MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-second Session
May 9, 2023

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 3:36 p.m. on Tuesday, May 9, 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 Fabian Doñate, Chair
Senator Rochelle T. Nguyen, Vice Chair
Senator Roberta Lange
Senator Robin L. Titus
Senator Jeff Stone

GUEST LEGISLATORS PRESENT:

Assemblywoman Tracy Brown-May, Assembly District No. 42
Assemblyman Max Carter, Assembly District No. 12

STAFF MEMBERS PRESENT:

Destini Cooper, Policy Analyst
Eric Robbins, Counsel
Mary Ashley, Committee Secretary

OTHERS PRESENT:

Chelsea Capurro, Earth Funeral Group
Tom Harries, CEO, Earth Funeral Group
Isaac Hardy, Nevada Conservation League
Chris Bell, Sierra Club - Toiyabe Chapter
Matthew Wilkie
Maggie Carlton
Bobbette Bond, Senior Director of Health Policy, Culinary Health Fund

Mason Van Houweling, Commissioner, Patient Protection Commission
Annette Magnus, Battle Born Progress
Paul Catha, Culinary Workers Union Local 226
Susie Martinez, Nevada State AFL-CIO
Marc Ellis, Communications Workers of America
Randy Soltero, International Alliance of Theatrical Stage Employees
Liz Sorenson, Nevada State AFL-CIO
Dionne Klug, United Food and Commercial Workers 711
James Creel, Compassion Center; Integrative Providers Association
Rita Weisshaar, Nevada Alliance for Retired Americans
Clarence McCarthy, National Association of Letter Carriers 709
Pat Kelly, Nevada Hospital Association
George Ross, HCA Healthcare
Sarah Watkins, Nevada State Medical Association
Dan Musgrove, Valley Health System of Hospitals
Misty Grimmer, North Vista Hospital
Paul Moradkhan, Vegas Chamber
Susan Proffitt
Irene Gutierrez, M.D., Program Director for Family Medicine, Dignity Health-St. Rose Dominican
Emily Osterberg, Henderson Chamber of Commerce
Dean Polce
Justice Forest
Eli Schwartz, Member, Nevada Commission for Persons Who are Deaf and Hard of Hearing
Catherine Nielsen, Executive Director, Nevada Governor's Council on Developmental Disabilities
Dora Martinez, Nevada Disability Peer Action Coalition
Beth Jones, Nevada Hands & Voices
Timothy Eli Addo
William Horne, Compassion Center
Erin Hickey
Jim Bartell
Julie Monteiro, Integrative Providers Association; Compassion Center
Jason Greninger, CEO, Atlas Alchemy
P.J. Belanger
Katree Saunders, Pardon Me Please
Vicki Higgins, Coalition for Patient Rights
Jessie Wadhams, Nevada Hospital Association

Adam Porath, Nevada Society of Health System Pharmacists
Ashley Kennedy, University Medical Center

CHAIR DOÑATE:
We will open with the work session. Our first item is Assembly Bill (A.B.) 24.

ASSEMBLY BILL 24 (1st Reprint): Revises the membership of the Committee on Emergency Medical Services. (BDR 40-222)

DESTINI COOPER (Policy Analyst):
I have a work session document (Exhibit C) describing the bill.

CHAIR DOÑATE:
I will entertain a motion on A.B. 24.

SENATOR TITUS MOVED TO DO PASS A.B. 24.

SENATOR NGUYEN SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR DOÑATE:
Let us move on to A.B. 40.

ASSEMBLY BILL 40 (1st Reprint): Revises provisions related to inspections of food establishments. (BDR 40-223)

MS. COOPER:
I have a work session document (Exhibit D) describing the bill.

CHAIR DOÑATE:
I will entertain a motion on A.B. 40.

SENATOR NGUYEN MOVED TO DO PASS A.B. 40.

SENATOR STONE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR DOÑATE:
Let us move on to A.B. 116.

ASSEMBLY BILL 116 (1st Reprint): Requires the provision of information and referrals concerning Down syndrome under certain circumstances. (BDR 40-569)

MS. COOPER:
I have a work session document (Exhibit E) describing the bill.

CHAIR DOÑATE:
I will entertain a motion on A.B. 116.

SENATOR NGUYEN MOVED TO DO PASS A.B. 116.

SENATOR TITUS SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR DOÑATE:
Let us move on to A.B. 136.

ASSEMBLY BILL 136: Requires certain facilities to be licensed as child care institutions. (BDR 38-326)

MS. COOPER:
I have a work session document (Exhibit F) describing the bill.

CHAIR DOÑATE:
I will entertain a motion on A.B. 136.

SENATOR NGUYEN MOVED TO DO PASS A.B. 136.

SENATOR LANGE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR DOÑATE:
Let us move on to A.B. 215.

ASSEMBLY BILL 215: Revises the residency requirements for appointment as a member on the Nevada Silver Haired Legislative Forum. (BDR 38-456)

MS. COOPER:
I have a work session document (Exhibit G) describing the bill.

CHAIR DOÑATE:
I will entertain a motion on A.B. 215.

SENATOR NGUYEN MOVED TO DO PASS A.B. 215.

SENATOR TITUS SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR DOÑATE:
Let us move on to Senate Bill (S.B.) 445.

SENATE BILL 445: Revises provisions governing emergency medical services. (BDR 40-1071)

MS. COOPER:
I have a work session document (Exhibit H) describing the bill.

CHAIR DOÑATE:
I will entertain a motion on S.B. 445.

SENATOR NGUYEN MOVED TO DO PASS S.B. 445.

SENATOR LANGE SECONDED THE MOTION.

SENATOR STONE:
With regret, I cannot support this bill. The fines collected by a regulatory agency should go into the General Fund. An agency could proactively fine people they are governing to boost revenue for their regulatory board. I am going to have to be a no today on S.B. 445.

THE MOTION CARRIED (SENATORS STONE AND TITUS VOTED NO.)

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CHAIR DOÑATE:
We will close the work session and open the hearing on A.B. 289.

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

ASSEMBLYMAN MAX CARTER (Assembly District No. 12):
Assembly Bill 289 is adding another classification into the statutes that enables cremation and aquamation. It is adding natural organic reduction, or human composting. I will have my co-presenters walk you through the bill.

CHELSEA CAPURRO (Earth Funeral Group):
I want to thank the sponsor for taking on this issue.

TOM HARRIES (CEO, Earth Funeral Group):
We are one of the first natural organic reduction providers in the United States. We currently operate in the Pacific Northwest. My background has been in the funeral industry for the past decade so I can speak about natural organic reduction and funeral regulation.

I would like to give a quick slideshow presentation (Exhibit I) that will give you an overview on natural organic reduction. The existing funeral practice is unsustainable. The two primary methods of disposition are burial and cremation. Both are harmful to the environment. Both are putting pollutants into the environment. The first uses nondegradable wood, metal, concrete and embalming fluid, which is a toxic chemical. With nearly 330 million deaths nationally over the next 80 years, it is impractical to continue to put people into

the ground. Cremation is the primary method of disposition in Nevada because 83 percent of our citizens are choosing to be cremated. However, this is a fossil fuel-driven process equivalent to a 600-mile car trip.

Natural organic reduction is an environmentally friendly alternative to burial and cremation. Instead of being cremated and turned into ash, the deceased person will be transformed into soil. The process takes 45 days and, at the end of the process, the family can choose how much of the soil will be returned to them. They can keep it, scatter it or use it for plants. We have seen people drive to National Parks and scatter it in places meaningful to them. They have used it to plant orchards or memorial gardens. The families have also used the soil to restore fire-damaged land. They are choosing meaningful ways to use the soil.

Any remaining soil is sent to conservation land where it is used for wildfire restoration, reforestation or to restore and protect land for future generations. The soil serves to return the goodness in our bodies to the natural world. Instead of blasting the nutrients up in smoke, we can return the nutrients to nature.

There is a science behind this process of composting. We are doing what would happen on the forest floor. We are optimizing this through science and technology. Each process takes place in an individual vessel, which controls temperature, moisture and oxygen levels. It is creating perfect conditions for microbes to break down the body on a molecular level. The output is nutrient-rich soil similar to what you would find at a garden center. In fact, I would challenge you to distinguish between the two soils. This is a completely natural process with no use of chemicals or insects. It is purely accelerating and optimizing nature.

This is a four-step process. We start by gently washing the body and wrapping him or her in a biodegradable shroud. The body is then placed in a vessel on a layer of organic mulch, woodchips and wildflowers to balance the carbon nitrogen. The body and organic material remain in the vessel for the 45-day process. During this time, the microbes are breaking everything down at a molecular level. At the end of the process, the family will have soil. As a family, they can choose what they want to do with the nutrient-rich, life-giving soil. Any remaining soil is sent to conservation land for restoration projects.

Natural organic reduction is simply a matter of consumer choice. You can choose to be buried or cremated. However, you can also choose to be gently transformed into soil and return to a beautiful piece of land. Natural organic reduction is ideal for people who are trying to minimize their carbon footprint or like spending time outdoors. It is also an option for those who do not resonate with cremation or burial.

One of the key benefits is it is a gentle natural process. It is also net carbon neutral versus 535 pounds of carbon dioxide produced by cremation. It restores and protects land for future generations and is your final resting place. A person can choose an area of iconic beauty like Lake Tahoe.

ASSEMBLYMAN CARTER:
I am sponsoring this bill because I am involved in the trauma and grief world. I know personally how you never know what is going to be that one thing that brings a little bit of light in a dark period in somebody's life. This bill is not narrowly tailored and will enable the practice with no proprietary means.

CHAIR DOÑATE:
I do have a request for my Committee members. Since we are talking about soil, before you ask a question, please tell us if you could be a tree what kind of tree you would be.

SENATOR TITUS:
I would be a maple tree because I am so sweet. Having said that, we do have other methods like alkaline hydrolysis, which was a bill we passed in 2017. It is my understanding that this method never took off. Do you reuse the vessels?

MR. HARRIES:
I would like to touch upon alkaline hydrolysis. It is a process that dissolves a body in an alcohol solution and washes it down the sewer.

SENATOR TITUS:
There are still some bones and other components left over. It does not really break down all of the products.

MR. HARRIES:
You are correct. However, it is not appealing. To answer your question, the process takes 30 to 45 days, and the vessels are reused.

SENATOR TITUS:
So, the body size can determine how long it takes. Is it aerobic as opposed to anaerobic because you add oxygen?

MR. HARRIES:
Yes, it is an aerobic process.

SENATOR TITUS:
I assume that by the proper temperature and the proper amount of water, you allow it to do a natural process.

MR. HARRIES:
Yes.

SENATOR TITUS:
Is the vessel sealed and oxygen is pumped in for it to work?

MR. HARRIES:
Yes.

SENATOR TITUS:
Many of my patients have a pacemaker or some other implantable device. Do you have to remove those before you put the bodies in the vessel?

MR. HARRIES:
We do not. Any inorganic items are removed and recycled at the end of the process. These items are not organic or biodegradable.

SENATOR TITUS:
Is it two other states that have this law?

MR. HARRIES:
There are six states that have passed legislation on this process. Washington was the first state, followed shortly by Colorado. Oregon was next and then Vermont, California and New York. In addition, there are ten states with bills. We are seeing momentum, and it has been grassroots-driven.

SENATOR TITUS:
Conceptually, I support this bill. I do recycle and have a large compost. I plan on being cremated and be thrown into the river on my property. You cannot throw this into Lake Tahoe because there are rules about silt and dirt. So, I would not use this area as an analogy.

You mentioned people can take as much soil as they want. Does the family have to come to you and get the soil? What is that process? You also stated the remaining soil is taken to a conservation area. It is it a designated area?

MR. HARRIES:
To clarify, I meant the forest land surrounding Lake Tahoe. I did not mean the soil would be scattered into the lake.

Families decide the amount of soil they wish to take. Some take all of it while others take no soil. For the average person, the process produces about a half cubic yard which is a lot of soil. Any remaining soil is sent to a conservation land, which is currently private land. The soil has been used for conservation projects such as reforestation and wildfire restoration.

