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

Eighty-Second Session
March 27, 2023

The Committee on Health and Human Services was called to order by Chair Sarah Peters at 1:33 p.m. on Monday, March 27, 2023, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda [Exhibit A], the Attendance Roster [Exhibit B], and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/82nd2023.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Sarah Peters, Chair
Assemblyman David Orentlicher, Vice Chair
Assemblywoman Cecelia González
Assemblywoman Michelle Gorelow
Assemblyman Ken Gray
Assemblyman Gregory T. Hafen II
Assemblyman Brian Hibbetts
Assemblyman Gregory Koenig
Assemblywoman Sabra Newby
Assemblyman Duy Nguyen
Assemblywoman Angie Taylor
Assemblywoman Clara Thomas

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblywoman Heidi Kasama, Assembly District No. 2
Senator James Ohrenschall, Senate District No. 21
Assemblyman Max Carter, Assembly District No. 12

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Eric Robbins, Committee Counsel
David Nauss, Committee Counsel
Terry Horgan, Committee Secretary
Ashley Torres, Committee Assistant

OTHERS PRESENT:

Naomi Lopez, Vice President, Healthcare Policy, Goldwater Institute
Peter Kasama, Private Citizen, Las Vegas, Nevada
Andrew M. Cohen, M.D., Radiation Oncologist, Comprehensive Cancer Centers
Helen O'Hanlan, Private Citizen, Las Vegas, Nevada
Annette Whittemore, President and CEO, Whittemore Peterson Institute
Beth McDougall, M.D., Chief Medical Officer, Immunacor
Joshua Smith, President, Immunacor
Wiz Rouzard, Deputy State Director, Americans for Prosperity
Eddie Diaz, Strategic Director, Libre Initiative
Christian Cardenas, Director, Grassroots Operations, Americans for Prosperity
Molly Marjie, Private Citizen, Las Vegas, Nevada
PJ Belanger, Private Citizen, Las Vegas, Nevada
Amari Ibarra, Private Citizen, Las Vegas, Nevada
Jesse Welsh, Private Citizen, Las Vegas, Nevada
William Graham Carter, Private Citizen, Las Vegas, Nevada
Karla Zelaya, Private Citizen, Las Vegas, Nevada
Rigoberto Soriana, Private Citizen, Las Vegas, Nevada
Jose Cortez, Private Citizen, Las Vegas, Nevada
Chelsea Capurro, representing Earth Funeral Group
Tom Harries, Chief Executive Officer, Earth Funeral Group
Isaac Hardy, representing Nevada Conservation League
Sarah Manns, representing Compassion and Choices
Vanessa Dunn, representing Nevada Public Health Association
John J. Piro, Chief Deputy Public Defender, Legislative Liaison, Clark County Public Defender's Office
Erica Roth, Government Affairs Liaison, Deputy Public Defender, Washoe County Public Defender's Office
Joan Hall, President, Nevada Rural Hospital Partners
Valerie Haskin, representing Rural Regional Behavioral Health Policy Board
Joanna Jacob, Manager, Government Affairs, Clark County
Sarah Adler, representing Vitality Unlimited; New Frontier Treatment Center; and FirstMed Health and Wellness

Chair Peters:
[Roll was called, and protocol was reviewed.] We will move on to our agenda. We have two Committee bills right now. We are waiting on two more. We will introduce these. If another one comes in while we are in Committee, we will introduce those. We are going to recess after Committee and then we will have bill introductions. We are going to start with these two bill introductions. A reminder that voting to introduce a bill does not bind you to that vote at all. It just allows us to introduce the bill on the floor. We will start with Bill Draft Request (BDR) 57-652, which revises provisions governing prescription drugs.

BDR 57-652—Revises provisions governing prescription drugs. (Later introduced as Assembly Bill 434.)

ASSEMBLYWOMAN GONZÁLEZ MOVED FOR COMMITTEE INTRODUCTION OF BILL DRAFT REQUEST 57-652.

ASSEMBLYWOMAN TAYLOR SECONDED THE MOTION.

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

Our second BDR is BDR 39-653 which revises provisions governing behavioral health.

BDR 39-653—Revises provisions governing behavioral health. (Later introduced as Assembly Bill 435.)

ASSEMBLYWOMAN TAYLOR MOVED FOR COMMITTEE INTRODUCTION OF BILL DRAFT REQUEST 39-653.

ASSEMBLYWOMAN GONZÁLEZ SECONDED THE MOTION.

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

Thank you so much. Those are going to get prepared to be introduced this afternoon. We are going to move into bill hearings. We are going to start with our first bill, Assembly Bill 188, which revises provisions governing investigational treatments. I would invite the bill sponsor to the table.

Assembly Bill 188: Revises provisions governing investigational treatments. (BDR 40-567)

Assemblywoman Heidi Kasama, Assembly District No. 2:
Thank you so much. Good afternoon, Chair and Committee members. It is my privilege to be here. I am here with my Senate colleague, Senator Ohrenschall, to present Assembly Bill 188, a critical expansion of the current Right to Try law.

This bill seeks to address the pressing issue faced by patients diagnosed with life-threatening diseases or conditions who have exhausted all approved treatment options and cannot participate in clinical trials. The Right to Try Act at both the federal and state level has long provided these patients with the opportunity to access investigational treatments. However, it is now time to evolve and adapt the law to the changing landscape of medical innovation. As we stand here today, advances in medical technology have led to the development of personalized treatments based on an individual's genetic information. These treatments are becoming increasingly vital for patients with rare and ultra-rare diseases who have been left with no other options.

Unfortunately, the current Food and Drug Administration (FDA) regulations are not well suited to handle these cutting-edge personalized treatments, often acting as a barrier to lifesaving medications patients desperately need. It is our responsibility to address these shortcomings and create a more flexible and patient-centric regulatory framework. Assembly Bill 188 represents a significant step in the right direction by building upon the success of existing right to try laws; this bill aims to foster an environment that gives access to the latest cutting-edge technologies, enabling patients to access therapies specially tailored to their genetics. Across the country, patients facing terminal illness have been able to access treatments that have undergone basic FDA safety evaluation, but have not yet been fully approved, all thanks to the right to try laws.

These laws have improved and save the lives of individuals suffering from illnesses such as cancer, amyotrophic lateral sclerosis (ALS), and now COVID-19. Medical innovation is rapidly outpacing regulations that were established decades ago for a very different era of medicine. The FDA's approval process was not designed with individual treatments in mind. As such, it can take an unacceptable amount of time for these lifesaving medications to reach patients.

In conclusion, as lawmakers we need to recognize and adapt to the ever-evolving landscape of medical treatments. By expanding the right to try laws through A.B. 188, we can ensure that patients in dire need have access to the most advanced personalized treatments available without being hindered by outdated regulations. Let us put patients first, allowing them the right to try and fight for their lives. I would now like to turn it over to my esteemed colleague, Senator Ohrenschall, to give remarks. Afterwards, Naomi Lopez, Vice President for Healthcare Policy at the Goldwater Institute, will give remarks and go through the bill.

Senator James Ohrenschall, Senate District No. 21:
Good afternoon, Chair Peters. It is a real honor to be here before the Assembly Health and Human Services Committee. I want to thank Assemblywoman Kasama for reaching out to me to cosponsor Assembly Bill 188. During the 2015 Session, I was approached by constituents who had relatives who were terminally ill, and many had to go out of state to try to get some of these investigational treatments. In 2015, we reached out to the Goldwater Institute and worked on what was Assembly Bill 164 of the 78th Session. That was a bipartisan effort to try to help some of our constituents facing these dire situations get these

treatments and these medications. Looking at Assembly Bill 188, I am so proud of what it does and what it will build upon in terms of opening opportunities for patients to get treatments that otherwise they might not be able to have.

If you look at the cost to travel out of state, for so many of our constituents, it becomes very prohibitive. This bill goes a long way to try to make sure that some of these therapies and treatments will be here in Nevada for our constituents. Thank you very much for hearing the bill, and I am proud to be a cosponsor.

Chair Peters:
Thank you, Senator Ohrenschall, for being here. It is a pleasure to have you in the People's House. We appreciate your being here. Please go ahead when you are ready, Ms. Lopez.

Naomi Lopez, Vice President, Healthcare Policy, Goldwater Institute:
Thank you for allowing me to offer my insights and expertise regarding Assembly Bill 188 as you consider this important issue—protecting the right to try to save one's own life without having to beg the federal government for permission to do so. The Goldwater Institute is a public policy research organization. We work through the courts, legislatures, and communities to defend and strengthen the freedom guaranteed to all Americans in the *Constitution of the United States* and the 50 state constitutions.

Reducing FDA red tape to allow patients access to potentially lifesaving treatments and allowing medical professionals to practice at the top of their education and training are important priorities in our organization's health care work. We are experiencing a medical revolution; new and promising treatments are being discovered almost daily. Some diseases that were death sentences merely one decade ago are now chronic conditions and, in some cases, have been cured. Treatments using a patient's own unique and personal genetic information, for example, are now a reality for some illnesses and very promising for many more.

Unfortunately, the current clinical evaluation system was created more than a half century ago, and it was intended to test treatments for large groups of populations. Would we want to seek treatment from a doctor whose most recent information was from the 1960s or who is still using 1960s technology to diagnose a serious illness? Of course not. Today, we know far more about illnesses and diseases and how to treat them, which is why we have taken a leading role in the right to try movement. Over that time, we are discovering diseases and illnesses can be very specific to individuals. For example, there is not one kind of breast cancer; there are hundreds. Just a few years ago, terminally ill patients were forced to endure the FDA's slow-moving approval process in order to access potentially lifesaving treatments. Today, patients have new hope and more options under the original Right to Try Law, which is now the law of the land.

Thanks to the work of citizens and state lawmakers, including in Nevada, Right to Try is now federal law and has opened new pathways for terminally ill patients to access treatments. Today, right to try is working; dying patients nationwide have been able to pursue—with

their doctor's recommendation and oversight—treatments that have passed basic safety evaluation but have not yet received full FDA approval. It has improved and saved the lives of people with illnesses like cancer, ALS, and now COVID-19.

