for bringing forth this bill. I was wondering if there is a percentage of patients who asked for this medicine that decided to depart away from it and decided not to do it? If they did decide that, what happens to the drug afterword?

Carol Parrot:
The medicine can be turned in to specific toxic substance collection agencies, or it can be turned into the police department. The police will take care of that; they have lockers and things for controlled substances, and they will dispose of it. I have had a patient who mixed the medicine, but then died before the cup was ever put in her hand. The police came when they were notified of the death, and the medicine was given to the police. It should be disposed of quickly. Each state determines where they want the medicine to be sent.

Assemblyman McCurdy:
You said it must be discarded according to law. Say this was to move forward, what would that time frame be and how would we follow up on its proper disposal?

Carol Parrot:
The time frame should be as soon as the family remembers the medicine is there. Most families do not fill the prescription unless the patient wants to take it. Why would you spend so much money to not take it? Most patients have limited funds after they have been sick for a long time. If they have to shell out $700 and they are not sure they are going to take their medicine, they should not fill that prescription, so it is rarely an issue. If someone will only sleep at night knowing he or she has it, it can be filled. If they never take it, the family should make a point to take it to the state's designated drop-off area.

Assemblyman McCurdy:
The first question I asked was what is the percentage of folks who decide not to move forward with this after going through the proper steps?

Carol Parrot:
In the combined data of Washington and Oregon, of the number of prescriptions written, the number of prescriptions taken is 66 percent, while 34 percent were not.

Assemblyman Oscarson:
The physicians I have spoken with, in some instances, are wondering how it would be prescribed. Is there any kind of a training mechanism that physicians would have to go through before they prescribe this? Is there any assessment they would do that would enable them to feel more comfortable doing this? It is contrary to what they are taught to do. It is completely contrary to the Hippocratic Oath they took. I am interested to know how you will work through that process with the physician and how you will prescribe this.

Carol Parrot:
As far as it being contrary to the Hippocratic Oath, there are divided opinions on that. The Hippocratic Oath says I am taking the best care of my patients and their family, as well. Other factors of the patient's life actually come in to play. I do not think it is against the Hippocratic Oath.

Now, as far as what medicine is prescribed and how doctors would find out about it, this process started out very small. In 1998 in Oregon, they started using megadoses of sleeping pills. Because of politics and capital punishment, pentobarbital is no longer available in the United States because France will not send it here because it is used for capital punishment. Secobarbital is about as good and is made from a Canadian drug company. That drug company has increased the price from $500 to $3,500 in the last six years. That is not affordable for most patients. That is why we came up with a new formula last summer.

It started out with eight physicians. We did trials on it. That information is available to physicians in all states. All you have to do is call End of Life Washington, Compassion and Choices, or you can call the Death with Dignity National Center. You can get information on which prescriptions are being used in all of the states.

In Washington, I just finished working on a primer for participating physicians with one of the medical directors of End of Life Washington. It is about a ten-page booklet that will probably be put on the Internet through the End of Life Washington website for physicians only. That would also be shared. There are some publications out there. We are starting to publish in medical literature.

There is no continuing medical education (CME) available on this yet. There have not been enough states doing it until just now. It may be that the CME is developed. The Death with Dignity National Center has committed to developing a CME if it is so wanted, whether it is your state that requests it, or whether another state requests it. We were discussing that earlier today.

Geoff Sugerman:
We did indeed discuss that very issue with Assemblywoman Titus this morning. Our executive director and our organization have committed to developing a CME. We believe that it fits within the existing statutory law of Nevada and does not require any additional amendments. We will certainly work with the Legislature and the Board of Medical Examiners here to prepare that CME and offer it to Nevada as well as other states. In addition, I think most of the doctors who work in this field are doctors who are oncologists or who are working with people who have terminal diseases. They do communicate with each other. What we saw in Oregon, and what I think Dr. Parrot was saying we have seen in Washington, is that those doctors do find each other and work together. They talk about what the best practice is and what the best standards of care are. They will continue to do that as well.

Chairman Sprinkle:
What is the half-life of the drugs that are used?

Carol Parrot:
Using the drugs, the time to sleep is about five to ten minutes. Patients fall asleep comfortably and do not wake up. The average time to death with both sets of drugs is probably about two hours.

Chairman Sprinkle:
I am really asking how long those drugs stay potent.

Carol Parrot:
If the drugs are dispensed as a powder, their shelf life is six months. If they are dispensed as a solution by a compounding pharmacist, it is two weeks.

Chairman Sprinkle:
We have talked several times now about sections 36 and 37 regarding what it is that insurance companies can and cannot do. I am going to ask you again on the record. In the other states that already have this in law, have there ever been any documented cases where insurance companies have broken the laws that are spelled out in the language here? If so, what were the legal ramifications implied afterward? They are breaking the law and that is what this piece of legislation is trying to address.

Geoff Sugerman:
We know of no instances where life insurance policies have been denied in direct controversy to the statute in that state.

Chairman Sprinkle:
Is that for both life insurance and health insurance?

Geoff Sugerman:
Yes.

Chairman Sprinkle:
With that, thank you very much for your presentations. I certainly appreciate it. I will ask anyone in support of this bill to come forward. Once again, please do not repeat what has already been said. We need to keep this short because I owe it to the opposition to have some time to present as well and we are running short on time.

Frankie Sue Del Papa, Private Citizen, Carson City, Nevada:
I am here to speak to the main consideration for me regarding this legislation, and that is self-determination. Yesterday's *New York Times* front-page article that takes up almost six full pages is a piece entitled, "The End, A Parting Gift—The Death and Life of John Shields." It is a very comprehensive story of a former Catholic priest's last journey, of dying openly and without fear, which, in his words, made him feel empowered over his disease, rather than crippled by it. I could share with you many things, such as the experiences of the statewide task force that Barbara Thornton and I co-chaired on Death with Dignity, now over 20 years ago. We did this, in large part due to our respective observations of our parents' deaths. I could share the experiences of the Nevada Center for Ethics and Health Policy, which was established at the University of Nevada, Reno with the strong support of former state Senator Bill Raggio. I could go on and on. I respectfully urge your favorable consideration of S.B. 261 (R1) in the name of self-determination. Our families deserve it. Nevadans deserve it. However, it is about much more than death with dignity. It is also, as the *New York Times* article says—a parting gift.

[(Exhibit F) was submitted as additional testimony.]

