MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Eighty-first Session
March 12, 2021

The Senate Committee on Commerce and Labor was called to order by Chair Pat Spearman at 8:00 a.m. on Friday, March 12, 2021, Online. Exhibit A is the Agenda. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Pat Spearman, Chair
Senator Dina Neal, Vice Chair
Senator Melanie Scheible
Senator Roberta Lange
Senator Joseph P. Hardy
Senator James A. Settelmeyer
Senator Keith F. Pickard

GUEST LEGISLATORS PRESENT:

Senator Heidi Seevers Gansert, Senatorial District No. 15

STAFF MEMBERS PRESENT:

Cesar Melgarejo, Policy Analyst
Lynn Hendricks, Committee Secretary

OTHERS PRESENT:

Brooke Maylath
Eric Mattson
Elliot Butler
DuAne Young, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Randi Lampert
Kent Ervin, Nevada Faculty Alliance
Briceida Castro, Progressive Leadership Alliance of Nevada
Brian Pence
Albi Smedley

Andre Wade, Silver State Equality
Holly Wellborn, American Civil Liberties Union of Nevada
Chelsea Capurro, Health Services Coalition
Sy Bernabei, Gender Justice Nevada
Nicole Willis-Grimes, Silver Summit Health Plan
Aimee Holdridge
Priscilla Maloney, American Federation of State, County and Municipal Employees Retirees
Brady McGill, President, Las Vegas Pride
Jasmin Tobon, Planned Parenthood Votes Nevada
Cristina Hernandez
Josh Foli, Lyon County Comptroller
Tom Clark, Nevada Association of Health Plans
Serena Evans, Nevada Coalition to End Domestic and Sexual Violence
Susan Fisher, State Board of Osteopathic Medicine
Jeanette Belz, Board of Occupational Therapy

CHAIR SPEARMAN:
I will open the work session on Senate Bill (S.B.) 90.

SENATE BILL 90: Revises provisions relating to the regulation of providers of health care. (BDR 54-188)

CESAR MELGAREJO (Policy Analyst):
I have a work session document (Exhibit B) summarizing the bill. No amendments were received.

SENATOR HARDY:
I need to clarify that the National Practitioner Data Bank only gets complaints after the relevant board has made a decision that results in an adverse action. However, as we said in the hearing, any form or application that asks if you are "under investigation" must still be answered in the affirmative as the law now stands. This bill will correct that.

SENATOR SETTELMEYER MOVED TO DO PASS S.B. 90.

SENATOR SCHEIBLE SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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CHAIR SPEARMAN:
I will open the hearing on S.B. 139.

SENATE BILL 139: Requires certain health insurance to cover treatment of certain conditions relating to gender dysphoria. (BDR 57-54)

SENATOR MELANIE SCHEIBLE (Senatorial District No. 9):
This bill requires insurance companies to provide for the treatment of gender dysphoria, making sure transgender people are treated equitably and with dignity. I have been working with stakeholders, including Medicaid, the Public Employees' Benefits Program (PEBP), the Health Care Coalition and the Nevada Association of Health Plans, to address their concerns with the bill. All these organizations have expressed a sincere desire and willingness to provide equitable coverage for their transgender members. I will continue to work with these organizations and other stakeholders to develop a consensus. I plan to present an amendment at the time of the work session on this bill, should there be one.

BROOKE MAYLATH:
I am employed by the Division of Public and Behavioral Health, Department of Health and Human Services (DHHS), but I am testifying this morning as a private citizen. I have written testimony (Exhibit C) giving background on the history of gender affirming healthcare coverage and explaining what this bill will do. My testimony references the "Final Rule on Section 1557 of the Affordable Care Act" (ACA), prepared by the U.S. Department of Health and Human Services (Exhibit D); Bulletin 15-002 from the Division of Insurance (Exhibit E); and a legal opinion from the Legislative Counsel Bureau addressed to Assemblyman Michael Sprinkle (Exhibit F).

ERIC MATTSON:
I am in support of S.B. 139. I am a 32-year-old paralegal for a financial advising firm based in Las Vegas, Nevada. I am a husband and will soon be a father.

In March 2018, my wife sat me down to watch "Gender Revolution," a documentary from 2017 that explores gender identity. As a hair stylist with a

diverse clientele, my wife takes pride in creating a safe and loving space for her clients. When one of her clients shared that they were in the early stages of their transition, my wife asked for suggestions of shows, articles and any other information she could get her hands on to gain knowledge and become an ally for her client.

What started as just another documentary ended up being life-changing for me. After the credits ended, my wife turned off the TV and turned to me. I was in tears. It took a moment for me to work up the courage to speak, but my first words were, "Do you think this is me?" I was not afraid of what my wife would say, but I was afraid of what this discovery meant for me. Who could I turn to for information about hormone therapy? How could I afford the help I knew I would need?

In early April 2018, I had my first appointment with a therapist specializing in gender identity. Luckily, my first appointment and the ten that followed were covered by my employer-provided medical insurance, with a small out-of-pocket expense to myself. Without that coverage, I would not have been able to afford 11 sessions at $150 each. One session alone was the equivalent of two and a half weeks of groceries for my wife and me.

After my first therapy session, I was referred to a clinic specializing in health care for the LGBTQ community. The medical expenses started to increase when I started taking testosterone in May 2018, with bloodwork and a checkup every three months for my first year and 0.5 cubic centimeters of testosterone every week for the rest of my life. Once again, my medical insurance provided coverage for it all and left me with small manageable copays. Without coverage, I cannot imagine what my wife and I would have to go without in order to keep up with the demands of hormone replacement therapy.

When I hit my one-year anniversary on testosterone, I began my search for a plastic surgeon to perform my masculine chest reconstruction, which is known as top surgery. After choosing a surgeon and submitting my medical records and letters of referral to my insurance, I underwent surgery in September 2019 with the help of my insurance.

For me, top surgery was a necessary step to have my exterior match the person I knew in my soul I was meant to be. Therapy provided me with clarity and helped me to build my self-confidence. Hormone replacement therapy continues

to support the masculinization of my secondary sex characteristics, such as facial hair, body hair and distribution of body fat. It is hard to imagine what my life would be like if I had not had the insurance to cover the many aspects of my transition.

I consider myself to be very lucky to have been surrounded by love and support throughout my transition. My wish for my fellow gender-diverse individuals is that they feel loved and supported by those elected to be their voice. I humbly ask for your support of S.B. 139.

