MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON COMMERCE AND LABOR

Eighty-First Session
March 24, 2021

The Committee on Commerce and Labor was called to order by Chair Sandra Jauregui at 1:09 p.m. on Wednesday, March 24, 2021, Online. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/81st2021.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Sandra Jauregui, Chair
Assemblywoman Maggie Carlton, Vice Chair
Assemblywoman Venicia Considine
Assemblywoman Jill Dickman
Assemblywoman Bea Duran
Assemblyman Edgar Flores
Assemblyman Jason Frierson
Assemblywoman Melissa Hardy
Assemblywoman Heidi Kasama
Assemblywoman Susie Martinez
Assemblywoman Elaine Marzola
Assemblyman P.K. O'Neill
Assemblywoman Jill Tolles

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblywoman Alexis Hansen, Assembly District No. 32
Assemblywoman Michelle Gorelow, Assembly District No. 35

STAFF MEMBERS PRESENT:

Marjorie Paslov-Thomas, Committee Policy Analyst
Terri McBride, Committee Manager
Paris Smallwood, Committee Secretary
Cheryl Williams, Committee Assistant

OTHERS PRESENT:

Millie Custer, Private Citizen, Winnemucca, Nevada
Heidi Sterner, representing Nevada Association of Health Underwriters
Nicole Ting, Insurance Regulation Liaison, Division of Insurance, Department of Business and Industry
Jack Childress, Insurance Actuarial Analyst II, Division of Insurance, Department of Business and Industry
Lewis Trout, Private Citizen, Winnemucca, Nevada
Christopher Carothers, President, Nevada Association of Health Underwriters
Rick Bronstein, Private Citizen, Las Vegas, Nevada
Tom Clark, representing Nevada Association of Health Plans
Maya Holmes, Healthcare Research Manager, Culinary Health Fund/UNITE
Bobbette Bond, Senior Health Policy Director, Culinary Health Fund
Stacie Stasso, Executive Director, Health Services Coalition
Donna Kelly-Yu, Private Citizen, Las Vegas, Nevada
James Sullivan, Political Director, Culinary Workers Union Local 226
James L. Wadhams, representing Nevada Hospital Association
Keith Lee, representing the Board of Medical Examiners
Susan Fisher, representing the State Board of Osteopathic Medicine
Lindsay Knox, Vice President, Government Affairs, McDonald Carano
Kendahl Servino, Private Citizen, Reno, Nevada
Jacob Zucker, M.D., Private Citizen, Reno, Nevada
Joyce Reinecke, Executive Director, Alliance for Fertility Preservation
Amanda Klein, President, Nevada Fertility Advocates
Cari Herington, Executive Director, Nevada Cancer Coalition
Carrie Bedient, M.D., Private Citizen, Las Vegas, Nevada
Connie Munk, Private Citizen, Las Vegas, Nevada
Jamie Rodriguez, Government Affairs Manager, Washoe County
Tray Abney, representing America's Health Insurance Plans
Laura Rich, Executive Officer, Public Employees' Benefits Program
Cyrus Hojjaty, Private Citizen, Las Vegas, Nevada

Chair Jauregui:
[Roll was called. Committee protocols were explained.] Today our first agenda item is going to be the introduction of a bill draft request (BDR). Bill Draft Request 10-812 originated with the Committee on Commerce and Labor and was assigned to the Committee for committee introduction. This measure addresses issues relating to the sale of residential property.

BDR 10-812—Revises provisions governing real estate. (Later introduced as Assembly Bill 398.)

Remember that a vote in favor of introducing a bill draft does not imply a commitment to support the measure later pursuant to Assembly Standing Rule No. 57, Section 7. All this

action does is allow the BDR to become a bill and then go to the floor to be referred to a committee for possible hearings. I will entertain a motion to introduce BDR 10-812.

ASSEMBLYWOMAN CARLTON MOVED FOR COMMITTEE INTRODUCTION OF BILL DRAFT REQUEST 10-812.

ASSEMBLYWOMAN CONSIDINE SECONDED THE MOTION.

Is there any discussion on the motion? [There was none.]

THE MOTION PASSED UNANIMOUSLY.

Thank you, members. Next item on our agenda is bill hearings. We have four bills on the agenda today, starting with Assembly Bill 180. I will now open the hearing on Assembly Bill 180, which revises provisions governing policies of insurance which provide for the payment of expenses which are not covered by Medicare. I believe we have Assemblywoman Alexis Hansen with us. Welcome to the Committee, Assemblywoman Hansen, and you may proceed when you are ready.

Assembly Bill 180: Revises provisions governing policies of insurance which provide for the payment of expenses which are not covered by Medicare. (BDR 57-857)

Assemblywoman Alexis Hansen, Assembly District No. 32:
Thank you so much, Chair Jauregui, for the opportunity to present Assembly Bill 180. Good afternoon and thank you, Committee on Commerce and Labor, for hearing this bill today. It is in the course of the work that we do as legislators that we get the unique opportunity to meet with our constituents and hear their needs and consider what we might be able to do for them here.

When I am done with my opening remarks, I am going to let Millie Custer from Humboldt County tell you a little bit about her story if that is okay, Chair. I have discussed Millie's concerns with her and found out there are many in the same situation as she in Nevada. I am here today, though, to present Assembly Bill 180, which requires insurers offering insurance policies for the payment of expenses not covered by Medicare to offer at least one such policy to provide certain coverage to persons under the age of 65 with disabilities. For Americans who become eligible upon turning 65, enrollment in a Medicare Supplement plan, also known as a Medigap plan, is guaranteed during the six-month federally mandated enrollment period. During this time, all available Medigap plans are guaranteed issuance regardless of a person's medical history.

Medigap is a set of standardized plans that supplement what Medicare does not cover. These plans pay for items such as deductibles, copays, and coinsurance. States can create their own rules to ensure that disabled Medicare beneficiaries under the age of 65 are able to enroll in supplemental insurance coverage, and the majority of states have done so. Nevada has not

enacted a provision to ensure access to supplemental coverage for those who are disabled and under the age of 65, and there do not appear to be any plans of guaranteed issuance available for this population.

I would like to walk through the bill really quickly—I will not say that word "simple" because we know what that can do. In the bill, in section 1—there are just the two sections—the new language would be that "The regulations must require each insurer offering such a policy to offer at least one such policy to provide coverage for persons with a disability who are less than 65 years of age and eligible for Medicare." There are two friendly amendments that are up on the Nevada Electronic Legislative Information System [Exhibit C and Exhibit D].

I would like for one of my constituents, Millie Custer from Winnemucca, to have a moment to share her story and the statement of need that led me to bring this bill forward. As a resource for answers to any questions, since this certainly is not my expertise, I am happy to have Heidi Sterner from the Nevada Association of Health Underwriters with us. Also, there is Jason Casey, a Medicare senior benefits person from Reno, as well as Mr. Childress and Ms. Ting with the Division of Insurance, Department of Business and Industry. Chair, if it is okay, we can proceed however you would like with Millie Custer from Winnemucca, and those who are here as well.

Chair Jauregui:
Would you like to start with Ms. Custer?

Assemblywoman Hansen:
Yes, that is fine. Ms. Custer, if you would like to, we would appreciate it if you would share your story with us.

Millie Custer, Private Citizen, Winnemucca, Nevada:
Good afternoon, everyone. I am from Winnemucca, Nevada; we have lived here 21 years. I have been partially paralyzed for 36 years from a brain aneurism. I am on Medicare, but due to the fact that I am under 65, I am unable to buy into supplemental insurance to help with the Medicare, so I am stuck with the 20 percent copay all the time. And I already have two knees replaced, I need two new hips, and so on and so on.

I am not looking for a handout, just an option. Nevada is one of six states that does not offer any kind of a program. There are a lot of people in my boat; one in six people on Medicare are under 65 years old, and I would really like to have an option if we can see how to do something. And I think that it is needed for both parties; it is a bipartisan thing, and we would appreciate it if you could help us out. Thank you.

Chair Jauregui:
Thank you, Ms. Custer, for being here with us today and for your testimony. Assemblywoman Hansen, would you like to go to your next presenter, Ms. Sterner.

Assemblywoman Hansen:
Yes, Chair. Ms. Sterner has a PowerPoint presentation [Exhibit E]. It is a very short one and I think she told me she could probably get through it in about three or four minutes. We thought it might be a good idea for us to have an overview of Medicare and what we are looking at as far as the supplements that are currently not offered to those under 65, and what we are trying to fix with this legislation. I will turn the time over to Ms. Sterner.

Chair Jauregui:
Ms. Sterner, thank you for being here today. When you are ready, please proceed with your PowerPoint.

Heidi Sterner, representing Nevada Association of Health Underwriters:
We are going to talk primarily about Medicare Supplement plans [Exhibit E]. To understand Medicare supplements, I think you need to get a little bit of a view of the various parts of Medicare. First off, Medicare is a federal program; it is available to people who are 65 or older and certain younger people with disabilities, and people who have end-stage renal disease, which is a permanent kidney failure requiring dialysis or a transplant [page 3, Exhibit E].

There are four parts to Medicare [page 4, Exhibit E], but the two parts we are going to primarily focus on are Part A and Part B. Part A covers the inpatient hospitalization; Part B covers your outpatient care such as doctors' visits, lab work, X-rays, and services related to outpatient. But it does not cover prescription drugs, which is going to be your Part D. We are not here to talk about Part D, but it is important to know that a person would have the option of the Part D coverage. By virtue of having Part A and Part B, a person can purchase a Part D prescription drug plan.

Persons in certain areas of Nevada have other options and they do have a Medicare Advantage option, which kind of rolls all of that into one plan and gives you the Part A hospitalization, the Part B outpatient services, and often the Part D prescription drug plans in one plan. There are plenty of these options in two or three counties, but about nine counties only have a few plans, which may not appeal to everybody.

We are going to focus on Part A and Part B [page 5, Exhibit E]. Hospitalization, Part A, is a zero-cost premium if a person has worked for 40 quarters and paid into Medicare payroll taxes. There would be a premium if you have not met those 40 quarters for the Part A. Everyone who enrolls in Part B will have the standard premium of $148.58 per month, which is the 2021 rate. And then you have your out-of-pocket deductibles and coinsurance. For Part A, a person who goes to the hospital would have a $1,484 per-year deductible and then they are going to pay coinsurance.

You can see that I have broken this down here by days so the cost depends on how many days a person is in the hospital [page 5, Exhibit E]. At the 151-day mark, they would be responsible for all costs. They would also have varying copays for skilled nursing based on the number of days. There is no maximum out of pocket in Part A if you are in the hospital.

Under Part B, which is the outpatient care for services such as doctors' visits, lab work, and X-rays, there would be a $203 per-year deductible and then once that is satisfied, the member or the beneficiary would pay 20 percent of all costs that Medicare does not pay. Medicare pays about 80 percent of covered expenses and the member would pay 20 percent. Again, there is no maximum out of pocket.

This is where Medicare Supplement plans come into play—they are also known as Medigap plans [page 6]. They help fill the gaps that original Medicare does not cover, and they are sold by private insurance companies. That again would cover the deductibles, coinsurance, and copayments, for example. To purchase a Medicare Supplement plan, you have to have original Medicare Parts A and B [page 7]. It does not replace original Medicare; it is just a supplement to those two parts. You get them from private insurance companies and there is a monthly premium; this premium is in addition to any Part A and Part B premiums. They are guaranteed renewable as long as the premiums are paid and that the plan also stays active.

Generally, the supplemental plans do not cover long-term care, vision, dental, hearing aids, eyeglasses, or private duty nursing. A person can enroll in the first six months, and that is called your open enrollment period [page 8]. That typically begins when you turn age 65 and you enroll in Medicare Parts A and B and then you have that six-month window. It is a guaranteed issue, and you cannot be denied due to your health status during this period of time, and you can purchase the Medicare supplements policy, which is sold in Nevada without a health status review.

Outside of that open enrollment period—around the time you turn 65—currently the option to purchase outside of that period is limited. If you are on a group health plan, for example, and you have Medicare Part B and you lose your group health plan, you would have, for example, 63 days to enroll in a Medicare supplement. Outside of that you can apply for coverage, but your approval is not guaranteed; the coverage could be denied, or you could have a premium assessment attached due to your health history.

People under the age of 65 do not have that option currently, and federal law does not require that insurance companies sell these Medigap policies to people under age 65 [page 9]. There are over 30 states that have the option for people under age 65 with disabilities to purchase a Medicare Supplement plan. Nevada is not currently among that group of states.