Barbara Thornton, Private Citizen, Reno, Nevada:
I was a professor at the University of Nevada, Reno where I taught medical ethics. Death has always been an issue. It became a serious issue about 20 years ago. I attended a national bioethics institute conference where a physician told us he was going to leave his post as head of the British Medical Association because he knew that he and all of his contemporaries did help their families with the end of life. That moved me to think that we needed to start talking about death honestly and openly. This was best done when Brittany Maynard's mother came to tell us about Brittany's death. She was 29 years old and newly married when she became violently ill. She knew she was going to die, and she wanted to die openly so that other people would understand this process and why she would ask for physician help. She had to leave California to go to Oregon because, at that point, California did not assist with the medication. She decided to talk very openly about her case. I think it was very moving. I am sure all of you heard her talk about it.

The issue here is one thing. The issue is self-determination. That is why this bill uses those words. The only person who should determine they take the medication is the patient himself or herself. It is irresponsible for all of us to tell them what to do. At the same time, physicians and family members must have a role in all of this. No one has to be coerced in any profession or any patient. We just need to have self-determination in making the decision.

Kat West, National Director, Policy and Programs, Compassion and Choices, Portland, Oregon:
Compassion and Choices is the largest nonprofit in the nation committed to improving care and expanding choice at the end of life. Compassion and Choices is able to provide accurate and evidence-based information to policymakers because we play a very important role. I am here to talk about the implementation phase of medical aid in dying law. Once a law becomes enacted, we work very closely with doctors, hospice staff, and health systems to provide education and to provide technical assistance. We also work closely with terminally ill people and their families to provide education and support.

Assemblyman Oscarson asked about education. There is a large body of education for doctors. In the *Journal of Palliative Medicine,* in 2015, the clinical criteria around medical aid in dying were published. In addition, there is a large body of education on Compassion and Choices' website specifically aimed at supporting and educating doctors and medical physicians. We have the Doc2Doc Program, which is a free and confidential line where doctors across the nation can call and learn about the medication.

Assemblywoman Titus asked if there have been any complaints with any medical boards in any of the states that have authorized medical aid in dying. There are six states right now plus the District of Columbia. There have been no complaints with the medical boards. You also asked about the immunity that is provided in medical aid in dying laws. I would like to take a second to explain that.

The medical community is provided immunity from charges such as assisted suicide or homicide. It gives them immunity for compliance with the steps of the act. It does not provide immunity for malpractice or any other potential malfeasance. It is very focused on that. Thank you very much.

[(Exhibit G) and (Exhibit H) were submitted as additional testimony.]

Debbie Black, Private Citizen, Carson City, Nevada:
I was diagnosed with breast cancer 27 years ago, when my son, who is here to support the bill, was only five months old. About six and a half years ago, I was diagnosed with metastatic breast to brain cancer. My biggest worry has been that my son's last image of me will be of someone he does not recognize anymore—the stereotypical image of someone dying from cancer, a shadow of a person who once was; frail, doped up with so much medication just to tolerate the pain with no quality of life left. In the past, I have considered moving to another state where they have legalized this, but to do so would take me away from my only son, my new granddaughter, my family, extended family, and my friends. I know some people do look at this as assisted suicide, but I do not. I did not choose this terminal illness, but I should have the right to choose how much I want to suffer. The reality is my cancer is going to kill me. I hope you will consider what I have said here today and make it possible for me and others living with terminal illness to make that decision when our time comes.

Holly Welborn, Policy Director, American Civil Liberties Union of Nevada:
I will submit longer, prepared arguments, but I do want to testify in strong support of S.B. 261 (R1). The right of individual autonomy protects people's constitutional right to control their bodies and to make end-of-life decisions. There is value in having aid in dying legal and transparent. States with bans have tolerated gray markets where people with resources can find sympathetic doctors to give them medications, but those with limited resources often use self-induced means that fail. When the process is open and transparent, it can be regulated and we can keep people safe and keep the process transparent. End of Life Choices already recognizes an accepted legal principle; a competent adult's unqualified legal right to decline medical care is accepted where clear and convincing evidence exists that the patient wished to end life support, such as through an advanced directive.

Finally, aid in dying laws open communications between the doctor and the patient to promote the right of the person to choose to keep living. A statistic from our Disability Rights Project showed that 1 in 25 patients who asked a physician about aid in dying actually requested the medication. Because the patient and the physician can speak openly about end-of-life options without fear of criminal liability, those patients are free to discuss their fears more openly and seek alternative options. For these reasons, we strongly support this bill and encourage your vote.

Nick Vassiliadis, Private Citizen, Las Vegas, Nevada:
What brings me here today is a promise I made to the daughter of one of my mentors who passed away earlier this year after the third time he had a battle with cancer. That last one was just too much. I know you have asked us to keep it brief, so I just urge this committee to watch the testimonies during the Senate Committee on Health and Human Services hearing of this bill. Please strongly consider supporting this bill because this means a lot to many people.

Wendy Stolyarov, Legislative Director, Libertarian Party of Nevada:
I would simply like to say we strongly support this bill as a matter of individual autonomy. We echo the comments of the American Civil Liberties Union of Nevada, and we urge you to support it. We do not presently have a position on the insurance provisions of this bill, but we encourage you to support it.

Jan Gilbert, Co-Founder and Director Emerita, Progressive Leadership Alliance in Nevada:
We say ditto. I am at an age where many of my friends talk about this. They talk about going to Oregon and collecting this medication as well as other things. This is a humane way to do it. Please pass this bill. Nevada needs to be at the forefront of this.

Marlene Lockard, representing Nevada Women's Lobby:
We strongly support this measure for the reasons you have heard today. We feel this is very much an issue of self-determination. We urge your support.

Chairman Sprinkle:
I appreciate everyone staying concise and to the point. Is there anyone in southern Nevada wishing to come forward under support?

Linda (Lindy) Bruzzone, Private Citizen, Laughlin, Nevada:
I am an author, an investigator, and a retired peace officer. More importantly, I am a mom. More importantly, I am a mom and I am a grandmother. My family has hereditary cancers. We have watched everyone in our family die of cancer up until our generation. I have a twin brother and one sister. Between the three of us, we have had seven cancers. We know how we are going to die sometime. Our children and grandchildren also have this genetic condition. Statistically, 1 out of every 270 to 370 people have this condition. Less than 10 percent are diagnosed. We have aggressive cancers and they keep coming. Most of us have had resections. We have done everything we can to embrace life. We love living, but we know how we are going to die someday, and we have seen how our families have died. We are asking that you please take into consideration that this bill is not about life. This bill is about the process of dying and it is preserving the reputation and the character of the individual during life. When our children look at us, they say we are a reflection of them. We do not want them to be a reflection of someone dying of cancer. We want them to be a reflection of someone living. Thank you for your time and for listening.

[(Exhibit I) was submitted as additional testimony.]

Chairman Sprinkle:
Is there anyone else in support wishing to come forward in southern Nevada or northern Nevada? [There was no one.] We will open it up for opposition.