ELLIOT BUTLER:
I have been on testosterone for one year. I am currently in the process of trying to arrange to have top surgery. My insurance company denied my first referral from my doctor, which means I have to raise $10,000 for top surgery. This is a struggle; I have to work four jobs and pay other bills as well. The denial from my insurance company was heart-breaking. I will have to try to find ways to raise this money, including fundraisers.

I now have a referral letter from my therapist to review with my insurance company to cover the top surgery. I will have a consultation on March 26, so I am hoping the insurance company will approve it. Right now, however, the chances of my being able to afford top surgery are looking very slim. I have been able to afford testosterone injections through the clinic at a reasonable, affordable fee. Now I am just waiting to hear if I will be approved.

I hope you will proceed with passing this bill and helping all the transgender people in Las Vegas.

SENATOR PICKARD:
As I review the bill, I notice that we require practitioners to abide by the definitions in the bill. I wanted to get a little more information on this, so I looked them up in the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) and realized that though they are substantially similar, the definitions are different. By not following the definitions in the DSM-5 verbatim, have we created a dichotomy that the providers are now going to have to struggle with? How is this going to affect their ability to diagnose under the DSM-5 when there may be some differences in the verbiage?

SENATOR SCHEIBLE:
This language was provided by the Legal Division of the Legislative Counsel Bureau and matches other language in the *Nevada Revised Statutes* (NRS). I am not sure it has to match the DSM-5 language exactly in order for providers to be able to utilize the DSM-5 and also be compliant with our law. We looked more closely at the World Professional Association for Transgender Health (WPATH) standards, which match our definitions as close as possible to allow for consistency with the NRS. The purpose is to be consistent across insurance plans and providers.

I do not know what the exact differences are with the DSM-5; if there is specific language from the DSM-5 missing from S.B. 139, I could speak to that. Otherwise, I do not think the differences are substantial enough to result in any kind of confusion about what treatment people should receive.

SENATOR PICKARD:
I am trying to figure out if the differences in definitions will create loopholes that can be exploited.

MS. MAYLATH:
The DSM-5 is critical for the appropriate diagnosis of the patient. It does not set out a treatment plan. Assigning a diagnosis from the DSM-5 does not give enough detail for an appropriate treatment plan, which has to be tailored to the individual. For example, not everyone wants to have gender-affirming surgery done. Some are happy with just social acceptance and affirmation. Some people might want to have hormone therapy only, which is quite inexpensive overall. Others may need a higher level of intervention and additional medical treatments to treat their symptoms. In the same way, not every person with high blood pressure or heart disease needs the same treatment plan. Every patient needs to be able to have a treatment plan that specifically fits their needs and treats their issues. The goal of S.B. 139 is to allow the same right to individual treatment plans for people with gender dysphoria.

SENATOR PICKARD:
You mentioned WPATH, which is a private organization. I do not believe Nevada has adopted the WPATH criteria within our diagnostic panel. However, I am not an expert in that. I would be interested to know if this bill is intended to adopt those standards.

MS. MAYLATH:
The WPATH standards are not strict guidelines. They are merely standards, as for any other type of medical intervention. On occasion, the individual patient may need to navigate within those standards in a different manner. This bill allows that individual patient to reach that medically necessary route to a particular treatment with the help of appropriate, experienced clinical providers. This is not an open door to anything and everything. This is a pathway to allow the individual patient to reach a desired result.

SENATOR PICKARD:
I appreciate that, but it sounds like you are saying that this bill does not adopt the WPATH standards. We adopt standards to give guidance. We start with a diagnosis, presumably based on the DSM-5, and move to a treatment plan based on the WPATH standards. If we do not adopt these standards and something goes awry, we do not have an adopted standard to look at, and it creates confusion if this gets litigated. That is the crux of my concern.

I read Exhibit E, and Mr. Butler's testimony seems to fly in the face of this opinion from the Division of Insurance (DOI). When I read the opinion, it made me wonder if S.B. 139 is ultimately unnecessary because we already have a legal ruling on this. Why was this opinion not followed? Did the DOI just fall down on the job?

SENATOR SCHEIBLE:
You have hit the nail on the head. What people are experiencing in practice is inconsistent with the ruling by the Commissioner of Insurance. I am not the first Legislator to come up with a legislative solution to this problem. This bill puts the DOI's interpretation of the law into statute.

SENATOR PICKARD:
I completely agree with that. Unfortunately, we see that a lot. Did we seek enforcement and the DOI refused to enforce it? If we already have a legal opinion, we often try to avoid adding to existing law that is ignored anyway. How is this not an issue in enforcement if the law already exists, according to the DOI?

MS. MAYLATH:
This is a typical bureaucratic puzzle. When a preauthorization is denied, the terms and conditions of the insurance plan may require the individual to appeal

the denial before a complaint can be made to the Commissioner. From what Mr. Butler said, his case has not reached that point yet.

That is one of the inherent issues. The policy may be understood by the insurance company and their representatives in this building, so they can say, "We are meeting the obligations of the law." But when someone who did not read that memo from six years ago is still automatically denying these claims, we put patients in distress and potential harm, despite it being illegal and possibly arbitrary and capricious.

With this bill, we are hoping to create a sweeping mandate that if you meet all the requirements—have a letter from a therapist that you have persistent and insistent symptoms of gender dysphoria and the best treatment for it is to have top surgery—your procedures will be covered. Why are we denying these claims? It is a $5,000 to $6,000 procedure. This bill is not going to break the insurance company, considering the number of transgender people who exist within the State.

SENATOR HARDY:
I am trying to figure out the definition of "medically necessary" in this bill. You seem to be saying that it is "medically necessary" to have the person's body conform to their feeling of gender affirmation or confirmation. For most people who want breast implants, that is not covered by their insurance because it is not medically necessary even if they work in an industry where such augmentation would give them a career boost.

I would also like more information about what you are calling "top surgery." What procedures does that include?

SENATOR SCHEIBLE:
The point of the bill is to cover a number of different procedures. Science improves, medicine improves, and we develop new procedures on a regular basis.

One of the procedures we talked about during testimony is commonly referred to as "top surgery." This is a procedure for transgender people who are born female and have breast tissue they want removed in order to affirm their true gender, which is male. It is akin to a mastectomy, but it can take different forms for different people. Some transgender men might need to have both

breasts completely removed; some might only need them reduced. Some might need to have both breasts removed and have some masculinization reconstruction on their chests. We are not asking that people be allowed to walk into a clinic, pick surgeries from a menu and say, "These are the things I want." They must go through the process our advocates described: meet with a therapist, a plastic surgeon and an endocrinologist to determine which procedures are necessary for that person and in what time and order. The whole team can then come together and say to the insurance company, "This is what this person needs in order to be whole, in order to live in the body they have."

