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

Eighty-First Session
May 5, 2021

The Committee on Health and Human Services was called to order by Chair Rochelle T. Nguyen at 1:36 p.m. on Wednesday, May 5, 2021, Online and in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/81st2021.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Rochelle T. Nguyen, Chair
Assemblywoman Sarah Peters, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblywoman Annie Black
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblywoman Lisa Krasner
Assemblyman Andy Matthews
Assemblyman David Orentlicher
Assemblywoman Shondra Summers-Armstrong
Assemblywoman Clara Thomas
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Joseph (Joe) P. Hardy, Senate District No. 12
Senator Julia Ratti, Senate District No. 13
Senator Roberta Lange, Senate District No. 7

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Karly O'Krent, Committee Counsel
Nick Christie, Committee Manager
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

John Packham, Associate Dean, Office of Statewide Initiatives, University of Nevada, Reno School of Medicine
Joelle Gutman Dodson, Government Affairs Liaison, Washoe County Health District
Bradley Mayer, representing Southern Nevada Health District
Kyra Morgan, Chief Biostatistician, Division of Public and Behavioral Health, Department of Health and Human Services
Margot Chappel, Deputy Administrator, Division of Public and Behavioral Health, Department of Health and Human Services
Antonina C. Capurro, D.M.D., M.P.H., M.B.A., State Dental Health Officer, Division of Public and Behavioral Health, Department of Health and Human Services
Jessica Woods, R.D.H., M.P.H., Interim State Public Health Dental Hygienist, Division of Public and Behavioral Health, Department of Health and Human Services
Edward Ableser, representing Nevada Dental Association
Vilas Sastry, Chief Executive Officer, TeleDentistry.com
Felipe M. Paleracio, D.D.S., President, Las Vegas Dental Association
Cody L. Phinney, M.P.H., Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Chelsea Capurro, representing Health Services Coalition
Stacie Sasso, Executive Director, Health Services Coalition
Bobbette Bond, Director of Public Policy, Culinary Health Fund
Maya Holmes, Healthcare Research Manager, Culinary Health Fund
Katherine Gudiksen, Private Citizen, Piedmont, California
Rusty McAllister, Executive Secretary-Treasurer, Nevada State AFL-CIO
Paul Catha, Political Organizer, Culinary Workers Union Local 226
Deanna Leivas, Secretary Treasurer, United Food and Commercial Workers Union Local 711
Juston Larsen, Member, Culinary Workers Union Local 226
Todd Ingalsbee, President, Professional Fire Fighters of Nevada
George Ross, representing Sunrise Hospital and Medical Center; MountainView Hospital; and HCA Healthcare
James Wadhams, representing Nevada Hospital Association
Katie Roe Ryan, System Director, Nevada Government Relations, Dignity Health-St. Rose Dominican

Dan Musgrove, representing Valley Health System
Misty Grimmer, representing North Vista Hospital
Chris Bosse, Chief Government Relations Officer, Renown Health

Chair Nguyen:
[Roll was taken. The Chair reminded Committee members, witnesses, and members of the audience of Committee rules, protocol, and procedures for virtual meetings.] We will now move to our first agenda item, which is the work session. For the audience's information, I will be taking Senate Bill 188 (1st Reprint) off the work session.

Senate Bill 188 (1st Reprint): Establishes programs for certain persons of low-income and persons in foster care. (BDR 38-711)

[This bill was not considered.]

I will start at the top with Senate Bill 21 (1st Reprint).

Senate Bill 21 (1st Reprint): Revises requirements relating to background investigations conducted by certain institutions, agencies and facilities that serve children. (BDR 5-303)

Patrick Ashton, Committee Policy Analyst:
As a nonpartisan member of the Legislative Counsel Bureau, I cannot advocate or oppose any measures that come before you today. We thought we might have a consent calendar today; however, we will just move through every bill on the work session.

We will start with Senate Bill 21 (1st Reprint), which we heard on April 28, 2021 [Exhibit C]. This bill provides that, in addition to the current requirement to conduct background checks on current employees, public or private institutions and agencies to which a juvenile court commits a child and certain facilities that provide residential mental health treatment to children must conduct background checks of applicants for employment to determine whether a potential employee has charges pending against him or her or has been convicted of several specified crimes. The bill revises and standardizes the specified crimes for which such institutions and agencies are required or authorized to deny an application for employment or to terminate employment of a current employee.

An institution or agency may waive the prohibition on hiring an applicant who has been convicted of a specified crime if the agency adopts and applies an objective weighing test whereby certain mitigating factors are considered. An agency may not waive the prohibition against hiring an applicant who has been convicted of a specified crime without applying the test, and an agency decision is not appealable. A review of relevant data must be conducted every two years to determine the efficacy of the test and identify implicit bias, and applicants and employees are allowed to correct information that they believe has been reported incorrectly. There are no amendments.

Chair Nguyen:
Are there any questions from Committee members? Seeing none, I will take a motion to do pass.

> ASSEMBLYWOMAN BENITEZ-THOMPSON MADE A MOTION TO DO PASS SENATE BILL 21 (1ST REPRINT).
>
> ASSEMBLYWOMAN PETERS SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYMEN BLACK, HAFEN, KRASNER, MATTHEWS, AND TITUS VOTED NO.)

I will assign the floor statement to Assemblywoman Summers-Armstrong.

The next bill on our work session is Senate Bill 146 (1st Reprint).

Senate Bill 146 (1st Reprint): Revises provisions relating to mental health services for children. (BDR 39-870)

Patrick Ashton, Committee Policy Analyst:
Senate Bill 146 (1st Reprint) was heard on April 28, 2021 [Exhibit D]. This bill revises laws related to behavioral health care for children with emotional disturbance who are subject to the jurisdiction of a juvenile court for reasons relating to protection from abuse and neglect. Specifically, when such a child is admitted to a public or private inpatient psychiatric treatment facility, the bill requires the administrative officer or staff of the facility to ask the person or entity with legal custody of the child whether he or she has a health care provider who regularly provides mental or behavioral health care. If the child has such a provider, staff of the facility must make a reasonable effort to consult with the provider concerning the child's admittance and care and to coordinate on a plan to discharge the child from the facility. There were no amendments.

Chair Nguyen:
Members of the Committee, do we have any questions? Seeing none, I would entertain a motion to do pass.

> ASSEMBLYWOMAN PETERS MADE A MOTION TO DO PASS SENATE BILL 146 (1ST REPRINT).
>
> ASSEMBLYWOMAN TITUS SECONDED THE MOTION.
>
> THE MOTION PASSED UNANIMOUSLY.

I will assign that floor statement to Assemblywoman Titus.

Next, we will move to Senate Bill 156 (1st Reprint).

Senate Bill 156 (1st Reprint): Revises provisions relating to crisis stabilization centers. (BDR 40-488)

Patrick Ashton, Committee Policy Analyst:
We heard Senate Bill 156 (1st Reprint) on April 23, 2021 [Exhibit E]. The bill expands the authority of the Division of Public and Behavioral Health of the Department of Health and Human Services (DHHS) to issue an endorsement as a crisis stabilization center not just to a psychiatric hospital, but to any licensed hospital that meets certain requirements. The bill also expands the list of organizations by which a hospital may be accredited to qualify for renewal of an endorsement, and it exempts rural hospitals from the accreditation requirement.

Additionally, the bill expands the existing requirement that DHHS take any action necessary to ensure crisis stabilization services provided at a psychiatric hospital with a crisis stabilization center endorsement are reimbursable under Medicaid to include such services provided at any hospital with this endorsement.

Finally, the bill makes conforming changes to existing law requiring health maintenance organizations or managed care organizations that provide services through Medicaid or the Children's Health Insurance Program to negotiate in good faith to include a hospital with an endorsement as a crisis stabilization center in their provider network. There were no amendments.

Chair Nguyen:
Are there any questions from Committee members? Seeing none, I would take a motion to do pass.

> ASSEMBLYWOMAN PETERS MADE A MOTION TO DO PASS SENATE BILL 156 (1ST REPRINT).
>
> ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

Do we have any comments on the motion?

Assemblywoman Titus:
I am going to vote this out of Committee with the right to change my vote.

Chair Nguyen:
I will remind all Committee members that you always have the right to change your vote. I appreciate that all Committee members have been very diligent about letting me know if they do plan on doing that. Are there any other comments on the motion? [There were none.]

> THE MOTION PASSED. (ASSEMBLYMEN BLACK AND MATTHEWS VOTED NO.)

I will give the floor statement to Assemblyman Orentlicher.

We will go next to Senate Bill 251 (1st Reprint).

Senate Bill 251 (1st Reprint): Revises provisions relating to genetic counseling and testing. (BDR 40-478)

Patrick Ashton, Committee Policy Analyst:
We heard Senate Bill 251 (1st Reprint) on April 23, 2021 [Exhibit F]. This bill requires primary care providers to attempt to determine whether adult women to whom they provide services have a personal or family history of certain cancers or meet other criteria for which the United States Preventive Services Task Force recommends screening for a harmful mutation of the BRCA [Breast Cancer] gene. If certain criteria are met, primary care providers must screen for the mutation, provide written notice of the need to discuss genetic counseling and testing, provide genetic counseling, and, if clinically indicated, provide genetic testing.