T. Brian Callister, Coalition Spokesperson, Nevadans Against Doctor Prescribed Suicide:
I thank you for giving us the courtesy of adequate time to present our opposition to this bill. First and foremost, you need to know that this coalition against assisted suicide in Nevada is diverse. It comes from the right and it comes from the left. It is made up of physicians, nurses, and pharmacists. It is people who believe this policy is wrong for a variety of reasons that I will address briefly.

First, we need to address the question of pain head-on. I noticed in the Senate hearings, and I hear it again today: it is as if there is this underlying premise that the end of life guarantees pain and suffering. We hear unending pain. Honestly, I feel for every one of these patients and families that you have heard tell their stories. But, I also need to tell you, as a physician on the front lines, that on May 29, 2017, if you are terminal, you do not have to die in pain. We have the medications, the skill, the expertise, the training, and the programs for you to die a comfortable death without having to overtly kill you.

With that being said, I think it is critically important to understand that a terminal diagnosis of six months or less is an educated guess at best. The physician from Washington who attempted to answer your question said this is the same rule as hospice uses. That is true. Assemblywoman Titus and others can attest to the fact that all physicians will tell you that we put people on hospice and say we think it is six months or less. We take them off hospice as well. I see patients in the grocery store two years later who were on hospice that say, "Doc, I am still around." At the beginning of the terminal diagnosis, we really do not have a good idea. The medical literature is clear on this. Our average error ranges from 50 to 70 percent off, but it is sometimes shorter and sometimes longer. I would not want to have you, who could have years and months of quality time left in a despondent state, in an impulsive way say you want to end your life. I have had numerous terminal patients tell me that was their fear and that if those pills had been available during a dark night on month three or month four, they would have taken those pills. I talked to a patient, JJ Hanson, this week, whose testimony is on NELIS (Exhibit J). He has the same diagnosis as Brittany Maynard. He is three years out, and he tells me he is doing great. He told me if he had those pills in his nightstand somewhere around month five, he probably would have taken them.

Now we need to go briefly to the poll that the proponents keep telling you about; a poll they sanctioned where they say 70 percent of Nevadans are for this. That is very interesting. One of the questions in the poll was the following statement: "It is my body and my choice to make the best medical decision for myself in consultation with my doctor, including my end of life decisions." Who could be against that? Like any poll, it is all about how you word the question. In fact, to refute that, if you go to your legislative website, as of noon today, 949 people have weighed in on this bill and 700 of your own constituents are against this bill. That is 74 percent against this bill. That has been consistent since this bill has been introduced. It has ranged from 73 to 76 percent against this.

We are bad at predicting how long you have when we give you a terminal diagnosis. When you get to the very end, we have the ability to control your pain and symptoms. Are we perfect? The answer is no, but that is where we need to spend our time—continuing to improve end-of-life care and making sure more physicians are trained rather than giving you these pills as a wild guess with perhaps months or years to go while saying, "Oh let us not take a chance and just kill yourself now."

With that being said, I like to tell a story about an insurance situation I have had. I want to address this upfront because people have asked me why I do not name insurance companies and name patients. It is because of the Health Insurance Portability and Accountability Act (HIPAA). Neither one of the patients I had in the story I am about to tell you is able, available, or capable of being here or even signing a release. I ran my story by a HIPAA lawyer who told me that, just by identifying the insurance companies, the numbers are small enough that I could be open to HIPAA prosecution because those patients could be potentially identifiable without their permission. That is the only reason I have not named the insurance companies or the patients.

I had two occasions where I was trying to get patients transferred, one to Oregon and one to California, for life-saving procedures—not palliative care and not hospice. These would have been curative procedures. The insurance company said they would not cover it. As physicians, we battle with them all day on the phone. I thought I just had to convince the insurance medical director this was best for the patient. In both cases, the insurance medical director said that they would not cover the procedure or the transfer, but they asked if I had talked to them about assisted suicide. I was stunned. We did not request it, and we did not ask for it. It was offered verbally on the phone to me. If you want evidence, I am right here. If you want cases of coverage being denied, look no further than Barbara Wagner. It was first reported in ABC News in 2008 in Oregon. It is easy to Google and find. This is not something you cannot locate.

Is it a quick, easy death? In Washington State, their statistics show that the time to death ranged from nine minutes to two hours. In Oregon, it ranges from two minutes to four and one-half days.

The last thing I want to bring up is to look at who is testifying for this. You have Compassionate Choices, formerly known as the Hemlock Society. It is probably a good thing they changed their name since Hemlock is a poison. The cofounder of the

Hemlock Society, Derek Humphry, lives in Oregon. If you do not think economics plays a role here on limiting access, look at what he wrote in his book. It says, "In the final analysis, economics, not the quest for broadened individual liberties or increased autonomy, will drive assisted suicide to the plateau of acceptable practice."

I helped craft the Physicians Orders for Life-Sustaining Treatment (POLST) law in this state. I am solidly for great end-of-life care and choices of what to do and what not to do. I am as adamantly against assisted suicide as I am for POLST because there is too much risk. There are too many perverse incentives, and we as physicians are wrong too often. With the suicide rate in Nevada being as high as it is, I applaud Assemblyman Thompson for his bill [Assembly Bill 105], making sure we are educated in recognizing the signs of suicide, and what to do about it. Yet, in Oregon, less than 4 percent of patients are referred for psychiatric or psychological evaluation before giving them the prescription. This is a travesty. I urge you not to let it become a tragedy.

[(Exhibit K), (Exhibit L), (Exhibit M) were submitted as additional testimony.]

Chairman Sprinkle:
Thank you for your comments. I let you go a little longer since you were the first in opposition. We do need to keep the comments short. There are a lot of people in opposition.

Kirk Bronander, Private Citizen, Reno, Nevada:
I am an associate professor of medicine at the University of Nevada, Reno, School of Medicine. I want to state a few things that have not been spoken of by Dr. Callister. I want to go over these safeguards because they keep talking about safeguards. The safeguard that two physicians have to sign off on: this is not an adequate safeguard. Physicians always refer to people that we trust and who will agree with us. We do not refer to folks that will disagree with us. That is how the practice of medicine works. You heard from someone from Compassion and Choices. She said they are here in the post-implementation phase to help the physicians. That is what they do; they refer the patient to the physicians that will help them do this. Two physicians are very easy, and it will not be a safeguard. It is not a second opinion that is unbiased.

Secondly, only one witness needs to have nothing to gain from this. The other witness can be an heir to a fortune. It is very easy to find another witness that will just say, "Yes, this person is competent." That is all the witness is really saying.