In 2019—and this data is from the Kaiser Family Foundation which they got from the Centers for Medicare and Medicaid Services—there were 561,986 Nevadans eligible for Medicare; 467,847 of those were due to their age; 63,717 were due to being disabled. Of that 561,986, there were 99,256 enrolled in a Medicare Supplement plan, and 197,619 were enrolled in a Medicare Advantage Plan [page 10, Exhibit E]. The remainder would either be the disabled who are not eligible to enroll in a Medicare Supplement plan, or folks who are on an employer plan or a union plan or coverage through their spouse. And that is a brief overview of the Medicare supplements. I would be glad to take any questions that you have and thank you for allowing us to present.

Chair Jauregui:
Assemblywoman Hansen, we will go to questions now.

Assemblywoman Carlton:
This might be more for the Division of Insurance, but since this is the underwriters, I want to have a conversation about opening up a new selection for insurance. We know insurance is a pool and the more people in it, the more the dollars get divided. Also, if you have folks who are more high cost, sometimes it can have an effect on the premiums. By opening this up to folks under 65 who are disabled to be able to buy this, will it be mandated that each insurance company sell this, or are we just giving them that option? Has anyone done an analysis to see what this might do to that particular insurance product and to see what the cost consequences might be?

Heider Sterner:
I am going to kick that over to the Insurance Commissioner's office simply because it is dealing with rates, and that is the entity that would deal with any rating factors with regard to insurance companies and their risk pools.

Assemblywoman Carlton:
On the other part of the question, this will just be an option for them to sell the supplement plans? We are not going to mandate that they will have to sell them?

Heidi Sterner:
The way the bill reads, each insurance company that offers Medicare Supplement plans would have to also offer a plan to folks under age 65 with a disability.

Assemblywoman Carlton:
So, it is an insurance mandate?

Heidi Sterner:
It is a mandate for them to offer coverage, yes.

Assemblywoman Carlton:
All right, thank you.

Chair Jauregui:
Ms. Ting, I believe you are here on behalf of the Division of Insurance. Did you want to address the first part of Vice Chair Carlton's question?

Nicole Ting, Insurance Regulation Liaison, Division of Insurance, Department of Business and Industry:
Yes, I would love to. I have with me Jack Childress, who is our Medicare Supplement policy specialist. He has done some research, and he has talked with other states regarding possible rate increases. If it is okay with you, Madam Chair, may we ask Jack Childress to testify?

Chair Jauregui:
Yes. Mr. Childress, are you with us?

Jack Childress, Insurance Actuarial Analyst II, Division of Insurance, Department of Business and Industry:
Yes, I am here. In answer to your question, the way the states treat this is different among the states. I surveyed the states to be prepared to answer your questions related to the rating, and some states will put the members under 65 in a separate pool or risk category so they can rate them up higher. Some states require them to have the same rates as the people who are age 65. Some allow them to rate them at a certain factor such as three to five times those at age 65. Some states may cap it at the age 99 rate, so it just varies depending on the state.

Assemblywoman Carlton:
Do you have any indication how the state of Nevada will look at this and where they might go as far as the rating and rates on this?

Jack Childress:
Right now, in our regulations through *Nevada Administrative Code* Chapter 687B, the only rating requirements we have currently are the loss ratio requirements, whether the policy is individual or a group basis. We do not tell the actuaries how to develop their rates or how they are going to pool their experience, so at this time it would be up to them.

Assemblywoman Carlton:
Just to clarify, because we are doing "insurance speak" here and not everybody who is listening might know this language of insurance speak. The individual companies that will be mandated to provide this will do an actuarial look at it and decide where they think their rates might be. There will not be any guidance from the State on whether it should be a separate risk pool or not. That will be left up to the individual companies.

Jack Childress:
At this point I would probably have to talk to the Commissioner to find out for sure, but at least the way our regulations are currently written, that would be the case.

Assemblywoman Carlton:
Thank you, Mr. Childress. Insurance can be very confusing, and I always want to make sure when we make a record that it can be understood in plain English for folks.

Chair Jauregui:
Members, any other questions? [There were none.] At this time, we will go to testimony in support of Assembly Bill 180.

Lewis Trout, Private Citizen, Winnemucca, Nevada:
I am a resident of Humboldt County, and I am also a board member on the Humboldt County Hospital District, although I am speaking as an individual today, not as a representative of the District. The current situation that has been described is an inequity that needs to be

corrected. During the sacred time of the year leading up to Passover and Easter, as President Biden has made clear, we all have a social responsibility to assist those in need when we can, and A.B. 180 provides such an opportunity to help disabled people with a helping hand. Thank you, Madam Chair.

Chair Jauregui:
Next, we will hear testimony in opposition to Assembly Bill 180. [There was no one.] Is there anyone wishing to testify in the neutral position? [There was no one.]

Assemblywoman Hansen, would you like to give any closing remarks?

Assemblywoman Hansen:
Thank you to all of you for your time. Thank you to those who helped me with understanding this and presenting this. And just a reminder that in the amendment, we are asking for the Medicare guaranteed-issue plans so that these can be affordable for those who are disabled under the age of 65 and to be able to get this Medigap insurance that will help them out. I am available for questions offline as this bill progresses.

[Exhibit F, Exhibit G, and Exhibit H were submitted but not discussed and will become part of the record.]

Chair Jauregui:
Thank you, Assemblywoman Hansen. I am closing the hearing on Assembly Bill 180. At this time, I would like to turn the virtual gavel over to Vice Chair Carlton for the next agenda item.

[Assemblywoman Carlton assumed the Chair.]

Vice Chair Carlton:
Thank you very much, Madam Chair, I am happy to help out. With that, we will open up the hearing on Assembly Bill 250, which is being presented by Assemblywoman Jauregui.

Assembly Bill 250: Revises provisions relating to insurance which provides for the payment of expenses not covered by Medicare. (BDR 57-142)

Assemblywoman Sandra Jauregui, Assembly District No. 41:
I am here today to present Assembly Bill 250, which establishes the "Birthday Rule" for persons who are currently enrolled in a Medigap plan. The genesis for Assembly Bill 250 was from my constituent Rick Bronstein, whom you will hear from today. Over coffee, Mr. Bronstein explained that Nevada has never had an open enrollment for Medicare Supplement plans.

As you know, the Medicare program, which is administered by the Centers for Medicare and Medicaid Services, also known as CMS, is the federal health insurance program under which qualified individuals receive health care. Medicare does not cover all medical services, and it

also does not pay 100 percent of certain covered services. Although Medicare pays for certain preventative services and covers most medically necessary services, the percentage of out-of-pocket health care expenses for Medicare beneficiaries can be sizable and typically increases with age.

Medicare Supplement plans, also known as a Medigap policy, is a distinct type of insurance policy which is sold by private companies to fill the gaps in original Medicare plan coverages. Medigap policies are guaranteed issuance at certain times for eligible beneficiaries as specified by state and federal law. For example, at the point where an individual first becomes eligible for Medicare, there is an open enrollment period when Medigap coverage can be purchased without medical underwriting. Medigap policies are guaranteed renewable as long as the premium is paid and, generally speaking, cannot be canceled because of a person's health condition or for any reason other than nonpayment of premium. Insurers can, at their discretion, increase the premiums for Medigap coverage. However, unless eligible for open enrollment or guaranteed issuance, Medicare beneficiaries wishing to purchase Medigap coverage or change plans are subject to medical underwriting and can be denied coverage based on their health status or claims experience.

What is so great about the Birthday Rule? It provides an opportunity to enroll in a plan from a company that may offer better coverage to suit the needs of the consumer without medical underwriting. This means that—just like when a person first signs up for a supplemental insurance policy during the open enrollment period—an insurance carrier is prohibited from denying coverage based on preexisting health issues. Assembly Bill 250 requires an insurer, nonprofit hospital, and medical or dental service corporations that issue an insurance policy that provides for the payment of expenses not covered by Medicare, to offer an annual enrollment period to change to a plan of equal or lesser benefit without being subject to medical underwriting. The open enrollment period would begin on the first day of the birthday month of an enrollee and continue for 60 days. This bill also provides that 30 to 60 days before the beginning of the open enrollment period, an insurer must notify enrollees of the date that the open enrollment period begins and ends, any rights of the insurer to change to a different plan, and any modifications of the current benefits.

Assembly Bill 250 offers Nevadans who have Medigap policies to annually review the price and coverage of their policies. I would like to be clear, though, this measure is not a free pass for people to obtain Medigap policies who do not currently have them. Instead it allows enrollees to consider if other policies are available that better suit their needs. I would now like to turn it over to Christopher Carothers with the Nevada Association of Health Underwriters to give brief remarks. He will be followed by my constituent, Mr. Bronstein, who will also give some brief remarks.

Vice Chair Carlton:
Thank you very much. If we could have the next presenter, please?

Christopher Carothers, President, Nevada Association of Health Underwriters:
Thank you, Madam Chair, Vice Chair, and Committee. I have been in the brokerage business and selling insurance for 30 years here in southern Nevada. Our organization is for the health underwriters; we are a professional organization for our health insurance industry. Assembly Bill 250, as we call it the Birthday Rule, is an important bill that would help many Nevadans who are insured by Medicare with a Medicare Supplement, also known as a Medigap plan.

Currently anyone who has medical insurance has an open enrollment once a year regardless of their health status, when they can move, change, or switch to another medical plan. This would include Nevada Health Link, Medicaid, small and large employers, and Medicare Advantage Plans, except those who have Medicare Supplement plans. This bill would allow for those who have a Medicare Supplement plan to switch to another Medicare Supplement plan once a year around their birth month to another insurance company, or they can also go with their current insurance company at new lower rates that they are offering and with no reduction in benefits regardless of health status.

As insurance producers, we have had our clients receive rate increases every year for their supplemental plan. The clients contact us to help them change plans, yet we cannot help them change a plan due to health conditions. They do not have to be serious health conditions; it can just be something that they are trying to manage that is very manageable; we just cannot help them.

Our Association has been discussing the Birthday Rule for some time now, and we have discussed it with the Division of Insurance and insurance carriers. We have had our meetings to discuss the impact to our clients, and we are in support of the passage of A.B. 250.

One other thing I thought about in listening to the other speakers is the reason why people ought to choose a Medicare Supplement plan is choice. You can pretty much go to any doctor or any hospital in America. That means a lot when you deal with people with some serious conditions, and the doctor whom they trust is not contracted with one of the local health maintenance organizations or preferred provider organizations. These rural areas in Nevada need a choice to have access to doctors and that is what Medicare Supplement plans do. We have limited these people financially because the rates keep going up, yet they are on the edge of "How do I pay for my insurance and take care of myself and still seek the care I need from my doctors that I trust?" We are in full support of A.B. 250. It is long overdue and I am happy to answer any questions. Thank you.

Assemblywoman Jauregui:
Thank you, Mr. Carothers. Vice Chair, if we could go next to my constituent, Mr. Bronstein.

Vice Chair Carlton:
Please, Mr. Bronstein, welcome to the Committee.

Rick Bronstein, Private Citizen, Las Vegas, Nevada:
Thank you very much, Vice Chair, and of course to Assemblywoman Jauregui for letting me speak about this. I have been in Nevada for five years. I have been licensed since the beginning of time, 1977, and I have been in Medicare since 1993. I come from California—as probably 90 percent of us do—and in California, the Birthday Rule has been around for a while. It currently says you can apply to change a plan without underwriting—you cannot go up in benefit—30 days prior to your birthday with an effective date no earlier than your birthday and you can apply up to 60 days after your birthday. It gives everybody who has a Medicare Supplement plan, including those under 65, the ability to not have to overpay for their policy.

I will go over it very quickly. I did some quick rate comparisons because I am sure the concern, or at least a question by somebody will be, What happens to rates, now that we are going to let people move all of the time, what is going to happen to the rates? I did a comparison using a ZIP Code in Henderson and a ZIP Code in San Francisco. The population using a ZIP Code in San Francisco is about 3.3 million and in Clark County it is about 2 million, so it is kind of similar. Looking at a 70-year-old using United Healthcare—not because they are the lowest price, but they have the preponderance of business in both states—the rate is $4 less in San Francisco; for a 75-year-old, it is $11 less; for an 80-year-old, it is $40 less. It is the same company, same benefits, and I used Plan F, which I am not a big fan of, but that is the one that covers 100 percent of everything.

Even in Nevada, a 70-year-old can save $40, a 75-year-old can save $60, and an 80-year-old could save about $70 a month just by switching from one company to another, and that is not even doing a rate comparison; it is the same exact plan. If they wish to "downgrade" and have the same plan but pay the $203 deductible, which means going from Plan F to Plan G, that 70-year-old who is paying $200 right now can go down to a premium of $133 a month.