The short answer to your question is that top surgery could include a number of different procedures. It might include some type of mastectomy, chest reconstructive surgery, breast implants or reductions. It can also include a tracheal shave to reduce a prominent Adam's apple or facial feminization surgery. I would be happy to follow up with you offline and talk about some of the procedures transgender people are able to access and some of the new procedures that are being invented every day.

MS. MAYLATH:
In the transgender community, surgical intervention above the waist is referred to as "top surgery," and surgery below the waist is called "bottom surgery."

You also had a question about breast augmentation. When a cisgender woman has undergone a mastectomy, breast augmentation for chest reconstruction is considered medically necessary and is covered by insurance companies. Breast augmentation for transgender women is only necessary if the effects of the feminizing secondary sex characteristics induced by hormonal therapy have not made an affect.

That is only necessary if the individual has already gone through male puberty. For young people who have identified and started treatment for gender dysphoria at an early age and been put on puberty blockers, which are covered by the memo in Exhibit E, puberty is arrested until it is deemed appropriate for that person. Hormone replacement therapy can be introduced at an appropriate age, so they only have to go through puberty once. This can benefit the insurance community overall by allowing an appropriate pathway early on through puberty blockers, hormonal therapy, etc., which can mitigate the need or even the desire for later surgical interventions. That is a better outcome for everybody.

SENATOR NEAL:
What are the costs of the prescriptions that are going to go into this? I know in the bill I had last Session, A.B. No. 254 of the 80th Legislative Session, I had to specifically get into the formulary; I had to specify in statute what I wanted to see in terms of drug access through Medicaid. I do not see that language here. Is that contemplated?

DUANE YOUNG (Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
Medicaid policy, when it is administered, covers both fee-for-service and managed care. There are differences in what is preferred and non-preferred because every pharmacy and therapeutics committee is run separately by its own managed care organization and by the State through its SilverScript pharmacy board. In S.B. 139, medications are not called out because those medications are already covered. While there may be some nuances in criteria about what is preferred, there is an acceptable alternative in each category.

The State's fiscal note refers to additional services that are not covered by Medicaid at this time. There is a nuance, as Senator Hardy alluded to, regarding what is considered medically necessary regarding some of the more cosmetic procedures, such as voice therapy and hair transplantation. Those services are represented in our fiscal note.

I will also note that we have spoken with the sponsor to work through some of those issues to align it more closely to our current policies.

SENATOR NEAL:
My second question has to do with the Federal Medical Assistance Percentage (FMAP). What is going to happen with the federal contribution rate in this scenario?

MR. YOUNG:
The FMAP is applied based on a person's eligibility and aid category. For instance, if they are the traditional population or medically disabled or blind, they will have around a 66 percent FMAP. If they are newly eligible, it will be 90 percent. We have not had a great number of these cases. I believe they fall across all FMAPs, but I am happy to follow up to see the specific trends regarding FMAP for the cases of gender reassignment we have already had.

SENATOR NEAL:
What is the provider rate for plastic surgery in these cases?

MR. YOUNG:
I do not know our physician rates offhand. I will tell you that plastic surgeons are enrolled as a part of what we call provider type 20, or our physicians group. They are paid no differently than any other physician performing services.

Just to clarify, federal reimbursement bars certain plastic surgeries in certain instances. We pay for plastic surgery in the instances Ms. Maylath has pointed out, where there is a medical need for those services. That is covered as part of what is considered top surgery.

SENATOR NEAL:
Does Medicaid cover plastic surgery for cancer patients who have had a double mastectomy?

MR. YOUNG:
I will look up the specific instances in which that would occur. If there is a medical necessity for those services and the physician has gone on record that the procedure is medically necessary, those services would be applied.

In the history of Medicaid, we have argued about the definition of "medical necessity" and how that applies. As a physician, Senator Hardy knows that physicians have to attest to the absolute medical need for a surgery as part of the prior authorization process. The surgery is then approved based on that definition. Cases that do not meet the threshold of medical need will be denied; cases that do meet the threshold will be approved.

SENATOR SCHEIBLE:
In my research on this subject, I found that sometimes plastic surgery is covered for some accidents, such as when someone breaks a limb or has some kind of traumatic injury that requires both internal and external repairs. Plastic surgery has sometimes been approved in those cases.

SENATOR NEAL:
In the discussion about A.B. No. 254 of the 80th Legislative Session, we were dealing with a population that was roughly 2,000 people in Nevada. The insurance companies worked for the entire Session to get me to change the

wording from "comprehensive" to "medically necessary" so they could reduce what they covered and did not cover. When I saw the term "medically necessary" in S.B. 139, it looks good and it sounds good, but you may find the use of those two words gets you into a fight between what you interpret as needed and what a doctor says they are going to do.

I have traveled this road, and this is just a caution. If there is already bias, these two words are going to make you have to fight.

SENATOR SETTELMEYER:
I am trying to make sense of some of the fiscal notes. It sounds like this is already required by law, but Clark County says it could potentially mean a hit of $1.5 million. Are we the first state to do this? If there are other states that have done this, how much has it raised insurance premiums overall? I remember when we considered a similar bill regarding autism, the insurance companies all swore the sky would fall and rates would double. After it was passed, we found the actual increase was only a dollar or two. It was obviously more than worth doing to help people out.

MS. MAYLATH:
We would be the first state to have something this broadly mandated. Many states refuse to follow the guidance of the Affordable Care Act (ACA), although the federal law does apply. This makes it much more difficult for an individual patient to go through the complaint and an appeals process.

When the memo in Exhibit E came out in 2015, it mandated the expansion of procedures that were already covered for cisgender people be covered for transgender people too. The increased cost was measured in pennies. A study out of San Francisco showed that when insurance plans did this, it ended up costing the individual member an additional 3 cents per person. When we looked at other plans here in Nevada, it comes out to a rounding error. If an employer is paying $20 million for its employee packages, the expense of serving their transgender employees and their families is under $50,000. It is a decimal point of a percentage rate. It is pennies for this life-affirming beneficial type of treatment.

This bill expands, very slightly, a few other types of procedures that are considered medically necessary by WPATH in their standards of care. Excluding transgender people from this coverage has been challenged in the courts

throughout the U.S., and the plaintiffs have won, costing insurance plans hundreds of thousands of dollars in penalties above and beyond the cost of the actual procedures. With that in mind, S.B. 139 acts in the best interest of the insurance companies by preventing potential litigation and sparing them the resultant huge penalties.