Another safeguard is supposed to be self-administration. The patient has to self-administer a medication that causes his or her death. How would anyone know that he or she self-administered the medication? They would be dead. There is nothing in the law that says someone has to witness that. An heir could give this medication to the patient and they will get the money once the patient is dead. It is a perfect crime.

There are many privacy laws, as Dr. Callister mentioned. We cannot violate HIPAA, so all you know about these things is what is sent in the data that the physicians and pharmacists are required to send to the state. It is published every year in the state of Oregon. It is 12 pages long. That is all we know. That is everything we know every year; a 12-page glossy brochure. You do not know which physicians do this. You do not know if they are ophthalmologists, or who they are. It could be any physician. You will not know their names and you will not know their specialties. You will know almost nothing about them because the only thing you will know is the data that is sent in. I think this is a dangerous law. You can see that the safeguards are false, and I urge you to reject it.

[(Exhibit N) was submitted as additional testimony.]

Evan M. Klass, Governor, American College of Physicians, Nevada Chapter:
The American College of Physicians (ACP) represents 145,000 specialists in internal medicine nationwide. In Nevada, we represent over 800 physicians. The American College of Physicians has been called the conscience of medicine, not by me, but by many, including Charles Bryan who published this in *The Lancet*. It has always been our approach that the patient comes first. I am here to speak strongly against physician-assisted suicide.

Make no mistake about it; this is a physician-assisted suicide bill. Since 2001, ACP has had a policy on physician-assisted suicide, and it has strongly and consistently adhered to that policy. It was articulated in a position paper published in the *Annals of Internal Medicine* in 2001. At that time, Oregon had become the first state in the nation to legalize physician-assisted suicide. Since then, only five other states have similarly acted. In 2017, ACP reaffirmed this position in a new position paper. In that time, they have accrued requests for a physician-assisted suicide that have most often been, not for relief of pain, but because of the interpersonal and existential suffering, including dependency, hopelessness, and indignity. Often, support for physician-assisted suicide is framed as support for patient autonomy and, in view of the lack of harm to others and the intensely personal nature of the request, ought not to be prohibited. That is a weighty argument. However, this is not truly an autonomous act; this involves the physician. So, this is not purely patient autonomy; this is an action that requires the active participation of the physician.

The American College of Physicians has always supported the right of patients to refuse care as well as extraordinary efforts to minimalize or eliminate pain, even if there is a chance that life will be shortened. The American College of Physicians recognizes that relief of all suffering is beyond the scope of the physician. As physicians, we commit to compassionate care, which includes palliation of pain and nausea, depression, and anxiety. To us, being compassionate means to suffer with another person. We commit to not abandoning our patients, but to standing beside them through the interpersonal and existential pain of dying, and to enlist the support of others including clergy, social workers, and family.

It is not for the physician to intentionally end the life of the patient to ameliorate those symptoms, but rather represents an egregious overreach that subverts the integrity of our profession and diverts attention from the real issues of caring for the dying. It is far more urgent that we ensure all Nevadans have access to high quality health care, including hospice and palliative care, so that no patient is ever faced with the cruel option of selecting physician-assisted suicide because they cannot access the best palliative care because they reside in a rural or underserved community.

[(Exhibit O) was submitted as additional testimony.]

Kathleen Rossi, Private Citizen, Reno, Nevada:
I have been a registered nurse in Nevada for over 30 years. I have cared for hundreds of people with terminal illness, and I have been at the bedside of numerous dying patients. I am here today in opposition to S.B. 261 (R1). My years of experience tells me that although this may be well-intentioned by some, this bill is a very bad idea and will ultimately harm the very people that it proposes to help. In medicine, we assess caring in view of its benefit versus risk. Removing immorality from this issue, any possible benefit of making assisted suicide public policy is immensely outweighed by the risk. Assisted suicide seeks to justify what has always been ethically wrong and dangerous for the medical community and removes the specific boundaries that exist for a reason. I would advise you as consumers of medical care to be very careful what you wish for. Physician-assisted suicide will only increase the tendency of medical professionals to make judgments about a patient's quality of life and whether they deserve treatment. The truth is it is done now.

Implicit bias has been studied at length, and it shows that minorities and disabled people, as you will hear today, often receive different treatment. Assisted suicide will change attitudes, and not for the better. Taking care of sick people is hard work. If patient A does the noble thing by taking his life, why is patient B still here when his care is so physically and financially taxing? The so-called right to die will become a duty to die. Nurses are, in most cases, understaffed and asked to give more care with less. If our society decides that the answer to a patient's physical and emotional suffering is found in taking their life instead of paying for excellent nursing care throughout the dying process, then eventually nurses and hospitals will agree. In today's financially troubled health care system, this will inevitably limit patient choice and make the inequities that exist within health care worse.

I would also like to address the fact that as a nurse, you see terminal patients very depressed who tell you they want to do this, but we see them functioning months later. People are going to die early because of this. They will take it in that "down" stage. Also, as nurses, we see a lot of very dysfunctional families. It does not take a lot of imagination to see people persuaded to do this by family members who have another interest in it.

My last point would be that it is simply not true that this is taking place without problems where it is legal. Abuses in Oregon and Washington include doctor-shopping, lack of psychiatric consultations, coercion by family members, and a breakdown in the following of rules and conduct attendant to the law. People are not being prosecuted who have not followed this law. The Disability Rights and Education Fund has documented these abuses in detail. In the Netherlands last month, a female in her 20s with severe anorexia nervosa and post-traumatic stress disorder deemed incurable, was given this medication for assisted suicide. It started out with the chronically disabled, and now we are killing those with nothing wrong with them but mental problems. Thank you.

[(Exhibit P) was submitted as additional testimony.]

Brianna Hammon, Private Citizen, Reno, Nevada:
I am an international disability advocate born and raised here in Nevada, speaking in opposition. Please note I have an incurable and irreversible condition that could not be cured or modified by any current medical therapy or treatment. In fact, I have several. They are called disabilities. So, even though the bill cleverly does not say the word "disability," there I am. All you need is an opinionated doctor to make a subjective pronouncement of my imminent death, which many would be very willing to do. I meet the definition of terminally ill. I am amazingly healthy, but I am at risk here.

I think it may be hard for you to imagine what it is like to seek medical services as a person with a disability. I have a very hard time getting many medical professionals to listen to me. It is as if they have a script in their head about the poor disabled girl, and they assume they need to make decisions for me. I explained to a doctor that I have a significant gag reflex and would need sedation for a procedure, but he kept ignoring me and assuring my mother that I was not a behavior problem. Many professionals are as uncomfortable around me as the public because I have the Stevie Wonder head bob. People prefer to talk to the people I am with who have an easier time making eye contact. Family members have so much influence in the medical field and not all of them want what you want.