Right to try for individualized treatments applies this principle to the latest medical treatments. This proposed law does not change or alter the original law in any way. What it does is create new pathways for those patients whose rare or ultra-rare diseases are unlikely to have enough patients for a clinical trial or enough commercial interests to pursue a trial.

It would have helped patients like Kira Riley. The Riley family has three daughters. Olivia was just a toddler when she started regressing neurologically and physically. They had her tested and discovered that she had metachromatic leukodystrophy (MLD), which is a very rare but devastating illness that affects the motor and neurological functions, usually of young children. Young children do not usually live past the age of five or six. Since they knew this was a genetic disease, they immediately tested their baby, Kira. Kira was just a few months old, and they discovered she had it too. There was no treatment; there was no cure, but there was something being trialed in Italy. During the height of the pandemic, the Riley family, who lived in the Phoenix area, raised half a million dollars and relocated their three children to Italy so Kira could try this gene therapy. I am happy to report that in January, Kira turned three years old. She is doing well, and she is thriving. She is climbing, and she is riding a bicycle. Sadly, her sister Olivia is now in hospice care. They had to go to Italy.

It does not have to be that way. United States lawmakers have the responsibility and authority to ensure safe pathways for patients like Kira Riley and many others. Similar to the Right to Try Law for individualized treatments, this will have important and trusted safeguards to protect patients who are pursuing treatments. First, the law will require patients to have considered approved treatment options. Second, the treatment will have to be recommended by a doctor who is in good standing with his or her licensing organization, and the doctor cannot be compensated directly by the manufacturer of a specific drug for prescribing it. Patients cannot be charged more than the direct cost of the treatments, but it certainly does not preclude insurance from paying for these treatments. Third, the patient will have to give written, informed consent regarding the risks associated with undergoing this investigational treatment. Fourth, the rules regulating these treatments and how these treatments are created and manufactured are governed by what is called the Federalwide Assurance. This is a set of laws, rules, and regulations that already govern, and have for decades, these types of facilities creating these treatments. Instead of trying to create a new regulatory scheme, we wanted to go with something that was already well known, has been tested, and would not require new effort rather than trying to test something that had not been done before.

I would like to briefly explain what the law does, section by section. The first section basically adds individualized investigational treatment to Nevada's current law. Section 2 describes that the patient has to be diagnosed with a life-threatening or severely debilitating disease which has to be attested to by their physician. It also waives liability, so a private

cause of action against the manufacturer of an investigational treatment or investigational drug or product or against any person involved in the care of the patient—so long as they are following the law and so long as they are acting in good faith—cannot be taken. This was the same kind of language that was used in the original Right to Try Law as well. Section 3 adds additional language regarding individualized, investigational treatments. Section 5 does something similar.

I would like to talk about what Federalwide Assurance is and what it means. A facility that is doing any work on human subjects, if it is taking any federal government money, has to abide by a comprehensive set of rules and regulations. Let us say for an example, a Nobel laureate physician or physicians want to create a treatment; they are not allowed to go into a Federalwide Assurance facility and make something. Just having Nobel Prizes does not give them that entrée into the facility. They have to go through that facility's institutional review board for approval to engage in activities within that facility. They also have to provide a treatment protocol. In other words, they explain what they will be doing with what they create. They have to be very explicit about what they are making in that facility.

The institutional review board also certifies that all of the patient consent requirements have been met. In this law, we also make sure the state has authority over the practice of medicine. We do not want to do anything that would undermine the state's authority to go after any bad actors. But what we do say in the law is that if a physician is abiding by the law, he or she cannot be disciplined solely for that. Of course, they can be disciplined if they are not acting according to the law or if they are doing something else. We want to be very clear there is nothing in this law which changes or undermines the authority the state already has as it relates to the practice of medicine.

I want to close by saying we are in divisive political times, but there is a way for lawmakers on both sides of the aisle to act in the best interests of patients. Doing what is right for patients has nothing to do with political party, and it has nothing to do with how you vote. This is about making sure your citizens have more opportunities to seek out the treatments their physicians believe might be able to help them. Thank you very much for your time, and I would be happy to answer any questions now or in the future.

Chair Peters:
Thank you so much for the presentation. Are there questions from the Committee?

Assemblyman Gray:
I am happy to sign on to this one. This is a good bill, and you both answered my questions. First question was going to be about other trials and if you know what effects might happen. The other was about the protocols. The question I do have, though, and that remains unanswered, is will they have to report to any higher authority or the institutional review board (IRB) or anybody about adverse reactions or positive outcomes? Will they have to report their results at some point?

Naomi Lopez:
In answer to your question about if the results will have to be reported, there will be a requirement at the federal level that the Department of Health and Human Services promulgate rules and regulations around the use of right to try for investigational treatments. We did the same thing for the original Right to Try Law. The final rules were just promulgated this past fall. Then as a matter of course, any adverse events must be reported to the FDA. This current proposal does not change federal law, nor could it. That is still a requirement.

Assemblywoman Newby:
I have a question about how it works on the ground level and what kinds of doctors we would see or what kinds of qualifications they might have. I mention this because it has been something I have been working on in my professional life, but also up here in terms of clinical trials and trying to get the biomedicine sector built up here in Nevada. My question is, in order to not have to travel to Italy, do we have to have doctors in the state who can be part of clinical trials and be certified to do whatever medical treatment it is that our citizens are seeking?

Naomi Lopez:
I am going to give you two different answers. The first answer is, any treatment that would be created or provided in Nevada would have to be approved by the institutional review board that governs that facility. Could you have a physician who was unqualified seek to make a treatment in the facility? Yes, absolutely. The institutional review board would reject the application. It would not proceed. We have many layers of protections in this law. Like I said, these rules have been around for decades and they work. We know they work. The same rules that would keep an unqualified doctor from creating a treatment last year would do so in the future.

Now to answer your next question: from what we have seen from the original Right to Try Law, a lot of innovations we did not necessarily expect or plan for have come about. Once you make the ground fertile, establish clear rules, and create pathways, you have innovators and physicians come into the space and create new programs around treatments for patients. I am optimistic that having a law like Right to Try for Individualized Treatments would garner the attention of manufacturers and companies, stimulating the establishment of new programs that are not in existence right now because the legal and regulatory environments are not friendly.

Senator Ohrenschall:
This bill will complement the teaching hospitals we now have in our state—in both parts of the state. I think about growing up here in Nevada, we had the medical school up here in the northern part of the state. We did not have a medical school down south. Now, the opportunities for a bill like this to help in our teaching hospitals are tremendous. When I was growing up in Nevada, many people, if they had a serious life-threatening illness, would try to travel to a center of excellence, whether it was to the coast or to the Midwest. Now, we

have some of these centers of excellence here, and a bill like this may help people struggling to find the right treatments to get them here.

Assemblyman Orentlicher:
Thank you, Chair, and thank you for your concern about access to investigational treatments. You are absolutely right. We need to make sure patients have access. I have some disquiet because there are lots of concerns about this pathway. I am sure you know the FDA allows expanded access for investigational treatments. According to one report, more than 99 percent of requests for access to investigational treatments are generally approved within a matter of hours or days. What is different about this is, yes, as you pointed out, there are institutional review board reviews, but there are no FDA reviews, which is part of the expanded access.

I have served on institutional review boards. They are important, but there is a lot of concern in the profession and among researchers that IRBs do not have the capacity to do the jobs you want them to do and that the FDA needs to be in the picture. I would appreciate more explanation of why you think it is a bad idea to have the FDA play a role in making sure that these drugs are safe before patients receive them.

Senator Ohrenschall:
My recollection from working on the bill in 2015 is the feeling was not that it was bad for the FDA to play its important role, but what I learned from constituents and from people I was working with was, even though there was the compassionate use exception that the FDA has and other ways that people could try to work through the FDA, many times we found it was not that fast. I am pleased to hear you saying things are quicker now. I know in 2015, the concern was not that the FDA did not have a role, but they moved so slowly that some of these treatments that could help our constituents were not made available to them.

Naomi Lopez:
I would like to point out that under the original Right to Try Law in Texas, before there was a federal right to try law, Dr. Ephraim Delpassand, who was head of Nuclear Medicine at the University of Texas MD Anderson Cancer Center at the time, was trialing a drug at his own clinic for neuroendocrine cancer. He had cleared the formal clinical trial process and was waiting for the FDA green light, which can take about two years after completion of the trial. He had patients lined up for compassionate use approval and the FDA told him he had to shut it down; they had enough data. Dr. Delpassand was ready, willing, and able to treat those patients. He used the Texas Right to Try Law to treat about 180 patients with neuroendocrine cancer. Some of those patients were flying to Germany for treatment. One of those patients was a veteran who mortgaged his house to fly to Germany to try to save his life. These are examples of how the FDA falls short in putting patients first.

I would also like to point out, and you may not remember, but U.S. Representative Steve King and House Speaker Nancy Pelosi sponsored a private bill for Jaci Hermstad. She was a twin with ALS [amyotrophic lateral sclerosis] and her sister had already died. They were trying to get an individualized treatment bespoke for Hermstad's ALS. The FDA said

no, so Representative King and House Speaker Pelosi introduced this private bill. That pressure forced the FDA to allow Hermstad to move forward with the treatment. It is these kinds of obstacles the FDA will not tell you about. That is the reason we need this type of law.

Two weeks ago at a nationwide conference, an FDA director basically said because the FDA did not have the capacity to do more Zoom calls, they could not rectify small problems in applications to move treatments forward into clinical trials in the first place. The capacity of the FDA is limited. There is also the principle of whether or not a federal regulator should get a veto stamp over whether or not you should get a treatment your doctor thinks might help you. That is why we are moving forward with right to try for individualized treatments.

Patients do not have time to wait on the FDA. As state lawmakers, you have the authority to move forward and create this pathway so your citizens do not run out of options; so they do not have to travel the globe; so they are not put in unnecessary danger seeking treatment from people who may not be working in their best interest.

