MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-ninth Session
May 10, 2017

The Senate Committee on Health and Human Services was called to order by Chair Pat Spearman at 3:52 p.m. on Wednesday, May 10, 2017, in Room 2149 of the Legislative Building, Carson City, Nevada. and Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Pat Spearman, Chair
Senator Julia Ratti, Vice Chair
Senator Joyce Woodhouse
Senator Joseph P. Hardy
Senator Scott Hammond

GUEST LEGISLATORS PRESENT:

Senator David R. Parks, Senatorial District No. 7
Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27

STAFF MEMBERS PRESENT:

Megan Comlossy, Policy Analyst
Eric Robbins, Counsel
Martha Barnes, Committee Secretary

OTHERS PRESENT:

Peg Sandeen, Ph.D., Executive Director, Death with Dignity National Center
Deborah Ziegler, Death with Dignity
Holly Welborn, ACLU of Nevada
Keith Lee, Nevada Association of Health Plans
Laura Packard
Jerry Cade, M.D.

Barbara C. Thornton, Ph.D., Emeritus Professor, Founder, Nevada Center for Ethics and Health Policy, University of Nevada, Reno
Debbie Black
Trudy Larsen, M.D.
Patrick Class, M.D.
Jason Henkle, Nevada Death with Dignity Action Project
Wendy Stolyarov, Libertarian Party of Nevada
Bradley Combs, Intern for Senator David R. Parks
Nick Vassiliadis
Sandra Antunez
Richard Harris, Nevada Death with Dignity Action Project
Lindy Bruzzone
Lee Johnson
Marlene Lockard, Nevada Women's Lobby
Jan Gilbert
T. Brian Callister, M.D.
Peter Fenwick, M.D.
Kathleen Rossi
Maureen Leck
Sharon Frank, M.D.
Kathleen Miller
David Walker
Sally Ramm
Evan M. Klass, M.D., Associate Dean, School of Medicine, University of Nevada, Reno; Governor, American College of Physicians, Nevada Chapter
Margaret Dore, President, Choice is an Illusion
Mary Conklin
Keith M. Shonnard, M.D.
Tim Doyle, M.D.
Brianna Hammon
Deidre Hammon
Stephanie Packer, Patient Rights Action Fund
Kevin Burns, Chair, United Veterans Legislative Council
John Fudenberg, Coroner, Clark County
Catherine O'Mara, Nevada State Medical Association
Lea Cartwright, Nevada Psychiatric Association
Shane Piccinini, Food Bank of Northern Nevada
Deborah Braun, Chair, Board of Directors, Food Bank of Northern Nevada

Jon Sasser, Legal Aid Center of Southern Nevada; Washoe Legal Services
Jodi Tyson, Three Square Food Bank
Elise Esquenazi, Bridges to a Thriving Nevada
Stacey Shinn, Progressive Leadership Alliance of Nevada; President Elect, Human Services Network
Caroline Mello Roberson, State Director, NARAL Pro-Choice Nevada
Regan Comis, Nevada Association of Health Plans
Chelsea Capurro, Health Services Coalition
Ryan Beaman, Clark County Firefighters Local 1908
Todd Ingalsbee, Professional Firefighters of Nevada
Vivian Leal
Michael Hackett, Nevada Primary Care Association; Nevada Public Health Association
Steve Dolan
Elizabeth Castillo
Rebecca Goff
Laura Cadot
Pam Straley
Lisa Cady
Liliana Trejo Vanegas
Rebecca Hanley
Jetzain Gutierrez
Peggy Lear Bowen
DuAne Young, Chief, Behavioral Health and Pharmacy, Division of Health Care Financing and Policy, Department of Health and Human Services
Janine Hansen, State President, Nevada Families for Freedom

CHAIR SPEARMAN:
I will open the hearing on Senate Bill (S.B.) 261.

SENATE BILL 261: Revises provisions governing prescribing, dispensing and administering controlled substances designed to end the life of a patient. (BDR 40-17)

SENATOR DAVID R. PARKS (Senatorial District No. 7):
On behalf of terminally ill patients suffering unbearable pain and loss of physical control at the end of their lives, I am pleased to introduce S.B. 261 today. The policy in this bill proposes that suffering patients should have the right to a peaceful and dignified death. I bring this bill forward as a promise to a dear

friend who at the end of her life pleaded with me to introduce a bill that would mirror Oregon's Death with Dignity Act.

Under this law, a patient diagnosed to be within six months of death and of sound mental health as determined by at least two physicians, may request and receive medication to self-administer and peacefully end his or her life.

I believe that the safeguards, procedures, written requirements and reporting functions of this law will provide a safe framework for patients to make this request and be able to live their final days under their own control.

Other states have enacted similar laws to provide a dignified death for dying patients. These states have seen an increase in palliative and hospice care, have discovered that patients who eventually use the law are almost universally participating in hospice, and importantly, find these terminally ill patients most often die at home surrounded by loved ones and friends.

Five states and the District of Columbia have passed laws similar to S.B. 261 that allow for patient self-determination in dying. The other states are California, Colorado, Oregon, Vermont and Washington. In addition, a Montana court ruling protects physicians who aid dying patients from prosecution, effectively legalizing the process.

Section 1 deals with the death certificate.

Sections 4 through 10 provide definitions.

Section 11 details the requirements for eligibility. Patients eligible to self-determine they would like assistance in dying must be: 18 years of age; a Nevada resident; diagnosed as terminally ill by both the attending physician and at least one consulting physician; make an informed and voluntary decision without coercion by others; and be competent, meaning they have the ability to make and understand the nature of the decision. Dr. Sandeen will address the coercion safeguards.

PEG SANDEEN, PH.D. (Executive Director, Death with Dignity National Center):
When Senator Parks asked for my help with this bill, I wanted to make sure I was able to bring the best legislation that we have seen around the Country. The language "making an informed and voluntary decision without coercion by

others" was important. It is a new provision passed in the California law that mandates the attending physician to meet privately with the patient, without anyone else present, to ensure there is no coercion involved with the decision. This is a good requirement added to the California law.

SENATOR PARKS:
Section 12 details the process for requesting such assistance. Patients must make two verbal requests to the attending physician, the second of which may be made no sooner than 15 days after the first. A written request, signed by two witnesses not related to the patient and not standing to benefit from the patient's death, must also be submitted to the attending physician.

Section 13 outlines the written request referenced in section 12.

Section 14 outlines the responsibilities of the physicians. Before writing a life-ending prescription, the physician must: verify the patient understands the diagnosis and prognosis; refer the patient for a consultation to confirm the diagnosis and prognosis; inform the patient he or she may revoke the request; review all available means of treating or managing the terminal condition, including comfort care, hospice and pain control; describe the probable effects of the prescribed substance; discuss the importance of having another person present when he or she self-administers the prescription; instruct the patient against administering the prescription in a public place; and recommend the patient notify his or her next of kin about the decision.

Section 15 states, if either the attending physician or the consulting physician is concerned the patient may not be competent, the attending physician shall refer the patient for a consultation with a psychiatrist or psychologist and must not write the prescription until after the competency status is determined.

MS. SANDEEN:
Section 15 is important because we do not want someone who is not mentally competent to be ingesting medication to end their life. What we have done in section 15 is raise the standard for both the attending physician and the consulting physician. If either of them sees anything to make them believe the patient is not competent or is depressed to the point where they cannot make health care decisions, that patient must be referred for a psychiatric evaluation before the process can continue.

We have heard the argument in Oregon and Washington and other states that we should mandate psychiatric evaluations. There is a researcher from Oregon Health & Science University who I believe is the Nation's leading researcher on individuals with capacity and death with dignity and the interaction of the two. She has concluded in the *Journal of General Hospital Psychiatry*, Volume 36, Issue 1, that "psychiatric evaluations for individuals requesting assisted death in Washington and Oregon should not be mandatory."

SENATOR SPEARMAN:
Could we get a copy of your reference material?

SENATOR HARDY:
Is it copyrighted?

ERIC ROBBINS (Counsel):
Normally, the document would have to be made available, but it would not be posted on the Nevada Electronic Legislative Information System (NELIS). People generally use copyrighted material as exhibits in hearings, but we cannot always post the material on NELIS because of the copyright.

SENATOR PARKS:
Section 16 outlines further responsibilities of the physician. The physician must notify a pharmacist of the prescription and transmit it directly to the pharmacist, either electronically or by hand delivery. The prescription may be dispensed only to the patient or to the prescribing physician or to an agent of the patient identified to the pharmacist as such.

Section 16.5 provides a very important safeguard, declaring the drug shall not be prescribed based on age and/or disability of the patient. Specifically, this bill does not condone or legalize end-of-life prescriptions for anyone other than terminally ill patients as described in the sections above. This is important as we made it a stand-alone section within the bill.

MS. SANDEEN:
When Senator Parks and I discussed how we protect vulnerable populations in other states, I made a recommendation to make it a stand-alone section in the bill. This is absolutely declarative, a person cannot access death with dignity based on age or disability alone.

CHAIR SPEARMAN:
Do you have an amendment for this bill?

SENATOR PARKS:
Yes, it is Proposed Amendment 4571 (Exhibit C) to S.B. 261.

Section 17 requires the attending physician and the consulting physician, and if applicable, the mental health expert, to document in the patient record all the steps described in the previous sections. Also, both the attending physician and the dispensing pharmacist must report specific information to the Division of Public and Behavioral Health within certain time frames.

Section 18 clarifies the patient's right to revoke his or her decision at any time, and that revocation is effective immediately. This bill is strictly voluntary.

Section 19 specifies that only the patient who receives the prescription may self-administer the drug. The patient can also choose not to proceed.

Section 20 states within 30 days of each scenario, the attending physician who prescribed the drug must report to the Division of Public and Behavioral Health of the Department of Health and Human Services, the name and amount of the substance prescribed, and the dispensing pharmacist must report the name and amount dispensed. The Division may adopt regulations to require the physician or pharmacist to report other information, as long as it is not personally identifiable. All such information submitted to the Division is deemed confidential.

Section 20.5 requires the Division to compile an annual report to include: the number of patients for whom a prescription was written and dispensed; the number of patients who self-administered the drug; the drug prescribed; and the frequency with which each such drug was prescribed. The Division is also required to post the report on the Internet and submit it to the Legislative Counsel Bureau to transmit to the Interim Health Committee or to the Legislature, depending on the year.

Section 21 speaks about physicians, psychologists and/or pharmacists who participate in the processes described in this bill who are not subject to professional discipline and do not violate applicable standards of care.

Section 22 states the death of a patient under the protocol described in this bill is not a suicide or homicide and may not be reported as such.

Section 23 prohibits any person from requiring a patient to make or revoke a request for the prescription as a condition of receiving health care or as a condition in a will or other legal agreement.

SENATOR HARDY:
I do not have section 20.5. Is the information on NELIS?

SENATOR PARKS:
Section 20.5 is in the Proposed Amendment 4571 to S.B. 261, (Exhibit C).

Section 24 states it is unlawful for any person to: forge a request for a prescription described in this bill; exert undue influence on an ill person to request such a prescription; or encourage an ill person to self-administer the life-ending medication.

Section 25 provides important protections of conscience. The State does not require attending physicians to provide such prescriptions to their patients, nor are pharmacists required to dispense such drugs.

Section 26 provides the same protections for the owners and/or operators of health care facilities.

Section 29 provides upon the effective date of this bill, that a will requiring a person to request—or prohibiting a person from requesting—a prescription as described in this bill is unenforceable and void.

Section 30 provides that a person is not deemed to need a guardian based solely on his or her request for or revocation of a request for a prescription designed to end his or her life.

Section 31 addresses confidentiality of records and data collection. Sections 32, 33 and 39 through 53 have been deleted in the amendment. These deletions make the bill silent on health care insurance products. There is neither a mandate nor a prohibition that the care described in this bill be considered a covered service.

Section 34 limits the provisions of this bill to attending physicians only, although there are other health care providers who may prescribe controlled substances under other circumstances.