Well-meaning doctors look at me and think I would be better off dead. They will think it is a favor to offer to suicide me. Over and over again I will be educated about my right to die. Do you know what it is like to be told you should suicide, that you should fill out paperwork to end treatment, or that you should have a do-not-resuscitate order? Everyone wants to educate me. No one wants to tell me my life is worth living. If you pass this bill, you make it the law, and you make it worse.

Deidre Hammon, Private Citizen, Reno, Nevada:
I just wanted to go back to one of the original speakers who talked about the case that is being heard in New York City tomorrow [*Myers v. Schneiderman*]. I think it is important to know that the attorney for the New York Court of Appeals brief, Adam Prizio, said:

> Our basic position is that when some people get suicide prevention while other people get suicide assistance, and the difference is the person's age, disability or health status, that is unlawful discrimination. It is a problem that certain people are being told that others not only agree with their suicide, which is bad enough, but will even help them carry it out. It is a deadly form of discrimination and, as our brief says, it violates the Americans with Disabilities Act.

Health officials should prioritize providing the best treatment to the disabled and ill. The proper role of health care providers and other professionals is to be telling people that their lives are worth living, whatever that experience may look like. Regardless of the patient's condition, helping someone to end his or her life would be aiding in a suicide. Why are we talking about carving out this group of old, ill, and disabled from our state and national policies on suicide prevention? It is mostly economic.

One last thing would be in section 15 where it talks about the competency of the patient. As far as we are concerned, if you are asking for suicide, you are depressed. We encounter people who are depressed all of the time. We encounter people who are living within these six-month windows that just keep going and going. We have taken people out of hospice; we have taken people out of nursing homes who were on hospice. We have seen people outlive diagnoses who would be dead today if this bill were enacted.

[(Exhibit Q), (Exhibit R), (Exhibit S), and (Exhibit T) were submitted as additional testimony.]

Chairman Sprinkle:
Thank you both for being here. If there is anyone here for Senate Bill 189 (1st Reprint), we will not be hearing that bill today.

Senate Bill 189 (1st Reprint): Revises provisions relating to child care facilities. (BDR 38-61)

We will continue with opposition testimony for S.B. 261 (R1).

Peter Fenwick, State Delegate, American Medical Association:
I have practiced medicine in Nevada since 1978, and I am also an assistant clinical professor at the University of Nevada, Reno, School of Medicine. I am in your presence today to present information relevant to S.B. 261 (R1). I would like to read for you a statement from the American Medical Association Principles of Medical Ethics, which is important. "Physician-assisted suicide is fundamentally incompatible with the physician's role as a healer, would be difficult or impossible to control, and would pose serious societal risks."

The laws in Oregon state patients must be mentally healthy, but surprisingly, over 96 percent of these patients had absolutely no psychiatric or psychological assessment whatsoever. That leaves the 4 percent who they say were depressed. Over 50 percent of the patients who apply for assisted suicide gave the main reason of becoming a burden to their family, friends, or caregivers, which is extremely sad. An ill or disabled person should never be regarded as a burden. Some patients have actually regurgitated the medicines they had been given and did not attempt to do it again as it was an unsuccessful attempt. No one who has had an unsuccessful attempt at assisted suicide tried to do it again. Also in Oregon, there were recorded cases of an insurance company denying treatment, which may have been life-saving procedures, though expensive, and suggesting, and authorizing, payment for assisted suicide. This is a very dangerous precedent.

Finally, in Oregon and proposed in Nevada, the physician is instructed to state on the death certificate that the cause of death is not the overdose of the given drug, but the reason of the assisted suicide. This is 100 percent not true and any coroner will confirm this. Interestingly, in Great Britain, a physician who partakes in assisted suicide is subject to fourteen years imprisonment and loss of medical license.

Please do not let this bill drag down medical standards in Nevada. Let the physicians continue to practice good medicine in treating pain and suffering, which we are fully capable of doing. At no time should any physician be made to falsify a death certificate.

Tadea France, Private Citizen, Reno, Nevada:
I want to urge you to vote no on S.B. 261 (R1). Also, if I have your permission. I wanted to read the statement of JJ Hanson. Would you rather I submit that?

Chairman Sprinkle:
Yes, submit that and it will be available to everyone (Exhibit J). You can say any other comments you have.

Tadea France:
JJ Hanson is the president of the Patients' Rights Action Fund. He is a United States Marine war veteran. He is a husband and a father and unable to travel. Three years ago, he was living the American Dream. He was diagnosed with the same grade IV glioblastoma brain tumor that Brittany Maynard had. As you can see, he is still living. The point is that a terminal illness diagnosis is not always accurate. He also struggled with post-traumatic stress disorder and relates it similar to this terminal diagnosis. He believes if he had had to make a decision to take this medicine for suicide at the time he was diagnosed, his choice would have been different than it is today. For those reasons, he hopes you agree to vote no on S.B. 261 (R1).

Chairman Sprinkle:
We will move to testimony in southern Nevada.

Linda Buckart, Private Citizen, Henderson, Nevada:
I am not in favor of this bill. I can see that there could be greedy children who want to see their parent die because they do not like them or do not get along with them. I think it is wrong for someone to make decisions like this. When I am on my deathbed, I want my children there and I just want their comfort. I oppose this whole bill. Thank you.

Chairman Sprinkle:
We will bring it back to the north.

Jeremy McNeil, Private Citizen, Reno, Nevada:
I wanted to mention to Assemblyman Hambrick that I had a similar situation. I did not have cancer, but my mother had cancer. She was given six months to live. Five years later, two weddings, and numerous grandchildren, she did pass away. We are extremely happy that we had her example and her wisdom during those five years. I think that is so important, and it is missed, I believe, when someone who may be in a state of depression decides to take one of these solutions, which is not really a solution at all.

As a lawyer, I generally practice in business. When you are in business, your clients will ask you to help them with their estate planning or trusts and what not. I speak both to the heirs and to the elderly. Some have money and some do not have money. I know that those who are older do not want to be a burden to their families. I know that if not for some other reason, they would be persuaded in such a circumstance to say they do not want to be a burden on their family. The families, on the other hand, generally are not the kind of money-grabbing heirs who would say, "Hey, let us knock off grandma so that we can get the money." However, there is that conflict which could occur. There could be hundreds of thousands of medical expenses coming up and the heirs could look at that and have this undesired conflict that they never wanted, but now it is here. That is something they all want to avoid. I think that we, as a society, ought to avoid that.

There was a discussion about this overarching principle of self-determination. I agree that, sure, everyone wants to have some sort of self-determination. At what point does the principle of self-determination become so great that we think it is a good thing as a society to encourage suicide six months from death. According to the Centers for Disease Control and Prevention, Nevada is eighth in the nation in suicide rates. We want to reduce that. We do not want to increase that. By creating a law that says suicide is alright in certain circumstances makes young people think that suicide is a potential out if they are having a hard time to where it is so bad that they cannot even go to school anymore. I think we want to avoid that. This kind of a law legitimizes suicide, even for those teens.