Assemblywoman Taylor:
Thank you, Madam Chair, and thank you to our colleagues from the Assembly and the Senate, and thank you all so much for being here and for your work. You mentioned the State of Texas and looking at modeling around what they have done, is it predominant across other states that have this? I love how you call it the Right to Try Law. As a cancer survivor myself, if I needed experimental treatment, I would have wanted to be able to try. I certainly understand that. What does this look like in other states?

Naomi Lopez:
Thank you for your question. The original Right to Try Law was passed in 41 states including Nevada before it became federal law in 2018. The current right to try for individualized treatments, which does not affect the original law but simply creates a new pathway for individualized treatment, has been passed in Arizona. It is now law in Arizona, and we have introduced it in multiple other states that are now considering it.

Assemblywoman Taylor:
This individualization, which is clearly pointed out in the legislation, that is the newness going on across the country.

Chair Peters:
Are there other questions from the Committee? Ms. Lopez, would you briefly go over the criteria for patients as they are written in the bill? Please give us an idea for the legislative record of what kind of criteria a patient would have to meet and what the doctor's expectations of that patient would be prior to requesting this authority or being approved for the authority to do a trial treatment.

Naomi Lopez:
Under this current law, the patient has to be facing a life-threatening or severely debilitating illness as defined in federal law. We use that in order to create the state versions of the legislation. The patient has to have considered other FDA-approved treatment options as well as those treatment options that are in clinical evaluation. The physician has to be recommending specific treatment for that specific patient, and the doctor has to attest that the patient does in fact meet the criteria in terms of the seriousness of the illness. The patient has to also provide informed consent. There are several layers of protection of informed consent, which is at the state level, but also through the Federalwide Assurance. There are multiple layers. They have to also be informed of the risks for both the negative and positive outcomes as possibilities from the treatment.

Chair Peters:
We will begin with support testimony on Assembly Bill 188 at our physical locations and then move to the phones.

Peter Kasama, Private Citizen, Las Vegas, Nevada:
Thanks for this opportunity to speak about my own experience. Almost a year ago, in April of last year, I was diagnosed with stage four stomach cancer, and I have gone through chemotherapy treatments for a couple of months. Then my oncologist told me to see a surgeon. We went to a surgical center. I was getting very weak, and I could not drive myself. I had my buddy, Tony Cosentino, take me to the surgeon's office. She said after looking at the film, I had two dark spots on the liver outside of the stomach and my lymph nodes were getting darker. She said, We are not going to perform a surgery, you are too late. When I heard that, I asked, "What is ahead of me, then?" She said, "Enjoy your life and make arrangements with hospice." That was a death sentence for me.

I remember after the meeting, I got into the car and told Tony about it, and Tony said, "Peter, that really sucks." He and I cried in the car. We decided to seek some other possibilities. That is when we reached out to Comprehensive Cancer Centers. Dr. Rupesh Parikh changed my life. The first thing he said was, "Peter, we are going to incorporate immunotherapy along with the chemotherapies; is that okay?" I had no idea; of course I said, Yes, please do.

That really turned me around in a short period of time. Two or three months later, I was ordered to take the computerized axial tomography scan. When Dr. Parikh saw the picture, he said, "Wow, I cannot believe this." The darkness and the two dark spots on the liver had almost disappeared, and activities around the periphery of my tumor in my stomach, which was 6 x 8 in. with an almost inch thick tumor, the activities around the perimeter of the tumor had subsided. He was happy about the results and we continued the same treatment, a combination of chemo and immunotherapy for another couple of months.

Then, he ordered a positron-emission tomography scan. At that time, the two dark spots on my liver were totally gone, and the darkness of my lymph nodes was gone. He ordered the endoscopy, to stick a tube in my throat. I remember the day, and Dr. Ryan, who performed the endoscopy. I was coming out of the anesthesia and waking up a little bit. He was right in

my face and said, "Peter, that is only a 4-centimeter ulcer, which is not cancer." What does that mean? I am cancer free? About a week later, I met with the Dr. Parikh in his office and he said, "Peter, you are cancer free." It was an incredible turnaround in such a short period of time.

Thank you for this opportunity to talk about my own experience, which serves as a sort of real-case example of how this new technology saved my life, and I was able to hit a hole in one.

Chair Peters:
Thank you, Mr. Kasama, for sharing your story with us today. It is amazing what technology is doing in health care, and the more we can expand access to that health care, the better off our populations will be.

Andrew M. Cohen, M.D., Radiation Oncologist, Comprehensive Cancer Centers:
I am here to testify on behalf of Mr. Kasama's doctor and Helen O'Hanlan's doctor, Dr. Rupesh Parikh. Helen will be testifying next as a patient of his. Mr. Kasama's and Ms. O'Hanlan's cases illustrate situations that are very similar. They have been helped by lifesaving treatments that were individualized to them and would not normally have been offered elsewhere.

[Read from written testimony.] Dr. Parikh would say, I am here to speak in support of A.B. 188, which would allow and expand individualized investigational treatment for patients diagnosed with life-threatening or severely debilitating diseases. New advances in precision medicine are rapidly altering the way physicians diagnose and treat cancer. The availability of biomarker testing that factors in the patient's genomic and cellular profile can now allow us to truly customize these treatments in a way that was not previously possible. Based on a patient's genomic and cellular profile, we can now determine that a treatment for one specific cancer type may be effective in treating an entirely different cancer type, thereby giving a stage four cancer patient more options to fight the disease and preserve his or her life.

This was the case with Assemblywoman Kasama's husband, Peter. Helen O'Hanlan is also here to provide testimony, as I mentioned before. She had stage four granulosa cell tumors, a rare form of ovarian cancer. According to Dr. Parikh, when he first met Ms. O'Hanlan, she was out of curative treatment options and about to go into palliative care only. She had had multiple surgeries, and further surgery had been ruled out. She had tried standard chemotherapies which were ineffective and caused multiple toxicities. Based on Ms. O'Hanlan's tumor makeup, Dr. Parikh and radiation oncologist Dr. Dan Curtis determined her tumors would respond to a treatment called stereotactic radiation therapy with the CyberKnife, even though this type of targeted radiation treatment had not been used before on her specific cancer type. Extrapolating from other tumor types that have responded, they determined it could potentially work for the eight tumors that were debilitating her body at that time.

The problem was that the CyberKnife was not yet considered a proven treatment for Helen's type of cancer. After some convincing, Ms. O'Hanlan agreed to the CyberKnife procedure, and it worked miracles. To date, she has had three CyberKnife procedures which eliminated all her existing tumors, and there have been zero new tumors since then. In the past, she had a dozen surgeries, with the last one nearly killing her, before she came to Comprehensive Cancer Center. The doctors knew CyberKnife could be effective, as it had been for similar conditions. In addition to the CyberKnife, they also used a drug called letrozole, which was off-label and not considered standard in the treatment of the granulosa cell tumor.

Together with all their input, Dr. Parikh and Dr. Curtis went outside the normal protocols, and it apparently has paid off, as Ms. O'Hanlan is free of disease at this time. She is a great example of why it is important for a patient to have the right to try when faced with a stage four cancer diagnosis. In Nevada, we need to think outside the box and continue to advocate for measures and laws that allow us to do so. We all have a voice and can generate many more success stories just like Ms. O'Hanlan and Mr. Kasama.

Helen O'Hanlan, Private Citizen, Las Vegas, Nevada:
Good afternoon, Chair Peters and members of the Assembly Health and Human Services Committee. My name is Helen O'Hanlan, and I am a stage four cancer patient. I refused to accept "There is nothing else we can do to save you" as the answer. Thankfully, I am alive and thriving today. I moved back to Las Vegas in 2017, after I had endured seven recurrences of stage four granulosa cell tumor, a rare form of ovarian cancer. I had 12 surgeries to remove them and 3 different chemotherapies. I ran out of options in Chicago, so I moved back home to Las Vegas to be around family and friends, and to complete my life in my time here and die in peace.

When I came back to Las Vegas, I needed to reestablish care and was connected with Comprehensive Cancer Centers of Nevada. During a visit with Dr. Parikh, he urged me to discuss CyberKnife—a high energy X-ray machine that delivers targeted radiation beams that destroy tumor cells—with his colleague and radiation oncologist, Dr. Dan Curtis. Initially, I did not believe it would work. I wanted to appease the doctor and go along with the consult, even though I had been told there were no other treatment options. I had accepted my fate. Luckily for me, the other doctors were wrong, because I was able to try CyberKnife and it has proven effective for my cancer type. I never thought I would see my 50th birthday, and today I am 51.

I still have cancer. I will always be a cancer patient. I have to take maintenance therapies and monitor my situation closely. For the first time since I was diagnosed in 2007, I have zero tumors in my body. I want to thank the two doctors at Comprehensive for thinking outside the box and for saving my life. I am an example of why it is so important that we support a bill like A.B. 188.

Chair Peters:
Thank you for sharing your story today. I got chills when you were talking about what the Cancer Center is doing for patients. We would like to invite other folks to the table who would like to share their support of Assembly Bill 188.

Annette Whittemore, President and CEO, Whittemore Peterson Institute:
I am the cofounder and chief executive officer of the Whittemore Peterson Institute, a medical research institute located on the campus of the University of Nevada, Reno, which is dedicated to those impacted by myalgia encephalomyelitis or chronic fatigue syndrome, [MECFS] and similar postinfectious diseases.

Our daughter was bedridden and homebound for many years due to MECFS, a chronic, complex, and disabling disease. It took two years and costly trips to multiple specialists to receive a diagnosis. During her most severe periods of illness, she had to be carried to the bathroom, fed liquid nutrition, and even helped to raise her head. She had to be treated by an anesthesiologist for pain control. She became isolated from friends and other family members, and she could not attend school or engage in social activities.

Her illness became so severe at the age of 20 that her doctor suggested she receive two pacemakers, one for her heart and one for her stomach. Instead, she was able to receive an experimental drug that stimulated her own immune system to suppress the various viruses and pathogens that had become chronically activated. This was a clinical trial she was able to access because we live in Nevada, and there was one doctor here who had applied and was doing a clinical trial. There is only one other doctor in the United States who is also capable of giving this drug. Going off script a little bit, you can imagine what that is like for all the other people, for the millions who are suffering and do not have that option. Under this bill it would give other people the option to access this treatment without entering into a clinical trial or having to move to one state or another.