Section 35 reinforces that prescriptions are not public records and must not be divulged by pharmacists, except under certain circumstances, including the report to the Division described in section 20.

Sections 36 and 37 provide that life insurance policies may not deny a claim, cancel a policy or impose additional charges and/or refuse to sell or issue a policy or charge a higher rate to cover a person solely because the insured had requested or revoked the request for a prescription designed to end their life.

Finally, returning to section 1, the Clark County Coroner requested we clarify the details to be included on the death certificate and this section requires the attending physician to sign the certificate and the cause of death be listed as the underlying terminal disease.

SENATOR RATTI:
I have received many emails from both sides of this issue, and there has been some compelling testimony with concerns regarding the elderly and people with disabilities or their advocates. Could you walk me through the protections one more time?

MS. SANDEEN:
There are two ways these individuals are protected in this bill. The first way is in order to qualify to be a patient under this bill, the person has to be terminally ill with a prognosis of six months or less to live. The patient is also protected by having two physicians say the person has six months or less to live. If a person has a disability that is not a terminal condition, there would need to be two physicians who would have to agree in order for the person to qualify for this program.

The second protection is by having the stand-alone section 16.5, that says a person may not qualify because he or she is a person with a disability or because of age. These are disqualifiers.

SENATOR HARDY:
Does someone have to be with the patient when he or she takes the life-ending medicine?

MS. SANDEEN:
There is no mandate in the bill that someone is with the patient when he or she ingests the medication. There is a mandate that the physicians recommend to the patients that someone be with them.

SENATOR HARDY:
I have concerns about a physician being alone with a patient when the mandated discussion occurs. That discussion should theoretically get rid of coercion unless the coercion is on the part of the physician. You and I both know physicians are not as good at predicting when someone is going to die as we think we are. Any patient with a prognosis of six months may live longer than that or shorter than that. This is a fact of life or a fact of death. When the next of kin is notified, there are feelings that could be construed as coercion one way or the other. The safety of the prescription that is given is a lethal dose and a challenge.

We have spent many hours talking about suicide during this Session, especially regarding veterans and trying to prevent it. With this bill, it is now okay to take a suicidal dose of medicine. We are trying to fight death on one hand and providing help with death on the other hand. We sometimes talk about an amyotrophic lateral sclerosis (ALS) person who wants to die, but that would be called a disability under this bill, so they would be unable to qualify for the life-ending medication. The ALS person may not have the ability to swallow or take the medication by himself or herself. The insurance issue is interesting, because the insurance may or may not cover suicide, and it is difficult for a physician to give a lethal dose of something, after the patient takes it not to call it a suicide. The prescription monitoring program we have in Nevada requires the reporting of written prescriptions. Can you solve these problems for me?

MS. SANDEEN:
In Oregon, the No. 2 underlying condition listed as the reason for the people using the Death with Dignity Act, is for ALS. We also have data from Washington state that tells us the same thing. What we know about these ALS patients is that their conditions have progressed to the point that they are terminally ill, but a few of them are still able to ingest the medication. Not every

person with ALS qualifies because of the trajectory of their disease, but some do. The reason these patients qualify is not based on their disability, but the trajectory of the disease allows them to meet all of the criteria.

SENATOR HARDY:
I thought a patient could not qualify for this life-ending medication because he or she has a disability, but he or she can qualify if the disease has become terminal. Is qualification not based on the disability, but more on the advanced stage of the disability?

MS. SANDEEN:
Yes.

SENATOR HARDY:
What about the prognosis of six months?

MS. SANDEEN:
Two physicians have to determine a prognosis and they both must say the condition of this person will lead to death within six months. This is never a known number. With some diseases, the trajectory is very clear. There are some conditions where medically we can determine a trajectory to death based on symptoms. Some of those conditions are frequently used in death with dignity.

Research demonstrates that physicians tend to overestimate how long someone has to live rather than underestimate. If a person receives a six-month diagnosis, the research demonstrates they would typically have less time to live. The idea that there are many people getting six-month diagnoses and receiving death with dignity although they could live much longer—the science does not bear that out. The data does not demonstrate this is the case.

SENATOR HARDY:
Hospice is a good example where we tell someone they will pass away within six months, when they live longer than that we say we lied and increase the prognosis. This is quite common. When a patient is in hospice, they oftentimes live longer than the six months they have to have in order to qualify for hospice care.

MS. SANDEEN:
I believe the median hospice stay across the United States is between three days and two weeks. That suggests even if someone qualifies at 6 months, really people are staying in hospice, before death, for a period of 3 to 14 days depending on how the data is collected. I believe this supports my argument that people are receiving a six-month diagnosis and living for a shorter time. The good news is, if you live longer than your diagnosis, that is a good thing. People get to spend time with their families, think about the meaning of their lives and go on living their lives until the end.

SENATOR HARDY:
We face an issue with veterans wanting to commit suicide and the interaction between trying to give them hope and keeping them alive. Have you seen any interaction where the veterans are committing suicide more often when we are trying to keep them alive? Has your "magic journal" addressed this topic?

MS. SANDEEN:
Yes, my magic journal has addressed this issue. The *Southern Medical Journal* looked at whether death with dignity laws led to an increased number of suicides and found there was no statistically significant relationship between the two. Death with dignity and suicide are two completely different things. Death with dignity is the act of a dying person ingesting medication to hasten their death and to control the timing and manner of their death.

Suicide is when somebody feels like there is nothing left to live for, he or she has unresolved issues and we see an irrational act to end his or her life. These are two very different acts. Death with dignity is a person writing something down, making a request with two doctors providing a terminal diagnosis. The two are not linked.

SENATOR HARDY:
If you do not count death with dignity as a suicide, then the suicide rate will not increase.

MS. SANDEEN:
It is not suicide. These people are dying.

SENATOR RATTI:
We discussed the scope of who is included in this bill, what is the experience in the states that already have death with dignity laws? How many folks have chosen to pursue their controlled death, gotten the prescription and then taken the medication? How many do not take the medication?

MS. SANDEEN:
The states of Washington and Oregon have reporting requirements and the data is published. California also has reporting requirements, but its first year ends in July, so the data is not yet available. There are also reporting requirements included in S.B. 261. The information I am sharing was extracted from published data.

There are about 100 to 125 individuals a year in Oregon who receive a prescription to hasten their deaths. About a third of those individuals choose not to ingest the medication to hasten their deaths. The number of individuals in Oregon who hasten their own deaths is about 80. Over the 19 years since Death with Dignity has been in effect, about 1,000 individuals have hastened his or her death. It is a very low in number of individuals and equates to 4 deaths out of 1,000 in Oregon.

SENATOR RATTI:
Has there been any research about a person obtaining the medication to end his or her life and then not following through with ingesting the medication?

MS. SANDEEN:
I do have some anecdotal evidence and a little bit of research. It appears to be peace of mind. For the one-third of individuals who choose not to ingest the medication, simply the process of qualifying and knowing they can get the medication allows them to deal with their symptoms every day. A person thinks right now the symptoms are tolerable and I can spend time with family. It seems to be peace of mind that there is another option. I do have some exhibits I would like to submit to the Committee, my written testimony (Exhibit D), Endorsements of Death with Dignity Legislation (Exhibit E), Death with Dignity: A Gift of Control (Exhibit F), and A New Poll Shows 72 Percent of Nevadans Support Death with Dignity as Legislative Committee Prepares to Hear Bill (Exhibit G).

CHAIR SPEARMAN:
Section 12, subsection 1, paragraph (a) says a patient must make 2 verbal requests, with the second verbal request to be made at least 15 days after the first verbal request. Section 12, subsection 1, paragraph (b) says a patient must make a written request for the controlled substance in a manner prescribed pursuant to section 13. It seems there has to be a conscious decision to pursue this form of activity.

MS. SANDEEN:
This is correct and mirrors what we have seen in other states where the law is enacted.

DEBORAH ZIEGLER (Death with Dignity):
I am Brittany Maynard's momma. I want to thank the forward-thinking Senators of Nevada who are supporting S.B. 261, the assisted dying bill. I have provided the Committee with my written testimony as well (Exhibit H).

As I flew into Reno, I looked at the beauty, and it felt like your State was trying to heal me. I thought about the people who live here so close to the wildness and beauty of nature. Nevadans know about death. They get it. They know not all deaths are the same. Some deaths are really bad. I think that is why seven out of ten people in Nevada are saying we want some control if this terrible thing happens to us. Some deaths are worse than others. My heart is broken. It cannot be unbroken. If my daughter had not had this law, I do not know where I would be today.

My beautiful girl was given a death sentence at age 29. She was told she had a brain tumor that had been in her brain for ten years and had invaded three out of the four lobes.

She was told the tumor would kill her and that there was no cure. Buying time was iffy. But she fought. That is just who she was. She loved this crazy, beautiful world and agreed to a craniotomy. For eight hours, they tried to remove as much of the tumor as they could. They were able to extract less than 40 percent of the tumor because it was tangled in her brain like an octopus.

Ninety days later, hoping that we had bought some time, we waited for the results of the magnetic imaging scan. The cancer had roared back and filled the space. The tumor had jumped grades, growing faster. "Momma," she said, "death is coming for me." Sometimes you can call everyone in the world. You can call doctors all over the world and death will not back down. Sometimes pain cannot be mitigated. Sometimes pain cannot be managed.

My daughter asked us to support her by moving to a place where it was legal to take medicine to fall asleep and die peacefully. If I had not done that for her, I do not know if I could live with myself. When we moved to Oregon, her face grew softer. Her gaze grew more steady. We had some beautiful times. She lived some of the rest of her life. She was no longer a terrified animal. When the pain became too much, the tumor grew too big, the seizures got worse, she started falling down, lost her sense of smell, her hearing, and her sight. She knew the ability to think, stand and walk would be the next to go.

She said, "It's time." She said, "Momma, pay it forward. Speak up, even if your voice is shaking. Do not let other people suffer." She said "goodbye." She slept. I read poetry to her. She slipped away. It was what Brittany called the best situation in a completely messed up situation. She said it was as good as it gets.

It is a small world, you heard the numbers, but these people count. There may not be many of them, but they count and they need your help. These people need you to advocate for them. Please pass S.B. 261.

SENATOR HAMMOND:
I have a question regarding the reported numbers from Oregon. Dr. Sandeen mentioned there were 137 who had asked for the medication to end their lives and only 80 had followed through by taking the medication. Does Oregon also keep data on the numbers of patients who did not follow through? Were their lives longer than expected? Are there reports of how long some of these patients lived past the diagnosis date?

MS. SANDEEN:
I would like to correct the numbers previously provided. Last year, 204 people requested medication and 133 ingested the medication. Oregon does not collect data about the length of life if the medication is not ingested. Those questions are not asked of the patients.

CHAIR SPEARMAN:
There will be a 2-minute time limit per speaker and a total of 30 minutes for those people who wish to testify in support of S.B. 261.

HOLLY WELBORN (ACLU of Nevada):
We strongly support the right of an individual who is terminally ill to make the deeply personal decision to end his or her life and about how that person will face those final days. This includes support for the patient's right to ask a physician for help in carrying out that decision. The right of individual autonomy protects all people's constitutional rights to control their bodies during the course of their lives.

There is also legal and transparent value in having aid in dying. States with bans have created and tolerated grey markets for people with resources to find sympathetic doctors to help them die peacefully. Other desperate patients try self-induced and sometimes unsuccessful methods for ending their lives.

Bringing aid in dying out of the shadows creates an open process and gives patients with terminal diseases peace of mind knowing they can choose the timing of their own death.

End-of-life choice is already recognized as an accepted legal principle. A competent adult's unqualified legal right to decline medical care, even when the result is certain death, is universally accepted where clear and convincing evidence exists that the patient wished to end life support such as through an advance directive.