SENATOR NGUYEN:
If I were a tree, I would be a palo verde because it has yellow flowers. It is native here and is drought-tolerant. I also like the dragon fruit tree. Those are my two plants.

What is the cost for this process? I have heard it could be more economical and there is an environmental savings. Can you talk about the cost?

MR. HARRIES:
The average cost of a funeral in the United States is about $8,000. Our company currently charges $5,000 in the Pacific Northwest. We expect the cost to decrease over time due to wider adoption of the process, decreased cost in technology and operating at higher volumes. We will achieve economies of scale in due course and bring the price down.

SENATOR STONE:
This is no reflection on my ego, but I like the giant sequoias. My wife's family has been in the funeral industry for a long time. My father-in-law and I were discussing this bill, and he had positive things to say about it. He did caution

families need to understand that they will not be receiving their loved one's remains in a small vessel. They will receive the soil in a large vessel. I am not sure if it will be the vessel used for decomposing the body or a disposable vessel. How do you deliver the soil? If the family does not want the soil, then is it transferred to a preserve? Will you give the family the location of the soil? I would like for you to explain that process.

You mentioned it is a 45-day process. Are there microbes you put in the vessel or is it part of the flora that helps the degradation process?

MR. HARRIES:
The picture of the vessel on page 5 of Exhibit I is used for processing the remains. People are not taking that vessel home. It is expensive because it controls the moisture, aeration and temperature. It is also seven feet long and three by three feet in diameter. The container is dependent upon how much soil the family wants returned to them. Approximately 90 percent of the families take only a portion home, which is similarly sized to cremated remains. If a family wants a larger amount returned, then they would have to collect it themselves. At this point, the family is transferring big chunks of soil, and it is a logistical endeavor that we have not undertaken ourselves.

In terms of forest land, we do inform families where the soil is going. This resonates with people as an opportunity for their loved one's final resting place to be one of natural beauty. At the moment, we have a piece of land on the Olympic Peninsula in Washington. We would do something similar in Nevada as well. We would find an iconic piece of local land.

The microbes are naturally occurring either within the body or in the organic mulch. We are not adding anything, and it is pure nature.

SENATOR STONE:
Senator Titus mentioned certain prosthetics or cardiac devices. These are not going to decompose, and you mentioned it will be recycled. In a morbid sense, these items have value. Do you return gold teeth to the family?

When I was admitted to the University of Southern California, School of Pharmacy, I could not afford to attend this class, but my family pitched in to cover the cost of the school. It included living with my grandmother who had been widowed for about seven years. She gave me my grandfather's dresser

drawers and as I went through them, I found his dentures. When I started to throw them away, I saw a flash from a gold bridge. My grandmother gave me the gold and I made a piece of jewelry out of it. I was close to my grandfather, and I wore this jewelry for 40 years. My grandfather's name was Edward Friedman, and he always encouraged me to go to school. He did not have the opportunity to go to school because he was an immigrant from Russia.

When my son won the primary for a Riverside County Superior Court judge, I passed the jewelry onto him. He was shocked, but I informed him that it had brought me luck. I wanted him to have good luck. I would like to add he won his election. At any rate, sometimes those little gold pieces mean a lot to a family. I appreciate that you are going to sift through the remains and give those items back to the family.

SENATOR TITUS:
For clarification, is the vessel a tumbler?

MR. HARRIES:
The vessel agitates gently side to side.

ISAAC HARDY (Nevada Conservation League):
When my wife and I were in college, we both worked at a funeral home. We would see families mourning a deceased loved one. The family would spend thousands of dollars on packages to honor their loved one.

This method offers a more affordable option than a traditional burial or cremation. It is a more personal and meaningful way to dispose of a loved one's remains. We are in full support of A.B. 289. We urge the Committee to support it as well.

CHRIS BELL (Sierra Club - Toiyabe Chapter):
I am in support of A.B. 289. I have submitted my written comments (Exhibit J) to this Committee.

MATTHEW WILKIE:
I am calling in full support of A.B. 289. This eco-friendly alternative to traditional cremation allows individuals to leave a positive impact on the environment even in death. The inclusion of natural organic reduction to the definition of cremation is a welcome update to existing provisions. I also

appreciate the exemption from certain requirements for soil resulting from natural reduction, which makes this process even more appealing to those who value its sustainability. Thank you for considering this bill and supporting environmentally responsible options for a disposition of human remains.

ASSEMBLYMAN CARTER:
To answer the Chair's question, I would be a mesquite tree. I am a native-born Nevadan, and there is nothing more Nevadan than a mesquite tree.

CHAIR DOÑATE:
I would be a willow tree, but it depends on the day. On to a serious question, I have been thinking about the plots of land that the soil would be distributed on. If you have a lot of trees nearby, some may argue it could become a haunted forest. Can you elaborate on if this bill would lead to a haunted forest?

ASSEMBLYMAN CARTER:
Anything is possible. Nevada is good at turning anything into a tourist attraction. We will need to leave that one open.

CHAIR DOÑATE:
We will close the hearing on A.B. 289 and open the hearing on A.B. 11.

ASSEMBLY BILL 11 (1st Reprint): Revising provisions governing hospitals. (BDR 40-382)

MAGGIE CARLTON:
I am a former Nevada Senator and Assemblywoman, and I am here today as someone who worked on a lot of items from the Patient Protection Commission through the Legislature. Prior Legislative Sessions have tackled large healthcare issues like your Committee is tackling this Session. We would have conversations on how to address the big issues, but the Session is limited to 120 days.

The State does have interim committees that also do a lot of work. However, they can only do so much in the interim. To create comprehensive data-driven policies, the State created a Patient Protection Commission. After passing legislation in 2017, the State started to work on establishing the Commission. Former Governor Steve Sisolak had mentioned the Commission in his Executive Budget. In 2019, we started working on the proposal and the Commission was

doing a lot of good work to address individual items. In 2021, the State made changes to the Commission, and it has done an excellent job tackling complex healthcare issues.

One of the reasons why I am presenting A.B. 11 is due to the vacancy of the Commission's executive director. In compliance with legislative protocols, there is no one from the Commission who can present the bill. A person who is working on the Commission as a commissioner or in support of the bill cannot present a bill. As a Legislator who tackled these issues over 20 years, I was asked if I would present this bill to you.

Assembly Bill 11 is one of three bills that came out of the Patient Protection Commission. It was approved by consensus when the commissioners voted on their bills. They have a give-and-take atmosphere for selecting the bills. The Governor's Office sent a letter (Exhibit K) requesting that these bills not advance during this Session. The letter asked the Commission not to move the bills forward. I was concerned about this request. The Commission spent time and effort to work on these issues. The bills were drafted and were in queue to be presented to the Legislature. There is no reason to not have the discussion. It is up to the Legislature to decide what is public policy in this State.

BOBBETTE BOND (Senior Director of Health Policy, Culinary Health Fund):
I am a commissioner on the Patient Protection Commission. As discussed by former Senator Carlton, a commissioner typically does not speak about Commission bills. However, we are in a unique Session because our bills do not have someone to present. Assembly Bill 11 is the first of three bills that may be in front of this Committee.

I wanted to discuss the history of how we ended up with the corporate practice of medicine (CPOM) bill. At this time, I would like to introduce my copresenter and fellow commissioner, Mr. Mason Van Houweling.

MASON VAN HOUWELING (Commissioner, Patient Protection Commission):
I worked with my fellow commissioners on this legislation. Our process was thoughtful with deliberate conversations. The Commission is proud of these bills that we are moving forward.

MS. BOND:
The Commission was presented with 15 proposed bills. Of those 15 bills, there was information submitted by the proponents of each bill. The Commission was tasked with evaluating the bills and reducing it to three.

Assembly Bill 11 is in response to the Commission's concern about the CPOM. One of the other two bills is trying to make sure patient access to medical records is easier and interoperable. The third bill is trying to create a benchmark program in Nevada to track the cost and the price of health care as we try to control healthcare costs.

I have submitted a presentation (Exhibit L) on this bill. It is the history of the Nevada law on the CPOM and the reasons it ended up becoming a concern for the Commission from a patient's perspective. Currently, physicians are being hired as employees in Nevada's private hospitals. This was not always the case. There are laws on the books that created structure for the CPOM. The question is can a corporation hire a physician? Since the 1970s, three Attorney General (AG) opinions have been issued trying to address this question.

Nevada statutes have a strange approach to the CPOM. Instead of listing who cannot operate as an entity that hires physicians, Nevada and many other states list who can hire a physician. In short, the entities that can hire are listed in statute as the exceptions and the rest cannot. Until recently, this is the way it has been in Nevada.

I am going through the three AG opinions and other evidence from prior testimony suggesting what has been the state of play until now. We can then discuss why the Commission wants to move forward with this bill. For ease of review, on pages 3 through 5 of Exhibit L, I highlighted areas of each opinion.

The first one is Op. Nev. Atty Gen. 77-219 (Oct 3, 1977) (Exhibit M) about whether physicians could be hired by private hospitals. It is from 1977 when Robert List was the AG. Physicians and surgeons under corporate practice are only legal under chapter 89 of *Nevada Revised Statutes* (NRS). It was illegal to hire a doctor if it was a corporation under NRS 78. In 1977, the conclusion of this first question to the AG was the corporate practice of medicine by a general corporation organized under NRS 78 is not legal. The conclusion continued "Nevada licensed physicians who aid or abet a corporation to illegally practice

medicine may be charged with unprofessional conduct and have their licenses suspended or revoked."

To clarify, we are not trying to discuss all corporations. This bill specifically targets hospitals that hire physicians. The Commission's concern is not being able to access a physician in a hospital in the absence of prohibition.

The next opinion, Op. Nev. Atty Gen. 2002-10 (Feb 26, 2002) (Exhibit N), was issued in 2002 when Frankie Sue Del Papa was the AG. She was asked to opine on a couple of questions related to the CPOM. Her findings were a review of Nevada statutes and caselaw reflecting that the law is generally unchanged from the previous opinion from Attorney General Robert List in 1977. The CPOM is still prohibited unless in the form authorized by NRS 89, NRS 695B, NRS 695C, NRS 695F and NRS 695G. If corporations engaged in the practice of medicine and do not fall within one of the referenced statutes, it would be unlawful.

The third opinion (Exhibit O) is from 2010 when Catherine Cortez Masto was the AG. Her office opined that the State Supreme Court and the Nevada Legislature have never expressly determined private hospitals licensed under NRS 449 cannot employ a physician. The letter continued:

> It has been the longstanding practice in Nevada that physicians only work as contractors for private hospitals, and not as employees. To depart from this practice would mark a significant change that would be tantamount to a change in State public policy.

These opinions have led us to your doorstep and is the reason that we are here today. In addition, nothing has been legislated since 2010. Additional history lends credence to this topic. Private hospitals could not hire physicians but could contract with them. Private hospitals could also provide privileges to physicians.

In 2002, a Legislative Commission subcommittee was tasked to determine the relationship that hospitals and quick care centers should have in the private sector and the nonprofit sector. The minutes (Exhibit P) indicate Mr. Alan Stipe, who at that time was Sunrise Hospital and Medical Center's CEO and president, was testifying on the impact of the hospitals and quick care centers. On page 8

of Exhibit L, he referred to the corporate practice of medicine law as an unnamed federal statute. He continued that private sector hospitals cannot hire physicians, but the University Medical Center (UMC) of Southern Nevada can. He explained that the private sector must demonstrate medical malpractice insurance. However, that is the reason why we are here today. The president and chief executive officer of Sunrise Hospital believed, and nothing has changed since 2002, that private hospitals do not hire physicians, instead they contract with them.

Senate Bill No. 412 of the 74th Session increased the type of facilities that could hire physicians. In testimony on this bill, Dr. Michael Harter of Touro University Nevada (Exhibit Q) testified "there is a prohibition against the corporate practice of medicine if the corporation is not owned by physicians." Dr. Harter continued that the AG had written legal opinions on two occasions and the result is that private nonprofit corporations such as a Touro University cannot hire physicians.