In addition, the bill requires a notice to be sent with the results of a mammogram advising women who have a familial history of certain types of cancer to speak with their doctor about genetic counseling and testing.

Physicians, physician assistants, and advanced practice registered nurses may receive credit toward applicable continuing education requirements for completing a course related to genetic counseling and genetic testing.

Finally, certain public and private health plans must cover screening, genetic counseling, and testing for harmful BRCA gene mutations where such services are required as set forth in the bill. The Commissioner of Insurance of the Division of Insurance of the Department of Business and Industry may take various actions, including suspending or revoking a health insurer's certificate, for failure to comply with these requirements. There were no amendments.

Chair Nguyen:
Members of the Committee, are there any questions regarding S.B. 251 (R1)? Seeing none, at this time I would entertain a motion to do pass.

> ASSEMBLYWOMAN GORELOW MADE A MOTION TO DO PASS SENATE BILL 251 (1ST REPRINT).
>
> ASSEMBLYWOMAN TITUS SECONDED THE MOTION.

Do we have any comments on the motion?

Assemblyman Orentlicher:
For the record, while I applaud the intent of this bill, there is one provision I think is problematic—the one granting protection from professional discipline for a physician. I think that is a bad precedent to create—to excuse physicians from their professional responsibilities to patients—so I will be voting no.

Chair Nguyen:
Are there any other comments regarding S.B. 251 (R1)? [There were none.]

> THE MOTION PASSED. (ASSEMBLYMAN ORENTLICHER VOTED NO.)

I will assign that floor statement to Assemblywoman Black.

Next, we will move to Senate Bill 309 (1st Reprint).

Senate Bill 309 (1st Reprint): Establishes a reinvestment advisory committee in certain larger counties. (BDR 38-956)

Patrick Ashton, Committee Policy Analyst:
We heard Senate Bill 309 (1st Reprint) on April 26, 2021 [Exhibit G]. It establishes a reinvestment advisory committee in each county of the state with a population of 700,000 or more, which is currently Clark County. The bill outlines membership of the committee and prescribes the duties of a reinvestment advisory committee, which include:

- Reviewing reports from the Division of Health Care Financing and Policy of the Department of Health and Human Services and Medicaid managed care organizations (MCOs) regarding reinvestment of funds in the communities they serve;

- Reporting to the Division and MCOs about local initiatives to address homelessness, housing issues, and social determinants of health;

- Making recommendations regarding the use of funds by MCOs to develop innovative partnerships with community development organizations and providers of housing services and to support certain local government initiatives; and

- Compiling an annual report on these issues and the committee's activities.

There were no amendments.

Chair Nguyen:
Are there any questions regarding S.B. 309 (R1)? Seeing none, I will entertain a motion to do pass at this time.

ASSEMBLYWOMAN PETERS MADE A MOTION TO DO PASS SENATE BILL 309 (1ST REPRINT).

ASSEMBLYWOMAN SUMMERS-ARMSTRONG SECONDED THE MOTION.

Do we have any comments on the motion? [There were none.]

THE MOTION PASSED. (ASSEMBLYMEN BLACK, HAFEN, KRASNER, MATTHEWS, AND TITUS VOTED NO.)

I will assign that floor statement to Assemblywoman Gorelow.

Next on our work session, I will move to Senate Bill 364.

Senate Bill 364: Revises provisions relating to emergency medical care for a victim of sexual assault or attempted sexual assault. (BDR 40-1004)

Patrick Ashton, Committee Policy Analyst:
Senate Bill 364 was heard in this Committee on April 21, 2021 [Exhibit H]. This bill requires the State Board of Health to adopt regulations requiring a hospital or independent center for emergency medical care to provide certain training to employees who provide care to victims of sexual assault or attempted sexual assault. These facilities must inform victims of their right to receive emergency contraception and provide such contraception upon request. Failure to comply with the bill's requirements may result in disciplinary action for these facilities, including administrative sanctions or the denial, suspension, or revocation of a license. There were no amendments.

Chair Nguyen:
Members of the Committee, are there any questions regarding S.B. 364? Seeing none, at this time I would entertain a motion to do pass.

ASSEMBLYWOMAN PETERS MADE A MOTION TO DO PASS SENATE BILL 364.

ASSEMBLYWOMAN TITUS SECONDED THE MOTION.

Do we have any comments on the motion?

Assemblyman Matthews:
I will be voting yes today but will be reserving my right on the floor.

Chair Nguyen:
Do we have any other comments from members? [There were none.]

THE MOTION PASSED. (ASSEMBLYWOMAN BLACK VOTED NO.)

I will assign that floor statement to Assemblywoman Krasner.

Next on the work session is Senate Bill 376 (1st Reprint).

Senate Bill 376 (1st Reprint): Revises provisions relating to child welfare. (BDR 38-503)

Patrick Ashton, Committee Policy Analyst:
Senate Bill 376 (1st Reprint) was heard on April 28, 2021 [Exhibit I]. The bill requires child welfare agencies to assign one of the following dispositions to a report concerning the possible abuse or neglect of a child upon determining that an investigation is not warranted or upon the conclusion of an investigation:

- Substantiated;
- Unsubstantiated;
- Unable to locate or contact; or
- Administrative closure.

In addition, S.B. 376 (R1) prohibits the reporting of dispositions other than substantiated to the Statewide Central Registry for the Collection of Information Concerning the Abuse or Neglect of a Child and prohibits the release of information from the Central Registry regarding reports of child abuse or neglect that received a disposition other than substantiated, except to a child welfare agency. There were no amendments.

Chair Nguyen:
Do we have any questions from Committee members regarding S.B. 376 (R1)? Seeing none, at this time I will take a motion to do pass.

ASSEMBLYWOMAN KRASNER MADE A MOTION TO DO PASS SENATE BILL 376 (1ST REPRINT).

ASSEMBLWOMAN PETERS SECONDED THE MOTION.

Do we have any comments on the motion at this time? [There were none.]

THE MOTION PASSED UNANIMOUSLY.

I will assign that floor statement to Assemblywoman Thomas.

Last on our work session is Senate Bill 398.

Senate Bill 398: Revises provisions relating to the Legislative Committee on Child Welfare and Juvenile Justice. (BDR S-507)

Patrick Ashton, Committee Policy Analyst:
We heard Senate Bill 398 on April 21, 2021 [Exhibit J]. The bill requires the Juvenile Justice Oversight Commission to submit a report to the Legislative Committee on Child Welfare and Juvenile Justice by August 1, 2022, containing an update on the progress made by the Division of Child and Family Services of the Department of Health and Human Services in implementing its current 5-year plan as well as any recommendations for legislation relating to improvements to the upcoming 5-year plan, any disparities in the juvenile justice system related to race or ethnicity, and compliance with the federal Juvenile Justice and Delinquency Prevention Act, 34 U.S.C. §§ 11101 et seq. There were no amendments.

Chair Nguyen:
Members of the Committee, are there any questions regarding S.B. 398? Seeing none, I would entertain a motion to do pass S.B. 398.

> ASSEMBLYWOMAN PETERS MADE A MOTION TO DO PASS SENATE BILL 398.
>
> ASSEMBLYWOMAN KRASNER SECONDED THE MOTION.

Do we have any comments on the motion? [There were none.]

> THE MOTION PASSED. (ASSEMBLYMEN BLACK AND MATTHEWS VOTED NO.)

I will assign that floor statement to Assemblywoman Krasner.

That concludes our work session. We do have three bill hearings, and I am going to take them slightly out of the order as they are listed on the agenda. At this time, I will open the bill hearing on Senate Bill 379 (1st Reprint). Welcome to the Committee, Senator Hardy. Please begin when you are ready.

Senate Bill 379 (1st Reprint): Provides for the collection of certain data concerning providers of health care. (BDR 40-457)

Senator Joseph (Joe) P. Hardy, Senate District No. 12:
Senate Bill 379 (1st Reprint) is interested in data, and we need data in order to figure out how we sit presently and how we want to get more practitioners and providers. The bill is pretty simple in its organization. We want to attract more providers—especially for the underrepresented groups and specialties. The mechanics would work like this: After you have initially been licensed or certified, when you go for renewal, there will be a survey sent—hopefully electronically—and the practitioner/provider will fill out the survey.

The survey is interested in things that will tell us where that practitioner/provider is at. That is on page 3, lines 3 through 32. All those items are what we are interested in so we can figure out how we can improve our delivery of health care and be able to make our people healthier. The working group that will be set up under the direction of the director of the Department of Health and Human Services will meet. They have to create a questionnaire, and they will do that. The goal is on page 4, line 18, "Attract more persons, including, without limitation, members of underrepresented groups," et cetera, and then on line 22, "Improve health outcomes and public health in this State."

The survey response cannot be used to disqualify someone from approval of their license. It is confidential. The survey will include doctors of every kind, nurses, mental health providers, chiropractors, oriental medicine, podiatrists, marriage and family counselors, sociologists, psychologists, and alcohol, drug, and gambling counselors.

Chair Nguyen:
Are there questions from the Committee?

