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

Seventy-Ninth Session
April 7, 2017

The Committee on Health and Human Services was called to order by Chairman Michael C. Sprinkle at 1:10 p.m. on Friday, April 7, 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
Assemblywoman Teresa Benitez-Thompson
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:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Committee Policy Analyst
Mike Morton, Committee Counsel
Kailey Taylor, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Dan Musgrove, representing Valley Health System
Panayiotis N. Varelas, M.D., Director, Neurosciences Intensive Care Unit, Henry Ford Health System, Detroit, Michigan
Paul Janda, D.O., Program Director, Neurology Residency Program and Director of Neurology and Stroke, Valley Hospital Medical Center
Joseph Ferreira, President/Chief Executive Officer, Nevada Donor Network, Inc.
Donna Feliz-Barrows, Private Citizen, Las Vegas, Nevada
Brian Evans, representing Nevada State Medical Association
Brooke Maylath, President, Transgender Allies Group, Reno, Nevada
Michael Hackett, representing Nevada Public Health Association; and Nevada Primary Care Association
Shannon Sprout, Chief, Policy Development and Program Management, Division of Health Care Financing and Policy, Department of Health and Human Services
Chelsea Capurro, representing Health Services Coalition
Regan J. Comis, representing Nevada Association of Health Plans
Ryan Beaman, President, Clark County Firefighters, Union Local 1908
Jodi Tyson, Government Affairs Director, Three Square; and representing Food Bank of Northern Nevada
Ed Guthrie, Chief Executive Officer Emeritus, Opportunity Village, Las Vegas, Nevada

Chairman Sprinkle:
[Roll was called. Committee rules and protocol were explained.] With a couple of items that I am still working on for Assembly Bill 374, I am going to roll that to one of our meetings next week, so A.B. 374 will not be heard today.

Assembly Bill 374: Requires the Department of Health and Human Services to make coverage through the Medicaid managed care program available for purchase. (BDR 38-881)

We will have our work session first. Then we will hear Assembly Bill 424, then Assembly Bill 408, and Assembly Joint Resolution 9. We will now start the work session.

Assembly Bill 224: Revises provisions relating to persons with disabilities. (BDR 39-780)

Marsheilah Lyons, Committee Policy Analyst:
We begin with Assembly Bill 224 in the work session document (Exhibit C). This revises provisions relating to persons with disabilities. It delineates a developmental disability as one which: (1) is attributable to a mental or physical impairment or a combination of

the two; (2) is manifested before 22 years of age and is likely to continue indefinitely; (3) substantially limits certain major life activities; and (4) results in a lifelong or protracted need for individually planned or coordinated services, support, or other assistance.

Assemblyman Carrillo submitted an amendment for consideration. The major provisions of that amendment include replacing references to "related condition" with the term, "developmental disability;" and specifying that such a disability is defined as autism, cerebral palsy, epilepsy, a visual or hearing impairment, or any other neurological condition diagnosed by a qualified professional that is manifested before the age of 18 years and is likely to continue indefinitely; substantially limits certain major life activities; and results in a lifelong or protracted need for individually planned and coordinated services, support, or other assistance.

An amendment that is not included in the work session document (Exhibit C) that the sponsor has asked to be presented for the Committee's consideration is in section 17, subsection 5(a) of the bill—retaining what was in the original bill, "the age of 22 years," rather than the age of 18 years.

Chairman Sprinkle:
Is there any discussion or questions from the Committee?

Assemblywoman Titus:
What section was that?

Marsheilah Lyons:
Section 17, subsection 5.

Chairman Sprinkle:
Are there any other questions? [There were none.] I will accept a motion to amend and do pass.

> ASSEMBLYMAN THOMPSON MOVED TO AMEND AND DO PASS ASSEMBLY BILL 224.
>
> ASSEMBLYWOMAN BENITEZ-THOMPSON SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

I will give the floor statement to Assemblyman Carrillo.

[(Exhibit D) was submitted but not discussed.]

We will move to Assembly Bill 304.

Assembly Bill 304: Revises provisions relating to autism. (BDR 38-363)

Marsheilah Lyons, Committee Policy Analyst:
[Read from (Exhibit E).] Assembly Bill 304 revises provisions relating to autism. It revises language to provide for the provision of services to persons who are "diagnosed or determined" to have an autism spectrum disorder. Sections 1 through 7 of this bill revise the definition to mean a condition that meets the diagnostic criteria for autism spectrum disorder published in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association or the edition of the Manual that was in effect at the time the condition was diagnosed or determined. No amendments have been proposed for this measure. For the Committee's information, a technical correction moved the Autism Treatment Assistance Program from the Division of Public and Behavioral Health into the Aging and Disability Services Division.

Chairman Sprinkle:
Are there any questions on this bill? [There were none.] I will accept a motion for do pass.

> ASSEMBLYMAN YEAGER MADE A MOTION TO DO PASS ASSEMBLY BILL 304.
>
> ASSEMBLYMAN McCURDY SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

This is an Assembly Committee on Health and Human Services bill, so I will take the floor statement. We will move on to Assembly Bill 305.

Assembly Bill 305: Requires each public school to post a toll-free telephone number for a child abuse or neglect hotline. (BDR 34-362)

Marsheilah Lyons, Committee Policy Analyst:
[Read from (Exhibit F).] Assembly Bill 305 requires each public school to post a toll-free telephone number for the child abuse or neglect hotline. The bill requires the Division of Child and Family Services of the Department of Health and Human Services to design and distribute, to school districts and charter schools, a poster that prominently displays the toll-free telephone number for the child abuse or neglect hotline and prescribes the requirements for the content of the poster. The bill requires the board of trustees of each school district and the governing body of each charter school to ensure that every public school conspicuously displays, in an area that is frequently and easily accessed by pupils, the poster that prominently features the State and, if available, a local telephone number for a child abuse or neglect hotline. Assemblyman Oscarson proposed two amendments for the measure. The first is to require private schools in the state to display the poster, and the second is to authorize districts, charter schools, and private schools to promote the child abuse and neglect hotline through electronic and online resources, including social media.

Chairman Sprinkle:
Are there any questions on this bill? [There were none.] I will take a motion to amend and do pass.

> ASSEMBLYMAN McCURDY MOVED TO AMEND AND DO PASS ASSEMBLY BILL 305.
>
> ASSEMBLYWOMAN JOINER SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

Assemblyman Oscarson will take the floor statement. Next is Assembly Bill 366.