As later promoted by Attorney General Cortez Masto, this question was brought to the Legislature. Senate Bill No. 412 of the 74th Session was legislating this issue. In section 5 of that bill, the authority allowed a nonprofit medical school and a nonprofit medical research institution to hire a physician rather than contract with them.

We have three AG opinions and testimony from related bills that set the record on what our position should be. The Health Services Coalition, which has done 20 years of hospital contracting, has always thought this was the situation as well. As you have heard from the Nevada Hospital Association, until this year, physicians were not hired by private hospitals. They have a contract with the physicians to provide privileges at the hospital.

About 2015, the American Medical Association (AMA) issued an opinion. The subject of the opinion was the reasons not to have physicians hired directly by the hospital. They succinctly state that the problem with physician employment, rather than contractual relationships, is medical care became even more commercialized. Obligations to shareholders may not align with a physician's obligations to patients. Finally, it can interfere with independent medical judgment.

In addition to the problems pointed out by the AMA, Nevada has a shortage of physicians. It is causing more shortages by having doctors tied up with one facility that they work for, instead of ability to provide privileges and services at all community service hospitals. Nevada hospitals are community servants. They are community assets, and patients need to be able to use them. Unlike a retail facility, a hospital is a unique entity.

The shortage of medical care is the reason it was brought to the Commission. Nevada does not have enough hospitals. There are not enough doctors to be hired by every hospital. There is a movement nationwide, including Nevada, to consolidate the hospital and healthcare industries. It will make it easier for hospitals and healthcare systems to build market share. As healthcare systems consolidate, they want the physicians on staff. If they have the facilities but not the doctors, then they cannot provide services. The doctors are the key reason why hospitals are in business at all.

MR. VAN HOUWELING:
The University Medical Center is the largest public hospital in the State. We have been serving our community since 1931 starting with one doctor and one nurse caring for the workers of the Boulder Dam. Fast forward to today, we have the highest level care in the State and are proud of our large teaching mission. We train the next generation of healthcare workers and currently have 2,000 students.

As mentioned, I am a commissioner on the Patient Protection Commission. I would like to talk about the CPOM that applies to hospital corporations. The existing law is meant to protect the sanctity of the physician-patient relationship. Decisions are made in the best interest of patients and, unfortunately, not in the best interest of the corporation's bottom line. The corporate practice of medicine doctrine requires clarity in Nevada. As Ms. Bond alluded to, we do need to clean this up and bring clarity. There are clear exceptions currently found in NRS 450.180 and NRS 630.365.

The actual prohibition is discussed in three AG opinions, as Ms. Bond discussed. It is time to clarify the rules around the law and a policy that already exists. Except in limited situations set forth in NRS exceptions, physicians form their practices utilizing professional corporations and professional limited liability companies. One reason for this is to ensure that the individual malpractice liability will pass down to the physician owners.

Most, if not all, healthcare professional licensing statutes already contain fee-splitting, which is a technical and professional component. Therefore, even in states that do not follow a corporate practice of medicine, these professionals need to be extremely concerned when they are sharing their fees for their professional charges without a clear exception under law.

On behalf of the Commission and many Nevadans, your support and advocacy of A.B. 11 will prevent the commercialization of medicine. You are going to hear many things today, and we know that Nevada already has a medical care shortage. This bill will prevent a misalignment of physician obligations under the Medical Practice Act. It will not exacerbate the shortage of doctors. It will ensure and grow independent doctors working at multiple hospitals. They can contract and have privileges with any hospital. Finally, we need to prevent patients from being directed to specific hospitals thus reducing overall consumer choice.

MS. BOND:
On page 12 of Exhibit L, we have summarized what other states are doing on CPOM. Seventeen states do not have anything, but two-thirds, or 34 states, do have something on it. I have submitted a detailed report (Exhibit R) on each state's status. Twelve states create an exception for nonprofits, and 11 states create an exception for specific types of nonprofits. In addition, 11 states do not have a nonprofit exception. There are specific places in NRS where it is allowed in Nevada. The exceptions support the rule that the rest are not allowed.

We have operated under this CPOM for at least 45 years. We have the three AG opinions supporting that physicians should not be hired by hospitals. Since 2010, there have been some legislative attempts by the hospitals to permit a private hospital to hire physicians. The legislation never passed. We are at the same place we were in 2010 when the last opinion was issued. The statute offers exceptions, and it is important to acknowledge those exceptions.

Hospitals are doing well in Nevada. I state this to preempt testimony you will hear today and have heard at other hearings. Statements have been made that hospitals still struggle from COVID-19. I educate this Committee that the hospitals had $1.8 billion in net income in the four last years. On page 14 of Exhibit L, I have listed the four hospital systems which own 70 percent of the

revenue. The rest are comprised of 14 rural hospitals and 1 county hospital. This group would have 30 percent of the total revenue.

We are concerned that consolidation of healthcare systems is increasing. It is getting bigger and most big systems in Nevada have healthy profit margins. Through A.B. 11, we want to confirm the long-standing practice from the last AG opinion that a hospital cannot hire physicians in private practice. While we want to keep the exceptions in statute, we want to add an allowance for graduate medical education (GME) programs in hospitals. Additional GME programs in Nevada are something we should consider. This is something the Commission wanted to address but has not completed.

This bill's intent is to ensure patients can get care at all hospitals with doctors who have contracts or privileges. We want Nevada doctors to practice in any hospital where they have privileges or want to have privileges. We are concerned that there will be many patients in hospitals with no doctors. We cannot allow the lack of containment to continue because Nevada does not have enough doctors for every hospital to hire.

The Assembly amended A.B. 11 with a couple of important provisions. The current hiring practice of physicians has significant use of nondisclosure agreements and noncompete clauses. This was a concern raised by doctors, Legislators and other people. In response, we supported an amendment to include that a hospital cannot require noncompete and nondisclosure agreements. These agreements were adding to the problem of the physician shortage. If a doctor had signed a noncompete clause and stopped working, then he or she would be unable to find another job in that community during the two years of noncompete.

The second change was in the creation of an Interim committee to study how the State should address this issue. The committee would need to address when it is appropriate for physicians to be hired by a hospital. The committee would need to analyze the net impact of CPOM law or the lack thereof. The committee would try to determine how to recruit more doctors to Nevada. We need to make sure patients in every hospital can receive care from a doctor.

If the bill passes, the Commission looks forward to the Interim committee. Our Commission has 12 members with 4 commissioners' terms expiring in June.

This will cause a transition on the Commission. An Interim committee will allow the work on this issue to continue. I hope you can support this bill.

SENATOR NGUYEN:
Coming from the practice of law, it is too bad there is not a similar structure. Lawyers cannot fee share or partner with nonlawyers. Corporate practice of medicine is concerning to me and others, having venture capitalist firms and other people working on profit and not necessarily health. Potentially, they are making decisions about profits over people. I appreciate the intent of this bill and wonder if it will expand noncompete language to other areas. Is there a desire to expand outside of the hospital field as well? I know that you discussed transparency with provider groups not allowing a doctor to leave a certain provider group. Are there intentions to expand this to protect patients in other aspects beyond hospitals?

MS. BOND:
The Commission did raise this concern. From my perspective, it would be good to allow doctors to have as much freedom as possible to operate where they want to and need to.

However, I do not know what complications would arise. For example, we need to follow HIPAA laws. Speaking as a coalition member and not a commissioner, we would embrace it. The Commission has not addressed this topic.

SENATOR NGUYEN:
I listened to some of the hearings, including opposition. There was testimony on how some hospitals have the only ear, nose and throat (ENT) specialty in town. In these situations, I have concerns about pricing and costs because they are the only game in town for a specialist. Should this be prohibited by law? Although it should not be done, should the law specifically state the increase is not allowed. Can you explain how that works? I am talking from a patient's perspective, when there is only one specialist who works at one hospital. What happens to patient choice and pricing?

MS. BOND:
Since you are asking about patient perspective, we are seeing a lot of movement on consolidating this industry. Hospitals are buying physician groups and surgery groups. It is done in the name of efficiency, but it also generates monopolies. If there is only one ENT that operates in one hospital, then the

patient has no choice of a hospital. If ENTs hired employees, not contracted, then they do not have the opportunity to transport the patient to another hospital.

MR. VAN HOUWELING:
I spend a lot of time with doctors who realize after they sign some of these hospital contracts, they have strict noncompete clauses. It prevents them from working within a certain area of the community or even the State. The doctors ultimately have to leave the State or community. They cannot even do things like telemedicine or teaching.

To answer your question, I can give you an example of a crisis that we fortunately averted. For cardiovascular thoracic surgery, the patient has a primary care doctor referring him or her to a cardiologist. Perhaps the provider found an issue requiring a valve replacement or the patient had a heart attack that requires a surgeon to intervene. Unfortunately, Las Vegas does not have a lot of these specialists. The specialists that we did have were either restricted to privileges at one hospital or have a strict noncompete agreement. If the patient did not go to a particular hospital, then he or she may have to leave the State to receive the procedure. Clark County's UMC is a level-one trauma center, and cardiovascular thoracic surgery is part of its requirements. As a patient, imagine not being able to have cardiac surgery and not having options in your community. We were able to avoid this crisis.

You are going to hear testimony about a doctor shortage, but there really was no solution to backfill those doctors. It has put patients in peril.

SENATOR TITUS:
It is good to see you, former Senator Carlton. We did have our moments in the Assembly that we agreed on issues; however, the most contentious moments were on issues with the Patient Protection Commission.

Does UMC hire physicians?

MR. VAN HOUWELING:
Yes, we do have employed physicians. We are exempt from the CPOM.

SENATOR TITUS:
To clarify, you have an exemption and can employ physicians. So, you are exempt from A.B. 11 and you are testifying we should support this bill? That is my first concern.

Do you allow your hired physicians to work at other hospitals? One of the issues presented is the concern doctors cannot work anywhere else.

MR. VAN HOUWELING:
You are correct, we have an exemption and can hire physicians. Given our charitable mission and academic program, UMC provides services like no other hospital. As pointed out earlier, GME programs are exempt. In addition to our program, the University of Nevada, Las Vegas (UNLV), is exempt as well. Other public hospitals throughout the State also have an exemption. I know UMC is the largest, but the exemption helps other hospitals Statewide.

SENATOR TITUS:
I am concerned there is a conflict. Do you let your doctors work at other hospitals?

MR. VAN HOUWELING:
Our doctors will work 40 hours a week, and we do require them to work during the scheduled hours. The doctors are privileged and credentialed at UMC, but we do not prohibit them from working at other hospitals after hours. On their own time, they can do things like telemedicine. Since they are employed at UMC, the doctors will be teaching or doing our safety net mission.

SENATOR TITUS:
For clarification, when the doctors are working, they are in your facilities. While they are scheduled to work, do you allow them to go work at another hospital or clinic? Can they see patients off-site in a facility not associated with UMC?

MR. VAN HOUWELING:
If doctors are working at UMC, then they are practicing at our hospital or one of our 14 clinics, including telemedicine. After hours, many employees, like nurses, have part-time jobs.

Other hospitals can contract with any provider in the community. The medical malpractice insurance does not travel with the doctor to other hospitals.

Physicians typically buy their own insurance, but we purchase it on behalf of the physicians employed at UMC. However, coverage does not carry to other facilities.

SENATOR TITUS:
I was in private practice for many years but could not afford to stay in it. I then worked for a hospital district. It was the only way I could survive in the practice of medicine.

To be clear, UMC hires physicians. However, you are testifying on a bill that will not let other private hospitals hire physicians. You allow your doctors to work at other facilities, but they must provide their own insurance. Is that what I am hearing you say?

MR. VAN HOUWELING:
If a doctor is an employee of UMC, then he or she is obligated to work at a UMC facility. What they choose to do after hours or on weekends is not under the UMC flag. When scheduled to work at UMC, providers cannot work at a private hospital in the middle of their shift. These providers are covering areas like the trauma center, the neonatal intensive care unit and a transplant case.