Let us make sure we can direct that money to the patients who need it rather than having to spend it in court battles, tying up court time and going to lawyers to reach the same outcomes as S.B. 139 does. Let us pay for medically necessary procedures. That is all we are saying here. The bill is designed to be equitable to all the stakeholders—the health plans, the patients, Medicaid and the citizens of Nevada. Let us bring transgender people into that circle of humanity and treat them for their medically necessary needs the same as we expect for every cisgender person that those medically necessary needs are met. Let us remove the administrative kerfuffles, barriers and biases that have existed for years.

SENATOR SETTELMEYER:
What are we going to do about the definition of "medically necessary"? There are bad doctors who will call any procedure medically necessary. I can agree with the situations you describe, but we already have situations in which people find doctors to authorize surgeries that are merely aesthetic, not medically necessary. What type of penalties exist in law for this situation? How do we deal with people gaming the system?

SENATOR SCHEIBLE:
There are a couple of ways to deal with that. One would be through medical malpractice statutes; another would be through fraud statutes. A doctor who is fraudulently approving procedures and writing prescriptions, fraudulently representing to an insurance company that something is medically necessary when it is not, would be liable for fraud.

I also want to point to an important part of the definition of "medically necessary" in the bill. Section 1, subsection 4, paragraph (b), subparagraph (3) states that in order to be considered "medically necessary," the procedure must be "Not primarily provided for the convenience of the patient or provider of health care." That is a bar to overcome for anyone to prove that the procedure being requested is not for their convenience or that of their doctor. That strikes at the heart of the issue you were asking about: how do we separate people

who simply want a procedure from people who need the procedure because they experience gender dysphoria and the procedure will alleviate that dysphoria?

I am open to amendments refining this definition, but the difference between need and convenience is a good barometer. That is one of the safeguards already written into the bill to ensure providers have some guidelines regarding medical necessity. They cannot just say, "I'm a doctor and I say it's medically necessary." They need to say, "I'm a doctor, I have evaluated points one through five, and this procedure is medically necessary in this case."

SENATOR SETTELMEYER:
I appreciate that answer. I worry not about the true cases we are discussing, but about bad doctors and bad actors out there who could potentially use this statute to say, "Hey, I'm getting older and I'm tired of losing my hair, so I'll use this to get my Rogaine paid for." I am just worried about those types of potential loopholes. Many of the terms in the bill are unfamiliar to me, so I will research them.

CHAIR SPEARMAN:
This is a difficult bill because you are dealing with a relatively new science. When things are new, sometimes they are scary. In the early 1900s, it was commonly believed that Black people were genetically inferior to those of European descent, and they proved it in various ways. We found out later that was not true, and as science advanced, we were able to kick that idea to the curb. We now have to deal with the residue of racism we incurred because of that.

The first bill I sponsored when I came to the Senate included transgender persons in the statute regarding hate crimes. I remember some of the questions I got: "How do we know they really are transgender? Maybe they just stand up at a concert and say 'I'm transgender,' and then they start a riot." I said no. Once a transgender person makes the transition, that is where they are.

I remember being taught in seminary that there was a time when people who had a physical disability were not allowed to take communion because it was postulated that their disability meant God had something against them. I mention that because the, quote, religious aspects of this will probably come

into play. Those are things we probably cannot do anything about because people think what they think.

It is unfortunate, but Nevada has never dealt with the number of transgender women who are killed because of who they are. That is why I wanted to add to the hate crimes statute. There are also cisgender women who have decided to die from breast cancer rather than get a mastectomy because it changes the way they see themselves, their mental image of who they are.

In yesterday's meeting of the Senate Committee on Health and Human Services, we heard a bill from Senator Ohrenschall, S.B. 146.

SENATE BILL 146: Revises provisions relating to mental health services for children. (BDR 39-870)

That bill was about children with emotional challenges. Some of the testifiers mentioned that the medical doctor and the psychiatrist work together to figure out the best treatment for the child. Is there anything in this bill to require a medical doctor and a psychiatrist to work together to decide what is medically necessary for the person?

SENATOR SCHEIBLE:
I appreciate your insight into this, and I agree with you. The short answer is I think there is. In talking to people who would be affected by this bill and representatives from the healthcare plans, I have not found a provider network that would approve these procedures or treatments without signoff from both a mental health professional and a physical health professional. That is something that can be written into the plan and will be.

You also touched on an important issue we all face: the provider shortage. I cannot solve that problem with this bill; I cannot ensure we are going to have enough providers in Nevada to treat all the people who experience gender dysphoria, especially people of color and other marginalized groups. I wish we could. At the same time, this bill does provide the groundwork for everyone to have their insurance cover these procedures so we can attract more providers to Nevada.

The bill is not designed to tell insurance companies how to evaluate what is medically necessary, other than the five factors listed in section 1,

subsection 4, paragraph (b). I would certainly hope that everyone who benefits from this bill has a team of experts by their side to help them get through this and get the best care possible. At the same time, I do not think we should be setting up a system that further prevents them from getting adequate care if they cannot find all the providers they need and deserve. It provides some flexibility for Nevadans to work with the doctors they have, work with the doctors they can find and get their health insurance companies to help cover the cost of these procedures and treatments.

CHAIR SPEARMAN:
I do not want to add another barrier, but maybe there is some type of compromise that would define "medically necessary" as including both mental and physical health. That is just something to consider.

Senator Settelmeyer brought up a good point. What about people who are going to game the system? Mr. Young, if this bill passes, would this be the first time someone would try to game Medicaid, to defraud Medicaid?

MR. YOUNG:
No. We have a whole unit that is dedicated to rooting out fraud, waste and abuse within Medicaid.

CHAIR SPEARMAN:
How much money is involved? I am trying to establish if this bill is going to cause a problem we have never dealt with before, or if it is something the system expects.

MR. YOUNG:
Medicaid experiences millions of dollars of fraud, but it is spread across multiple provider types and multiple disciplines. I am happy to provide that data if you wish. I will speak to this particular set of services.