Although the drug was not a cure, it kept her hopeful and alive. Many others who have been refused access to medications take their own lives rather than live in darkened rooms to avoid the pain caused by light, starving for lack of food, isolated, and in constant pain. Without treatment, these individuals lose hope of ever getting well.

Tragically, people affected by MECFS are six to ten times more at risk of dying by suicide than the general population. Those we know of who are severely ill and without treatment options are not that rare and they are just the tip of the iceberg. A higher risk for suicide was found when a person has greater functional impairment, is homebound or bedbound, is physically isolated, is unable to work, and feels hopeless from lack of treatments. There are zero FDA-approved drugs for this disease. I support this bill because I believe if it is within our power, we should provide individuals a chance to improve their health and to live with hope for relief from their suffering by allowing them to try medications that show promise for treating their diseases. Thank you, Chairwoman, for your time and attention to this important matter. And thank you for the opportunity to appear before this Committee.

Beth McDougall, M.D., Chief Medical Officer, Immunacor:
It is an honor to be here. I have been practicing medicine for 25 years and I began dealing with the most complex medical disorders. In my career, I have seen so many people with chronic fatigue syndrome, and it is very disheartening to work with them because for some, their life is so small; it is limited to bed; they need help getting to the bathroom and with all activities of daily living, and they really cannot engage in life at all.

What we have spoken about primarily today are life-threatening illnesses. This is a life-debilitating illness that takes someone's life from them. So many times, over the years I have had to send people outside of the United States. Now in this era of precision medicine with immuno-fingerprint testing that we can do, as well as genomic testing, we can identify precisely an immunomodulatory agent alone or in combination with antivirals that could help them in their situations.

Oftentimes, those medications are not approved in the United States. Sometimes people have familial support and the resources and wherewithal to be able to fly somewhere else to get their treatments, but oftentimes they do not, because many of my chronic fatigue patients cannot work and have been disabled for so long that they long ago depleted all their financial resources. To be able to offer them therapies locally is really something I am passionate about.

Joshua Smith, President, Immunacor:
Thank you, Madam Chair and the entire Committee, for hearing the important details of this bill. We are living in a time of unprecedented medical innovations. One of the most exciting areas of development is personalized medicine. Thanks to new technologies, it is now possible to take an individual's genetic sequence and information and create a treatment tailored specifically for them. New technologies are bringing down the costs every year. For example, a patient's gene sequence 20 years ago was $50,000, 10 years ago it was $10,000, and today, the cost is $600. This is fantastic news for patients, especially those with rare and ultra-rare diseases who have exhausted all other treatment options.

However, today the FDA clinical trial system is designed for treatments on large populations and does not have an approval criterion in place to handle the treatment developed for an individual patient. I emphasize, the FDA does in fact approve most right to try for new drugs that are in clinical trials. But it is not possible for the FDA to put a drug made for an individual into its clinical trial scheme.

For example, a therapeutic cancer vaccine can be designed based on unique genetic mutations of an individual's tumor cell. This treatment only works for that patient and no one else. The FDA's clinical trial system cannot handle this singular type of treatment. We must provide additional pathways that work in tandem with federal law and protections for patients to allow these personalized treatments to be accessible to those who need them. We must allow a more streamlined, patient-centered process that ensures safety and efficacy while providing patients with access to lifesaving medication.

In conclusion, the right to try movement is about ensuring patients have access to the right treatment at the right time. This includes personalized medicine. Nevada can be among the first in the nation to modernize our health care system to keep pace with the latest advancements in medicine so patients can benefit from these lifesaving treatments.

Wiz Rouzard, Deputy State Director, Americans for Prosperity:
[Read from Exhibit C.] In the spirit of time, I will keep my statement short, but I will say I want to applaud Senator Ohrenschall for opening up this opportunity for all Nevadans in 2015, and a round of applause to Assemblywoman Heidi Kasama for taking that torch and extending more freedoms to Nevadans. With this bill, we truly believe in making not only Nevada an economic state for more prosperity for all Nevadans, but we are talking about helping individuals reach their greatest potential. Although we are a grassroots organization that fights for freedom and liberty, we are happy to join and support this bill to help people fight for their lives as well. This is what this bill is about, personalized medicine. We should not relegate individuals to waiting for institutional boards to review and pass something when literally minutes, days, or hours are crucial when we are talking about personalized medicine. Assembly Bill 188 does that. I am super proud along with, not only the activists in the state, but particularly the 40-plus activists in Las Vegas going to testify in support, no matter how young or old they are, who really recognize that as a state, we should be providing all the tools necessary to every single Nevadan who wants to wake up and give another fight before their end days. I urge you to support A.B. 188.

Eddie Diaz, Strategic Director, Libre Initiative:
The Libre Initiative is a grassroots, freedom-based solutions organization. Dear members of the Committee, on behalf of our Libre Nevada community, some of whom are joining me here today, we would like to ask for your support for A.B. 188. We constantly hear from Latinos and other Nevadans who have critical and life-threatening conditions, such as cancer, about how they try to look for different medical alternatives from outside the country. Unfortunately, not everyone has the time or money to access this. We should not have to rely on other countries to get certain medical treatments. Instead, we should empower our state's doctors to be able to practice to their full potential.

We thank Assemblywoman Kasama for introducing A.B. 188, which will allow terminally ill patients to work directly with their doctors to seek treatments without having to first get government permission. This would allow the doctors to work to their full potential and bring hope to patients and families. Assembly Bill 188 can make all the difference for terminally ill patients who are running out of options. Alternative treatments could potentially save patients' lives by giving them the right to try. The terminally ill do not have time for political games. We encourage you all to work to remove red tape and political ploys and focus on working for patients' right to fight for their lives. These patients and their families are counting on our legislators to get to work and extend to them the hope they so desperately need and deserve. That is why we urge you to support A.B. 188.

Chair Peters:
Thank you so much. I just received copies of the sign-in sheets from Las Vegas. We have five sheets of folks who are here to testify today, particularly on this bill. Due to time, I would ask you, if you can, to double down on somebody else's comments and just say, I agree. If you do need to share your story, that is also fine. I just ask, for the sake of time, that you not repeat other people's testimony.

Christian Cardenas, Director, Grassroots Operations, Americans for Prosperity:
I would just like to say, I am 22 years old and in good health. However, that could always change in an instant. My family has a history of cancer and diabetes, and that could potentially be a threat to me in the future. I know there are plenty of others who could be in that same situation, and nobody is prepared to face a life-threatening condition. If we had to, those who are facing it deserve every tool in the toolbox available. Individuals should be able to try treatments that are potentially lifesaving if they make the choice themselves. I know if I were in that situation, I would be willing to try if I had no other options left. I am asking you to please support Assembly Bill 188.

Molly Marjie, Private Citizen, Las Vegas, Nevada:
In 2016, my mom was diagnosed with stage three double metastatic breast cancer at the age of 48. After going through treatment and multiple surgeries, she was able to beat the cancer and continued living life. Following this victory, she moved to Las Vegas. In April 2020, the cancer came back four times more aggressive than before. After a few different medications and chemo and radiation, nothing was helping. After an aggressive fight, she lost her battle on July 18, 2020, only three months after her second round of cancer was diagnosed. I realize now, at the age of 23, that at the time of her diagnosis, I should have asked more questions and fought for her right to be included in other forms of treatment that would have potentially saved her life. That is why I am here today. Although my mom did not have the available resources, I urge you to consider this bill as a means for more options to be available for those currently in the fight against cancer and other terminal illnesses.

PJ Belanger, Private Citizen, Las Vegas, Nevada:
I just put my hair back so that you can all see that I am dealing with goiters on my thyroid. They were huge, as big as a baseball, and I have been shrinking them all naturally. I turned 60 this last birthday, and I am a candidate for something called ablation that is not available here in the United States. I wish it were because it would save my thyroid completely from destruction. The actual statistics from ablation treatments in Italy, Germany, Korea, and other countries that I read about have benefits for up to five years after one treatment. I would get continual reduction in size of these cysts on my thyroid. By the way, I may not have a terminal illness, but these are fatally risky when I choke because they deviate my windpipe.

No, I do not want my whole thyroid cut out, thank you very much. I am not into being butchered. Then even if I did, it is a 50/50 chance for a good quality of life and I would, for sure, be a customer for the pharmaceutical industry for the rest of my life. These types of alternatives need to be available for people like me, for people with all sorts of different,

fatal, terminal, restricting, and debilitating illnesses. I have been battling autoimmune diseases my whole life. I am a certified health educator and wellness educator. When I was teaching, I was diagnosed with lupus in my thirties. I have been helping people overcome sickness and disease naturally since I was 16 years old, but I did not know I was going to need it myself. The thing I have learned is when the medical industry says it is incurable, it means we need to cure from within, and I am living proof. I am 60 years old; I have been battling autoimmune diseases my whole life, all naturally, and I need to be able to have more alternatives.

Amari Ibarra, Private Citizen, Las Vegas, Nevada:
I am growing up in a family that has many health problems. My grandma has suffered the most. She has two kinds of cancers in the fourth stage. She has been through so many treatments, old and new. She is now cancer free. There are so many new treatments that can help so many people. For all those purposes, I support A.B. 188.

Jesse Welsh, Private Citizen, Las Vegas, Nevada:
I might be healthy; however, several of my close friends and family members have dealt with cancer and other life-threatening diseases. Some have made it, unfortunately, others have not. If there were less restrictions on more individualized care, perhaps more important people in my life would still be around.

William Graham Carter, Private Citizen, Las Vegas, Nevada:
I have an organization of my own called American Truth Alliance. I am here to support A.B. 188. I was blessed to be in Carson City last week and see Assemblywoman Kasama speak. I am still in tears from her gratitude. I got to see her husband speak today and I was in tears for that. I live in the United States of America, not the "United Fed of America." I have the Bill of Rights on my wall, and whenever I meet anybody in uniform, I thank them for their service, for protecting our rights. Somewhere we got the idea that appointed bureaucrats have more power than you elected people. It is time we took our states back.