Finally, aid-in-dying laws open up communications between doctor and patient that promote the right of a patient to choose life. For example in Oregon, the first state to allow physician-assisted suicide, only 1 in 25 patients who ask a physician about aid in dying actually request the medication. One-third of the people who request the medication actually take it, because patients and physicians can speak openly about end-of-life options without fear of criminal liability. Patients are free to discuss their fears more openly and physicians can offer information on alternative forms of care.

KEITH LEE (Nevada Association of Health Plans):
We worked through some concerns we had which resulted in the amendment to delete sections 39 through 53. We support the bill with the proposed amendment.

MS. SANDEEN:
When Senator Parks asked for help from the Death with Dignity National Center in passing this legislation, I suggested we commission a poll to investigate how the people in Nevada felt about this legislation. The results are noted in Exhibit G. A full 72 percent of Nevadans support this proposed legislation.

The Public Policy Polling key findings from the survey (Exhibit I) and Public Policy Polling Survey Results (Exhibit J) speak to support being bipartisan, diverse and broad-based with majorities of women at 69 percent, men at 76 percent, Democrats at 80 percent, Republicans at 66 percent, Hispanic voters at 63 percent, Catholics at 76 percent, and Protestants at 65 percent in support of the bill. Support for the proposal grew as voters heard more about the measure during the poll. After listening to a series of statements about the provisions of the bill, 75 percent of voters stated they were strongly in favor of the bill; this is an increase of 3 points from the initial numbers.

The data demonstrates the people of this State have spoken, and it is time to bring death with dignity to Nevada. This survey was conducted from April 28 to April 30 with 602 Nevada voters who were polled with a margin of error plus or minus 4 percent.

LAURA PACKARD:
About a month ago, I was diagnosed with stage IV lung cancer. My story hopefully has a happy ending because it turns out I have Hodgkin's Disease which is often curable. This issue is very important to me because it is something I have been dealing with for a couple of weeks. I thought I had eight to ten months to live. This would not be a good death. This would be extremely painful and horrific. It is important for people who have to face this in their lives to have options for a gentler death if they so choose. I submitted written testimony via email (Exhibit K).

JERRY CADE, M.D.:
I introduced the human immunodeficiency virus (HIV) program at the University Medical Center (UMC) of Southern Nevada in 1985. Between 1985 and 1996,

the prognosis for a patient diagnosed with acquired immune deficiency syndrome (AIDS) was less than three years. We had mechanisms in place to make that determination and we were not far off. I get asked this question countless times and can say as a young, eager physician who was going to change the world, I did not immediately embrace the idea. As time went on, I watched how my patients died uncomfortably and in pain. I decided there are some things that are worse than death, such as dying without good feelings and good times. In 2017, HIV is now a thing of the past if the patient takes medication. Each time I signed a stack of death certificates, I swore I was going to quit, because to a physician a death certificate is a level of failure.

I chair the Ethics Committee at UMC, which we began in 1989. There are four pillars on which ethics are based: autonomy, non-malfeasance, beneficence, and justice. Autonomy is the ability to make your own decision. Non-malfeasance means not to intrude in someone's life. Beneficence means to do the right thing. Justice means to be more sociological. Autonomy trumps everything else, and that is what this bill is about. This is the last chance for someone to have some semblance of control over his or her own life. It is psychologically the best thing we can do for a patient. I support S.B. 261.

BARBARA C. THORNTON, PH.D. (Emeritus Professor, Founder, Nevada Center for Ethics and Heath Policy, University of Nevada, Reno):
I feel very strongly about the principle of self-determination. I taught medical ethics at the University of Nevada, Reno (UNR) where we discussed death and dying considerably. With then Attorney General Frankie Sue Del Papa, we began a statewide effort to look at death and dying in Nevada. We published a report that resulted in a huge grant from the Robert Wood Johnson Foundation to fund a center in Nevada. The center serves the entire State. We discussed death with dignity in very different terms then. We found that death and dying was a major issue, but there was not much help available. How could we make someone's death easier for the parents and families. We found many ways to help the parents and families cope, but not many ways to cure the terminal illness. We watched many people suffer horrifically.

Since we began our work 30 years ago, we are just now talking about self-determination. This is the patient's right, not his family's right, not the doctor's right, not the nurse's right; it is the patient's right to make this decision. We have to proceed with ways to help the patient practice self-determination wisely and well. This is not an issue of suicide; it is an issue of deciding how to end one's life as peaceably as possible with a medication that will help an individual to do that. I have submitted my written testimony to the Committee (Exhibit L).

DEBBIE BLACK:
I was diagnosed with breast cancer 27 years ago when my son was just 5 months old, and he is here with me today in support of this bill. Six and a half years ago, I was diagnosed with metastatic breast to brain cancer and I have been living with my terminal illness ever since. My biggest worry is that my son's last image of me is someone he will not recognize, the stereotypical image of a person dying from cancer. A shadow of someone who once was, stripped of life, frail, skin and bones, doped up on medication just to be able to tolerate the pain with no quality of life left. I think about this often, and it breaks my heart knowing my son is going to have watch me suffer before I die.

When I started following Brittany Maynard's story back in 2014, I was hopeful I would be given the right to make that choice whether to die peacefully in a humane way rather than to die suffering. In the past, I have considered moving to a state where this is legal, but to do so would take me away from the comfort of my own home, my only son, my new granddaughter, my family, extended family and friends. I know some will look at this as assisted suicide, but not me. I did not choose this terminal illness, and there is no cure. I do not want to die, but the reality is my cancer is going to kill me. Why not allow me the right to die with some dignity.

TRUDY LARSEN, M.D.:
I have been an HIV/AIDS doctor for 35 years. Dr. Cade and I have been long-term colleagues. In the early days, when there was nothing to help people with AIDS, they died a terrible death. There were fear, stigma and misunderstanding about the transmissibility of the virus. In addition to dying in extreme pain and suffering, the HIV patients were discriminated against. I took care of these patients, I held their hands as there was little else I could do for them. The patients begged. They kept asking if there was something I could do to help them with the pain. When the patient's caregiver became ill, he or she talked about the same thing. The caregiver did not want to go through what they had watched their partner go through. Is there something you can do?

At a national AIDS conference in 1989, one of the physicians gave one of the most amazing talks I have ever heard. He talked about death with dignity for our patients who had no options. We talked about having a cocktail of drugs with a bottle of wine and friends and loving in order to take control over death. My patients often hoard their medications in anticipation of being in that same predicament. The patient is sick with nothing else that can be done for him or her. This bill gives a wonderful framework for how to do this correctly, and I believe it provides a means for death with dignity.

PATRICK CLASS, M.D.:
I have been a practicing physician in Nevada for 35 years. I am here because of my personal life experiences. My wife at age 44 was diagnosed with stage III breast cancer. At the time I had three children below middle school age, and my wife was so concerned about the dying process she became a hospice volunteer. Fortunately, my wife is still alive, and her survival prognosis was less than five years. In the meantime, I have had a brother-in-law and a very close friend die of glioblastoma, which is a horrible type of brain tumor.

Both had very ugly deaths. One of the men died here in Reno. He was one of the few Olympians from Nevada, a fellow swimmer and good friend. We were in Mexico a few months prior to his diagnosis. He had the brain tumor removed and after several trips to San Francisco and valiant attempts to live, he underwent a horrible prolonged death. If he had the option, knowing there was no good outcome, would he have chosen death with dignity?

I have a sister-in-law who is a very well respected reporter in Cincinnati whose option for dying when she had a central wasting disease was voluntary starvation and the withholding of water. Over an excruciating seven to ten days while she was writing about it, she died. I wondered if this is the best we have to offer. If you read the journals of palliative care today in hospice, that is one of the options we still allow individuals to choose. An individual can starve to death. It would be nice to have more tools in our box and large doses of morphine.

JASON HENKLE (Nevada Death with Dignity Action Project):
From 1998 through 2015 with Oregon and Washington combined, we had 1,845 patients who have taken advantage of the physician aid in dying (Exhibit M). Of those patients, 76 have died of some form of cancer. Using the cancer death count and population data combined with the data from Oregon and Washington, I was able to make a projection if S.B. 261 passed in Nevada. Essentially, my projection shows 146 people per year would take advantage of

physician aid in dying from 2018 through 2022. This is a total of 728 people for the first 5 years of implementation if this bill were to become law.

I authored a report with Attorney Richard W. Harris (Exhibit N) where my calculations reside for your review. I support physician aid in dying. It is not suicide because the individual is dying from the underlying illness. It is not euthanasia because the locus of control remains with the patient for the entirety, including self-administering a lethal drug.

WENDY STOLYAROV (Libertarian Party of Nevada):
We support this bill very strongly. We believe S.B. 261 creates a legal pathway for terminally ill people to reclaim their dignity and autonomy. It is a lantern on certainty in the darkest of circumstances. The Libertarian Party of Nevada believes that the right to life, liberty and the pursuit of happiness also includes the freedom to end your own life in that pursuit. Not all terminal patients feel this way, and I know some would never choose this path, but the choice must be available.

We recognize that some sections of the bill would impose certain requirements on health insurers, and we presently have no opinion on those sections.

If a terminally ill patient wants to end his or her life, he or she will, whether or not this measure passes. The absence of a legal pathway for death with dignity has never stopped a person who genuinely wanted to end his or her life as we see in the 45 states that do not have these laws. Fate has been cruel enough to terminal patients. We as Nevadans should find the compassion, bravery, and respect for individual autonomy in our hearts to grant this option to those who seek it. The Libertarian Party of Nevada is proud to support S.B. 261.

BRADLEY COMBS (Intern for Senator David R. Parks):
I am here to testify in support of S.B. 261. I would like to begin by discussing what end-of-life options are not. End-of-life options are not about disrespecting the sanctity of life as some may claim. End-of-life options are not about cost savings. End-of-life options are not about easing the pain on anyone but the patient. Most importantly, end-of-life options are not about giving up.

What end-of-life options are about is giving patients the ability to expire on their own terms, giving them control over when and where they wish to end their journey. In fact, many of them do not even use the medication, instead getting comfort in the idea that they alone have control over their destinies. It is not always the fear of death that the patient suffers from but the fear of a painful death.

As an Intern for Senator David R. Parks, I was given the option of choosing which bill I wanted to research and testify on in support or opposition. Upon learning that S.B. 261 provided end-of-life options for the terminally ill, and with personal experiences, I knew this would be the bill I would choose.

I had a family member suffer from ALS or Lou Gehrig's disease. Watching the specter of death haunt my uncle made me realize that the end goal of medicine is not always to allow the patient to keep going but to give them comfort and ease in their final days. I observed that one could still find hope, love and compassion for others. Most importantly, I realized that even though my uncle wanted to press on until the last moment, not everyone would. That is the beauty of this bill; it allows something very simple, a choice.

No one deserves to die in pain. While death is inevitable for all living things, there is no reason for needless suffering. All humans deserve a peaceful death, not only for themselves, but to give comfort to their friends and family. Like a book, life is marked by an end and a beginning.

NICK VASSILIADIS:
I made a promise to the daughter of my mentor who passed away earlier this year. That promise was that no one would have to go through what her father went through. I watched him deteriorate over eight weeks into something that was no longer him. He had lost all mental faculties. He had lost the ability to do anything. It did not need to be that way. He and his daughter had a conversation before it got to that point and agreed it was time. He had fought cancer three times and was successful twice. The last time was what got him and he had to suffer needlessly. For that reason, I support S.B. 261.

SANDRA ANTUNEZ:
I have made the decision that if I get a life threatening disease, I do not want to live with it. I have had conversations with my children, and the only way is to commit suicide. I support death with dignity so I could be surrounded by my family and my friends. I do not want to be hyped up on medications and drugs to keep me comfortable until I pass and lose bodily functions. I want to have the choice not to suffer or make my family suffer.