Assembly Bill 366: Creates four behavioral health regions in this State and a regional behavioral health policy board for each region. (BDR 39-987)

Marsheilah Lyons, Committee Policy Analyst:
Assembly Bill 366 creates four behavioral health regions in this state and a regional behavioral health policy board for each region. The bill creates the Northern, Washoe, Rural, and Southern Behavioral Health Regions. Section 6 of this bill creates a regional behavioral health policy board for each of the four regions. Section 6 also provides that the membership of each policy board consists of 12 persons, including 11 members appointed by the Director of the Department of Health and Human Services; and 1 member who represents the criminal justice system appointed by the Governor. Each policy board is required to: (1) advise the Department, the Division of Public and Behavioral Health, and the Commission on Behavioral Health on certain regional behavioral health issues; (2) promote improvements in the delivery of behavioral health services in the behavioral health region; and (3) coordinate and exchange information with the Department, Division, and Commission regarding behavioral health services in their respective behavioral health region. The report currently submitted by the Commission annually to the Governor and biennially to the Legislature is revised to include (1) recommendations from each policy board; (2) the epidemiologic profiles of substance use and abuse, problem gambling, and suicide; (3) relevant behavioral health prevalence data for each behavioral health region; and (4) the health priorities set for each behavioral health region. Assemblyman Araujo submitted several amendments for the measure including an amendment proposed by Senator Hardy. Three of those amendments were presented in Committee. There is a new amendment, which begins on page 2 of the work session document (Exhibit G).

I can walk the Committee through that. Assembly Bill 366 is being proposed to be amended in section 5 to place Lincoln County in the Rural Behavioral Health Region, which was a request from Nevada Association of Counties. In section 6, subsection 2, related to the makeup of the policy boards, it is proposed to amend it to increase the number of members of each policy board to 13, rather than 12, and to require the additional member to be a legislator appointed by the Legislative Commission. It also establishes that six members of the policy board be appointed by the Governor or his or her designee. It establishes that three members of the policy board be appointed by the Speaker of the Nevada Assembly and three members of the policy board be appointed by the Majority Leader of the Nevada Senate.

Section 6, subsection 2, paragraph (a), subparagraph (4) relates to qualifications for a member in response to some questions that came up during the Committee hearing. The sponsor has asked that we prioritize the appointment of an individual who has received behavioral health services in this state, or a family member of such a person. If neither is available to serve, an individual who represents their interests could serve to make sure there is either a patient or a family member of a patient on each of the policy boards.

The fourth amendment is in section 6, subsection 2, paragraph (a), subparagraph (6) to specify that the law enforcement agency representative be required to have a background of interacting with individuals with mental illness.

Section 6, subsection 5 currently specifies that on or before July 1 of each biennium, the Speaker of the Assembly will designate one member of each policy board to act as Chair. The amendment would now require that each policy board Chair be by election from that body itself. The Director of the Department of Health and Human Services or his or her designee will preside over the Chair's election at the first meeting of the policy board.

The final amendment is to authorize each policy board to have one bill draft request.

Chairman Sprinkle:
Are there any questions on this bill or the amendment? [There were none.] I will take a motion to amend and do pass.

> ASSEMBLYMAN YEAGER MOVED TO AMEND AND DO PASS ASSEMBLY BILL 366.
>
> ASSEMBLYMAN CARRILLO SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

Assemblyman Araujo will take the floor statement. We will close the work session. I am turning the meeting over to the Vice Chair.

[Assemblywoman Joiner assumed the Chair.]

Vice Chair Joiner:
We will open the hearing on Assembly Bill 424.

Assembly Bill 424: Revises provisions governing the determination of death. (BDR 40-1025)

Assemblyman Michael Sprinkle, Assembly District No. 30:
I am here today to present Assembly Bill 424. In November 2015, the Nevada Supreme Court sent the tragic case regarding 20-year-old University of Nevada, Reno, student Aden Hailu and a northern Nevada hospital back to Washoe County family court for another hearing regarding what the justices stated were extraordinarily broad standards. The question was if the hospital had met the state law requiring a finding that irreversible cessation of brain stem functions met acceptable medical standards that are uniformly applied among the states that enacted the Uniform Determination of Death Act (UDDA). Aden's father had filed the suit to prevent the removal of life support treatment. Sadly, before the lower court had a chance to have a new hearing, the young lady's heart stopped on January 4, 2016. Assembly Bill 424 has been proposed to tighten up those guidelines that the Supreme Court believes were extraordinarily broad.

In essence, this is going to be referring to something new; I think in today's day and age, we are more scientific than back in 1985 when UDDA was first accepted by all 50 states. In essence, we are talking about science here, including the advanced technology that must be taken into consideration, which has advanced since 1985. This bill will first require the use of "Evidence-based Guideline Update: Determining Brain Death in Adults: Report of the Quality Standards Subcommittee of the American Academy of Neurology," published June 8, 2010, by the American Academy of Neurology (AAN).

Secondly, one of the amendments will reference the 2011 "Guidelines for the Determination of Brain Death in Infants and Children: An Update of the 1987 Task Force Recommendations" or any subsequent future revisions.

Finally, the one other thing this bill does is to enact the 24-hour requirement to terminate all life-sustaining treatment once determination of death has occurred. At this point, I would like to turn it over to Mr. Musgrove to give you more information.

Dan Musgrove, representing Valley Health System:
Specifically, I am really representing our Valley Health System Ethics Advisory Council. Our ethics advisory council is a group of folks that encompasses our six hospitals in southern Nevada. That includes doctors, nurses, residents, caseworkers, palliative caregivers, chaplains, and a member of management. They take on issues that are of an ethical nature. In the past few years, we have had issues regarding brain death in our hospitals. Once the Supreme Court made the decision that Nevada standards were too broad, the ethics advisory council decided to take that on as an issue. They came to Assemblyman Sprinkle, discussed this with him, and were very pleased that he had been following the case and was willing to take on this issue. Again, this is a very tragic issue to deal with. It talks about a very momentous occasion in any family's life when a family member or friend is determined to be brain dead. We thank the Committee for its willingness to take this on and have an open discussion on the standards. We had a letter that was submitted on the Nevada Electronic Legislative Information System (NELIS) from Dr. David Greer of Yale School of Medicine.

He is in charge of their neurology department, and he was one of the senior authors of the AAN's guidelines that set these parameters into science (Exhibit H). The work that he did was based on science.