Assemblywoman Titus:
I have some concerns and questions regarding the questions on this questionnaire and what the ultimate purpose is. Section 5, subsection 1, paragraph (b), mentions race and ethnicity, and paragraph (l) mentions future plans. How is that relevant to somebody's qualifications when they renew their license?

Senator Hardy:
This survey has nothing to do with the licensing of the person as much as it has to do with who they are and what they are doing. The confidentiality is really crucial, because if there is a physician or practitioner who is planning on going somewhere else, we do not want that person to be identifiable; therefore, the confidentiality will be of utmost importance. It is designed to be upon renewal, so there will not be an issue of, Well, I think you kept me out because of, which we are not supposed to be able to do.

Dr. John Packham is on Zoom, and he can probably answer questions about the mechanics of the questionnaire. I will note that where I am coming from—an old white male—I may not be as trustworthy or trusted in some communities as in others. If I do not have people who look like other people, then they may not trust those people, so I am very interested in getting and recruiting people who are, for lack of a better word, a BIPOC [Black, Indigenous, People of Color] community member for instance, and having that opportunity to grow the trust factor in the medical and counseling world of Nevada.

Assemblywoman Titus:
I appreciate that answer and that is one of my concerns—that it may be used to, perhaps, not hire somebody or focus on how someone identifies. What if they do not want to answer this? Would that lead to denial of their licensure?

Senator Hardy:
No, it is not mandatory.

Assemblywoman Titus:
It is going to be an elective option. You can opt in?

Senator Hardy:
Correct. It will have nothing to do with your license being allowed to continue. It is not before you get licensed; it is upon renewal, so it will not have an effect on your hiring or firing. It will be confidential.

Assemblywoman Titus:
That is reassuring if it is optional—which is a good thing. Then it will be used statewide maybe to identify some priorities and certain recruitment. I guess Dr. Packham will have to answer how this will help us change how we see it. In my mind, to solve some of these problems we need to make sure we encourage people from every background to go into the fields where we need them. In health care, as you pointed out, it is critical that you have confidence in your provider. It helps if your provider understands your background or can identify with you and you can identify with them; I understand that component, but I am not sure this questionnaire gets us there because it is on the back end already. That is where I need some reassurance that it is going to help us get that right mix.

John Packham, Associate Dean, Office of Statewide Initiatives, University of Nevada, Reno School of Medicine:
[John Packham supplied a policy brief, Exhibit K, and a PowerPoint, Exhibit L.] This bill provides a wonderful, very efficient mechanism for collecting data not only on physicians and nurses, but on any health professional who is renewing their license in the state of Nevada. Our primary purpose for bringing the bill is to improve the data that is used to establish and maintain HPSA [health professional shortage area] designation. That is very important for a number of programs that are critical to bringing and keeping physicians and other health professionals in the state of Nevada. In addition to that, the bill will improve the collection of data to inform a wide range of where our health care needs are by profession.

Senator Hardy:
Dr. Packham, could you make sure the acronym that you just used—HPSA—is well understood so we are all on the same page.

John Packham:
The acronym HPSA stands for health professional shortage area. There are three types of shortage areas or designations: primary care, oral health or dental, and mental and behavioral health professionals. These are critical for making Nevada providers and facilities eligible for loan repayment and [unintelligible] reimbursement and so forth. I would stress the urgency. When we talk about access to care, access to care is affected by those designations,

and it is critical for us to get it right and to take advantage of those particular designations. I would like to reemphasize this is not simply or purely a data collection bill. It is a data collection bill that will inform and improve access in our state.

Assemblywoman Summers-Armstrong:
I have not met you before, Senator Hardy, but this is a wonderful introduction on an issue that is very important in my community. I would like to ask why your request does not include an exit survey, if that is at all possible. Why do doctors leave? Our family lost our pediatrician. He was our pediatrician from the time my two older sons were 7 or 8 years old all the way up to our youngest son who just turned 19. He is a Black man; we grew up in the same city—Oakland, California. We had these things in common, and to have a man who looked like my sons take care of them all their lives, to be able to speak to them and have a relationship with them and our family made a huge difference in how they responded to health care and the instructions he gave them. All of a sudden, he was gone, and I never found out why. I just lost my OB/GYN whom I had for 20 years—same thing. Even as we are collecting data about why people re-up their licenses, if there would be any way you could find out why people leave—because that also might inform about why we have shortages here.

Assemblywoman Benitez-Thompson:
I would like to start with the mechanics concerning how we are going to collect this data. In section 5, subsection 2, it reads, "The Director shall develop and make available . . ." and that would be the director of the Department of Health and Human Services. The director shall develop and make available to each professional licensing board, and those licensing boards are listed in *Nevada Revised Statutes* (NRS) 629.031 paragraphs (a) through (bb). Is there a way to collect this data electronically? For the record, could you tell us how that will be implemented?

John Packham:
There are a variety of ways that can be done technologically. What the licensing boards would like for us to consider or think about on this is, when you renew your license online, as you proceed through that renewal process, there would be a link to click on that would take you to the Department of Health and Human Services where you would complete a survey we would have available. When you complete that survey, you would return back, provide your credit card information, and renew your license with the state of Nevada. The whole idea is to make this as seamless as possible so that every two years—for most professions—when you renew your license, you are spending from five to eight minutes providing very valuable information that the State and other agencies would use to inform policy.

There is a document as an exhibit [Exhibit K]. It is a background paper put together by about a dozen of us who have been working on this issue. It provides some great examples of how other states have done this. The beauty of this proposed piece of legislation is that we do not have to reinvent the wheel. There are a number of state models. We received wonderful

advice from both the National Conference of State Legislatures as well as from the National Governors Association. They have some tried-and-true models out there ready to roll if and when we proceed on this. I am confident that this is worth the lift.

Assemblywoman Benitez-Thompson:
Are all the boards in a place where they will be able to do this? Conversations with different boards at different times indicate they are in different states of data technology. I know one board a few years back was still doing paper application renewals because the cost to go to an electronic version was going to be north of $30,000. A couple of sessions back, we were trying to figure out how to pool some of those tech needs among some of the smaller boards. Just knowing this is a really big swath of boards—and for the legislative record—are all the boards going to be in a place where they will be able to dovetail into the system you are talking about?

John Packham:
My honest answer would be no, they will not all be in the same place. By my count, there are 28 boards that license or regulate anywhere from 7 to 75 professions, and they are all over the map in terms of the software they use for licensure renewal. Some still do pencil and paper, et cetera. Again, I am hoping that the way this bill has been crafted or proposed is one that is mindful of those differences and allows boards to implement this, phase this in as they see fit, and with enough time to take into account those variations. If you have seen one licensing board, you have seen one licensing board.

Assemblywoman Benitez-Thompson:
I appreciate the honesty of that, because in looking at the end of the bill, I see we have different implementation dates for different sections. It looks like you have done an assessment of the boards, so depending on where the boards are at, you are addressing different implementation dates. Is that why we are seeing different ones except for the boards that are already doing renewals and licensing electronically? They can dovetail into this sooner, and those still using paper will need to figure out a way to get to an electronic base. They have until July 1, 2022.

John Packham:
Another thing I would point out is that the time in which health professionals renew their license varies from board to board. Some are on a yearly basis and some are every other year, I believe. With the state Board of Medical Examiners, you renew your license every two years by June 30. The way to think about this is that the data will not start rolling in immediately. It will be phased in over the next couple of years, but in two or three years, we will begin to have some solid data on health professions and not just practice characteristics and sociodemographic characteristics. If it is the pleasure of this Committee, we can address some of the concerns raised in a previous question about retirement plans or the likelihood of leaving or exiting the profession and the state. Those are important questions. The point I want to make is the data capture will not be immediate but will be phased in based on the way each board collects that data and the timeline in which they collect that data.

Assemblywoman Benitez-Thompson:
For the boards that still need to address the tech issue, does this require them to figure out how to get themselves to an electronic renewal, or would they stay with paper? For instance, there could be an insert notification in the renewal letter that says, go to this link and do this survey electronically, until they can afford the cost to do everything online and with all the tech.

John Packham:
I think the answer to that is a qualified yes. We need to be flexible in how this is going to be implemented and rolled out. Some states have a superagency overseeing licensing, so you are dealing with one type of software and one common way of renewing your license. We are different. Each board is different, and I think we will have to be flexible and patient in how this is implemented given that variation.

Assemblywoman Benitez-Thompson:
That was my question on implementation, but I have another about the specific data being collected. For the record, in section 5, subsection 1, paragraph (f), the working hours and location, what are you looking for in that? When a licensee goes to complete that, is that going to be a qualitative sentence or are you looking for a delineation of their hours?

John Packham:
Let me speak to the general intent of that. I did a survey about ten years ago on registered nurses in the state. One of the things I discovered in that survey is that about 15 percent or 20 percent of those nurses worked in a county that was different from where they had their licensure renewal mailed back to them. While it is good to know how many licensed physicians or nurses work in a particular county or part of the state, we really need to know where they are practicing—where they are working and the type of employer they are working for. Are they working in a hospital or clinic setting or in a public health agency? The intent of that type of question is to get a better sense—for example, with respect to a health professional shortage area designation—of whether they are providing care in a medically underserved area? What percent of the patient panel of population is on Medicaid, et cetera? As we are trying to assess that, we are getting better information on actually where they practice medical care as well as whether the person is providing patient care, because a number of physicians work in administrative or university settings. This will give us a better handle on exactly where care is being provided, how much, and what types of populations those professionals are serving.