The *Medicaid Services Manual* (MSM), chapter 607, page 3, specifies that those seeking gender reassignment surgery have to have separate letters from a psychiatrist or psychologist and a medical doctor. Those two letters have to state and attest that they have performed certain levels of therapy and medical interventions before the person qualifies for the surgery. The policy as it exists now is fairly rigorous to ensure that the individual has been diagnosed with gender dysphoria disorder and has sought several levels of treatment prior to

having the surgery authorized by Medicaid. There are safeguards within the policy. I will not tell you that our policy is perfect by any means, but Medicaid staff have done their due diligence in meeting those WPATH standards to ensure that those receiving this surgery have followed the appropriate steps and have aligned with other policies and procedures within this chapter of the MSM.

CHAIR SPEARMAN:
I am sure it comes as no surprise to Ms. Maylath and anyone else who works with DHHS in the LGBTQ space, but I continue to be disappointed at the lack of diversity in this effort. I would like to see both ethnic and geographic diversity represented here. People in the LGBTQ community do not like to admit it, but racism exists in that world as well. If you are a white gay man, you still have some of the same privileges as a white heterosexual man. There is no way for policy to compensate for that unless you have those lived experiences at the table. Right now, it is lopsided because we do not have diverse lived experiences at the table. I will be glad when we can say there is diversity in this discussion. Lived experiences and representation matter. There are diverse opinions, and you can only get them from people who are diverse, or at least people who have worked with diverse communities and who have some credibility. If S.B. 139 passes, you will need people in the community who have credibility to explain the process. If you do not have that right now, it is going to be difficult to get it later.

SENATOR HARDY:
If I understand this bill correctly, it affects insurance companies as well as Medicaid. Is that right? I am not sure how it affects the Employee Retirement Income Security Act of 1974 plans.

SENATOR SCHEIBLE:
You are correct. This would not just affect Medicaid; it would affect all insurance plans. I believe we have a couple of providers waiting to testify on this.

RANDI LAMPERT:
I am in support of S.B. 139. As a pediatrician in Nevada, I know from my practice and from the literature that youth with untreated gender dysphoria suffer from increased depression and anxiety. In fact, their rates of suicide attempts range from 30 percent to 50 percent, compared to 14 percent in cisgender youth. With gender-affirming treatments, these rates drop to the same

levels as their cisgender peers, and other mental health measures also normalize. The American Academy of Pediatrics supports early gender-affirming care, including social affirmation, access to mental health treatments, legal affirmation and, when age appropriate, medical and surgical treatments. It is important to note that most treatments recommended for young people are completely reversible, as are most treatments under the age of 16 years. I state this in anticipation of arguments against treatments for youth.

This treatment is not accessible for most people if it is not covered by health insurance. This bill will increase access to life-saving treatment for young people in Nevada.

KENT ERVIN (Nevada Faculty Alliance):
We support S.B. 139. It is a modest expansion of the covered services for PEBP, adding only voice therapy and some additional services for members under 18 years of age. You would have to ask PEBP for details, but our best estimate of the cost to PEBP for these services is less than 0.2 percent of all medical claims. It is a small cost for these vital services.

BRICEIDA CASTRO (Progressive Leadership Alliance of Nevada):
I am the Economic Justice Program Manager with the Progressive Leadership Alliance of Nevada, here in support of S.B. 139. As a queer woman of color, I am lucky to have a family who supports me, but other friends and family have been displaced from their homes because of their sexual preference and gender identity.

Housing and health care are basic needs. Vulnerable groups require health care based on medical necessity and must not be denied coverage based on external biases and discrimination. Medical providers must have the discretion to treat vulnerable patients without interference and bias from insurance providers. Public and private insurers currently have considerable discretion and routinely ignore or bypass medical necessity in rendering covering decisions without adequate justification.

We urge your support of this bill. These are real problems that are happening to our loved ones who have other worries besides finances.

BRIAN PENCE:
I would like to support S.B. 139 on behalf of my family. We have a transgender son who started his transition about 3 years ago and has been on hormone therapy for about 18 months. He is currently scheduled for top surgery in May. All the expenses—hormone therapy, endocrinologist visits and the scheduled surgery—have been denied by our insurance. We are in the lucky position of being able to afford this; we will go into some debt, but we are going to be able to pay for it so our son will be able to exist as a healthy man.

I want to reiterate how important it is to get insurance companies to accept these claims and reduce denials. We can probably fight the denial via legal means, but that throws more cost to us to get the procedure done.

ALBI SMEDLEY:
I am a nonbinary transgender Asian-American person born in Las Vegas. I am a Clark County School District (CCSD) educator. I teach high school. This is my seventh year of teaching. I am a former small business owner, and I run a small grassroots activism group called Trans Vegas.

I urge everyone to support S.B. 139 and consider the human lives that will be affected by this bill. Healthcare plans that exclude gender affirmative care are discriminatory and dehumanizing. When something so fundamental and necessary as health care for basic needs is not covered by your trusted employer, it is a demoralizing experience. This bill is essential to ensure consistency among insurance plans and to normalize the way healthcare providers work with transgender people.

I am employed by one of the largest employers in Las Vegas, and I have had struggles with health care. My insurance had a blanket exclusion for all gender-related health care until about a year ago. Even though some of that is covered now, I still pay out of pocket for all my hormone therapy and diagnostics; in fact, I just got a bill last night for $300. It is difficult to go through the process to get those things covered, and the company still includes a blanket exclusion for any surgery-related care. This is the only substantial health care I have ever sought coverage for, and surgery-related care is completely unfeasible for me financially.

I see these struggles every day. I consider myself to be in a relatively privileged position. People who are in historically marginalized populations need this

support from the top down. I cannot stress enough the dehumanizing effect of seeking care for fundamental health needs and being unsupported by your employer, your insurance or your government. Please consider supporting S.B. 139 so the transgender residents of Nevada will get the same level of care as everyone else.

Living your life authentically as a transgender person is empowering and affirming. However, it comes with societal stigma, judgment and some inner turmoil. To suggest that people would willingly go through that just to game the system minimizes that experience greatly. It is a dangerous argument to make.

ANDRE WADE (Silver State Equality):
We support S.B. 139.

HOLLY WELBORN (American Civil Liberties Union of Nevada):
We are in strong support of this legislation.

Ms. Maylath did an incredible job of laying out some of the legal guidelines and civil rights aspects of this matter. I would like to add that the DOI bulletin in Exhibit E does correctly state the law. This bill comports with the requirements of Title 7, but it also provides us with a State statutory tool when litigating these cases. The ACLU has been successful litigating this in different states, but having the extra protection in State laws insulates from any future changes at the Supreme Court level, should that happen. I am incredibly grateful for this.

