MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Eighty-second Session
April 3, 2023

The Senate Committee on Commerce and Labor was called to order by Chair Pat Spearman at 8:15 a.m. on Monday, April 3, 2023, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Pat Spearman, Chair
Senator Roberta Lange, Vice Chair
Senator Melanie Scheible
Senator Skip Daly
Senator Julie Pazina
Senator Scott Hammond
Senator Carrie A. Buck

COMMITTEE MEMBERS ABSENT:

Senator Jeff Stone (Excused)

STAFF MEMBERS PRESENT:

Cesar Melgarejo, Policy Analyst
Bryan Fernley, Counsel
Veda Wooley, Counsel
Kelly K. Clark, Committee Secretary

OTHERS PRESENT:

Daniel Royal
Charles Green, Secretary-Treasurer, Nevada Board of Homeopathic Medical Examiners
Blayne Osborn, Nevada Rural Hospital Partners
Brian Reeder, Receivables Management Association International

David Reid, General Counsel, Receivables Management Association International
Jamie Cogburn, Nevada Justice Association
Samantha Sato, Community Association Management Executive Officers Inc.; Comprehensive Cancer Centers of Nevada
Kristina Kleist, Clark County Collection Service
Sandy O'Laughlin, Commissioner, Division of Financial Institutions, Nevada Department of Business and Industry
Cari Herington, Executive Director, Nevada Cancer Coalition
Chivonne L. Harrigal, M.D.
Kelley Miner
Alex Tanchek, Nevada Advanced Practice Nurses Association
Aodhan Downey, Comprehensive Cancer Centers of Nevada
Vanessa Dunn, Nevada Public Health Association; Nevada Primary Care Association
Amy Thompson
Darcy Phillips
Will Pregman, Battle Born Progress
Briana Escamilla, Planned Parenthood Votes Nevada
Yvonne Battaglia
Randy Johnson, American Cancer Society Cancer Action Network
Barry Cole, M.D.
Connor Sweeney, Susan G. Komen
Elizabeth Barnes
Sarah Watkins, Nevada State Medical Association

CHAIR SPEARMAN:
It is the first week of April and we are in a winter storm. How about that? The flight from Vegas could not land in Reno this morning and diverted to Sacramento. Senator Stone and Senator Ohrenschall are on that plane. We are going to divert the work session until this Wednesday. I want to give all the Committee members a chance to participate. Senator Ohrenschall has asked Daniel Royal to present Senate Bill (S.B.) 336.

SENATE BILL 336: Revises provisions relating to the regulation of certain healing arts. (BDR 54-886)

DANIEL ROYAL:
Senator James Ohrenschall of Senatorial District No. 21 is not here today to present S.B. 336 and he has asked me to introduce the bill on his behalf.

I appreciate the opportunity to come before you today to present S.B. 336, which pertains to the expansion of exemptions for certain practitioners of healing arts, allowing them to practice within the scope of their authority without being subject to the provisions governing other healthcare professionals.

Senate Bill 336 is essential as it recognizes the diverse range of healthcare professionals and their unique expertise, to ensure they are not unfairly constrained by regulations designed for other disciplines.

To provide some context, existing law stipulates those provisions regulating the practice of physicians, physician assistants, perfusionists, and practitioners of respiratory care do not apply to those practicing other healing arts within their scope of authority.

This bill aims to extend similar exemptions to other practitioners of healing arts, such as dentists, nurses, osteopathic physicians, physician assistants, podiatrists and optometrists. This change is significant because it acknowledges the importance of allowing healthcare professionals to practice within the scope of their training and expertise, without being subject to regulations that may not be applicable or appropriate for their specific disciplines.

Sections 1 through 5 detail the exemptions for the mentioned practitioners of healing arts, ensuring they can practice within the boundaries of their authority without being subject to the provisions governing other healthcare professionals. This will enable these practitioners to provide the best possible care for their patients, while still adhering to the highest standards of their respective professions.

Section 6 of this bill has important implications for disciplinary actions and investigations involving practitioners of healing arts. It states that the provisions outlined in Sections 1 through 5 apply to any conduct by a practitioner before, on, or after the effective date of this bill, which has not been the subject of a final order from the relevant regulatory boards.

Section 6 requires these boards to terminate any investigation or disciplinary proceedings for conduct that falls outside the scope of their jurisdiction.

So that was the statement by Senator Ohrenschall. I want to add a few words of my own.

I am a licensed osteopath and homeopath in the State of Nevada as well as a licensed attorney with the State Bar in Nevada. I am here in support of this bill. It is something that we have been working on over the last year. It is long needed and overdue.

Senate Bill 336 introduces the phrase in the *Nevada Revised Statutes* (NRS) chapters where prescription rights are at issue, such that said chapter does not apply to "Any person permitted to practice any other healing art under this title who does so within the scope of that authority." This phrase already exists in NRS Chapter 630.047, subsection 1, paragraph (e), for the allopathic or medical board.

Senator Ohrenschall has worked with the Legislative Counsel Bureau to have this same phrase included in the NRS chapters of all Nevada healthcare boards that have regulatory authority for prescription drugs. It should be noted that NRS 629.079 contains a provision in subsection 1 that a jurisdictional analysis is to be made where dual licensure is concerned, and the healthcare licensing board that receives a complaint against a dual licensee shall "refer the complaint to the other health care licensing board within 5 days after making the determination," but NRS 629.079 is not always sufficient.

With respect to dual licensees, the medical boards have overlapping jurisdiction to regulate the prescribing and administering of drugs by a dual licensee unless some other provision of law removes such overlapping jurisdiction. For example, because homeopathic medicine is a separate healing art from allopathic medicine, the provisions of law governing allopathic medicine do not apply to a homeopathic physician when the homeopathic physician is practicing within the authorized scope of his practice for homeopathic medicine.