Assemblywoman Benitez-Thompson:
Because the list under NRS 629.031 is so exhaustive, your intent would be that those professions that are listed who work in the health care field would take the survey. If they were not working in the health care field, there would not be the assumption that just because their licensing type is listed in here, they are necessarily working in the health care field. That is something you would ask first and foremost. Some of them are more obvious, like physicians, but some others may or may not be in the health care field—for instance, a social worker. Some might be in child welfare and some might be in medical, so I guess you would

ask this question first: Are they in the health care field? If they are, then you want to capture this data because otherwise it would just be erroneous data you would be collecting from people who are not in the medical field.

John Packham:
Our idea would be to ask every health professional renewing their license, so we could get our arms around that. For example, if we are getting data on physicians whose primary specialty is family medicine, it is important to not only know what the universe of family medicine physicians are in the state or in a given county, but from that, how many are actually providing patient care. How many have an active license and how many are working full time, because we know that for every 100 physicians in family medicine, maybe 80 percent or 85 percent are actually in direct patient care. In that subset, some are working full time, and some are working part time. Again, as we try to get our arms around what the capacity of the state is and where we may or may not have gaps in provider coverage, this type of data will really inform that much better than anything we currently have. I can tell you how many family physicians are licensed in Clark County; I have no clue what the full-time equivalent of that number is providing direct patient care or serving Medicaid patients or working in medically underserved areas, and so forth. We need answers to those questions.

Assemblywoman Benitez-Thompson:
I appreciate that. You keep using the example of physicians, and this is why I am asking for the record because that list refers to all of the healing arts. You are not just looking for a subset of the healing arts, you mean the entire list of everyone in NRS 629.031. Since I got a firm yes on that, I am thinking that, with some of the licensing types such as social workers, it is anyone who is licensed by the Board of Examiners for Social Workers, but not all of them work in health care. Therefore, once you get the data, you will clean it up so that not everyone who is working in child welfare or working in anything other than health care is represented as a part of a workforce that indeed they are not a part of.

John Packham:
Correct. We are interested in the state's primary care capacity, and that does not mean just family medicine or internal medicine doctors. It also means getting our arms around advanced practice nurses and physician assistants who we know are critical to primary care capacity in our state. If your profession would have that kind of variation—how many are practicing, how many are providing patient care versus administrative work, and so forth—I think the answer to that question is, yes.

Assemblywoman Benitez-Thompson:
There are a couple of others like music therapists in there. They may or may not be in a medical setting. There is another one, I think it is a sports trainer, who may or may not be in a medical setting—there were just a couple I was not quite sure about. I believe we should flesh out on the record what you were trying to scoop up and the scope of it, because it will be a lot of people to these licensing boards. My licensing board asks me about the county I work in, the kind of work I do, the institution I work for, and those kinds of things.

For some of the professions, a lot of this will not be new. I am thinking about how I am going to answer a lot of these things, such as working hours and locations. I might spend part of my time outpatient and part of my time inpatient. I guess you would want to know how many hours I am in the hospital versus how many hours I am at the office versus how many hours I am spending in patient homes. I would just report that. I assume you will give me a freeform box to report that as more of a qualitative response, as opposed to just a drop-down box with numbers; then you will sort all that out.

John Packham:
The way to think about that phrasing [unintelligible] we could capture that data are to be determined. The standard methodology in this line of research is to phrase the question, "In a typical work week, how much of your time is involved with direct patient care, administrative work, et cetera?" I am hoping that the bill is not overly prescriptive on the wording of questions, questionnaires, and so forth. Again, going back to the original plan A, finding out how many providers—regardless of what field they are in—are providing direct patient care.

Chair Nguyen:
I want to remind Committee members that this is a bill that came out unanimously from a work session from the interim Legislative Committee on Health Care. There is an interim committee report available on the Nevada Electronic Legislative Information System that I would encourage our members to reach out and look at. There is a work session document that has some of this in the minutes from a discussion of this bill as well.

Assemblywoman Benitez-Thompson:
That is an important point. I also think it is important to note that the legislative record we create in committee is the legislative record. We do not have a precedent for referring to interim committees and the work they do as legislative record. It may be helpful for us, but the only formal actions we take are when we are in session, so I always think it is helpful to ask these kinds of questions for the record. If you do not ask how it is going to get done, this is the only place where bodies, boards, the people who write regulations, can look back for direction.

Chair Nguyen:
I do not disagree, and I am not discouraging questions and creating a legislative history. I just wanted to make sure the Committee members knew that. It was left out during the introduction of the bill, and I know the interim committee wanted to make sure that was also included on the record in case people had some additional information they wanted to look at—those other discussions that occurred during the interim. Again, I would encourage anyone to ask questions and create that legislative history, because I agree that we do need to have the intent clearly on the record.

Do we have any other questions from Committee members at this time? Seeing none, we will begin testimony in support of S.B. 379 (R1).

Senator Julia Ratti, Senate District No. 13:
I was the vice chair of the interim Legislative Committee on Health Care. It was chaired by Assemblywoman Lesley Cohen. This particular item came forward specifically because of an experience with one of our federally qualified health care centers in Washoe County. They have been able to use one of the wonderful programs from the federal government to do loan repayments to some of the health care professionals. Unfortunately, because Nevada did not have sufficient data to be able to compete well, when the time came around to renew that kind of program that helps us recruit health care providers, and specifically health care providers to serve low-income and underserved populations, we did not have the data, we did not compete well, and we lost that program.

I want to underscore that this is not just about collecting data but absolutely about collecting enough data to be able to compete well and to know where we need to invest our resources and energy, but also to be able to draw down some federal resources so we can recruit providers, particularly into hard-to-serve communities.

Chair Nguyen:
Is there anyone else to testify in support of S.B. 379 (R1)?

Joelle Gutman Dodson, Government Affairs Liaison, Washoe County Health District:
We wanted to thank Dr. Packham and Senator Hardy for staying the course with this bill throughout the session. We are really pleased with [unintelligible] this session. As the good doctor said, knowledge is power, and the more we know about where providers are and are not, the better we can work to serve our communities. We believe this will help health outcomes in Nevada and, therefore, improve the public health of Nevadans. Thank you for allowing me to testify. We urge your support.

Bradley Mayer, representing Southern Nevada Health District:
I am echoing Joelle Gutman Dodson's comments, and we want to thank Dr. Packham and Dr. Hardy for bringing this bill forward. We think collecting this data can have a meaningful impact on how we deliver health care in Nevada, so we urge your support of this bill.

Chair Nguyen:
We will go to our next caller in support. [There was no one.] At this time, I will begin testimony in opposition to S.B. 379 (R1). [There was none.] Next, I will go to neutral. Is there anyone to testify in neutral to S.B. 379 (R1)?

Kyra Morgan, Chief Biostatistician, Division of Public and Behavioral Health, Department of Health and Human Services:
I wanted to provide a little bit of clarity on data collection. The idea behind data collection is that the survey would be created and maintained by the Department of Health and Human Services (DHHS), and my office would be involved in that process. A simple web link to that survey would be provided to the health professionals upon renewal of their licenses.

This is an important piece of clarity because it really would just require—from a technical perspective—the person renewing their license to have access to either a computer or a smart phone in order to be able to follow that link and complete the survey.

There really is no technical requirement from the perspective of the survey distribution on behalf of the boards with the exception of just making that link available to their members. The data would then be submitted via an individual following that link. They would be taken to a page to complete the questionnaire, and the responses to those questions would be directed back to DHHS without actually having to be received by the boards themselves. I think that not only eliminates a lot of workload from the perspective of a technical requirement of the boards, but also eliminates concern that those responses could be used in any negative way in regard to confidentiality of the data. I wanted to make those clarifications.

Chair Nguyen:
Ms. Morgan, will you please hold on for a minute. I want to see if our Committee members have any follow-up questions for you specifically. Do we have any follow-up questions for Ms. Morgan?

Assemblywoman Benitez-Thompson:
The responsibility of the board would just be to make the link available to their licensees; that is a good distinction because I was worried that our boards were going to have to stand up an electronic web base. Some are moving there, but some are not, so we could inadvertently be causing some of the smaller boards to really get their tech in line, which typically means more licensing fee increases. Would that happen in the time frame this implementation date was looking at? As long as they provide the information to their licensee, which could include a piece of paper—a notice—in their renewal notice, then the board has met its obligation for this legislation.

Kyra Morgan:
That is correct. The idea was that we would take the burden of maintaining the survey away from the licensing boards. We would cover the technical aspect of that, and anyone with access to a smart phone or computer would be able to follow that link and submit their data directly to DHHS.