With us on the phone is another one of those senior authors. He will talk about the research they did and give you an opportunity to ask some questions. I know from my discussions with many of you, you do have a concern about the requirement to put the 24-hour mandate into law. Candidly, I can tell you I have had my own personal experience with this. I was sitting in the Assembly Committee on Ways and Means last session, on April 17, when I got a text from my sister in Spokane saying I needed to figure out a way to get to Spokane as soon as possible because my 86-year-old mother was about to pass away. I left the committee, flew to Las Vegas, jumped on a plane to Spokane, arrived at 6 p.m. and was lucky enough to be sitting with my mother at 4 a.m., holding her hand when she passed away. That was something that was special to me, that I was there when that happened. I had the ability to get to her. This is an issue that the Committee needs to discuss—whether that 24-hour requirement should be placed in statute. I think the doctor on the phone, as well as a witness in Las Vegas, will be able to talk about what is seen on behalf of the caregivers who have to deal with these situations. On the phone, we have Dr. Panayiotis N. Varelas, Director of Neurology at Henry Ford Health System in Detroit, Michigan. He is also a leading professor at Wayne State University.

Panayiotis N. Varelas, M.D., Director, Neurosciences Intensive Care Unit, Henry Ford Health System, Detroit, Michigan:
Thank you for having me. It is an honor. Would you like to ask me questions about this first, or shall I talk first?

Dan Musgrove:
Please give a quick overview of the research you did and the work the committee did to establish the 2010 guidelines, and then you can open up for questions.

Panayiotis Varelas:
As you know, in 1980 the Uniform Determination of Death Act was published as the precedent for state laws regarding death by neurological criteria. As you can imagine, you are born one way, but you die in two ways in the United States—either when your heart and lungs stop functioning or when your brain irreversibly stops functioning, which is death by neurological criteria. Unfortunately, in the UDDA, the determination of death by neurological criteria was left to the physicians, and should be done in accordance with accepted medical standards. It seems then, what has happened is that each state has developed its own laws; most of them follow the UDDA, and then each hospital in the United States develops policies regarding brain death. These policies have to be followed by the physicians who do the determination.

But it is not as simple as that. For instance, in 2008, we published a study where we looked at the policies of the 50 best hospitals at that time according to *U.S. News and World Report*. We found that in their policies there was tremendous variability. To give you an idea, we had 38 out of 41 different responses from these 50 hospitals. Out of 38 policies, there were 11 different temperatures, which called for beginning the brain-death exam. One out of every three policies was different. One was saying that you can do it with the temperature of 32 degrees Celsius, another one was saying you can do it at 32.1 degrees, another one 33 degrees. There is variability. It should not be like that because you are born in one way and you die in one way. There should not be many different standards.

In 1995, the American Academy of Neurology published the first guidelines. These guidelines were based on the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research study on brain death and the UDDA. In 2010, David Greer, Eelco Wijdicks, some other people, and I sat down to look at these guidelines. We had some questions. One of them, the most important, was if you follow the 1995 guidelines, is there any proof that anyone was pronounced brain dead by neurological criteria and came back? We looked at 667 articles, and more specifically at 38 which met the inclusion criteria we had, and we did not find anybody that woke up after following the AAN guidelines from 1995. We published these guidelines in 2010; we fine-tuned the 1995 guidelines and made some changes to make it easier and more acceptable to everyone. For instance, instead of having two different temperatures to do the exam and apnea test, we put only one temperature. We also simplified it by saying that you do not need too many exams; even a single brain-death exam is enough if you are convinced that there is irreversible damage to the brain. We published the guidelines and it seems that they have been used by many hospitals in the United States. I applaud you for putting this in Nevada law.

Assemblywoman Miller:
I appreciate this bill, and I want to make sure that we are all crystal clear on what this bill is. It seems like a simple piece of paper for something so complex and sensitive. We are not saying that the hospitals are making decisions to remove life support; we are saying that a person has already, clinically and legally, been declared dead. Are there times now when people who have been pronounced dead have not been taken off life support?

Panayiotis Varelas:
Yes. It is an issue because there have been some cases. The most famous is a young lady in California [Jahi McMath] who had a terrible complication and became brain dead. It was confirmed in California by several physicians. The family did not accept that and tried to keep her on the ventilator, and eventually transferred her to New Jersey. She may still be there. There have been precedents like that.

I have encountered families who want to keep their patients on the machine. When the brain dies, you lose control of the other organs in the body. The brain controls everything. It controls the heart and lungs; you cannot breathe without the medulla, the lowest part of the brain. It also controls the functions of the kidneys and everything. If you do not do anything and you keep the patient on the ventilator, the vast majority of them go into cardiac arrest within the first 48 to 72 hours. There have been very rare cases, one that I know of was a pregnant woman [Karla Perez], and they tried to keep her on the ventilator with hormonal replacements, fluids, and tube feedings. They were able to maintain her in that condition for many days until the fetus became viable and they could deliver the baby. I think this is what you have in your legislation.

Assemblywoman Miller:
You are correct. It does address a woman who is pregnant with a fetus. I do recall those national cases where people had been kept on machines for extended lengths of time. I think that was addressed as well in the definition of "dead" being too broad, and we are closing the gap of what type of death and definition. My other question is, would the family have the ability to ask the hospital, once the person has been declared dead, to remove life support sooner than 24 hours?

Dan Musgrove:
Absolutely. This would just be the worst-case scenario. The outer limit of time would be the 24 hours.

Assemblywoman Miller:
Is that 24 hours extended in cases where families or loved ones have not been able to get there yet?

Dan Musgrove:
That is why Assemblyman Sprinkle wanted to give the Committee the opportunity to debate. One of the things that I have found in my discussions with you, as well as other folks at the Nevada State Medical Association, is that they do have a concern about that hard and fast 24 hours.

Assemblyman Sprinkle:
That initial 24-hour period was for us as a body to make some legal decisions that sometimes can be very difficult for family members who are grieving. Since then, I have had plenty of input. There is someone I believe will be testifying later who has concerns about donation. This bill addresses already-established donors, but what happens if someone has not been established? Just to get through the process of allowing someone to be a donor, the 24 hours might not be enough. I am hoping this body can contemplate that one section of the bill to determine if 24 hours is enough. The flip side of this is the practical reality. When people lose someone, they are in a grieving process. Consider a person who is kept alive for two or three weeks on life support at $80,000 per day, when six to eight months later the family has come to grips with the death of their loved one. Now the family is looking at considerable bills that perhaps at the time of neurological death they just were not able to think about, because they were dealing with the emotional consequences of the situation. I felt like that was something for us as a legislative body to have the discussion about.