We are exempt, and I am assuming the hospital you worked for was part of the exemption to the CPOM.

SENATOR TITUS:
Ms. Bond, I am aware you are on the Patient Protection Commission, but do you have other employment? Do you work for the Culinary Union?

CHAIR DOÑATE:
I would ask that we keep questions related to A.B. 11.

SENATOR TITUS:
My question is relevant to this bill. Do insurance companies make profits?

CHAIR DOÑATE:
Once again, I would ask that we keep comments to this bill.

SENATOR TITUS:
One of the issues about hiring physicians and the CPOM is that heaven forbid medical providers make money. You want to control physicians in this world of overregulation. If a private company wants to hire a doctor, are you worried that he or she will make a profit?

MS. CARLTON:
As part of my investigations of the CPOM, a number of different documents were provided to me. The AMA had a couple of bullet points that a corporation's obligations to its shareholders may not align with the physician's obligation. This is not just about the patient but also the physician and the corporation. The physician should have autonomy to treat the patient in the way the physician would like.

A corporation should never oversee what a physician does. This is not about the money but access. We want to make sure physicians and corporations stay in the correct lane. When a physician is an employee, it may interfere with independent judgment. If that physician prescribes a certain treatment and the hospital does not provide it, then what will the physician do?

Being a mother who has had to take her child out of state because Nevada does not have a doctor to treat the illness is bad enough. For years, we have discussed the best place to receive medical care in Las Vegas was the airport. We can change that because we brought physicians into the State. Nevada does not have enough and needs more specialists. The State is continuing to work on this, like the medical school at UNLV.

How would you feel if you are a parent and had to take your child out of state? There is a doctor at a hospital three miles away from the family home that could have treated the child but was not allowed to because the family does not have access to that hospital. This is not about the profits. It is about patients having access to a physician with independent thought and action who is not controlled by a corporation. This is the essence of the CPOM for someone who is a regular patient like me.

SENATOR TITUS:
As a provider who was employed, at no time was my medical judgment based on my employment by the hospital. Instead, it was what we could offer in that location. I have not heard or read any justification other than the concern that

perhaps doctors would not be able to order tests that they wanted to do. I have not seen a justification about increased charges or private hospitals tying up these doctors.

I do agree with the component of the bill regarding the noncompete clause. It is critical to supply providers. I do not see in this bill how it changes how doctors practice medicine. Most doctors no longer go into the hospital to see their patients. The hospital has physicians making rounds. The practice of medicine has changed, and to regulate that into a narrow scope is wrong.

In your testimony, you walked us through the three AG opinions. None of the opinions said anything against hiring a physician. Now you want to codify in statute that they cannot hire a physician. As a physician, I understand what you are trying to do, but I think this bill is doing the opposite.

SENATOR STONE:
In your testimony, we heard the word profit. In my short tenure in Nevada, profit seems to be a bad word. I do not agree because I am a true capitalist. I am a pharmacist by profession, and I would like to share my experience. I was a county supervisor in Riverside County, California. Our county had a hospital and we hired physicians who gave care to people who did not have the resources needed at private hospitals. These physicians taught as well.

The practice of pharmacy has transitioned. I graduated from pharmacy school and had a chain of small apothecary pharmacies. With the rise of chain stores, I ended up getting bought out and pivoted into compounding. This change allowed me to continue to be the master of not only my destiny but my patients' destiny. I was rewarded for it.

We have a shortage of specialists and primary care doctors. I wish Nevada was like California because the latter hears every bill. This resulted in California hearing a bill about occupational licensing recognition. A bill like this would allow some specialists to come to Nevada without the bureaucratic limitations for time and exams. We have a limited amount of these professionals and after the COVID-19 crisis, we burned out many healthcare professionals.

Rising insurance, inflation and personnel issues have caused many physicians to want to work for somebody. Specialists, like thoracic surgeons, get hired by a hospital and sign a noncompete clause. I would think they are compensated for

the noncompete clause. However, if you have only one of these specialists in a particular area, then you could call it a monopoly. If he or she is the only one who can provide that service, then this is a benefit to that hospital. I think we are seeing the foundation of medical care. It is transitioning, unfortunately, just like other industries. For example, the retail industry has been impacted by Amazon.

This is what they call progress. Things can be done more efficiently, less expensively or more competitively. It will prevail in a capitalistic society. I do not want to strap what a hospital can do or who they can hire. I believe in freedom of choice for the individual, the hospital, the entity, the medical group and someone who wants to go into private care.

It sounds like the issue is bringing more specialists into the community to create competition. There are three AG opinions that you have alluded to in which corporations, namely hospitals, cannot hire physicians. As I read it, the 2010 opinion is clear. It may not be the practice of previous administrations, but I think it is lawful. I would opine that the purpose of this bill is to codify in statute that it gets rid of the gray area.

Is that how you see this bill? Is it intended to clear the ambiguities on whether a hospital can hire a physician?

CHAIR DOÑATE:
Before you answer, I would like our legal counsel to clarify the 2010 opinion from then Attorney General Cortez Masto and what her office alluded to.

ERIC ROBBINS (Counsel):
My reading of the legal opinion is it does not firmly state if it is lawful or unlawful. It is a gray area, but it is not prohibited under current law. Generally, things that are not prohibited are then authorized. Given the two previous AG opinions and the provisions providing affirmative authorization, could a judge read some sort of common law prohibition? It is not out of the question.

Generally, things that are not prohibited are authorized. I do not think that the law is 100 percent clear on that.

SENATOR STONE:
Thank you for that opinion. I think if you get five attorneys in the same room you will get five different opinions. That is why we go to court. That is why we argue. So, I am going to argue that my interpretation is that it is allowed.

Is the purpose of this bill due to the cloudiness of this issue? Is it to ensure that hospitals can hire physicians?

MS. BONDS:
In my opinion, the purpose of this bill is to pick up where the last AG opinion left off in 2010. If the State is going to change what is happening, then it should be done at the legislative level. One way or another we are in front of you because this is a legislative issue.

We would like this bill to create a statutory time-out. We need the next Interim committee to have a discussion on what the State wants to legislate. I understand you believe it is gray, but in our opinion, we will continue to see messy situations where patients cannot receive care.

SENATOR STONE:
I respect your answer and am assuming you are responding yes. You want to have clarifying legislation and a statute that prohibits a hospital from hiring a physician. To me, that is the purpose of this legislation: to eliminate the clouded areas you brought up with the AG's opinions. Is that correct? A simple yes or no would be fine.

MS. BOND:
We want to take the question to the Interim study. We want to pause on hiring physicians. We need to pause and take this to the Joint Interim Standing Committee on Health and Human Services for a robust conversation about what Nevada needs.

MR. VAN HOUWELING:
To answer your question and follow up with Ms. Bond, we have two exceptions in NRS. We are trying to bring clarity on CPOM, so we can bring this to rest. Our Commission is trying to understand the exceptions to some policies or laws. For over a year, the Commission has worked on this question.

I can appreciate the noncompete clause conversation as well. Moving this bill forward and getting it into an Interim study can answer your question.

SENATOR NGUYEN:
I was thinking we have benefited from Senator Stone in his previous residence to the west of us because for several years CPOM has been banned by their state legislature.

It seems without this statute, Nevada would have a situation where a hospital could contract with the only specialists and negotiate any kind of rates just like in the capitalist market. The hospital could charge more because it is holding the magic key to health care in the community. I am supportive of limitations placed in addition to some of the noncompete agreements. I have heard from several doctors who are practicing out of state because of the noncompete agreements.

SENATOR LANGE:
I understand the importance of a study group, but for the whole Senate, we get three study groups. I sit on three Committees, and we have had nine study group requests. I am interested in how you could see your bill proceeding if we do not get a study group. Since it is part of your bill, we can either pass all of it or none of it. This becomes complex when we deal with a study group.

CHAIR DOÑATE:
The bill legislation is tasked with the Joint Interim Standing Committee on Health and Human Services. As a result, this bill would not count as part of the three study groups.

MS. CARLTON:
You are correct, Chair, because it is cited in the bill. It would be tasked to that Committee. If the bill was not passed, there is nothing to stop the Interim Committee from discussing it. We want the other provisions to make it through because we need to have a pause.

I am concerned with legislation that has a list of exemptions because anything not listed is then not exempted. It would be ideal for the State to let doctors know we are not going to interfere with their contracts. We would like to take a pause and make sure we are moving forward on what is best for the State. This bill is a good way to address all the issues and not hurt anybody in the

meantime. No one wants to prevent a doctor from practicing in Nevada. It is all about making sure doctors can practice in this State.

CHAIR DOÑATE:
I usually do not have the opportunity to question a lawmaker with such institutional knowledge. Why is it important for our State, as an institution, to follow precedent? In this circumstance where we have a Commission pushing forward a bill to come to the Legislature, why is it important for our Body to follow precedent that has been predicated from any of us serving in this Body?

MS. CARLTON:
For clarification, is this in reference to the three bills that came from the Commission? Is it about these bills having a hearing in this Body and moving forward?

The Legislature is a gang of 63 who have an awesome responsibility. You are now part of a select club of people in the State who will make a difference to the children coming behind you. You need to leave things better than you found them. When someone does the work and puts in the time as the Patient Protection Commission did, why not have the public discussion? Why not bring the bills to you? The bills have been discussed and voted out of the Assembly. The bills are now in the Senate. This is the State's process. You will have these discussions and move it forward. If we are lucky, they will make it to the Governor's desk. I am uncertain what the discussion will be there, but it is all about the 63 Legislators having thoughtful, deliberative discussions. You should not be told or recommended that an issue should not be discussed at this time. Anything that comes forward should be discussed.

SENATOR STONE:
Do you envision that if this bill was passed into law, it would be applicable to Employee Retirement Income Security Act-funded health centers?

CHAIR DOÑATE:
The bill specifically outlines the circumstances and the exemptions. It follows what laws have been passed in different states. I do not believe that is an appropriate question for this bill.

ANNETTE MAGNUS (Battle Born Progress):
We are here in support of A.B. 11 because the corporatization of health care is bad for Nevadans. This bill addresses the longstanding norm in Nevada against the CPOM.

Corporate practice of medicine can lead to decisions that prioritize financial interests over patient care. When medical decisions are made by nonmedical professionals who are primarily concerned with profits, Nevadans will suffer the consequences. Please support A.B. 11.

PAUL CATHA (Culinary Workers Union Local 226):
We support A.B. 11. The Culinary Health Fund is one of the largest healthcare consumers in the State. It is sponsored by the Culinary Union in the Las Vegas area and provides health insurance coverage to over 145,000 Nevadans. Through vigorous engagement of members, the Culinary Union has maintained one of the strongest healthcare plans in the Nation with no monthly premiums, no deductible for covered services and free generic prescription drugs at multiple pharmacies across southern Nevada.

We are experiencing a severe physician shortage. Even with one of the best healthcare plans in the Nation, when providers are not present, our members cannot receive the care they deserve and need. Assembly Bill 11 will ensure doctors have the freedom to see patients at whichever hospital they choose. It guarantees doctors are free to make medical decisions as they see fit.

Guaranteeing doctor independence from out-of-state hospital corporations will benefit all Nevadans. We support A.B. 11 and encourage your support of this bill.

SUSIE MARTINEZ (Nevada State AFL-CIO):
On behalf of over 150,000 members in 120 unions, we are in full support of this bill. Capitalism can be good, but unfortunately, it is always on the backs of labor. This is the reason why we are having our nursing shortage. Let us not continue to have the nursing shortage because of capitalism. We do not want it to become a doctor shortage as well.

MARC ELLIS (Communications Workers of America):
We support A.B. 11

RANDY SOLTERO (International Alliance of Theatrical Stage Employees):
We support A.B. 11

LIZ SORENSON (Nevada State AFL-CIO):
I am here today in full support of A.B. 11.

DIONNE KLUG (United Food and Commercial Workers 711):
We support A.B. 11.