Assemblywoman Summers-Armstrong:
I am learning today that all the boards do not have full web capability, but would the link be available somewhere on their websites even if they do not have the ability to have online renewal? I heard Assemblywoman Benitez-Thompson speak about a piece of paper, but often people go to websites to look things up. Is that possible, and will you be able to help those boards maintain that link to make sure it is fresh and functional in addition to any physical papers they might share with their board members?

Kyra Morgan:
Similar to what Dr. Packham stated earlier, there are a number of ways we can accomplish this. I think the bill keeps it broad and does not prescribe exactly how it will be done, but absolutely, yes. Once the survey is created and a link is provisioned, that link could be distributed via an email list, it could be printed in hard copy, or it could be posted on a website; there are a number of ways that could be distributed. From a technical perspective, how that works is, as we update the survey, as long as we keep it at that link, maintenance as far as where that link is stored is extremely minimal. The short answer is yes, but we do not have the exact details worked out. There are a number of mechanisms we could utilize.

Chair Nguyen:
Do we have any other questions from Committee members? Seeing none, let us continue with additional testimony in neutral on S.B. 379 (R1).

Margot Chappel, Deputy Administrator, Division of Public and Behavioral Health, Department of Health and Human Services:
This data is important to the HPSA designations that our office is responsible for periodically for the Health Resources and Services Administration at the federal level, and it will greatly assist us in creating that data and reporting it more easily on a regular basis.

Chair Nguyen:
Is there anyone else on the line who wishes to testify in neutral? [There was no one.] With that, I will turn this back over to Senator Hardy for any closing remarks.

Senator Hardy:
This is a committee bill that came out of the interim, and Senator Ratti is really the one responsible for it. I do not want to claim any responsibility or any accolades, because all of this was committee work.

Chair Nguyen:
With that, I will close the hearing on S.B. 379 (R1). Next, we will move to Senate Bill 391 (1st Reprint).

Senate Bill 391 (1st Reprint): Revises provisions relating to dentistry. (BDR 40-455)

Senator Julia Ratti, Senate District No. 13:
As the vice chair of the interim Legislative Committee on Health Care, I am bringing forward to you another bill that passed out of that committee unanimously. This bill has been through quite the journey. Chair Cohen and I recognized at the beginning of the interim that Nevada has significant struggles when it comes to oral health care. The interim committee had voted to focus on a couple of areas, and we chose oral health as one of the areas it was appropriate for us to focus on because of the significant negative outcomes in Nevada when it comes to oral health care.

I did not know that we have a State Dental Health Officer within the Department of Health and Human Services (DHHS) until last session, so we went to our State Dental Health Officer and asked her to help us with a survey of best practices across the nation when it comes to oral health and places where we could move the needle when it comes to oral health care. Dr. Antonina Capurro did some phenomenal work. She brought forward a package of things we could consider, and we had a couple of good days of hearings on oral health during the interim. Then there was the pandemic, so coming into this session, we knew that we probably would not have very much success with anything that had a significant fiscal note. During the interim, we pared that list back significantly and eliminated most of the things that had fiscal notes, knowing this was not the time to be looking at significant expansions of programs or services.

What we were left with were two very important pieces where we could move the needle on oral health care. One is focusing on oral health professionals—the whole spectrum including dental hygienists, dental therapists, or dentists and their roles in response to an emergency. One thing we have learned during the pandemic is that we have this whole field of professionals who could lean in; but when it comes to oral health, we have very little infrastructure built in terms of an emergency management structure—very little training, very little identification of who is available and how they could be available—and that was something we needed to rectify. That was the first piece. The second is that our state and our *Nevada Revised Statutes* (NRS) lag when it comes to the concept of teledentistry. We have done a lot of work in this legislative body over multiple sessions on telehealth, and telehealth has certainly seen a dramatic expansion and acceleration of acceptance during the pandemic, but we had not done a lot of work on teledentistry. As a result, we wanted to update the statutes when it came to teledentistry. Those are the two concepts that came out of the interim Legislative Committee on Health Care. I am going to ask Dr. Capurro to walk through those sections, because most of it is her work that she helped support the committee to work through.

Since the interim, I have had a couple of conversations with Richard Whitley, the director of the Department of Health and Human Services, about some of the challenges for recruiting the state's own dental health workforce. We have two staff in the state of Nevada who support dental health. One is our State Dental Health Officer, and Dr. Antonina Capurro is that person. The other is a State Public Health Dental Hygienist who works for the state. They were structured very differently in statute than were their comparable peers. For example, the State Dental Health Officer was structured very differently than the Chief Medical Officer, specifically when it comes to licensing, so we addressed the licensing for the State Dental Health Officer to make it more comparable to the Chief Medical Officer. Then, specific to the State Public Health Dental Hygienist, there is a piece in state law that says that if you work as the State Public Health Dental Hygienist, you cannot take any outside work. That typically makes sense with our state employees. We say if you are going to have a full-time job with the state, you probably should not be doing any outside work with the exception that our State Public Health Dental Hygienist is a part-time position because we have not had the resources to fund it at a full-time level. To recruit someone into that position, we are basically saying that we would like to hire that person for a part-time job

but the person is not allowed to do any other work to be able to pay the bills. That is just impractical on its face. I will take you through the parts that are very specific to the oral health staff, and then I will ask Dr. Capurro to take you through the specific sections about telehealth and emergency response in the oral health community.

If you look at Senate Bill 391 (1st Reprint), section 1 states that the State Dental Health Officer is not required to be a licensed practitioner. This is a position that is not sitting in a clinic doing dental health work on most days, so that license is not necessarily appropriate. The person could be a licensed dental practitioner: that is one option. However, the bill allows for an alternate option which is that the person would have a master's degree in public health and have graduated from a dental health college approved by the Commission on Dental Accreditation (CODA) of the American Dental Association. The person would have completed a dental health education in a CODA-approved educational facility and would have a master's in public health. This would allow for recruitment of someone who might have been working in academia for a while and no longer using their practitioner's license and not updating it. It will allow for much greater ease of recruitment from out of state, so when a dental health officer would come here, they would be able to get this license that is specifically created for our State Dental Health Officer.

Section 1.3 is the section that removes the prohibition on the dental hygienist from having outside work. Again, that is now a part-time position, and I think it is only fair that that person be allowed to have other outside work.

Section 27.5 is the section that authorizes the Board of Dental Examiners of Nevada to issue this limited license for the dentist and dental hygienist, as applicable. Section 27.5 also prohibits the holder of a limited license from practicing dentistry or dental hygiene, as applicable, and section 39.5 requires that it be renewed annually. Sections 39, 40, and 41 all make the conforming changes. I will pause there because those are the sections of the bill that specifically relate to the licensing of the dental health professionals, and ask Dr. Capurro to go through the teledentistry and emergency response sections of the bill.

Antonina C. Capurro, D.M.D., M.P.H., M.B.A., State Dental Health Officer, Division of Public and Behavioral Health, Department of Health and Human Services:

I oversee the Nevada Oral Health Program within DHHS. I am joined by Ms. Jessica Woods, our Interim State Public Health Dental Hygienist. She will also provide additional details on this bill.

I want to start with some background. The landscape of health care is changing, as is our service delivery model, so to adapt to these changes and implement lessons learned from the dental community's response to the pandemic, this bill has been created. The components of the bill are built on the foundation that oral health is critical to overall health for individuals of all ages. Poor oral health can lead to pain and tooth loss that affects quality of life and can impact employment.

Research has identified an association between poor oral health and chronic disease conditions such as diabetes, heart disease, lung disease, and stroke. However, in 2019 what we saw was 35.3 percent of Nevada adults reported they had not visited a dentist or dental clinic within the last year, and 23 percent of Nevada adults responded that they experience anxiety due to conditions of their mouth and teeth. We know that low-income adults, individuals, and families, as well as racial and ethnic minorities, are disproportionately affected by oral health problems, and the COVID-19 pandemic has aggravated these health care inequities. It has led to dental office closures to all but emergency services. From March 16, 2020, to May 4, 2020, we had cancellation of school-based preventive touch points. There has also been a change in the dental workforce which we may not realize for several years. Many of the lessons learned from providing dental care during the pandemic, including the expanded use of teledentistry and inclusion of dental professionals as emergency responders, is addressed in this bill.

Sections 10 to 16 define the educational and training requirements that are needed for oral health professionals to respond to a public health disaster or any type of state of emergency. It also establishes the Committee on Dental Emergency Management. These sections are based on the concept that emergencies and disasters strain the state's health resources, and without a more robust disaster workforce, the lives and well-being of Nevadans are at risk. Dental practitioners who are well versed in emergency management are deployable health care professionals during a public health crisis, terrorist threat, or natural disaster. There are numerous dental professionals who are technically trained to save lives, but who do not have the specific types of training that would be necessary to step in during an emergency or public health disaster. This lack of training impairs the state's ability to respond quickly and efficiently to emergencies and disasters, so this training is addressed in these sections. Section 17 adds a dental emergency responder to the Committee on Emergency Medical Services. The last component in the bill is teledentistry.