RICHARD HARRIS (Nevada Death with Dignity Action Project):
I am a local attorney and have a Ph.D. in public policy from UNR. I am here to voice my support for S.B. 261. I am one of the cofounders of the Nevada Death with Dignity Action Project. My colleague and I recently published an opinion letter in the *Reno Gazette-Journal* (Exhibit O). We outlined the many reasons why we think S.B. 261 is a policy that should govern end-of-life decisions in Nevada.

I speak to you today in a request for freedom. Nevadans value freedom and freedom to choose is certainly one of the most elemental and basic acts of humanity. Please provide that opportunity to our community.

LINDY BRUZZONE:
I am from Laughlin and drove up here to speak personally to the Committee. I have a hereditary cancer syndrome called Lynch syndrome as identified in the presentation provided to the Committee (Exhibit P). My whole family has this hereditary cancer syndrome. The entire family of my grandparents died of cancer. They died devastating deaths. My father, his sister and his father all died of cancer. My brother, sister and I have all experienced at least one cancer, and among the three of us, we have experienced eight different cancers.

I have two children and three grandchildren. Of those two children and three grandchildren, four have cancer. Since the cancer is genetic, there is no sure treatment and there is no sure cure. We deal with everything primarily with resection if the gateway physicians diagnose us at all. Many physicians do not know about Lynch syndrome. We spend a great deal of time in hospitals and have yearly screenings, but we also die. My nephew is dying now. We knew as children how we were going to die. It is not the dying that frightens us, but it is the process of dying. Every time we see someone die of cancer in our family, we see ourselves. We see our fate. We know we are going to die that way. It is the same for our families.

I am the founder and former Chief Executive Officer of Lynch Syndrome International; and there are thousands and thousands of families throughout the world who have this hereditary cancer syndrome. They all feel the same about having options. There are many families like us. We do not know if we will use the aid-in-dying option, but we know it gives us a choice. Senate Bill 261 gives us comfort because we already know how we will die.

LEE JOHNSON:
I want to read a letter (Exhibit Q) from Governor Edmund G. Brown when he signed into law California's end-of-life option. As a prologue, I want to point out that Mr. Brown graduated from a Catholic high school and attended a Catholic seminary.

MARLENE LOCKARD (Nevada Women's Lobby):
The Nevada Women's Lobby feels this is a very important piece of legislation that will offer relief and comfort to those that are afflicted with such terrible news that their life has been shortened. We strongly support S.B. 261.

JAN GILBERT:
I want to thank you all for your thoughtfulness about this very difficult issue. I also want to represent Progressive Leadership Alliance of Nevada. You have heard so many wonderful arguments for this very, very important bill. I know in my network of friends, we talk about this a lot. I have heard all kinds of things that people say about stockpiling drugs. People are concerned and ready to move to a state that has this option. Most people do not want to leave their friends and family. Please pass S.B. 261 so Nevadans can make the choice for themselves with their doctors' help.

CHAIR SPEARMAN:
I will add to the record, written testimony in opposition received from Rhonda Ashurst (Exhibit R), Sheila Danish (Exhibit S), and Ashley Cardenas (Exhibit T).

T. BRIAN CALLISTER, M.D.:
I have been a practicing physician in Nevada for three decades. I work in the hospital. I work every day on the front lines with folks who are going through the death and dying process. One aspect of the bill that needs to be considered very carefully are the perverse incentives and potential for abuse.

I have had two patients already, one from Oregon and one from California, who were in the hospital here in Nevada and required lifesaving treatments. I tried to transfer each of those patients, one to Portland and one to Sacramento for a lifesaving treatment. Not a palliative treatment, but a life curative treatment. In both cases, the insurance medical directors, two different individuals from two different states, rejected the requests. That was not unexpected because we fight with insurance companies all of the time. What was unexpected and stunned me, was when they told me they would not cover the life curative treatment, but would I talk to the patients about assisted suicide because the insurance company would cover it.

This is an access-to-care issue. Relative to some of the Oregon data you heard earlier, in 2016, of the people who requested end-of-life drugs and did not take them, only 40 percent of individuals died within an entire year. We are very bad at predicting how long someone is going to live when we provide them with a terminal diagnosis. We are often very, very wrong. There is still quality of life out there because once a person takes those pills, there is no going back.

This bill is not about assisting patients to die; this is a bill about giving doctors the right to kill. There is no going back on that. I submitted my written testimony (Exhibit U).

PETER FENWICK, M.D.:
I have been practicing medicine in Nevada since 1978 and have some relevant information regarding S.B. 261. The State of Oregon legalized assisted suicide in 1997, so we have 20 years of data pertaining to this act to review.

The law in Oregon states patients must be mentally healthy which includes they have no significant depression or anxiety, but surprisingly, over 96 percent of these patients were given lethal drugs without a psychological or psychiatric assessment to confirm their mental status.

Over 50 percent of patients who applied for assisted suicide gave the main reason as becoming a burden to their families, friends or caregivers, which is very sad. An ill or disabled person should never be regarded as a burden.

The method used is to take 90 capsules of a sedative, which is not easy to do, and some patients have actually regurgitated some or all of the capsules. Six patients who took the full dosage regained consciousness and died later of natural causes. No patient having gone through the experience and failed is reported to ever try it again.

Also in Oregon, there are recorded cases of an insurance company denying bone marrow transplants which may have been lifesaving procedures, which though expensive, suggest an authorized 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 the cause of death is not the overdose of the drugs, but the reason for the assisted suicide. This is not true, and any coroner will confirm this.

Another Nevada physician and I have over 100 years of experience in medicine between us and feel it is totally unnecessary to help a patient kill himself or herself for any medical reason. Neither of us have ever assisted a patient to kill himself or herself or let someone suffer unreasonably. We have palliative care and hospice physicians available who specialize in patient care for the terminally ill.

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

KATHLEEN ROSSI:
I am a registered nurse who has practiced in Nevada for over 30 years. I have cared for people with terminal illnesses and have been at the bedsides of numerous dying patients. I am here today in opposition of S.B. 261. My years of experience tell me that although well-intentioned, this bill is a very bad idea and will ultimately harm the people it proposes to help.

In medicine, we assess care in view of its benefit versus risk. Removing any morality from this issue, any possibility of making assisted suicide public policy is immensely outweighed by the risks. The problems in pain and suffering are important to nurses. Fortunately, there have been great advances in pain management since I first began nursing. I do not doubt stories of people dying in pain, but I do question whether they received the correct care. Good hospice and palliative care takes great skill. My fear with assisted suicide is that incentives to improve this type of care will change in favor of the easier and more affordable practice of offering a bottle of pills. I also disagree that this is the next step in patient autonomy.

Once we decide assisted suicide is indeed a medical treatment, the standard of care will change. That very patient autonomy is lost and given to those that pay the bill. This has happened in Oregon and California as people will testify. Severely depressed patients could receive assisted suicide. I have cared for depressed patients in terminal and painful conditions who tell you they want to die only to see them later in functioning happy states. The fact that proponents feel no psychiatric evaluation is needed defies common sense and is truly malpractice. There is the potential for family members to pressure the patient into this choice. As nurses, we do see a lot of dysfunctional families, and that worries me.

I also worry about what this will do to the medical profession because implicit bias does exist. Assisted suicide will change attitudes. Follow the logic: if patient A does the noble thing by taking his own life, why is patient B still here when his care is so taxing? The so-called right to die will become a duty to die. Nurses are, in most cases, understaffed and asked to give more for less. Our society may decide the answer to patients' physical and emotional suffering is taking their lives. We would prefer it be about receiving good nursing care. I have submitted my written testimony for the Committee (Exhibit V).

MAUREEN LECK:
I have worked as a registered nurse in Nevada for over 40 years. The past 15 years have been spent working in hospice care. Hospice patients and their families have given me an invaluable education in not only the process of dying but also in living until a person dies.

Hospice has been an opportunity for me to witness the great gifts that the end of life has to offer. It can be a time for the dying people, their families or their caregivers to mend and heal relationships, a time to forgive, a time to love and trust, a time to prepare for life without their loved ones, a time to make memories. Based on what I have seen as a hospice nurse, I believe it is important to allow a person to journey through the end of life in their natural time. We need time and space to complete the life cycle.

As a hospice nurse, it frustrates me greatly when I hear about people dying in pain. The hospice team includes a medical doctor who is well-equipped to prescribe proper pain and symptom management. The hospice team also includes nurses, social workers, chaplains, and personal care aides who assist in reducing the patient's suffering, whether it be physical, emotional or spiritual. In addition, there are many other resources and trained professionals available to help those who are dying to discuss their fears, and to find meaning and peace at the end of their lives.

Many family members feel it was a gift for them to participate in the care for a loved one. Some told me they thought they would not be able to provide end-of-life caregiving, but found that not only did they have the strength to support and care for the dying person, but that it was something they would not have changed for the world.

Enacting legislation which encourages patients to opt for physician prescribed suicide is not the answer to the needs of persons facing the end of life. Please protect vulnerable populations and ensure appropriate and ethical care for dying persons by voting no on S.B. 261. I have also submitted my written testimony to the Committee (Exhibit W).

SHARON FRANK, M.D.:
I am a licensed physician in Nevada. I have practiced medicine clinically for 20 years and worked for 6 years as a physician reviewer for insurance companies. I have several concerns about S.B. 261. Physicians have a great deal of difficulty in accurately diagnosing the length of time that a patient will live. I am opposed to what was stated by Dr. Sandeen. Physicians frequently underestimate how long a patient has to live. This bill requires a second opinion, and it is very unusual for a second opinion to overturn the first opinion. As a clinician, if you do not agree with the first opinion, as a doctor you would no longer receive referrals. There is going to be pressure on the second opinion doctor to agree with the first opinion doctor.

As a physician who worked at approving what insurance companies will pay for a patient, I have great concern that if suicide is an option, insurance companies will begin to go the cheaper route in treating the patient. The insurance companies may choose to cover the shorter treatment by ending the patient's life sooner.

My husband was diagnosed with metastatic brain cancer. Four physicians said he had a 5 percent chance of living for 6 months and he lived for a year and a half. During the year and a half, we had many wonderful life experiences. As a breast cancer survivor, I am glad that suicide was not an option then. Five surgeries and two years of treatment later, I am very happy with my life.

KATHLEEN MILLER:
I am a marriage and family therapist. Like Dr. Frank, my mother was diagnosed with an idiopathic pulmonary fibrosis. When she was diagnosed, the prognosis

was to have less than five years to live. With a very large family, if physician-assisted suicide had been available, they may have thought suicide was the more compassionate route to take. Thankfully, she lived for another 17 years. The doctors were amazed, and it was good for all of us. She was able to witness more grandchildren, marriages and life experiences that physician-assisted suicide would have negated. I urge you to vote no on S.B. 261.

DAVID WALKER:
I am a grandfather. I think the bill detracts from the joy of life. In Nevada, we have one of the highest teenage suicide rates and suicide rates in general. Rather than discourage patients from enduring some hardships, we should be trying to bolster people's opinion on the value of going through the tough times and enjoying their families as much as possible.

SALLY RAMM:
I am a recently retired Elder Rights Attorney from the Aging and Disability Services Division. I am here personally because I intellectually, emotionally, and morally feel that doctor assisted suicide is not the right thing to do. My father was struck with a potentially fatal illness when my sisters and I were little girls. He knew if he survived, his life and our lives would be changed forever. He wanted to die and asked everyone who came into his room to please unplug the machines that were keeping him alive. He felt our family would be better off without him. He felt the hopelessness that often comes from knowing he would be disabled.

He did not die. He lived in a wheelchair for 30 years. Despite being disabled in a time when disability was considered a weakness, he was employed, he and mother bought their first house and he watched his daughters graduate, marry and begin their families. He taught us courage, perseverance and creative ways of overcoming the burden of constant pain to be optimistic and loving.

During the years I spent with the Aging and Disability Services Division of the Department of Health and Human Services, I learned some people will do anything they can to get money or to save money, including neglecting the vulnerable people for whom they have taken responsibility. We also knew that sometimes, maltreatment of vulnerable people is a result of caregiver burnout.

