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

Eighty-Second Session
April 10, 2023

The Committee on Commerce and Labor was called to order by Chair Elaine Marzola at 6:09 p.m. on Monday, April 10, 2023, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda [Exhibit A], the Attendance Roster [Exhibit B], and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/82nd2023.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Elaine Marzola, Chair
Assemblywoman Sandra Jauregui, Vice Chair
Assemblywoman Shea Backus
Assemblywoman Bea Duran
Assemblywoman Melissa Hardy
Assemblywoman Heidi Kasama
Assemblywoman Daniele Monroe-Moreno
Assemblyman P.K. O'Neill
Assemblywoman Selena Torres
Assemblyman Steve Yeager
Assemblyman Toby Yurek

COMMITTEE MEMBERS ABSENT:

Assemblyman Max Carter (excused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Marjorie Paslov-Thomas, Committee Policy Analyst
Sam Quast, Committee Counsel
Joe Steigmeyer, Committee Counsel
Cyndi Latour, Committee Manager
Elizabeth Lepe, Committee Secretary

Julie Axelson, Committee Secretary
Garrett Kingen, Committee Assistant

OTHERS PRESENT:

Deanna Leivas, Secretary-Treasurer, United Food and Commercial Workers Union Local 711
Jessica Ferrato, representing United Food and Commercial Workers
Marlene Lockard, representing Service Employees International Union 1107
Susan Martinez, representing Nevada State AFL-CIO
Paul Catha, representing Culinary Workers Union Local 226
Kent M. Ervin, Ph.D., State President, Nevada Faculty Alliance
Juanita Figueroa, Member, United Food and Commercial Workers Local 711
Wendy Colborne, representing Building and Construction Trades Council of Northern Nevada
Edward Goodrich, representing International Alliance of Theatrical Stage Employees Local 363
Robert Sumlin, Member, International Association of Machinists and Aerospace Workers Local Lodge No. SC711
Larry Wilson, Member, United Auto Workers
Beverly Williams, Secretary-Treasurer, Southern Nevada Central Labor Council, AFL-CIO
Shelbie Swartz, representing Battle Born Progress
Liz Sorenson, President, Nevada State AFL-CIO
Tiffany Hoffman, Cofounder and Secretary, Nevada Midwifery Licensure Collective, Reno, Nevada
Amanda Macdonald, Treasurer, Nevada Midwifery Licensure Collective, Reno, Nevada
Andrea Thompson, Private Citizen, Reno, Nevada
Melissa Mayfield, Private Citizen, Fernley, Nevada
A'Esha Goins, Vice President, Las Vegas Branch, National Association for the Advancement of Colored People
Cassie Franco, Private Citizen, Las Vegas, Nevada
Heather Areshenko, Private Citizen, Reno, Nevada
Elizabeth Marrett, Private Citizen, Reno, Nevada
Bron Roberts, Private Citizen, Reno, Nevada
Juliamarie Mayes, Private Citizen, Las Vegas, Nevada
Andrea Koell, Private Citizen, Fernley, Nevada
Brenden Turner, Private Citizen
Marina Barrett, Private Citizen, Reno, Nevada
Kanani Espinoza, representing Nevada State College
Kiley Lester, Private Citizen, Reno, Nevada
Kate Woeber, Director, Midwifery Program, University of Nevada, Las Vegas
Jeff Sohler, Private Citizen, Gardnerville, Nevada
Ben Ediss, Private Citizen, Carson City, Nevada

Rafael Arroyo, Private Citizen, Nevada
Lenny Sue Tinseth, representing Nevada Midwives Association; and Great Basin Midwives
Brian Abbott, Private Citizen, Gardnerville, Nevada
Tara Abbott, Private Citizen, Gardnerville, Nevada
Rebecca Wells, representing Nevada Midwives Association
Faith Bosket, Private Citizen, Pahrump, Nevada
Camila Santiago, Private Citizen
Tiffanie Gonzales, Private Citizen, Henderson, Nevada
Cassia Lopez, Private Citizen
Laniqua McCloud, Private Citizen, Las Vegas, Nevada
Sjana Wagner, Private Citizen, Reno, Nevada
Monica Breitenbach, Private Citizen, Fallon, Nevada
Emily Barney, Executive Director, Cofounder, Doula Co-op of Reno
Samantha De Andrea, Cofounder, Doula Co-op of Reno
Leslie Quinn, Private Citizen, Las Vegas, Nevada

Chair Marzola:
[Roll was taken and Committee rules and protocol were explained.] Today, we will hear two bills: Assembly Bill 386 and Assembly Bill 437. We will be taking those out of order, and we will have a work session as well. We will do the work session first. We will begin our work session with Assembly Bill 334.

Assembly Bill 334: Revises provisions relating to insurance for motor vehicles. (BDR 57-949)

Marjorie Paslov-Thomas, Committee Policy Analyst:
[Read from Exhibit C.] Assembly Bill 334 revises provisions relating to insurance for motor vehicles. It is sponsored by Assemblywoman Brown-May, and was heard by the Committee on March 24, 2023. There are five proposed amendments by the sponsor:

(1) Amend section 1 of the bill to increase the time period in which an insurer must conduct an inspection for repair or further inspection of a motor vehicle relating to a claim by an insured or claimant from six business days to eight business days.
(2) Amend the bill to require that at the time of inspection or further inspection of a motor vehicle, an insurer must provide a copy of its estimate, which must at a minimum indicate the extent of known damage and manner of repair.
(3) Amend section 1, subsection 4 of the bill to include "and furnish a copy of its estimate."
(4) Amend section 1, subsection 5 of the bill to include "claimant"; and
(5) Delete section 1, subsection 6 of the bill, and instead provide that a person who violates the provisions of the bill is subject to an administrative fine of $1,200 per violation.

Chair Marzola:
Members, are there any questions? [There were none.] I will entertain a motion to amend and do pass Assembly Bill 334.

> ASSEMBLYWOMAN JAUREGUI MOVED TO AMEND AND DO PASS ASSEMBLY BILL 334.
>
> ASSEMBLYWOMAN MONROE-MORENO SECONDED THE MOTION.

Is there any discussion on the motion?

Assemblyman O'Neill:
Chair, I am going to be a yes to get it out of Committee today because I know we are coming up on a deadline. I think the bill still needs some work done, and I will be a no on the floor if there are not some amendments made to this bill. I will be yes with reservations, please.

> THE MOTION PASSED. (ASSEMBLYMEN HARDY, KASAMA, AND YUREK VOTED NO. ASSEMBLYMAN CARTER WAS ABSENT FOR THE VOTE.)

I will assign the floor statement to Assemblywoman Brown-May. Just so everyone knows, I am pulling Assembly Bill 415. It will not be in work session today.

Assembly Bill 415: Revises provisions relating to dispensing opticians. (BDR 54-846)

[Assembly Bill 415 was agendized but not heard.]

Next is Assembly Bill 443.

Assembly Bill 443: Expands the institutions which certain recipients of the Governor Guinn Millennium Scholarship are authorized to attend. (BDR 34-352)

Marjorie Paslov-Thomas, Committee Policy Analyst:
[Read from Exhibit D.] Assembly Bill 443 expands the institutions which certain recipients of the Governor Guinn Millennium Scholarship are authorized to attend. It is sponsored by the Committee on Commerce and Labor, was heard on April 7, 2023, and there are no proposed amendments.

Chair Marzola:
Members, are there any questions? [There were none.] I will entertain a motion to do pass Assembly Bill 443.

> ASSEMBLYWOMAN MONROE-MORENO MOVED TO DO PASS ASSEMBLY BILL 443.

ASSEMBLYMAN YUREK SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYMAN CARTER WAS ABSENT FOR THE VOTE.)

I will assign the floor statement to Assemblywoman Jauregui. That will conclude our work session for today. [The Committee recessed at 6:15 p.m. and reconvened at 6:17 p.m.]

[Assemblywoman Jauregui assumed the Chair.]

Vice Chair Jauregui:
I am now going to open the hearing on Assembly Bill 437.

Assembly Bill 437: Limits the amount a provider of health care may charge for filling out certain forms associated with certain leaves of absence. (BDR 54-670)

Assemblywoman Elaine Marzola, Assembly District No. 21:
With me today is Deanna Leivas, secretary-treasurer from the United Food and Commercial Workers Union Local 711. I am here to present Assembly Bill 437, which limits the amount a provider of health care may charge for filling out certain forms associated with certain leaves of absence. Passed in 1993, the Family and Medical Leave Act (FMLA) is a federal law that entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons. The Family and Medical Leave Act did not cap the fee a doctor may charge a worker to complete the form employers need. The burden of paying the fees falls upon the employee, as the federal law does not require employers or insurance companies to pay the doctors' fees. Workers must have providers process forms to receive their FMLA leave. Across the Las Vegas Valley, provider offices are charging over $100 to process an FMLA, or leave of absence, certification. This far exceeds the national standard of $25 to $30. The unregulated cost creates a financial burden for working families in Nevada who are also taking leave from work to address medical needs for themselves or loved ones. Assembly Bill 437 is a very short bill. As you can see, section 1 prohibits a provider from charging more than $10 to complete a form required for an employer. With your indulgence, Madam Vice Chair, I will now turn it over to Deanna Leivas in Las Vegas.

Deanna Leivas, Secretary-Treasurer, United Food and Commercial Workers Union Local 711:
I am here to testify in support of A.B. 437, which would place a $10 cap on FMLA certification fees. United Food and Commercial Workers Union Local 711 represents over 7,000 workers throughout Nevada. Our members work in grocery stores, retail drug establishments, and cannabis cultivation facilities and dispensaries. Our members were designated as essential workers during the pandemic and kept our communities fed throughout our state. This issue is very important to all working families in the state of Nevada because at some point, everyone is going to need to take time away from work to care for themselves or a family member. The Family Medical Leave Act is the nation's first and only federal law designed to help people meet a dual demand of work and family.

It guarantees eligible employees up to twelve weeks of unpaid leave each year to care for a newborn, a newly adopted child, a seriously ill family member, or to recover from one of their own serious health conditions, including pregnancy. America's workers have used the FMLA more than 315 million times to take time off when they need it the most without having to worry about losing their job or health insurance. An overwhelming majority of worksites report no difficulty complying with FMLA labor and community leaders. Leaders have all seen the signs and heard the stories of the continuing rising costs of FMLA certification fees in our state. We have heard from members that some of those costs are upwards of $100. Working families should not have to continue to cover this cost while taking unpaid time off for family or medical leave. After all, they already paid to see their health care provider and should not have to pay again for a form. The worker will be stepping out of the workforce under FMLA, and forcing them to bear this additional cost is wrong. Nevada legislators must act to provide consistency and lessen the financial burden for working families. I urge you to do so by supporting A.B. 437. Thank you for your attention to this issue and for the opportunity to speak with you today.

Assemblywoman Marzola:
We will stand for questions, Vice Chair.

Assemblywoman Kasama:
Can you give me some context? I am not familiar with the form. Is it one page, half a page, or ten pages? What is involved with filling out the form?

Jessica Ferrato, representing United Food and Commercial Workers:
I am here on behalf of United Food and Commercial Workers to help answer some questions. Most of the forms are two pages. They vary a bit depending on the employer, but we can get you some examples so you can have a few examples of what they look like.

Assemblywoman Kasama:
That is probably good, just a two-page form. Is there any consideration for the $10 charge having a consumer price index to it? If we are here twenty years from now and $10—it does not cover the form. That is my thought; I do not know if you thought about that.

Jessica Ferrato:
We have not thought about that yet. Most states that do this have a sort of standard rate. I think we are looking at something that would be more affordable for working families. I think we have not considered that at this point, but we can continue discussions.

Assemblyman O'Neill:
Chair, in your testimony, you said the average cost across the country is around $25?

Assemblywoman Marzola:
That is correct. The national standard is around $25 to $30.

Assemblyman O'Neill:
Why are you not going with $25? That would probably take care of inflation for some time. Why did you settle on $10?

Jessica Ferrato:
That is a range, so $25 to $35 is just an average. There are some that are lower; there are some that are higher. I think we started on the low end because we wanted it to be affordable for workers in the state of Nevada, but we are open to suggestions.