In other words, the allopathic board is prohibited from taking disciplinary action against a dual licensee who is licensed by both the allopathic board and other healthcare boards for actions relating to the prescribing or administering of drugs so long as such prescribing or administering of drugs falls within the authorized scope of practice of the dual licensee's other healthcare board.

In chapter 633 of NRS, which governs the practice of osteopathic medicine, NRS 633.171, subsection 1 does not apply to some healthcare licensees, such as dentistry and podiatry, but unlike the provisions governing the allopathic board, this statute does not exempt the practice of homeopathic medicine from the provisions of law governing the practice of osteopathic medicine.

Consequently, in areas where the practice of osteopathic medicine and the practice of homeopathic medicine overlap, such as the prescribing or administering of drugs, a homeopathic dual licensee is subject to the provisions of chapter 633 of NRS and the jurisdiction of the State Board of Osteopathic Medicine. Conversely, the allopathic board lacks such authority.

In the Nevada Supreme Court case, *Nevada Mining Association v. Erdoes*, the court stated "[w]hen the Legislature chooses one option and not another, it is presumed that the Legislature did so purposely." An implied removal of the authority of a healthcare board would occur only if that authority irreconcilably conflicted with the statutes and regulations authorizing a healthcare licensee to prescribe or administer drugs.

In summary, because NRS 630.047, subsection 1, paragraph (e) exempts a healthcare professional who is licensed as an allopathic physician, but who is acting within the scope of the practice of a dual licensee's other healthcare board, the allopathic board is not authorized to take disciplinary action against such dual licensee for prescribing or administering drugs so long as the dual licensee is acting within the scope of practice of his other healthcare board.

In contrast, because such a provision of law does not exist with the other healthcare boards to provide a similar exemption for a dual-licensed healthcare professional, a secondary healthcare board is authorized to take disciplinary action against a dual licensee for prescribing or administering drugs in a manner that the secondary healthcare board determines violates its NRS, even if such prescribing or administering of drugs is within the scope of practice of the dual licensee's primary healthcare board.

Senate Bill 336 remedies this conflict in the law by resolving this patent unfairness to dual licensees that prevent Nevada patients from exercising their choice for medical treatment options.

CHARLES GREEN (Secretary-Treasurer, Nevada Board of Homeopathic Medical Examiners):
Dr. Sean Devlin, the Nevada Board of Homeopathic Medical Examiners President, is a dual-licensed physician with both the Osteopathic and Homeopathic Boards. He has asked me to represent him here today.

The Homeopathic Board heartily endorses S.B. 336. We appreciate Senator Ohrenschall's work on this issue. Essentially, we have two competing forms of medical care: a sick care system, where disease systems are managed, and the healthcare system, where optimal wellness is maximized.

This often leads to competing forms of treatment including where the administration or prescribing of drugs are at issue. Homeopathic physicians are allowed to use medications for off-label and/or alternative purposes as permitted pursuant to NRS 630A.047, subsection 1, paragraph (e).

For example, last year, a homeopathic physician was disciplined by another healthcare board for practicing as he was trained, educated and licensed to do. In this case, the homeopathic physician was using a low-dose form of chemotherapy to treat cancer patients.

This alternative treatment is known as insulin potentiation therapy where insulin is used to lower blood sugar, so that a lesser amount of chemotherapy may be used, such as 10 percent to 20 percent of the recommended full dose. This is because cancer uses 20 times more sugar than normal cells and lowering blood sugar makes cancer more vulnerable to chemotherapy. This treatment is safe. It has been used since the 1930s for the treatment of cancer. Patients opt for this treatment because it minimizes the side effects of chemotherapy, such as losing hair, anemia and suppressing white blood cell function.

However, the other healthcare licensing board took exception to this homeopathic licensee's use of this alternative approach to the treatment of cancer. Because the homeopathic physician was not using full-dose chemotherapy, he was found to be practicing "below the standards of medical care" for the other healthcare board with which he was duly licensed. It should be noted that we have other physicians in the State who are dual-licensed with the Homeopathic Board that use similar alternative cancer treatments for their patients. It is only when they are dual-licensed as an allopathic physician with the Board of Medical Examiners that they are allowed to practice their healing

art as homeopathic physicians where the prescribing or administering of drugs are at issue.

Senate Bill 336 is simply a good policy. The citizens of the State should be allowed to have choices in their medical care. However, the current overlap in jurisdiction over the administering or prescribing of drugs has created a problem to limit those choices by inhibiting homeopathic physicians from practicing as they are fully authorized and licensed to do. This unfairness needs to be remedied. The remedy is found with S.B. 336, and now needs to be expressly applied to all other healthcare boards. It is in the best interest of dual licensees and patients alike.

BLAYNE OSBORN (Nevada Rural Hospital Partners):
We are here in support of S.B. 336. We ran out of time to finish some language on a friendly amendment before today's hearing, but we are working with Senator Ohrenschall and the Legislative Counsel Bureau on it.

We have a similar scope of practice discrepancy between the *Nevada Administrative Code* 632.500, which allows Certified Registered Nurse Anesthetists (CRNAs) to "select, order and administer" anesthetics. However, CRNAs are not listed in NRS 453.375 and 454.213, which list the persons able to possess and administer those drugs.

We are seeking to amend this bill to add CRNAs working in Critical Access Hospitals (CAHs) to these lists. In our three CAHs that provide obstetrics and routine delivery services, CRNAs are the only source of anesthesia for their patients. This discrepancy affects their scope and puts those services at risk. We are hoping to solve that issue with this bill. We are in full support of S.B. 336.