I, like Ms. Belanger who spoke, am more into natural kinds of things, and I talked to a doctor who has a thing out in Florida; it is called Epiphany Health. He charges each of his patients $80 a month, and they get anything at the clinic. There are several doctors and all kinds of nurse practitioners. He went around to all the Steinbergs [Steinberg Diagnostic] and all the peripheral companies and said, if I bring you cash clients, how much? Eighty-five percent less; so there are different ways of doing things.

I have a friend who 30 years ago told me that she had gotten—I had just gotten my inheritance—she had gotten hepatitis C from a one-night stand and wanted me to send her to CHIPSA [Centro Hospitalario Internacional del Pacifico, S.A.]. It is a Tijuana-based, six-story, serious hospital based on alternative medicine. I might have done it, but it would have broke me, and back then they gave out their protocol. They were the ones who came up with this individualized medicine of testing a person and coming up with a vaccine themselves. I called down there and the director, Dr. Dan Rogers, answered the phone, and he said hepatitis C could be cured by hyperbaric oxygen—he knew because he cured his

mother. In America, you cannot get into hyperbaric oxygen except for severe gangrene and things like that. He said, if your friend can get scuba tanks and go down for 60 minutes a day, that will do the same thing. The FDA seems like more of a roadblock than anything else to me. These bureaucrats are not accountable to anybody. You are elected. I am strongly in favor of this, and I hope that you pass it.

Karla Zelaya, Private Citizen, Las Vegas, Nevada:
I support A.B. 188 as someone who is currently not a doctor but is planning to become one. I firmly believe every individual should be given an equal opportunity to overcome their health condition.

Rigoberto Soriana, Private Citizen, Las Vegas, Nevada:
I am here as a volunteer for Libre Initiative, and I support A.B. 188.

Jose Cortez, Private Citizen, Las Vegas, Nevada:
For all purposes I support A.B. 188 because my family had a disease problem from certain kinds of cancer. Last year, my grandmother was able to face all those struggles, and she won, but I am afraid it may strike again. Thank you very much.

Chair Peters:
We will go into opposition testimony in our physical locations. Is there anyone who would like to provide opposition testimony. [There was no one.] We will go into neutral testimony on Assembly Bill 188. [There was none.] I hope we are streaming. This would be really tragic if we have not been streaming this whole time. I would ask the bill sponsor for closing remarks.

Assemblywoman Kasama:
Thank you, Chair, and thank you to all the Committee members. I did not know we had so many supporters here, but it speaks to the passion that everybody has about this bill. Thank you for giving me the time to hear this. I am grateful for the people who did some of the clinical trials to help bring some of these drugs forward that my husband and Ms. O'Hanlan could avail themselves of. If it had been a few years ago that they had some of these things diagnosed, these treatments would not have been available to them. We want these treatments to be available for somebody who was diagnosed last week, this week, and next week. We need our regulations to keep up with the fast pace at which our medical treatments are moving.

The other thing I want to point out is the great doctors from the Comprehensive Cancer Centers in the state of Nevada. These great people did not fly out of state and did not go anywhere else. We have good doctors, and we have good treatments in the state of Nevada. My goal is that we make sure we are no longer a medical desert, but we are a medical oasis here in the state of Nevada.

Chair Peters:
We will go ahead and close the hearing on Assembly Bill 188, and we are going to take a brief recess. [The Committee recessed at 2:49 p.m. and reconvened at 2:51 p.m.]

We are going to take this second bill out of order. We are going to start the hearing on Assembly Bill 289, which enacts provisions relating to the natural organic reduction of human remains.

I am particularly excited about this. I just recently listened to a podcast on some of the work that has been done in other states around the composting of human remains. I am looking forward to the hearing.

Assembly Bill 289: Enacts provisions relating to the natural organic reduction of human remains. (BDR 40-606)

Assemblyman Max Carter, Assembly District No. 12:
I am the Assemblyman from District 12, the east side of Las Vegas, and I am here today to present Assembly Bill 289. It is about natural organic reduction, also known as human composting. What this bill is doing is enabling another method for the disposal of human remains or the final disposition. As we know, we have cremation which uses fossil fuels and creates greenhouse gases. Traditional burial puts all sorts of chemicals and items into the ground that are slow to decompose.

I am going to tell you, the main reason I am bringing this is I am very involved and very open about my work in the trauma and grief world. This is a process that could possibly bring a bit of light in somebody's darkest hours. We never know what it is that is going to provide solace, a little bit of comfort. I believe this could be one of those things that possibly could. With that, I am going to turn this over to Tom Harries to walk us through the bill and answer any questions, as will Chelsea Capurro next to me.

Chelsea Capurro, representing Earth Funeral Group:
We have coached Tom Harries on the proper pronunciation of Nevada.

Tom Harries, Chief Executive Officer, Earth Funeral Group:
Thank you for the opportunity, Chair Peters and members of the Assembly Committee on Health and Human Services. We have prepared a quick presentation [Exhibit D]. There is a lot of stuff on the Internet about body composting, human composting, or the legal phrase for this, which is natural organic reduction. I wanted to provide a brief overview of what the process entails and why people resonate with this as a process.

Assemblyman Carter has given a quick context as to why this is relevant. Just to add to that, burial and cremation are the two primary methods of disposition in the U.S. Burial puts all sorts of harmful pollutants in the ground, including nondegradable wood, metal, concrete, and toxic chemicals, which is embalming fluid. Cremation, hilariously, has been considered the more environmentally friendly option. Anything that uses fossil fuels, burns fossil fuels,

and produces carbon dioxide is not environmentally friendly in my opinion, and it produces carbon dioxide equivalent to a 600-mile car journey. Nevada does about 81.6 percent cremations which is one of the highest, if not the highest, cremation rates in the country.

What is natural organic reduction [page 4, Exhibit D]? Natural reduction is an environmentally friendly alternative to burial and cremation. It is conceptually quite similar to cremation, but instead of being cremated and turned into ash, you are being gently transformed into nutrient-rich soil over a 30- to 45-day process. At the end of the process, families may choose how much soil they would like returned; they can keep it, scatter it, or plant in ways that are meaningful for them. That might be a plant; it might be a memorial garden; that might be planting trees; or it might be scattering in national parks or other places of meaning. Any remaining soil—there is about a half cubic yard to one cubic yard produced by this process—is sent to conservation land for restoration projects including things like reforestation and wildfire restoration. The soil is serving as a means to return the goodness in our bodies to the natural world instead of being blasted into the atmosphere via cremation.

The science and technology behind this process is quite simply optimizing and accelerating nature. The process takes place in a vessel [page 5]. This is a vessel from Earth Funeral Group. The vessel is controlling temperature, moisture, and oxygen levels. The science behind this is composting. What we are doing is creating perfect conditions for microbes to break the body down at a molecular level. The output is nutrient-rich soil. Just to be completely clear, there are no chemicals used during this process, and there are no insects. It is completely natural as a process.

The process itself takes place in four steps, and you will see the sort of gentleness and the niceness of the process as we walk through it. We start by gently washing and wrapping a body in a biodegradable shroud [page 7]. The body then gets placed in the vessel that we have just seen on a layer of organic mulch, wood chips, and wildflowers [page 8]. This is balancing carbon and nitrogen. The body then remains in the vessel for the 30- to 45-day process. We are optimizing temperature, optimizing moisture, and optimizing oxygen levels. This is creating the microbial environment to break the body down, and again, the output is nutrient-rich soil [page 9]. At the end of the process, families choose how much soil they would like returned to them and the remainder is sent to conservation land. It is a very simple, nice, gentle, and natural process [page 10].

Why do people want this? This is gaining a lot of momentum quickly throughout the country. Washington State was the first state to legalize this several years ago, and various other states have followed thereafter. There are several active bills this year, as well. Broadly speaking, this is a matter of consumer choice. This is a perfect process for individuals who are trying to minimize their carbon footprint [page 12]. This is a perfect process for individuals who enjoy spending time outdoors and in nature; it is a gentle, natural process that returns you to nature. There are also a lot of people who simply do not resonate with burial and cremation. We are providing a nice alternative to those people.

Some of the key benefits are the gentleness of the process and the naturalness of the process [page 13, Exhibit D]. It is net carbon neutral versus the 535 pounds of carbon produced during cremation. At its heart, we are restoring and protecting land for future generations. The final bullet here got left off, but we talk about final resting places of natural beauty. I think an example of this in Nevada would be Lake Tahoe.

Chair Peters:
Are there any questions from the Committee?

Assemblywoman Thomas:
I think this was pretty good, especially when I could visualize where you would be putting the body. My question has to do with donating vital organs; would someone still have the option of this procedure?

Tom Harries:
Absolutely, yes.

Assemblyman Koenig:
I see how you are giving part of the compost to the family to plant in their garden and the rest goes to the conservation. What if I want all of my compost in my garden and to not donate part of it? Does the person have to give half of their body to the conservation project, or could they give it all to their family to put in the garden?

Tom Harries:
You can keep all the compost if you would like it. The reason we offer the option for the conservation land is that a half cubic yard is quite a lot for a lot of people. That is why that exists. Yes, if you would like all of it, you can absolutely take all of it.

Assemblyman Gray:
Do the skeletal remains break down as well? I mean, does it decompose enough to where there is nothing identifiable and you have removed it all, medical hardware and dental hardware, prior to returning the soil to the family?

Tom Harries:
At the end of the process, the bones and any remaining bone fragments are reduced to a fine powder and reintroduced with the soil; bones are biodegradable. They are just very slow; they do ultimately biodegrade. Any medical implants are also removed at the end of the process and recycled.

Chair Peters:
Does that include things like mercury in fillings?

Tom Harries:
Yes, during cremation mercury is emitted along with carbon dioxide. This is one, sequestering carbon in the soil; and two, avoiding any harmful emissions around carbon dioxide or mercury or any other harmful gases during the cremation process.

Assemblywoman Gorelow:
This is really interesting and I am kind of curious because you mentioned 30 to 45 days. How do you know when the process is done? What tips you off?