Assemblywoman Miller:
I appreciate that. I would be comfortable with extending it a little past 24 hours because I also know that we have family members on other continents and in the military and things like that.

Panayiotis Varelas:
If the patient becomes a donor, when they are declared brain dead you approach the family. After that, the organ procurement organization approaches the family about donation. If the patient is a donor on the registry, there is no question. If the patient is not on the registry, the family decides whether the patient becomes a donor. If the patient becomes a donor, they have to wait until the organization finds the appropriate recipients. That usually takes 24 to 48 hours. That is no problem because you can save up to eight lives. If the patient is not able to be a donor, it becomes an issue, not only financially. As soon as you pronounce someone brain dead, he or she is dead. No health maintenance organization or Medicare would pay for a dead patient. It can be a substantial bill to keep that patient in the intensive care unit (ICU).

The second issue is also ethical. Let us say you do not have any ICU beds and you have a young trauma patient in the ER and you need an open bed to admit this patient. Imagine if you have a patient who is "dead" occupying the bed in the ICU. Some people have actually called this abuse of a corpse. There have been many issues. We did another study where we looked at 331 U.S. hospitals from 25 different states and the District of Columbia. We looked at the policies they had. To give you an idea, 61 percent of the policies that did not require any religious accommodation did have a brief compassionate period, without saying how long this period was.

Assemblywoman Titus:
I have two concerns. I see why we have this bill. It is helpful and it gives us guidance. As a physician who has been placed in this position more than once, it certainly gives us guidance. My concern revolves around what has already been identified. In section 1, subsection 1, it says life-sustaining treatment must be withdrawn within 24 hours. That does not allow out-of-town families to get there to even make a decision about being a donor. I get that there are a lot of things involved with that and that there needs to be a finite time. We are never going to make that perfect. I do not know if it should be 72 hours or what, but I know 24 hours is too short. In my rural area, it is almost impossible to get someone from the rural communities even to Las Vegas.

The next concern I have is in section 2, subsection 2(b) where it talks about how these guidelines are made in accordance with the 2010 guidelines based on the standards published on June 8, 2010. Those are the current standards, but in the letter we received, Dr. Greer mentioned that it is important that states and hospitals use the most current guidelines and that we should not be wed to the guidelines when other guidelines arise that are more appropriate. I am just wondering if we could have a little language in there to tweak that.

Assemblyman Sprinkle:
Yes, the amendment you have in front of you and on NELIS addresses that specifically (Exhibit I). What it says at the very end is "or any subsequent revisions." It is whatever the most current revision of the guidelines is.

Vice Chair Joiner:
Relating to the 24 hours, I do not see anywhere in here where it talks about notifying the family members or the person's authorized representative. I understand that this provision would not require family consent to end the services, but I wonder if there might be an opportunity, or if you have considered at least requiring that the family be notified so that they would have an opportunity to get there. That would be my concern. Even if you wait the 24 hours, maybe no one told the people who would care.

Dan Musgrove:
That is absolutely normal hospital policy. This is just at the point of determination of death and how long the life-sustaining equipment would be maintained. Doctors and caregivers are going to be in consultation with the family during that whole period of time. Again, this is regarding the final test that establishes that everything humanly possible has been done and brain death has occurred.

Vice Chair Joiner:
Thank you. It is great to have on the record that would be the expectation.

Dan Musgrove:
I have one more witness in southern Nevada, Paul Janda. He is not only a physician, but an attorney as well. He is the Neurology and Stroke Program Director of the Neurology Residency Program at Valley Hospital Medical Center as well as the Director of the Stroke Center. He is also in private practice at the Las Vegas Neurology Center.

Paul Janda, D.O., Program Director, Neurology Residency Program and Director of Neurology and Stroke, Valley Hospital Medical Center:
I am a board-certified neurologist and an attorney. I am also the president of the American Heart Association for the Las Vegas Chapter. I gave this a lot of thought prior to speaking to you. I echo all of the sentiments, and I feel that our state would benefit from this legislation from a variety of perspectives as mentioned. I also have concerns pertaining to the 24-hour window, in terms of that narrative. Perhaps 48 hours or 72 would be appropriate to give the family ample time and to allow for adequate use of resources. As ICU beds are heavily limited, if patients are declared brain dead from a legal and medical standpoint, we should have some sort of reasonable time cap on this.

Assemblyman Edwards:
From your experience, what do you see as the cost for keeping someone alive, on a daily basis, after he has been declared brain dead?

Paul Janda:
That is difficult to answer, as I am not an economist, but it would at least be on the order of tens of thousands of dollars per day. There have also been issues in which we have patients that are legally brain dead, yet the family is on a different continent and does not have access to visas or other travel documents. These are factors that we should all consider when coming up with appropriate time limits.

Assemblyman Edwards:
Is there any requirement to advise the family that they are going to start to incur those tens of thousands of dollars of costs, or should we add that into the bill?

Paul Janda:
It may be worthwhile to add that into the bill to give full disclosure.

Vice Chair Joiner:
We will open up testimony for all of those in support. We will start in Las Vegas.

Joseph Ferreira, President/Chief Executive Officer, Nevada Donor Network, Inc.:
Nevada Donor Network, the federally designated organ procurement organization, serves 14 of the 17 counties in the state of Nevada. I have been involved in this mission both clinically and administratively for almost 20 years. Thank you for the opportunity to testify in regard to Assembly Bill 424. As you may know, there are currently 118,000 people in the United States who are awaiting lifesaving organ transplants. More than 580 men, women, and children are Nevada citizens. Every ten minutes, a new name is added to the waiting list and 22 people die every day in this country because there are simply not enough organs to meet the demand and save their lives. Timing is of the essence for us, and we want to make sure that is taken into account. It is clear the Committee understands timing is the major issue to which we want to contribute some revised language (Exhibit J). We support the bill because we believe it will lead to a standardized process, with clinical diagnosis, made to preserve patient safety and public trust. We believe that to be very important in our mission so that we do not violate that trust the family puts in us.

I just want to emphasize our appreciation of the Committee, Dr. Janda, and Dr. Varelas for understanding that organ donation could be one of the unintended consequences of placing a time limitation. Oftentimes, these families may not have the resources to get here. Even if they have the desire and ability to come, they may not have the financial resources. We ask that be considered in this discussion so there can be an allowance for more time. Other than that, I will refer to the testimony I have provided for the record (Exhibit K).