CHAIR SPEARMAN:
Hearing no public comment, we will close the hearing on S.B. 336 and open S.B. 276.

SENATE BILL 276: Revises provisions related to collection agencies. (BDR 54-158)

SENATOR ROBERTA LANGE (Senatorial District No. 7):
I will present S.B. 276, which aims to improve the regulatory environment surrounding collection agencies, collection agents and debt buyers. Financial services play a critical role in our society, providing the resources and opportunities needed for individuals and businesses to grow and prosper.

However, with these opportunities, there are some challenges and at times financial hardships. In some circumstances, the actions of collection agencies and debt buyers can significantly impact the lives of those affected by debt. Debt collection can be an intimidating and stressful experience for those involved. With the potential for aggressive tactics and harassment threats, it is crucial that we establish guidelines and safeguards to protect consumers by regulating this industry.

We can ensure that collection agents act fairly and responsibly, and they do not resort to abusive or deceptive practices. This will create a more balanced and equitable system allowing debtors to address their financial obligations without fear of unnecessary stress.

As we consider the importance of regulating collection agencies, collection agents and debt buyers, let us remember that we are dealing with real people and real people's lives. The impact of debt collection practices extends beyond numbers on a balance sheet. It touches the everyday lives of those affected by debt. It is our responsibility to create a fair and just system that balances the needs of creditors and the rights of consumers.

For these reasons, S.B. 276 is an essential bill, as it provides a more comprehensive regulatory framework for collection agencies, debt buyers and collection agents. It addresses current industry trends such as remote work and ensures that agencies and agents are held accountable for their actions. By implementing these changes, we can better protect consumers and maintain a fair and transparent debt-collection industry.

BRIAN REEDER (Receivables Management Association International):
I am Brian Reeder, with Receivables Management Association International (RMAI). David Reid, General Counsel to RMAI, will provide a brief overview of the bill.

DAVID REID (General Counsel, Receivables Management Association International):
I am General Counsel of RMAI, a nonprofit trade association representing more than 620 companies that purchase or support the purchase of receivables on the secondary market. I am here to speak in support of S.B. 276. Our membership includes debt buyers, law firms, collection agencies, banks, credit unions and fintech companies. We have members in all 50 states.

Our organization is known for operating the industry's national self-regulatory certification program, which holds our members to standards that meet and, in most instances, exceed the requirements of state and federal law.

The RMAI launched this self-regulatory program ten years ago with the strong encouragement of both the Consumer Financial Protection Bureau and the Federal Trade Commission. We support the passage of S.B. 276.

We worked on the proposed amendment (Exhibit C) with industry stakeholders because it will not only require debt-buying companies to be licensed, but it will also modernize an act first adopted in 1969, eight years before the federal Fair Debt Collection Practices Act (FDCPA).

Among the changes, this bill adds debt buyers to the definition of a collection agency. That will require debt buyers to be licensed. This bill will replace qualified managers of a collection agency with compliance managers. This is in alignment with the requirements of the FDCPA certification, which places an emphasis on having an employee dedicated to complying with state and federal laws and regulations.

This bill will also permit employees to work from home provided the collection agency abides by rigorous requirements designed to ensure oversight compliance and data security. This bill will also streamline the licensing process by only requiring a single corporate license rather than multiple licenses for each branch facility.

Most other states have eliminated similar licensing requirements with no negative impact on consumers or the industry. On the main application for the license, the branch offices are still required to be listed. This bill will also delete antiquated language related to out-of-state and foreign collection agencies.

Under the revised language, all collection agencies would be treated the same regardless of location, and the commissioner's power would be the same for all collection agencies. This bill will also permit affiliated debt-buying companies to share a single license in certain circumstances. This is the modern trend that has been recently adopted in California, Connecticut and Maine. This allows for a single audit to be performed of the entire corporate structure at the same time.

Finally, this bill modifies an out-of-date requirement that a license be framed and displayed in a conspicuous place. Given that these facilities are generally not open to the public, this is a commonsense change. It would be replaced with a requirement that the license number be displayed on the collection agency website. I have submitted a list of summarized changes in the conceptual amendment, Exhibit C, which I will read.

SENATOR DALY:
I have a question in section 17 regarding confidentiality. Section 17 modifies NRS 649.065. Confidentiality is established in existing law; you guys change it around a little bit, probably improve it and make the whole application and all the information in that section that you collect more confidential and clearer than before.

Check with legal, but to me, it creates a conflict. Section 20 lists out all the information that you are supposed to give in the application, but on page 14, you add a new subsection 7. It says any residential address provided to the Commissioner pursuant to this section is confidential.

You already made the application confidential. I think if you have this in there and someone wanted to be mischievous, they might say all the other information in that section would be public because it is not specifically listed as confidential. That creates a conflict. Then that would allow you to eliminate adding a new section on confidentiality at the end in NRS 239.

BRYAN FERNLEY (Counsel):
We can certainly discuss that with the sponsor. It makes sense to clean it up.

CHAIR SPEARMAN:
In the military, we would identify that the full scope, including compartmentalization of any item in the document, was illegal. Mr. Fernley, does that make sense to you?

MR. FERNLEY:
That is an option that would also make that language reference in section 20 unnecessary.

SENATOR DALY:
In my understanding of the law, everything is public unless it is made confidential. In my view, the information on the license is, and should be, public. You would not want to put in the law that this makes it specifically public because then it creates an argument for the expectation that if the Legislature wanted something to be public, they would have stated as much. It is public unless it is made confidential. Eliminate the conflict you have between section 17 and section 20.

To me, the license is public because it was not made confidential. I know that the application has some sensitive information, like financial proprietary stuff, social security numbers. So, it should be confidential. Just try not to create a conflict.