People often say, it is my life, but our lives are a gift to us and to our community. Everybody suffers during their lifetime and feels hopeless at one time or another, but taking one's own life is usually thought of as a breakdown of mental health. Extreme suffering during the final days, weeks or months of life is something that is unimaginable to those of us who have not been through it. There must be a better solution than to pass a law that makes suicide a viable decision. I have also submitted my written testimony (Exhibit X).

EVAN M. KLASS, M.D. (Associate Dean, School of Medicine, University of Nevada, Reno; Governor, American College of Physicians, Nevada Chapter):

The American College of Physicians (ACP) represents over 143,000 specialists in internal medicine nationwide. I am speaking for a chapter that represents over 800 internal specialists in Nevada. The ACP has been called the conscience of medicine by a well-known medical historian, and the commitment has always been to put the patient first. I would like to read you a letter (Exhibit Y).

MARGARET DORE (President, Choice is an Illusion):

I am a lawyer from the State of Washington where assisted suicide is legal. Choice is an Illusion is opposed to assisted suicide and euthanasia. What does the bill do and what does the bill say? The bill does not say what the presenters say it says. If you read it carefully, the bill does not say what you think it says. As an example, self-administer is not defined in the bill. The act of ingesting is defined in the Washington law, which allows euthanasia. Be very careful with these definitions.

The bill is not for end of life, but for ending lives under these definitions. People can have years or decades to live. The definition of terminal condition which is the criteria being used not suffering or dying. The definition is similar to the one being used in Oregon which includes chronic conditions such as diabetes. People with these conditions can have decades to live. There is also the idea of a misdiagnosis. I have a friend who was talked out of suicide almost 17 years ago. She was refusing treatment and her doctor convinced her to be treated instead. This bill has a far broader reach than you might think.

This bill creates the perfect crime. The easiest thing to see if the death occurs in private, two people can be there. I am a probate lawyer and have seen the horrible things people do to each other. "Hey Dad, you are feeling better, let's have a drink." After drink number one, two, three, four, everyone is pretty happy then drink five contains a lethal dose to end his life. Dad is now dead and the death certificate must reflect a natural death. It is the perfect crime. I have submitted a handout (Exhibit Z) for the Committee to review.

MARY CONKLIN:
I am a nurse by profession. I want to read from a letter by J.J. Hanson (Exhibit AA), a U.S. Marine war veteran, a husband and a father. These words come from him and he knows we are speaking them today as he is unable to be here.

Only three years ago I was living the American dream, happily married, our son had just turned one and I had a job I loved. Then, life changed in an instant. That is when they found cancer—grade 4 glioblastoma multiforme. The neurosurgeon told me it was inoperable, and I was given a prognosis of four months.

I had not only one but three different doctors tell me there was nothing they could do. Surgery, chemotherapy and radiation rarely work with this type of cancer. I, fortunately, did not listen to those doctors.

I am so thankful that I did not accept their initial prognosis. And while I continue to fight my disease, I am going on three years since my diagnosis. This is two years and eight months longer than the prognosis the doctors gave me. Despite difficulty, I am thankful for the last three years. If this legislation was legal at the time I was diagnosed and I was told I was terminal, I could have gotten the doctor-prescribed suicide pills when I was in good spirits and motivated to fight my illness. I would have had them with me when I was in bed during Month 5, feeling terrible and in pain. I was questioning whether life was worth living. I thought about ending my life. I did not end my life, and my son and my wife are happy I am still here.

KEITH M. SHONNARD, M.D.:
I am a physician here in Carson City and have practiced for 21 years as an interventional radiologist. I am in opposition to S.B. 261. We have had many people testify today about patients with terminal diseases who have lived longer than expected. As a physician who has practiced in this field for a long time, we do not always know how long someone has left. When I have to tell patients they have a terminal illness, it is about the worst thing I can ever do. It is also the worst thing a patient can ever hear. There is going to be a grieving process

as the patient tries to understand the disease. There will be many down times for the patient. Those down times are when this bill will put these patients at great risk. This down time is when a patient might pursue this end-of-life option. Good times and bad times will change. That is what many patients who live through this process go through. I am concerned the patient and his or her family will be put at risk. I do not believe this will be good for the physician-patient relationship.

I have a friend who has rectal cancer which is considered a terminal disease. He decided to be home with hospice care. He basically did not eat or drink for about two weeks and woke up one day and said this is not for me. He came in to pursue treatment. This patient went through the down time, and if this bill had been law I am afraid he would have taken a lethal dose of medication.

TIM DOYLE, M.D.:
I have been a neurologist here in Carson City for 22 years. I am in opposition to the bill largely because it is against the Hippocratic Oath. I want to remind everyone the essence of medical practice is the vocational commitment to all patients without doubting whether or not any of them are worthy of our efforts. Not too many years after I came to town, I saw a woman in the emergency room who had a first-time seizure. Her diagnosis was a brain tumor. Shortly after that she was given six months to live. She was still around two and a half years later and happy to be here. Her husband, who was a psychiatrist, was also happy she was still around. This brings up an important aspect of the considerations.

I would like to read something from an opinion article titled, "The Assisted-Suicide Movement Goes on Life Support," in the *Wall Street Journal*, May 22, 2015 by Dr. Aaron Kheriaty, a psychiatrist from the University of California, Irvine, talking about Oregon.

> A large body of psychiatric research has demonstrated that 80% to 90% of suicides are associated with depression or other treatable mental disorders. Yet only 5% of the individuals who have died by assisted suicide under Oregon's permissive law were referred for psychiatric consultation before their death. This lack of basic psychological evaluation and treatment constitutes medical negligence.

These patients who are not given a psychiatric evaluation before they take this step are not of sound mind in my evaluation with any degree of certainty. Although, that is the first thing a patient signs when the consent is signed to proceed. Just because a patient does not have Alzheimer's disease does not mean the patient is not of sound mind. It has no relation to the soundness of mind.

BRIANNA HAMMON:
I am here in opposition to S.B. 261. Unlike other presenters, I am not going to pretend that this bill is about end-of-life issues for anyone. This bill is a gift to insurance companies, Medicare and Medicaid. The gift is cold hard cash. The gift is the death of those of us who may have expensive health needs. Insurers are the lobbyists pushing this bill. Maybe they pay some wealthy white folks who have never experienced the medical apartheid those of us from minority groups have. Maybe they still hold on to a mythology about control and choices. I am not going to let you all pretend the debate is about people's needs.

I am a person with a disability, and I already have a hard time getting an informed choice. I got a letter from Medicare a few weeks ago that I am cured and do not need a wheelchair. The tactic there is to deny, deny, deny and hope I die in the meantime. I started the process to get a new wheelchair a year ago. Now, I have to start over. It is frustrating to be a person who relies on state or federal insurance. The systems abuse you. Attendance care services have not had an increase since 2003. Do you know how hard it is to get care with 2003 wages? The frustration of dealing with this stuff can be overwhelming. Do you think people with disabilities get counseling options from knowledgeable counselors? No. If this bill passes, what we will get is a mouthful of poison. Do not kid yourselves. Please vote no on S.B. 261 to support the lives of people with disabilities and the elderly. Do not make us a treat for already bloated insurance companies and state or federal budgets. Be a voice for the least of us.

DEIDRE HAMMON:
Spare no expense, keep me alive. We heard a lot today about choice, and I think people in general already have a choice. You heard a lot of people who were storing medications, talking about mixing medications with alcohol. We are not talking about giving people choices. We are talking about physicians' rights. We are talking about the right of the physician to give a lethal substance to people. The testimony we heard today was also filled with many people who outlived

their six-month diagnoses. Many people might not be here had this bill already been in effect. I will submit my written testimony (Exhibit BB).

STEPHANIE PACKER (Patient Rights Action Fund):
I was denied treatment. For $1.20 I can kill myself, but my insurance will not pay for my life-extending treatment to stay with my kids. I do not want to be unfair, but I agree with everything that has been said in opposition to this bill. I will not get to live as long as I can if people continue to get these laws passed. I am not the cheapest option. Please consider those of us fighting for every last moment with our families and friends.

KEVIN BURNS (Chair, United Veterans Legislative Council):
I represent the major veterans organizations within the State. We are testifying neutral today because this is a fracturing type of issue and it has split us down the middle. We have held veterans on the battlefield who we willed to die because their shattered bodies were so bad, but by the same token we have saved some who should have died. We see both sides of this issue.

Our major concern was voiced by Dr. Hardy early in the presentation. This comes through our community as state-sanctioned suicide. This legislation would lower boundaries for those of us who are suffering from depression, then turn around and say the state says it is okay for anybody to kill themselves if they are in pain. Every third day a veteran kills himself or herself. We are trying to stem that number.

JOHN FUDENBERG (Coroner, Clark County):
We are neutral on S.B. 261, as amended. We wanted to include clarifying language to specifically direct coroners and medical examiners to handle the process of dealing with the investigation or not investigating this type of death. All of our issues have been addressed.

CATHERINE O'MARA (Nevada State Medical Association):
The Nevada State Medical Association is neutral on this bill. Following discussions related to this bill, there are sincerely held beliefs on both sides of the issue. For physicians it is difficult to balance a core value of respect for the autonomy and fidelity to their patients with a code of ethics that prohibits physician-assisted suicide. I did provide the American Medical Association Principles of Medical Ethics as it relates to the end stages of death (Exhibit CC). As neutral, we are not intimating to you to process this bill or not.

If you do choose to process this bill, we hope you will remember our concerns in section 20.5 which requires an annual report concerning the implementation of these provisions. When we first reviewed the bill, we were concerned about the provision that had the cause of death on the medical death record to be the terminal illness and not the actual technical cause of death. Statutes currently require physicians to put the actual cause of death on the medical record. This bill will allow a legal exception to this requirement. We want to ensure, if this bill passes, and these deaths are tracked, that we are able to use the data for public health decisions. Which diseases are commonly leading to these kinds of deaths and where should we be putting our resources. We want to make sure everyone knows what is happening and we have the ability to track the deaths to make sure it can be assessed from a public health perspective.

LEA CARTWRIGHT (Nevada Psychiatric Association):
The Nevada Psychiatric Association provided a proposed amendment (Exhibit DD) to S.B. 261. We approached the sponsor of the bill with this amendment but it was not accepted. We feel it is a reasonable request that if a physician sees any indication that the patient may have a mental disorder, they must request a mental health evaluation. Mental health disorders can impact the decision-making capacity, and we would like to see people evaluated if there is any indication of a mental health disorder.

MS. SANDEEN:
The process is very important to begin to think about how we will serve terminally ill Nevadans. The proposed law is at its core a medical standard of care designed to provide physicians and pharmacists with best practice guidelines for situations in which a terminally ill and competent patient requests the right to control the timing and manner of his or her death. By enacting this law, Nevada will send a strong message that a compassionate response to suffering is available in Nevada. A law that contains significant and carefully regulated safeguards to protect patients and prevent misuse. As you read this bill, you will note a series of safeguards designed to protect the patient.

The multiple safeguards include:

- A diagnosis that the patient is within six months of death verified by a second opinion;

• A mandatory counseling referral if either the primary or attending physician believes the patient may not be competent to make health care decisions;

• Two oral and one written request and 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, 15 days and 48 hours; an independent meeting with the physician to ensure the patient is not being forced or coerced;

• Information must be provided to the patient on all forms of palliative care, hospice care and other end-of-life options;

• The patient may opt out at any time and for any reason; and

• The patient must self-administer the medication, no other person may do that for them; and the patient or any health care professional may choose not to participate.

Throughout the bill there are many safeguards but it allows individuals who are terminally ill to have a choice about the timing and manner of their death. Senate Bill 261 is an important bill for your consideration.

CHAIR SPEARMAN:
I received two other letters of opposition to the bill, one from Dr. Kirk Bronander (Exhibit EE) and one from Don Nelson (Exhibit FF) that will be included in the record. I appreciate everyone's indulgence and understanding of the time constraints in order to hear both sides of S.B. 261. This bill is very emotional and people are passionate on both sides of the issue.