I would like to add that my soon-to-be brother-in-law just finished transition. This is a process that takes years. It is grueling; it is emotionally and physically draining for the individual and for families. Being able to have this in statute and insulate folks is incredibly important. Thank you for bringing this bill forward.

CHELSEA CAPURRO (Health Services Coalition):
We are here in support of this bill. We are working on an amendment with Senator Scheible. We hope to come to a point where we can agree on that amendment and look forward to continued conversations.

SY BERNABEI (Gender Justice Nevada):
Gender Justice Nevada is a local advocacy group for transgender, nonbinary and gender-nonconforming people in Nevada. I am a transgender, nonbinary person.

I paid out of pocket close to $9,000 for my recent top surgery because I did not want to go through the mess of dealing with private insurance.

I want folks to know that this is not something that transgender, nonconforming people do lightly. It is an act of bravery to begin transitioning socially and medically. I have been working in this community for more than 20 years. I have seen depression, self-harm and suicide when gender-affirming procedures and hormone therapy are not covered by insurance. Making health care not accessible increases those problems. Living authentically is the most important thing we can do. Gender dysphoria is real. For those who do not understand the experience of transgender people or what gender dysphoria means, I would invite you to the trainings or discussions we have talking about the transgender, nonconforming community.

We very much support this bill and look forward to how much it will help our community.

NICOLE WILLIS-GRIMES (Silver Summit Health Plan):
We want to be on the record in support of S.B. 139.

AIMEE HOLDRIDGE:
I am a cisgender woman of color and a mother of two who is a ten-year resident of Clark County. I am a CCSD parent volunteer and an organizer. I am not transgender, gender diverse, gay or intersex, but I know my life is better because of transgender and gender-nonconforming members of my community. I am a human being, just like my transgender brothers and sisters. Transgender people are worthy human beings as we all are. They deserve the equity many of us are afforded more often than they are. I want to live in and contribute to a state that cares about all of its residents and works to protect all its residents. I want to raise my kids in a Nevada that enacts legislation to ensure those protections are for all Nevadans.

I hope we pass this bill in some way, shape or form.

PRISCILLA MALONEY (American Federation of State, County and Municipal Employees Retirees):
We are in support of S.B. 139. This bill was discussed yesterday at the PEBP Board's legislation tracking meeting. The only discussion regarded cost, and there was some robust debate about the initial findings from the program. It

was a modest cost under any circumstances, but even that may be subject to some revision, as we asked for further clarification on that cost, feeling, along with the subject matter experts who testified yesterday, that the cost in the fiscal notes was somewhat exaggerated.

I would like to make sure the Committee understands that the services in this bill are already covered under PEBP. There are just a couple additions in the bill that would add these additional costs.

I would like to add on a personal note that in the last ten days, I received a phone call from a loved one who has a family member undergoing treatment for gender dysphoria. The person called me because I had a medically required mastectomy for cancer six years ago, and they wanted more information about the procedure. I cannot stress enough that having a good treatment plan, whatever your life situation, is really important to recovery, and in this context, to transition into a happy, healthy and meaningful life in our society. I personally am also in support of this bill.

BRADY MCGILL (President, Las Vegas Pride):
We are here in support of S.B. 139. We support this and other measures that expand access for minority groups, as it helps us all.

JASMIN TOBON (Planned Parenthood Votes Nevada):
We are in support of this bill. Access to health care is a critical issue. Many LGBTQ people, especially transgender, intersex, nonbinary and gender-nonconforming individuals, have long been denied their rights for medically necessary treatment despite the ACA mandating equal coverage for transgender affirming procedures. Their identity does not exempt them from the need for health care; instead, it exacerbates the barriers to receiving health care. Transgender, nonbinary and gender-nonconforming folks are subject to greater hurdles to health care, including, and especially, those who are low income, unhoused, living with chronic illness, or with pre-existing conditions. Vulnerable groups require health care based on medical necessity and must not be denied based on external biases and discrimination.

This bill would expand healthcare access, decrease disparity and create a more equitable healthcare system. It would quite literally save lives.

CRISTINA HERNANDEZ:
I am calling in support of S.B. 139:

JOSH FOLI (Lyon County Comptroller):
I am speaking in opposition to S.B. 139 from a fiscal standpoint only. This is one of the more expansive bills that has been proposed across the Nation.

I know when you look at it as a percentage of a very large plan, the increase is a small one. This is not true when you start with a small plan. For example, in Lyon County, when we had a single person start taking the drug Humira, we had a significant increase in our insurance year to year. Last fiscal year, we had a 15 percent increase in our health insurance rates, and we have to pass that on to our members who have dependent care coverage. We currently subsidize 30 percent of their dependent care coverage up to a cap of $250. Our rates are going up another 10 percent this year.

It is challenging to get your arms around what is medically necessary and what is not. My two-cents' worth on this bill is it has a disproportionate impact on smaller insurance plans for smaller entities. If we can keep the language as it is, really to what is medically necessary and not be expanding significantly some of those different definitions, that would be our preference.

MR. YOUNG:
The Division of Health Care Financing and Policy is neutral on S.B. 139. Nevada Medicaid has covered these services since 2017.

The bill twice uses the phrase "without limitation" when describing required coverage. Some of the providers listed, such as voice therapists, perform other services that are not currently covered in our policy. We have worked with Senator Scheible on some potential language to correct this oversight.

We are also aware that other State agencies, such as PEBP, bill to their policies based on the coverage provided by Medicaid, so we have been communicating with them as well. This bill has a small fiscal note of less than $1 million total computable and exactly $214,000 over the biennium in State General Funds.

We look forward to continue working with Senator Scheible on an amendment that aligns with policy and provides equitable coverage for all populations across Medicaid.

TOM CLARK (Nevada Association of Health Plans):
We are neutral on S.B. 139. We are continuing to work with Senator Scheible on this important legislation to make it a bill we can all support.

CHAIR SPEARMAN:
Senator Scheible, the gentleman who spoke in opposition mentioned increased insurance rates. Could you gather some actuarial numbers on this for the Committee? That would be helpful, because that is a valid point. Mr. Foli also mentioned the impact of this bill on smaller plans. You might want to consider some type of floor, a lower limit on the size of plans that will be affected.

I would like to add that there may be some folks listening who think the psychological abuse transgender people go through is not real. It is. A few years ago, I was called by a pastor because one of their parishioners was in a rehabilitation center after having been shot. This person was transgender and had their new name and gender on all their records. In spite of this, the facility they were in refused to use the new name and gender. In fact, some of the staff refused to change this person's bandages, and their mother was required to fly in to provide this basic care. I immediately called the director of DHHS, and in less than 24 hours the facility, which was receiving Medicaid funds, understood that what they were doing was not correct. The pain and trauma of being ridiculed, ostracized and ignored is real.