Melissa Clement, President, Nevada Right to Life:
I have been asked to read a statement from an attorney so I will submit the statement on NELIS (Exhibit U). I will ask you to please read it because it does bring up some interesting questions concerning what the actual protections are.

My next point is that today is Memorial Day. It is a special day and I am very sad we are all here rather than celebrating our veterans, particularly my father. My father is 93 years old, and seven years ago, he got a six-month terminal prostate cancer diagnosis. As I said, he is still alive today. The best thing that happened in the intervening seven years is that I was able to take my father to the World War II veteran's memorial three years after he was supposed to be dead. I know that we are hitting this over and over. When my niece went into hospice care three years ago, she did not have the choice to quit or choose suicide. As a result, she is still alive today.

The other thing is, I have two teenagers. If any of you know teenagers, one of the most upsetting things that is going on right now is the Netflix series called *13 Reasons Why*. It follows a high school student as she goes through thirteen reasons why she is committing suicide. I watched it and it was horrible. I only did it because my 18-year-old daughter watched it, and all of her friends were talking about it. Suicide is one of those contagions. When my daughter and her friends see something like that, they may think it is okay and maybe it is glorified. They may think that this would be the way that people would listen to them finally, or maybe that it is okay for some people so it might be okay for them.

Brianna Hammon just asked me to urge you to read Diane Coleman's testimony for full research on the disability position on this bill. Thank you so much for your time.

Keith M. Shonnard, President, Northern Nevada Guild, Catholic Medical Association:
I have just two short points. First, to bring up the point that the physician in favor brought up, which perverted the Hippocratic Oath, which I will read directly here: As a physician, "I will use treatment to help the sick according to my ability and judgment, but never with the view to injury and wrongdoing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course."

The second point is with regard to a follow-up on self-determination. I am very concerned that choice will soon become duty, as pointed out, and that physicians who are unwilling to participate will be seen as intolerant to someone's self-determination. That is of great concern. I am very much opposed to this legislation. I do not think it is going to help care in this state, and I do not think we should follow the other states that have done this.

Janine Hansen, State President, Nevada Families for Freedom:
I had not planned to testify today, but as I listened to the testimony, I wanted to testify and tell you how much I oppose this bill. I had the opportunity and the blessing to take care of both my father and my mother in their last years and to help them make the decisions for their care. It was a great blessing and I found, through that opportunity, a wonderful time, which may have been denied, had this bill been operative. I think that when people's lives

are diminished, it is a blessing for others to be able to grow in compassion, concern, and care and to reach out in a compassionate way to take care of those who are least able to take care of themselves. It is our duty to preserve and protect, in every way we can, those who need our protection in the preservation of their life.

I have a daughter who suffers from depression. When I read this bill, I thought, What about those who suffer from depression and would choose this option instead of working towards finding other answers in life. I think it is very dangerous, especially considering the perverse economic incentives that are here for insurance companies and ultimately the government, to get rid of those who are costly and who may not be viewed as being able to contribute totally to society. I urge you to consider what future generations may think when it becomes a standard of care to get rid of those who are considered inconvenient and costly.

Chairman Sprinkle:
That will end testimony in opposition. I do just want to ask everyone else here in opposition to raise your hand so that we could acknowledge you all. I will open up for testimony in neutral.

John Fudenberg, Coroner, Office of the Coroner/Medical Examiner, Clark County:
I am the coroner of Clark County. I have also been in discussion with Dr. Laura Knight, who is the Chief Medical Examiner in Washoe County. For the record, we are neutral on S.B. 261 (R1). I would like to thank Senator Parks for working with us on the language. We worked with him for many weeks. If this bill passes, there is one section in particular that is very important to us. Assemblywoman Titus discussed this section earlier. It is section 1, subsection 3. I would like to point out that it states the attending physician must sign the death certificate. That is very important. If they do not sign the death certificate, it will initiate an investigation on the part of the coroner or medical examiner, and that really goes against the intent of the bill if we have to investigate the cause of death. In that case, it will turn into being listed as a suicide. That section is very important to us.

Kevin Burns, Chairman, United Veterans Legislative Council:
I am representing the major veteran organizations within the state and a large majority of the 250,000 veterans. We are split on this one, just as everyone else seems to be. Many of us have held those on the battlefield as they were dying and we willed them to die so their pain would go away. We definitely understand that. However, we all have a major concern about what the bill says to our community. Every three days, a Nevada veteran kills himself or herself. Since this session started, to the end of this week, that will be 40 veterans who have killed themselves. That means that this is going to be read by many in the community as state-sanctioned suicide. We are concerned that the passage of a bill like this will enable many to lower the stigma of suicide and enable them to kill themselves. Assemblyman Thompson has done a wonderful job in helping us view and surmount some of these issues; we do not want to see that go to waste.

Leandra Cartwright, representing Nevada Psychiatric Association:
We are here in neutral. Our parent organization, the American Psychiatric Association, has no position on this legislation. We do have an amendment we proposed to the sponsor (Exhibit V). He did not accept it, so we are hoping to bring it to you. It would be in section 15 and it would ask for a screening if the physician believes there are indications of a mental disorder. We ask for that because the bill states, if they think "the patient may not be competent." You either are or are not competent. Mental disorders and mental health issues may affect your decision-making ability and decision-making capacity on a continuum. If you have something like anxiety, attention-deficit/hyperactivity disorder, depression, post-traumatic stress disorder, or obsessive-compulsive disorder, those can affect your ability to make a decision, and it can affect your quality of life.

If you are at the end of life, you deserve to have the best quality of life possible. If we can treat the underlying mental disorder and give you time to plan for your end of life, to spend time with family and friends how you see fit, I think we can give that to people.

Chairman Sprinkle:
That amendment is up on NELIS. Is there anyone else here or in southern Nevada wishing to come forward under neutral? [There was no one.] I will close the hearing on S.B. 261 (R1). I will open the hearing on Senate Bill 394 (2nd Reprint).

[(Exhibit W), (Exhibit X), (Exhibit Y), (Exhibit Z), (Exhibit AA), (Exhibit BB), and (Exhibit CC) were submitted but not discussed.]