JAMIE COGBURN (Nevada Justice Association):
We are in full support of this bill. Any bill that creates additional protections for consumers, we support.

SAMANTHA SATO (Community Association Management Executive Officers, Inc.; Comprehensive Cancer Centers of Nevada):
We appreciate the bill sponsor and the proponents of the bill. We will work through the weekend on the amendment. Today we are still opposed.

KRISTINA KLEIST (Clark County Collection Service):
We are testifying neutral today. Originally, we were in opposition, but we appreciate the extensive collaboration with the proponents and the sponsor of the bill. We will continue working and look forward to seeing that amended language come out of the Legislative Counsel Bureau.

SANDY O'LAUGHLIN (Commissioner, Division of Financial Institutions, Nevada Department of Business and Industry):
I am the Commissioner of the Division of Financial Institutions. With me is Mary Young, Deputy Commissioner. We are neutral and we are continuing to work with the bill sponsors. We are here to answer any questions.

SENATOR LANGE:
Thank you for hearing S.B. 276. It takes significant steps toward improving the regulation and management of collection agencies and collection agents. I urge your support.

CHAIR SPEARMAN:
We will close the hearing on S.B. 276 and open the hearing on S.B. 330.

SENATE BILL 330: Revises provisions related to health care. (BDR 57-161)

SENATOR ROBERTA LANGE (Senatorial District No. 7):
Thank you for the opportunity to present S.B. 330 which aims to enhance our healthcare systems' coverage of essential breast cancer screening and diagnostic tests.

This bill builds upon past efforts and expands coverage in a way that will positively impact countless lives. Breast cancer remains a significant public health issue affecting millions of people globally. Early detection of breast cancer is critically important to improving treatment outcomes and reducing mortality rates.

As a part of our ongoing efforts to combat this devastating disease, our existing statutes mandate that most healthcare insurance plans cover mammograms, a vital tool in the early detection of breast cancer. According to the Health Resources and Services Administration in the U.S. Department of Health and Human Services, screenings should occur at least every two years and as frequently as every year. Women with an increased risk of breast cancer should undergo periodic screening.

The Affordable Care Act (ACA) requires health plans to cover mammogram screenings at least every two years and as frequently as once a year for women between 40 and 74 years of age. Under the ACA, insurers must cover

screenings at no cost to patients. I will go through the sections of the bill and then ask my copresenters to speak.

The bill seeks to revise and expand the existing provision within our statute that requires coverage for mammograms.

Sections 1 through 7 mandate that the same policies, plans and contract of health care that cover mammograms also provide coverage for additional imaging tests, screenings for breast cancer and diagnostic imaging testing for breast cancer. This explanation of coverage will benefit certain covered individuals by providing them with better access to potentially lifesaving screenings and diagnostic procedures.

A notable aspect of this bill is that it aims to make critical services more accessible by eliminating sections with financial barriers. Sections 1 through 7 stipulate that no deductible copayment, coinsurance or any other form of cost sharing should be required for these covered imaging tests and procedures.

By removing these financial hurdles, we can ensure that more individuals have access to the care they need. Ultimately, it increases the chances of early detection and successful treatment.

Section 8 of this bill makes conforming changes that exclude the Public Employees' Benefits Program (PEBP) from the requirements of this bill. While PEBP is not mandated to provide expanded coverage outlined in this bill, it may still choose to do so at it is own discretion. In conclusion, this important bill seeks to enhance our existing statutes by expanding coverage for essential breast cancer screening and diagnostic tests, making them more accessible to those in need.

By removing financial barriers and promoting early detection, we are taking a significant step forward in our fight against breast cancer. I urge your support of this bill to continue our efforts to save lives and improve health care for our communities.

CARI HERINGTON (Executive Director, Nevada Cancer Coalition):
We are a Statewide nonprofit. We bring together public and private health entities as well as stakeholders, including Susan G. Komen and the

American Cancer Society, to work on reducing the burden of cancer in our State. We have submitted a letter of support (Exhibit D).

The intent of S.B. 330 is to find breast cancer earlier when it is easier to treat and ultimately to save lives. The bill eliminates out-of-pocket costs for medically necessary screening and diagnostic breast imaging, providing more equitable access to care.

We have essentially updated the annual mammograms and are providing that to all insured patients starting at age 40. We have also aligned the statute with the most current recommendations. We are also providing imaging testing to screen for breast cancer when medically necessary at any age and at any interval. There are patients at high risk. For example, those with a family history of breast cancer, dense breast tissue, or who carry the BRCA gene, require additional screening. These tests can include breast magnetic resonance imaging (MRI), breast ultrasound and other clinically indicated testing.

We have also provided for diagnostic imaging testing, again when medically necessary. This typically happens when we need to either rule out breast cancer or confirm the need for a biopsy. These tests are conducted for people with symptoms of disease or abnormal test results from their screening mammogram. Again, these can include MRI, breast ultrasound or other clinically indicated diagnostic testing. We are providing these for privately insured patients.

It is very important to note that this bill does not impact federally regulated insurance, including the Employee Retirement Income Security Act plans. It is also important to note that Nevada Medicaid covers everything that we have described in this bill. They already cover that for patients at absolutely no cost. To date, eight states have already passed similar legislation. We are very excited that Nevada is one of 24 states currently working on similar bills.

Breast cancer is expensive. The National Cancer Institute reports that national expenditures associated with cancer have continued to increase in the U.S. That is no surprise, but breast cancer remains the costliest cancer. Treatment costs amounted to just under $30 billion in 2020.