Tom Harries:
We monitor the conditions in the process quite carefully. As I said, we are optimizing temperature, we are optimizing moisture, and optimizing oxygen levels. Because this is a microbial process, the microbes consume oxygen. Once they are finished, the oxygen levels do not dip; we are able to monitor the process through sensors and computers. We know definitively when it is done. We also test the soil at the end as well so we know that it is safe for humans, wildlife, plants, et cetera.

Assemblyman Hibbetts:
I have two questions, if you do not mind. The first question, I did not see in the presentation, but I do believe I spoke to Ms. Capurro about it earlier. Can you explain the cost of the procedure and the whole thing?

Tom Harries:
Yes, absolutely. We are active in Washington State at the moment. I cannot speak for other providers, but Earth Funeral Group charges $4,950. The average cost for a funeral in the U.S., cremation and burial, is closer to $7,000. Prices vary, so you get a full range of prices. You can get really low-cost cremation as low as $1,000. You also get burials costing tens of thousands of dollars. Price does vary. I think price with this comes down over time. This is a new technology and as this becomes more mainstream, prices will come down over time. It is not that much more expensive or, in many instances, is more affordable than burial particularly, but also cremation.

Assemblyman Hibbetts:
My second question is just for the record. There is nothing in this bill that would allow you to bury your loved one in the backyard, correct?

Tom Harries:
No.

Assemblyman Gray:
Is there any disease or process that would prevent you from doing this with somebody, or would restrict you from it?

Tom Harries:
Yes, there are a few diseases that we will not perform the process on. They are very rare diseases, things like Ebola virus and prion diseases. Ninety-nine percent of people are eligible for this process. The only other exclusion is if someone dies of a radiological accident, which again is pretty rare. The quality of the soil out is driven by the body going in and the natural materials that we use. There are exclusions to who can undergo this process.

Chair Peters:
Tell me about testing of the soil. What are you looking for in the soil to qualify it as being ready to go to the family?

Tom Harries:
At the end of each process, we perform what is called a Solvita test. This is common for composting. It is looking at carbon dioxide evolution and ammonia. Based on those results, we know whether the process has finished and is stable and mature—those would be the technical words. We then perform additional testing to check for metal contaminants. This is incredibly rare. I do not think of the 200-plus processes we have done to date since launching last year, we have had a single instance of this. Yes, the testing is thorough at the end of the process, and it is very rare to find someone who would not pass.

Assemblywoman Taylor:
This is an interesting thing that you talk about when you are a legislator that you would probably have never talked about at any other time in your life. This is very good. Is this happening in other parts of our country? Can you give us a little information?

Tom Harries:
Yes, it absolutely is. This was first legalized in Washington State in 2019; Colorado followed shortly thereafter; Oregon, Vermont, and California passed this last year. New York has passed a bill. Those are the states that have approved bills and have written legislation around this. There are active bills in many other states. I will try and name some of them, but I am not going to get all of them: Illinois, Massachusetts, Connecticut, Maine, New Jersey, Delaware, Maryland, and—New Mexico might have a bill.

A lot of this is driven by grassroots activism and consumers writing to local politicians and requesting it because people resonate with this as a nice alternative to the existing options. Yes, absolutely this is happening elsewhere.

Assemblywoman Taylor:
What does this look like? Is there a company that builds something you can house bodies in while they decompose, for lack of a better word? What does that look like in practicality?

Tom Harries:
Yes, it is very similar to a crematory. Crematories are typically in a warehouse. You have a retort, which is connected to building systems so, power and gas and chimney and things like

that. This is very similar to that. The process takes place indoors, and the vessels are stacked one on top of each other for space efficiency and remain there during this process. The building system for us includes a bit of power, water, and aeration.

Assemblywoman Taylor:
Is it in the building? In the crematory, bodies are not hanging around for 30 or 45 days.

Tom Harries:
Yes, they remain inside during the process.

Chair Peters:
I believe in crematories they often do lay around for a month or more. During COVID-19, we saw that increase to up to 18 months in some cases.

Assemblywoman Newby:
I was wondering, for the grieving families, is there interaction or the possibility of the interaction of the family in this process? If so, what is that?

Tom Harries:
Yes, absolutely. We consider this a direct swap out for cremation. We are not trying to change any ritualization at all. Families can still have visitations beforehand. They can still have services before and after. It is literally swapping out a cremation process for the natural organic reduction process. People engage with this process in new ways. At the facility in Washington, for example, we have families who come and participate in placing the body into the vessel, and they often bring flowers from their garden, handwritten notes, that sort of thing. It can be a very participative process if people would like that. We are not replacing funeral ritualization at all. We are offering an environmentally friendly alternative to cremation.

Assemblywoman González:
The last question sparked my question: If families had religious things they would like to bury with the person, what would that look like?

Tom Harries:
Anything that is biodegradable can go in the vessel. Anything that is not biodegradable cannot.

Assemblywoman González:
How many people have used this, and what does this look like in terms of where the remains have gone?

Tom Harries:
I can speak to Washington State. The first facility opened at the beginning of 2020. To date so far this year, about 0.5 percent of deaths in Washington have chosen this method of disposition. This is very new. I would expect it to grow quite significantly in popularity

over the next few years. Washington is the most advanced state or has the most data at this point. There is a report in 2020 from the National Funeral Directors Association (NFDA) that said 4.1 percent of people would be interested in this as a process. Again, I imagine that has gone up considerably because the press and media have given it a lot of attention since. We believe if a hundred percent of people knew about this, a very large percentage of them would choose it for the aforementioned reasons—gentle, natural process, net carbon neutral, being returned to nature.

Assemblywoman González:
The family gets to keep a portion and the rest would go to land or projects. In that process we are talking about, like Tahoe, for example, is there going to be a sign or anything saying this was decomposed human remains? What does that look like in the real world?

Tom Harries:
The example I can give, again, is in Washington State. In Washington State, Earth Funeral Group has a piece of land on the Olympic Peninsula surrounded by trees and mountains; it is peaceful and beautiful. It is private land and there will ultimately be a memorial stone in commemoration of those whose soil is there. There are many different ways to do this, and we are not trying to trick people with there being human remains there.

Assemblywoman González:
What would that look like in Nevada, though? Is this buying a piece of land? Is it planting new trees? What would that look like here?

Tom Harries:
There are many different ways this could work. We have not thought too much on operationalizing in Nevada. The first step is getting it approved. The easiest path is buying private land, and then there is no issue, and no one can be upset with the use. A lot of families use this on their own private land, as well. Families can take all the soil if they wish. It is not something that has had any issue in Washington, so far.

Assemblywoman González:
In the processor you use, for bones, you said it is the same as with cremation. I was just curious. In your opening remarks, you talked about the environment deficit that happens when we use cremation. I was just wondering, is it different for your facility or process? If so, what does that look like?

Tom Harries:
The big issue with cremation is it is a fossil fuel-driven process with burning natural gas to perform this process. The emissions include carbon dioxide, mercury, and other harmful gases. Our process is completely natural. It is using microbes. We are creating perfect conditions in our facility. We use renewable energy as well, and it is electric, which makes the process net carbon neutral versus the 535 pounds of carbon emissions from cremation.

Assemblywoman Gorelow:
You mentioned funeral directors would be the ones who would be doing this. What kind of training do they need in order to start one of these processes?

Tom Harries:
This is being regulated identically to crematories. The Cremation Association of North America provides most of the training in the U.S., and the NFDA is getting similar training. A lot of the training is around chain of custody—making sure it is the right body, making sure bodies are treated respectfully, et cetera, so it is consistent. Then companies that operate themselves will give specific training on their equipment, Occupational Safety and Health Administration [OSHA] training, that sort of thing. It is in line with existing training.

Assemblyman Gray:
You must have certification and a license to operate a crematory, to load them in and take them out. Is the state going to have to create a new certification or a new class of license for this, because it seems a little more sensitive than cremation. At least with cremation, you go back in and finish the job, if need be. I am wondering if the state would need to do that.

Tom Harries:
The way this bill is written is this is broadening the definition of cremation. This precedent was set a few years ago when alkaline hydrolysis cremation was legalized. This is getting regulated identically to cremation. Yes, you need a facility license, and people who work there have to be licensed operators. It has been strictly monitored in much the same way cremation has.

Chelsea Capurro:
If I may just jump in a little bit here too. In section 5 of A.B. 289, the new subsection 3 says "The Board may adopt regulations prescribing requirements . . . ." The Board is the Nevada Funeral and Cemetery Services Board, which can also adopt regulations it sees fit to regulate this in the state.

Assemblyman Carter:
I want to follow up with that. This is a broad bill. It is not a narrowly tailored bill. It is put in place to enable anybody who wants to come in and bring this process. It is not tailored to one company. Also, you will notice there is a two-thirds [majority pass requirement] note on this bill. The fiscal note is zero and it was done with the exact same language and exact same pattern as what Mr. Harries just mentioned. Alkaline hydrolysis, aquamation, which was passed in 2017, did not have the two-thirds vote requirement on it at the same time. As I said, the fiscal note on this is zero.

Assemblyman Gray:
Maybe counsel from our Legal Division could address why there is a two-thirds note put on it.

Eric Robbins, Committee Counsel:
I will have to look at that and get back to you.

Chair Peters:
Thank you so much for following up with us on that. Are there other questions? Seeing none, we will move into support testimony.

Isaac Hardy, representing Nevada Conservation League:
We are in support of A.B. 289. In addition to the list of environmental benefits we have heard here today, human composting has a number of other benefits. It is a job and business creator bringing a new industry to our state. It also offers a more affordable option than traditional burial or cremation. It offers a more personal and meaningful way to dispose of a loved one's remains. We are in support of this bill, and we urge the Committee to support it as well.

Sarah Manns, representing Compassion and Choices:
Compassion and Choices is the largest national organization supporting everyone charting their own end-of-life journey. We are in support of this bill.

Chair Peters:
I will go ahead and open for testimony in opposition to Assembly Bill 289. [There was none.] We will move on to neutral testimony for Assembly Bill 289. [There was none.] I would like to invite the bill sponsor to deliver closing remarks.