I will close the hearing on S.B. 261 and open the work session with S.B. 394.

SENATE BILL 394: Revises provisions relating to Medicaid managed care and required coverage provided by health insurers. (BDR 38-950)

MEGAN COMLOSSY (Policy Analyst):
Senate Bill 394 was heard on April 5, as noted in the work session document (Exhibit GG). The bill was heard in work session on April 12; however, it received a waiver and new amendments were proposed. The original bill

requires the director of the Department of Health and Human Services (DHHS) to sell Medicaid on the Silver State Health Insurance Exchange and makes various changes to align State law with provisions of the Affordable Care Act. However, as you can see in the amendment section and in the attached Proposed Amendment 4453, it deletes all sections of the bill related to selling Medicaid on the Exchange and also those provisions that align Nevada law with certain provisions of the Affordable Care Act.

In addition, an amendment proposed by Danny Thompson, representing Laborers' International Union Local 872/AFL-CIO was proposed during the hearing and is located in section 36.5 of the mock-up.

Another amendment was proposed by Senator Spearman to require the Legislative Committee on Health Care to study certain issues related to providing a program similar to Medicaid on the Exchange during the 2017-2018 Interim and is also included in the mock-up in section 48.5.

CHAIR SPEARMAN:
Because we already voted on this in a prior work session, we need to rescind the previous action and move forward with voting on the new amendment.

> SENATOR RATTI MOVED TO RESCIND THE PREVIOUS ACTION TAKEN ON S.B. 394.
>
> SENATOR WOODHOUSE SECONDED THE MOTION.
>
> THE MOTION PASSED. (SENATORS HAMMOND AND HARDY VOTED NO.)

*****

> SENATOR RATTI MOVED TO AMEND AND DO PASS AS AMENDED S.B. 394.
>
> SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION PASSED. (SENATOR HAMMOND AND HARDY VOTED NO.)

*****

CHAIR SPEARMAN:
I will open the work session on Assembly Bill (A.B.) 20.

ASSEMBLY BILL 20 (1st Reprint): Revises provisions relating to services to assist persons with disabilities in obtaining employment. (BDR 38-225)

MS. COMLOSSY:
Assembly Bill 20 was heard in Committee on April 26, as noted in the work session document (Exhibit HH). The bill revises provisions relating to services to assist persons with disabilities to obtain employment. No amendments were proposed for the measure.

SENATOR WOODHOUSE MOVED TO DO PASS A.B. 20.

SENATOR RATTI SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

*****

CHAIR SPEARMAN:
I will open the work session on A.B. 31.

ASSEMBLY BILL 31: Revises provisions relating to the Specialist for the Rights of Elderly Persons and the Community Advocate for Elder Rights. (BDR 38-130)

MS. COMLOSSY:
Assembly Bill 31 was heard in Committee on April 19, as noted in the work session document (Exhibit II). The bill revises provisions relating to the specialist for the Rights of Elderly Persons and the Community Advocate for Elder Rights. No amendments were proposed for this measure.

SENATOR HARDY MOVED TO DO PASS A.B. 31.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

*****

CHAIR SPEARMAN:
I will open the work session on A.B. 95.

ASSEMBLY BILL 95 (1st Reprint): Revises provisions governing child support. (BDR 38-197)

MS. COMLOSSY:
Assembly Bill 95 was heard in Committee on May 1, as noted in the work session document (Exhibit JJ). The bill revises provisions governing child support. No amendments were proposed for this measure.

SENATOR RATTI MOVED TO DO PASS A.B. 95.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION PASSED. (SENATORS HAMMOND AND HARDY VOTED NO.)

*****

CHAIR SPEARMAN:
I will open the work session on A.B. 108.

ASSEMBLY BILL 108: Provides for the periodic review of Medicaid reimbursement rates. (BDR 38-209)

MS. COMLOSSY:
Assembly Bill 108 was heard in the Committee on May 3, as noted in the work session document (Exhibit KK). The bill provides for the periodic review of Medicaid reimbursement rates and no amendments were proposed for the measure.

SENATOR RATTI MOVED TO DO PASS A.B. 108.

SENATOR HARDY SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

*****

CHAIR SPEARMAN:
I will open the work session on A.B. 142.

ASSEMBLY BILL 142: Establishes provisions concerning children seeking federal status as special immigrant juveniles. (BDR 38-739)

MS. COMLOSSY:
Assembly Bill 142 was heard in this Committee on April 26, as noted in the work session document (Exhibit LL). This bill establishes provisions concerning children seeking federal status as special immigrant juveniles. There is one proposed amendment attached that was not included in the work session document initially.

The Proposed Amendment 4375 allows a district court to make factual findings in additional chapters relating to juveniles. Initially, the bill related to *Nevada Revised Statutes* (NRS) 432B, but this extends the language to NRS 62B, general administration related to juvenile justice; NRS 125 related to the dissolution of marriage; NRS 159 related to guardianships and NRS 432B. The amendment provides the court must not make additional findings regarding the asserter, purported or perceived motivation of the child seeking status as a special immigrant juvenile or the person requesting the court to make such findings. The amendment authorizes the court to appoint a guardian to a person if the ward or proposed ward is unmarried and between the ages of 18 and 21 and consents to the appointment. The guardianship to people between 18 and 21 years of age terminates when the child reaches 21 years of age unless the person petitions the court to terminate the guardianship.

SENATOR WOODHOUSE MOVED TO AMEND AND DO PASS AS AMENDED A.B. 142.

SENATOR HAMMOND SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

* * * * *

CHAIR SPEARMAN:
I will open the work session on A.B. 214.

ASSEMBLY BILL 214 (1st Reprint): Establishes a program to increase participation by certain demographic groups in clinical trials. (BDR 40-707)

MS. COMLOSSY:
Assembly Bill 214 was heard in the Committee on April 26, as noted in the work session document (Exhibit MM). This bill establishes a program to increase participation by certain demographic groups in clinical trials. The sponsor proposed an amendment following the hearing to authorize the Division of Public and Behavioral Health to apply for and/or accept any gifts, grants, donations, or contributions from any source to support the program.

SENATOR HAMMOND MOVED TO AMEND AND DO PASS AS AMENDED A.B. 214.

SENATOR HARDY SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

* * * * *

CHAIR SPEARMAN:
I will open the work session on A.B. 236.

ASSEMBLY BILL 236 (1st Reprint): Authorizes an agency which provides child welfare services to obtain the education records of certain pupils. (BDR 38-838)

MS. COMLOSSY:
Assembly Bill 236 was heard in this Committee on May 1, as noted in the work session document (Exhibit NN). This bill authorizes an agency which provides

child welfare services to obtain the education records of certain pupils. No amendments were proposed for this measure.

SENATOR HAMMOND MOVED TO DO PASS A.B. 236.

SENATOR WOODHOUSE SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

*****

CHAIR SPEARMAN:
I will open the work session on A.B. 305.

ASSEMBLY BILL 305 (1st Reprint): Requires each public school and private school to post a toll-free telephone number for a child abuse or neglect hotline. (BDR 34-362)

MS. COMLOSSY:
Assembly Bill 305 was heard in this Committee on April 26, as noted in the work session document (Exhibit OO). This bill requires each public and private school to post a toll-free telephone number for a child abuse or neglect hotline. No amendments were proposed for this measure.

SENATOR WOODHOUSE MOVED TO DO PASS A.B. 305.

SENATOR RATTI SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

*****

CHAIR SPEARMAN:
I will open the work session on A.B. 340.

ASSEMBLY BILL 340 (1st Reprint): Requires the Department of Health and Human Services to take certain actions to improve access to diapers and diapering supplies for recipients of public assistance. (BDR 38-871)

MS. COMLOSSY:
Assembly Bill 340 was heard in this Committee on May 1, as noted in the work session document (Exhibit PP). The bill requires the Department of Health and Human Services to take certain actions to improve access to diapers and diapering supplies for recipients of public assistance. No amendments were proposed for this measure.

SENATOR HARDY MOVED TO DO PASS A.B. 340.

SENATOR HAMMOND SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

*****

CHAIR SPEARMAN:
I will open the work session on A.B. 346.

ASSEMBLY BILL 346 (2nd Reprint): Enacts requirements relating to certain providers of child care. (BDR 38-283)

MS. COMLOSSY:
Assembly Bill 346 was heard in this Committee on May 1, as noted in the work session document (Exhibit QQ). This bill enacts certain requirements relating to child care. No amendments were proposed for this measure.

SENATOR WOODHOUSE MOVED TO DO PASS A.B. 346.

SENATOR RATTI SECONDED THE MOTION.

THE MOTION PASSED. (SENATORS HAMMOND AND HARDY VOTED NO.)

*****

CHAIR SPEARMAN:
I will open the work session on A.B. 347.

ASSEMBLY BILL 347: Establishes certain requirements relating to surgical technologists. (BDR 40-721)

MS. COMLOSSY:
Assembly Bill 347 was heard in this Committee on May 1, as noted in the work session document (Exhibit RR). This bill establishes certain requirements related to surgical technologists. No amendments were proposed for this measure.

SENATOR WOODHOUSE MOVED TO DO PASS A.B. 347.

SENATOR RATTI SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

* * * * *

CHAIR SPEARMAN:
I will open the hearing on A.B. 427.

ASSEMBLY BILL 427: Revises provisions governing eligibility of certain convicted persons for public assistance. (BDR 38-1054)

ASSEMBLYWOMAN TERESA BENITEZ-THOMPSON (Assembly District No. 27):
The idea for A.B. 427 was brought to me by the folks at the Food Bank of Northern Nevada which addresses red tape when enrolling people in the Supplemental Nutrition Assistance Program (SNAP) more commonly referred to as Food Stamps.

SHANE PICCININI (Food Bank of Northern Nevada):
This bill was the work of our social work intern, Jessica Preston, who is taking a final today and could not join us. I had asked her to identify a public policy that she would like to see changed. When Jessica was working with our Food Stamp outreach team, she saw an individual with a drug felony conviction who had to be turned away because he came from another state. The conviction was ten years old, but the man was still ineligible for the program due to the technicality that exists in the law.

Referring to the presentation (Exhibit SS), the problem exists in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, more commonly known as the Welfare Reform Act, noted on page 2. That law prohibited anybody convicted of a drug felony from receiving either federally funded cash assistance through the Temporary Assistance for Needy Families (TANF) program, formerly the Aid to Families with Dependent Children. Drug felonies are the only criminal convictions that are barred access to TANF or SNAP.

When individuals with drug convictions are denied food stamps and cash benefits, establishing economic stability upon reentry into society becomes more difficult. This makes their recovery incredibly complicated. By helping these individuals lead more stable lives, public assistance and food stamps can improve reentry outcomes to have a positive effect on public safety.

The bill removes the treatment program requirement from NRS for clients with drug convictions to access either the SNAP or TANF programs. This bill is removing one of the last barriers to help families receive the food assistance they need.

DEBORAH BRAUN (Chair, Board of Directors, Food Bank of Northern Nevada):
I am here on behalf of the 14-member Food Bank of Northern Nevada Board of Directors in support of A.B. 427. The Food Bank of Northern Nevada provides emergency food assistance to approximately 95,000 individuals per month in northern Nevada and northeastern California. Almost half of these individuals are children and seniors, 89 percent are not homeless, 30 percent of client households have one member who is a military veteran and 70 percent live in poverty. The Food Bank assists individuals with completing SNAP applications under an agreement with the Division of Welfare and Supportive Services.

Currently, our clients with drug felonies must provide documentation to the Division that they are enrolled in or have completed a 30-day drug rehabilitation program. By removing the need to prove completion of the treatment program, the Division will no longer have to require this proof before determining eligibility. The Division already has procedures in place to obtain the information as outlined in A.B. 427. When individuals with drug convictions are denied SNAP or cash benefits, establishing economic stability when someone trying to reenter the workforce meets with difficulty. The Food Bank Board of Directors knows SNAP and TANF benefits reduce hunger and help individuals lead more stable lives and improve outcomes.