Assemblyman O'Neill:
I know when I have been to the doctors when I was operated on and needed a return-to-work form—to say that I was up to par again—it was just part of my natural doctor's appointment and there was no billing, and insurance picks up that visit anyway. I am a bit confused about how many providers charge up to $100 for this form. Is it part of what they are charging for? The medical examination is $100, and the form is just part thereof?

Assemblywoman Marzola:
I have a constituent who needed FMLA forms filled out from her own treating physician and the doctor would not do it unless she paid $120 in cash.

Assemblywoman Duran:
I know to get recertified for FMLA, the companies can have you do that and keep making you go back to the doctor to get those forms filled out. Is that correct?

Assemblywoman Marzola:
That is correct. It all depends, but usually the certification is once a year.

Assemblywoman Duran:
I know from working in the industry that some of the places will sometimes have you recertify up to six months after for that. I know some places have you go once a year, but some places make you go more than once. Is that correct?

Jessica Ferrato:
My knowledge was once a year, but we can get that information because I think it depends on the amount of leave you are taking and your employer's internal policies, so we will find out some more information and get you something.

Assemblyman Yeager:
Thankfully, I have never had to use FMLA, so I do not know a lot about how it works, but I have a couple of questions that I hope will be quick. I am assuming the federal law requires the form to be filled out and that is why it is being done?

Assemblywoman Marzola:
That is correct.

Assemblyman Yeager:
Which doctor is filling out the form? If I am taking family leave to take care of a family member, is it the family member's doctor who fills out the form, or if you have a newborn at home—I am just trying to figure out—is it going to be my doctor or is it somebody else's doctor who fills the form out?

Jessica Ferrato:
Typically, if you are taking care of a family member, it would be their doctor. If it is for yourself, it would be your doctor.

Assemblyman Yeager:
I want to clarify. This $10 cap that is in here, that is not the maximum you pay for the actual doctor's visit? You are just talking about the filling out of the form? Whatever your relationship is with your physician or a family member relationship, they are going to have all that come into play with copays? If they do not have insurance, out-of-pocket costs? I am seeing yes, nodding of heads, so maybe we do not need a response. Also, I honestly like the bill, but I feel like it should be no cost, to be quite honest. I mean, $10 in today's world is not much, but I understand we have to give some sort of compensation, but I would be in favor of saying they cannot charge anything.

Vice Chair Jauregui:
Committee members, are there any other questions? [There were none.] I want to take a moment to say thank you for bringing this bill, because I know that my doctor who I go to for my annual checkups has notices posted in every one of his waiting rooms. He charges a minimum $100 as well, so thank you. With that, we will go to testimony in support. If anyone wishes to testify in support of this bill, please approach the table.

Marlene Lockard, representing Service Employees International Union 1107:
The current practice of some health care providers charging excessive fees for filling out FMLA forms creates an unfair and unnecessary barrier for employees asking to exercise their rights under this important federal law. These fees can quickly add up, placing an undue burden on employees who are already dealing with the physical, emotional, and financial challenges of a medical leave. This proposed bill to limit the amount a provider of health care may charge for filling out FMLA forms is a much-needed step towards ensuring that employees are not deterred from taking necessary medical leave due to financial constraints. By setting reasonable and standardized fees for completing the forms, this bill will help protect the rights of employees to access the benefits they are entitled to under FMLA. We urge your support of this bill.

Susan Martinez, representing Nevada State AFL-CIO:
On behalf of over 150,000 members and 120 unions, we are in full support of A.B. 437.

Paul Catha, representing Culinary Workers Union Local 226:
I cannot do it better than Ms. Lockard, so I will not. We support A.B. 437.

Kent M. Ervin, Ph.D., State President, Nevada Faculty Alliance:
Being able to use FMLA is very important for our members to keep their families together and come back to work. We believe the fees for the certification part on top of the regular medical evaluation should be reasonable.

Juanita Figueroa, Member, United Food and Commercial Workers Local 711:
I have worked for Smith's grocery store for over twenty years, and I have been a member of the United Food and Commercial Workers Local 711 for just as long. I come from a large family. Growing up, I was one of eight siblings. I was my mom's right hand in the family and she taught me to work hard every day. Now, as a single mom myself, I was able to see my twenty-five-year-old daughter get married. When it comes to high fees for FMLA forms, it makes it harder for working men and women in Nevada at a time when they are already financially and emotionally stretched with either a new baby, a family member being deployed, or a serious illness. For me, it was a serious illness. Eight years ago, I was diagnosed with cancer, and at the time, I was a single mom trying to pay my bills and raise my daughter. I had insurance at the time because the union collectively bargains that for us, but things were tight. I am not sure that I would have been able to cover the cost of a $100 form on top of everything else. I can imagine all the other men and women in Nevada without insurance or a union that must pay these fees out of pocket just to keep their obstetricians. Please support A.B. 437 and place a $10 cap on this fee and ease some of the hardships men and women face in our state when taking FMLA leave.

Wendy Colborne, representing Building and Construction Trades Council of Northern Nevada:
We support this bill and urge the Committee to support it also. For a lot of working people in Nevada, the cost of filling out these forms is an obstacle to workers trying to care for their families at critical and sensitive moments in their lives. No one should have to carry any extra burden at moments like these.

Edward Goodrich, representing International Alliance of Theatrical Stage Employees Local 363:
We are in full support of A.B. 437 and any other legislation that restrains undue and outrageous financial burdens on workers for legally required standard forms.

Robert Sumlin, Member, International Association of Machinists and Aerospace Workers Local Lodge No. SC711:
I support this bill because workers should not have to pay a burdensome amount of money out of their own pockets to receive information required by their employers. We strongly urge the Committee to support A.B. 437.

Larry Wilson, Member, United Auto Workers:
We stand in strong support of this bill because it is a burden for our members to have to pay in order to have family sick leave.

Beverly Williams, Secretary-Treasurer, Southern Nevada Central Labor Council, AFL-CIO:
I strongly urge the Committee to support A.B. 437. It is an undue burden on our members, as they have to pay for their doctor bill, and then on top of that, pay extra money to have their forms filled out.

Shelbie Swartz, representing Battle Born Progress:
[Read from Exhibit E.] We are in support of A.B. 437 because it ensures that folks have access to the important leave benefits like FMLA that they are entitled to, as well as job protection and income support for individuals who need time off work due to serious medical conditions, injury, or to care for a family member. If the cost of obtaining these forms is prohibitively high, it can create a barrier to accessing the benefits, particularly for individuals who are already facing financial hardship due to their medical condition or caregiving responsibilities. Also, it is important to note that many individuals who require these forms may already be facing significant medical expenses, including costs for treatment, medications, and other health care services. We urge your support.

Liz Sorenson, President, Nevada State AFL-CIO:
For all of the reasons stated by the previous caller, I am also in strong support of A.B. 437. I urge this Committee to support the bill as well.

Vice Chair Jauregui:
Is there anyone else who would like to testify in support? [There was no one.] We will now go to testimony in opposition. Is there anyone wishing to testify in opposition to A.B. 437? [There was no one.] Is there anyone wishing to testify in the neutral position? [There was no one.] I will now close the hearing on Assembly Bill 437.

[The Committee recessed at 6:41 p.m. and reconvened at 6:43 p.m.]

[Assemblywoman Marzola reassumed the Chair.]

Chair Marzola:
Before I open the hearing on Assembly Bill 386, today for testimony in support, testimony in opposition, and testimony in neutral, I will be taking 30 minutes for each. There will be 30 minutes for support, which will be 10 minutes here, 10 minutes in Las Vegas and 10 minutes on the phone. I will do the same for opposition, and I will do the same for neutral. With that, I will open the hearing on Assembly Bill 386.

Assembly Bill 386: Revises provisions relating to midwives. (BDR 54-111)

[The Committee recessed at 6:44 p.m. and reconvened at 6:46 p.m.]

Assemblywoman Daniele Monroe-Moreno, Assembly District No. 1:
[Presentation was submitted, Exhibit F.] I am here to present Assembly Bill 386, which revises provisions relating to midwives. I am joined today by Tiffany Hoffman and

Amanda Macdonald, who are both certified professional midwives (CPM) here in Nevada. As a legislator, there have been a few subject matters that I have focused my work on in this building, those being updating Nevada's grants management and acquisition process, issues dealing with juvenile justice, and issues dealing with behavioral health care and maternal and child health care. Tonight, we are here to discuss a maternal and child health care bill. I sponsored Assembly Bill 169 of the 80th Session, establishing the Maternal Mortality Review Committee (MMRC), which required the Committee to review each incident of maternal mortality or severe maternal morbidity in the state. Last legislative session, I sponsored Assembly Bill 287 of the 81st Session, which revised certain terminology and provided for the licensing and regulations for freestanding birthing centers, which passed this legislative body with bipartisan support and became effective upon passage. As you may recall, last session, I also sponsored a midwife bill, Assembly Bill 387 of the 81st Session. At the end of session, it passed this body with bipartisan support, but the bill ultimately did not pass out of the Senate on *sine die* by one vote. This session, Assembly Bill 386 picks up where last session's bill ended.

I am not a midwife or an attorney, but I am a mom and a grandma. I have my own birthing stories and those of my children. We are not here tonight to discuss my stories. However, I did share parts of my story during the 2019 MMRC bill presentation, which prompted many constituents to reach out to me during that interim, sharing their stories, some of which were heartbreaking. I was asked to work on legislation that provides birthing families with safe, healthy birthing options. I say birthing families, and not necessarily birthing parents, because we have learned over the last few years that not every woman who carries a child is the parent of a child. My birth mother carried me; I have yet to meet her. She gave me up for adoption.

In 2020, we were right in the midst of the COVID-19 pandemic. Women were entering hospitals alone to give birth. They were searching for options so their families could be with them. At that time, they were looking for options of freestanding birthing centers and midwives, and some asked me, Was there a list in the state of Nevada for licensed midwifery? I went searching for one and found there was not because Nevada does not provide a licensure for midwifery. I went to work to find answers to the questions I have been asked by my constituents: What are the healthy birthing options for birthing persons? I found a few certified midwives in our state who also wanted to provide a licensure to fill that question. Since 2020, Ms. Hoffman, Ms. Macdonald, and I have held several stakeholder meetings—some in person, some virtually. They held more than I was able to attend because my workload was a little high here at the Legislature and in the interim. We have worked tirelessly during the past interim, seriously listening to the opposition on this piece of legislation.

As a background, and to refresh your memory if you forgot from last session, midwifery has been in practice in the United States for hundreds of years. Midwives provide care through the prenatal, delivery, and postnatal stages of childbearing to women who are healthy and experiencing a normal pregnancy. A midwife monitors the physical, psychological, and social well-being of the birthing parent throughout the childbearing cycle. When needed,

a midwife identifies and refers the few women who need obstetrical care to the proper doctors. I carried the MMRC bill because as a Black woman in America—well, let us just say this—birthing outcomes in America are, I would say, dismal in comparison to some third world countries, which is sad because we are such a developed nation. But when it comes to Black and Brown women, we are dying at higher rates when giving birth in America. Having healthy options is something I never want to take away from women, so I was very happy when Ms. Hoffman and Ms. Macdonald joined me on this mission. As I said, I am not a midwife, so I am going to turn the presentation over to the midwives and then come back and walk you through the bill and close out for questions.

Tiffany Hoffman, Cofounder and Secretary, Nevada Midwifery Licensure Collective, Reno, Nevada:

I am here with my colleague, Amanda Macdonald, and we are CPMs practicing in Reno, as well as licensed midwives in the state of California. We are here today to share our interest in licensure for CPMs in the state of Nevada. Nevada has a proud history of reproductive choice. Writing this bill has been a focused effort to maintain and expand that choice, reduce harm, honor traditions, increase accessibility, and improve outcomes for all birthing people in Nevada. The questions we have asked in creating this bill both last session and this year are: How can we improve safety and satisfaction for consumers? What is the bottom line to improve outcomes according to the available research? How do we honor and respect the history of midwifery while advancing the profession? How do we protect choice for Nevada families? How do we best improve access to community birth for all Nevada families? How do we increase the number of underrepresented midwives to provide culturally and linguistically congruent care? How do we begin to bridge the divide between community and hospital providers that is so desperately needed?