The bottom line is, even after paying the deductible, at virtually every age, regardless of health, a person could save $900 a year. And I have used female rates—California has no gender rating, but I wanted to keep it equal. If we look at rates for men, it would probably be even more. In California I have many clients who would otherwise not qualify, but I was able to get them a much lower price because of the Birthday Rule. It is not fair that somebody buys a policy from—and I will not even mention the company—one company that keeps changing their pool every couple of years, starts a new company, closes the old company, where healthy people can leave, and people who are not healthy have to stay at ever-increasing rates with no options.

I have a client who is 76 years old who has an illness that would keep him from getting insurance, but he has not had treatment for over 20 years. It is not going to happen to him. If he was in California, I could have saved him $1,100—same benefits, no difference. Beneficiaries in Clark County, Washoe County, and a few other counties at least have the option to go into Medicare Advantage despite the fact that they have a limited network and may or may not get the treatment that they need. But what about rural areas? These people really have no options. If they buy a Medicare Supplement when they turn 65 and it goes up

in price to the unaffordable stage, what are their options? If they are not healthy, they cannot save any money. If they drop their expensive supplement, they may be out thousands and thousands of dollars if they need care. This is why I got together with Assemblywoman Jauregui and spent almost two years now, I think, to discuss this and immediately she saw the need and that is terrific. I am here for any questions.

Assemblywoman Jauregui:
Thank you, Mr. Bronstein. Vice Chair, I did want to let the Committee know that I submitted an amendment that is available on NELIS [Nevada Electronic Legislative Information System] to clarify that the bill I am introducing is only to apply to Medicare Supplement plans [Exhibit I]. I added the Supplement plans to the language so it was clear that the bill is only for Medicare Supplement plans. I do not have an amendment yet, but I am working on one with some of the insurance groups to address the notification. They did say that having it be a mandate requiring them to send out annual notifications prior to the open enrollment period might increase costs. I am working with them to see which notifications they send out annually now that we can add this. We want to ensure that there are no further costs there which would translate into increased costs to the insurers. With that, we are open for questions, and I do have Mr. Carothers here to help answer questions as well as the Division of Insurance.

Vice Chair Carlton:
Thank you very much, Assemblywoman Jauregui. Your presentations made things very clear. I think it would have been great if my husband and I could have talked to Mr. Bronstein before we had to make the decision a couple years ago on which plan to buy. It is a very tough decision the first time you sit down and look at it, and then knowing in the back of your mind that once you have made that decision, you are kind of stuck with it for a while. Knowing that this just gives a person an option—and that is what I am hearing—I just want to make sure that this gives a person an option to basically do what we preach to folks: shop your insurance and try to get the best rate that you can. Is that my understanding of the bill?

Assemblywoman Jauregui:
Yes, and I will answer that and then allow either Mr. Bronstein or Mr. Carothers to come in after. But yes, and it is important to note, it provides an option to move to an equal or lesser insurance plan. I think it is important that we note that. Mr. Carothers or Mr. Bronstein, I am not sure if you have anything else to add to that.

Rick Bronstein:
I am an insurance agent, so I am always willing to talk. Yes, that is exactly what happens in California. If you are on Plan F, which covers 100 percent of everything including all of your out-of-pocket cost, and you want to downgrade, you can save even more money if you just do the math. It gives people the option to do what is best for them, and it gives insurance agents the opportunity to help more people. To me this is not a partisan issue at all. It helps the consumers in Nevada, and it does not harm insurance companies based upon California rates. I really hope that it passes; it is so good for consumers.

Vice Chair Carlton:
Thank you very much, Mr. Bronstein. Committee members, is there anyone who has a question for Assemblywoman Jauregui or for Mr. Bronstein or Mr. Carothers as far as the particulars of the bill?

Assemblywoman Kasama:
Thank you so much for the presentation and the overview. Just to clarify again, you said that the bill only applies to Medicare Supplement plans. It is also the ability to move to an equal or lesser plan, to downgrade. My question is, if you move down, could you later move up again, or once you have made that decision, you remain at that level?

Christopher Carothers:
First of all, we did not cover one thing that I want to make sure is clear, which is that the federal government standardized the supplemental plans A-N, so now they are alphabetical. So when a consumer wants to switch plans from an F to an F or a G to a G, being like kinds, they are exactly the same plan essentially. There is no difference in plans, it is just different rates, different companies. The idea is to be able to allow people to move to a like plan, equal to or less than.

And the reason why we left it generic in nature, our thought process was, what if the federal government decides to eliminate any of these alphabet plans and add new alphabet plans? The idea is to allow people to move sideways to something equal to or less than, but to answer your question specifically, no it is not meant to upgrade. That is something that has been discouraged in our industry for years because that is really unfair to the insurers on that level. We need people to be able to pay to play, if you will, and then everyone benefits by it. But just to jump back and forth when you feel like it, Oh, I am healthy now, I want to buy down; and then, Now I am sick, I am going to buy up. It is really not a fair thing to do.

Assemblywoman Kasama:
Thank you, that makes sense. Just so I can understand, I would like a clarification to the Birthday Rule, because we are also changing that. So right now, there is just an open enrollment, let us say November 1. And that is what it is for everybody. Now we are going to make it so you can do it on or around your birthday month, is that correct?

Rick Bronstein:
You are talking about the "November Rule." That does not apply to Medicare Supplements. There is an open enrollment for Medicare Advantage, there is an open enrollment for the prescription drug plan, and, of course, the Patient Protection and Affordable Care Act has an open enrollment. This is specific to Medicare Supplement/Medigap plans. They do not have any open enrollment period other than when you first get your Medicare Parts A and B. Now, you can be 65, you can be 70, hopefully you can be disabled; I would love to see Assembly Bill 180 pass as well. But it has nothing to do with anything other than people who have chosen a Medigap plan. For example, I am—unfortunately or fortunately—over 65. When I turned 65, I bought from a particular company. Their rates went up in the

last two years, and because my health is okay, I was able to switch carriers and save $30 a month, same plan. What if I could not do that? What if I had carpal tunnel syndrome? What if I am taking a pain killer just for my back?

Assemblywoman Kasama:
What is the current time frame? How is it currently done to get a Medigap plan?

Assemblywoman Jauregui:
Ms. Sterner's presentation taught me a lot, but it also showed how the Medicare Supplement worked. You can only enroll in a Medigap plan when you first become eligible for Medicare insurance without health underwriting. The reason the Birthday Rule is so important is because without the Birthday Rule, you do not have another open enrollment period where you can change policies to an equal or lesser policy without health underwriting. We currently do not have an open enrollment period for supplemental plans, so if you did want to change, you would then be subject to health underwriting. If you now have a preexisting condition, your supplemental plan would be more expensive.

Assemblywoman Kasama:
I am just thinking that right now, let us just use November 1, everybody signs up on November 1 and if you miss it, you have to wait for November 1 again versus your birthday month.

Assemblywoman Jauregui:
Right now, there is no November 1 open enrollment period for supplemental insurance plans, so they would not have to wait. There is no second open enrollment period. If they wanted to, they would have to go through a health underwriting process. That November 1 open enrollment period does not apply to supplemental plans.

Assemblywoman Hardy:
I think this was a great presentation because unless you get in and work in Medicare, it can be really confusing. I have learned a lot in the last few years navigating those, trying to help my own parents, and understanding when they can enroll, what all the different plans are, and what they need. I think that was a really good introduction. In section 1, subsection 1, you put remaining open for at least 60 days. I was just curious how you arrived at those 60 days as opposed to 30 or 90.

Assemblywoman Jauregui:
I just modeled it after current laws in other states that allow for the 60-day period.

Assemblywoman Hardy:
My question is, just thinking of the logistics of it, we have established there are certain enrollment periods where folks are able to enroll in different Medicare plans. With this, people would be enrolling every day or throughout the year. This might be best for the Medicare folks, but how do you see that affecting the ability to take care of the other members; logistically, how do you see that working?

Assemblywoman Jauregui:
Is your question directed to insurance brokers, or is that for the insurance companies?

Assemblywoman Hardy:
If you are having an enrollment date every month, basically for an individual's birthday, they are able to enroll no matter who is handling the enrollment. Is that the individual insurance company or is it Medicare? I am just trying to figure out how logistically it is going to work. Is it going to be a large increase in caseloads? Do they foresee that?

Assemblywoman Jauregui:
That seems like a question that would be directed to the health insurance groups like UnitedHealth Group or Anthem, and I do not believe we have anyone here from those groups to help answer that question. But I will reach out to them and get an answer for you and the Committee as well.

Assemblywoman Dickman:
This is pretty complicated. My question, and maybe it has nothing to do with this bill, is that you said you cannot switch levels. Can you switch between companies and maybe get a better rate?

Rick Bronstein:
Using the Birthday Rule, you can switch within a company or you can switch to another company. Whatever works best for you; you can do what you would like. It just gives you the opportunity to change your plan.

Assemblywoman Dickman:
But currently can you switch companies yet not switch levels?

Rick Bronstein:
If you are healthy enough to pass underwriting, you can do anything in every month, anytime you want. The Birthday Rule just gives you a once-a-year open enrollment. The logistics is not an issue. I can submit an application for a Medicare supplement for a 70-year-old, underwritten. Or if it is in California, I can submit it under the Birthday Rule, not underwritten. It is the same application and it is not harder on anybody; in fact, it is easier on the companies.

Vice Chair Carlton:
Is there anyone else wishing to ask a question at this time? [There was no one.] With that, we can go to those testifying in support of the bill. [There was no one.] Can we give the opportunity to those who may be testifying in opposition? [There was no one.] We will go to the neutral position.

Tom Clark, representing Nevada Association of Health Plans:
I would like to thank Assemblywoman Jauregui for bringing this bill and for the extensive work she has done with us leading up to the hearing. As you have heard, the Birthday Rule

in other states allows individuals with a Medicare Supplement plan to move to an equal or lesser plan, policies that we would support here in Nevada. As Assemblywoman Jauregui acknowledged, we are working with her on an amendment that would change the language in A.B. 250 from "open enrollment" to a "guaranteed issue rights" kind of a situation. This is because the term "open enrollment" can cause quite a bit of confusion. We look forward to continuing to work with her on the language to address those concerns and I will also reach out to Assemblywoman Hardy to answer some of her questions as well. Thank you, Madam Vice Chair.

Vice Chair Carlton:
Thank you very much, Mr. Clark, for offering to answer those questions. We appreciate it. If you would make sure to share that information with Assemblywoman Jauregui so that all the Committee members could have the opportunity to hear that answer, we would greatly appreciate it. Do we have anyone else in neutral? [There was no one.] Assemblywoman Jauregui, do you have any closing comments?

Assemblywoman Jauregui:
I just want to thank you and thank the Committee members for hearing Assembly Bill 250. I would like to thank my constituent, Mr. Bronstein. He is correct; he first brought this issue to my attention almost two years ago over coffee, and I am happy that he did because I am proud to be a part of it and proud to carry this bill. I will make sure that we do get that question answered that Assemblywoman Hardy had and shared with the whole Committee. With that, thank you, Vice Chair Carlton.

Vice Chair Carlton:
I will close the hearing and hand the virtual gavel back to Assemblywoman Jauregui so that she can continue with the meeting and we can move on to the next bill. Happy to be your backup, Assemblywoman Jauregui.

[Assemblywoman Jauregui reassumed the Chair.]

Chair Jauregui:
Members, we are going to take our next agenda item out of order. Our presenter for Assembly Bill 274 is caught up in another committee, so if we have our presenters for Assembly Bill 278 here, I would like to go to that agenda item next. Assemblywoman Duran, are your presenters here and would you be willing to go next?

Assemblywoman Duran:
Yes, they are here.

Chair Jauregui:
Thank you so much, Assemblywoman Duran. I am sorry that I put you on the spot like that. Members, I will now open the hearing on Assembly Bill 278, which provides for the collection of certain information from physicians. We have our own Assemblywoman Bea Duran here to present the bill. Assemblywoman Duran, when you are ready, the floor is yours.

Assembly Bill 278: Provides for the collection of certain information from physicians. (BDR 54-771)

Assemblywoman Bea Duran, Assembly District No. 11:
Thank you for your time today and for allowing me to present Assembly Bill 278, which requires a physician to complete a data request when renewing his or her license or registration. Today I will provide background information, and Bobbette Bond, Director of Public Policy at the Culinary Health Fund, and Maya Holmes, Healthcare Research Manager for the Culinary Health Fund/UNITE, will provide the details of the bill. [Assemblywoman Duran read from written testimony, Exhibit J.]

Nationally, private equity firms are making a splash in health care. According to the *Journal of the American Medical Association*, acquisition of physician practices by private equity firms more than doubled from 2013 to 2016. However, the extent that the firms have infiltrated the industry has been difficult to quantify due to the nondisclosure agreements and other business practices.