Assemblyman Carter:
Thank you for listening to the presentation. What we just saw here and what I just saw here is the same thing that I have been experiencing constantly since it came out that I was presenting this bill—curiosity. What we are trying to provide is another choice for end of life. Thank you all for your consideration.

Chair Peters:
[The hearing on Assembly Bill 289 was closed.] We are going to move on to our last bill which I am presenting today. I will move my way to the front and pass off the chairmanship to Vice Chair Orentlicher.

[Assemblyman Orentlicher assumed the Chair.]

Vice Chair Orentlicher:
I will now open the hearing on Assembly Bill 201, which revises provisions relating to planning for the provision of behavioral health care. Welcome, Chair Peters.

Assembly Bill 201: Revises provisions relating to planning for the provision of behavioral health care. (BDR 39-325)

Assemblywoman Sarah Peters, Assembly District No. 24:
During the previous interim, I was honored with chairing the Joint Interim Standing Committee on Health and Human Services; in short, the Health and Human Services (HHS) Interim Committee. Major focuses of the committee's work were issues related to behavioral health disorders and access to care for adults and children. We had two committee meetings dedicated to behavioral health for these populations including substance use, treatment, crisis response, and systems of care, to name a few.

However, behavioral health was pervasive throughout most of our meetings. It came up when we discussed chronic diseases, maternal health, and when we received updates from the Regional Behavioral Health Policy Boards. We even considered it during a joint meeting with the Interim Standing Committee on Natural Resources regarding the impact of climate change on mental health and well-being.

Assembly Bill 201 is a result of the many productive discussions we had during the interim. To put this bill in context with other measures that you have heard or will hear, I will briefly provide an overview of the state of behavioral health in Nevada and the HHS Interim Committee's work on behavioral health. As you have heard, Nevada, like the rest of the country, is witnessing a growing concern regarding the prevalence of behavioral health disorders in both adults and children. According to the Behavioral Health Barometer [from the Substance Abuse and Mental Health Services Administration], Nevada consistently ranks among the highest in the nation for behavioral health disorders. Our state suffers from years of gaps in its continuum of care for behavioral health services. However, the Department of Health and Human Services (DHHS) has been working to develop a comprehensive continuum of care for those in behavioral health crises. We furthered these efforts with various legislation measures during the past sessions. To build on this work and to address the challenges in our state's behavioral health care system, the HHS Interim Committee voted on several bill draft requests introduced this session to address some of these challenges. I will summarize them quickly.

First, we must acknowledge the significant shortage of behavioral health care providers. Many rural and urban areas in Nevada lack sufficient access to behavioral health care services. To tackle this problem, we need to invest in initiatives that encourage professionals to work in these underserved communities and promote telehealth services to bridge the gap in behavioral health care accessibility. We have several bills this session addressing the severe shortage and promoting telehealth services. For instance, Senate Bill 119 from the HHS Interim Committee would make temporary reimbursement parity requirements for certain telehealth services permanent.

Second, primary areas for improvement are early intervention and prevention. By investing in school-based behavioral health programs, we can identify children struggling with behavioral health disorders early on and provide timely and appropriate support. Schools

should collaborate with behavioral health providers to create safe and nurturing environments that promote emotional well-being. Related to this, the HHS Interim Committee voted to introduce another bill, Assembly Bill 237, to expand and strengthen services at school-based health centers.

Third, we must work to enhance the coordination and integration of behavioral health services with primary care. Integrating care can lead to better outcomes for individuals, reduce costs, and help streamline the process for patients and providers alike. This approach also ensures individuals receive comprehensive care that addresses their physical and behavioral health needs. We already heard Assembly Bill 138, which is aiming to expand Medicaid coverage for behavioral health integration services including the collaborative care model.

Fourth, we must tackle the substance use crisis in our state. While our state experienced an increase in opioid-related overdose deaths to an all-time record of 566 deaths in 2021, we also saw a significant increase in overdose deaths by substances other than opioids over the last several years, especially methamphetamines which were involved in the highest number of unintentional overdose deaths other than from opioids in both 2019 and 2020. One measure that intends to reduce the amount of harm by substance use and resulting overdoses is Assembly Bill 156, which this Committee has also heard.

Finally, we must provide the transition of Nevada's behavioral health care system to a community-based system of care model. The objective is to address the behavioral health needs funding and resources to expand access to behavioral health services across our state, especially for our children. State officials from the Division of Child and Family Services (DCFS) testified last interim that youth depression and anxiety were at record highs. This increase in behavioral health disorders in children and adolescents coincides with a severe shortage of school personnel and behavioral health providers which exacerbated the need for behavioral health interventions.

As you know, the United States Department of Justice concluded an inquiry into Nevada's behavioral health systems last fall and found the state institutionalizes kids with behavioral health issues without a need, in violation of Title II of the Americans with Disabilities Act. Nevada relies on segregated, institutional settings like hospitals and residential treatment facilities among others, rather than offering children with behavioral health disabilities adequate community-based services. This is the reason we are hearing Assembly Bill 201 now, which, as introduced, would establish regulatory clinical oversight of behavioral health care for adults and children and reinvest cost savings into the children's behavioral health system of care. This is the goal; it is where we want to be and someday intend to be. However, the limited resources and capacity of the state in this area require that we look at more feasible options. Subsequently, I would refer you to the amendment which I will now go over [Exhibit E].

The amendment for A.B. 201 deletes all provisions requiring the Division of Public and Behavioral Health (DPBH) and DCFS to make state plans on the provision of behavioral health services. Instead, the HHS Interim Committee shall study the feasibility of a comprehensive state plan. It also revises the cost savings and reimbursement provisions to require DHHS to track federal and state funding for the children's behavioral health system of care and analyze the annual costs avoided through such expenditures and directs DHHS to provide an update to the HHS Interim Committee prior to the next legislative session.

To address the continuum of care, we included language to create a statewide mental health consortium which was set forth in Assembly Bill 273 of the 81st Session. This is important because we will subsequently add certain members of the consortium to the Subcommittee on the Mental Health of Children appointed by the Commission on Behavioral Health as set forth in *Nevada Revised Statutes* 433.317.

In conclusion, the prevalence of behavioral health disorders in children and adults in Nevada is a pressing issue that demands our immediate attention. By addressing the challenges in our behavioral health care system and capitalizing on the opportunities for improvement, we can make a meaningful difference in the lives of countless individuals in our state. It is our collective responsibility to work together toward creating a healthier and more compassionate Nevada for everyone. Vice Chair and Committee members, I urge your support of A.B. 201, and I stand for questions from the Committee.

Assemblywoman Taylor:
I noticed on the amendment, item number two, the recommendations for there to be a requirement to conduct an interim study on the feasibility of the actual goal. Can you talk us through that a little bit, the shift?

Assemblywoman Peters:
The shift is related to the state's capacity and resources. We want to be taking care of our children and the people in our state who need behavioral health care. We do not have the resources to put to it right now. Our desire is to ensure that everybody has access and that access is in the communities people come from and is supporting them in living normal lives every day or helping reestablish what normal looks like for them.

We do not have the resources to do that at the moment. My goal with this particular rewrite of the bill is to create a pathway forward. Where do we start if we cannot have the resources in place today? How do we get there? What is the path forward? Is it hiring additional staff? Is it creating a new division? Is it the financial resources on which we are really limited? Yes, that is an obvious yes. What is the quantity of that? Is it tenfold, is it a hundredfold? What do we have in existing capacity? The important piece we are directing DHHS to do is to quantify cost savings. We spend money on behavioral health care. We know that spending money on preventative services and even on triaging services saves us money in the long run. We see fewer people in the hospitals when they are being treated up front for whatever it is that ails them. That cost savings, being able to capture that picture of how much we are saving as a state in providing those services for somebody, would allow us

to return that money into the General Fund or expand Medicaid in other areas. That would allow us to look at the quantification of cost savings in providing preventive behavioral health services into the back end of additional preventive behavioral health services.

We need to know how to do that. Right now, quantifying that is a task you and I cannot do. The Department of Health and Human Services has all the people there to be able to do that, and they have fantastic data analytics—we have seen that throughout this session—to be able to capture that picture, tell us what it is that exists, and have the Interim Standing Committee study tell us where the best place to put that reinvestment would be to get us from the resource-limited place we are facing right now to a better continuum of care model.

Assemblyman Hibbetts:
To clarify the conceptual amendment, is that going to remove the cost and the two-thirds vote necessity on this particular bill?

Assemblywoman Peters:
The cost would be replaced by the DHHS's effort in developing the tracking mechanisms for the cost-savings effort. It is not quantified yet, but it will be significantly less, I believe, than setting up a whole new licensure structure, which is what was proposed in the initial bill.

The fee is related to establishing those certifying criteria or licensing structures in the original bill, and with the removal of that structure, the fee would be removed and the two-thirds vote requirement would be removed.

Assemblyman Hibbetts:
May we have the Legislative Counsel Bureau follow up and confirm that the two-thirds vote would be removed with this conceptual amendment?

Eric Robbins, Committee Counsel:
Yes, absolutely. The fee is associated with the certification. If we are taking the certification out, that would remove the two-thirds vote. There is a part of the conceptual amendment that talks about authorizing DPBH to certify inpatient behavioral health care facilities, but they already have the authority to do that. It would be more of a clarifying change. That would not carry a two-thirds requirement.

Assemblyman Nguyen:
In terms of the date here in the amendment in item three, with the update deadline being June 30, 2024, then final recommendations by December 31, 2024, is this a one-time schedule? Are these data going to be quantified for just this one time? I guess my two thoughts are, is this enough time for us to do all of this? This data compilation is just going to be humongous. Second, do we have a provision in terms of how this can be continued if for some reason these types of collections are somehow running behind or they need more time?