We have extensively reviewed research statements from major organizations invested in improving outcomes for childbearing people and babies internationally and in the United States; listened to consumers of all types of midwifery services; listened to families who have experienced loss and bad outcomes; listened to all types of midwives, physicians, lobbyists, and legislators. Everyone interested in this topic is extremely passionate; middle ground is very hard to find. Every attempt has been made to come to a center. We are two of eight who currently vocally support licensure of midwives with A.B. 386. For clarity, we will be using the preferred term "community birth" to refer to any planned birth outside of the hospital setting in homes and birth centers. Before we begin, I want to let you know, we will be sharing some information that might be hard for some people to hear, so please take care of yourselves.

The U.S. currently has a dire maternal health crisis. Our country fails to provide equitable, accessible, respectful, safe, and affordable care. In the Centers for Disease Control and Prevention data released last month, maternal mortality is at its highest rate since 1975. More people died per capita from pregnancy and childbirth in the U.S. than any other high-income country in the world. Our health care system spectacularly fails communities struggling with the burden of structural inequities due to racism and other forms of disadvantage. Black women in Nevada are 5.5 times more likely to die from

pregnancy-related causes. This is compounded by the fact that a large part of Nevada is a maternity care desert, and even in urban areas, many pregnant people are unable to obtain early prenatal care. There is an urgent need for a more equitable and cost-effective maternity care system with better outcomes and more options for birthing families. Recent research has highlighted the key role that community midwives and community birth settings play in this transition. The majority of research from other countries comparing planned home and birth center births to hospital births have found no difference in fetal and neonatal deaths, low Apgar scores, or neonatal intensive care unit admissions. However, applying this research to all states in the U.S. is not truly accurate. This is due to lack of integration across settings and consistency in legal recognition of credentialed midwives.

Amanda Macdonald, Treasurer, Nevada Midwifery Licensure Collective, Reno, Nevada:

Although cesarean sections can be lifesaving, they are currently vastly overused and carry short- and long-term risk for birthing people and babies [Exhibit F]. An American College of Obstetricians and Gynecologists (ACOG) statement on reducing primary cesareans and California Maternal Quality Care Collaborative (CMQCC) vaginal birth toolkit risks to birthing people and babies are high when cesarean rates are high. Nevada currently has the highest cesarean rate in the Western United States. That means that one of every three birthing people who enter the hospital will leave having had major surgery. This is where midwives come in.

Tiffany Hoffman:

What is a CPM? A certified professional midwife is an autonomous primary prenatal care provider for pregnant people with essentially healthy pregnancies. We are a distinctly different profession from nursing or medicine, with a national certification. We provide comprehensive care in the preconception period as well as perinatally during labor, birth, and the postpartum period. We provide well-woman and well-person care including Pap smears and sexually transmitted infection (STI) testing. We are experts in the wellness model: person-centered, physiologic approach to pregnancy and birth. Our training and expertise are in attending birth in homes and freestanding birth centers. We are the only type of perinatal care provider required to have experience in the community setting for certification.

What are the benefits of CPM care? Our philosophy is vastly different from the traditional medical model of care. Rather than viewing pregnancy and birth as a pathological state or medical condition that needs to be managed in the same way as an illness would be, we consider birth to be a normal physiologic process best supported through a person-centered focus on wellness. Research shows that 97 percent of families who had a community birth were satisfied with their care and experience. We provide longer prenatal visits and more postpartum visits, often in your home. Along with clinical checks, significant time is spent in relationship- and trust-building, providing support and education, and answering questions. Very often, we have met and gotten to know several members of your family. We have spent time in your home. We have listened to your deepest hopes and desires as well as your fears during our often hour-long visits, and we are invested.

When labor starts, there is more freedom and autonomy than with birth in the hospital. With freedom of movement, eating and drinking without limitation, choice of any and all support people you want with you during your birth, help with nonmedication comfort measures because you are the ultimate decision maker—we follow your lead. We honor the physiology of birth and, if needed, we discuss judicious use of interventions when indicated or requested with full consent. At-home birth midwives have the luxury of providing focused one-on-one care with just one laboring person. We spend hours with you in labor and several more hours with you celebrating you and the work you have done, helping you bond with your baby while continuing to monitor you and your baby's well-being. Because we are able to offer a truly personalized one-on-one physiologic approach to perinatal care for essentially healthy pregnancies, we see a significant reduction in interventions during labor and birth.

What does the research show particularly in well-integrated locations? In a recent Cochrane review, it is stated that increasingly better observational studies in different settings suggest that planned hospital birth for women at low risk of complications is not any safer than planned home birth assisted by an experienced midwife with collaborative medical backup. However, hospital birth may lead to more interventions and more iatrogenic complications. Two additional systematic reviews and a Washington State study on low-risk birthing people planning community births in high-income countries found that people giving birth at home were more likely to have a vaginal birth, no tearing or episiotomy, and exclusive breastfeeding at six weeks; and less likely to have a cesarean birth, epidural medications to speed labor, vacuum and forceps delivery, severe tearing, and severe postpartum hemorrhage. In Washington State, they reported a perinatal mortality rate comparable to nations with strong midwifery integration across all birth settings. Babies at home have similar rates of stillbirth and early newborn death, are less likely to be born preterm, less likely to be low birth weight, and are significantly less likely to be admitted to neonatal intensive care units.

Certified professional midwives can also provide access to care in rural areas and those experiencing a perinatal care shortage. Certified professional midwives provide cost savings to families, the state, and insurance companies due to these lower intervention and cesarean birth rates.

Amanda Macdonald:
Interest in community birth vastly exceeds use. In the Listening to Mothers in California report, 40 percent expressed interest in a birth center for their next birth, and 22 percent expressed interest in a home birth. Lack of access interferes with a childbearing person's right to choose. The choice of birth settings and provider are deeply personal choices that are informed by subjective assessments of benefits, risks, and weighing the two. From 2004 to 2019, community births rose 91 percent. Of those, it was home births rising 83 percent, and birth centers were rising 130 percent. In Nevada in 2021, the community birth rate was 2 percent, and that is up from 1.7 percent three years ago. The current national rate is 1.4 percent. Some of the reasons for increased utilization would be inconsistent insurance coverage and high deductibles; high level for self-pay; loss of rural hospitals and maternity

units; provider shortages; the COVID-19 pandemic; rising publicity about and fear of disrespectful and unsafe treatment, particularly for Black birthing people in the hospital setting; desire to avoid interventions and cesarean sections. According to the ACOG reVitalize paper, only one in twenty birthing people experience a physiologic birth without major intervention in the hospital. Also, there is the desire for control of environment and choices, along with fear of the hospital and prior bad experiences.

According to public information, national and state databases, there are currently 19 active certified professional midwives, plus 1 not in active practice in Nevada, and 10 active uncertified midwives plus roughly 9 not in active practice. It is harder to track the number of uncertified midwives in the state of Nevada because there is no database, so we are also using some information that we have heard from other uncertified midwives in meetings we have had with them. There are five certified nurse-midwives (CNM) practicing in the community setting. We have heard claims that up to 70 community midwives exist in Nevada. However, we have been unable to find data to support those numbers, which seem to be inflated. Between current CNMs and newly licensed CPMs, should this bill pass, about 80 percent of Nevada's midwife-attended community births could be attended by a licensed health care provider, versus the current 20 percent. That is a 300 percent increase. Nevada stands alone in the West as the only unlicensed state. This map [referred to Exhibit F] shows current licensing trends in the U.S. There are 37 states that license their CPMs, and those are green [on the map]. Five states have active CPM bills like Nevada, and they are light pink. Five states are planning CPM legislation; they are the darker pink color. Only three states are legislatively inactive. There are national midwifery organizations working hard to achieve licensure for CPMs in all 50 states for the benefit of the public and the midwifery profession itself.

Tiffany Hoffman:
Why is licensure good for the public? Licensure is a mechanism by which the members of the midwifery profession are held accountable to the public for providing safe care that is consistent with the scope of practice defined by the profession and upheld by state law and subsequent regulatory guidelines. There is accountability. There is currently no recourse for families if a midwife is practicing outside of their scope or otherwise practicing unsafely. This bill would provide official processes and paths for both the family and the state if warranted. It improves safety, legal access to life-saving medication for midwives, in addition to integration, collaboration, and other points that will be listed further. There is also transparency that comes with mandatory reporting of practices and outcomes in a state database. There is access through cost savings; people are less likely to experience the benefits of home birth in jurisdictions in which home settings and providers are less integrated into the health care system, as shown by research.

Integration is important. We all share the goal of healthy outcomes for birthing people and babies, but lack of reliable integration across providers and settings in the U.S. contributes to inferior outcomes relative to our peer nations. What would improve that? Integration improves that. *The Lancet* study on midwifery and quality care showed that, on a global scale, maternal and perinatal outcomes are better in jurisdictions where midwives are

regulated and have the legislative authority to practice to their full scope across birth settings, including collaborating with or referring to other health professionals. Who is doing better than us? Washington State is one of the exceptions and makes the case for greater integration nationally: legal recognition; the presence of a strong, well-established professional organization; Medicaid reimbursement; many in-network insurance options; and a relationship between midwifery providers and their perinatal quality collaborative are all contributors to the great outcomes in Washington State. We also know from studies in other countries that community birth can be as safe, and for some variables, safer, than birth outside of the hospital in an integrated setting.

In the U.S., we do not have an integrated system of seamless collaboration and transfer across all settings, and in many areas of Nevada, midwife-physician relationships are nonexistent, strained, or even openly hostile. When talking with providers who review cases of catastrophic outcomes, one of the most common issues is complicated transfers. Unwillingness, inability, or unfamiliarity on the part of emergency medical services and hospital providers, as well as midwives and working together does not serve the best interest of families. We are relieved to see an Assembly bill establishing a perinatal quality collaborative. It is much needed in Nevada and there is much room for improvement. In that bill's presentation, we saw that Nevada's March of Dimes report card score is a D- and our integration score for midwifery in the U.S. in the state of Nevada is 29 out of 100. To add to that, currently most community midwives in Nevada are unable to refer clients to a perinatologist or consistently refer them to hospital-based providers when they develop a condition that requires a different level of care. Many obstetrics providers will not see clients who are not under their care for pregnancy, and many medical doctors will not see pregnant clients who require treatment for STIs, nausea, urinary tract infections, or glucose monitoring supplies—all things that are very commonly needed in pregnancy—which affects timely access to needed care.

Home-to-hospital transfers are often strained at best and contentious at worst. Lack of collaborative training has led to inefficient and ineffective transfers from home to hospital. Two states whose perinatal care collaboratives have led the way in supporting midwives and working towards collaborative relationships and improved outcomes are California and Washington. The CMQCC, in late 2022, added to their Toolkit to Support Vaginal Birth and Reduce Primary Cesareans—an addition that outlines integrating midwives and community-based care more fully into the medical system. Representation of licensed midwives within the Washington State Perinatal Collaborative, for more than two decades, has fostered interdisciplinary collaboration, and that relationship has led to the Smooth Transitions Quality Improvement Program which works to create efficient, safe, and respectful hospital transfers from planned community births. Another benefit has been greater willingness of obstetricians and hospital-based nurse-midwives to consult and collaborate with community midwives prenatally. The current bill to create a perinatal quality collaborative in Nevada does not guarantee an opening for CPMs or a home birth provider. We hope that changes.

Amanda Macdonald:
The Midwifery Integration Scoring System (MISS) was created by a multidisciplinary group of experts to determine whether integration of midwives into the health care system improved outcomes. A score of 100 would indicate that a family in that state would have full access to high-quality maternity care in all settings. I am not going to go over the whole charts with you for the sake of time. There are two charts in your packet of information that go over Nevada's numbers, along with the three states that have the highest numbers in the nation, which would be Washington, New Mexico, and Oregon.

Tiffany Hoffman:
We are going to move on to access. Access does not meet demand. Currently, the National Partnership for Women states, too often childbearing people and their families, especially those in communities of color, cannot access and benefit from the midwifery model of care in the community setting. Increasing access to this model of care is an urgent priority that will improve maternal care experiences and outcomes in the United States. In 2020, only 3 percent of hospital births were paid out of pocket, but almost 70 percent of planned home births and 34 percent of birth center births had to be paid out of pocket. Medicaid pays for 42 percent of all births in the U.S., and 50 percent in Nevada. Certified professional midwives currently cannot bill Medicaid in Nevada. How do we improve access? Nonrestrictive practice, early prenatal care, culturally congruent providers, increased access to birth centers, Medicaid and private insurance coverage. A lack of insurance coverage for community birth providers creates insurmountable financial barriers for many who would otherwise choose to birth in the community setting. Despite the clear value of midwifery care, especially as a way to help improve consumer satisfaction and obtain better outcomes for birthing people and babies, there are significant limitations to the accessibility and availability of midwives. This bill is just the first step.