Breast cancer also has the highest treatment costs of any cancer including the highest out-of-pocket costs for patients. These costs increase at each stage of breast cancer diagnosis. In fact, the cost for a stage 4 diagnosis can be

60 percent to 90 percent higher than treatment for breast cancer that is found at an earlier stage.

Thanks to the ACA, widespread access to preventive screening with a mammography machine is available to millions of people at no cost. However, if you are a patient at high risk for breast cancer or the results of your mammogram are in question, additional testing is required to rule out breast cancer or confirm the need for a biopsy. Thanks to both research and huge advances in technology, we now have the tools to detect and diagnose breast cancer in its earliest stages for all patients.

However, these tools are not equitably accessible to everybody. Additional testing might leave a patient with hundreds to thousands of dollars in out-of-pocket costs even before diagnosis or starting treatment for cancer. Patients who face these costs often delay the needed care or skip these screening tests altogether.

The Centers for Disease Control and Prevention data shows that screening reduces cancer deaths by 26 percent. In other words, 7 deaths are averted for every 1,000 people screened. Due to screening, we have decreased the number of people diagnosed with late-stage cancer. Screening has contributed to a 29 percent reduction in the number of people diagnosed with breast cancer that could have spread to other parts of their body.

We absolutely know that screening detects cancer sooner when it is much easier to treat. Almost 98 percent of people diagnosed with cancer in the early stages live for at least 5 years or more. That occurs for only 31 percent of women who are diagnosed at an advanced stage when the cancer has already spread.

This bill is the result of healthcare partners across the State, who are seeing far too many late-stage breast cancer cases in Nevada. There are patients whose outcomes could have been different and lives that could have been saved.

This bill is the culmination of two years of collaborative effort by physicians and organizations working together to try to change the story and save lives in Nevada. I will pass it to Dr. Harrigal, one of those physicians.

CHIVONNE L. HARRIGAL, M.D.:
I am a radiologist who specializes in breast cancer. My job is to read mammograms and to catch breast cancer. I have lived and worked here in northern Nevada for more than ten years.

When I first started working in Nevada, I was shocked at how many of my patients presented with late-stage breast cancer, including stage 4 breast cancer. Many of these women had not had a mammogram in many years. Some of these women had breast cancers the size of a baseball, which would have been easily caught on a mammogram.

Besides skin cancer, breast cancer is the number one cancer diagnosed in Nevada. According to the American Cancer Society, more than 2,620 of our friends, family members, neighbors, and colleagues will be diagnosed with breast cancer by the end of 2023. As many as 440 Nevadans will die of the disease this year.

Further, breast cancer does not affect all racial and ethnic groups equally. While White women are more likely to be diagnosed with breast cancer, Black women are more likely to die of breast cancer than any other group in Nevada. There are 32.8 deaths per 100,000 for Black women, compared to 23.7 deaths per 100,000 for White women.

This is a health disparity that cannot be ignored. Black women are more likely to be diagnosed with triple-negative breast cancer and inflammatory breast cancer. Both are more often detected with additional tests like breast ultrasounds and breast MRIs as these cancers do not show up as well on standard mammography.

As I learned about the lower rates of mammograms and the high death rates from breast cancer in Nevada, I wanted to understand the barriers to access. Over and over, I would meet women who could not afford to get mammograms or supplemental imaging. These included many working women who thought they had good insurance and were shocked to find out that their insurance companies did not cover tests necessary to catch breast cancer. I met women who delayed getting breast care because they had to choose between paying rent and paying for a diagnostic mammogram or ultrasound. The lack of insurance coverage, high copays and out-of-pocket expense delay care and treatment for many women in our community.

Countless women have told me that they knew they had a higher risk of breast cancer due to family history or dense breast tissue. But their insurance companies would not cover the cost of additional tests like MRI, 3D mammography, and ultrasound, which are proven to catch more breast cancers in these women.

To give you some background: A mammogram is a very safe low-dose xray picture of the breasts. A screening mammogram is a test on a woman who does not have any symptoms like a breast lump. A diagnostic mammogram is a test done to address a clinical symptom, like a breast lump or breast pain or an abnormal result from the screening mammogram. The 3D mammography, known as tomosynthesis, is a more advanced type of mammogram that has been shown to catch more breast cancers and result in fewer false alarms than a standard mammogram.

The 3D mammogram also helps find more breast cancers in women who have dense breast tissue. Dense breast tissue is associated with a higher chance of developing breast cancer, as well as a higher rate of cancers being hidden and missed on a standard 2D mammogram. Breast MRI is a tool without xrays or radiation with the highest cancer detection rate. It is often used to find breast cancers in women who have a greater than 20 percent lifetime risk of developing breast cancer, including women who have a known genetic mutation, like the BRCA genetic mutation, and women with a strong family history of breast cancer.

Breast ultrasound is an imaging test that has been shown to catch more breast cancers in women with dense breast tissue and in women who have a higher risk of developing breast cancer. It is also a test done to better characterize abnormalities seen on mammograms. Breast ultrasound is also used to evaluate breast lumps and breast pain.

One thing I have learned in the past ten years working in Nevada, people want their cancers found as early as possible. I have had the unpleasant job of telling hundreds of women in our community that they have breast cancer. No one wants their cancer found when it is too advanced, and too late to cure.

Earlier detection of breast cancer is the key to saving lives. The bigger a cancer is at the time of diagnosis, the more likely a patient will die from it. Patients diagnosed with stage 4 breast cancer will die sooner from their disease than

patients diagnosed with stage 1 breast cancer. They will also have to endure expensive treatments, which can cost the patient and their family tens of thousands of dollars a year.