Private equity firms have been at the center of the surprise billing controversy that has taken the industry by storm. Congress is looking at the billing practices of physician groups that are owned by private equity firms, which may be behind the bulk of the balance billing, a practice which leads to unexpected, excessive medical bills for patients.

Research is limited to the impact of physician practices being acquired by private equity firms. There may be unintended consequences in other parts of health care, including on how delivery and quality of care will be affected in the long term.

Another national trend is consolidation. When local hospitals merge into massive health systems, it can significantly affect the practices of private physicians. According to the Lown Institute, from 2012 to 2016 the number of hospital-acquired physician practices increased from 35,700 to more than 80,000. By 2018, 44 percent of physicians were employed by hospitals or health systems, nearly double the rate in 2012.

Hospitals often claim consolidation helps improve care coordination and efficiency, but research studies have not shown consolidation improves patient outcomes. Rather, consolidation may lead to higher prices for health care services because larger health systems command greater market share. According to researchers at the Health Care Pricing Project, prices at hospitals that have a regional monopoly are 12 percent higher overall

compared to hospitals that have four or more rivals. Nevada, like other states, is limited in ensuring these changes in the marketplace do not have a negative impact on patients and public and private payers.

Briefly, A.B. 278 requires a physician to complete a request for certain data when renewing his or her license with the Board of Medical Examiners and the State Board of Osteopathic Medicine. The Department of Health and Human Services must develop the data request. The confidential information obtained by the licensing board must be sent to the Department, which will collect and maintain it.

Assembly Bill 278 is an initial effort to monitor health care consolidation and protect competition between health care facilities. We will continue to see consolidation across all facets of the health care system. It is not a question of whether consolidation is good, but the question that must be answered is how investment and consolidation will provide patients access to cost-effective, high-quality care in Nevada.

And with that, Madam Chair, Ms. Bond and Ms. Holmes will discuss the details of the measure. At the conclusion of their remarks, we would be happy to answer any questions regarding the bill.

Chair Jauregui:
Thank you, Assemblywoman Duran. Ms. Holmes, when you are ready, the floor is yours.

Maya Holmes, Healthcare Research Manager, Culinary Health Fund/UNITE:
I am here today with Bobbette Bond, the Senior Health Policy Director for the Culinary Health Fund [Ms. Holmes read from written testimony, Exhibit K]. We want to thank Assemblywoman Duran for bringing this important bill forward. We would also like to thank Chair Jauregui, Vice Chair Carlton, and the Committee members for their consideration of this important legislation.

As you may be aware, Nevada has one of the largest physician shortages in the United States. We are forty-fifth in the nation in providers per capita and fiftieth for primary care providers. Nevada ranks forty-eighth in the country for clinical care, forty-fourth for access to care, and forty-second due to adults avoiding care because of cost. Lastly, Nevada ranks forty-seventh in the nation for quality of care. Yet little is known about the specific market forces that may impact the physician shortage: access, affordability, and quality, including basic information such as who owns or has bought any given physician practice in the state.

Ownership of physician practices has changed dramatically over the last decade. The American Medical Association announced in 2019 that more physicians were employed in hospitals and health systems than were independent for the first time. The Physicians Advocacy Institute and Avalere Health conducted a study that found 44 percent of physicians were employed by hospitals in 2018, up from 25 percent in July 2012. Yet, this is often national data based on periodic surveys. We do not have a comprehensive picture for our state, much less one that is current or demonstrates trends in Nevada's health care markets.

Some reports indicate hospitals now employ physicians who had been in private practice because of increasing overhead, reimbursement issues, and the administrative responsibilities of ownership. However, independent doctors have lower burnout rates. The employment status of doctors may also affect patient access. Employed physicians typically see fewer patients in a day, on average, than private practice doctors. Physician employment status can also affect affordability. Hospital acquisitions of physicians increase physician prices an average of 14 percent, 33.5 percent for cardiologists, and 12 to 20 percent for orthopedists, according to research. Other studies have shown that private equity ownership of physician practices also leads to higher prices.

Physician ownership can also affect referral patterns. A Stanford study showed that physicians increased referrals to the hospitals that employed them and that patients were more likely to be treated in "a high-cost, low-quality hospital when their admitting physician's practice is owned by that hospital." This bill would allow policy makers, providers, patients, and payers to understand critical trends in Nevada's health care market and their impacts on physician volume, density, and practice.

Specifically, the bill proposes to add to existing licensing renewal and biennial registration requirements for physicians, a field that specifies whether the physician is employed or independent, and if employed, where the physician practices and which entity owns that practice. Specifically, the following would be included in licensing information:

1. Whether the physician is employed as part of a hospital or health system-owned practice or independent.

2. If employed by a hospital or health system, the hospital or health system name.

3. If employed by another entity, the ownership legal entity name and fictitious firm name.

4. Whether the physician is in a solo and single-location small practice or multi-specialty, multi-location group practice.

Applicants for renewal of a license by the Board of Medical Examiners and the State Board of Osteopathic Medicine would provide the information prescribed by the Department of Health and Human Services pursuant to the bill's provisions. The Boards are to include these data requests in applications for license renewal and biennial registration and transmit the data to the Department.

Any reporting on this data would be aggregated to protect provider privacy requests and not reveal the identity of the physician. However, as Assemblywoman Duran noted in her opening remarks, it really is critical that policy makers, public and private payers, and patients understand the role of entities like private equity and other major players that are consolidating the physician market to understand consolidation's impact on access, quality, and affordability. For example, we know that in Nevada, neonatal intensive care unit and

emergency room physician groups are now owned by large private equity groups in a number of cases, and we would like to see how that impacts price, access, and contracting status over time. But without any reporting of who owns these and other practices in Nevada, such trends will be impossible to evaluate.

The intent of the legislation is to simply add an additional data request to already required licensing and registration reporting steps. This information would obviously be known to the physician, so we do not believe it is adding administrative burden. The information requested is also already in the public domain for each provider—that is, if you wanted to research websites and public filings, you could find the information—but it is not currently collected or aggregated in a way that is accessible, meaningful, and useful for policy makers, providers, patients, and payers. Now I would like to turn it over to Bobbette Bond. Thank you.

Bobbette Bond, Senior Health Policy Director, Culinary Health Fund:
I really appreciate Assemblywoman Duran's bringing forward the bill [Assembly Bill 278] today. This is the result of a couple of years of our trying to understand what is going on in the health care market in Nevada and ways that we can get more disclosure and more transparency into the system in Nevada. Just one more data point to add to the data that Assemblywoman Duran and Maya Holmes just gave you that has been recently added to the *Journal of the American Medical Association*: the pandemic has led to even more consolidation than was already occurring at a really high level. In just the last half of 2020, there were more than 150 private equity deals nationally that were closed, covering a range of health care sectors [Ms. Bond read from Exhibit L]. And two-thirds of them were about providers and their health care services, so Las Vegas has been dramatically impacted by this.

Unless you contract for health care all day long, it is hard to see it happening. We do not have either the technology or the data to start monitoring this, and it is a huge cost driver for Medicaid, for the Public Employees Benefits Program, for our private health plan, and for the county health plans. So, the coalition is supporting it as well as our health services coalition. These large companies can really take over a whole industry sector. As Ms. Holmes said, they are in the ER departments of several of our hospitals.

This bill would impact two boards, and I am sure you will be hearing about them—the Board of Medical Examiners and the State Board of Osteopathic Medicine. What we wanted to do is create a quick and efficient funnel to provide this information from the physicians to the boards and then have the boards send that via the Department of Health and Human Services (DHHS). That way we would be able to see these patterns over time and the trends that they are creating without a lot of new burden and a lot of new fiscal analysis. It is an efficient way to do it. And that is all I wanted to add, and I am happy to answer questions. We are involved in the contracting of greatest need to understand the system better. Thank you for your time.

Chair Jauregui:
Members, we are now going to the question section of the bill hearing. Do you have any questions?

Assemblywoman Carlton:
Thank you, Ms. Bond and Ms. Holmes, it is always nice to see you and work with you. You are so smart when it comes to this stuff. I know Nevada has kind of a pseudo-corporate practice of medicine. The physicians have to be involved in the actual practice, but what I am hearing is these private equity firms are coming in and buying some of these practices up so the doctors are still involved but they are really owned by the private equity firms.

We know a private equity firm has a fiduciary duty to its shareholders, but not necessarily to the practice of medicine. Basically, what you are asking for is transparency in being able to see whom these doctors actually work for. The way you propose to do that is on the yearly or biennial registration—just basically have the doctors fill in another line stating who actually are the major players in their company or their practice. I just want to make sure I got that straight.

Bobbette Bond:
That is absolutely right. We do not have a lot of transparency in our system around ownership, almost none. We do see it in private equity buying up these practices, but we also see it in the first issue that you raised, which is the corporate practice of medicine. We are unclear at this point what the hospitals are doing with the physician practices, but we know it drives up cost when they own the practice because a facility fee has been added to the practice that did not exist previously. There are ways that this is generating a cost impact and an access impact. We are not sure if it is having an impact on the doctors themselves whom we so desperately need to keep, and we do not have enough data to even start measuring it.

Assemblywoman Carlton:
Thank you, I appreciate that. For too long in this building we have made a lot of decisions based on anecdote and not data. I am so pleased to see that we are moving towards getting all that data. On the registration piece, though, do you know—maybe this is more for the board later on—I believe they have gone to a lot of digital registration, online registration. This would basically be just adding another section to the registration, which is to fill out this information and then they would compile it and forward it to DHHS every year or once every two years. Is that the procedure that you would see?

Bobbette Bond:
Yes, because the physicians have to apply for their licensure to renew their license. This was the easiest place to put it, but we agree that it should be digital if possible. There might just be fields that can be added to the digital applications rather than this form that is in the bill right now. We could present a conceptual amendment that would simplify this process because if both boards are operating digitally, it would be way better. Then that electronic file could just be lifted at DHHS instead of another piece of paper having to move around.

Assemblywoman Carlton:
Thank you, Ms. Bond and Ms. Holmes, I believe that answers my questions.

Assemblywoman Kasama:
Will we be hearing from the physicians' groups as far as impact, or if this can be done or what their input is on that?

Chair Jauregui:
I believe the insurance groups would probably be in the testimony portion of the hearing.

Assemblywoman Kasama:
I see the goal of collecting this extra data, and I have a feeling my question will be answered when I hear their testimony as well. I am just wondering what the end goal is with all the data, because it sounds like we already know that equity acquisitions are growing, and usually when that happens, it is because the doctors are not making enough money. Whether it is Medicaid reimbursement or whatever the issue is there, they are not making enough money, or their overhead is not good enough. They are being attracted to these groups or consortiums. I am just wondering what the end goal is with all this data, because it sounds to me like this consolidation is usually due to money and having more of the data. How would that fix it? Is it a burden? And perhaps it will not be a burden. I will find out; I am just curious.

Bobbette Bond:
I do not know that we know what is driving physicians to sell their practices. I think that is part of the mission here, to see if there is a trend in acquisition that continues but seems to be related to one specialty. I do not know that it is income-related, and I do not know if the physicians even make more after they sell their practice to a private equity. Those are all questions that would be wonderful to have as a policy program in this state. But we are just trying to start collecting the data to see if there are any trends.

Assemblywoman Tolles:
Thank you to the presenters. I just wanted to check and see—because I did not see it anywhere in the language—what happens if a physician either fails to or refuses to answer these questions? Is there any kind of penalty?

Bobbette Bond:
I do not see in the bill that there is a remedy for that at this point. I think there would have to be some discussion about how physicians would be treated. Again, it seems like this is an ideal process because they are required to complete their licensing application and renewal in order to stay licensed. It seems like a simple way to make sure everybody is getting the data in.

Assemblywoman Tolles:
That might be a question for the Board of Medical Examiners and the State Board of Osteopathic Medicine as they will be collecting the data. I have looked at similar types of

proposals—I was actually going to bring a different kind of data collection proposal—but was just wondering if they would not renew the license if they did not fully complete that. Maybe that is a question that is better for the boards.

Assemblywoman Duran:
We are still going to try to amend some of the language and also check with the Legislative Counsel Bureau (LCB) to see if there are any other costs or penalties that can incur with this. We do not want it to be punitive; we just want to collect data. We need choices for our doctors. That is the bottom line for all our families. We need good, quality health care and when we have doctors who are leaving, we do not have much of a choice. Our primary goal is to make sure that Nevada still has a choice for our constituents across the state to have a good choice of doctors.

Assemblyman O'Neill:
My question is twofold. One, how many other states have done such a requirement, and two, has it shown to reduce the cost of health care and/or improve health care delivery to the communities?