During the 2020 stay-at-home orders, there was an exponential rise in the number of teledental visits. In June 2019, there were roughly 102 teledental visits to Medicaid patients. That number grew to 934 in May 2020. This increase occurred without a framework for safe and efficient utilization of teledentistry. Sections 19 to 21 include a teledental exam that meets certain criteria as an option to fulfill school entrance requirements. Sections 22 to 27 define what teledentistry is, and sections 28 to 31 require a dental practitioner to follow clinical requirements, ethical standards, and confidentiality of the patient's information during a teledental visit. It also outlines the practitioner-patient relationship and outlines it for consent as well. Sections 32 to 35 ensure communication complies with all Health Insurance Portability and Accountability Act laws, and the patient information is secure and encrypted. Section 33 outlines when referrals should be made to ensure that there is adequate in-person care when it is needed. Section 34 requires the Board of Dental Examiners of Nevada to adopt regulations governing teledentistry, and sections 37 and 39 outline a one-time teledentistry education course for dental practitioners.

Section 1.7 and sections 42 to 45 create options for hospital systems in the state to leave the established network of dental professionals that are enrolled in the dental managed care

organization to bring those teledental services to individuals who are having a real-time dental emergency at a hospital. Sections 19 to 39 and sections 42 to 45 are the sections that establish this framework for teledentistry to reduce those traditional barriers to care, to foster equality, and allow Nevada to leverage new technology that expands access to dental care for all patients in the state regardless of where they are located, a parity with in-person services, practitioner-patient relationship, informed consent, patient record requirements, confidentiality of the information, and referrals and regulations to be created by the Board of Dental Examiners are all outlined in these sections.

Senator Ratti:
I believe that is the entirety of our presentation, and we stand ready for questions.

Assemblywoman Titus:
Thank you for bringing this bill forward. I was a member of the interim Legislative Committee on Health Care; however, we never see the bills actually written. They are generally just concepts of what the priorities will be for a bill presentation, so I have a couple of questions on the bill. Under section 1, subsection 1, paragraph (b), subparagraphs (1) and (2), you are removing the requirement that they be a licensed dentist in the state, so at no time can our dental health officer see patients, practice on anyone, give advice, or consult. You are removing from them their ability to practice, or will we ultimately require that they get a license in the state? I understand that perhaps you might want to recruit someone who is not currently licensed in Nevada and there may be a delay—the individual might not have a license at the time—but I am concerned that ultimately they may never need a license to practice in the state.

Senator Ratti:
Section 1 creates the alternative path to licensure, and that is where you see the word "or." Right now, it has to be someone with a current license to practice. Section 1, subsection 1, paragraph (b), subparagraph (2), creates the alternate pathway which is the master's or doctorate degree in public health or a related field and be a graduate of a dental college or residency program accredited by the Commission on Dental Accreditation. That is the accrediting body for educational institutions for oral health. Then, if you will follow me to page 19 and section 27.5, this is the section which states, "The Board shall, without a clinical examination required . . . issue a limited license to a person to practice dentistry or dental hygiene who: (a) Has entered into a contract . . . to serve as the State Dental Health Officer . . . or the State Public Health Dental Hygienist" and satisfies the requirements of those chapters of NRS and pays the fee. Then the bill talks about the limited license—how you get that license; the fee; and then on page 20 at line 21, the bill states:

> "Shall not, for the duration of the limited license, engage in the private practice of dentistry or dental hygiene in this State or accept compensation for the practice of dentistry or dental hygiene in this State except such compensation as may be paid to the person by the Division of Public and Behavioral Health . . . ."

You see it there, and it is only within the scope of his or her appointment as the dental health officer or the dental hygienist. Section 27.5, subsection 6 is important. It states, "Not later than 7 days after the termination of a contract . . . ." Now they are no longer an employee of the state. Subsection 6, paragraph (a) continues with, "Provide to the Board written notice of the termination; and (b) Surrender his or her limited license to the Board."

If they were interested at that point in going back into practicing dentistry, or maybe practicing dentistry for the first time in the state of Nevada, they would have to apply for and obtain their license to practice. It is the combination of section 1 and section 27.5 that lays out what the new path is and what the requirements of the new path are.

Assemblywoman Titus:
Thank you for that clarification. I have another question. In section 1.7 it reads that if a Medicaid recipient presents to the emergency room, there is a list of dental providers that must be given to them or displayed somewhere. In my practice, we always made sure everyone—those who were not on Medicaid, those who were uninsured or underinsured—had follow-up instructions and access to lists of providers we would refer them to whether it was the ophthalmologist, the orthopedist, et cetera, including a dentist. Why are you singling out that the Medicaid recipient has to have this list and it has to be posted?

Senator Ratti:
I will turn that one over to Dr. Capurro. There were many conversations with providers that resulted in some compromise language, and she had more involvement.

Antonina Capurro:
This language specifically talks about Medicaid recipients because that is the patient pool that we know services are provided for. When they come in for a nontraumatic dental emergency right now—someone who is seen at the hospital—there is no definitive treatment that is provided. Providing teledental services to that group will ensure that they are able to access real-time care and those services are provided under Medicaid. That is why this language has come about, so there is some type of information when in the hospital emergency room and they do not go from that emergency room back to the emergency room when their condition flares up again. Adults in the state have dental coverage for emergencies, but we are trying to link them to a provider. That is why this is more specific to the Medicaid patient, but I would hope that if the hospital had signage about teledental providers or used teledentistry, any patient in the hospital would become aware of that and would use the services.

Assemblywoman Titus:
I just want to make sure that the Medicaid patient is not seen as getting lesser care because they are forced to use teledentistry, whereas another patient might be referred right to the dentist—an in-person visit. I wanted to make sure there was parity there and not that a person who is on Medicaid would have to use teledentistry. I am always anxious when

a certain subset is provided one avenue and not everyone else is provided with that avenue, or the reverse. I needed some clarity that, indeed, there is health care for all patients, and I am not seeing that.

[Assemblywoman Peters assumed the Chair.]

Antonina Capurro:
We are not trying to change what is provided in the hospital. All patients would still have to be triaged in the hospital; this is simply a referral mechanism to ensure that those patients who have this Medicaid benefit are able to receive it. It is a type of care coordination.

Vice Chair Peters:
Are there other questions from the Committee?

Senator Ratti:
Having served on many health committees with Assemblywoman Titus, I know where she is going with that line of questioning, and I would be happy to look into it a little bit further. I will say that the origin of this is that we have set up a dental provider managed care organization within the state and we see underutilization. For whatever reason, our Medicaid patients are not figuring out that they also have dental insurance. I do not know if we see that same problem for someone who has their own insurance and knows about their insurance, but we are definitely seeing in the Medicaid market a significant underutilization of a service that we are investing a significant amount of resources into. This is really trying to get at that underutilization of our Medicaid dental health benefits, but I am happy to take a look at it and see if we need to expand the language to read that anybody who has a dental emergency should get this list. I think that will happen naturally, but that is the genesis of this if that is helpful for context.

Assemblywoman Titus:
Thank you, Senator Ratti. That is much appreciated.

[Assemblywoman Nguyen reassumed the Chair.]

Chair Nguyen:
We will go next to Assemblywoman Thomas.

Assemblywoman Thomas:
My question concerns clarity or understanding. In section 13, subsection 5, it reads:

> A dental responder may not be held civilly or criminally liable for any act or omission performed while providing or supervising the provisions of emergency medical care, immunizations, medical care in a mobile clinic or humanitarian care in accordance with this section and the regulations adopted pursuant thereto unless the act or omission: (a), Amounts to willful misconduct or gross negligence.

Who determines what is willful misconduct or gross negligence? I am not seeing where the patient who is under the care of a dental responder has the ability to tell authorities that they feel like there was misconduct or negligence.

Senator Ratti:
I feel relatively confident that this is the boilerplate language that is in place for all emergency response, so it acknowledges that in an emergency response sometimes our providers are going to need to take emergency action. We try to give them some protection—a limited protection—from liability if they are operating within the scope of their license to provide assistance to somebody in an emergency. That is the first premise. Specifically getting down to the exceptions to that—and these are very important exceptions, so this is not a get-out-of-civil-court or get-out-of-criminal-court-free card. It does not amount to that at all because if there has been willful misconduct or gross negligence, or they were under the influence, you lose that liability protection.

At the end of the day, the decider will be the judge, right? Really, this is about if there were a criminal charge filed or if there were a civil complaint, so if that patient perceived he or she had been harmed, the remedy would be to file a civil complaint. A judge would look at that civil complaint. The judge's starting point would be that there is some limited immunity here because it was an emergency, unless they were under the influence or it meets the standard of willful misconduct or gross negligence—which are legally defined terms that courts are accustomed to working with. This is really all about that system—the court system—and the judge would be the person who would decide.

Chair Nguyen:
Ms. O'Krent is on the Zoom now, and I will turn it over to her to confirm what you just mentioned.

Karly O'Krent, Committee Counsel:
That is absolutely correct. It would be up to the court to make a determination regarding whether willful misconduct occurred, and "willful" is defined in *Black's Law Dictionary* to have a particular meaning, so that would be interpreted by the court at that time.

Assemblywoman Thomas:
To me, it looks like that patient does not have the ability to seek restitution, but it might be just the way it is worded here. That is my opinion.