Assemblywoman Peters:
Those dates are really to drive and clarify the fiscal note on this. Once we set up a process to look at the cost savings and the reinvestment structures, we will continue to do that in perpetuity. It just makes sense to reinvest in the system of care, especially since it has been ignored fiscally for so long. However, you are correct, and we should probably negotiate out a longer-term standard, maybe every six months or so with an update. I do not anticipate these updates to be a comprehensive report with an assessment and recommendations for the interim committees or for other standing committees to make actionable tasks out of them. I expect it to give us an idea of how things are going. What are some barriers? Do we have the staff available to be able to do it? It is easy to quantify the Medicaid investment, but it is harder to quantify the community-based investment. Do we need to create structures in which the community-based investment can be captured by some mechanism? It is more like ensuring we are touching base with DHHS and not just leaving them to collect data for no reason.

Assemblyman Hafen:
I am trying to wrap my head around the conceptual amendment today. I think I understand the study portion. I am going to ask about the statewide consortium now being added to this. Could you explain why we are doing this here instead of in the other bill?

Assemblywoman Peters:
I knew this would come up because the consortium was not a part of the original draft of this bill. However, I wanted to make sure in this bill we were talking about the Commission on Behavioral Health that in the original language we were directing to do the investigation on cost savings and reinvestment structure. I still think that the Commission will be an important piece. It is already tasked in existing legislation to provide best practices in the behavioral health care system. I wanted to make sure that we were giving it the right committee members to address children's behavioral health care. In our hearing on the statewide consortium bill, we learned that the statewide Children's Behavioral Health Consortium would really be where children's behavioral health care is addressed. Having two members from that consortium sit on the subcommittee on mental health of children that exists within the Commission on Behavioral Health would provide the kind of connection missing in the original drafting of the statewide consortium bill.

I am happy to talk to you about this outside of the Committee to help you understand what I would like to do with Assembly Bill 265 and this bill, to try and marry them up together. I could not put in here to include members from a consortium that does not exist. I had to include the consortia to be able to direct them to provide those members be a part of the Commission. I probably should have started there.

Assemblyman Hafen:
That makes more sense, that you cannot direct something that does not exist. I understand and I would take you up on your offer to discuss this a little bit further.

Assemblywoman Newby:
I, too, have read the Department of Justice (DOJ) report on our failings, and it strikes me that when you get a report like that from the Department of Justice, it is really nothing to be trifled with. I know we are not the money committee, but it seems like there is a lot of money right now. Have you heard any further on any forthcoming actions or any next steps on that DOJ report? I ask that because not only are we in a terrible situation with children's mental health, but I am also concerned our state is open to sanctions or to other actions through the DOJ or other federal agencies if we do not fix this soon.

Assemblywoman Peters:
I wish this were a question that was more topical to this bill, so that I had prepared for it. This is due in part to the conversations we had in the interim related to that DOJ report. However, I also do not sit on the subcommittee on health and human services in the money committees. That is where some of the investment in making some changes that are really essential, based on that report, are being heard. I think at the beginning of this session we did hear from the Division of Child and Family Services; the testifiers mentioned a few things they were working on. I do not know where they are with regard to possible action.

Assemblywoman Newby:
How much do you think this planning effort would be helpful in trying to address those identified shortcomings?

Assemblywoman Peters:
Again, we have to make stepwise plans in this state; we do not have buckets of money that we can toss at issues and come up with solutions in whole. We end up having to do things incrementally, and we are scrappy by nature. We try to find where we can have cost savings so we can reinvest in other areas that are needed. This is really fundamental in how we address that stepwise nature, making sure that we are making wise decisions on where to reinvest and also how much is quantifiable to be reinvested.

I am not directing in this amendment that the statewide plan address the DOJ issues. That is really the state's existing charter. We have to address those issues. We were audited by the Department of Justice. We are obligated to come up with a solution. In order to not get in the same situation again, having a plan in place that says this is how we are going to get ourselves out of the situation we are currently in and into a better system where we have planned for a continuum of care that is a living continuum of care that can address things as they come up, that will put us in a better position for any future issues that come up, as well as addressing the issues we see as unfundable at the moment because we just do not have the financial structure to do it.

Vice Chair Orentlicher:
Anyone here wanting to testify in support of Assembly Bill 201, please come up.

Vanessa Dunn, representing Nevada Public Health Association:
We would just like to offer our support.

John J. Piro, Chief Deputy Public Defender, Legislative Liaison, Clark County Public Defender's Office:
Some of the biggest things we deal with in our job are the mental health issues that go unresolved in our community. If we could catch things on the front end, we would save a lot of money because we spend a lot of money on the back end in incarceration and prison costs and treatment. For those of you not on the Assembly Judiciary Committee, I say a lot of times in my job, I am one of the first people to recognize that somebody has a mental health problem. That is a long way to go through life, where I am the first person that catches it and then gets the person treatment. If we could fix that issue in our state, where we do not have a lot of front-end services, we would be much better off. I strongly urge support of this bill.

Erica Roth, Government Affairs Liaison, Deputy Public Defender, Washoe County Public Defender's Office:
I want to thank the bill sponsor for bringing this forward and I echo the sentiments of Mr. Piro. He is correct. We are very often the first to recognize our clients have been suffering with mental health issues or substance abuse issues. That is unacceptable, and the more we can move upstream and address these issues on the front end, the better off the state will be.

Joan Hall, President, Nevada Rural Hospital Partners:
I am here today in support and thank the sponsor for taking time to listen to us and incorporate some of what we suggested into our amendment. I still need to scratch things out and figure out what goes where. We are in support.

Valerie Haskin, representing Rural Regional Behavioral Health Policy Board:
I am here today to speak on behalf of the Rural Regional Behavioral Health Policy Board, which lends support to A.B. 201. This was even before the amendment, and I am confident that the Board is going to like this bill even more with the amendment.

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

Assemblyman Orentlicher:
Is anyone here to testify in opposition of Assembly Bill 201? [There was no one.] Does anyone here want to testify in neutral of Assembly Bill 201?

Joanna Jacob, Manager, Government Affairs, Clark County:
I am here supportively in neutral because I have not had the opportunity to discuss this amendment with the Chair. I just wanted to get on the record. Obviously, we have been before this Committee and others about the needs that we have on children's behavioral health systematically in Clark County, also, I would argue, statewide. Impacts of not funding on a statewide basis does impact us in Clark County. We very much want to be part of this conversation as we work through the conceptual amendment and into writing it. We would like to have us be part of this information gathering as a county and not as a behavioral health entity, but as a separate entity that is obviously very involved. This fits in nicely with a bill we currently have pending in the Senate about another study before the interim health care

committee about systematic review of our child welfare system. I think these fit together very nicely. Thank you, Chair Peters, for your efforts on moving this forward. Neutral today but hoping to move into a position of support as we write it up.

Sarah Adler, representing Vitality Unlimited; New Frontier Treatment Center; and FirstMed Health and Wellness:
I think if we had more time, we would be fully supportive of the bill as amended. The Chair hit on a key point which is to use the Office of Analytics within DHHS as kind of a hub point to really grasp investments and the outcomes of those investments and use that data to make best investment decisions. My clients would like to say there is a lot of planning that goes on that they are sometimes invited to, but they do not have time to participate in because they are providers. There is already a lot of planning going on. They see the value in that, but at the same time, they have needs for responsiveness from the agencies that would be part of this work. There is only so much time for a variety of functions of these different agencies. I feel at this moment that this hits a very strong center point.

Vice Chair Orentlicher:
Assemblywoman Peters, do you have any closing remarks?

Assemblywoman Peters:
I do. I just want to thank those who have come up in support, and we will continue to work on this amendment and make sure we capture the parts and pieces that are important to moving forward with the bill. I appreciate the opportunity to present it to you all. I am very excited for where we are moving in the state. I wish we could be making greater advancements, but we are chipping away at it strategically, as we do in the state of Nevada.

Vice Chair Orentlicher:
Thank you, Chair, for your commitment to behavioral health. As you say, this is a really critical issue, and we are grateful for all the work you are doing. I will now close the hearing on Assembly Bill 201 and stall while the Chair comes back to assume her responsibilities.

[Assemblywoman Peters reassumed the Chair.]

Chair Peters:
Thank you, Vice Chair, and thank you all for entertaining that. We are pushing our time here a little bit, but we have a legal response on the question that Assemblyman Gray asked earlier. I cannot remember which bill number exactly, but I will let Mr. Robbins take the lead.

Eric Robbins, Committee Counsel:
This was a question about Assembly Bill 239 [later corrected to Assembly Bill 289] and why there was a two-thirds requirement on the bill. Section 4 of the bill allows a crematory that only performs natural organic reduction to get a license from the Funeral Board. There are

fees associated with that license. The theory behind the two-thirds requirement is that without this bill, people would not be getting a license to run a crematorium; with this bill, they would be getting a license to do that and perform natural organic reduction, and because of that, there would be an increase in revenue necessitating the two-thirds requirement.

Chair Peters:
It is not a new fee or tax. It is just a new entity who would be invited to participate. I wanted to correct, that was Assembly Bill 289. If we could correct that in the meeting notes.

We are going to go ahead and move into public comment. [Public comment was heard.]

That was the end of our agenda for today. Thank you all for hanging in there for a long one. Our next meeting will be this evening. We are still waiting on two bills. I am going to go into recess rather than an adjournment, and we will adjourn on the floor. Our next official meeting where we will have bill hearings will be on Wednesday at our regular time of 1:30 p.m. With that, we are in recess [at 3:58 p.m.].

[The meeting was adjourned at 6:55 p.m. on the floor of the Assembly.]

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Recording Secretary

_____
Spencer D. Wines
Transcribing Secretary

APPROVED BY:

_____
Assemblyman David Orentlicher, Vice Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is written testimony, dated March 27, 2023, presented by Wiz Rouzard, State Deputy Director, Americans for Prosperity, in support of Assembly Bill 188.

Exhibit D is a copy of a PowerPoint presentation titled "Introduction to Natural Organic Reduction," presented by Tom Harries, Chief Executive Officer, Earth Funeral Group, regarding Assembly Bill 289.

Exhibit E is a proposed conceptual amendment to Assembly Bill 201, dated March 27, 2023, presented by Assemblywoman Sarah Peters, Assembly District No. 24.

Exhibit F is a letter dated March 12, 2023, submitted by Ashley Ellis, Private Citizen, Reno, Nevada.