SENATOR SCHEIBLE:
I would like to remind the Committee that when we do not treat gender dysphoria, we end up treating the symptoms of it in the form of other mental health crises. In the worst cases, we end up paying the incomputable cost of suicide. Young people, adults and old people can be affected by gender dysphoria and the effects of not having it properly treated.

CHAIR SPEARMAN:
I will close the hearing on S.B. 139 and open the hearing on S.B. 196.

SENATE BILL 196: Prohibits the performance of a pelvic examination in certain circumstances. (BDR 54-34)

SENATOR ROBERTA LANGE (Senatorial District No. 7):
This bill seeks to prohibit healthcare providers from conducting pelvic examinations on patients without their informed consent. Healthcare providers

are required to obtain informed consent from patients to provide medical treatment. However, currently State law does not prohibit providers or medical students practicing under their supervision from performing pelvic examinations on anesthetized and unconscious female patients.

While it may be surprising, this appears to be a common practice. In a *New York Times* article published on February 27, 2020, a nurse in Arizona outlined her unsettling experience after being admitted to the hospital for stomach surgery. The nurse, who had a history of sexual abuse, reported having panic attacks and traumatic memories triggered after she learned that a resident conducted a pelvic exam while she was unconscious. This happened after she explicitly told her physician that she did not want medical students to be directly involved in her surgery.

This story is just one of many that have led states across the U.S. to consider or pass legislation requiring informed consent for pelvic exams. In fact, the issue is so pervasive that women have begun sharing their stories with the hashtag #metoopelvic. While medical teaching is crucial and training medical professionals to identify normal and abnormal anatomy is necessary, some exams by their very nature are intimate and invasive. A study published in *The Lancet* found that 100 percent of women said "they would prefer to be asked before their pelvis is used as a teaching tool." A pelvic exam performed without a woman's consent in any other context is considered sexual assault.

This bill does not prohibit performing pelvic examinations when they are necessary, nor does it prohibit the instruction of medical students to perform this exam. Rather, the bill requires obtaining the informed consent of the patient before the exam is performed.

Section 1 of S.B. 196 prohibits healthcare providers from performing or supervising examinations they are not appropriately licensed, certified or registered to perform and that are not within their scope of practice. Section 1 also prohibits healthcare providers from performing or supervising pelvic examinations on anesthetized or unconscious patients without first obtaining the person's informed consent, unless:

- The pelvic exam is within the scope of a surgical procedure or diagnostic examination to which the patient has given informed consent;

• The patient is unconscious and incapable of providing prior informed consent, and the pelvic examination is for a diagnostic purpose and is medically necessary; or

• The patient is unconscious and an alleged victim of sexual assault, and the physician or physician's assistant reasonably concludes that the circumstances justify conducting a forensic medical examination.

In addition, section 1 of the bill prohibits a person who is not licensed, certified or registered as a healthcare provider and who is working under the supervision of a healthcare provider, such as a student or trainee, from performing or supervising a pelvic examination that the supervisor is prohibited from providing. These unlicensed individuals are also prohibited from supervising the performance of a pelvic examination if conducted by a person outside the immediate presence of his or her supervising provider of healthcare.

Sections 2 through 12 of S.B. 196 authorize the imposition of professional disciplines or denial of a license or certificate for providers of health care who perform or supervise a pelvic examination when prohibited.

This bill is important legislation that has the support of many medical professionals. To date, 15 states have banned unauthorized pelvic examinations, and 7 states have introduced similar language in 2021. I hope you will all agree that codifying in statute the requirement to obtain a patient's informed consent is vitally important for women in Nevada.

I have a letter (Exhibit G) from the women who asked us to bring this bill forward.

SENATOR SETTELMEYER:
This is a good bill to try to address the issue. Will this cover all bad actions, or is it just pelvic exams?

SENATOR LANGE:
This bill specifically deals with pelvic exams.

SENATOR SETTELMEYER:
I will discuss other issues with you offline.

SENATOR PICKARD:
I seem to remember many cases, including some that reached the Nevada Supreme Court, that have held this sort of thing was a violation of the law. Is this practice not currently illegal in Nevada?

SENATOR LANGE:
This is currently legal in teaching hospitals, and it seems to be done all the time. This bill makes it illegal in Nevada. Physicians must have the consent of the woman first unless they meet one of those three circumstances I mentioned. We want to require them to get prior consent; it is not okay to just do it without asking first.

SENATOR PICKARD:
I once had a procedure done at a teaching hospital, and I had to sign a consent to allow students to be involved. I did not have a problem with that, but I am wondering if this bill needs to say that the consent form must specify the procedure and not just be a blanket consent for all procedures. If the patient signs a blanket consent that does not specify this type of exam, does that meet the requirement? That might be something to consider on the legal side.

SENATOR HARDY:
The focus of the bill is to prevent anyone taking advantage of people who are anesthetized. People who are anesthetized cannot give permission.

I would like to clarify that medical residents are not students. They are physicians.

I would also like to note that for all disciplines, the practice is to have at least two people other than the patient present when a pelvic exam is done, whether the physician is male or female. It is also standard practice that the patient is awake and knows what you are going to do and the reasons for it.

It might be redundant to have a separate consent form when you are going to do a pelvic exam. Pelvic exams are almost always done in medical offices, not in surgical suites and not with the patient under anesthesia. One exception might be when you are looking for a mass after laparoscopic surgery and need to figure out how extensive it is. In this circumstance, the forms the patient signed before surgery allow the physician flexibility, because you are not going to wake the patient up and say, "Can I do a pelvic exam?"

This bill is trying to get at a specific problem, and it does just that. It makes the person who does this liable for his or her very license. There can hardly be anything more motivating than "You'll never be a doctor again in your whole life if you do this." This is respectful of women by making sure they are awake and know what their doctors are doing.

SENATOR PICKARD:
I am concerned that if we allow a blanket informed consent without specifying that a pelvic exam might occur, it might provide a loophole we want to avoid.

SENATOR NEAL:
Section 2, subsection 1, paragraph (v) of the bill refers to "Performing or supervising the performance of a pelvic examination." What part do residents play? Can you explain the use of the word "supervising" here? I am just trying to understand this bill.