Senator Ratti:
I appreciate the clarification and the perception. It is relatively standard language we have in all our emergency responses. It is not my intent to remove a patient's right to seek remedy. They absolutely have that right to seek remedy; however, they would only achieve that remedy if there was willful misconduct or gross negligence or someone was under the influence. That would be the way to think about it; and thank you for the comment.

Chair Nguyen:
Assemblywoman Thomas, do you have any follow-up questions?

Assemblywoman Thomas:
No, but I appreciate it.

Chair Nguyen:
Do we have any other questions from Committee members?

Assemblywoman Summers-Armstrong:
If memory serves, we had a bill yesterday in the Assembly Judiciary Committee that talked about removing the dental board—consolidating some of the boards. That was really surprising, so I texted my dentist and asked if he knew anything about it. How would this bookend into that?

Senator Ratti:
I am not in a position to answer that question because it was not my bill and I have not sat on the committees that heard that bill, so I cannot claim to be familiar with it in a detailed way. Legal counsel might want to chime in and explain what happens if two bills pass that are in conflict with each other. We certainly have lots of statutes that call out the licensing boards, and if there is a change to the licensing boards, my assumption would be that all the other statutes would have to conform to that.

Chair Nguyen:
Ms. O'Krent, is there any clarification you can give to Assemblywoman Summers-Armstrong at this time, or do you need additional time to research those two bills?

Karly O'Krent:
I would need some additional time to research the specifics of that bill, but Senator Ratti is correct. In the event a bill passes and is enrolled that conflicts with another bill, our office has a review process whereby we ensure that subjects of conflict are not passed without being addressed during the legislative session.

Chair Nguyen:
Are there further questions?

Assemblywoman Krasner:
I am looking at sections 19, 20, and 21 that talk about teledentistry and dental homes and virtual dental homes. Section 19 talks about public schools, private schools, and child care facilities that require children to receive dental examinations. Then it says that the "dental home," which is a group of people including a dentist, can have a virtual dental home. It just has to be a dentist licensed in Nevada. I am wondering if it can be a dentist who is licensed in Nevada but living and practicing in, say, Florida or some other state or country?

Senator Ratti:
Thank you for the question, but I will turn that one over to Dr. Capurro. We have learned a lot about telehealth generally and what works well, but I will turn the details on that one over to her.

Antonina Capurro:
It is specified in section 28 that a person who provides teledentistry would need to be licensed in this state, so they would need to be licensed in Nevada. What I have seen in other states that have a virtual dental home model is more for a patient who might be living in a rural community where there is not a dentist nearby. They are receiving care via teledentistry with the licensed provider in the state they are living in. There is also language regarding informed consent that determines that a patient is in the state the dentist is practicing in.

Assemblywoman Krasner:
Because they can have a virtual home, I think dentists can be licensed to practice in more than one state, is that correct? If that is true, could the dentist be licensed in, say, Nevada and Florida both, and have a virtual home in Nevada where the dentist does teledental exams on the children, but they are physically located in a different state? Is that possible with this bill?

Antonina Capurro:
If the provider is licensed in multiple states but is also licensed in Nevada and following Nevada's statutes and laws, then that would technically be possible. The provider would also need to provide referrals, and that is also outlined in the bill. If the patient needed care that the dentist could not provide through teledentistry, they have to be aware of the surrounding provider network and refer the patient to care. Therefore, the child would not be without a referral network if that was the case.

Jessica Woods, R.D.H., M.P.H., Interim State Public Health Dental Hygienist, Division of Public and Behavioral Health, Department of Health and Human Services:
I have worked in this model before, so one thing that might be helpful is to think of us like a hub-and-spoke model where the dentist may be in one location but other members of the dental team—like a dental hygienist or dental therapist—would be out in a rural community collaborating with that dentist. Often, the dental hygienist or the dental therapist will be collecting some sort of information such as X-rays or intraoral pictures and sending them back to a dentist who is not actually in that community—maybe not even in the state—but giving the direction to a provider who is actually located there. This language would allow for that.

Senator Ratti:
It does end up becoming critically important for a state like Nevada that has so many communities right on the border. In some of our eastern Nevada communities, a big chunk of their care might come from Salt Lake City, Utah. In our southern Nevada communities,

a good chunk of their care might come from across the border in Arizona, or right here where we have some good relationships with our California providers. Yes, the model is intended. There is nothing in the bill that prohibits that virtual home from being outside the state.

Chair Nguyen:
Seeing no more questions at this time, we will begin testimony in support of S.B. 391 (R1).

Edward Ableser, representing Nevada Dental Association:
Thank you for hearing the bill and the testimony as provided by Senator Ratti. We want to extend our appreciation to Senator Ratti for sponsoring and bringing the bill out of the interim, and for the hard work that was done in the interim on this topic. Also, thank you to Dr. Capurro for her efforts in bringing these much-needed pieces of policy before you. We ask for your full support on the bill, on behalf of the dentists throughout the state of Nevada. Thank you for hearing this, and we appreciate your time.

Chair Nguyen:
Is there anyone else in the room or on Zoom who would like to testify in support? [There was no one.] Are there any callers waiting to testify in support? [There were none.]

[Exhibit M, Exhibit N, and Exhibit O, letters in support, were submitted but not discussed and will become part of the record.]

At this time, I will open testimony in opposition. Is there anyone in the room or on Zoom who would like to testify in opposition? [There was no one.] Are there any callers waiting to testify in opposition?

Vilas Sastry, Chief Executive Officer, TeleDentistry.com:
I was trying to figure out the navigation of the mute and unmute. I am in support of this bill. I want to say thank you to all the members on the call as well as to Senator Ratti and Dr. Antonina Capurro for putting together this legislation and want to offer my full support for it.

Chair Nguyen:
People occasionally have technical difficulties. We will classify that testimony as support. Do we have anyone in opposition?

Felipe M. Paleracio, D.D.S., President, Las Vegas Dental Association:
I am a licensed practicing dentist in Nevada and, at the same time, president of the Las Vegas Dental Association. I am here to oppose S.B. 391 (R1). The State Dental Health Officer needs to be a qualified Nevada-licensed dentist. The State Dental Health Officer needs to have passed [unintelligible] to be able to understand the oral health needs of Nevadans. The public citizens of Nevada are not protected when the State Dental Health Officer is not capable to diagnose patients and has not been trained clinically to examine patients. The current State Dental Health Officer, Antonina Capurro, earned over $200,000 last year in her

position. The current State Dental Health Officer, Antonina Capurro, is under investigation for the illegal practice of dentistry and violating the terms of her license which was based on the condition that she would not then practice dentistry.

Senate Bill 391 (1st Reprint) proposes to change the law that the State Dental Health Officer does not need to be a Nevada-licensed dentist, thus allowing Antonina Capurro to keep her very highly paid job earning over $200,000 per year, and then forcing the dental board to give her a dental license. Senate Bill 391 (1st Reprint) changes the law that the State Public Health Dental Hygienist should be allowed to work outside of her state position. The current interim State Public Health Dental Hygienist is already working outside of her position, thus possibly violating current state law. Why would a Nevada legislator who is responsible for protecting the citizens of Nevada propose S.B. 391 (R1) to have an unlicensed and unqualified individual be the State Dental Health Officer? It seems to me that this bill has been designed in order to protect someone. For the record, I am a long-time Medicaid provider, and there are a lot of problems we encounter, and I would be glad to testify during [unintelligible] if there is a need, and I would like to discuss the [unintelligible] dental care and the Medicaid Program. [Unintelligible.]

Chair Nguyen:
Could we go to our next caller in opposition? [There was no one.]

[Exhibit P, letters in opposition, was submitted but not discussed and will become part of the record.]

Now, I will go to any neutral testimony.

Cody L. Phinney, M.P.H., Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
I would like to go on the record as saying that Dr. Capurro's help for the Nevada Medicaid Services program has been greatly appreciated. Having that clinical experience for our policy development has been a great boon to us in trying to improve our dental policy and dental programming, and we appreciate the help.

Vilas Sastry:
I want to speak in support of Dr. Capurro and everything she did last year.

Chair Nguyen:
We have already heard your testimony on this bill in support and reclassified it. If you have any additional comments, I encourage you to wait until public comment.

Is there anyone else in neutral? [There was no one.] With that, Senator Ratti, would you like to make any closing remarks?

Senator Ratti:
I want to let the Committee know that no one has contacted me with any concerns about the bill directly or asked for any conversation or changes to the bill. Sitting here in today's hearing was my first knowledge that there were any concerns—none of this came up in the Senate.

I would also like to note that the changes in the bill with regard to the current health staff are neutral and not intended to be specific to any one individual. They came about because of a conversation I had with the director of DHHS about the challenges for these particular positions. Again, the chief dental officer position is aligned very similarly to what we do with the Chief Medical Officer, and I think there are some very legitimate reasons why we would want to do that. I am disappointed that anyone wants to make this about any one individual or person and would like to give you my assurance as the chair that this is about good policy and nothing more than that.