JAMES CREEL (Compassion Center):
We support A.B. 11.

RITA WEISSHAAR (Nevada Alliance for Retired Americans):
We are in full support of A.B. 11. We urge the Committee to support it as well.

CLARENCE MCCARTHY (National Association of Letter Carriers 709):
We support A.B. 11. I urge the Committee to support this bill as well. It will address the shortage of doctors.

PAT KELLY (Nevada Hospital Association):
We just heard a great presentation about the past going back to 1977. I would like to talk about the future and where we need to go. I know you are aware of the terrible healthcare statistics facing Nevada. We are near the bottom for access to health care. Large portions of the State are designated by the federal government as health professional shortage areas. We have a shortage of all types of healthcare workers.

I have submitted my written comments (Exhibit S) to this Committee. In addition, 25 of 39 specialty areas did not have the number of physicians to keep pace with Nevada's population. Why would we do anything to impair the State's ability to recruit and retain physicians? Assembly Bill 11 prohibits Nevada's private hospitals from employing physicians. Examples of private hospitals are Carson Tahoe Health, Renown Regional Medical Center, Dignity Health, Sunrise Hospital and Medical Center and many other hospitals, including those in rural areas. Hospitals are one of the primary recruiters of physicians, particularly specialty and subspecialty physicians. Why would Nevada eliminate a large number of hospitals from employing physicians when we have a shortage?

Calendar year 2020 was the first year in which less than half of patient care physicians worked in private practice. Almost 40 percent of physicians worked directly for a hospital or for a practice that was partially owned by a hospital health system. Only one-third of physicians under the age of 40 worked in a private practice.

We are seeing a shift in practice patterns for several reasons. Many younger physicians leave school with large debt. They do not want to go to the bank and borrow more money to start a practice. They do not want to see patients all week and then spend weekends handling office matters. These physicians want a work-life balance. They want to practice medicine and not run a business. Older physicians are tired of running their practices, keeping pace with regulatory issues and the hassles of private practice.

The AMA has an interesting employment statistic for doctors. Women physicians and younger physicians are more likely to be employed than male physicians and older physicians. In 2020, 56.5 percent of women physicians and 70 percent of physicians under the age of 40 were employed. The latter statistic is key because it demonstrates the trend where the Nation is going.

Nevada competes with communities across the Nation for physicians. We need every available employment option to entice doctors to practice and live in our State, including hospital employment. In our healthcare delivery system, hospitals are in the perfect position to identify community needs.

The AMA addressed the issue of conflicts of interest between the doctor and the corporation. It stated:

> Physicians should be free to enter into mutually satisfactory contractual arrangements including employment with hospitals, health care systems, medical groups, insurance plans and other entities.

This is from 2020, and the AMA would not make this statement if it feared hospitals would interfere with the clinical judgment of a physician.

It is ironic that A.B. 11 allows venture capital funds to hire physicians but not hospitals. Hospitals are licensed and regulated by Nevada, and many have a long history of serving Nevada communities. It is counterintuitive to allow large

private equity firms to employ physicians in Nevada but prohibit Carson Tahoe Health, which is a hospital down the street. This hospital has been a part of Carson City for decades.

Assembly Bill 11 was amended to prohibit certain contractual restrictions between hospitals and physicians. Currently, some contracts prohibit providers from practicing at other facilities during and immediately after their employment. Reasons exist for these restrictions, including recruiting is expensive. It can cost hundreds of thousands of dollars to bring a specialist to Nevada. When a hospital hires a physician, he or she does not start working right away. Many times, the doctor has to adjust to the system or wait for the license to clear. During this time, the hospital is paying the doctor. A hospital is guaranteeing income, and the doctor is not bringing in any revenue. Frequently, the insurance companies take forever to pay. Given the cost to recruit, hospitals need some type of protection.

Assembly Bill 11 allows public hospitals and academic institutions to employ physicians. Do they really have the capital needed to recruit and hire all the physicians Nevada needs? Does it make sense to allow all hospitals for profit and not for profit to use their capital to recruit physicians? This bill is taking Nevada in the wrong direction. Please vote against it.

SENATOR NGUYEN:
I appreciate your concerns about other physician practices contractually obligating them. This sounds like we are trying to say we cannot do this here because we are not doing it in other places. We all know that legislation sometimes moves incrementally. Do you know when Nevada started hiring doctors within the hospital setting? When did the recruitment investment start to bring people in and employ them in hospital settings?

MR. KELLY:
I do not know that, but I believe it has been around for a while.

SENATOR NGUYEN:
Do you know how many doctors are currently employed within the hospital system?

MR. KELLY:
I do not know that information.

SENATOR NGUYEN:
It would be helpful if you can obtain that information for the Committee to review.

SENATOR STONE:
One thing I heard today is a hospital dictates the way a physician would practice. Can you allude to the independence that a physician has to ensure that the patient is the primary interest and not the profitability of the hospital? Can you elaborate on what is in place to ensure that independence?

MR. KELLY:
The regulations governing physicians in the State are clear. The regulations do not allow a physician to have anything interfere with their medical judgment. In addition, the Joint Commission comes in and looks at a hospital closely. They want to make sure there is a separation between the business functions of the hospital and clinical functions. This is the reason why a hospital goes through this whole elaboration on medical staff. It is to ensure they are creating and making the clinical judgements for the hospital.

CHAIR DOÑATE:
On the personal side, I have seen noncompete agreements that are egregious. I have seen Nevada entities, and this is me speaking with healthcare executives, where the radius is too big. Medical providers are limited and are forced to leave for somewhere else. There should be an expansion of all of this to be covered in health care and not just in hospitals. It is a pervasive issue of noncompete agreements which restrict providers. We do not want a situation where they have to leave.

The CPOM is an open conversation and should be debated. We are witnessing a shift to consolidation in health care. At what point is there too much consolidation? We have some specialties that have limited numbers of specialists in Nevada. Should they have been acquired? There is nothing in law prohibiting the acquisition.

As my colleague mentioned, the capitalistic mindset exists. However, what will happen when the healthcare delivery impacts patients or there are no controls over the market to increase the costs? What if this should fall into the wrong hands like venture capitalism or private equity. It does have some ramifications on how healthcare delivery is occurring. Having said that, I know many states

already operate under a CPOM doctrine. These states have established that hospitals cannot control or employ physicians.

What are the problems that you are facing if everyone is on a contractual basis versus an employment basis? Are there services that cannot be delivered because of that difference? Should we adopt this policy? This is what we are seeing in other states.

MR. KELLY:
No one asks how do physicians come to Nevada? Physicians do not send a resume in. We have to search for these physicians, and there are hospitals across the Country that are searching for these physicians. It is very competitive. When you bring them in, the physicians have expectations for housing and moving assistance. They also want an income guarantee. Recruiting is incredibly expensive. If the hospitals are not investing in this, my question is who is going to do it? I am fearful this bill is going to create a situation where no one is recruiting, and Nevada will no longer have specialists brought into the community.

There have been discussions about an Interim study to look at this topic. Why are we taking the action before the study? We have had thoughtful conversation about where CPOM is going. We should have the discussion and then decide on the appropriate action. I was on an advisory committee for the Patient Protection Commission. However, we never met. When asked when we would meet, the response was after we get our work done. The advisory committee should have been offering their opinion. I am now in a position to provide two-minute statements every month. I write letters, but I do not know if anyone reads them. There was not the input that should have occurred.

CHAIR DOÑATE:
Thank you, but we need to proceed with the hearing. In the near term, please submit the number of physicians who are employees. It would be helpful for the Committee. It is an important conversation in general in terms of the data points, but we will proceed with testimony.

GEORGE ROSS (HCA Healthcare):
We do not hire many doctors, but we do hire those who we need to get to Nevada. All of them are here because we recruited and employed them. To answer your question, we have 16 employed doctors. We have six at Sunrise

Hospital and Medical Center and ten between the other two hospitals. In addition, we have one employee managing the GME program.

If we focus on one hospital where people can be employed, what happens to the other hospitals throughout Clark County? How can they provide the same level of specialist services? To get specialized high-end people to come to Nevada, we need to hire them.

Parenthetically, we have no problem with nearly all of the amendment. We do not say a medical provider cannot work at another hospital and we have had people who do that. We do not have a problem with the noncompete clauses. However, as Mr. Kelly alluded to, we are concerned about the two-year moratorium on hiring. It should not be there. It is basically stating that for two years, Nevada will stop improving. It is preventing the addition of high-end services and replacing doctors who leave.

It was interesting to hear that UMC can hire doctors because it is a safety net hospital. Our facility, Sunrise Hospital and Medical Center, serves 25 percent of all the Medicaid patients in Clark County, while UMC serves 13.8 percent. Sunrise serves 25 percent, and 60 percent of its emergency room patients are on Medicaid. Another 13 percent are uninsured, which tells you who that hospital serves. Now we are told that we cannot continue to offer high-end services. If we cannot hire those doctors, then the public will not have the stroke center, or there would be only one center in the city.

Every second, every minute counts as to whether you will survive a stroke and how you will come out of it mentally and physically. Half of our pediatric open-heart surgeries could not have taken place. We have two surgeons, and one is an employee. The other has been totally subsidized by his practice because he has many children on Medicaid. What happens to those parents? They all have to make a choice because their child has to go out of state. They have to decide if they should quit their job, so they can go with their child.

This bill is going in the wrong direction. We are not providing more choices. This bill is taking choices away. The only place you can get these specialists will go away too. We have a large GME program. If you need to employ doctors for your GME program, then why are we not given the same consideration that UMC is given?

SARAH WATKINS (Nevada State Medical Association):
We are here in to oppose A.B. 11. Our Association is the largest physician-led advocacy organization in the State. We advocate and share this Committee's goal to attract and retain physicians in Nevada. We must be able to compete with other states to recruit and retain physicians. Hospitals in many other states employ physicians. Our hospitals should be able to do the same. This bill does not improve access to care, nor does it support the shared goal to improve access to care. We are opposed.

DAN MUSGROVE (Valley Health System of Hospitals):
Many of the questions today have been exactly what we should be debating. Should hospitals be allowed to hire physicians? That is what this bill is all about. It is a yes or a no. We believe the argument should be yes for all the reasons that Mr. Kelly and Mr. Ross talked about.

Valley Health System of Hospitals provides GME. As Mr. Ross touched on, we are talking about students learning to practice in internal medicine, family practice, general surgery, psychiatry, orthopedics, pulmonary, neurology and emergency medicine. What happens when those doctors graduate and want to stay in Nevada? As statistics show, they want to be employed rather than contracted. Are we going to respond that we are sorry you cannot be an employee? What happens when Senator Titus decides that she wants to go to work for someone because she cannot be in private practice anymore? Are we going to tell her, sorry Senator Titus, you cannot work for a hospital? You will have to survive on your own.

We cannot remove this tool from our toolbox because Nevada is last in everything. What is going on now is not working. Why would we not continue to expand this attraction to recruit those needed to practice in Nevada? We do not have to go to the airport.

MISTY GRIMMER (North Vista Hospital):
We are also in opposition to A.B. 11. North Vista Hospital is the only hospital in North Las Vegas, and we are not exactly in the fancy part of town. It is important to us to have every tool in our toolbox. We need to have the ability to bring physicians to our facility.

PAUL MORADKHAN (Vegas Chamber):
We oppose A.B. 11. We had concerns with the original version of the bill and continue to do so with the amended version. The noncompete provision in section 7 of the bill will not help retain doctors in Nevada. Rather it causes additional stress to the healthcare system in our hospitals and care for Nevada citizens, especially those needing specialized medical care in a hospital setting.

SUSAN PROFFITT:
I have with me my Silver State insurance card. There is something odd about it, because I am 63 years old and was assigned to Desert Valley Pediatrics. We do not have the infrastructure. Unfortunately, with the new immigrants coming in and getting Medicare, if you pass that bill, this will implode what we already have.

CHAIR DOÑATE:
Are your comments related to A.B. 11?