Bobbette Bond:
I believe we would have to do a pretty deep dive to see what information every state board requires as part of licensing. We do not have that information available today on what is required of state licensing nationally. I do think there is a growing need to understand how the markets are changing nationally with the private equity issue. I would say that this is about transparency. This legislation is about creating the transparency to then answer the next questions that some of the Assembly members are thinking ahead of, the net impact later on. But you need the transparency to even see if there is a relationship, and we cannot even see that right now.

Maya Holmes:
I also wanted to add that it is very clear in the data, in the research, that health care consolidation is the leading, if not the driving factor in increasing health care costs. I think, as Assemblywoman Carlton raised earlier, this is really about having the data so we can begin to understand and address what is happening. It is very hard to make informed policy that we will want to be in a position to make without that data and just relying on anecdote.

Assemblyman O'Neill:
I appreciate your wanting to collect the data, but would you admit that there could also be other factors besides consolidation of doctors in their practices, such as the cost of medical school, the cost of running a business, the personnel cost, et cetera? Those could also contribute, rather than just consolidation. I am hearing you say you just want the data on consolidation, and I think there are probably other data factors that could contribute to the cost of health care.

Maya Holmes:
I agree, I think there are probably multiple factors. I think the research has just shown that consolidation is such a critical factor and that is a piece we do not have. But I definitely agree, health care is complex and there are a lot of factors, so we are just trying to pull the information together so we have a full picture.

Assemblyman O'Neill:
I appreciate that, Ms. Holmes. I missed all of your statistics at the beginning of the presentation, so if you could get those to us, I would really appreciate that.

Chair Jauregui:
Members, any other questions? [There were none.] We will move on to the testimony portion of the bill hearing. We will start with testimony in support.

Stacie Stasso, Executive Director, Health Services Coalition:
The Health Services Coalition represents 25 employer- and union-sponsored health plans in southern Nevada with an estimated 300,000 lives. Our focus has always been on bringing quality, affordable health care to the lives we represent, and we are testifying today in support of A.B. 278. We feel transparency in the health care market will continue to ensure patients in our state have access to providers. Understanding the changes in the marketplace will help patients navigate their health care and make informed decisions on where they seek care. Oftentimes, changes in ownership take place without notice and cause unexpected consequences to patients and payers. We appreciate the work that is being done on this issue.

Donna Kelly-Yu, Private Citizen, Las Vegas, Nevada:
Hello, Nevada legislators. I am speaking in support of A.B. 278. I have been a Culinary Workers Union member for 22 years. As someone with underlying health conditions, I have had to change my primary doctor before, and that has become difficult as someone who wants to be an empowered and informed patient.

My husband and I had a primary health care physician for a couple of years, and he was great. He was the doctor who diagnosed me with my diabetes, who explained the diabetes to me, prescribed me medicine, and gave me a sheet of paper with suggested foods that I should eat. I was able to lose 40 pounds under his care. My health improved so much under his care; I felt great. He was a kind, caring, encouraging doctor. I would even have to drive 30 minutes each way to see him. Everything was going great until I found out I could no longer see him, and I never found out why. It felt like a setback, and I had built a relationship with a great doctor and then all of the sudden he was no longer available.

As a patient, I am concerned about rising health care prices and our access to quality doctors. Doctors are changing hands all the time. Sometimes they get bought out by big hospital systems or large corporations, and I am worried about how that impacts my health care. Patients should have information on what is happening with our doctors, who owns their practice, and how the changes will impact our health care access, quality, and price. I urge Nevada legislators to support A.B. 278. Thank you so much.

James Sullivan, Political Director, Culinary Workers Union Local 226:
The Culinary Workers Union supports A.B. 278 because health care affordability, quality, and access are critical concerns for 60,000 Culinary Union members and their families. The Culinary Workers Union, through the Culinary Health Fund, is one of the largest health care consumers in the state. The Culinary Health Fund is sponsored by the Culinary Workers Union and the Las Vegas-area employers. It provides health insurance coverage for over 145,000 Nevadans: the Culinary Union's members and their dependents.

The Culinary Workers Union supports efforts to bring transparency to the health care industry and to understand market forces in Nevada's health care market. This information is critical for the state, policy makers, employers, payers, and patients because market forces can reshape health care and we should have data to understand what is happening and the impact. The Culinary Union urges Nevada legislators to support and pass A.B. 278.

Chair Jauregui:
Thank you, Mr. Sullivan. Next, we will hear testimony in opposition.

James L. Wadhams, representing Nevada Hospital Association:
We have just experienced, under the leadership of Governor Sisolak, a declaration of emergency for the COVID-19 pandemic, and all of us have witnessed the incredible resourcefulness of medical professionals, from physicians to nurses and other health staff. We are concerned that this bill places a significant burden upon the very people we rely upon for our health care in terms of additional reporting, potential encroachment on personal information, and we are concerned that this may discourage the investment in our health care system that is so critical as we face this pandemic. We look forward to continuing to work with any other stakeholders should the Committee decide to move forward and further discuss this bill.

Chair Jauregui:
Thank you for your testimony, Mr. Wadhams. We will now move into the neutral testimony.

Keith Lee, representing the Board of Medical Examiners:
The Board of Medical Examiners is neutral on the policy in A.B. 278 but has some questions regarding the implementation and effect of A.B. 278, and I have shared those with the sponsor. Specifically, in the acknowledged shortage of health care providers in Nevada, the question is if the applicant for renewal does not even attempt to fill out the questionnaire, do we, the Board of Medical Examiners, immediately deny relicensure or is there a grace period? While the bill itself does not mention what the remedy is, LCB's digest suggests that as the Board of Medical Examiners, current existing law, NRS 630.3065, empowers the Board of Medical Examiners to deny licensure if a knowing or willful failure to perform any statutory obligation is presented itself. I think that, at least according to LCB's digest, the remedy would be a specific denial of the relicensure and so we would seek clarification on that.

If the applicant for renewal submits the questionnaire but does not answer all of the questions, do we deny relicensure? Likewise, who is the entity that would determine if the submission of the answers is sufficient to meet the statutory requirements? Finally, the Board of Medical Examiners would prefer not to be the recipient of the answers but merely a middleman to assist in getting the questionnaire answered.

I would suggest an answer to Vice Chair Carlton's questions would be that the Board of Medical Examiners has instituted a new electronic application process where we can provide a link in the application for relicensure that would go directly to the DHHS questionnaire and have the answer go directly to DHHS. Then we would only be the facilitator to have those questions answered. The beauty of this new application process is if the applicant for relicensure fails to click on that link to open the questionnaire, then the applicant cannot proceed further with the application and it would be an incomplete application for relicensure.

And finally, we have a question for the Legal Division, LCB. In order to maintain the confidentiality of this information, we would ask whether we need to amend NRS 630.220 and/or NRS 630.339 to provide specifically for the confidentiality of this information. Thank you, Madam Chair, and members of the Committee. We look forward to working with all of the interested parties on this bill to resolve some of these questions that we have and any other matters that might expedite the fulfilling of the statutory obligation presented in A.B. 278.

Assemblywoman Carlton:
Thank you, Mr. Lee, for being half a step ahead of me on the digital side. As far as the concerns about filling out the form and the licensure, we ask folks on a lot of different forms to fill things out and if they do not, they all have to comply with the standard repercussions of that. I would assume that is where we are going, but I look forward to your being able to work with the sponsor on the bill and make sure that we answered that. As far as the digital goes, I know there are questions about the burden of being able to fill this out. So if I understood you right, you would basically have a link on your application and it would go right to a form with DHHS, but they would not be able to complete the application until they complete that form. Is that correct?

Keith Lee:
I misspoke if that is the impression I left. My understanding of how our new application would work, in particular reference to the issues at hand, is that we could provide in the application for relicensure, that is now electronic, a link that the applicant for relicensure would have to click on and supply the answers. If the applicant did not click on that link, then the applicant could not complete the application for relicensure. In other words, if the applicant did not click on the link to the questionnaire and to DHHS, the application for relicensure would be incomplete until the applicant did that. That would be the assurance that at least the applicant clicked on the link to go to the questionnaire for relicensure purposes.

Assemblywoman Carlton:
So by clicking on the link they would be able to fill out the form, but on the back side of that they could fill it out and put in a bunch of x's and a bunch of dashes and not answer the questions. They would still get their license because they clicked on the link and filled something out. So, there is really not an accountability factor there.

Keith Lee:
That is correct. There is not an accountability factor built into the statute, but we can build it in in several different ways. We can put a certification in that application for relicensure that the person has not only clicked on the link but has answered the questions. We can also provide some method, and I am not sure how we do it, but a method with DHHS that they would confirm back to us that the questionnaire has been filled out.

Right now, we suggest that there be a link directly to DHHS. I believe the question was how do we confirm that, in fact, the link was clicked on and the answers were given. There are a couple of ways to do that. We can include in our license application a certification that the applicant has not only clicked on the link but answered the questions. Or we could also go back and confirm with DHHS that the link has not only been clicked on but has been answered to the satisfaction of DHHS. I refer to a bill from last session, Senate Bill 171 of the 80th Session, which did not ultimately pass, but in which we dealt with a similar issue with information from the applicant to the University of Nevada, Reno. We developed a system through that. My recollection is that allowed the Board of Medical Examiners to confirm that the questionnaire had been answered. I think there is a way to deal with a confirmation that the applicant has in fact answered the questions. But we can work with all the folks involved, particularly the DHHS folks and their computer folks and the Board of Medical Examiner's computer folks, to figure this all out.

Assemblywoman Carlton:
Because the board was in neutral and because they are the ones that are going to have to implement this, I just wanted to get a feel for myself and for the Committee on what the ramifications would be and how this would work. The information from Mr. Lee was very helpful. The only other question that I had was on the confidentiality side, but I am sure he is going to be reaching out to the sponsor of the bill and to the other members regarding that. I understand the confidentiality and what I think he is trying to get at, but we do not want it to be so confidential that we cannot get the data and really study what is going on. I think there is going to be a real balancing act there, and I am sure the sponsor and the proponents of the bill will be working with the board to make sure we get good public policy, so thank you.

Susan Fisher, representing the State Board of Osteopathic Medicine:
Like the Board of Medical Examiners, the State Board of Osteopathic Medicine is neutral on A.B. 278, but we do have concerns as well. I do not have an official position because our board has not had an opportunity to review this in an open meeting subject to the Open Meeting Law, so I am speaking in the neutral position right now. We do already gather a lot of information, as you know, and the bill does require us to gather information through our

renewal process. The information is then forwarded as we get it to DHHS. This means that we will possess the information in our computer system first and then send it to DHHS. Our initial thoughts are that we are a little bit uncomfortable having that information. If it was provided in a link that goes directly to DHHS, that would give us a little bit better comfort level.

I would also point out that according to our statutes, if a licensee or an applicant does not complete every single question, we do not process the application. We process our initial licensing and our renewal applications very quickly; however, if there is missing information and we have to go back to the applicant, that holds up the licensure. We are a little bit concerned about the risk of losing practitioners who do not want to provide information to the State that they may consider intrusive. Section 2, subsection 4, of the bill does state that the data is to be confidential and not disclosed to any person or entity outside of DHHS, and I think that covers most of our concerns at this time.

Chair Jauregui:
Assemblywoman Duran, would you or your copresenters like to give any closing remarks?

Assemblywoman Duran:
Thank you, Chair Jauregui and the Committee, for allowing us to present A.B. 278 today. Assembly Bill 278 is an initial effort to monitor health care consolidation and protect competition between health care facilities. It is not a question whether consolidation is good, but the question that must be answered is how the investment and consolidation will provide patients' access to effective, high-quality care in Nevada. I am happy to work with any and all stakeholders of A.B. 278 going forward, and I ask your support of A.B. 278.

[Exhibit M was submitted but not discussed and will become part of the record.]

Chair Jauregui:
Thank you, Assemblywoman Duran, and thank you again for being so flexible and presenting before the hearing on Assembly Bill 274. I will now close the hearing on Assembly Bill 278 and go to our last bill for the day, Assembly Bill 274.

I will open the bill hearing on Assembly Bill 274, which requires certain health plans to cover fertility preservation services. We have Assemblywoman Gorelow here to present the bill. Welcome to the Assembly Committee on Commerce and Labor. Assemblywoman Gorelow, when you are ready, the floor is yours.

Assembly Bill 274: Requires certain health plans to cover fertility preservation services. (BDR 57-482)

Assemblywoman Michelle Gorelow, Assembly District No. 35:
Thank you, Chair Jauregui and members of the Committee. I truly appreciate your flexibility. This afternoon I am presenting Assembly Bill 274, which, as mentioned, requires

certain health plans to include coverage for standard fertility preservation services. I am joined by a panel of supporters and experts who will offer their input, share personal stories, and answer technical questions for the Committee.