SENATOR HARDY:
The language in section 1, subsection 2, paragraph (a), where it says, "is not currently possessing, using or distributing controlled substances;" this defines many substances, not the least of which is legal marijuana, legal codeine, or other substances if an individual breaks a toe. How do you make the clarification?

ASSEMBLYWOMAN BENITEZ-THOMPSON:
There are many different distinctions in the bill. Section 1 is in regards to people who have been convicted of a felony for possession or distribution after August 22, 1996, when TANF went into effect. At that point, Nevada had a choice to make. The first one did not allow anyone with a felony conviction to apply for supplemental food assistance programs. The second one allowed those with a felony conviction to apply for supplemental food assistance programs and the third one allows the application with conditions. Nevada made the decision to allow those with a felony conviction to apply for supplemental food assistance programs with conditions.

What you see in section 1, subsection 2, is if a person has been convicted of a felony, then he or she has to present a certificate that a 30-day substance abuse treatment program has been completed. This has not been the best way to determine if someone is free of substance abuse problems.

One of the solutions brought up in the last hearing is to check if an individual has been testing with a parole officer. The Division has the ability to contact the parole officer and ask if the individual is testing clean or testing dirty. If the individual is testing clean, they will be eligible for these programs but if they test dirty, they are not eligible. This seems to be a much more effective way than completing a 30-day treatment program with all of the possible barriers.

These individuals could have a lack of insurance to enter a program or lack of money to pay for a program. Individuals can complete programs, but an addict typically relapses eight times on the road to recovery. We think there are more effective ways to determine eligibility than just a certificate. The certificates have become more of an obstacle than an efficient way to determine eligibility.

SENATOR HARDY:
Real people have real problems. We do not want individuals to steal in order to get what they need. We want the individual to be a participant in these

assistance programs. How do I, as a physician, avoid making the individual ineligible for these programs when he breaks his leg and I prescribe a narcotic for his pain?

Can we include language that says a real doctor can legitimately prescribe something so the individual will not be kicked out of the program for using a controlled substance or possessing a controlled substance? We do not want the individual distributing the controlled substance he was given, but we need to somehow protect him or her from getting kicked out of the program again. He or she needs to be able to eat and stay alive.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
The intent of the reference in U.S. Code is that it is not about prescriptions but illegal substances. It gets complicated in Nevada regarding certain types of controlled substances.

SENATOR HARDY:
I would like to have this language added to the bill, so if you can figure out how to do that, I will vote for the bill.

MR. PICCININI:
We may be able to handle this during the regulation process with the Division of Welfare and Supportive Services.

CHAIR SPEARMAN:
The stereotype of someone who is convicted of a drug offense is usually male. We also know the number for females is increasing. I am looking at opioid addictions among women and do not know if that counts as a felony or not. It would probably have to be something like selling. We heard in the Senate Committee on Commerce, Labor and Energy this week that there were several women who testified they were recovering addicts. If this bill passes, is this something that will benefit women as well as the stereotypical male?

ASSEMBLYWOMAN BENITEZ-THOMPSON:
When we talk about substance abuse and substance abuse issues, we know disproportionately there are higher convictions among minority populations. The number of parents with children who want to reunite with their family after their release is also a concern. There are survivors of trauma who self-medicate,

which seems higher among veterans and women survivors of sexual and domestic abuse.

According to data, statistics from 2007 determined more than 50 percent of women in jail reported to have been physically or sexually abused before their imprisonment compared to 10 percent of men. The number of drug offenders has risen by 37 percent between 1996 and 2002, representing the largest source of growth in the jail population.

JON SASSER (Legal Aid Center of Southern Nevada; Washoe Legal Services):
We support the bill. The SNAP benefits are 100 percent federal funded. The administration of SNAP uses a state share. The more administrative hassles you create, the more we pay. The federal government brings money and food into Nevada without cost to us if we do not create extra hassles.

JODI TYSON (Three Square Food Bank):
We support the bill.

ELISE ESQUENAZI (Bridges to a Thriving Nevada):
This bill creates food security for people with families who are trying to rebuild their lives. I came from one of those families, and it is a benefit for many people.

STACEY SHINN (Progressive Leadership Alliance of Nevada; President Elect, Human Services Network):
I would like to put on the record, both entities I represent as being in support of this bill. Coming from an education in social work, it is my duty to stand up for people who are looking for a second chance.

CHAIR SPEARMAN:
I would like to include for the record: a letter of analysis from the Center on Budget and Policy Priorities (Exhibit TT); a letter or support from the Center for Law and Social Policy (Exhibit UU); a paper from New York University titled, "The Abuse-Incarceration Connection" (Exhibit VV); The Sentencing Project" letter of support (Exhibit WW).

I will close the hearing on A.B. 427 and open the hearing on A.B. 249.

ASSEMBLY BILL 249 (1st Reprint): Requires the State Plan for Medicaid and all health insurance plans to provide certain benefits relating to contraception. (BDR 38-858)

ASSEMBLYWOMAN TERESA BENITEZ-THOMPSON (Assembly District No. 27):
I will be speaking from the Proposed Amendment 4546 to A.B. 249 First Reprint (Exhibit XX). This bill allows us to be as accommodating to women and their families as we can by ensuring their access to contraceptives. Through the different insurance plans built into statute, we are asking providers to make contraceptives available without a co-pay, coinsurance or a deductible. We have come to a consensus agreement as to what the insurers are able to provide. Each has a preferred contraceptive in one of the 18 categories listed in section 11, subsection 11, paragraph (a) through paragraph (r). However, above that, you will see caveats in regards to how we allow for the disbursement of the contraceptives. There can be an initial prescription of up to three months and the second prescription is up to nine months. The following year, if the woman remained with the same health plan, the woman could get access to the contraceptive she needs for the entire year.

Ideally, we wanted to be able to say that all of the contraceptive needs could be met with one doctor appointment, and one prescription for a time period of one year. We had to work forward from that ideal to find something equally accommodating. Other concerns were also alleviated. The tiered system is what was agreed upon.

Beginning with NRS 422, which addresses Health Care Financing and Policy and Medicaid, section 1 explains how the process will work within Medicaid. You will see the same type of language repeated throughout each of the different insurance plans. In the Medicaid sections, we addressed an unlawfully prescribed prescription for a contraceptive. The language has to be U.S. Federal Drug Administration (FDA) approved. There will be language pertaining to 18 different methods of contraception with a list located in section 1, subsection 7 of the bill. There will be a preferred drug for women to access.

Section 3, NRS 287 applies to employees of the governing body of a county, school district, municipal corporation, political subdivision, public corporation or other local government agency of the State. The language regarding how the contraceptive will be dispensed repeats throughout the bill. Section 4.5 relates to the pharmacy and the pharmacist. Where the dispensing plan is laid out: for the first time, 3 months; the second time, 9 months; and if the individual is in the same plan a year later, 12 months.

Section 7 relates to NRS 689A, specifically to individual health insurance plans. Language is added regarding one type of contraceptive per category. We moved some language relative to good practices and not penalizing a provider of health care who provides benefits to an insured including, without limitation, reducing reimbursements.

Sections 8 and 9 are still the individual health care plan sections.

Section 11 speaks to group and blanket health insurance plans. The language repeats itself. There is also language from our work with stakeholders to accommodate medical management techniques. A medical management technique is defined as a practice in which it is used to control the cost or utilization of a health care service or prescription drug use without limitation or devices based on cost type or method of administration. We did not want to limit tools used by the insurance providers to keep costs down.

Section 14 is the health insurance for small employers.

Section 16 addresses fraternal benefits societies with the same language carried through the chapter.

Section 21 covers health maintenance organizations.

If you support women and the families they support, you can improve their lives by making their access to contraceptives easier.

CHAIR SPEARMAN:
I was looking at language for carriers or plans that have religious exemptions.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
There is some language in section 7, subsection 7, which covers religious exemptions. That language was moved from a different area in the chapter. You will see this language repeated throughout the other insurance chapters within the bill.

CAROLINE MELLO ROBERSON (State Director, NARAL Pro-Choice Nevada):
I submitted my written testimony (Exhibit YY), so I will summarize it for the Committee. Assembly Bill 249 is a bill that has come a long way since we first began talking about it. We have taken the interest of many stakeholders into consideration. The NARAL is a nonprofit organization that looks to defend reproductive freedom for all Nevadans. We have been in Nevada for less than a year and are powered by people. We strongly believe in protecting affordable and accessible contraception.

The bill removes two important barriers. One of the barriers is cost; by protecting the no co-pay provisions, we will ensure that birth control remains affordable. The other barrier is access. Allowing women the opportunity to receive 12 months of birth control at once will significantly reduce unplanned pregnancies. There is research in the *American Journal of Obstetrics & Gynecology* that indicates 46 percent fewer unintended pregnancies and 30 percent fewer abortions. We know this bill will benefit Nevada women and families. There have been some helpful changes to the bill.

NARAL feels strongly that medical management techniques are permissible but should not get in the way of a woman and her preferred method of birth control. The Affordable Care Act (ACA) has gone through many iterations with many thousands of pages in terms of what is the best contraception coverage. The ACA mostly deals with step therapy and prior authorization. We want to ensure women have the ability to choose the right birth control method for them, prescribed by their doctor, and have it covered by insurance. We support the bill.

MS. SHINN:
As a woman who has lived abroad, I was shocked in Scotland when I was handed a bag with a 12-month prescription for birth control pills, which was amazing because I only had a 6-month visa. There were no co-pays and I had no exams. Then I moved to Chile and received over-the-counter access to contraceptives. After experiencing policies from other countries, this is a good common sense policy. I have had better access in other countries than in my own, so please support this bill.

REGAN COMIS (Nevada Association of Health Plans):
We appreciate the sponsor and other stakeholders working with us to draft Proposed Amendment 4546 so we can all support the bill.

CHELSEA CAPURRO (Health Services Coalition):
I appreciate working with the stakeholders on the amendment to get to a point where we can support A.B. 249.

RYAN BEAMAN (Clark County Firefighters Local 1908):
We run our own self-funded nonprofit plan for our employees and their families. We appreciate the stakeholders and sponsor working with us on a very difficult issue to take some of the regulations from the ACA and include them in Nevada statute. It was not an easy task and the Legislative Counsel Bureau was very helpful with finalizing the language. We are in support of the bill.

TODD INGALSBEE (Professional Firefighters of Nevada):
We support A.B. 249.

VIVIAN LEAL:
I testified for the first time on this bill during the Assembly hearing. I spoke about how my husband and I married at 21 and were lucky to have accessible and affordable contraception. This allowed us to pursue our education and build our careers. We were able to have children once we were able to provide for them and fund their education. In the weeks since, I have been reflecting on this process. Why is it even necessary in 2017 for so many women to come forward to ensure we are trustworthy with contraceptives, or prove our worth or fiscal economy of planning our families in order to have independent lives.

We give birth to our Country's children even in cases of unwanted pregnancies. While the majority of men leave, women stay. We raised or co-raised everyone's children. My question has become why is this bill not the right thing to do? Almost all of the objections have been amended out of the bill. As women, we have been contributors and supporters to our communities. I wonder why we find ourselves forced to scratch out these 3-month, 9-month and 12-month prescriptions in a most basic bill in order to take charge if and when we have children so we can own our lives. The bill should have the unanimous and bipartisan support of the Nevada Legislature and of the Governor. The passing of A.B. 249 would be a perfect gift from the men on this Committee, for Mother's Day.

MICHAEL HACKETT (Nevada Primary Care Association; Nevada Public Health Association):
We are in support of A.B. 249. It is a more efficient, effective and convenient way to ensure access to and the continued use of birth control.