Thankfully, there is now hope. We are living in an exciting time in medicine every day. There are breakthroughs being made in the fight against breast cancer. Today, we have many tools in our arsenal to catch breast cancer sooner, when it is smaller and more treatable. We have tools that can detect breast cancers when they are the size of a BB instead of the size of a baseball.

But sadly, in Nevada, many of these tests are not covered by insurance companies. The out-of-pocket costs for these tests range from $200 to $2,000. You can save lives from breast cancer, by passing S.B. 330. You would also be helping thousands of families in Nevada by reducing the financial burden that comes with necessary breast cancer screening and diagnostic imaging.

MS. HERINGTON:
As partners in the fight against breast cancer, we know how important it is for all patients to have fair and equitable access to breast imaging that could save lives. While cancer is not wholly preventable, it is much easier to treat when detected early. The chance of dying from cancer is greatly reduced when it is detected early. The expenses incurred by individuals, families and our health system are greatly reduced. By eliminating these financial pressures and allowing all people to receive screening and diagnostic imaging at no cost, we know we can reduce the number of deaths and reduce costs to Nevada's healthcare system, to insurers and, most importantly, to our friends and families dealing with this devastating disease.

SENATOR PAZINA:
I am very supportive of S.B. 330. I saw this bill does not cover the Public Employees' Benefits Program. Does it cover Medicaid and Medicare? Does it cover only private plans? Which health plans are included?

MS. HERINGTON:
Medicaid already covers this imaging, typically with no out-of-pocket costs. I assume Medicare does as well. This bill applies only to private insurance at this time. We are not including PEBP because we understand that might create an upfront cost to the State budget. But again, we would highly recommend that the PEBP Board consider this coverage for their members.

SENATOR PAZINA:
I agree; I would hope imaging is included in all health plans because it is so important.

CHAIR SPEARMAN:
I totally agree with my colleague. I knew some men in Texas who were diagnosed with breast cancer; how rare is that? Has that increased?

DR. HARRIGAL:
Breast cancer is far more common in women than in men, but there are some men who get it every year. We catch it in men when they present with lumps in general. The incidence of breast cancer in men is rising an estimated 1 percent to 1.25 percent per year.

According to the American Cancer Society's national statistics, 2,800 new cases of invasive breast cancer will be diagnosed in men and about 530 men will die from breast cancer in 2023 alone. This incorporates all Nevadans; basically, everyone is included in this bill.

CHAIR SPEARMAN:
Sometimes there is talk about the disparity in women's health care versus men's health care. Cancer is equal opportunity. In 2020, we established that racism is a public health crisis. Some of what I heard you say appears to me to be part of the systemic racism that is still prevalent in America. It may be something we do not want to deal with, but we need to. As long as we do not deal with it, then this type of health crisis will continue. You mentioned stopping imaging at age 70. Why is that?

DR. HARRIGAL:
Decades of research in screening mammograms support screening. The upper limit of screening has not yet been scientifically proven past the age of 74. In America, we see patients living into their late 80s and 90s. Patients are encouraged to keep getting mammograms as long as they would want to act on that information and as long as they are in good health. But there are many patients who might have other health issues that would limit their life expectancy. Those patients might not consider getting a mammogram because they have other, more pressing clinical matters. Patients are allowed to continue imaging past the age of 74, but that is a decision between the physician and the patient.

CHAIR SPEARMAN:
One of the reasons why this bill only applies to private insurance is the cost that would be incurred, right? Consider the PEBP plan as an example, which is for public employees. In your research, is there any way to look at this collectively or holistically so that it would encourage more insurers to cover breast cancer screening?

What we see is based on our own perspective. Unless it hits your family, it is always somebody else who is sick; the chances of cancer getting me is probably not great. Sometimes we tend to take these things in isolation. Sociologists understand that all of these things are working together, and they impact us at different times in our lives.

When we look at the cost of covering additional mammograms and testing, it seems to me it is basic maintenance. Just like the car, we can either get an oil change at the required intervals, or we can replace the engine. What is the cost versus the investment?

MS. HERINGTON:
The states that have already worked through this legislation have fiscal analysis that showed the extra costs to premiums could increase somewhere between 4 cents and $1.04 a month.

So, it might increase premiums for insured people at that amount. But again, this is fairly new; we do not have a lot of data on it yet. What we do know is for breast cancer diagnosed at stage 4, the cost to treat is 60 percent to 90 percent higher than the cost of treating breast cancer at stages 1 or 2.

For instance, early diagnosis could reduce the amount patients pay out of pocket or insurers pay to treat stage 4 breast cancer. Screening that catches cancer earlier costs everyone so much less time, money and life.

CHAIR SPEARMAN:
This is my last statement; I just want to connect the dots. Nevada is growing and graying. Whatever we do not fix today for people with something other than private insurance, there is a good possibility that cost may be going up.

This Committee is on Commerce and Labor. I understand it is not a money committee, but it occurs to me that when we start talking about abatements

that is about reducing taxes. Sometimes that is good. Sometimes it is questionable. But maybe that is something we as legislators need to consider when we are talking about abatements. What is the return from an abatement?

You apply that to healthcare. What is the return on healthcare costs? From a business perspective, people say we cannot afford it. But when you look at the other side of it, if it is your daughter, your mother, your wife, your husband, your somebody, then you think we cannot afford not to do it.

KELLEY MINER:
Thank you for giving me this opportunity to tell you my story in support of S.B. 330. I come to you as a breast cancer survivor.

I prefer to be called a thriver or a warrior, because you do not just survive this terrible disease. You have to fight. Sometimes you have to fight the insurance system to continue to live a life after diagnosis of this terrible disease. I might not be here today if I did not get my early diagnosis.