I will begin by talking about fertility preservation in general. Fertility preservation describes a variety of treatment options that allow patients to have children in the future. Examples of fertility preservation procedures include sperm banking, egg freezing, and in vitro fertilization (IVF) with embryo freezing. While everyone can access these services, preservation procedures are disproportionately used by persons with conditions that cause or lead to infertility. For instance, cancer patients may opt to receive fertility preservation services before undergoing radiation and/or chemotherapy treatment, which have been linked to infertility.

The Alliance for Fertility Preservation estimates that of the 125,000 people under the age of 45 diagnosed with cancer nationwide, about half will receive treatments that will affect their ability to have children. Fertility impairment is often a major concern for young and reproductive-age adults who would like to have the freedom to have a family in the future. In fact, a survey conducted by the *Journal of Clinical Oncology* found that 30 percent of breast cancer patients reported that infertility concerns affected their treatment decisions. No one should have to choose between cancer treatments on the basis of their fertility effects. Likewise, no cancer patients should be discouraged from starting a family because pregnancy is too expensive.

Assembly Bill 274 seeks to provide men and women with health conditions the opportunity to access fertility preservation by mandating insurers to cover basic procedures. As part of the bill in section 1, subsection 5, paragraph (c), "Standard services for fertility preservation" is defined as "the procurement, cryopreservation and storage of gametes, embryos or other reproductive tissue" for fertility preservation. The bill limits insurance coverage to two categories of people. The first category includes those with medical or genetic conditions that may directly or indirectly cause infertility. The second category of covered persons includes those expected to receive medical treatments that may also directly or indirectly cause infertility.

For all intents and purposes, qualifying conditions and treatments will be established by the American Society of Clinical Oncology, the American Society for Reproductive Medicine, and the American College of Obstetricians and Gynecologists. Public and private insurers alike would be required to provide coverage to qualifying persons under the measure. This would include insurance plans covering maternal benefit societies, group and blanket health insurance, health insurance for small employers, HMOs [Health Maintenance Organizations], individual health, Medicaid, nonprofit corporations, and public employees.

Ultimately, A.B. 274 is a life-affirming bill. It gives hope to people diagnosed with diseases that do everything to extinguish hope. We have been communicating with stakeholders in the insurance market to understand and work through their concerns. I am now going to turn it over to Lindsay Knox, Vice President of Government Affairs at the McDonald Carano law

firm. She has developed a conceptual amendment that is available on NELIS [Nevada Electronic Legislative Information System] for the Committee's review and will also address some concerns. After Ms. Knox presents, we will turn it over to Kendahl Servino and hopefully followed by Dr. Zucker, although he may be gone, as he has patients to see this afternoon. Thank you very much.

Chair Jauregui:
Thank you, Assemblywoman Gorelow. Ms. Knox, when you are ready.

Lindsay Knox, Vice President, Government Affairs, McDonald Carano:
As Assemblywoman Gorelow stated, we have a conceptual amendment [Exhibit N] that we have worked on to try to alleviate some of the concerns that insurance has. One of the main changes is the effective date. We are going to change that from July 1, 2021 to January 1, 2022. This will allow the plans to properly prepare if this bill were to pass. Another part of the amendment will also include a waiver in the Medicaid section. The reason we did this is that initially we were concerned about having Medicaid in the bill due to the recent cuts and putting an additional burden on the state for that coverage. What the waiver would do is allow the director to file a waiver with the Centers for Medicare and Medicaid Services as well as make an amendment to the state plan. This would allow them additional time to get things prepared. So for Medicaid, this bill would actually become effective January 1, 2023.

The last that we currently have would be for the self-funded plans providing an opt-in provision, understanding that there are certain self-funded plans that have truly struggled during the pandemic and to cause more burden would just be unfair. We are working with the Health Services Coalition on an amendment in hopes that we can come to a resolution there. We know that there will be more issues coming, and we are happy to work with all stakeholders and hopefully come up with some tighter language to make everybody happy.

I want to introduce our next speaker, Ms. Servino. Ms. Servino came to me back in June of 2020. I sit on the Susan G. Komen Board of Directors here in Nevada and Ms. Servino was interning. She told me her story and asked me to help her figure out a way to get fertility preservation here in the state. Her story was so touching to me, and I hope to all of you. I will turn it over to Ms. Servino. Thank you, Chair, for allowing me to step in and introduce her.

Kendahl Servino, Private Citizen, Reno, Nevada:
Good afternoon everybody, and thank you, Ms. Knox, for that wonderful introduction. I am a first-year medical student at the University of Nevada, Reno School of Medicine and also a breast cancer survivor. About a year and a half ago, during my last semester of college at the University of Nevada, Las Vegas (UNLV), I was diagnosed with breast cancer. Receiving the news, as I sat by myself in the radiologist's office, was the worst day of my life. A cancer diagnosis is incredibly devastating, and anyone who has received the news themselves or has a loved one who has been diagnosed knows this.

Now when you think of cancer, you typically think of losing your hair, chemotherapy, radiation, all of which I went through last year. But what does not really come to mind, and what I did not know about prior to my own diagnosis, was fertility preservation and the possibility that the toxic effects of chemotherapy might render me infertile. Prior to starting chemotherapy, I was recommended to visit a fertility specialist. Unfortunately these services—the fertility preservation procedure itself which involved extracting eggs and saving them, a term called cryopreservation, or the drugs, or the visits—none of this is covered by insurance the way that the majority of my cancer treatment, thankfully, had been covered by insurance thus far, which I and my family are thankful for. But for fertility preservation, this was a burden that my family and I had to bear, and it was an enormous cost of ensuring that I might have a family in the future. And personally, for me it felt like one more unfair item added to the long list of the concomitant struggles associated with a cancer diagnosis, on top of dealing with cancer as a full-time college student, preparing for medical school, and enjoying my 20s. It was a lot to bear.

So last summer I became involved with Susan G. Komen through internship, and one of the goals that I had was to see if I could make a change on fertility preservation here in Nevada. I was aware that some other states provide insurance coverage for patients who are undergoing chemotherapy like myself or are receiving medically necessary treatment that would similarly induce infertility. I realized in my position as a future physician, but now also as a cancer survivor, that I had the voice, the advocacy, and the title to speak up, not only for myself but for my future patients; not only my future patients, but many other patients here in our state of Nevada. And so I got connected to the wonderful Lindsay Knox and also Amanda Klein, and then soon our team began to double in size, and it started growing into the tremendous number of supporters we have today. It is amazing to see this change taking place right before my eyes, and I am so grateful to be here today and to share the importance of this bill and what it would mean for so many for it to be passed. Thank you, Assemblywoman Gorelow, for introducing this bill and thank you to everyone today for taking the time to listen to my story.

Chair Jauregui:
Thank you, Ms. Servino, for sharing your very personal story. I know how difficult that can be and for being brave enough to be here and take on that initiative.

Jacob Zucker, M.D., Private Citizen, Reno, Nevada:
Good afternoon, Assemblywoman Gorelow and members of the Committee. I am a pediatric, adolescent, and young adult oncologist currently practicing in Reno. I thank you for the opportunity to speak in support of Assembly Bill 274 today. I especially want to thank our last speaker for an incredible introduction of this bill because she is the reason why I feel passionately about this bill. She is the embodiment of why it is important. So please have that be the image in your mind as we move forward with this bill because it is the most important.

I would like to take a quick moment of my allotted time to introduce myself. I am a third-generation physician in my family to practice medicine in the great state of Nevada. My grandfather and father before me have both built incredible reputations for their exceptional care and patient advocacy. My grandfather in the south and my father up in the north had a lasting impact on countless Nevada families and both helped to shape the landscape of medicine in the state. It is clearly within my DNA to advocate for all of our patients here in the state of Nevada, and that is why I am speaking on behalf of Assembly Bill 274 today.

Almost five years ago I moved back to Reno, and I established a local, hospital-based pediatric, adolescent, and young adult program to serve northern Nevada families so they could receive oncology care right here in their communities. My purpose was simple: to provide safe and effective oncologic care and to obviate the unnecessary travel, expense, and emotional burden of all their care. Our program to date has received national and international recognition as a member of the Children's Oncology Group. In keeping with that original purpose, I really do feel that we have eliminated a tremendous amount of stress and burden for our northern Nevada families such that they can concentrate on their care and on their health. This is a theme that you have heard by our last speaker and also one that I will continue with in the rest of my presentation.

In my current practice I see patients ranging in age from birth to 25 years of age; sometimes I will see patients up to 30 years of age. My patient population overlaps very nicely with the adult oncology colleagues whom I have in town, specifically in what we define as the "AYA," which is the Adolescent and Young Adult population. Together the age range of 15 to 40 constitutes approximately 10 percent of all the diagnosed cancer cases each year. Importantly, a statistic that I hope you all take to heart is that 80 to 85 percent of this population will indeed survive their disease.

Unfortunately, enduring the therapy and surviving cancer is not the only challenge that the patients face. My patients, especially those who are younger at the time of their diagnosis, will be faced with long-term health, emotional, and even financial burdens of their therapies lasting well beyond the completion of their therapy. There is a bright side in that there have been great efforts that have been made to mitigate the late effects of their therapy. Current trends focus on primary prevention, reducing toxicity and cancer regimens, as well as secondary prevention through close follow-up and survivorship clinics, which are considered to be a standard and included in the comprehensive care of patients and included in their insurance payments.

Quality of life for our survivors is indeed improving; however, there are still areas of survivorship that are only now starting to receive proper attention. Fertility preservation is one of the areas for improvement. The risk of infertility varies. With diagnosis and prescribed therapy, nearly all patients who will be receiving chemotherapy will be at some risk of sterility or infertility. A majority of them—and that is that 50 percent statistic that

you had heard, and I would actually argue in my population, higher—are at a moderate or high risk of infertility and sterility. Unfortunately, as part of my initial meeting with patients, I am faced with delivering some of the same information time and time again:

1. Your child, or you, has a cancer diagnosis which is life-threatening if left untreated.

2. You or your child will receive chemotherapy with the intention of curing your disease; however, the therapy itself may cause extreme or even life-threatening toxicity and you will be at risk of another cancer caused by the medications we are treating you with.

3. Unfortunately, your life-saving therapy may prevent you from being able to conceive biological children.

My discussion with the patients and their families oftentimes differs ever so slightly, but one thing does not change: you have cancer, your treatment may cause health problems, you may even have another cancer in the future, and your treatment may render you infertile.

There is no way around it. In that initial discussion of the cancer diagnosis, a patient and/or their family loses some control over the outcome, or at least that control over the outcome is tremendously challenged. They are left feeling powerless over their disease and of their future. This feeling of being powerless contributes directly to other comorbidities to include depression, anxiety, and even sometimes deconditioning. Any control over that outcome that can be restored has profound and positive impacts on patients, their well-being, and even indirectly on other health care costs by eliminating those comorbidities. The tone of the conversation can immediately change if we add to the discussion that your life-saving therapy may prevent you from being able to conceive biological children, but we do have a solution.

And there is a solution and that is fertility preservation. Fertility preservation is a standard of care in AYA oncology. It should be offered to every patient who has a risk. More to the point, I very much advocate for legislation which not only makes fertility preservation an option but makes it feasible for patients and families who are already struggling with the financial burden of their underlying disease.

There are many factors which ultimately influence a patient's decision to pursue fertility preservation. The most common barriers include, but are not limited to, the age of the patient—if they are too young to be able to undergo procedures, too young be able to donate or bank sperm, the timing of their cancer therapy. I am often challenged with having to start life-saving therapy on a patient and balancing that with the amount of time it would take to go ahead and proceed forward with fertility preservation. Unfortunately, a third barrier that oftentimes comes up is regarding the cost to the patient. Of the three barriers listed, we are left with little option regarding the first two. However, the third option is one that we should ensure that cost is not a deciding or dissuading factor for the patient.

I do want to share with you a story of a 19-year-old patient of mine who just completed the process of fertility preservation and provided me with the following direct quote, "No one decides to be infertile. The expense of already having to deal with medical bills associated with childhood cancer as well as the physical and emotional trauma it has caused is already more than anyone should have to handle. Going through fertility treatment at such a young age under these circumstances is already stressful enough; wondering how to pay for college is already stressful enough. It is my hope that no teenager would ever have to decide between paying for fertility preservation and purchasing college textbooks." It is clear from the statement that fertility preservation is a topic that matters to our patients, especially to our AYA patients, and especially our young adults.

Infertility is associated with depression and low self-esteem and is often a source of disruption in family dynamics and planning. There have been many studies that have shown—and I have many cases—where patients have requested that their therapy be changed, altered, or even compromised to avoid infertility or sterility and thus increasing the risk for treatment therapy failures and for mortality. These are not decisions that any teenager or young adult should have to make.