Donna Feliz-Barrows, Private Citizen, Las Vegas, Nevada:
I am a graduate student at the University of Nevada, Las Vegas, working with the Minority Health Coalition on Assembly Bill 141. I am also a donor parent. My son David passed away Christmas Day 2010. It was the most horrific thing. I appreciate the fact that the gentleman [Dan Musgrove] lost his mother, but I think what people do not understand is that a lot of donors are children. To put a time limit on parents to accept what has happened, and be able to make the decision that it is time to let them go and to allow them to be a donor, is difficult. That is how we get many donors. My son was 22 years old. Putting a time limit on families tells them that their grief does not matter. Even six years later, this loss is so emotional, but I have to do this because I had to bring a face to this issue. These are people that are dying to save other people's lives. It is such an important thing. I do not want to see the chance of a donation not happening because of a simple fact that you only gave parents 24 hours to accept that their child is dying. I would like to see you give them a lot more

time. I appreciate the statements that have been made, but as a parent, I am so proud of what my son was able to do. Please do not take that away from another parent. Donation does not take our pain away, but it does give us a little relief in saying that our children helped someone else and gave someone else a chance at life.

I noticed in the bill that you said "donors." I am asking you to use "potential donors" because you do not always know until you are faced with that. My son and I never discussed his being a donor; it was a decision I had to make, and then he had to go through testing to make sure he could be a donor. Unfortunately, they were only able to take his corneas, but there are two people out there seeing because of him. I want to thank Assemblyman Sprinkle for bringing this bill. This is such an important matter, and we do need to have laws out there so that everyone is getting the same determination of death. People are dying, and people are grieving. Whatever you do with the time limit, do not forget the griever.

Vice Chair Joiner:
Is there anyone in Carson City in support? [There was no one.] Is there anyone in opposition? [There was no one.] Is there anyone neutral?

Brian Evans, representing Nevada State Medical Association:
We are here in neutral. I would like to thank the sponsor and Dan Musgrove for working hard on this piece of legislation. We originally had three concerns, two of which were addressed with the amendment regarding adding pediatrics and the subsequent revisions of data. The last one was the 24-hour time period. After hearing the testimony today, we feel that we can continue to work on that.

Vice Chair Joiner:
Is there anyone else in neutral? [There was no one.] The sponsor may come back and give closing statements.

Dan Musgrove:
I want to thank the Chairman for his leadership on this issue. I think the debate we had and discussion has been wonderful. What we are doing here today is important. There are inconsistencies all over the nation. By doing this and putting it into statute, Nevada would be the first state in the nation to take on the responsibility of adding the scientific guidelines into statute for our determination of death. I think we can all be proud of that because, as you heard, that is such an emotional time period for folks. I think that with clarity, we will get good results. I think we have gotten a lot out of this with the discussion we have had today.

Assemblyman Sprinkle:
I think this is truly why we do what we do. We are here to make hard decisions and have hard conversations that sometimes cannot be had outside these chambers. That is the reason I brought this bill forward. I am completely open to your thoughts and suggestions, especially in regards to the 24-hour time limit. I do understand the difficulty with that.

I think we can get there. We have the chance to do something that could be transcendent for the rest of the nation, but it makes sense. I am such a big proponent of science and where we are today. Thank you for your attention.

Vice Chair Joiner:
I will now close the hearing on A.B. 424.

[Assemblyman Sprinkle reassumed the Chair.]

Chairman Sprinkle:
I will now open the hearing on Assembly Bill 408.

Assembly Bill 408: Revises provisions relating to Medicaid and health insurance. (BDR 38-957)

Assemblywoman Amber Joiner, Assembly District No. 24:
Thank you for hearing Assembly Bill 408 today. The purpose of this legislation is to enshrine in state law many of the protections provided by health insurance that our families currently have in federal law. We must codify in state law some of the key provisions of the Affordable Care Act (ACA) so that whatever happens at the federal level, the key protections will remain by state law.

Before the Affordable Care Act, we used to put everything that we wanted insurance companies to cover in the statute individually. One of the more recent ones was requiring that they cover autism treatment. Over the years, we would include, line by line, things we thought insurance companies should provide if they were going to operate in Nevada. This bill resumes that process by putting in statute the things that we have come to enjoy now, as people who are covered by insurance that could possibly go away, depending on what happens at the federal level. This is not inconsistent with how we used to tell insurance companies what we thought should be provided for our constituents. This is not the entire Affordable Care Act in this bill. To be clear, I have just picked out the pieces that have provided the greatest protection to people. I believe we need to secure those in state law, regardless of the position on the Affordable Care Act, which unfortunately has become a very contentious political issue. I hope that today we can focus on the individual policies and whether putting these protections in state law is the right thing to do.

While preparing for this hearing, I was reminded of what our world was like just a few years ago, before the Affordable Care Act came into effect. There are many important changes that this law made, but just to give you one vivid example that struck me—do you remember a few years ago when women in Nevada were charged as much as 45 percent more than men for the same insurance coverage? Many plans did not cover maternity benefits. Many women who became pregnant were not able to find health insurance because it was considered a preexisting condition. That is a world we cannot return to. This bill will ensure the following provisions: First, no copays or coinsurance for preventive care; this includes contraception, vision, oral and health screening for kids, and immunizations. You will see in the bill that the way we enable that is the Department of Health and Human Services will adopt regulations to keep that list current. In drafting this bill, it was challenging for the Legal Division of the Legislative Counsel Bureau (LCB). Although these lists are readily available online on healthcare.gov, because they are part of the federal regulatory process, they are not easily benchmarked or referenced. What I originally envisioned was that the Legal Division of LCB could reference the current *Code of Federal Regulations* that have these essential health benefits in the lists, but unfortunately the bill could not be drafted that way. Instead, what we have developed is a way to develop the list through our state procedures.

Second, there can be no coverage denial or discrimination, which means no higher costs based on health status—this is the preexisting condition issue that we had before—and no higher costs or discrimination based on gender. Third, young adults can stay on their parents' insurance until the age of 26. Fourth, carriers cannot drop your coverage if you become too sick or too expensive for them to cover, which is what used to happen. We used to hear that story often with cancer patients; they would hit a point where their insurance carrier would drop them because they became too expensive to cover. That is another world I do not want to return to.

This bill looks long, but it is actually not. If you had a chance to look through it, it is repeating over and over again the same provisions in all of our chapters relating to insurance. That is why it is so long, but the actual provisions are not that long. I can go through section by section quickly to highlight the points, but what I wanted to point out first is the conceptual amendment that I have.