Amanda Macdonald:
You are going to see this chart [refers to Exhibit F], which talks about the density of CPMs in states. Some opponents to Nevada CPM licensure claim it is going to reduce the number of midwives in the state of Nevada. Data collected by the North American Registry of Midwives (NARM), which is our certifying body, would suggest this is often not the case. It is like the saying: if you build it, they will come. Certified professional midwives are often hesitant to move to an unlicensed state due to concerns about access and legality. The exception is CPMs who may move to Nevada after having restrictions to their license in other states. Those midwives are under no obligation to disclose this information to clients, and it is currently happening in our state right now.

Tiffany Hoffman:
Cost savings is another large piece of the picture. Childbirth is the number one reason for hospitalization in the U.S. As mentioned, 50 percent of births in Nevada are paid for by Medicaid. As demonstrated in a Washington State independently conducted cost-benefit analysis commissioned by the Washington State Legislature, both excellent outcomes and significant cost savings were conferred by licensed midwifery care. The total savings to Washington Medicaid was approximately $1.6 million per year when facility fees and

reductions in costly medical procedures were factored in. This is largely based on the greatly reduced cesarean rates between home and hospital birth settings achieved with CPMs. On a national scale, on average, CPMs cost the state $3,374 less than a low-risk hospital birth. It has been projected that the U.S. could attain a savings of $321 million annually with a shift of just 1 percent of births from the hospital to the home setting, and an additional annual savings of $189 million with a shift of 1 percent of births from hospital to birth center, which is half a billion dollars a year in savings.

What has been shown to improve home birth outcomes? Collaboration, integration, and autonomous practice are heavily supported by research. The reason the U.S. home birth outcomes cannot directly be compared to the improved outcomes of home birth in other countries and in a few states is due to the lack of integration of CPMs, lack of collaboration between perinatal care providers, and the inability of CPMs to practice to their full scope. According to the "Mapping integration of midwives across the United States: Impact on access, equity, and outcomes" (*PLOS One*, 2018), outcomes are best globally when midwives are regulated in practice to their full scope. Studies show that interprofessional teamwork is essential to the provision of high-quality maternity care. United States midwives with nationally recognized credentials provide expert care for birthing people and are educated to identify when a birthing person or baby needs higher levels of more specialized care than midwives can provide. Outcomes are best when midwives are regulated and practice autonomously to their full scope.

Amanda Macdonald:
Collaboration is the active participation between autonomous individuals. Research shows that when professionals collaborate on decision making and when coordination of care is seamless, fewer intrapartum, neonatal, and maternal deaths occur during critical obstetric events. In the committee hearing for Assembly Bill 179 that happened last month, Dr. Bryan Iriye, a perinatologist practicing in Reno and Las Vegas at the High Risk Pregnancy Center, said, when people work together, we know as we work as a team, we all do better. Perinatal care has a wide range of providers: obstetricians, midwives, neonatologists, and nursing staff. He went on to share that a collaborative approach including all providers increases communication, which we all want. However, in northern Nevada, CPMs are unable to refer clients directly to either of the two perinatology practices, including High Risk Pregnancy Center. Previous poor outcomes from some midwives have caused these practices to refuse direct patient referrals from CPMs. Perinatologists cite liability concerns, lack of licensure, lack of educational standards, lack of accountability, and lack of physician oversight. We are not viewed as autonomous providers, and we are not offered the option to collaborate with these specialists. The next closest perinatology practice is over two hours away. This lack of timely, responsible, and safe referral options does not serve pregnant people, their babies, or their families. It only serves to harm. Another vital reason for collaboration is when patients perceive interprofessional conflict, the culture of safety is diminished, and the potential for the patient to experience trauma following the birth is increased.

Tiffany Hoffman:
How does A.B. 386 help Nevada? There is substantive research that shows outcomes are best globally where midwives are regulated in practice to their full scope. The goal of A.B. 386 is to improve outcomes, provide accountability, and improve accessibility, all while providing CPMs the ability to practice autonomously. Assembly Bill 386 would require direct on-site supervision of students and midwifery assistants; it would require basic training for midwife assistants; it requires anti-bias and anti-racism training for license renewal—North American Registry of Midwives now requires anti-racism training at each renewal, but we want to make sure it always remains a requirement for Nevada CPMs—it allows the opportunity for CPMs to accept Medicaid; it provides legal access to medications; it requires statewide reporting; it establishes a transfer and collaboration work group to improve seamless transport; and creates access to licensed CPMs.

Amanda Macdonald:
Speaking about licensed CPMs, access to licensed midwives has been shown to improve safety. Numbers from birth certificate data in Oregon from 2012 to 2020, Oregon tracks birth statistics differently from other states, so they can provide information that other states in the U.S. currently cannot. Oregon offers a legal option for traditional midwives, which means they are unlicensed and uncertified to practice. It is important to note that this data on the graph [referred to Exhibit F] cannot tell us the reason for the differences in rates between licensed midwives and traditional midwives—only that it exists. There are several possibilities. This research suggests there is more to safety than location of birth alone.

Midwifery Integration Scoring System scores, which we talked about earlier, also correlated with the density of midwives for access to care across settings. The North American Registry of Midwives does a jobs analysis every six to eight years, and this graph [referred to Exhibit F] is based on responses from CPMs themselves. When asked about the effects of licensure, most respondents believe that licensure had a positive effect on their state, with 71 percent agreeing that the benefits of licensure outweigh the drawbacks. Sixty-four percent report that the number of midwives in their state has increased. There has been concern among Nevada's midwives who oppose licensure that the number of midwives will decrease in our state, and the research from our own accrediting body would not support this idea.

Assemblywoman Monroe-Moreno:
Madam Chair, before we go to questions, would you like me to walk through the bill?

Chair Marzola:
Please.

Assemblywoman Monroe-Moreno:
Sections 2 through 32 of the bill generally provide for the licensure and regulation of licensed CPMs by the Division of Public and Behavioral Health of the Department of Health and Human Services, and the regulations of licensed CPMs by the Division and the Board of Licensed Certified Professional Midwives created by section 17 of the bill. Sections 2 through 14 define: "Board," "certified nurse-midwife," "certified professional midwife birth

assistant," "certified professional midwife student midwife," "co-manage," consult," "licensed certified professional midwife," "medical facility," "practice of certified professional midwifery," and "refer." Section 15 exempts other providers of health care from the requirements governing the regulations of licensed CPMs. It also does not prohibit gratuitous services of a person in an emergency or care by friends or members of the family. Sections 17 through 19 create the Board of Licensed Certified Professional Midwives, which is composed of nine members who are appointed by the administrator of the Division and prescribe the duties and operations of the Board. In addition, the Board must adopt regulations governing midwifery, which includes licensure, qualifications, investigations of misconduct, and discipline management of a client who is at a moderate or high risk of an adverse outcome, and certain other aspects of that practice of midwifery.

Section 20 provides the requirements of the issuance of a license as a licensed certified professional midwife. Section 21 authorizes a licensed certified professional midwife to use a birth assistant to perform certain simple routine tasks and prescribes the training for a birth assistant. Section 23 prescribes the authorized activities of a certified professional student midwife and requirements governing the supervision of a student midwife by a preceptor. Section 24 of the bill requires a licensed certified professional midwife to obtain informed consent of each client before providing service. A midwife must provide a community birth disclosure to all clients. Currently, only certain licensed practitioners who are registered with the State Board of Pharmacy may prescribe drugs and devices. Sections 25, 40, 41, and 74 of the bill authorize a licensed certified professional midwife to order, possess, and administer certain drugs, devices, chemicals, and solutions, and order certain devices and vaccines for a client. Similarly, sections 21, 23, and 79 authorize a certified professional midwife, birth assistant, or certified professional student midwife under the direction and supervision of a licensed certified professional midwife to administer certain drugs, devices, and chemical solutions. Additionally, a student midwife may administer or implant a contraceptive device under the supervision of a preceptor who holds an appropriate special endorsement. Sections 26, 40, and 78 authorize a licensed certified professional midwife to apply to the Board for special endorsement for his or her license to order, dispense, and implant contraceptive devices or possessions, and administer, prescribe, or possess certain dangerous drugs.

Section 27 of the bill imposes specific requirements concerning the management of a client who is at a moderate or high risk of an adverse outcome. Section 105 reverses some of those requirements on the effective date of the regulation adopted by the Board. Section 27 also exempts (1) a licensed certified professional midwife from liability resulting from the informed refusal to consent of such a client to consultation; co-management with a referral to another health care provider; transfer to a medical facility; or the inability of such a midwife to arrange for such consultation or carry out such co-management referral or transfer, and (2) other health care providers for liability for the actions or omissions of such a midwife. Section 28 requires a licensed certified professional midwife to annually report certain information concerning his or her practice to the Division when he or she renews his or her license. Section 30 of the bill requires the Division to maintain records of proceedings relating to licensing, disciplinary actions, and investigations, and declares certain records

must be confidential and other records to be available to the public. Section 31 prohibits a person who does not hold a license from representing that he or she is licensed to engage in the practice of certified professional midwifery. However, a person who is licensed in another district, state, or territory of the United States may represent that he or she holds such a license.

Further, a certified professional midwife student is prohibited from engaging in midwifery in circumstances other than those authorized by this bill or representing that he or she is qualified to engage in the practice of certified professional midwifery without supervision. Section 32 of the bill authorizes the Division or the Attorney General to seek an injunction against any person violating the provisions related to the licensure and regulation of licensed certified professional midwives and student midwives. Section 37 requires a licensed certified professional midwife to report misconduct by a person licensed or certified by the State Board of Nursing to the executive director of the Board. Sections 48 and 49 of the bill provide that a licensed certified professional midwife is not liable for civil damages resulting from providing emergency care or gratuitous care to an indigent person under certain circumstances. Section 65 requires Medicaid to cover the services of a licensed certified professional midwife and provide reimbursement for such services at comparable rates to other health care providers for such services. Sections 70 and 71 require a licensed certified professional midwife who attends a birth that occurs outside of a hospital that is not also attended by a physician or advanced practice nurse to prepare a birth certificate and provides that a person who provides such false information of a birth certificate may be fined. Section 76 clarifies that a licensed certified professional midwife is included in the definition of "provider of health care" and therefore including him or her in requirements for billing standards, for advertisements, and criminal penalties for acquiring certain debts. Section 107 of the bill creates the collaboration and Transfer Guidelines Workgroup to make recommendations to the Board for the regulations governing transfer of such clients. [Exhibit G and Exhibit H were submitted but not discussed and are included as Exhibits for the meeting.]

Madam Chair, there are proposed amendments [Exhibit I] and you should have that amendment up on the Nevada Electronic Legislative Information System, but I will walk you through the amendments if you would like.

Chair Marzola:
If you can, walk us through the amendment.

Assemblywoman Monroe-Moreno:
The amendment adds two co-sponsors, Assemblywoman Summers-Armstrong and Assemblywoman Thomas. In section 17, subsection 2(e), it changes "voting member" of a social worker to a "non-voting member." It deletes section 20, subsection 1(a) and replaces that section with "Completion of an education program that is consistent with United States educational accreditation standards and the United States Midwifery education, regulation and association statement on licensure of Certified Professional Midwives." In section 26, subsection 2, "An application for the issuance or renewal of a special endorsement" has been

changed from $1,000 to $500. In section 81, subsection 4(b), it clarifies that term applies only to licensed certified professional midwifery, not a Midwife as defined by NRS 442.003. It deletes section 105 in its entirety.

That is the amendment as a whole. I have learned a lot in this process, working with the Department of Health and Human Services, who could not be here tonight but are at a good place with the policy and are neutral on the policy itself. We are working with the Nevada Justice Association (NJA). There is a provision in the bill for liability insurance, and we have heard time and time again before this body that doctors are having a hard time getting malpractice and liability insurance, and there is absolutely no way midwives, with their scope of care and the small risk pool they have, could afford the liability insurance that is required by our medical professionals. So NJA and I are working with what that amount should be, but it needs to be something that is commensurate with the job they actually do, and it would be required for those who receive the license. I truly believe in this four-year process that we have gone through on this. Licensing certified midwives is crucial for ensuring that birthing persons and their babies receive safe, high-quality care during childbirth. Certified professional midwives undergo rigorous education and are held to a standard of professional accountability. Requiring uncertified midwives to disclose their status is just transparency. We can help to ensure that birthing persons are fully informed about the care options they are choosing.