Senate Bill 394 (2nd Reprint): Revises provisions relating to health insurance. (BDR 57-950)

Nathan R. Ring, representing Labors International Local 872; and Operating Engineers Local 12:
I am here in place of Senator Spearman to present Senate Bill 394 (2nd Reprint). Senate Bill 394 (2nd Reprint) has two sections. The first section concerns information and transparency concerning health maintenance organizations. The second section concerns an interim study regarding Medicaid and other options under the Affordable Care Act. Primarily, S.B. 394 (R2), on behalf of my clients, is to provide a commonsense approach to insuring there are those responsible for managing care for members, that employers are able to obtain the best information possible and make educated choices concerning their members and their employees based on the information received. A much more aggressive version of this legislation was passed in California approximately four years ago. In the first two years for which they had data, health plans had saved $300 million in managing the care of their members. Like this bill, that bill was also opposed by insurance plans. Many of the same arguments that were made in opposition to that bill will be made by health plans to this bill.

Today, without the information that this bill seeks to provide access to, plan managers are left really with only two options. The first option is to agree to whatever rate increase the health maintenance organization (HMO) charges, without any explanation for the rate increase. The second option is to find a new health plan provider; however, you would not have any information about your plan experience. Without the information, plans like ours that contract with the HMOs for their members and employees have no way to identify what is causing rate increases. They cannot identify how much the care of their members costs compared to the premiums they are paying for the coverage and those costs. They cannot identify utilization patterns in their plans, like opioid use, overuse of emergency care, rates of diabetes, and other related chronic illnesses. This information is important to allow the plan to have education outreach events with members and employees. For example, if you have a large proportion of your members that are prediabetic or you have a large portion of your members that are overusing emergency care when they may be better off using urgent care, it would save them money as well as save the plan itself money. Those are things that we can use in educational outreach and health care events.

It is no secret that health care costs have increased and they continue to increase. We can debate about why that has happened, but that is not what this bill does. What this bill seeks to do is to provide information to keep the insurance costs and health care costs under control. Our plans need reliable and accurate information to allow us to negotiate better health care costs for our members and to improve care for our members. We must be permitted to distinguish between whether rates are going up because costs are going up, or because certain utilization in the plans are increasing that could be targeted through health fairs and other outreach events. Plans that are self-funded need this information to make decisions about benefits and activities. This data is an essential piece to health care management and frankly, the time is long past when it is acceptable to not have this information for these plans. Fiduciaries need the information to be good stewards with health care dollars, and this legislation will provide the ability to intelligently manage our plans instead of simply making payments into an amorphous black box and not understanding where the money is going and what it is going to.

It is important to point out a couple of things this legislation does not do. First, unlike the California HMO transparency bill, this does not mandate regulatory government structure for rates. It does not do that. It also does not require full public transparency for HMO plans. The information in this will only be provided to the group purchaser who purchases the HMO plan. It is not provided to the public. It does not seek individually identifiable information. Section 1 of the bill provides for the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other disclosure laws. It also does not ask for data that does not exist. After all, the HMOs are using this data to set rates. It does not duplicate what is already available under law. There are provisions within the *Nevada Revised Statutes* (NRS) that allow for individual persons within an HMO plan to get information pertaining to them. There is not a provision within NRS that allows a group purchaser to obtain information in the aggregate about all of the members in a plan. Most preferred provider organization (PPO) health insurance plans already provide information that is more detailed to their clients, and HMOs do not. Plans that individuals purchase on health exchanges are already required to provide certain information within this bill to the state. Plans like ours do not get that information from HMOs. Greater transparency from HMOs can help better control the ever-escalating cost of health care, protect members, protect employees, and protect the citizens of the state. Thank you.

Fran Almaraz, representing Teamsters Locals 631 and 986:
Our health trust has seen increases from the HMO plan. Last year it was 17 percent. The year before that it was 16 percent. We are getting these increases without the information to tell us why the rates are going up. We hope that if this bill is passed, it will allow the HMOs to give that information to our trust, and the other plans with trusts. We want to know why it is such a huge increase. We know the health care costs are going up, but what we do not know is if our members have been having a certain number of heart attacks or a certain number of diabetes cases. We can do outreach to our members and have training for better lifestyle choices so that the health care costs do not keep escalating as they have been. This is a simple bill. Mr. Ring explained in detail what it covers and what it does not cover. I ask your support on this bill. Thank you for your time.

Chairman Sprinkle:
Thank you very much. Are there any questions from the Committee? [There were none.] Is there anyone in support of S.B. 394 (R2)?

Rusty McAllister, Executive Secretary-Treasurer, Nevada State AFL-CIO:
I am here on behalf of the 200,000 members who belong to health insurance trust funds. Some have HMOs and some do not, but for those that do, this information is critical. No one should be told they have a 17 percent increase in their health plan due to significant raises in health care costs. That is the only information they get. That is unacceptable. It should not be happening. We believe this will help correct some of that behavior. We are in full support of this bill.

Chase Wortham, representing Southwest Regional Council of Carpenters Local 971:
We would like to say, "me too."

Ryan Beaman, President, Clark County Firefighters, Union Local 1908:
We run our own self-funded trust. We support this bill.

Mike Ramirez, Director of Governmental Affairs, Las Vegas Police Protective Association Metro, Inc.; and representing Nevada Law Enforcement Coalition:
As Mr. Beaman said, we also have our own trust and we are in support of this bill.

Todd Ingalsbee, Legislative Representative, Professional Fire Fighters of Nevada:
We support this bill.

Chairman Sprinkle:
Is there anyone in southern Nevada in support?

Stacie Sasso, Executive Director, Southern Nevada Laborers Joint Trust Funds; and representing Health Services Coalition:
We represent 21 employer and union health plans with about 300,000 covered lives in southern Nevada. We are testifying in support of S.B. 394 (R2). Allowing the transparency of HMOs is crucial to the groups we represent that offer an HMO benefit to their participants. The fiduciaries of these plans need information to continue to be good stewards of health care dollars. The legislation will provide them with the ability to intelligently manage their plans instead of agreeing to large increases requested without the benefit of knowing what rates are going up and if it is because costs are increasing or because utilization is increasing. Your support today with S.B. 394 (R2) is needed and appreciated. Thank you.

Chairman Sprinkle:
Is there anyone else in the north? Not seeing anyone, I will open up for testimony in opposition.

James L. Wadhams, representing Anthem, Inc.:
The opposition is to the bill, but not in terms of the disclosure and making sure that the customer has information. It is on the protection of that information. If we get detailed information that gets into the public realm, then the company that I represent has an unfair competitive advantage over the company that Mr. Alonso represents, so it is more rather than disclosure to the group user, but that the identity and the information, trade secrets, and proprietary information is protected from other competitors. Thank you.