You received a handout on the Nevada Electronic Legislative Information System (NELIS) with two key issues that we found in going through this bill, which I would like to propose as amendments (Exhibit L). The first is that the Silver State Health Insurance Exchange was drafted into this bill and it should not have been. They act as a facilitator for the purchase and sale of health insurance plans in Nevada. They do not actually engage in administering them or evaluating people. There is no requirement for them to meet the provisions required currently in section 91. My proposal would be to remove section 91; it just does not apply. I think what happened was we were copying all the insurance chapters and that one got in accidently.

The second amendment that I would like to propose is to clarify our legislative intent. The legislative intent is not to expand the current law. What I want to make very clear is that although there were drafting complications and it is difficult to benchmark things, the intent of this bill is simply to codify in state law what is the status quo, what is currently covered under insurance by federal law. I am not asking insurance companies to cover anything else in addition or to expand coverage in any way. It was pointed out to me that in the drafting of this bill, in several places it says "without limitation." That is a common drafting term that our staff uses, and it was explained to me that not only does that allow for expansion, which is what is concerning to some insurance companies I have spoken to, but it also works the other way in that it allows for future addition of things you might choose to add. In talking to our legal folks, I would like to clarify somehow, to add a declaration in the beginning of the bill expressing the intent of this legislature is to maintain the status quo, not add additional requirements by this particular piece of legislation, and to clarify that our intent is to simply codify in state law the federal health insurance requirements as of January 1 of this year.

There are some concerns that "without limitation" might lead us to expand the list in the future, and that is not my intent in this legislation. I am not going to walk through the entire bill, but I will quickly show you on page 3; this wording relates to both Medicaid as well as all of the insurance carriers in the state. You can see the list of things that will have to be covered. There are screenings, preventive care, and vaccinations. These provisions are repeated over and over again. The other reason that I think it is important to put in that conceptual amendment about not wanting anything to be more expansive is that several places in the bill you will see that we are benchmarking to lists that exist. For example, there is a list for the immunization practices of the Centers for Disease Control and Prevention, obstetricians have a list, and there is a list for supplements. I am finding that some of those lists are more expansive than what the ACA requires; so again, we just want to limit it to what the ACA requires.

Assemblyman Edwards:
My question revolves around two aspects. Even without the "without limitation" language, we are still including a whole lot of requirements that the federal government put in under the ACA. Those requirements are what are driving current insurance premium costs through the roof to a position where it is unattainable. The last election showed that it is unattainable. It is not working under the current list of requirements that has to be paid. My other concern is that if it should contradict federal law, we may end up eliminating providers in the state because they do not want to meet all of the other requirements. They would not be competitive simply because there are too many things they have to provide. How would you reconcile the result of putting this bill forward, and then the federal law trumping it? How do we reconcile that?

Assemblywoman Joiner:
That is why I made the statement that this is how we have always done insurance law in our state. Before the ACA, the states had the jurisdiction to be able to require certain protections in their insurance that they had at the state level. We are just continuing that. There should not be a conflict with the federal law. If, for example, the federal law was to remove from the list anything that you see in this bill, it has always been my understanding that the states have been allowed to offer more than the federal government, just not less. Currently in the ACA, states are still allowed to require the coverage of more, just not less than those essential health benefits. I do not believe there will be a federal conflict.

On your assertion about how it is driving the costs, I would respectfully disagree with you that the requirement list is the main driver, and then secondarily say that if there was an increase because of the list of benefits, I argue that these are essential health benefits that should be required. If you look at the list, we are not asking for the kitchen sink here; we are looking at things that are preventive, which are always less expensive on the front end than treating on the back end. Also, we are making sure that there is no discrimination based on gender or based on someone just getting sick. Any of us at any moment could fall into the category of having a catastrophic illness that would put us into bankruptcy. I think it is a value question: Is it important for our constituents and for the people of Nevada that we cover certain basic health benefits?

Assemblyman Edwards:
My concern is that I do not think we are going to be able to continue to afford all of that, given that there are always limited resources. As someone who saw his insurance go up 50 percent in the last couple of years alone, this puts us on the continued wrong track. I would love to reconcile it, and maybe we can talk about it offline.

Assemblywoman Joiner:
I would be glad to talk with you offline.

Assemblywoman Titus:
Section 70, subsection 2(d) of the bill, says a health maintenance organization shall not "Penalize a provider of health care who provides any such benefit to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care." So this bill would then mandate that the insurance companies pay me what I bill. That is awesome.

Assemblywoman Joiner:
My intent was to keep it as the status quo. If there is a drafting issue there that we need to look at, we will. I do not read it that way.

Assemblywoman Titus:
It says ". . . any such benefit to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care."

Assemblywoman Joiner:
I believe that is about penalizing. They cannot penalize you and then reduce your benefits in the future. I believe that is how it is intended to be drafted, but we will verify with legal. That was not my intent.

Chairman Sprinkle:
We will bring up support for Assembly Bill 408.

Brooke Maylath, President, Transgender Allies Group, Reno, Nevada:
[Brooke Maylath spoke from prepared text (Exhibit M).] One of the very important pieces in the Affordable Care Act for the transgender community is the no-discrimination portion. When we look at past discrimination in health care, prior to the Affordable Care Act, there were many times that transgender people were turned away. There has been a long history of discrimination from both health care providers and in health insurance coverage. In a national survey, 28 percent of transgender people have postponed necessary medical care when sick or injured; 19 percent have been refused care due to their gender identity;

28 percent have been subjected to harassment in medical settings; 2 percent have been victims of violence in a doctor's office; 50 percent have had to teach their medical providers about transgender health care; 1 percent report being attacked in the emergency room; and 33 percent have delayed or did not get preventive care.

Care and coverage have been denied due to gender marker conflict and insurance coding. Coverage has been denied for preventive care such as transgender men who need pelvic exams. Treatment and coverage for sex-specific cancers and diseases have been denied. The American Medical Association, the American Psychiatric Association, the American Psychological Association, and other medical communities recognize the necessity of hormone therapy and gender reassignment surgery to treat gender dysphoria. Many health care providers continue to exclude coverage because of outdated misconceptions. Many insurance companies are already providing certain coverage but will later deny the same treatment when connected to gender transition. These disparities result, directly and indirectly, in systemic stigma, minority stress, and discrimination, which increases the risk of depression, drug use, suicide, intimate partner violence, victimization, sexually transmitted infections, and human immunodeficiency virus (HIV).