In summary, fertility preservation should be offered and included in the comprehensive care of our adolescent and young adult cancer patients. The number of patients who will ultimately be appropriate for fertility preservation is proportionally small and, therefore, the overall cost of the service, too, is actually relatively small. The benefit, however, to the individual is great and would be in keeping with mitigation of unnecessary stress and burden for this patient population. And again, Chair, as well as Assemblywoman Gorelow, thank you to all the members for being able to hear me. This is an exceptionally important subject. You just saw right before your eyes, a real patient with a real story of why this is so important, and I encourage you to give great consideration to this bill.

Chair Jauregui:
Thank you, Dr. Zucker, for being here and for hanging on for us. It was important testimony and a presentation that you had. Thank you for the work that you do in our community as well. Assemblywoman Gorelow, are you ready for questions?

Assemblywoman Gorelow:
Yes, we are ready for questions.

Chair Jauregui:
Committee members, questions, please.

Assemblywoman Tolles:
Thank you so much for your presentation and for bringing forward this bill. Thank you especially, Ms. Servino, for sharing your story. As a mother of two daughters, I ask myself after reading this bill, how I would feel if they were in that same situation and I would want them to have this option as well. I really appreciate this legislation. I want to get a couple of questions on the record. I did have a chance to speak with the proponents beforehand, so

I just want to make sure I get those answers on the record so it is clear for others who might have those questions in the future. In section 1, subsection 5, paragraph (c), we have the definition for standard services for fertility preservation, and if you could just review what that includes and what that does not include.

Lindsay Knox:
What that covers is the medication, the retrieval, the appointments, and the storage. I believe that is everything that it covers.

Assemblywoman Tolles:
Thank you, and I think specifically the question came up, does this cover in vitro fertilization?

Lindsay Knox:
No, it does not.

Assemblywoman Tolles:
Thank you, and then the other question that arose was, Do we have procedures in place for, unfortunately, if the life-saving treatment was not successful? What is the process for what happens with the stored embryos and reproductive tissues and gametes?

Lindsay Knox:
I have a very long answer and a short answer; I will keep it short. There are legal requirements for the clinics that address this, where those get stored, those documents are signed there and reviewed.

Assemblywoman Tolles:
Thank you, and I just wanted to get that on the record that all the current procedures in place that address those concerns are already in place.

Assemblyman O'Neill:
I really think I like this bill and I appreciate Assemblywoman Gorelow's bringing it forward. It has been an interesting discussion I have heard. We talk so much about insurance payments, insurance companies—retroactivity, or preexisting condition. So Dr. Zucker, hypothetically, you have a patient, fertile or viable, but is going to be going under a therapy. You have already harvested the embryo or sperm and, they have already paid for it to go into storage. Is there any consideration for the insurance companies to pick it up at that time? In other words, for those who have already performed this act and suffered the treatment plans, unfortunately? I do not think that came across well enough.

Lindsay Knox:
Yes, I know what you are asking. On retroactivity, if somebody were to switch insurance, would that storage then be covered when they switch? Did I get that right?

Assemblyman O'Neill:
Yes, they switch, or they have already gone through the process of their storing, would the insurance company pick up the storage fees now?

Lindsay Knox:
They would not pick up the storage fees if it had been done prior, but what would happen is, let us say once this bill was implemented, what would happen is—I will use myself as an example—if I went in after this bill was passed and implemented, had cancer, decided to preserve my eggs and then let us say I switched jobs, and got new insurance, that new insurance would pick up that storage.

Assemblyman O'Neill:
That is what I was looking at; I appreciate that. And I did not hear it covered, but can someone answer what the approximate cost would be for the procedure and what does storage cost? Is it time limited or is it an indefinite freezing?

Lindsay Knox:
I have a chart right here that shows the costs. Again, you are going to have different rates based on your location. For egg freezing, the services cost between $10,000 and $15,000 with storage costing between $300 and $500 per year. Embryo freezing is $11,000 to $15,000 and storage is $400 to $600 a year. For men, sperm banking services cost $500 to $1,000, storage is $150 to $400 a year, and testicular sperm extraction is $7,500 to $10,000 and storage is $300 to $500 per year.

Assemblyman O'Neill:
I appreciate that. Chair, would you please get that for us so we all have access to that.

Chair Jauregui:
Ms. Knox, would you provide that chart so we can share it with the Committee members?

Lindsay Knox:
Yes, Chair, we will get that to you.

Assemblywoman Carton:
In the interest of fairness, this is a question I ask everyone who brings this type of bill and you heard it earlier on the first bill today. I would like to ask the sponsor just to clarify that this is indeed an insurance mandate.

Assemblywoman Gorelow:
Yes, it is an insurance mandate.

Assemblywoman Carlton:
Thank you. It is always good that we make sure we have a clear record. Typically, the mandates in this state do not apply to every form of insurance. I believe some of the Employee Retirement Income Security Act (ERISA) plans are excluded. I am not sure who

could answer this, but I did hear conversations about Medicaid, and I will have another question about Medicaid after this. Is it the intent that this would apply to all plans in the state, or are ERISA plans being exempted?

Assemblywoman Gorelow:
We are looking at options to opt-in for some insurance groups because we know that it can be a burden, especially with self-funded groups, and we are still talking with other groups as well.

Assemblywoman Carlton:
And if we could expand upon the Medicaid. I am going to put my Ways and Means hat on. I do not put it on in every committee, but I have to in this one because Medicaid was brought up. Could you expand upon how this would work with Medicaid? I have a concern about the underlying costs that would come to the state for this. If we were to ask for the waiver, do we have any number? Do we know if this would be under the newly eligible Federal Medical Assistance Percentage? Does anyone have an answer to that? If not, I understand; they are fairly technical questions.

Assemblywoman Gorelow:
I do not have those numbers, but perhaps Lindsay Knox might have them.

Lindsay Knox:
We have not seen a fiscal note yet from the Medicaid office, so those numbers are still unclear to us. Part of the reason we were putting in the waiver is to give them additional time, but I would like to see that fiscal note and understand what the impact would be. As I said in my introductory comments, that is a big concern to me. I do not want to burden the state more than it already is, especially since one of our special sessions included a 6 percent cut. I want to be very careful on how we approach that. So, we will work to get those answers and get them to you.

Assemblywoman Carlton:
Thank you very much. Maybe it is because of the way it was pulled together and I believe that was part of your amendment. We will work on that and get there. I know since the Affordable Care Act was passed and the Insurance Commissioner was tasked with setting up the essential benefits plans, it is my impression and recollection that any new mandate that comes in after the essential benefits have been established under the Affordable Care Act, there is a provision—I am going to have to have somebody look it up, I only have to look at it every couple of years—that the state could be responsible for part of that because it is outside of essential health benefits. I just want to put that on the record for our Committee staff and for Ms. Knox to look into. I believe there might be some unintended consequences with adding a benefit outside of the ACA essential benefit. I just wanted that on the record for the full conversation on the bill as we move forward.

Lindsay Knox:
We will definitely look into that, and I am already receiving text messages that we have an answer to that so we will get that for you.

Chair Jauregui:
Thank you, and if you could share that with the Committee, that would be great.

Assemblywoman Carlton:
If we have a representative from the Insurance Commissioner's office available and/or our Legal Division, I just want to make sure that we have all the information when it comes to that.

Chair Jauregui:
It looks like the Division of Insurance hopped off and Legal is currently drafting bills and is not with us today.

Assemblywoman Marzola:
Have any other states passed legislation such as this that we are trying to pass now?

Lindsay Knox:
Yes. Currently there have been ten states that have passed this in some form. And we currently have ten states that have active legislation. If you would like me to read those states for the record, I am happy to, or I can just send you the information once we are offline.

Assemblywoman Marzola:
If you can just send it to us, that would be great. I just want to say thank you to Ms. Servino for sharing her story and using her story to make such a change for the state of Nevada. I really appreciate it, and thank you, Ms. Servino.

Kendahl Servino:
Thank you so much, and thank you all for having me here today.

Assemblywoman Considine:
This question may have already been answered, but I just wanted to confirm it. From the way the doctor was talking, I assume there is a population of patients who would be eligible for something like this who are underage. In that situation I am assuming this would be under their parents' insurance. If you are looking at future storage, then at some point that would have to switch over to when that underage person becomes an adult and it switches to their insurance. Knowing that this is now in ten states, has that process been fairly seamless? Is that already set out that responsibility switches to that now-adult as opposed to it being under the parent?

Lindsay Knox:
It would switch over once that child became an adult and carried their own insurance. There is a little more to your question, and I think we are going to have to do a bit more digging to see if it has been seamless in other states. I want to make sure I get you the correct answer and I do not say anything out of turn. We will be sure to follow up with our folks whom we have been working with who have done this in other states, and we will get you that answer.

Assemblywoman Dickman:
I have a quick question maybe for the insurance people. The doctor seemed to tell us that this would not apply to very many people, but it is also very expensive. Do you have any remote estimates on how much this could increase insurance premiums for the entire pool of insurers who are paying premiums?

Lindsay Knox:
I actually do have those numbers. What we are looking at is based on a Nevada utilization calculation, which I can also share with the Committee. We are looking at about 740 people who would be eligible for this in the state. Again, we do not know the exact cost from a Nevada perspective, but what I can say is that we have cost estimates from what other states have done and what the premiums are—the per-member, per-month increase. In California it is 1 cent per month, which would potentially go from 1 cent to 6 cents, and then Connecticut was 10 cents to 24 cents.

Assemblywoman Dickman:
And that is for everyone who is paying an insurance premium?

Lindsay Knox:
You are correct.

[Assemblywoman Carlton assumed the Chair.]

Vice Chair Carlton:
Ms. Knox, I did not quite hear every single number, so if you could provide the document to the Committee, it will make it much easier for us to be able to look at the information. I know these treatments can be very expensive; we just need to be able to do the math on it from there.

Lindsay Knox:
Of course, we will get all of those documents to you.

Vice Chair Carlton:
We appreciate that. Are there any questions from Committee members at this time? [There were none.] With that, Assemblywoman Gorelow, we will go to those testifying in support.

[Assemblywoman Jauregui reassumed the Chair.]

Joyce Reinecke, Executive Director, Alliance for Fertility Preservation:
I just want to thank the Chair, Vice Chair, and Committee for allowing me to speak in support of Assembly Bill 274. The Alliance for Fertility Preservation is a national nonprofit organization that is dedicated to helping cancer patients to both understand and also navigate the reproductive consequences of their cancer treatment. I am also here as a cancer survivor and had a diagnosis of cancer in my 20s. Just as you heard from Ms. Servino, it is a terrifying process and it is really difficult to deal with that diagnosis and have a threat to your life, and then learn that your ability to have children would probably also be destroyed by your treatments.

I consider myself fortunate because I got really great medical care. At that time it was unusual that my oncology team shared with me the fact that my fertility was at risk. My husband and I had to really raid our savings and spend about $10,000 at the time to cover all of the costs of doing a round of embryo freezing. For me, I am 20 years out of my diagnosis, and I have healthy twin daughters and they were born as a result of that fortunate information that was shared with me in time.

As a result of that experience, it really redirected my entire professional life. I was working as a trademark attorney, very exciting, but for the past 15 years I have been working in this space, and I want to let you all know that I have met hundreds of young cancer patients, young adult patients, whom Dr. Zucker told you about. I have met their families, I have met their spouses, and I have heard just how important this issue is to them.

Years ago, this was really not an option for patients. Choices were very limited, especially for women, so there was really no discussion at all about insurance coverage. But, as Dr. Zucker told you, this technology has become standard—these techniques, especially—in the past decade I would say. Egg freezing for women has become accepted, efficacious technology that does provide a solution for patients if they are lucky enough to be able to afford it.

Unfortunately, however, insurers have not kept up with the standard of care, and they have continued to label fertility preservation as a type of infertility treatment like IVF and continue to label it something that is elective and therefore excluded. I want you to think about the loss of fertility and parenthood for a patient as not just a medical complication, but that it is really affecting parenthood and reproduction, which are fundamental life functions and deserve the highest levels of protection, especially for young vulnerable patients. At a minimum, I would ask that you think about this as a side effect of treatment and typically side effects such as antinausea medications and even breast reconstructions are covered by insurance.

As Ms. Knox told you, there are ten states that have passed this coverage, and the Veterans Health Administration, and most recently the Federal Employees Health Benefits Program, is adding this benefit, so this has really been the trend over the past three years. We are happy to share with you any information about the costs, which are really pennies per member, per month when spread across the whole population of insureds. It takes that burden from the

individual patient who may or may not be able to afford this. I would respectfully ask that you consider what we have discussed here today and pass this measure. Thank you so much for your time.