Alfredo Alonso, representing UnitedHealth Group, Inc.:
We have similar concerns over proprietary information. Simply put, we have had discussions with the sponsor. We have spent quite a bit of time on this. I believe that much of what we have been told that is being requested is already provided to many of the plans. I will provide a copy of this document. It goes through, at length, prescription costs and what medical costs for that year were billed and how they affected the plan. Perhaps, if we get a chance to have a little more discussion over this, we can provide much of what they are asking for already. I know one of the questions was how to forecast. That is an understandable question. It would be difficult to forecast ahead, but maybe there is a way to do that by looking at trends going back, say, five years. That may be something we can do. Again, our concern is not about the information, but about the amount of information. Thank you.

Keith L. Lee, representing the Nevada Association of Health Plans:
We have approximately seven members, all of whom write insurance in Nevada. I concur with my colleagues' statements. Thank you.

Chairman Sprinkle:
Is there anyone else in opposition here or in southern Nevada? [There was no one.] Is there anyone neutral to this bill? [There was no one.] Senator, do you have closing comments?

Senator Pat Spearman, Senate District No. 1:
As our majority leader often says, this is an example of a quintessential compromise bill. I think it is a good bill. Whatever the concerns are with respect to protecting information so that it does not give an unfair advantage to someone else, it can be mitigated. I think Ms. Almaraz has something to say in terms of how they already get some of that information from another place.

Fran Almaraz:
I just wanted to say that our PPOs give us this information now. We do not get it from the HMOs. This bill is only directed at the HMOs. We are not asking for any forecasts; we are asking for what has happened already and why they are raising our rates so that we can be more proactive with our members. It is just to help them be more healthful. I will also say that we worked with Brenda Erdoes from the Legislative Counsel Bureau on several occasions to make sure the language is tight and that this proprietary information goes nowhere except to the person who has that plan or the trust or entity that has the plan. Thank you very much.

Chairman Sprinkle:
Thank you all for being here. I will close the hearing on S.B. 394 (R2). I will open public comment. Hearing none, I will close public comment. We are adjourned [at 6:15 p.m.].

RESPECTFULLY SUBMITTED:

Kailey Taylor
Committee Secretary

APPROVED BY:

Assemblyman Michael C. Sprinkle, Chairman

DATE:

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is written testimony in support of Senate Bill 261 (1st Reprint), presented by Geoff Sugerman, Policy Analyst, Death with Dignity National Center, Portland Oregon.

Exhibit D is a document titled "Nevada Survey Results," done by Public Policy Polling, mentioned by Geoff Sugerman, Policy Analyst, Death with Dignity National Center, Portland, Oregon, in regard to Senate Bill 261 (1st Reprint).

Exhibit E is written testimony in support of Senate Bill 261 (1st Reprint), presented by Carol A. Parrot, M.D., Private Citizen, Lopez Island, Washington.

Exhibit F is written testimony in support of Senate Bill 261 (1st Reprint), presented by Frankie Sue Del Papa, Private Citizen, Carson City, Nevada.

Exhibit G is written testimony in support of Senate Bill 261 (1st Reprint), presented by Kat West, National Director, Policy and Programs, Compassion and Choices, Portland, Oregon.

Exhibit H is written testimony submitted by Kat West, National Director, Policy and Programs, Compassion and Choices, Portland, Oregon.

Exhibit I is written testimony in opposition to Senate Bill 261 (1st Reprint), presented by Linda (Lindy) Bruzzone, Private Citizen, Laughlin, Nevada.

Exhibit J is written testimony in opposition to Senate Bill 261 (1st Reprint), submitted by James J. (JJ) Hanson, President, Patients' Rights Action Fund.

Exhibit K is written testimony in opposition to Senate Bill 261 (1st Reprint), presented by T. Brian Callister, Coalition Spokesperson, Nevadans Against Doctor Prescribed Suicide.

Exhibit L is a document titled "Oregon Data on Assisted Suicide," submitted by T. Brian Callister, Coalition Spokesperson, Nevadans Against Doctor Prescribed Suicide.

Exhibit M is a document titled "Facts and Statements about Assisted Suicide," submitted by T. Brian Callister, Coalition Spokesperson, Nevadans Against Doctor Prescribed Suicide.

Exhibit N is written testimony in opposition to Senate Bill 261 (1st Reprint), presented by Kirk Bronander, Private Citizen, Reno, Nevada.

Exhibit O is written testimony in opposition to Senate Bill 261 (1st Reprint), submitted by Evan M. Klass, Governor, American College of Physicians, Nevada Chapter and Jack Ende, President, American College of Physicians.

Exhibit P is written testimony in opposition to Senate Bill 261 (1st Reprint), presented by Kathleen Rossi, Private Citizen, Reno, Nevada.

Exhibit Q is written testimony in opposition to Senate Bill 261 (1st Reprint), presented by Deidre Hammon, Private Citizen, Reno, Nevada.

Exhibit R is additional testimony submitted by Deidre Hammon, Private Citizen, Reno, Nevada.

Exhibit S is a document titled, "Problems with Nevada's Doctor Prescribed Suicide bill," dated April 12, 2017, submitted by Deidre Hammon, Private Citizen, Reno, Nevada.

Exhibit T is a document titled, "Summary Points Against Legalizing Doctor Prescribed Suicide," submitted by Deidre Hammon, Private Citizen, Reno, Nevada.

Exhibit U is written testimony in opposition to Senate Bill 261 (1st Reprint), submitted by Margaret K. Dore, Private Citizen, Seattle, Washington, mentioned by Melissa Clement, President, Nevada Right to Life.

Exhibit V is a proposed amendment to Senate Bill 261 (1st Reprint) presented by Leandra Cartwright, representing Nevada Psychiatric Association.

Exhibit W is written testimony in opposition to Senate Bill 261 (1st Reprint), submitted by Diane Coleman, President/Chief Executive Officer, Not Dead Yet.

Exhibit X is written testimony in opposition to Senate Bill 265 (1st Reprint), dated May 26, 2017, submitted by John B. Kelly, Director, Second Thoughts Massachusetts: Disability Rights Advocates against Assisted Suicide.

Exhibit Y is written testimony in support of Senate Bill 261 (1st Reprint), submitted by Jerry Cade, Private Citizen, Las Vegas, Nevada.

Exhibit Z is written testimony in opposition to Senate Bill 261 (1st Reprint), submitted by Izora Hoagland, Private Citizen, Reno, Nevada.

Exhibit AA is written testimony in support of Senate Bill 261 (1st Reprint), dated May 28, 2017, submitted by Annette Childs, Private Citizen, Reno, Nevada.

Exhibit BB is written testimony in opposition to Senate Bill 261 (1st Reprint), dated April 7, 2017, submitted by Maureen Leck, Private Citizen, Nevada.

Exhibit CC is written testimony in support of Senate Bill 261 (1st Reprint), submitted by Bradly Combs, Intern for Senator Parks.