Health insurance that meets the needs of the transgender community has been a huge step forward. With providers being paid for their services, we now have an increased assurance in providers learning how to best care for transgender patients in their practices and facilities. But, we still need protections from those who have been reluctant to accept this change.

These kinds of protections are absolutely necessary for us to be able to have health care in the future. That is the only thing that has allowed me to be able to have health insurance currently. There are many people like me as well. This is also a public issue because if we do not have treatment, if we do not have preventive care, that has an impact on every single one of you. Please support this bill.

Michael Hackett, representing Nevada Public Health Association; and Nevada Primary Care Association:
On behalf of the Nevada Public Health Association, one of our priorities for 2017, not just for the legislative session, but for the entire calendar year, is to improve access to health care and treatment. We want to do that with a particular emphasis on prevention and on wellness. We feel that Assemblywoman Joiner's bill is very important to ensuring programs that provide an emphasis on prevention and wellness are maintained, regardless from whom you obtain your coverage, whether it be publicly-funded health care plans or private plans. We think it is very important that these issues of prevention are still accessible by members.

I think this Committee is very familiar with what we have been doing with our patients in medical homes on behalf of the Nevada Primary Care Association and others. I think you understand very well that part of the patient-centered medical home model focuses on prevention and wellness as well as the continuum of care. We feel that by putting the provisions of the Affordable Care Act that address this into statute, the state will be better served.

Chairman Sprinkle:
Is there anyone else in support of Assembly Bill 408 here or in southern Nevada? [There was no one.] Is there anyone in opposition? [There was no one.] Is there anyone neutral to this bill?

Shannon Sprout, Chief, Policy Development and Program Management, Division of Health Care Financing and Policy, Department of Health and Human Services:
The Division of Health Care Financing and Policy, Department of Health and Human Services is neutral but would like to provide the following clarifying information. The provisions of this bill would ensure that the mandates in the Patient Protection and Affordable Care Act are upheld should the ACA be repealed. These provisions include coverage of certain preventive health care services, maternity and newborn care, coverage up to age 26 for adult children, and coverage of certain preventive health care services for women, adults, and children at no cost. Provisions of this bill also mandate that individuals enrolled in Medicaid must not be required to pay a higher deductible or any copayment or coinsurance. The Division currently has approved Nevada Medicaid and Nevada Check Up state plans to address the requirements of the ACA to include preventative health care services, maternity and newborn care, and coverage up to age 26 for adult children. Medicaid currently does not require enrolled persons to pay a deductible, copay, or coinsurance. However, if the ACA were to be repealed, federal funds would no longer be available for services that the federal government would not approve in the state plan. This would make the state responsible for funding 100 percent of the services under the *Nevada Revised Statutes*. Unfortunately, the Division is unable to determine what that fiscal impact would be, depending on what may be repealed in the ACA.

Chelsea Capurro, representing Health Services Coalition:
We want to thank Assemblywoman Joiner for taking the time to meet with us. Our concerns were just what she had stated—a few provisions of this do go above and beyond what the Affordable Care Act mandates. Of course, all of our plans are compliant with the Affordable Care Act, and should this pass, we would be happy to continue as we are. However, anything above and beyond that would cause some concerns.

Regan J. Comis, representing Nevada Association of Health Plans:
I, too, would like to thank the sponsor for taking the time to meet with us and listen to our concerns. I appreciate her conceptual amendment. With that amendment, we are neutral and would like to work with her on how she would like to state that it is not going above and beyond ACA requirements.

Ryan Beaman, President, Clark County Firefighters, Union Local 1908:
We are a group that has a self-funded, nonprofit, health insurance trust from which we provide benefits to our members, along with retirees. We appreciate the Assemblywoman

working with us about some of our concerns in regards to the ACA. Years ago, we became a non-grandfathered plan, and adopted the ACA. We had some concerns with regard to the limitations and some other words that were in the bill. I appreciate her addressing our concerns. We will continue to work with her.

Chairman Sprinkle:
Is there anyone else neutral to Assembly Bill 408? [There was no one.] Assemblywoman Joiner, you may come back up.

Assemblywoman Joiner:
Thank you for hearing this bill today. I would just like to emphasize that without enshrining these protections in our state law, Nevadans will once again face discrimination and not have protections against extreme medical costs. They could lose their coverage entirely if the ACA were to go away at the federal level. With all of that unpredictability in our national government, I know my job is to protect all of us in Nevada and all of our constituents, and I believe that this bill does that.

Chairman Sprinkle:
Thank you. We will close the hearing on Assembly Bill 408 and open the hearing on Assembly Joint Resolution 9.

Assembly Joint Resolution 9: Urges Congress not to repeal the Patient Protection and Affordable Care Act or its most important provisions. (BDR R-1084)

Assemblywoman Amber Joiner, Assembly District No. 24:
Thank you for hearing this resolution today. Assembly Joint Resolution 9 makes a recommendation to Congress not to repeal the federal laws relating to health insurance that we now have under the Affordable Care Act (ACA). Although unfortunately this law has been a partisan issue for many years, a recent poll by the Kaiser Family Foundation found that 75 percent of Americans believe that the current federal administration should do what they can to make the Affordable Care Act work, while only 19 percent say that the administration should do what it can to make the law fail so that they can replace it later. This poll finds that 89 percent of Democrats, 78 percent of Independents, and 51 percent of Republicans want the current presidential administration to make the law work. This resolution is consistent with that request.

The text of the resolution itself is very brief, but it acknowledges the importance of several key provisions: children stay on their parents' insurance until the age of 26; Medicaid is expanded, and establishing tax credits and subsidies to improve access to health insurance, which we saw through the exchanges; discrimination based on preexisting conditions is eliminated; lifetime and annual limits on coverage are eliminated, requiring the coverage of essential health benefits, and mandating coverage for preventive care and immunizations. There are many other provisions, of course, under the Affordable Care Act, but these are the key ones. It is essential that this law remain in place.

I have facts specific to Nevada that I would like to share with you. These were compiled by committee staff in the U.S. House of Representatives in January of this year. Here is what is at risk if the ACA is repealed: 253,000 individuals in Nevada who have gained coverage under the ACA could lose their coverage if it is repealed or partially repealed; 79,876 individuals who purchased high-quality marketplace coverage now stand to lose that coverage; 71,472 individuals who receive financial assistance from subsidies in the marketplace could lose those; 205,000 individuals who enrolled in Medicaid under the ACA now stand to lose coverage; 65,000 kids who have gained coverage since the ACA was implemented are also at risk of losing their coverage; and 19,000 young adults who are able to stay on their parent's insurance could lose the ability to do that.