I have dense breast tissue and it is harder to find and diagnose breast cancer with this condition. In September 2019, they found something abnormal in my 3D mammogram and asked me to come back for another mammogram and ultrasound within a couple of weeks. During that ultrasound, my doctor told me he was 90 percent sure I had cancer. This is never easy to hear, and I was not prepared for this diagnosis.

However, I consider myself one of the lucky ones. I am sure most people would say that being diagnosed with cancer is not lucky, but they were able to find my cancer really early; it was only stage 1. It was only discovered because I had a 3D mammogram.

They said it would not have been found with a regular mammogram. Once I received the results from my ultrasound, I was able to get a biopsy within a week and the cancer was surgically removed within three weeks. I believe my survival is due to the swiftness of the medical attention I received.

We all know what happened in 2020 when they shut down all nonessential medical procedures. If I had waited, this might be a different story. Who knows where I would be if I needed to wait for insurance approval? What if I had to save up to afford my copays? If it had spread, I might have had to go through

more painful, extreme and expensive procedures. Without the 3D mammogram, I might not even be here today to testify.

I was able to receive these expedited medical services because I had good insurance. Not everyone is as lucky as I am. When you receive this information from your doctor it can be emotionally and mentally crippling. You have thoughts like: Will I survive? How will the chemotherapy and radiation affect me? Will I lose my hair? All these thoughts can be devastating. The last thing you want on top of all that, is to also have to worry about how to pay for those lifesaving procedures and expensive copays.

I cannot imagine having to choose between buying groceries, paying my mortgage or paying my medical bills while worrying whether I will die. I have been on a schedule of mammograms and ultrasounds every six months for the last few years since my cancer was removed. I had another scare last year when I developed some lumps again. I needed to go in for a mammogram and ultrasound to make sure it was not a recurrence. Unfortunately, I had just changed jobs and there was a three-month wait for the insurance to kick in.

After many sleepless nights, I was able to go in for the mammogram and ultrasound. I was worried I would have to endure this traumatic process again. It was a mental health struggle, for sure. I was stressed that I may have waited too long, that the cancer had spread throughout my body. I thought it might be too late and I would not be able to recover.

It is projected nearly 300,000 women will be given this gut-wrenching diagnosis this year in the U.S. Some will lose their lives due to delayed diagnosis or because they could not afford the health care. It is essential for women's survival that these procedures occur in a timely manner.

No one should go bankrupt or have to worry about having to pay excessive medical bills. No one should have to choose between paying their living expenses or for lifesaving procedures.

I implore you to pass S.B. 330 so women can receive this vitally important health care. I am extremely thankful that I have been cancer free for three years, five months and six days due to my amazing team of doctors and the ability to afford my procedures. But this will be a lifelong journey.

Thank you for listening to me. I hope you will pass this bill to save the lives of mothers, sisters, grandmothers, daughters, nieces, and aunts who may not be as fortunate to have insurance or the financial means to afford to pay for these procedures.

ALEX TANCHEK (Nevada Advanced Practice Nurses Association):
We support S.B. 330. We believe the bill will help prevent life-threatening healthcare crises for individuals. It will also prevent far greater expenditures for treatment.

AODHAN DOWNEY (Comprehensive Cancer Centers of Nevada):
I am testifying in support of S.B. 330 on behalf of the Comprehensive Cancer Centers of Nevada. By eliminating financial pressures and allowing Nevadans to receive coverage for screening and diagnostic imaging, we can reduce overall costs in the system. More importantly, we can save lives. For these reasons, we respectfully urge your support of S.B. 330.

VANESSA DUNN (Nevada Public Health Association; Nevada Primary Care Association):
We represent members with interests in advancing public health and federal health clinics across the State. Both organizations would like to offer their strong support for S.B. 330. Breast cancer screenings offer an important early detection method for cancer with a high survival rate when caught and treated early.

AMY THOMPSON:
With over 10 years of experience as an oncology-certified nurse and certified breast cancer patient navigator, I strongly support S.B. 330. This bill would eliminate out-of-pocket costs for medically necessary screening and diagnostic breast imaging.

I have seen many women experience barriers to breast cancer screenings and diagnostic testing, including breast MRIs, due to high out-of-pocket costs. Some can cost hundreds to thousands of dollars depending on the type of tests ordered.

Delaying necessary supplemental screening and diagnostic imaging means delaying the identification of breast cancer, which is never in the best interest of the patient.

No one should ever have to decide to put off breast imaging due to costs. If our system cannot facilitate early detection by eliminating out-of-pocket costs for necessary screening and diagnostic breast imaging, we can expect continued disparities in access and increases in late-stage diagnosis. Ultimately, this will cause more financial difficulty due to delayed treatment.

As Nevadans, we can and should do better. By eliminating out-of-pocket expenses, we can allow all people access to these needed screenings and diagnostic breast-imaging tests. This will reduce deaths and reduce costs to Nevada's healthcare system.

Please support S.B. 330 and support equal access to lifesaving imaging for the early detection of breast cancer. Thank you for your consideration of this critical issue.

DARCY PHILLIPS:
I am a seven-year breast cancer survivor. I found my cancer myself in a self-breast exam just three months after a regular mammogram. I got in for an ultrasound immediately, a biopsy the next day, got the diagnosis the day after that. Two weeks later, I was scheduled for surgery and radiation.

This bill is so important. I will be getting diagnostic mammograms and ultrasounds for the rest of my life. If I ever need an MRI, my out-of-pocket cost will be $1,000. That is with good health insurance. I could possibly need that every single year. But so many of the people I volunteer and work with cannot afford that care.

WILL PREGMAN (Battle Born Progress):
We support S.B. 330. We are in strong support of anything that makes health care more accessible and affordable to Nevadans, especially those who face systemic barriers. Please support this bill.