The bill is not against uncertified midwives. The bill is simply for those midwives who choose to be certified and held at a higher accountability, asking for that licensure. The licensing option will provide a clear framework for the regulations and to ensure that these certified midwives who choose to be licensed are held to a standard of practice and accountability to help improve the overall quality of care provided by midwives and help promote public confidence in midwifery as a profession.

You will hear from some of the opposition when they come up that no one wanted to join me on this bill. If you were here last legislative session, it was an interesting process. I spent my career in law enforcement. I never had an inmate put a hit on me. I never had an inmate threaten my life, and I worked with some of the worst of the worst the community has to offer. But last legislative session, my husband called me while I was here and asked me what was going on. I asked him what he meant. He said the police are at the door, and I asked him what is going on? He said, No, what is going on in Carson City, they are here because there has been a hit put on you. And I said, Yeah, I know, it is the midwife bill. I never in my life would have thought someone who brings life into the world would want to take mine out. It was not just threats to me. It was threats to the ladies who are sitting here with me. Therefore, this legislative session, I intentionally did not ask anyone to join me in sponsoring this bill because no one needs to take on that responsibility. This is a bill that I chose to bring. Two legislators have asked, even knowing the risk. They were here last session, and they knew the risk. I am happy to report we have not had any of that this session, but this bill did that.

We have had conversations with educational institutions about bringing the training that we are asking for in this bill to Nevada, and what we have heard, time and time again, in conversations with University of Nevada, Las Vegas and University of Nevada, Reno (UNR)—and specifically with UNR Cooperative Extension because they are in our rural communities—they say, We would like to do the training, but there is no licensure, so why have the expense of building a program? But there is no licensure for people to enroll, so we are doing the work. You will hear from some of the supporters that they are waiting for this bill to pass to bring the training to Nevada. With that, Madam Chair, we will stand for questions.

Chair Marzola:
Committee members, are there any questions?

Assemblyman O'Neill:
I have to say, this bill is a bit longer than that last simple bill we had. With that, I need some clarification, if you do not mind, because we are talking about—if I get it correctly—licensed in that there are unlicensed or non-licensed midwives operating in Nevada. In the bill, what protections are there for those who want the traditional, non-licensed midwives? Is there any protection that they can keep practicing, or will this force them over?

Assemblywoman Monroe-Moreno:
When I initially decided to run this bill in the last legislative session, I made a promise to our community midwives, the traditional midwives, that I would not ask for a mandate for every midwife in the state to be licensed. There are a group of people who do not agree with that, but as I said, women have been having babies since the beginning of time, and when you are due to have your baby, that baby is going to come. And if you are lucky, you have someone there to help you through that birthing process. Long before there were obstetricians and gynecologists, there were midwives. I did not want to take that away, because that is a profession. However, in the state of Nevada, there was a mom who came to me who thought she hired a midwife who was licensed by the state, and she gave birth and lost her baby. She then sought out a remedy and found that the midwife she hired was not licensed because the state of Nevada does not have a license in the state. I do not know if that midwife was a certified midwife or not, but I believe that case is still in litigation.

I believe, as women, we have a choice in how we bring our babies into the world. I brought my children to the world in the hospital, but my oldest daughter—she did not. She decided to use a midwife and have a baby in a pool in her living room and I thought she was nuts. That was my very first session. When she went into labor, I was told by the Speaker that families come first, and you have to go. I drove over the hill to be with her. She had her midwife, there was a student midwife, there was a nurse who was in training to be a midwife, her best friend, a photographer, and me, all there for her. It was an amazing experience that, looking back on, I wish I would have had. That little "session baby" came out with spirit fingers. The midwife did her weight, took all of her birthing charts—but she was a licensed certified professional midwife in the state of California who had transfer authority. She had my daughter enroll at the hospital so if something were to happen, she could transfer her

over. When she went into labor, they informed the hospital that there was nothing bad that happened. It was an amazing thing that she went through. I do not want to take options away for birthing families at all. That is why this is simply for those who choose to be licensed.

Assemblyman O'Neill:
Is that stated in the bill in any place—that this is purely optional for those that care to—so the nonlicensed can keep practicing? I recall that being one of the big issues we had last session.

Assemblywoman Monroe-Moreno:
Yes, it is. The Legal Division could probably direct us to exactly where it is.

Sam Quast, Committee Counsel:
It is not explicit in the bill that you do not have to get this license. However, the provisions of the bill do not prohibit anyone from acting as a midwife unless they get this license. It is clear from the provisions of the bill as drafted that the provisions of the bill set forth the process by which a person may obtain this license. But there is nothing that prohibits a person from acting as a midwife without this license.

Assemblywoman Backus:
Hearing your story about your daughter made me think of my two friends, both in California, who had licensed midwives and both, unfortunately, had to go to the hospital to have their births due to two different complications. I thought—and maybe the Legal Division can chime in here—if you were unlicensed that there was a disclosure you may have to make, and I could not get my finger on it, and I did not know that would help my colleague, but that was a requirement and I thought that was something I liked about this bill, is that people could continue to practice but if they do that, there would have to be full disclosure to their patients. Maybe I can lean on the Legal Division. It was a pretty big bill and I read it a while ago.

Assemblywoman Monroe-Moreno:
That is part of the bill—that there would be a disclosure form to be filled out so the client would know exactly whom they were hiring. That is to protect the client and the midwife.

Tiffany Hoffman:
That disclosure would be for all midwives, not just unlicensed or uncertified midwives.

Chair Marzola:
Are there any additional questions? [There were none.] I have a couple; they are probably more for clarification. Nothing in this bill is mandatory, correct? As far as, are you mandating for the certified midwives to now be licensed?

Assemblywoman Monroe-Moreno:
The licensing is optional—it is for those who choose to be held at a higher standard and by doing that, would have other resources available to them to work in their profession that other unlicensed certified professional midwives would not have in our state.

Chair Marzola:
Right now, if you are only certified—and things happen along the way—is there a way that we are tracking that?

Tiffany Hoffman:
There is no way to track that, and there is no recourse for families—like the story the Assemblywoman shared—there is no recourse for families in that case. In many cases, it would protect midwives from criminal prosecution because there is a path and a process in place.

Chair Marzola:
There are 36 states that have regulated midwives, correct? Are we the only state on the western side that is not regulated?

Amanda Macdonald:
Yes, we are the only state on the western side of the country that has no regulation. There are those on that map, that you can see [refers to Exhibit F], that are either working on it or have a current bill. There are only three states in the entire country who are not doing anything about licensure right now.

Assemblyman O'Neill:
With the limited number of midwives we have here in the state, and since it is optional to join, is the licensing board—would it be sustainable, or what would the fees have to be to sustain that board for review and to handle the complaints, et cetera?

Assemblywoman Monroe-Moreno:
My conversations with the Department of Health and Human Services are that it would be sustainable.

Chair Marzola:
Are there any additional questions? [There were none.] We will move to testimony in support of Assembly Bill 386. I want to remind everyone that we are going to do 30 minutes of support testimony, 30 minutes of opposition testimony, and 30 minutes of neutral testimony. You have two minutes each. With that, is there anyone wishing to testify in support of Assembly Bill 386?

Andrea Thompson, Private Citizen, Reno, Nevada:
I am here in support of A.B. 386. I am a dual-certified family nurse practitioner and psychiatric nurse practitioner currently practicing in Nevada. I also focus on reproductive psychiatry and am probably one of the only ones certified in the state through Postpartum

Support International. Those sad stories that you hear then get referred to me when the mother's mental health is not well. I am also a mom of three and someone who also chose home birth as an option in Nevada when I moved here several years ago, and also hospital transfer because I am a nurse at heart and we have tough stories.

It is important to me that home birth is accessible here. It is also important to me that we have safety in mind. In states and communities where home birth is very successful, it is in areas where there are very good transfer options. It is in areas where there is good collaborative care between hospital providers, whether it is a medical doctor, nurse, midwife, or nurses, and those who are providing home birth care in this area. That is something we really lack here. As someone who hospital-transferred, it can be very difficult when you have basically been hiding from an obstetrician that you have been planning a home birth. If we had a licensure for these providers in the midwifery community who are providing community home births, these physicians and nurse practitioners would be more willing to collaborate care for transfer, whether that was during pregnancy or also during labor and delivery. It is important that we extend access.

As a nurse practitioner, I want to see Nevada move forward. We have to continue to push things like this in order to move our state forward for Nevadans, and not only keep providers here, but get better access to care and also improve outcomes. Our maternal mortality rate could certainly use improvement, and so could our infant mortality rate. I hope that you will keep patient safety in mind, as well as accountability. If you are thinking to yourself, I wish I could go to a physician or nurse practitioner who was not licensed, I think you should think about this particular bill as well as wanting to have a licensed provider.

Melissa Mayfield, Private Citizen, Fernley, Nevada:
I am a Washington-licensed midwife. I recently relocated to Nevada in November. I am a two-time home birth mother as well. I completed my training and practice in Washington State before relocating here. Licensed midwives are trained to carry and administer the lifesaving medications we have been discussing. We are also rigorously tested on the knowledge and use of them for the licensure process. As practicing providers, we are best suited for lobbying to establish, maintain, or widen our scope of practice to benefit the families we serve. It is my belief, through my experiences working within licensure parameters in Washington State and from the large-scale study conducted with the community birth data from there, that licensure as well as being well-integrated into the health care system maximizes the safety of community births. Through mutually collaborative relationships with higher-level providers, we are able to efficiently and responsibly refer for elevated care when the need arises because we are seen as legitimate practicing providers. This ease of collaboration increases not only the safety of birthing people and their babies, but also lowers the stress related to obtaining these sometimes-necessary pregnancy and postpartum services, thereby increasing satisfaction levels when their course of care becomes more complex. This is important because the emotional well-being of birthing families matters as much as their physical well-being during such a sacred time in their lives. I am not currently practicing in Nevada but am proud to be a licensed midwife and would enjoy doing so under the licensure that is being heard today.

A'Esha Goins, Vice President, Las Vegas Branch, National Association for the Advancement of Colored People:
As a mother, we know that Black women experience disproportionately high rates of maternal mortality and morbidity. A new study shows that Black and Brown birthing parents and families are dying in larger numbers since the 1970s. Certified midwives who are trained to provide culturally appropriate care and to address the unique needs of Black women can help to mitigate these disparities and improve health outcomes. I want to thank Assemblywoman Monroe-Moreno and also the presenters because I appreciate the proposed bill and how it recognizes that not all midwives have to be licensed—that they may choose, and therefore it does not require for licensed midwives. This approach strikes a balance between ensuring quality care for women and representing the choices of midwives who may not wish to obtain a license, also while sustaining autonomy for those birthing parents and families. Additionally, the use of the disclosure for all midwives will promote transparency and informed decision making among birth parents and families. This will help ensure that all parents have access to the information they need to make informed decisions about their care and to midwives who align with their values and preferences. In conclusion, I strongly urge you to support this bill, which seeks to allow licensure and also the disclosure of all midwives.

Cassie Franco, Private Citizen, Las Vegas, Nevada:
I am a certified professional midwife practicing in Las Vegas. I am also a licensed midwife in the state of Arizona. I support A.B. 386. I think the presenters did an excellent job of showing how it can benefit families here in Nevada. One of the points I feel strongly about is the disclosure. I am also a home birth mom. Two of my three kids were born at home here in Las Vegas. While I love my midwife, I would have appreciated that disclosure at the time. I feel very strongly about opening up midwifery care to Medicaid. I think we can greatly expand service and access to people who need it.