I could go on and on. I have data on cost-sharing, I have how many people it would affect, but I will not waste your time. I would be happy to provide it to you. The bottom line is that hundreds of thousands of Nevadans are at risk of losing their coverage if we do not have the ACA in place at the federal level. That is why I am proposing this Assembly Joint Resolution today.

Chairman Sprinkle:
Thank you for that presentation. I do not see any questions from the Committee. Is there anyone to speak in support of Assembly Joint Resolution 9?

Brooke Maylath, President, Transgender Allies Group, Reno, Nevada:
I came across some numbers yesterday on the number of Nevadans with a preexisting condition whose health insurance would be threatened if the ACA is repealed: 1.2 million Nevadans have a preexisting condition that could lead them to lose their health insurance and access to health care if the Affordable Care Act is repealed.

Michael Hackett, representing Nevada Public Health Association:
I am representing only the Nevada Public Health Association on A.J.R. 9. The Nevada Primary Care Association board did not have a chance to weigh in on this resolution. The Nevada Public Health Association is in support of this legislation for the reasons that were testified to earlier. I want to add that one of the concerns of the Nevada Public Health Association has to do with the state's ability to manage chronic disease, again with an emphasis on prevention. I think it is very well understood that for every health care dollar spent, the largest percentage is spent to treat chronic disease. The percentage is considerably higher when we are talking about publicly-funded plans that provide health coverage as well. I think this is a very important consideration for us as a public health association. For this and the other reasons, we are in support.

Jodi Tyson, Government Affairs Director, Three Square; and representing Food Bank of Northern Nevada:
We had a similar joint resolution in the Senate and I provided a story, which I think would be helpful to all of you, about the connections between food insecurity and health coverage. Three Square participates in the Silver State Health Insurance Exchange. We have a contract to go out and do prescreening for those who may be eligible for the expanded Medicaid program. We partner with Goodwill Industries. We were at a Goodwill store and came across a woman named Jerri who was there buying clothes. She is a paralegal and has been for 30 years. For 20 of those years, she was not covered by health insurance. She talked to one of our staff outreach folks and applied for Supplemental Nutrition Assistance Program benefits and then she was prescreened for health insurance. She did not know that she could be possibly covered under the expanded Medicaid program because she has a job. She was reluctant to believe she could end up having health insurance coverage after such a long time. She followed through and spoke to a broker that we referred her to, who connected her to a health insurance plan for the first time. She went to the doctor and had a series of health tests since it had been so long since she had seen a doctor. Through that series of tests, she found out she was in the early stages of breast cancer. She came back to the Goodwill store months later to say hello to Lydia, who had helped her apply for these benefits, and told Lydia that she had saved her life. We had her, Jerri, visit Three Square to present this information to our employees. The great thing is that Three Square can help provide some access, but it is the Affordable Care Act that provided the coverage. Because Jerri was 60 years old, it could have been another five years before she would have been eligible for any other type of health insurance. By finding this information out early in her cancer screening, she is healthy today. We just want to point out that those who are food insecure are not just food insecure; it is part of a vacuum of other things going on.

Chairman Sprinkle:
Is there anyone else here or in the south in support? [There was no one.] Is there anyone in opposition? [There was no one.] Is there anyone neutral? [There was no one.] Assemblywoman Joiner, you may come back up.

Assemblywoman Joiner:
I appreciate your consideration of this joint resolution. I hope that you will agree with me that the coverage we have now under the Affordable Care Act is beneficial to people. I appreciate the story that we just heard. I cannot top that. Thank you.

Chairman Sprinkle:
With that, we will close the hearing on Assembly Joint Resolution 9. We will open it up for public comment.

Ed Guthrie, Chief Executive Officer Emeritus, Opportunity Village, Las Vegas, Nevada:
I want to thank you for the chance to speak to the Committee. I especially want to thank Assemblyman Carrillo for bringing Assembly Bill 224 to the Committee. Opportunity Village believes in the intent of the bill, which is to provide more community

employment for individuals with intellectual and developmental disabilities. In 2016, Opportunity Village placed 55 people in competitive community employment at minimum wage or higher here in Nevada. We will also place another 60 people in 2017 into community employment.

We are just worried about the unintended consequences of section 45, subsection 2 of the bill. There are people in Nevada currently, and will be in the future, who have been assessed by the Bureau of Vocational Rehabilitation, Rehabilitation Division, Department of Employment, Training and Rehabilitation and deemed not eligible for services because the Bureau of Vocational Rehabilitation believes they are not capable of competitive employment. The only way that those individuals can make money is either to have access to a special minimum wage, or for the Governor and the Legislature to put money in the budget to subsidize those individuals' wages up to the minimum wage. Opportunity Village would support either of those options, but without those options, these individuals would not be able to access employment services until their twenty-fifth birthday. Thank you.

Chairman Sprinkle:
Thank you. Is there anyone else for public comment? [There was no one.] We will close public comment. Thank you for a hard week of work. We are adjourned [at 2:34 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 the Work Session Document for Assembly Bill 224, with Proposed Amendment 3198 dated April 2, 2017, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit D is written testimony submitted by Kenneth Taycher, Private Citizen, Las Vegas, Nevada, regarding Assembly Bill 224.

Exhibit E is the Work Session Document for Assembly Bill 304, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit F is the Work Session Document for Assembly Bill 305, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit G is the Work Session Document for Assembly Bill 366, with amendments, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit H is written testimony in support of Assembly Bill 424, submitted by David M. Greer, M.D., Professor and Vice Chairman, Department of Neurology, Yale University School of Medicine, dated April 1, 2017.

Exhibit I is a mock-up of Proposed Amendment 3527 to Assembly Bill 424, presented by Assemblyman Michael C. Sprinkle, Assembly District No. 30.

Exhibit J is a proposed amendment to Assembly Bill 424, presented by Joseph Ferreira, President/Chief Executive Officer, Nevada Donor Network, Inc.

Exhibit K is written testimony in support of Assembly Bill 424, presented by Joseph Ferreira, President/Chief Executive Officer, Nevada Donor Network, Inc.

Exhibit L is a proposed amendment to Assembly Bill 408, presented by Assemblywoman Amber Joiner, Assembly District No. 24.

Exhibit M is written testimony in support of Assembly Bill 408, dated April 7, 2017, presented by Brooke Maylath, President, Transgender Allies Group, Reno, Nevada.