SENATOR HARDY:
The resident is someone who has gone through medical school, and the last two years of medical school have been what we call clinical rotations, at least one of which has been in the field of obstetrics/gynecology. When medical students get out of medical school, they know how to do a pelvic exam. Residents are physicians. They work with attending physicians, but they may or may not be supervised while they work.

The resident is licensed as a resident physician. At some point in the residency, some states allow a resident to have an unlimited license, which I did after my second year of residency in Arizona. Licensing and credentialing happen through your residency program while the resident is under the supervision of attending physicians.

SERENA EVANS (Nevada Coalition to End Domestic and Sexual Violence):
We want to applaud Senator Lange and all of the cosponsors of S.B. 196. We are here in support of the bill.

The Coalition has been working with sexual assault advocates and programs throughout Nevada to examine Nevada's sexual assault and associated statutes, and consent is an important part of that work. This ongoing work group has had conversations around medical consent and the unfortunate victimization that occurs through uninformed pelvic exams.

Pelvic exams are intimate and invasive, and they can be very uncomfortable and have lasting effects. Every individual should have the right to give or withhold informed consent to what happens to their body during every medical procedure. In addition, consent to one medical procedure does not mean consent to all medical procedures. Many individuals are not comfortable being used for learning purposes.

Informed consent is an essential part of protecting patients who undergo medical procedures. Unconsented pelvic exams can be incredibly traumatizing and violating, especially to a patient who has been a victim of sexual violence. It should not be necessary to have protections to prevent patients from becoming victims of sexual impropriety or assault. Unfortunately, that is the reality of the world we live in. Patients, athletes and others are at risk, not only from doctors but also from physical therapists, coaches and others whom they trusted. Everyone should feel safe and empowered in seeking medical care, and we must not allow providers to take advantage of vulnerable patients.

We, as a coalition, will be working through the Interim and beyond to work on other aspects of the definition of sexual assault and consent language. Senate Bill 196 is an excellent first step in addressing medical informed consent. We encourage the passage of this bill.

SUSAN FISHER (State Board of Osteopathic Medicine):
We are in support of this bill. The Board expresses its appreciation to Senator Lange for bringing this bill forward. As one Board member said during our public hearing the other night, we should not even have to be discussing this and putting this in statute. Unfortunately, however, we do need to. This puts big teeth in the statute as well. We encourage passage of S.B. 196.

JEANETTE BELZ (Board of Occupational Therapy):
We are neutral on this bill. I would like to verify that this bill does not impede the ability of graduate level occupational therapists to get an additional certification in pelvic evaluation. This is because the bill amends NRS 640A. We look forward to discussion with Senator Lange to clarify that.

SENATOR HARDY:
I am at a loss. What does this bill have to do with pelvic evaluations by occupational therapists?

CHAIR SPEARMAN:
Ms. Belz appears to have left the discussion. Senator Hardy, please follow up with her offline and let us know the result.

SENATOR LANGE:
Thank you for considering this bill. It is important. A woman's body is her own, and she should have the right to say, "I don't want a pelvic exam." As was mentioned earlier, this is a first step in creating something in Nevada statute that deals with this issue. I look forward to working on the language and getting this bill passed.

CHAIR SPEARMAN:
I will close the hearing on S.B. 196 and open the work session on S.B. 100.

SENATE BILL 100: Enacts provisions governing the interstate practice of physical therapy. (BDR 54-153)

MR. MELGAREJO:
I have a work session document (Exhibit H) summarizing the bill and proposed amendments from the Physical Therapy Board. We have also received a proposed amendment (Exhibit I) from Kaylyn Kardavani, Nevada Justice Association.

SENATOR SETTELMEYER:
I want to make sure the sponsor is okay with the amendment in Exhibit I. I have no problem supporting it; it seems like a reasonable amendment. I am rather troubled, however, by the lateness of this amendment. I hope it does not become a common practice of individuals to submit amendments to the sponsor at such a late date. I find it problematic that this occurred.

SENATOR HEIDI SEEVERS GANSERT (Senatorial District No. 15):
We consider this a friendly amendment. It is just a clarification about immunity between members and licensees. We want to make sure it was clear. That is in Article VII, section 7 of the bill.

CHAIR SPEARMAN:
The person submitting the amendment contacted me yesterday to say they had come to an agreement and just needed to document it. Senator Seevers Gansert said it answered one of the questions we had when we heard the bill regarding

qualifications. She was working with the stakeholders to make sure she answered the question.

SENATOR SETTELMEYER:
I am happy to move the bill forward with all the amendments. At the same time, I feel those who ignored the process and delivered the amendment late should be admonished.

SENATOR SETTELMEYER MOVED TO AMEND AND DO PASS AS AMENDED S.B. 100.

SENATOR PICKARD:
I agree. I was expecting something fairly significant. In addition, I do not see how this amendment is necessary or germane to the article in which it is placed. I would like the proponent of the amendment to please explain in writing why they think this is necessary, particularly given the amount of time this bill has been in progress. I would also like to know why they thought it was necessary to bring this at the last minute. I do not think it is germane; I do not think it accomplishes anything with respect to the section.

CHAIR SPEARMAN:
If you have some heartburn with the amendment or the bill, however you vote today, you can always reserve your right to change your vote on the Senate Floor.

SENATOR HARDY SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

* * * * *

CHAIR SPEARMAN:
Senator Seevers Gansert, I would suggest you make the rounds with those who had issues with the amendment's language or its timing.

Is there any public comment? Hearing none, we are adjourned at 10:47 a.m.

RESPECTFULLY SUBMITTED:

_____
Lynn Hendricks,
Committee Secretary

APPROVED BY:

_____
Senator Pat Spearman, Chair

DATE:_____

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Begins on Page**	**Witness / Entity**	**Description**
	A	1		Agenda
S.B. 90	B	1	Cesar Melgarejo	Work Session Document
S.B. 139	C	1	Brooke Maylath	Written Testimony
S.B. 139	D	1	Brooke Maylath / U.S. Department of Health and Human Services	Final Rule on Section 1557 of the Affordable Care Act
S.B. 139	E	1	Brooke Maylath / Division of Insurance	Bulletin 15-002
S.B. 139	F	1	Brooke Maylath / Legislative Counsel Bureau	Opinion Addressed to Assemblyman Michael Sprinkle
S.B. 196	G	1	Senator Roberta Lange	Support Letter from Christine Smith and Teri Greenman
S.B. 100	H	1	Cesar Melgarejo	Work Session Document
S.B. 100	I	1	Cesar Melgarejo	Proposed Amendment from Kaylyn Kardavani