BRIANA ESCAMILLA (Planned Parenthood Votes Nevada):
I am here in support of S.B. 330. Planned Parenthood believes that all Nevadans, regardless of income level, deserve access to the preventative health care that they need to live healthy lives. Cost should never be a prohibitive factor in receiving lifesaving and medically necessary care.

YVONNE BATTAGLIA:
I am here to observe the Legislature today with Grassroots Lobby Days. I am a retired nurse and a resident of Carson City. I support S.B. 330. I can verify that Medicare covers screening mammograms; I had a mammogram and Medicare paid.

Medicare believes it is essential, and therefore, commercial insurance should also cover these procedures. I also take this bill personally. I know someone who died of breast cancer. She was young, she was vibrant, she was an intensive care unit nurse. She was a surfer, a wife and a volunteer who helped disabled kids ride a surfboard. She died way too young. I would like you to pass S.B. 330 to prevent early death.

RANDY JOHNSON (American Cancer Society Cancer Action Network):
We are pleased to support S.B. 330, which would eliminate out-of-pocket costs for medically necessary screening and diagnostic breast imaging.

This year, the American Cancer Society estimates over 17,000 new cancer cases will be diagnosed in Nevada, of which 2,620 will be diagnosed with breast cancer. Unfortunately, it is estimated that 5,850 Nevadans will die from cancer this year. Reducing the barriers to screening is the most important.

Ensuring access to medically necessary screening and diagnostic breast imaging can decrease the number of Nevadans diagnosed with late-stage cancer. I thank the Committee for your attention on this important issue.

BARRY COLE, M.D.:
I echo the sentiments of the others. We need to pass S.B. 330. If we had a comprehensive health system that worked, this would already be happening. The problem is our healthcare system is fragmented.

People are caught between different insurance parameters. I have seen breast cancer play throughout the life continuum. As a physician, I have seen my patients suffer with cancer. My mother and my daughter-in-law suffered with it. As a hospice medical director, it broke my heart to see people on hospice who could have had an earlier intervention and possibly a cure.

This is a good time to think comprehensively about preventative health care; it is National Public Health Awareness Week. We can use S.B. 330 as a means to get started helping men and women who might one day face breast cancer.

CONNOR SWEENEY (Susan G. Komen):
Susan G. Komen, the Nation's leading nonprofit breast cancer organization, strongly supports S.B. 330.

As you have heard, screening mammograms are often just the first step in the process of diagnosing breast cancer. Early detection would not be possible without diagnostic follow-ups, and the additional supplemental imaging required to either rule out breast cancer or confirm the need for a biopsy.

Unfortunately, our organization often receives calls and emails from individuals who tell us they are unable to afford the out-of-pocket costs for their recommended breast imaging. These patients, who delay or even forego these imaging sessions for financial reasons, risk their cancer spreading and becoming more deadly and more costly to treat.

It only makes sense to ensure all patients have equitable access to the entire screening continuum. The widespread availability of no-cost mammograms has shown us that increased access to screenings drives early detection. But this is not equally true across all demographics.

Significant disparities do exist when it comes to the diagnosis of breast cancer that we believe may be due to delays in medically necessary imaging. Evidence shows that Black patients who are commercially insured are diagnosed at a later stage and have a higher mortality rate when compared to their White counterparts with the same insurance status.

Eliminating out-of-pocket costs for these services would further improve access, eliminate that disparity and result in earlier detection of breast cancer across the board.

ELIZABETH BARNES:
I live in Reno. In May of 2014, I was diagnosed with breast cancer after having my yearly mammogram. I am at high risk due to dense tissue. No other mammogram type was offered to me. I had high out-of-pocket costs associated with any treatment or diagnostic services I chose. When two large tumors were

found, I was diagnosed with stage 3B cancer. I had just had a mammogram the year before.

Make diagnostic imaging available to both men and women. We know that early detection saves lives and saves money. I went on to pay very high out-of-pocket costs due to my private insurance. When the insurance year rolls over, there are more out-of-pocket costs. I strongly support S.B. 330.

SARAH WATKINS (Nevada State Medical Association):
Our organization is one of the State's largest patient-physician advocacy associations. We fully support S.B. 330.

SENATOR DALY:
This testimony reminded me we should all be thankful for the ACA, which eliminated preexisting conditions. Before that cancer was considered a pre-existing condition. People who had to switch health insurance back then lost coverage. It is important to remind everybody we have made progress, even though there is still more work to be done.

CHAIR SPEARMAN:
Last week I learned that the PEBP health plan, which would not be covered under this bill, has a $3,000 deductible. I do not know who can afford that. As legislators, it is important that we connect the dots. When people who can afford health insurance come to us asking for some type of tax abatement, we need to remember the people who do not get an abatement on their healthcare costs.

SENATOR LANGE:
In closing, I want to remind everyone that if we are proactive, we save dollars. If we are reactive, it will cost a whole lot more. We have plans like Medicare and Medicaid that are already covering these expenses. There is no reason why our private insurance companies cannot also cover these expenses. I urge you to vote yes in favor of this bill.

CHAIR SPEARMAN:
We will close the hearing on S.B. 330 and open it to public comment. Hearing none, we are adjourned at 9:47 a.m.

RESPECTFULLY SUBMITTED:

Kelly K. Clark,
Committee Secretary

APPROVED BY:

Senator Pat Spearman, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Introduced on Minute Report Page No.**	**Witness / Entity**	**Description**
	A	1		Agenda
	B	1		Attendance Roster
S.B. 276	C	9	David Reid / Receivables Management Association International	Conceptual Amendment from Brian Reeder
S.B. 330	D	14	Cari Herington / Nevada Cancer Coalition	Support Letter