MS. PROFFITT:
Yes, it is related. I am a recruiter. We charge 25 percent for a doctor placement fee. The average cost for a lower-level position is between $25,000 to $75,000 per position. For a specialist, the cost is between $100,000 to $200,000 minimum per doctor.

I think it is unconstitutional that you pick and choose which hospitals are going to be able to hire doctors. Nevada needs all the hiring professionals that we can get. It is not easy to recruit doctors to a state that does not have a decent education system. We are forty-ninth in the U.S. for numbers of doctors. We are desperate.

In addition to my assignment to a pediatrician, my husband is dying of lung cancer. He had to wait a full year to get a surgery. He refused to return to Florida for the surgery. This bill needs to be fixed because Nevada needs to hire as many doctors as possible.

IRENE GUTIERREZ, M.D. (Program Director for Family Medicine, Dignity Health-St. Rose Dominican):
I have spent my career training physicians and working to bring in additional primary care providers. We are the only not-for-profit, faith-based health system in southern Nevada.

We are in opposition to A.B. 11. The ramifications of this bill are significant. First it will decrease access to care for Nevadans. Hospitals are one of the primary recruiters and employers of physicians, in particular specialists. We will lose services and will be unable to expand access to services.

Secondly, passage of A.B. 11 will hinder our physician recruitment efforts because nearly three-quarters of all physicians want employment options. Many new medical school graduates prefer employment because they want to practice medicine, not run a business. The Nevada State Legislature has introduced several great bills this Session to incentivize medical students and other physicians. This bill will reverse all the good work being done in this area. If A.B. 11 passes, we may lose the physicians we currently employ.

Finally, if passed, it would prohibit physicians, employed by a nonprofit like us, from qualifying for federal student loan repayment programs. The Public Service Loan Forgiveness program requires employment by a nonprofit. All the high-quality health systems in other areas employ physicians. Health systems like Mayo Clinic, Cleveland Clinic and Cedars-Sinai Medical Center would not be where they are today without the ability to manage their clinical workforce. Other states that had laws like A.B. 11 have either removed the law or passed significant workarounds like California's foundation model.

Assembly Bill 11 is a bill in search of a problem. We do not need it, and it will take a bad situation in Nevada and make it worse. Please oppose A.B. 11.

EMILY OSTERBERG (Henderson Chamber of Commerce):
We oppose A.B. 11. Nevada already has a severe shortage of physicians, and our State is almost last in every access to healthcare category. Banning hospitals from the ability to employ physicians for two years will make it more difficult for hospitals to have adequate staffing. This is detrimental to an already fragile healthcare industry in the State. For these reasons, we are opposed to A.B. 11.

DEAN POLCE:
I am a cardiac anesthesiologist. Today there were many references to cardiothoracic surgeons. I know all of them in southern Nevada and many are employed. These doctors were in private practice when they came to Las Vegas, but like Senator Titus, they could no longer handle the work pressure of running a business. They went into the employee model. Doctors

need this option. Around the Country, it has been a popular trend for hospitals to employ anesthesiologists. This trend has a lot to do with the distortions of Medicare and Medicaid rates, which have not changed since 1984 and 1991, respectively.

I want to speak to Mr. Van Houweling about the exemption in this bill. The University Medical Center is paying for services that all of us render at a lower cost. Working two weeks on and then two weeks off is not fair market and is not how many of us work. It leads to access-of-care issues.

Centers of excellence exist for a reason, and they do a ton of volume. For example, the Cleveland Clinic Foundation does 5,500 procedures a year which is a stunning number. If I was going to have heart surgery, I would want to go there. If you want better care, then we need centers of excellence.

As far as the noncompete agreements, the people who are complaining about it by and large wrote and ignored the agreements. Hospitals are not requiring doctors to sign these. The anesthesiologist specifically in question wrote the agreement and ignored it. If these agreements are bad, then it should not have been put into law, signed or forced others to sign them. They are not set by radius; the agreements are set by referrals and facilities.

Please oppose this bill because there are other options.

MS. CARLTON:
This bill and this conversation prove why Nevada needs the Patient Protection Commission. This body is viable and is doing its job every 18 months because healthcare issues are passionate issues. We need a group of professionals that meets to examine the data, has discussions and narrows the scope. The Commission brings important issues to this Legislature. It will allow you to address these public policy issues in the limited 120 days you are here.

I appreciate all sides of this argument. What was done in the Assembly, which was replacing the total prohibition with a two-year pause while studying it, may get more people to come to the table and come to some agreement. I heard a statement earlier about another possible exemption that I did not realize existed. The more we discuss this issue and collaborate on it, we will create the best policy for the State.

CHAIR DOÑATE:
Thank you Senator Carlton, we appreciate you coming back to present this bill. We understand this is a difficult issue and that is why we wanted to make sure those in opposition received fair time to speak as well.

We will close the hearing on A.B. 11 and open the hearing on A.B. 206.

ASSEMBLY BILL 206: Revises provisions governing the Nevada Commission for Persons Who Are Deaf and Hard of Hearing. (BDR 38-563)

ASSEMBLYWOMAN TRACY BROWN-MAY (Assembly District No. 42):
I am honored to have the opportunity to present A.B. 206. I would like to introduce you to my copresenter Justice Forest, my legislative intern. He is a student at the University of Nevada, Reno (UNR), and will be presenting this bill to you.

JUSTICE FOREST:
I am here today to present to A.B. 206. This bill was created out of a need for an additional member of the Nevada Commission for Persons Who Are Deaf and Hard of Hearing. The mission of this Commission is to ensure all Nevadans have equal and full access to resources, services and opportunities in all aspects of community life.

Currently, there is no seat on the Commission reserved for an American Sign Language (ASL) interpreter. This presents a lack of representation and support for the very community the Commission seeks to serve. While preparing for this hearing, I learned that for many in the deaf community, ASL is their language, and it acts as a key pillar of the deaf culture's identity. The ASL interpreters are a vital component for ensuring access to all aspects of public life for deaf individuals. As such, they are an accessibility afforded to the deaf community under the Americans with Disabilities Act.

Throughout the last Interim, the Commission conducted a Statewide series of town hall meetings with the deaf and hard of hearing community. One of the most consistent points is the significant deficit in both the number and quality of available ASL interpreters. The State has taken several steps to address this deficit, such as revising the *Nevada Administrative Code* to increase the standards for working as an interpreter in the State. However, we still need to improve resources to support the pool of interpreters working in Nevada.

There are limited opportunities for training new interpreters or building skills among currently registered interpreters. The Commission has emphasized the need for input from someone who is registered with the Nevada's Registry of Interpreters for the Deaf. This registry is maintained by the Communication Access Services Program in the Aging and Disability Services Division (ADSD).

Section 1 of this bill amends NRS 427A.750 to increase the number of members on the Commission from 11 members to 12 members. Section 1 also requires that the additional member serves as an ASL interpreter as recognized by ADSD. Section 2 allows the Governor to appoint on July 1, 2023, the new member. Section 3 makes this bill effective on the same day, July 1, 2023. Thank you for considering A.B. 206.

SENATOR TITUS:
We care about this topic, and I took a sign language class in college. Early on, I was able to use it, but like any language, if you do not keep using it, you forget it. There may be some confusion created in the notes from a previous hearing. I wanted to clarify only the new commissioner will be required to know sign language. This requirement does not apply to all commissioners.

MR. FOREST:
That is correct.

SENATOR TITUS:
I have participated in legislation for a number of years to remove the term "deaf and dumb" out of our Constitution. During this process, I have worked with a family whose children have hearing issues. The children read lips or have implants. However, the children do not know sign language. I want to make sure that we are not just focusing on sign language as a need for the hard of hearing.

ASSEMBLYWOMAN BROWN-MAY:
We are not focused on one method of communication. During Interim meetings, the Commission hosted many members of the deaf and hard of hearing community. There are many ways to communicate. My husband is hard of hearing and utilizes captioning as his preferred methodology. Adding choices for communication is the most advantageous for everyone.

In the last Interim, it was identified by the Commission that this member was missing from their ranks. It would be valuable to add the perception in the existing membership.

ELI SCHWARTZ (Member, Nevada Commission for Persons Who are Deaf and Hard of Hearing):
Thank you for allowing me to make a statement in support of this bill. The Commission is tasked with making recommendations to the State on the establishment and operation of the program for persons who are deaf, hard of hearing or speech-impaired. The Commission would like to add another seat with a person who is a certified sign language interpreter and is registered in Nevada. This person should have proficient experience and knowledge in an educational setting and freelance interpreting services. By adding this seat, the Committee will be informed of any interpreting issue. There is a great need for interpreters in Nevada. Having someone with a direct connection to this community will allow the Commission to make informed decisions and recommendations to the Governor for Statewide proficiency and bill needs.

CATHERINE NIELSEN (Executive Director, Nevada Governor's Council on Developmental Disabilities):
We support A.B. 206. Deaf interpreters are linguistic experts that ensure people who are deaf, hard of hearing or who use sign language are afforded full and equal access to services and support in the community. A deaf interpreter is a specialist who provides interpretation, translation and transliteration services in ASL or other visual and tactical communication forms used by individuals who are deaf, hard of hearing or deaf-blind.

As a deaf person, the deaf interpreter starts with a distinct set of formative linguistic, cultural and life experiences. It enables a nuanced comprehension and interaction in a wide range of visual language and communication forms influenced by region, culture, age, literacy, education, class and physical cognitive and mental health. These experts, coupled with professional training, give the deaf interpreter the ability to effectively communicate across all types of interpreted interactions, both routine and high risk.

An interpreter facilitates communication between people who do not share a common language. Sign language interpreters are knowledgeable in the languages and cultures of deaf and hearing people. We hosted Statewide a series of town halls in conjunction with the Commission for persons who are

deaf and hard of hearing. During the town halls, there was an overwhelming number of requests to increase the number and quality of interpreters available in Nevada. There is a lack of representation of these professionals.

Ensuring an interpreter is on this Commission will be an opportunity for increasing the number of interpreters. It will aid in setting guidelines to improve the quality of certified interpreters in the State.

DORA MARTINEZ (Nevada Disability Peer Action Coalition):
We support A.B. 206.

BETH JONES (Nevada Hands & Voices):
I am in support of A.B. 206. I am also a mother of two children who are deaf and hard of hearing. I have been attending town hall meetings and Commission meetings for many years. I now sit on one of its subcommittees.

While my own children use spoken language and read lips, I have seen firsthand the need for qualified interpreters to sit in leadership positions to help contribute to the community they serve. The Commission needs professionals with expertise in sign language interpretation, as well as someone who has the experience and knowledge to interpret in primary, secondary and postsecondary educational settings. In addition to other benefits, the additional member is a crucial part of the team. We can improve the future for generations of Nevada's deaf and hard of hearing children.

TIMOTHY ELI ADDO:
I am a rare disease advocate, and I support A.B. 206.

ASSEMBLYWOMAN BROWN-MAY:
Thank you for hearing this bill. I want to get on the record that we did attempt to get a sign language interpreter to participate in this meeting today. We knew people from the deaf and hard of hearing community wanted to join us. However, we were not successful in that effort. We still have a little bit of work to do.

CHAIR DOÑATE:
I echo your sentiments. There is an important conversation that needs to happen on the infrastructure for language access. I will commit to working with you on this issue.

I have one document (Exhibit T) in support of A.B. 206. We will close the hearing on A.B. 206 and open the hearing on A.B. 411.

ASSEMBLY BILL 411: Requires certain medical facilities to allow certain patients who are terminally ill to engage in the medical use of cannabis at the medical facility. (BDR 56-1041)

WILLIAM HORNE (Compassion Center):
I am here to present A.B. 411. Mr. James Creel will assist in presenting this bill. After the presentation, Mr. Creel will discuss why this bill is here. We also have available Ken Zobel, an attorney who specializes in cannabis law; Heather Manus, a hospice nurse with an extensive background in cannabis and cannabis related therapies; Erin Hickey, an attorney who worked for California Senator Ben Hueso and had direct knowledge of interactions with the federal government; Dr. Larry Bedard, emergency physician and a trustee of the California Medical Association; and Julie Monteiro, a pediatric and emergency room trauma nurse, a medical educator and current president and education director for the Integrative Providers Association. Ms. Monteiro also teaches a basic course and a master's course that is AMA Physician's Recognition Award Category 1 accredited through the UNR School of Medicine. These courses offer up to six credits on cannabis, plant safety, dosing, pharmacology, nutrition and addiction.