STEVE DOLAN:
I support A.B. 249. I am old enough to remember the end of the Dark Ages and I will identify them being from 1873 to 1972, when it was illegal for contraceptives. My sisters were teenagers at the end of that age and were damaged because they could not get easily accessible contraceptives. When they were old enough to get married and begin their families, the damage caused prevented them from having children. Twenty years later, my wife and I were able to use contraceptives successfully and plan our lives with two wonderful children. One child just graduated from college and one just entered college. My daughter is on contraceptives and she is constantly complaining they are not accessible to her. She does some traveling in her education and that year-long accessibility will be good for her and also for those people who do not always have the funding available to get the contraceptives. It has already helped my family being able to make plans. I support the bill.

ELIZABETH CASTILLO:
I support A.B. 249. This bill means a great deal to people with medical conditions. I, along with about one out of every ten women in the Nation, have polycystic ovarian syndrome (PCOS). If left untreated it can lead to loss of fertility and endometrial cancer. Birth control pills are the top treatment for PCOS. I urge you to support A.B. 249 in order to help save lives, prevent cancer and ensure future fertility for women with PCOS.

REBECCA GOFF:
I support A.B. 249 specifically because it will be beneficial to those of us who live in rural communities. Accessing a pharmacy every month may not be convenient. Having 12 months of protection will be much simpler for rural Nevadans.

MS. ESQUENAZI:
I am here to represent myself, my sister, my mother and my grandmother. I am the first in my family to achieve a degree from a university, and birth control is a big part of that for me. It would be much easier if birth control was more accessible and I could get a 12-month prescription. I support the bill.

LAURA CADOT:
As a woman who was born in the 1950s, all I can say is, it is about time. Reproductive options are essential to women who are planning their families and essential to men as well. I do not know what has kept us from bringing this bill forward earlier.

PAM STRALEY:
I agree with all of the previous speakers pertaining to this bill.

LISA CADY:
I support A.B. 249 and agree with everything that has been said. I no longer need to use birth control, but it is important for all women to have the freedom to choose when to begin their families and have the access and ability to get a 12-month supply of birth control pills if they so choose. I have three daughters, two have graduated from an out-of-state university. Without transportation, it was difficult for them to get to a pharmacy due to class schedules. The school did not have access to birth control on campus. One of my daughters went abroad on a ship for a portion of her education. She could get a three-month supply of birth control pills but she was on the ship traveling from country to country for four months, plus she spent an extra month overseas. For the people in a lower socioeconomic status without the ability or education to get to a pharmacy, these are the people who will be helped by this bill.

LILIANA TREJO VANEGAS:
I am testifying from a place of privilege when it comes to access to affordable contraception. Since the age of 16, I have suffered from agonizing cramps as a result of my periods. Birth control makes my pain tolerable, and it is the reason I am able to sit in this room today. My prescription without coverage from insurance would cost around $300 a month. This is a cost that would mean the difference between contraception and basic necessities. This bill could help in abolishing the basis that reproductive freedom is tied to economic freedom.

While volunteering with NARAL in Carson City and lobbying alongside other Nevadans who believe access to affordable contraception is a right, one of the main concerns presented by those opposing this bill was relating to them being against abortion. As a woman who has tried many of the 18 forms of contraception, I can attest that these forms of contraception are not the abortion pill. That argument is invalid. Voting no on this bill is voting no on women. Proper family planning is only possible when women who statistically are more likely to be in charge of their family's health care provisions, have freedom to take control of their reproductive health.

REBECCA HANLEY:
I was born and raised in Las Vegas. During my time in college I was actually able to attend school in Oregon and take advantage of its contraceptive care. This was free contraception for anyone of a lower socioeconomic class. Without that, I would probably not have stayed in school. A program like this in Nevada would be an investment in Nevada's women and families for the future. I would like to see A.B. 249 pass.

JETZAIN GUTIERREZ:
I am here to represent my single mom and my teenage sister. I am in favor of their reproductive freedom.

PEGGY LEAR BOWEN:
I was a teacher for 35 years in mostly at-risk schools defined by economics. Contraceptives should be like any other medication for helping an individual to have control over her life. A woman should have the right to control whether or not there is a pregnancy. Too often I have heard comments that it seems to me that people care about the child being born, and then they do not care until the child turns 18 and can serve in the military. Everybody has a right to his or her opinion, and I am not saying he or she cannot have an opinion, but we need to care about children 24 hours a day, 7 days a week and 365 days a year from birth through death. The only way we can do that is by making sure the children were planned and not a surprise or the result of a rape. I married late in life and lost my opportunity to have children. I had a choice but because of the high risk of cancer in my family, I was put on birth control pills. I support A.B. 249.

CHAIR SPEARMAN:
I received letters of support from Nancy E. Hook, Executive Director, Nevada Primary Care Association (Exhibit ZZ) and Jon O'Brien, President, Catholics for Choice (Exhibit AAA). I would also like to include in the record the FAQS About Affordable Care Act Implementation, Part XXVI (Exhibit BBB).

DUANE YOUNG (Chief, Behavioral Health and Pharmacy, Division of Health Care Financing and Policy, Department of Health and Human Services):
This bill will require a Medicaid State Plan change, policy and computer system to implement the requirement. Proposed Amendment 4546, which removes the

Drug Utilization Review Board requirement, will also remove the fiscal note from the bill.

JANINE HANSEN (State President, Nevada Families for Freedom):
I am happy to see the religious exemptions have been returned to the bill. We were very concerned about that language being removed when A.B. 249 was first heard. I could not tell from the testimony if the bill still contains an unfunded mandate. If it does contain an unfunded mandate, we have concerns. I am the mother of 4 children; I have 2 daughters and 14 grandchildren. Seven of them are girls. I am representing them here today. Even though some of those children were accidents, we love them all.

I am looking at page 9 of Proposed Amendment 4546 because of the question about whether or not any of the listed contraceptives were abortifacients. I will read the ones that were verified as abortifacients by the doctor I contacted: implantable rods; copper-based uterine devices; progesterone-based intrauterine devices; progestin-based drugs and possibly extended- or continuous–regimen drugs; combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and antiprogestin-based drugs for emergency contraception. As a taxpayer, I object to paying for abortifacients and so do many of the people who are pro-life and have concerns about these issues.

CHAIR SPEARMAN:
Looking at section 7, subsection 6 of A.B. 249 reads:

> An insurer that offers or issues a policy of health insurance and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of health insurance and before the renewal of such a policy, provide to the prospective insured written notice of the coverage that the insurer refuses to provide pursuant to this subsection.

That is where the religious exemption exists in the bill.

MS. HANSEN:
I believe it is also repeated in other places throughout the bill. My objection is not with the religious exemption, but I am a taxpayer and do not want to pay for abortifacients. I also oppose unfunded mandates.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
For some people, this is a very sensitive subject and for others it is not. I am pleased with the peaceful and respectful tone in the conversations where everyone remained cordial. I can provide additional information to any Committee member who may want to review the contraceptives approved by the FDA. None of the methods listed are meant, intended or approved for anything other than preconception purposes.

Remainder of page intentionally left blank; signature page to follow.

CHAIR SPEARMAN:
I will close the hearing on A.B. 249. Since we have concluded the business of the Committee for this evening, we are adjourned at 7:15 p.m.

RESPECTFULLY SUBMITTED:

Martha Barnes,
Committee Secretary

APPROVED BY:

Senator Pat Spearman, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	2		Agenda
	B	20		Attendance Roster
S.B. 261	C	30	Senator David R. Parks	Proposed Amendment 4571
S.B. 261	D	2	Peg Sandeen	Written Testimony
S.B. 261	E	3	Death with Dignity National Center	Endorsements of Death with Dignity Legislation
S.B. 261	F	2	Death with Dignity National Center	Death with Dignity: A Gift of Control
S.B. 261	G	2	Death with Dignity National Center	A New Poll Shows 72 Percent of Nevadans Support Death with Dignity as Legislative Committee Prepares to Hear Bill
S.B. 261	H	2	Deborah Ziegler	Written Testimony
S.B. 261	I	1	Justin Mayhew / Public Policy Polling	Nevada Voters Overwhelmingly Support Proposal to Grant Terminal Patients the Right to End Life
S.B. 261	J	22	Public Policy Polling	Nevada Survey Results
S.B. 261	K	1	Laura Packard	Written Testimony via Email
S.B. 261	L	5	Barbara C. Thornton	Written Testimony
S.B. 261	M	29	Jason Henkle	Physician Aid in Dying (PAD) for Terminal Nevadans
S.B. 261	N	13	Jason Henkle, Richard Harris / Nevada Death with Dignity Action Project	Report: Physician Aid in Dying (PAD) presentation
S.B. 261	O	2	Jason Henkle, Richard Harris / Nevada Death with Dignity Action Project	RGJ Article: Nevada bill would let terminal patient request help dying
S.B. 261	P	30	Lindy Bruzzone	Lynch Syndrome Presentation

S.B. 261	Q	1	Edmund G. Brown	Letter
S.B. 261	R	3	Rhonda Ashurst	Written Testimony
S.B. 261	S	1	Sheila Danish	Written Testimony
S.B. 261	T	6	Ashley Cardenas / Compassion and Choices	Written Testimony
S.B. 261	U	1	T. Brian Callister	Written Testimony
S.B. 261	V	3	Kathleen Rossi	Written Testimony
S.B. 261	W	1	Maureen Leck	Written Testimony
S.B. 261	X	2	Sally Ramm	Written Testimony
S.B. 261	Y	2	Evan M. Klass / American College Physicians	Letter
S.B. 261	Z	1	Margaret Dore	Choice is a Big Fat Fib Handout
S.B. 261	AA	2	J. J. Hanson	Letter
S.B. 261	BB	2	Diedre Hammon	Written Testimony
S.B. 261	CC	9	American Medical Association	Code of Medical Ethics Chapter 5
S.B. 261	DD	2	Nevada Psychiatric Association	Proposed Amendment
S.B. 261	EE	2	Kirk Bronander	Letter
S.B. 261	FF	3	Don Nelson	Letter
S.B. 394	GG	27	Megan Comlossy	Work Session Document
A.B. 20	HH	1	Megan Comlossy	Work Session Document
A.B. 31	II	1	Megan Comlossy	Work Session Document
A.B. 95	JJ	1	Megan Comlossy	Work Session Document
A.B. 108	KK	1	Megan Comlossy	Work Session Document
A.B. 142	LL	5	Megan Comlossy	Work Session Document
A.B. 214	MM	1	Megan Comlossy	Work Session Document
A.B. 236	NN	1	Megan Comlossy	Work Session Document
A.B. 305	OO	1	Megan Comlossy	Work Session Document
A.B. 340	PP	1	Megan Comlossy	Work Session Document
A.B. 346	QQ	1	Megan Comlossy	Work Session Document

A.B. 347	RR	1	Megan Comlossy	Work Session Document
A.B. 427	SS	5	Shane Piccinini / Food Bank of Northern Nevada	SNAP Presentation
A.B. 427	TT	2	Stacy Dean and Elizabeth Wolkomir / Center on Budget and Policy Priorities	Letter of Analysis
A.B. 427	UU	1	Elizabeth Lower-Basch / Center for Law and Social Policy	Letter
A.B. 427	VV	4	Jialing Zheng / Arthur L. Carter Journalism Institute of New York University	The Abuse-Incarceration Connection
A.B. 427	WW	2	Nicole D. Porter / The Sentencing Project	Letter
A.B. 249	XX	42	Assemblyman Jason Frierson	Proposed Amendment 4546
A.B. 249	YY	2	Caroline Mello Roberson / NARAL Pro-Choice Nevada	Written Testimony
A.B. 249	ZZ	1	Nancy E. Hook / Nevada Primary Care Association	Letter
A.B. 249	AAA	2	Jon O’Brien / Catholics for Choice	Letter
A.B. 249	BBB	7	U.S. Department of Labor, Health and Human Services and the Treasury	FAQS About Affordable Care Act Implementation (Part XXVI)