Heather Areshenko, Private Citizen, Reno, Nevada:
I think giving birth should be and feel safe for someone like me. I have a chronic illness, so walking into a hospital facility is not a place where I ever feel safe. In my time there as a patient, it is a scary place to be. When I had my daughter, I received care from whom I believe was a provider who was inadequately prepared for normal variations of birth, which ultimately led to a cesarean section. The doctor who delivered my daughter was someone I met for the first time when I was in labor and delivery at the hospital. I was fully dilated with no medication or intervention thus far. I was not believed when I showed up and said I was having my baby that day because he said I was not in enough pain to be in labor. I had already labored at home in a comfortable environment, and pain only began when he came in the room, turned the lights on, made me lay down on my back, and started talking about me rather than to me. My child was breech. The doctor said since he was not trained to deliver a breech baby, even though he had over a decade of experience, that I would be having a cesarean.

Midwives are trained for those situations. They are trained to refer to a hospital when the need arises, and they are trained to recognize normal variations of birth and help women through that. I ended up with what I feel was an unnecessary surgical procedure, that according to a recent study I believe from 2019, increased my risk of severe complications by 50 to 80 percent, and most certainly impacted my mental and physical health negatively. The vast majority of births are not emergencies, but rather become emergencies due to the cascade of unnecessary interventions. There are often some women who are in the hospital and do not have access to a midwife. Our bodies and minds know what to do and how to birth, and when we are allowed to have a physiological birth in a quiet, calm environment, with support people whom we trust and who have helped educate us, it works. There are a billion people on earth who prove that. I was shocked to learn that in Nevada we are not licensed. [The Chair stops the testimony because of the time limit. Testifier concludes with closing remarks.]

Elizabeth Marrett, Private Citizen, Reno, Nevada:
I am in support of A.B. 386 for licensure for midwives. I had a home birth myself almost three years ago. I was so moved by the safe, high-quality care that my certified professional midwife provided me, that I am now currently a student midwife myself. I highly believe that every future birthing person in the state of Nevada deserves the safe and beautiful home birth that I was able to experience. My midwife's certification helped ensure that I was safe, my baby was safe, and that the professionals who were present were high caliber and aware of any and all possible outcomes. Personally, local midwife certification ensures I receive a higher standard of education of midwifery care so that I can continue to hold space for my future clients in their birth journeys. Lastly, the licensing would help current providers and my future self to build relationships with other health care providers in the community to better serve our clients if collaboration is necessary. In summary, I am in support of this bill.

Bron Roberts, Private Citizen, Reno, Nevada:
I am in strong support of this bill. In 2021, I birthed with a local CPM and did extensive research before choosing my provider. I chose this model of care for my birth because I felt the continuity of care was important to me. Unfortunately, I got a Bandl's ring. This is an extremely rare birth complication in which a restricting ring forms in the uterus. The baby becomes trapped by the ring and cannot descend. This is a condition that is extremely rare and cannot be predicted or tested for and does not have indications until late in labor. Bandl's ring is associated with infant mortality rates greater than 50 percent and requires a timely cesarean section. My midwife and her second were present through my laboring period, charting and monitoring me and my baby. We made the decision to transfer to the hospital, which we had planned for, and my daughter was safely born by cesarean section. I did not get the home birth experience that I desired. But most importantly, I felt that my midwife was informed in her assessment of my birth and had the appropriate education and training to guide my decision to transfer with informed consent. Although my transfer went well and the staff at Renown Health were as accommodating as possible, I can just imagine what a seamless experience it could be if there was greater integration, trust, and professional collaboration between midwives and other health care providers. I am now 37 weeks pregnant and planning a birth with the same midwife. I think my birth experience could have

been devastatingly different if I had a different midwife who did not follow the same practices. I did the research to find this incredible midwife, but I wish that everyone in our community could have that same access. Everyone should feel safe in choosing to birth with a midwife with the knowledge that there is transparency, accountability, and standards in place.

Juliamarie Mayes, Private Citizen, Las Vegas, Nevada:
I am testifying in support of A.B. 386, access to a licensed midwife. As a woman, mother of four, all of whom were delivered in Nevada, as well as a member of Women in the National Association for the Advancement of Colored People (WIN) for our local chapter, we are highly in favor of this bill. All birthing women, regardless of their socioeconomic status, should have the option of safe and healthy care from qualified midwives in Nevada, accomplished through disclosure, accountability, and higher professional standards, especially for the disparities we see in the quality of care women of color receive in both home and hospital births. It is still extremely disheartening to know that Black and Brown women are still subjected to unfair treatment and quality of care during some of the most delicate and vulnerable times of their lives, welcoming their children into the world. We hope the Committee sees fit to support this as well.

Andrea Koell, Private Citizen, Fernley, Nevada:
As a birth and labor doula and future birthing person, I support A.B. 386. The importance of having safe, healthy options for clients and birthing people cannot be understated. Having options for licensure for midwives is crucial in facilitating this.

Brenden Turner, Private Citizen:
I think the most logical thing stated about this is that it is allowing for the option of midwives to advance themselves in this community as opposed to tendering people's options. I think that whether somebody decides to give birth in a riverbed or in a hospital bed, people are going to choose to use their own autonomy as a free American however they see fit, and it is our responsibility to support and uphold our community and to make sure that people who choose to give birth at home have options and have access to professional care. We want to uphold a level of excellence here in our state of Nevada. We do not want to uphold a level of mediocrity. I think that is the most beautiful thing; we have everything to gain from this and nothing to lose, in my opinion. We should allow people the option for more.

Marina Barrett, Private Citizen, Reno, Nevada:
I am here to emphatically encourage you to support A.B. 386. I am mostly in support because of the safe options this bill provides the provider, the accountability, and the access to all in our community. You have heard birth stories from others and I have my own. I want to share that when you have a birth that goes bad, you do not wish it upon your enemy, and when you have it go well, it fills your heart in a way you want to share with everyone in the community. I think this bill is a way for our community to have more experiences like that, so I am in support of it.

Kanani Espinoza, representing Nevada State College:
Nevada State College graduated 47 percent of all bachelor's nurses from the Nevada System of Higher Education last year. Nevada State College supports safe and accessible health care for Nevadans. We thank the bill sponsor for bringing this legislation forward and support the passage of A.B. 386.

Kiley Lester, Private Citizen, Reno, Nevada:
I am a doctor of physical therapy and a board-certified pelvic floor specialist. The vast majority of my caseload is birth preparation and postpartum rehabilitation. I listen to birth stories every day, and over the years can report that very few patients who utilize midwifery care know that we currently do not even have licensure and are shocked and disappointed at this information. Thorough, informed consent is crucial, and I believe people deserve to know their options and the training of all their providers. In addition to my professional, hearty support of A.B. 386, I personally also chose to deliver both of my children at home with the support of two licensed California midwives who kept me safe and provided exceptional care. I would absolutely love that for the rest of our community.

Kate Woeber, Director, Midwifery Program, University of Nevada, Las Vegas:
I am a certified nurse-midwife and director for the University of Nevada, Las Vegas (UNLV) new nurse-midwifery program. I am excited to say that we received our preaccreditation today. University of Nevada, Las Vegas is in support of CPM licensure for at least four reasons. The first is the National Association of CPM supports CPM licensure. It says that licensure is key to making community-based midwifery more widely accessible, more integrated, and more accountable. Second, the better midwifery is integrated into the system, the more flexible the system is, and the more prepared Nevada will be for future shifts toward community birth that may be related to pandemics or other emergencies. Third, a system where midwives are more integrated is a system in which there is structural support for greater equity and perinatal care. For instance, making Medicaid reimbursement available to CPMs makes their care more accessible for families using Medicaid to cover their care. Fourth, Nevada has a severe and growing shortage of maternity care providers, which you are already aware of. It has one of the lowest numbers of obstetricians per capita nationally. Resolving maternity care deserts and improving perinatal health outcomes requires an all-hands-on-deck approach that utilizes the expertise of all qualified team members. The western one-third of the country already has licensed CPMs. You saw the map where Nevada is an island surrounded by other states that have licensed CPMs. Those states are already making progress toward integration, making strides toward maternal child health outcomes. Nevada can do just as well as them. That is why UNLV supports A.B.386.

Chair Marzola:
Is there anyone else wishing to testify in support? [There was no one.]

[All items submitted but not discussed will become part of the record: Exhibit J, Exhibit K, Exhibit L, Exhibit M, Exhibit N, Exhibit O, Exhibit P, Exhibit Q, and Exhibit R.]

We will now move to testimony in opposition to Assembly Bill 386. Is there anyone wishing to testify in opposition?

Jeff Sohler, Private Citizen, Gardnerville, Nevada:
I oppose this bill. I am a professional firefighter and paramedic here in northern Nevada for almost ten years now. I have been in numerous births, near births, labor complications, and a myriad of other medical issues. I am a father of four home-birthed children and husband of one phenomenal licensed certified professional midwife for over ten years. Fourteen years ago, we used a midwife along with her students and assistants. As my wife and I became experienced professionals, we still relied on our midwife and other students and different assistants in our last birth, eight months ago. Here we are, four years later, trying to pass essentially the same bill, which is two out of the over fifty midwives in Nevada pushing the support of this bill, for the ones that it is going to be directly affecting are not here. In my profession, when there are such drastic changes wanting to be made by mere minority, it is usually due to their own lack of performance or abilities, but I cannot speak to their agenda. I only know that none of their colleagues are buying what they are trying to sell.

This bill will force many midwives out of work. The remaining midwives will lose the use of their students and assistants. By reducing the number of qualified midwives in Nevada, it will be putting more of a strain on an already strained 911 and hospital service that already has a barely sustainable growth rate. In rural Nevada, if there is a medical emergency with either the mother or newborn or both, this would restrict students' and assistants' abilities to perform potentially lifesaving interventions while waiting for EMS or a midwife to arrive—in some cases upwards of over an hour. Midwives, their students, and their assistants are trained in cardiopulmonary resuscitation and neonatal resuscitation. The training provides the knowledge to perform resuscitation on a newborn baby. This class is not mandated in most, if any, fire departments and EMS agencies in Nevada as a special skill set with different algorithms, techniques, and supplies. Most agencies do not even carry the correct supplies for neonatal resuscitation. This bill would keep that person who is trained, has the knowledge, skills, and abilities to perform such interventions outside the home, by law, just because they are a student or assistant. Emergency medical services and fire departments would be used much more often if this bill passes, putting us into a specialized field that we know very little about.

Ben Ediss, Private Citizen, Carson City, Nevada:
I am a Nevada native, born and raised right here in Carson City, and I am the father to three amazing boys. All three of my boys were born at home under the care of midwives. Because of this, I have been asked by the opposition of this bill to speak to you today. At first, when I heard this bill was geared towards allowing the marginalized to have greater access to midwifery care, I could not fully understand why anybody would oppose it. I believe that all pregnant mothers should be under the care of a midwife so long as it is medically viable. However, after discussing this bill with those who are much more learned than I, I now stand in opposition precisely because this bill would have the reverse effect it aims to accomplish. While in theory, midwifery would be available to those who qualify for it, it would also effectively push out those who do not—those like me and my wife. When my wife was

pregnant with our youngest, we were going through some of the hardest financial times that we have ever had. At the time, we did not know how we were going to afford the prenatal and birth care of our coming child. That was until we discovered that someone within our community had donated the money to cover those costs. Community is the true heart behind midwifery. If this bill passes, it will remove the ability for midwives to work directly with their communities. Let me be clear: I am for the safety of babies and their mothers. However, after hearing everything this bill is trying to accomplish, it sounds as though midwifery would become just another regulated program in which state subsidy would act as a middleman to those like me who live in rural areas. It would crush small midwifery businesses all over the state of Nevada and alienate the small communities that make this state great. As a man who loves and fights for Nevada, I ask that you join me in that fight and protect our small rural communities. Do not take something our community cherishes and make it another government program.

Rafael Arroyo, Private Citizen:
I am here as a father of three children, and the first one we tried to have at home. After a 22-hour labor, we had to transfer to a hospital. He was born via cesarean section. The next two we were able to have at home with a traditional midwife. She was not licensed. She had about 35 years of experience and thousands of births under her belt, most of them in Las Vegas. I want to say that I think Assemblywoman Monroe-Moreno is trying to do a good thing here. I have spoken with her personally. I know her intentions are good with the bill. There are a lot of good things in the bill, like giving CPMs access to medicine if they want it and doing birth centers. I think those are good things for the people who want to exercise those options. My niece recently had a baby at the birth center in Las Vegas and had a great experience. However, I think there are a lot of detailed issues in the bill that are hard to translate. In a presentation like this, there is very precise language, and the midwives and the people in the community who are reading this stuff and are looking at it are finding some issues and some concerns, and they have communicated those to me. That is why I am in opposition. It is not because of the intention of the bill. I think there are a lot of good things and a lot of good stats, and I do support birth centers and home births, but I want to make sure the legislators understand what they are actually passing and that they do understand the detailed language. I do not want to have parents or midwives be criminalized because they are unlicensed, and that is something that has happened in other states where licensure begins and then there is a slippery slope to, basically, midwives being eliminated. I think that is the concern.