JAMES CREEL (Compassion Center; Integrative Providers Association):
I have submitted my written comments (Exhibit U) to this Committee.

MR. HORNE:
If the Committee has any questions, we will defer to Mr. Creel. He is the subject matter expert. In addition, we have reviewed the proposed amendment (Exhibit V) from the Nevada Hospital Association. We have agreed to accept this amendment except for the exclusion of hospitals and the date for implementation from July 2023 to January 2024.

SENATOR TITUS:
As a medical provider, I have never allowed patients to bring in their own medication. The concern is it may interfere with something we are prescribing to the patient and not knowing certain drug interactions. It was always one of the first things I did in the emergency room, an acute facility and in a long-term care facility. A patient could never bring in personal medications.

How would this be different? I mean, the risk of interference with other medications that the provider is prescribing without knowing the patient has cannabis. If the provider did not know, it would be counterintuitive to allow them to self-medicate.

MR. CREEL:
Cannabis does not compete with the same receptors as opioids. Since cannabis has its own receptors, CB1 and CB2, it competes with few receptors. The CBD binds with the fatty acid amide hydrolase suppressing it and allowing your body's own endocannabinoid system to engage. From what we have learned and compiled, there is little concern on the contraindications. However, I would like to defer to Dr. Bernard to answer your question.

SENATOR TITUS:
In the interest of time, let us move on. As a doctor, I know the pathways. The next question I have is the logistics of the lockbox. First, cannabis is outlawed federally. Hospitals have Medicare money coming in, and they have to follow the rules set by the Centers for Medicare & Medicaid Services (CMS) and potential issues on the regulatory process. How does California resolve this potential issue with CMS and allowing a schedule I drug in its facilities?

ERIN HICKEY:
Although I am here in a personal capacity today, I was formerly a California State Senate staffer for Senator Ben Hueso. He was the senator who carried the original version of Ryan’s Law in California, and I was the lead staffer on that legislation.

The only true opposition we had on this bill was the fear that facilities may lose their CMS funding if they participated. In fact, the first time that we tried this bill in 2019, Senator Stone was one of our coauthors. California vetoed the bill because of this fear.

In 2021, I reached out to CMS and inquired how it would treat the activities under this bill. It replied in writing that Medicare and Medicaid regulations do not address medical cannabis at all. They do not even mention those words.

SENATOR TITUS:
I have prescribed Marinol in the past. If a patient or the family has requested the use of THC, Marinol seems like a more logical pathway because we do not have

to worry about it being controlled in its own lockbox. Was there any discussion on the California pathway about Marinol?

MR. CREEL:
Ethan Russo has published numerous papers about the efficacy of "the entourage effect" for cannabis as a whole plant. Marinol is specifically a synthetic version of delta-9 THC. We have had a broad range of research begin to emerge over the past few years. Several other cannabinoids work better than delta-9. It is important we provide patients access to those products that are not currently available within the system.

You mentioned Marinol, but Epidiolex, the first Food and Drug Administration (FDA) approved version of CBD, is $1,000 for two ounces. It is something you can get at your local smoke shop for $10, and it is not covered by insurance. It puts patients in an odd position whenever they are trying to seek relief and have to sneak it in. This law will protect the facilities.

SENATOR STONE:
I have always been a medical marijuana advocate and have believed in the pharmacological benefits of cannabis. I am speaking as someone who is interested in seeing people get the kind of care they need.

To be clear, delta-9 THC is metabolized by the cytochrome P450 system and there can be drug interactions. I wanted to counter what I heard from you. It is not innocuous. There are drug interactions that a physician should be concerned about.

We have a federal government and a State government. I was supportive in California and Nevada of cannabis used medicinally for a variety of different things. However, federal administrations come and go. My worry is a hospital is the beneficiary of federal funds like Medicare, Medicaid and Tricare. In addition, hospitals have a Drug Enforcement Administration (DEA) license. Marijuana is still a schedule I drug. Are we putting hospitals in harm's way?

What if we get a U.S. President and an administration that reverses its position on cannabis? What if they decide to pursue institutions and people utilizing it? How did you get around this in California?

MR. HORNE:
We do have that communication (Exhibit W) between Ms. Hickey and CMS stating that it was not necessarily a target area of concern. This is what gave California a level of comfort to pass the bill. In 2013, I shared your concern as a member of this Legislative Body. I was a Majority Leader in the Assembly and was concerned about the federal government. Since that time, we have seen both Republican and Democratic administrations, and there has been no effort made in that regard.

The reason in part is due to the robust regulatory system in place. This is not on the federal government's radar because it has larger problems to deal with. As medical cannabis became more accepted, experts like you and Senator Titus realized the benefits. We are seeing a pathway happen. This is a good first step because it is only for terminally ill patients.

It is not allowing smoking or inhalation consumption of cannabis products. There are safety measures on a lockbox, and a physician is not going to be prescribing it. A nurse practitioner is not going to administer it. This is going to be the patient and family members alone. It is just going to be inside the facility.

These are the type of protections that will prevent an administration from pursuing or prosecuting this matter. I do not see it happening. We are seeing an evolution in the care of patients. The first step is for terminally ill patients.

SENATOR STONE:
Did the California legislation include all of the veterans' hospitals? Are these hospitals required by California legislation to allow cannabinoids to be brought in by terminal patients?

MR. HORNE:
Senator, I am uncertain; perhaps Mr. Creel knows the answer.

MR. CREEL:
I will need to bring in my copresenter, Jim Bartell, to elaborate on that question.

JIM BARTELL:
I had a testimony to give today. I will defer to Ms. Hickey.

MS. HICKEY:
I will need to research that question.

CHAIR DOÑATE:
In the interest of time, can you provide it to the Committee as a follow-up?

SENATOR STONE:
I was just going to suggest that a federal facility would be a shining example that this law is universally accepted, not only by the state but within the federal bureaucracy.

In section 2, subsection 1 reads:

> Except as otherwise provided in this section and section 3 of this act, a medical facility shall allow a patient of the medical facility to engage in the medical use of cannabis at the medical facility.

I would suggest the word "shall" is changed to "may." We have a veteran's hospital in Nevada, and it will cover all our bases. It will give a hospital that thinks it is at risk to opt out. I do hope hospitals take the risk because there are strong benefits for cannabis and terminal patients. I hope that it would be considered.

MS. MAGNUS:
We support A.B. 411. This measure is one that seeks to make sure those who are terminally ill are able to live their last moments in a way that is painless and compassionate, if they choose to do so. Cannabis has been shown to have potential benefits for patients with terminal illness, including reducing pain, nausea and vomiting, and improving appetite.

For patients who are nearing the end of their lives, these symptoms can be particularly difficult to manage and can significantly affect the quality of life. Medical cannabis can provide a care option that may alleviate some of these symptoms and improve overall well-being. As the bill states, this would all be done under medical supervision. It is the right thing to do. We have legalized marijuana in this State. Please support A.B. 411.

JULIE MONTEIRO (Integrative Providers Association; Compassion Center):
We support A.B. 411, and I have submitted a letter (Exhibit X) of support from the Integrative Providers Association. We have other sponsors and expert witnesses in support of this bill. It will be the start of integrating medical cannabis into our healthcare systems and allowing limited facilities to do so within their demographic. We are only talking about end of life people with one year or less to live. It is not all medical marijuana program patients, but it is a start.

Having this patient demographic approved first will make it easier for hospitals to integrate and write standard operating procedures and policies. These will need to be written prior to opening the floodgates to all medical cannabis patients.

It is important for patients to secure a continuum of care within the medicine of their choice. They should not have to conform to outdated hospital policies or synthetic pharmaceuticals that are dictated at this time. Patients deserve to choose their care and maintain a continuous care of their choice. Many patients are coming to the hospitals and given these harmful end-of-life medicines.

If you look at Ryan Bartell's story, he was able to integrate with his entire family in his last two weeks of life. This is why Jim Bartell is prepared to provide a strong testimony, which I hope we can hear.

We want to avoid social stratification and patient discrimination. Discrimination is something we see in all walks of life. Passing this bill is the right thing to do. It is compassionate and it is time. Whether the hospitals recognize it or not, patients are using it. They may not tell them. I have had many of my patients tell me that they are using it. Let us start to allow patients to have this right.

JASON GRENINGER (CEO, Atlas Alchemy):
I support A.B. 411. I have submitted my written comments (Exhibit Y) to this Committee. I have also submitted peer review documents (Exhibit Z contains copyrighted material. Original is available upon request of the Research Library.).

MS. PROFFITT:
Thank you, Dr. Titus and Senator Stone, for bringing up the question about drug interactions. It gives us one more reason why we want to pass this bill. Families are going to bring it into hospitals anyway. I know I would, if I was dying,

because I have been a medical marijuana user for the last six years. It has basically saved my life and made me healthier. When I go to bed, I take an edible due to nerve pain; otherwise, I will be unable to sleep.

I came here today to testify on another bill regarding legalizing cannabis for medical use at the federal level. It is a step closer toward legalizing it altogether. I hope it passes for medical purposes because it helps people for many different health problems. I have noticed that after taking it for a while, the cannabinoids do not make you feel high anymore, but you still get the medical benefits. This is a wonderful thing, especially when you are nauseous. It has come in handy a few times.

P.J. BELANGER:
I am a certified health educator, a certified wellness educator and certified in the technique of kinesiology. I am also a molecular hydration specialist. I am 60 years old and have been battling autoimmune diseases my whole life. This is in addition to post-traumatic stress disorder and attention deficit hyperactivity disorder.

I have been all-natural for most of my life. I have tried things that were "harmaceutical" and I do not want those in my body. I have survived two heart attacks and am overcoming a goiter as we speak. Yet I am healthier than most people in their 30s because I am all-natural. If anyone could show me any other 60-year-old woman who has opted for the medical route, or the "harmaceutical" route, that is doing half as well as I am, I would love to meet them.

My point here is twofold. Please consider how cannabis, or marijuana, became a schedule I drug when it is an herb from the earth. I would recommend you watch all three episodes of *The History of Weed* on YouTube. You need to be aware that it was deceitfully designated as a schedule I drug. It is an herb, not a drug. It was deceitfully manipulated to be outlawed, and the prohibition is evil. You should consider how it became a schedule I drug. We need to work together to get it removed from the schedule I list. Then we would not have these concerns we have been talking about. We need to return it to where it belongs. It is an herb from the earth.

Secondly, Marinol is not safe for everyone because it is a "harmaceutical" and could have side effects. In addition, some of us prefer to be all-natural and do not want synthetics in our bodies.

KATREE SAUNDERS (Pardon Me Please):
I support A.B. 411. I am a long-time patient advocate. I am also a patient and have been using medical cannabis for chronic pain, fibromyalgia, nerve damage and post-traumatic stress disorder. I know how important it is for patients to have safe access at the end of their life or at any point they need it. People should not be persecuted or criminalized for needing to have this.

I support Ryan's Law and believe terminally ill patients have the right to use medical cannabis. It has been shown to be effective in healing a variety of symptoms associated with terminal illness including pain, nausea and vomiting. It can also help improve appetite and allow better sleep. In addition, medical cannabis can be used to manage anxiety and depression, which is common among terminally ill patients.

I understand the concerns about safety of medical cannabis in a healthcare facility. However, it can be addressed through careful planning and implementation. For example, hospitals can develop protocols for safe use of medical cannabis. They can train staff on how to recognize and manage potential side effects. Ryan's Law would provide a valuable service to terminally ill patients. It would give them have access to treatment options that would potentially improve their quality of life.