Amanda Klein, President, Nevada Fertility Advocates:
Nevada Fertility Advocates is a coalition of organizations dedicated to infertility in cancer patients in Nevada. I am also cochair of the Nevada Leadership Board for the American Cancer Society and was Mrs. Nevada 2020. Like Ms. Servino, my mother was diagnosed with breast cancer during her reproductive years. My husband and I are also among the 1 in 6 couples who struggle with the disease of infertility.

After many years of medical intervention and every member of my family contributing financially, Mark and I were able to welcome our beautiful daughter Emma into the world last year. But knowing firsthand the mental, physical, financial, and emotional toll that infertility takes on families, I cannot imagine starting this journey with a cancer diagnosis. Assembly Bill 274 is a bipartisan bill that would support both men and women in the state of Nevada, and I am honored to testify in support of this bill. Thank you for your time and consideration, Madam Chair.

Cari Herington, Executive Director, Nevada Cancer Coalition:
As you heard already from Ms. Knox, Ms. Servino, and Dr. Zucker, for those affected by cancer, fertility preservation must be made available and accessible to both our men and women. It can mean the world to those of us surviving what is already a most difficult and very costly life circumstance, and it positively affects quality of life after treatment. As such, the Nevada Cancer Coalition and our partners wholeheartedly support A.B. 274. We thank Assemblywoman Gorelow, Ms. Knox, and Ms. Servino for bringing this bill forward. Thank you.

Carrie Bedient, M.D., Private Citizen, Las Vegas, Nevada:
Thank you very much for giving me an opportunity to support such an important piece of legislation for my patients and their families. I am a reproductive endocrinologist at the Fertility Center of Las Vegas, a clinical assessment professor at UNLV College of Medicine, and obstetrician/gynecologist (OB/GYN) residency, the director of reproductive endocrinology for the MountainView OB/GYN Residency program, and cofounder of Fertility Docs Uncensored.

I will be as concise as possible regarding my professional experiences with this. When I meet with patients who have a fresh cancer diagnosis, the hurdles in front of them are immense. They are dealing with a devastating, life-threatening diagnosis that has both physical and a very intense financial set of demands for tests and appointments needed to start their lifesaving treatment that will ultimately destroy their potential to build their own biological family.

They typically have two to three weeks between their cancer diagnosis and the start of their treatment to accomplish both cancer testing and fertility preservation. Those appointments are two to three times longer than average and the tears that are shed at them are very real and very profuse. Despite a willingness from the fertility clinic to drop everything to fit in a patient with a new diagnosis of cancer and help them get the treatment they need, the patients frequently cannot financially access those services due to a complete lack of insurance coverage. My office spends inordinate amounts of time trying to gain authorization from insurance companies for these patients. Many companies will deny coverage because these patients are not currently infertile despite the fact that their lifesaving cancer treatment is almost guaranteed to make them infertile. Retroactive coverage is unheard of. We cut fees as much as possible to cover just the required expenses.

Cancer patients do not have the time or resources to petition their insurance companies for important treatment. This is unacceptable as a fertility doctor and even more importantly, unacceptable for many patients who refuse or truncate their treatment in an attempt to save their chance of having their own baby. I cannot tell you the anguish of telling a patient that you can help them and then watching despair wash over them because they cannot afford the treatment now to help build their family later. Those tears cannot be fixed by any platitude; the effect is real and rapid. This bill will improve access to insurance coverage for medically necessary fertility preservation and will give patients not only their life, but their biological family as well.

I spoke yesterday with a 26-year-old man whom I froze sperm for four years ago—while he was acutely hospitalized with testicular cancer—after a tremendous effort from him, his family, his girlfriend, and our office. Because of those extraordinary actions for something that is relatively simple, we were able to get enough sperm to help him conceive. Now after three years of remission, he and his girlfriend are going to start working hard as they plan to build their family. That should be available for all of these young patients who have had purely rotten medical luck through no fault of their own. Thank you for your time, and on behalf of my patients, please support coverage of medically necessary fertility preservation.

Connie Munk, Private Citizen, Las Vegas, Nevada:
I support A.B. 274 because it is imperative that standard health plans have coverage for persons going through any type of medical procedure such as chemotherapy that could cause infertility. As a breast cancer survivor myself, I know the devastating effects that chemotherapy has on the body. I urge this Committee to support and pass A.B. 274 so that patients who want to preserve their eggs and sperm can be assured of fertility preservation through their insurance plans, and I thank you for your time.

Chair Jauregui:
Thank you so much for your testimony, Ms. Munk. It is so nice to have you with us in the Assembly again. Next, we will hear testimony in opposition.

Jamie Rodriguez, Government Affairs Manager, Washoe County:
I am here in opposition to the bill, not on the policy behind it, but really on the fiscal impact to it. I know that we received a fiscal note request, but it is not yet posted on NELIS, so I wanted to address that we do have some concerns regarding the cost surrounding this. I very much appreciate the Assemblywoman and the proposed amendment which allows for self-funded insurance plans to opt out. However, that only covers a portion of our insurance plans, and we do have some that are not self-funded. As a rule, Washoe County has always tried to create parity amongst our insurance plans. Allowing that service for some of our employees, and those who have insurance under the County and not others, would create some strong conflicts for us and then determining how to fund that. So again, I am not here in opposition to the policy behind it, but with some concerns about how we would be able to fund that. Just wanted to get that on the record and thank you for your time.

Tray Abney, representing America's Health Insurance Plans:
I certainly have the same concerns as Ms. Rodriguez, so I will be brief. We are always concerned about the expansiveness of a bill like this, and we try to be a constant reminder that increasing mandates increases costs for every policyholder. Of course, our position has nothing to do with the specific issues or policies we are talking about here, but the idea that, again, mandates increase costs. But despite all that, in the interest of time, I want to thank my good buddy, Ms. Knox, for proactively reaching out to us on this bill. It is always a pleasure to work with her on any issue, and we look forward to further conversation, so thank you, Madam Chair, for your time.

Tom Clark, representing Nevada Association of Health Plans:
I do not want to take up a tremendous amount of time in opposition to A.B. 274. We have met with Ms. Knox and appreciate her willingness to work with us. But as has been said, the mandates that are in this particular piece of legislation provide policy that has no guardrails, and that is going to lead to an increased cost of health care here in our state. We have a lot more questions than we have answers so far. I think it is important for us to put on the record that this bill's approach creates mandates that are static and incapable of reflecting changes that occur over time in medical technology and practice and potentially lead to a lower quality of care for others, overutilization, and, as Mr. Abney said, just a higher cost for premiums across the board. Thank you, Madam Chair, for allowing me to speak this afternoon.

Chair Jauregui:
Let us move into testimony in the neutral position.

Laura Rich, Executive Officer, Public Employees' Benefits Program:
I am testifying today in the neutral position as the Public Employees' Benefits Board has not had an opportunity to discuss this bill or take a position on it. Public Employees' Benefits Program (PEBP) anticipates a very small fiscal impact to the program. The impact comes from mandated coverage for services that are not covered by the PEBP self-funded plans today. The Public Employees' Benefits Program did perform an analysis on the use of these types of services and determined that there is a relative low utilization rate among members

participating in PEBP today. Should that utilization rate continue, we believe the impact will be approximately $35,000 a year, so relatively insignificant in the grand scheme of things. However, there is some thought that the utilization rate may increase with the added coverage levels and also increased awareness. That could affect future utilization and cost. I did hear Ms. Knox mention a possible amendment allowing self-funded plans to opt in, which would be very much appreciated as this would provide the PEBP Board the opportunity to address this for those state and nonstate members who participate in the PEBP. Thank you very much.

Chair Jauregui:
Thank you for your testimony. Do we have anyone else in the neutral position? [There was no one.] Assemblywoman Gorelow, would you like to give any closing remarks?

Assemblywoman Gorelow:
I would like to take a moment and express my gratitude to Lindsay Knox, Kendahl Servino, and Dr. Zucker for presenting with me today and all those who called in for support of A.B. 274. I also would like to take a moment and thank former Assemblywoman Connie Munk who originally had requested this legislation and asked me to carry it. I also want to thank those who called in opposition. This is part of the process and we look forward to continuing to work with all the stakeholders. And I would like to thank you again, Chair Jauregui and the Committee, for your time. We will keep you all updated on our progress.

[Exhibit O, Exhibit P, and Exhibit Q were submitted but not discussed and will become part of the record.]

Chair Jauregui:
Thank you, Assemblywoman Gorelow, Ms. Knox, Dr. Zucker, and especially Ms. Servino for sharing her story with us today on this very important issue. I will now close the hearing on Assembly Bill 274. Members, the last item on our agenda is public comment. [Public comment protocols were explained.]

Cyrus Hojjaty, Private Citizen, Las Vegas, Nevada:
Hello, the reason I called is because I hear a lot of people complain about health care and costs and everything and we need to start addressing the reason why our health care costs are so high. The fact that ever since we had the repeal of the Health Maintenance Organization Act of 1973, health care costs skyrocketed. We need to start addressing the root cause of why it is going up, about solutions. The Affordable Care Act has not overall reduced health insurance premiums.

When you look at other countries, every industrialized country guarantees health care, so perhaps this is something that we can look into or we can repeal the Health Maintenance Organization Act. That is certainly a step forward because health care costs are eating up our budget. It is even having a significant impact on our tourism community.

Our country is very divided. Increasing numbers of inequality, lots of polarization, dirty amounts of campaign contributions, and the people are not being represented. Here in the state of Nevada what we have is the casino fascist government where they control the unions like the Culinary Workers Union. Other interests like real estate have incredible control. We need serious campaign finance reform. Or, an idea given the division is to break up the country. That is why right now I am here passing flyers in the Asian district.

I know there are a lot of concerns, there is a lot of tension, and I am giving out flyers to consider breaking up the United States so people who have differences can live in separate societies and we reduce the tension. Perhaps we need a divorce. And I am also hearing a lot of people, not just on the right, but even progressives are not happy with the current administration and they were not even happy before.

[Unintelligible transmission]

Chair Jauregui:
Thank you so much for your testimony. Thank you, Committee members, for sticking it out. I know this was a long day for us in Commerce and Labor. That concludes our meeting for today, we are adjourned [at 4:08 p.m.].

RESPECTFULLY SUBMITTED:

_____
Paris Smallwood
Committee Secretary

APPROVED BY:

_____
Assemblywoman Sandra Jauregui, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a proposed amendment to Assembly Bill 180, dated March 23, 2021, presented by Assemblywoman Alexis Hansen, Assembly District No. 32.

Exhibit D is a proposed amendment to Assembly Bill 180, presented by Assemblywoman Alexis Hansen, Assembly District No. 32.

Exhibit E is a copy of a PowerPoint presentation titled "Medicare," submitted and presented by Heidi Sterner, representing Nevada Association of Health Underwriters.

Exhibit F is a document titled "Kidney Failure (ESRD) in Nevada," submitted by American Kidney Fund.

Exhibit G is a letter dated March 24, 2021, submitted by Melanie Lynn Lendnal, American Kidney Fund, in support of Assembly Bill 180.

Exhibit H is a letter dated March 26, 2021, submitted by Justin Iorii, Dialysis Patient Citizens, in support of Assembly Bill 180.

Exhibit I is a proposed amendment to Assembly Bill 250, submitted by Assemblywoman Sandra Jauregui, Assembly District No. 41.

Exhibit J is written testimony submitted by Assemblywoman Bea Duran, Assembly District No. 11, regarding Assembly Bill 278.

Exhibit K is written testimony submitted by Maya Holmes, Healthcare Research Manager, Culinary Health Fund/UNITE, regarding Assembly Bill 278.

Exhibit L is written testimony submitted by Bobbette Bond, Senior Health Policy Director, Culinary Health Fund, regarding Assembly Bill 278.

Exhibit M is a copy of an email dated March 24, 2021, to Chair Jauregui and the Assembly Committee on Commerce and Labor, submitted by Fran Almaraz, representing Teamsters Local 631, 986, and 14, in support of Assembly Bill 278.

Exhibit N is a proposed conceptual amendment to Assembly Bill 274, submitted by Lindsay Knox, Vice President, Government Affairs, McDonald Carano.

Exhibit O is a letter dated March 24, 2021, submitted by Dan Curtis, M.D., President, Nevada Oncology Society, and Monica Bertagnolli, M.D., President, Association for Clinical Oncology, in support of Assembly Bill 274.

Exhibit P is a letter dated March 24, 2021, submitted by Hugh Taylor, M.D., President, American Society for Reproductive Medicine, in support of Assembly Bill 274.

Exhibit Q is a letter dated March 24, 2021, submitted by Rebecca Birch, Director of State Policy and Advocacy, Susan G. Komen, in support of Assembly Bill 274.