Lenny Sue Tinseth, representing Nevada Midwives Association; and Great Basin Midwives:
[Exhibit S] I am a licensed midwife. I am also a certified professional midwife. I hold a Bridge certificate with North American Registry of Midwives, our organization, and I am a certified health coach. I have been practicing for 37 years in northern Nevada. I represent the Great Basin Midwives and the Nevada Midwives Association. This bill is opposed by the 20 midwives in Nevada Midwives Association and supported by only a handful, as we

understand it. This bill is poorly written and leads to contradictions concerning licensure requirements, educational routes, regulatory board fulfillment, status of students, and requirements for malpractice concerns, to mention just a few.

I would like to focus on the regulatory board which requires, as I understand it, three types of medical professionals and four licensed midwives. Boards where there are professions regulating another profession are not successful. I am licensed in the state of California and served families as well. The California Licensed Midwifery Practice Act of 1993 established a more medicalized board, as proposed in A.B. 386. It was a dysfunctional board, as midwives and the medical representatives were at odds when establishing regulations for midwifery. Licensure did not make a better working relationship between obstetricians and midwives in the state of California. After licensure was established, an experienced midwife was brought up on charges in California. Alison Osborn was exonerated and the judge's final statement was that obstetrician medical standards and midwifery medical model of care were like apples and oranges. They cannot be compared, they cannot be judged, or regulate each other.

California remediated the problem by dismantling the existing board and creating a midwifery board that consists of licensed midwives and citizens. There is a seat for an obstetrician, but it is presently empty. California has no midwifery educational programs. There was only one seat needed to be filled by a licensed professional that practices in the state who works in maternity and/or child services. [The Chair stops the testimony because of the time limit. Testifier concludes with closing remarks.]

Brian Abbott, Private Citizen, Gardnerville, Nevada:
I am the father of four boys. Our first was born in the hospital and the next three were all born at home with a midwife here in Nevada. I have a lot of problems with this bill. I do not think I can go over them all in two minutes. To me, the biggest part here is that we have heard a lot about this being an option—only an option. We have seen in lots of industries where, once a regulatory board is established, that board essentially continues to pass more and more regulation and push for registration and things that eventually edge out any competition. Even though today, as the bill stands, it would be optional, I feel strongly that in a year or five years or ten years, it would no longer be optional. As you just pointed out, often having a board of professionals who do not actually represent the people who they are regulating and are not accountable to the industry they are regulating or to the community in any way results in bad outcomes. That is the opposite of what we want to achieve.

I would also like to question why the bill requires midwives to seek a single specific type of certification to become licensed, when there are multiple different groups within the United States that certify midwives. Why are we standardizing on a single one of those? If this is totally optional and in support of community midwives, why do we not have the ability for the traditional midwives to become licensed through here? My fear would be that the cost—the associated schooling costs and the additional cost of licensure—is going to squeeze those

midwives out, which is going to harm both the small businesses that they run today, and also the access to that care in the communities they serve today. I do not think we need regulation for this at all.

Tara Abbott, Private Citizen, Gardnerville, Nevada:
I oppose this bill. As a student midwife, I was going through apprenticeship to become a traditional midwife. Because of some injuries that happened to me, I had to put that away for a little while, but I would love to become a midwife again. I have started picking up going to births. I am assisting right now, and because of that, I am required to do some specific training and be certified in different things and trained in special ways. As Mr. Abbott said, if we call 911 because we get to the birth before the midwife and something happens to the baby and the baby is born in the home alone with the parents, we have the person who is certified sitting outside waiting and unable to come in and help save the baby. It will limit my abilities with certifications that I do have and can use in my capability. The biggest thing is it will limit my ability to become a midwife because of the cost of schooling; I am raising four boys at home, I homeschool. It is going to really limit me in my availability to be able to become a midwife because of the type of training that I will have to go through. I am opposed.

Rebecca Wells, representing Nevada Midwives Association:
I have been a midwife in southern Nevada since 2010. There is overwhelming opposition to this bill within the industry of midwives. I am here to represent the Nevada Midwives Association (NMA) and the midwives who have spoken out against this bill and signed the following letter.

[Ms. Wells read from prepared text Exhibit T.]

> To whom it may concern: Nevada Midwives Association is an organization of midwives in Nevada that has been in existence since 1984. We are opposed to the licensure bill, A.B. 386, that has been proposed this session. The association behind this bill, the Nevada chapter of the National Association of Certified Professional Midwives, has limited membership and does not represent the industry as a whole. Only two practicing Nevada midwives have shown public support for the bill and they are the authors of this bill.

Side note, this was written before today's hearing and we have heard from a couple of more midwives, but that is how this letter was written.

> We have carefully been watching the surrounding states as they have adopted licensure for midwives and in every case, choice is removed from the women giving birth there. Nevada remains a free and legal state for practicing autonomous midwifery, is the last in the western U.S., and is often a haven for women who travel from other states to have their babies here in Nevada with our midwives. We provide accountability and peer review through our

> association and have since 1984. Our clients are overwhelmingly happy with our services and are appreciative of the freedom that they have to choose where and with whom to deliver their babies. We believe that freedom in childbirth is a human right and that women must retain autonomy over their bodies during the birth process. Placing midwives under a board not of their peers will remove this autonomy from women and is a major reason we are opposed to this bill.

Midwifery and obstetrics are two different professions. It is inappropriate to place on the board of one profession someone of another profession. Midwives should be governed by other midwives only, and this is signed by 29 Nevada midwives, 12 of whom are CPMs. And I did attach this to the letter, so you can see that list [Exhibit T]. Since I have a bit more time, I want to mention that we do have recourse for families through NMA and that has functioned. Also, the disclosure form that has been talked about—midwives have no problem providing informed consent. We do that already. However, that disclosure form is being written by a board that has an obstetrician on it and does not have any traditional midwives on it, although the traditional midwives would be required by law to have their clients sign that paper. [The Chair stops the testimony because of the time limit. Testifier concludes with closing remarks.]

Faith Bosket, Private Citizen, Pahrump, Nevada:
I oppose the midwifery bill, A.B. 386. I am a Black mother and midwife in rural Nevada. I have had the joy of birthing seven of my eight children in the safe, respectful comfort of my home. I chose home birth because I did not like the way my obstetrician was treating me and ignoring my thoughts and questions. I loved the care of this licensed caregiver and hired a midwife. This obstetrician was later charged with harming a Black baby when he arrived at Sunrise Hospital, drunk. Home birth families know that "licensed" does not guarantee safety. All of my home births were assisted by trained, experienced midwives. These midwives continue to encourage the next generation of midwives, including myself. I attended the Black midwives conference in Alabama in May of last year. Alabama has only one new Black midwife. Before licensure, there were three hundred. Licensure eliminates access to prenatal care for Black mothers. Licensure also eliminates pathways for Black women to become midwives and serve their underserved communities. Black mothers and babies die at five times the rate of other women. Black women do not need or deserve limited access to midwifery care. There has never been an illegal midwife in Nevada. There has never been a barrier to hiring any type of midwife in Nevada. I was very thankful when this bill died last session, and I hope it fails to damage the future access and freedoms of my eight Black children and our community. My family and the community thank you for opposing A.B. 386. I would also like to say, in rural Nevada, midwifery care is the only option for care.

Camila Santiago, Private Citizen:
[Exhibit U and Exhibit V] I am a Latina immigrant from Brazil, home birth mother of three daughters, and certified professional midwife with a Bridge certificate. I am also a committee member of Nevada Midwives Association, and a North American Registry of

Midwives Complaint Review board member for Nevada. The amended educational requirements in this bill raise many concerns. As a first-generation immigrant who did not come from a financially privileged position, the required education means being obligated to attend two or three years' worth of prerequisites because my overseas education is not valid here. Schools are expensive. Some programs can cost nearly $50,000. Very few provide financial assistance or scholarships. I personally have never qualified for any sort of financial assistance since I set foot in this country. This education would be an out-of-pocket cost for me and the great majority of midwives in the state. These school credits are not transferable. If I wish to advance my career to pursue nursing or medical school, for example, I would have to start from scratch. The CPM credential process is already extensive and not free, not to mention, the cost of books, gas, childcare, continuing education, and two years of unpaid apprenticeship at a minimum. Certified professional midwives with or without Midwifery Education Accreditation Council (MEAC) education take the same exam. The CPM process is a professional pathway that already keeps CPMs proficient and accountable. This requirement is a direct conflict of interest with the authors of the bill, who happen to be the only two midwives along with the new transplant to the state that have MEAC schooling in Nevada. I am aware of exceptions on a case-by-case basis. However, being obligated to plead to a board to open an exception because a midwife is part of a minority—how is that inclusive to all CPMs? I really wish I could obtain a degree from a MEAC school—do not get me wrong—but this being a requirement—[The Chair stops the testimony because of the time limit. Testifier concludes with closing remarks.]

Tiffanie Gonzales, Private Citizen, Henderson, Nevada:
I am a certified professional midwife practicing in southern Nevada, and I have been practicing for ten years. I am opposed to this bill, A.B. 386. I am very familiar with the process to become a CPM, as I have personally gone through the process and am also a North American Registry of Midwives preceptor. North American Registry of Midwives has an outline for each person who chooses to go through that process. The MEAC accreditation in the bill that talks about making that mandatory is going to eliminate pathways for people to become a midwife. I oppose this bill because of that. I also oppose the part of the bill for us to be represented as only midwives on that board. There are no other boards where you can have a different profession governing you. I oppose this bill, and I am a CPM here in southern Nevada.

Cassia Lopez, Private Citizen:
I live in rural southern Nevada, and I am a home birth mother and birth photographer. I am here to oppose A.B. 386. There have been a few meetings where concerns of families and many midwives have been able to be heard. However, in our opinion, they have not really been considered. There are issues that leave families and midwives in strong opposition because there have not been any substantial changes towards our wishes. I am here to oppose this bill for all the reasons stated already, additionally, because it is not the answer to the issues we have around birth services in Nevada. I have had the privilege, as a birth photographer, to witness many midwives serving families. Most people only get to see the ones they personally hire. I have seen many Nevada midwives and obstetricians serving

families over the past seven years. Every one of them is different in their style of care. But every midwife I have seen in Nevada serves their clients with abundant respect, wisdom, understanding, and skill. I want to emphasize the skill. Not every birth I have photographed was typical. I have seen breech, twin, up to 45 weeks gestation, and many vaginal deliveries after a cesarean. Every one of these has allowed me to witness an informed woman in her power, supported by skillful women who they get to choose to be with them. I have also experienced this care with my own three births. If we are aiming for greater access to these services, we should consider making changes to current policy in regard to who can bill Medicaid, who can work in birth centers, and expanding the privileges of CNMs [certified nurse-midwives], instead of introducing more regulations to currently practicing midwives.

Chair Marzola:
Thank you for your testimony. We have to go to the phones now. Please turn in your written testimony and we will make it part of the record. [Exhibit W, Exhibit X, Exhibit Y, Exhibit Z, Exhibit AA, Exhibit BB, Exhibit CC, Exhibit DD, Exhibit EE, Exhibit FF, Exhibit GG, and Exhibit HH were submitted but not discussed and will become a part of the record.]

Laniqua McCloud, Private Citizen, Las Vegas, Nevada:
As a mother, a future grandmother, and a Black and African mother, I completely reject this bill in its entirety with the contradictory language in the bill. A bigger question is, If we already have the option for midwives who would like to be licensed, can have the option to be licensed, then why are we requiring a regulation to begin with? I want to tell you a quick story, because the first time I had the option to have full autonomy over my pregnancy, it was with my second child. With my first child, I had a very traumatic experience in the hospital, and I had the full responsibility to research and find the midwife who worked for me. I was able to do that, but it required me to be responsible and take on the ownership of finding the midwife who worked for my family. If it had not been for the diligence, skills, and experience that my midwife had, I would not be here to tell you this story today. I was completely safe with my midwife and the support that she gave me in all aspects. We have been practically begging the bill sponsor to stop trying to implement more control over birth choices when we all know that freedom of choice is what works. Being licensed as an individual does not mean that you are the best or that you are safe.