I urge you to support this legislation.

VICKI HIGGINS (Coalition for Patient Rights):
I support A.B. 411. It is important for cannabis patients to use their medical cannabis in its many forms of delivery to assist in pain relief and quality of life.

Patients are treating themselves at home with cannabis. When they move into a facility, cannabis should be available for their quality of life and consistency of care. This is the first step to bring cannabis back into medical systems where it needs to be. This is a natural plant-based medicine and the preferred method for many patients. It should be integrated into their care plan.

MR. WILKIE:
I am calling in support of A.B. 411 and its efforts to provide relief to terminally ill patients who choose to use cannabis for medical purposes. It will give certain medical facilities the authority to permit patients, with valid registry

identification cards or letters of approval, to engage in the medical use of cannabis at the facility.

This bill helps ensure patients receive proper care and treatment with a medication that provides them comfort. Overall, this bill represents a step forward in providing compassionate care for those who need it.

I urge its passage.

MR. BARTELL:
Five years ago, on March 1, 2018, my oldest son, Ryan, at the age of 41 was diagnosed with stage IV pancreatic cancer. Seven weeks later, my son passed away on April 21, 2018.

The first hospital he was in treated his pain with fentanyl, which put him to sleep 99 percent of the time. For four weeks, I repeatedly tried to have fentanyl replaced with medical cannabis but, unfortunately, was unsuccessful in my attempts to do so.

After I arranged for him to be transferred to a hospital that allowed medical cannabis as a treatment option, the results were immediate. The nurses stored the medication in a locked area and were shown how to administer the tincture medicine under his tongue. The first morning after beginning medical cannabis, Ryan woke up pain-free and conversant. He was able to spend the last three weeks of his life awake and in contact with his family and friends.

The happiest days of my life were being present at the birth of my three children. The saddest day of my life was watching Ryan take his last breath. After he passed, I was angry with the first hospital for taking away four weeks of his life when he could have otherwise been awake and pain-free with family and friends.

This motivated me to spend the next three months researching what each state was doing to regulate the use of medical cannabis in hospitals. I found nothing, so I decided to take matters into my own hands. With the help of legal counsel Ken Sobel and nurse Heather Manus, I wrote legislation, Ryan's Law, which requires all hospitals to allow terminal ill patients to use medical cannabis for treatment or pain relief.

In February 2019, I introduced the bill in California and briefed all 120 legislators, including Senator Stone. I testified at all of the hearings. In July 2019, the bill passed unanimously in both houses and was sent to the governor's desk. However, Governor Gavin Newsom vetoed the bill. He had been convinced by the California Hospital Association (CHA) that they would lose Medicare and Medicaid funding if the bill was passed.

However, this did not deter me. In February 2020, I reintroduced the bill to the California legislature. Due to the conditions around the COVID-19 pandemic, I decided to pull the bill and reintroduce it again in February 2021. Once again, the bill passed in the California legislature. We knew the CHA would try to persuade the governor on the negative impact on Medicaid and Medicare funding. In response, we contacted CMS about this bill. We provided them with a copy of the bill and the Governor's veto letter from 2019. We asked CMS if it was true a hospital would lose Medicare or Medicaid funding if they allowed the use of cannabis. Their response was no; they had no regulations prohibiting a hospital from having cannabis. Therefore, the hospitals would not lose the Medicare or Medicaid funding. I sent a copy of their response to the governor. He signed Ryan's Law on September 28, 2021. This bill became a California law on January 1, 2022.

The bill is now being processed in several other states. It is my ultimate goal to have Ryan's Law adopted in all 50 states, so millions of families will not be forced to go through what my family experienced.

MS. HICKEY:
I am here in a personal capacity, but I formerly worked for a California state senator.

CHAIR DOÑATE:
I made a clear differentiation before the bill presentation that the presenters cannot testify on this bill. There was a clear delineation as to which capacity they are participating in. I did allow the parent, Mr. Bartell, who had sponsored the California bill to share his personal perspective. However, we do not want the bill presenters to go back and forth between bill presentation and testimony.

MR. ELI ADDO:
I am speaking in support of A.B. 411, and I echo the previous speakers as well. The Senate took a step forward with the approval of S.B. 239.

SENATE BILL 239 (1st Reprint): Establishes provisions governing the prescribing, dispensing and administering of medication designed to end the life of a patient. (BDR 40-677)

I am 36 years old. When I was aged 17, I was placed on permanent disability. For the first time in my life, I contemplated suicide. It took me on a long journey, and I stayed in Nevada. I studied about ethnobotany, so I could have the life that I always wanted. In support of A.B. 411, I had an experience when a friend transitioned from a brain injury. While in hospice, if you can imagine the process the parents went through saying goodbye to their beloved son, the mother decided to partake in cannabis.

In support of A.B. 411, it is important that we give access to those who are terminally ill. They should be able to have access to this medicine.

JESSIE WADHAMS (Nevada Hospital Association):
We oppose A.B. 411. The Committee has already discussed many of the same concerns that we have about this bill. Things like the federal illegality of the drug. I understand Nevada has legalized cannabis recreationally and medicinally. However, we do have a letter (Exhibit AA) from the DEA in the U.S. Department of Justice (USDOJ) that was sent to the CHA stating that under federal law it remains illegal.

We have concerns about the self-administration of other drugs in acute care and the time to implement it. If this is bill is enacted, it would have to be implemented and operationalized in a hospital within 53 days. This is not enough time. I appreciate Mr. Horne and the proponents giving some consideration to our amendment. I look forward to working with them to produce a good bill.

ADAM PORATH (Nevada Society of Health System Pharmacists):
We are in opposition to A.B. 411 primarily in the acute care setting. We agree with Senator Titus' comments about not allowing patients to self-administer medications within an acute care hospital. This would also include, with rare exceptions, permitting a patient to bring in personal medications.

Senator Stone brought up the drug interactions with cannabinoids. Mr. Creel testified to the potential benefits of the entourage effect with a naturally occurring marijuana product. However, I think that compounds the potential

drug interactions when you have multiple cannabinoids and terpenes in a product. We do not know how it all works. For those reasons, I cannot support this in an acute care setting.

ASHLEY KENNEDY (University Medical Center):
We are opposed to A.B. 411 because it places medical providers in a hospital at risk. Cannabis, while legal at the State level, remains an illegal schedule I controlled substance at the federal level.

This has three consequences for hospitals like University Medical Center (UMC). The first one is medical providers and employees of UMC may be subject to criminal penalties if the bill is passed. While on its face, the bill does not appear to require UMC clinicians to do anything more than allow a patient to use cannabis, however, this is not the case. There is no recognized supplier of medicinal cannabis at UMC. Pharmacy staff must verify that the substance provided to the patient is in fact cannabis. Staff would then have to dispense the cannabis to the patient. This will create a conflict because clinicians are prohibited from distributing cannabis which is not approved by the FDA. Staff involvement in the verification and distribution of a schedule I controlled substance could subject them to federal criminal prosecution. Currently, the USDOJ does not prosecute persons strictly following state laws related to cannabis. This policy is not federal law and is subject to change.

The second consequence is also severe. Our medical center is an accredited hospital. Requiring UMC to allow patients to use this schedule I controlled substance puts accreditation into question. It puts a hospital's federal funding at risk. This is a significant consequence for UMC because, unlike other hospitals in southern Nevada, Medicare and Medicare patients account for two-thirds of our patients. A loss of income could be devastating.

Finally, drug interactions are a concern. There are few studies about drug interactions with THC. Whether a prescribed drug will interact with THC is not something readily known by pharmacists. It is not flagged in UMC's drug database software.

This bill could have potential liability for UMC and, for these reasons, we are opposed.

MR. HORNE:
I will reiterate that nothing in this bill calls for a physician, a nurse or any staff at the hospital to administer or help to administer or prescribe cannabis in any way to any of the patients. The patients are simply utilizing cannabis for their care in their final time. This bill is only for terminally ill patients.

California and, I believe, Washington are already doing this. As far as fear of federal enforcement, I do not believe that they are going to try to roll back what many states are already doing. They certainly are not going to start to pursue people who are terminally ill and using cannabis for their final time on earth. The ship has sailed. The federal government is looking for direction from the states on how to proceed in end-of-life care and other areas that cannabis is used. The fears are misplaced at this time.

CHAIR DOÑATE:
I have received a response (Exhibit AB) to the previous question regarding veterans hospitals. I have one document (Exhibit AC) in support of A.B. 411 to put into the record. We will close the hearing on A.B. 411.

MR. ELI ADDO:
I am speaking as an applicant for the social equity cannabis lounges. Chair Michael Douglas of the Nevada Cannabis Compliance Board (CCB) made a speech to the Legislature on determining the CCB's stance on a bill regarding the licensing and regulation of cannabis consumption lounges. Chair Douglas stated, "the Legislature failed to put forth a meaningful social equity program." I wanted to state that the legislation had good intentions but was not executed with good intentions. It has left entrepreneurs in a dark place. I am not even sure what words to use, but I thought it was supposed to be a democratic process. Unfortunately, I have lost all respect for the process.

CHAIR DOÑATE:
Hearing no other business, the meeting is adjourned at 7:14 p.m.

RESPECTFULLY SUBMITTED:

_____
Mary Ashley,
Committee Secretary

APPROVED BY:

_____
Senator Fabian Doñate, Chair

DATE: _____

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Introduced on Minute Report Page No.**	**Witness / Entity**	**Description**
	A	1		Agenda
	B	1		Attendance Roster
A.B. 24	C	3	Destini Cooper	Work Session Document
A.B. 40	D	3	Destini Cooper	Work Session Document
A.B. 116	E	4	Destini Cooper	Work Session Document
A.B. 136	F	4	Destini Cooper	Work Session Document
A.B. 215	G	5	Destini Cooper	Work Session Document
S.B. 445	H	5	Destini Cooper	Work Session Document
A.B. 289	I	6	Tom Harries/ Earth Funeral Group	Presentation
A.B. 289	J	12	Chris Bell/ Sierra Club – Toiyabe Chapter	Written Support
A.B. 11	K	14	Maggie Carlton	Office of the Governor Letter of Opposition
A.B. 11	L	15	Bobbette Bond/ Culinary Health Fund	Presentation
A.B. 11	M	15	Bobbette Bond/ Culinary Health Fund	1977 Attorney General Opinion
A.B. 11	N	16	Bobbette Bond/ Culinary Health Fund	2002 Attorney General Opinion
A.B. 11	O	16	Bobbette Bond/ Culinary Health Fund	2010 Attorney General Opinion
A.B. 11	P	16	Bobbette Bond/ Culinary Health Fund	Minutes of January 23, 2002, Legislative Commission's Subcommittee

A.B. 11	Q	17	Bobbette Bond/ Culinary Health Fund	Testimony for S.B. No. 412 of the 74th Session from Touro University
A.B. 11	R	19	Bobbette Bond/ Culinary Health Fund	Corporate Practice of Medicine Summary by State
A.B. 11	S	32	Pat Kelly/ Nevada Hospital Association	Letter of Opposition
A.B. 206	T	46	Senator Fabian Doñate	Letter of Support
A.B. 411	U	46	James Creel/ Compassion Center	Written Testimony
A.B. 411	V	46	William Horne/ Compassion Center	Proposed Amendment from Nevada Hospital Association
A.B. 411	W	49	William Horne/ Compassion Center	Correspondence from the Federal Government to California Senator Staff
A.B. 411	X	51	Julie Monteiro/ Integrative Providers Association	Letter of Support
A.B. 411	Y	51	Jason Greninger/ Atlas Alchemy	Peer Review Documents
A.B. 411	Z	51	Jason Greninger/ Atlas Alchemy	Additional Information
A.B. 411	AA	56	Jessie Wadhams/ Nevada Hospital Association	Letter from Patrick Kelly to Support Opposition
A.B. 411	AB	58	Senator Fabian Doñate	Response from Erin Hickey
A.B. 411	AC	58	Senator Fabian Doñate	Letter of Support