And the bigger question I have is, why are we not requiring obstetricians to provide informed consent if you want to require midwives to do that for their patients? Why are we not requiring obstetricians to do the same thing if you want to have a layout of all their education? We all know that simply a mandate will likely occur if you just make an amendment. We all know that. My hope is that it is not for this to be pushed so that later it can be mandated for those midwives who do not want to be licensed.

Sjana Wagner, Private Citizen, Reno, Nevada:
I have three main points that I have concerns with regarding this bill. The first is the cultural sensitivity and racial training for the renewals. As a mother of seven home-birthed children, I care more about the continuing education training of my midwife than I do about meeting

critical race theory bullet points. I have never heard, in all of my years, of there actually being an issue regarding differences in race and equality. That is one thing that is very concerning, that we are going to focus on that one point for renewal instead of the actual educational requirements for the midwife. My second concern is—in listening to this, the gentleman who made the question earlier about, Is it going to be required or not, and if it is explicitly stated in the bill, and reading the bill, I never got the impression that it was an optional licensure. It was written and I understood it as, this is going to be required. For you to come in and say, this is optional—there is confusion because some of the individuals who spoke in favor of this bill actually specified with emphasis, all midwives, licensure for all. My third point is the informed consent stipulation. I understand that, and the midwives that I have experienced have all had that. In reading the bill, the third step is that the midwives are required to call 911 until they are relieved by a higher provider of care. [The Chair stops the testimony because of the time limit. Testifier concludes with closing remarks.]

Monica Breitenbach, Private Citizen, Fallon, Nevada:
I do oppose this bill. My reason for opposing is I would lose autonomy over my body and I would lose my freedom in birth. The reason I am stating that is within this bill, because of the way that I have had children—I am a mother of eight; three births, and eight early miscarriages at six weeks. My second pregnancy was an emergency cesarean section, and my most recent pregnancy was a breech presentation. I was delivering a baby at home with a trained midwife who knew what they were doing. I was not concerned for my safety. I was not concerned for the safety of my child. The midwife knew what they were doing. The midwives in northern rural Nevada, where I live, have already informed me that if this bill is to pass, they will no longer be able to practice midwifery, and I will be left with no options and no one to hire. It is important to note that these are women-owned, small businesses and we will be taking away from Nevada's economy and the businesses that women are running to support other women. I do oppose this bill as it removes my freedom.

Emily Barney, Executive Director, Cofounder, Doula Co-op of Reno:
I am a birth, postpartum, and death doula, end-of-life planner in Reno; the executive director and cofounder for the Doula Co-op; and a member of the Doula Advisory Committee for the Nevada Certification Board. As a doula, reproductive justice advocate, and hopeful mother-to-be, I oppose A.B. 386 for several reasons. This bill is not an example of equitable maternal health care and should be opposed if women and birthing people will maintain autonomy in their decisions surrounding the birth of their babies and if midwifery will remain a safe and effective option for families in Nevada. Over 80 percent of midwives all across the state oppose this bill. You have heard from many of them; this includes nearly every type of practicing midwife in the industry: student midwives, midwives, assistants, CPMs, traditional and community midwives. You have heard from the families to birth advocates and the other people who needed to speak their stories and share their voice.

Under the current bill, the terminology and the language will restrict the actions and educational opportunities for midwives, as you heard. It will also prevent me from ever having the midwife who I have chosen to attend my birth. She is a traditional midwife, and she will not be able to practice midwifery. Her education will no longer be able to qualify

for the provisions under the bill. She will have to start midwifery school over again. She is a single mother, and that would be incredibly hard on her and her family to do in order for me to have the birth that I want in the future. I oppose this bill for my future self and people out there who want to have the midwife they choose support their birth. This bill will not allow that to happen. I oppose it and I hope you do too.

Samantha DeAndrea, Cofounder, Doula Co-op of Reno:
I am a mother; a doula in Reno, Nevada; and a cofounder of the Doula Co-op, a 501(c) nonprofit in Nevada. I graduated from midwifery school last year and hope to continue on to be a community midwife in Nevada. This bill may be intended to improve safety and outcomes for underserved communities in Nevada, yet with the current language, it will restrict families, their autonomy, and their choices. It will restrict access to midwifery care, especially for rural communities. It will restrict accessibility to becoming a midwife for students, which will reduce the number of midwives able to serve families. This bill will serve to eliminate the essence of the midwifery model of care by medicine and the state, which are separate entities and should be kept that way. I oppose this bill and I hope you do too.

Chair Marzola:
Is there anyone else wishing to testify in opposition? [There was no one.] We will move to testimony in neutral. Is there anyone wishing to testify in neutral?

Leslie Quinn, Private Citizen, Las Vegas, Nevada:
In regard to A.B. 386, I am a little confused because I can see both sides of the coin. The confusion is all the legislation that is out there trying to give women their bodily autonomy, and yet this does not give women their bodily autonomy.

Chair Marzola:
Ma'am, are you testifying in a neutral position?

Leslie Quinn:
I can see both sides of this bill. I can see the side that is being promoted, and I can see the side in opposition. What I am trying to say is, as a neutral person, I am confused as to why this bill is here, or why someone would support it versus why someone would not. I can understand both sides of the coin. The coin is with all the legislation out there that wants to give women their bodily autonomy, this is not. This bill is not doing that, and that is the confusing part. That is why I am standing like that. I also was somebody who was in line when you asked for more callers, so please oppose A.B. 386.

Chair Marzola:
We will move your testimony to the opposition. Is there anyone else wishing to testify in the neutral position to A.B. 386? [There was no one.] [Exhibit II was submitted but not discussed and will become part of the record.] Assemblywoman Monroe-Moreno, would you like to give some final remarks?

Assemblywoman Monroe-Moreno:
Thank you, Madam Chair and the Committee, for hearing this bill and hearing both the support and the opposition. You can hear the passion from both sides of this bill. This bill does not require anyone to be licensed, which means it would not criminalize anyone either, unless someone were to say they were licensed once we have a licensure and they are not, and that is how they hold themselves out. It does require a disclosure. That is to protect the midwife and the birthing parents—the birthing family, the birthing person—so they know who they are hiring. I cannot testify what has happened in other states with their legislation and what went on in the drafting of the legislation or the consequences that happened in other states. What I can say—and I cannot predict what will happen here—is my intentions with this bill from Day One were to make it optional. Believe me, after everything I went through, my family went through, and the midwives who presented with me went through last legislative session, I truly wanted to go back on my word, but I believe that you are nothing in this building if you are not a legislator of your word. I said that this would be optional, and that is the intent of this bill: to create a licensure for those midwives who want to have regulation and have access. It was stated in the opposition about the MEAC training. In the amendment, as stated during my presentation, that had been removed from the bill. With that, I will say thank you again for hearing this and thank you for staying late on a Monday night in a deadline week.

Chair Marzola:
Thank you, Assemblywoman. I want to remind everyone again, and I encourage everyone who did not get to testify, whether in support or opposition—I do not believe we had any neutral—to please submit your testimony in writing so that it can be part of the record. With that, I will close the hearing on Assembly Bill 386. I will now open up for public comment. [Public comment was heard.] Committee members, are there any comments before we adjourn? [There were none.] This concludes our meeting for today. Our next meeting will be Wednesday, April 12, at 1:30 p.m. This meeting is adjourned [at 8:59 p.m.].

RESPECTFULLY SUBMITTED:

_____
Elizabeth Lepe
Committee Secretary

APPROVED BY:

_____
Assemblywoman Elaine Marzola, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is the Work Session Document for Assembly Bill 334, presented by Marjorie Paslov-Thomas, Committee Policy Analyst.

Exhibit D is the Work Session Document for Assembly Bill 443, presented by Marjorie Paslov-Thomas, Committee Policy Analyst.

Exhibit E is written testimony presented by Shelbie Swartz, representing Battle Born Progress, in support of Assembly Bill 437.

Exhibit F is a copy of a PowerPoint presentation titled "Licensure for Certified Professional Midwives: AB386", submitted by Assemblywoman Daniele Monroe-Moreno, Assembly District No. 1, regarding Assembly Bill 386.

Exhibit G is a document titled "Additional Sources Informing Midwifery Policy," submitted by Assemblywoman Daniele Monroe-Moreno, Assembly District No. 1, regarding Assembly Bill 386.

Exhibit H is a document titled "Types of Midwives Providing Community Birth Services," submitted by Assemblywoman Daniele Monroe-Moreno, Assembly District No. 1, regarding Assembly Bill 386.

Exhibit I is a proposed conceptual amendment to Assembly Bill 386, dated April 10, 2023, submitted by Assemblywoman Daniele Monroe-Moreno, Assembly District No. 1.

Exhibit J is written testimony submitted by Shelbie Swartz, representing Battle Born Progress, in support of Assembly Bill 386.

Exhibit K is a letter dated April 5, 2023, signed and submitted by Tristan Lipschutz, Private Citizen, Reno, Nevada, in support of Assembly Bill 386.

Exhibit L is a letter dated April 4, 2023, signed and submitted by Amanda Koeckes, Private Citizen, Fallon, Nevada, in support of Assembly Bill 386.

Exhibit M is a letter dated April 4, 2023, signed and submitted by Roxanne Cunningham, Private Citizen, in support of Assembly Bill 386.

Exhibit N is a letter dated April 10, 2023, signed and submitted by Danielle Turner, Private Citizen, Reno, Nevada, in support of Assembly Bill 386.

Exhibit O is a letter signed and submitted by Ann Edgington, Private Citizen, Sparks, Nevada, in support of Assembly Bill 386.

Exhibit P is a letter dated April 9, 2023, signed and submitted by Denise Rubinfeld, Private Citizen, Reno, Nevada, in support of Assembly Bill 386.

Exhibit Q is a letter dated April 10, 2023, signed and submitted by Kiki Jordan, President, National Association of Certified Professional Midwives, in support of Assembly Bill 386.

Exhibit R is a letter signed and submitted by Charisse Babcock, Private Citizen, Reno, Nevada, in support of Assembly Bill 386.

Exhibit S is written testimony dated April 10, 2023, submitted by Lenny Sue Tinseth, representing Nevada Midwives Association; and Great Basin Midwives, in opposition to Assembly Bill 386.

Exhibit T is a letter dated April 3, 2023, submitted and presented by Rebecca Wells, representing Nevada Midwives Association, in opposition to Assembly Bill 386.

Exhibit U is written testimony dated April 10, 2023, submitted and presented by Camila Santiago, Private Citizen, in opposition to Assembly Bill 386.

Exhibit V is a letter dated April 3, 2023, signed and submitted by Camila Santiago, Private Citizen, in opposition to Assembly Bill 386.

Exhibit W is a letter submitted by Kathya Raebel, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 386.

Exhibit X is written testimony submitted by Dixie Story, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 386.

Exhibit Y is written testimony submitted by Rachael Reed, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 386.

Exhibit Z is written testimony dated April 10, 2023, submitted by Kristin Gray, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 386.

Exhibit AA is written testimony submitted by Amie Norris, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 386.

Exhibit BB is a letter signed and submitted by Diane M. Schaub, Private Citizen, Sparks, Nevada, in opposition to Assembly Bill 386.

Exhibit CC is written testimony dated April 10, 2023, submitted by Wiz Rouzard, Deputy State Director, and Ronnie Najarro, State Director, Americans For Prosperity Nevada, in opposition to Assembly Bill 386.

Exhibit DD is written testimony dated April 10, 2023, submitted by Marcia Skanes, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 386.

Exhibit EE is written testimony dated April 10, 2023, submitted by Frank Skanes, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 386.

Exhibit FF is written testimony submitted by Dorsey Hinkley, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 386.

Exhibit GG is written testimony submitted by Cassia Lopez, Private Citizen, in opposition to Assembly Bill 386.

Exhibit HH is a letter signed and submitted by Joshua Welch, Private Citizen, South Lake Tahoe, California, in opposition to Assembly Bill 386.

Exhibit II is written testimony submitted by Heather Areshenko, Private Citizen, Reno, Nevada, in neutral to Assembly Bill 386.