I know there were some questions and concerns. If there is anyone on the Committee looking specifically for an amendment to this bill that would help you support it, I would ask you to reach out to me. We are getting to that point in the session where we are running out of time and there are some good things in this bill that really will help move the needle—be it ever so slightly—not as grandiosely or significantly as we had hoped during the interim—but it will make a difference, particularly on building that emergency responder workforce and getting some clarity in our statutes around teledentistry. If you are looking for some amendments, please reach out to me; otherwise, I very much urge your support. We need to do more when it comes to oral health, and these are some good steps forward.

Chair Nguyen:
With that, I will close the hearing on Senate Bill 391 (1st Reprint) and open the hearing on Senate Bill 329 (1st Reprint).

Senate Bill 329 (1st Reprint): Revises provisions relating to competition in health care markets. (BDR 40-998)

Senator Roberta Lange, Senate District No. 7:
Thank you for the opportunity to present Senate Bill 329 (1st Reprint) before you today. This bill aims to enhance transparency around health care consolidation and limit anticompetitive contract practices between hospital systems and health insurers in Nevada. As you are all well aware, health care spending is high in Nevada and nationwide. According to official estimates, total health care spending in the United States reached $3.8 trillion in 2019—a 4.6 percent increase from the previous year. In fact, national health care spending has been growing by 4 percent to 5 percent annually since 2014.

The key factor that contributes to increased health care spending is market consolidation and health care providers and facilities. According to a new report from the National Academy for State Healthcare Policy, rapid consolidation in nearly every state has created dominant health care systems that use anticompetitive contract practices to charge super competitive

prices especially to commercial insurance plans. The COVID-19 pandemic is expected to further accelerate this consolidation and, according to the Kaiser Family Foundation, a large body of research demonstrates that provider consolidation leads to higher health care prices for private insurance. Studies also show that consolidation of health care facilities reduces health insurers' ability to keep prices low because they have less market power than the hospitals. At the same time, these increased prices have little or no impact on quality of care, utilization rates, or efficiency.

Nevada currently does not have many tools to review or regulate consolidation in the health care market. We are a pretty high bar before mergers and acquisitions are reviewed by state agencies. Certificate of need laws only apply to certain parts of the state. We do not have any information about the impact of private equity in the health care markets, and nothing prohibits contracting practices that favor health care monopolies.

This bill aims to address these problems by taking the first step to monitor consolidation among health care facilities and limiting anticompetitive contracting practices between hospital systems and health insurance payors in Nevada. Joining me to provide additional information regarding the real-world effect of these issues as well as to discuss the technical details of the bill and amendments are Stacie Sasso, Executive Director, Health Services Coalition; Maya Holmes, Healthcare Research Manager, Culinary Health Fund; Bobbette Bond, Director of Public Policy, Culinary Health Fund; and Katherine Gudiksen, Senior Health Policy Researcher, The Source on Healthcare Price and Competition. Now, I will exchange seats with Chelsea Capurro, who will direct the questioning to the appropriate person.

Chelsea Capurro, representing Health Services Coalition:
We will start with Stacie Sasso.

Stacie Sasso, Executive Director, Health Services Coalition:
We want to thank Senator Lange for bringing this needed bill forward and working with us and other stakeholders on the language and intent. We would also like to thank Chair Nguyen, Vice Chair Peters, and the Committee members for their consideration of S.B. 329 (R1). The Health Services Coalition represents 25 union- and employer-sponsored health plans in southern Nevada, including the MGM, Boyd Gaming, firefighters, Las Vegas Metropolitan Police Department, and unions including the culinary, electrical workers, plumbers, and others. The coalition's main focus is to bring affordable, quality health care to our estimated 300,000 covered lives. It is the intent of our member groups to help our participants become good stewards of their health care dollars. In order to do that, transparency is key. At this time, I would like to turn the presentation over to Bobbette Bond.

Bobbette Bond, Director of Public Policy, Culinary Health Fund:
[Bobbette Bond presented a PowerPoint, Exhibit Q.] The Culinary Health Fund is a nonprofit health fund that provides comprehensive benefits for our 60,000 members and their dependents, so we cover about 125,000 lives. The part of the coalition you just heard about

from Ms. Sasso is a labor-management partnership that includes most of the hotels, downtown casinos, airport food services, and industrial laundries in Las Vegas. Our priority is to ensure access to high-quality and affordable health care in Nevada. For public and private payors and patients, health care dollars are precious and in limited supply, and you have heard a lot about that this session, as you have other sessions.

Health care is a critical need, though, so we have to be effective stewards of those monies. We spend our time trying to find what the cost drivers are, where there is opportunity to improve the system to reduce price, control price, and increase access and also educate our members and improve qualities. That is the space we try to fill in this community.

Nationally there has been tremendous consolidation in the health care industry. Hospital systems are buying out hospital systems, private equity is buying up doctor groups—including here—and other health care entities are consolidating as well. All the experts are saying that this trend is going to continue and is exacerbated by COVID-19, so there will be more industry consolidation moving forward. In Nevada, we have a lot of private, for-profit hospital care already, and we do not know very much about how the industry is changing. We know it is happening; we know consolidation is happening in the markets because we see it in our claims and in our contracts. We see it when we see that the hospital system has hired an emergency room (ER) group that now, instead of being owned by ER doctors in Nevada, is owned by a private equity company. We have had experience with this happening with a couple of ER groups in Las Vegas. There is no transparency about it for you, as policy makers, or for us to really understand the trends. Nevada is just behind on hospital transparency and behind on health care transparency in general in trying to identify our policy issues. Price is a contributing factor behind our health care costs. Compared to other nations, consolidation and lack of competition is a major high-price issue.

Let us go to slide 2 [page 2, Exhibit Q]. Prices for health care have increased much faster than inflation, and this slide is a testament. In the last 20 years, the cost of hospital services has increased 200 percent, when overall inflation increased 54.6 percent. To compare how that has hit all of us, college tuition in that time has increased 170 percent, other medical services have increased 120 percent, housing has increased 60 percent; so while the average overall inflation rate has gone up 54.6 percent, hospitals are at 200 percent. The next slide [page 3] demonstrates how that feels to us if the same thing had happened in the supermarket over the last 20 years. We would be paying $57 for some oranges, a dozen eggs would cost $65, and a gallon of milk would cost $160. This is the trend we are trying to interrupt.

There are three kinds of consolidation going on [page 4]. One is horizontal mergers, which I will talk about now, another is vertical mergers, and then the private equity issues. Studies show that health care consolidation results in higher prices and without improving quality. That is happening when hospitals buy other hospitals or doctor groups buy other doctor groups. That is what horizontal mergers are. You see an increase in prices, you see an increase in premiums, you see reduced wage growth for the workforce, and you do not see increase in quality in general. It is not an indicator of increased quality.

Vertical mergers are when one group buys a lower group in the health care tier such as a hospital buying a doctor group [page 5, Exhibit Q]. We have some state laws about that in this state, but we also have some cases where doctor groups are being bought by hospital groups. That results in higher clinical prices and also results in higher hospital prices and little to no quality improvement. Specific ways that this happens is when a hospital buys a physician group, it can then start charging a facility fee for the physician group. So you are paying an additional fee for no additional care because of the cost of the facility now when a hospital group buys a physician group. That is one clear way that prices are increasing.

In the last five years, there has been over $10 billion of private equity investment that has gone into health care nationally, and as I said, we are seeing that in Nevada now and the other [unintelligible] around it. State and federal authorities exist to protect this competition, and you can see the Attorney General's bill that moved through the session which you already heard. There is an attorney general's bill that tried to think about how to better look at these mergers, but these mergers fly too far below the radar screen for the attorneys general to be involved in them. The Attorney General only gets involved when a merger is so large that it changes the entire market all at once, and what we are seeing is incremental change that you do not see at all. You just feel it and you pay for it.

It can take years and tremendous resources to do this through the courts, and so what we are trying to do is increase our opportunity to interrupt the price trends that are going on with eliminating some of the noncompetitive language in our contracts, but also create enough transparency to see what is going on, even if you cannot interrupt it; to see some transparency laws that we do not have right now, and that is our goal. Now, Maya Holmes will talk about the bill itself.

Maya Holmes, Healthcare Research Manager, Culinary Health Fund:
Senate Bill 329 (1st Reprint) will ensure that Nevada has accessible data on what is happening in our health care markets. Collecting basic information on health care mergers and acquisitions is critical for the state—policy makers, patients, payors, employers, and other stakeholders—to understand consolidation in our health care markets and guide decisions that protect competition and patient choice. Senate Bill 329 (1st Reprint) will also prohibit anticompetitive contracting practices that hospitals and health care providers with market dominance can demand because payors need to have them in their networks. Senate Bill 329 (1st Reprint) will address market players using their market power to drive up prices and thwart competition based on price and quality. Recent settlements in two major antitrust lawsuits, one in California and another in North Carolina, ended many types of anticompetitive contracting practices through those settlement agreements. However, the settlements do not set legal precedent and only apply to the health systems involved in the lawsuits. Anticompetitive contracting practices like all-or-nothing and anti-steering and anti-tiering provisions prevent health plans from directing or incentivizing or communicating with patients to move them toward lower cost, higher quality care. These provisions also prevent other hospitals from benefiting if they offer better deals or higher quality. They also stop patients and health plans from shopping for and getting the best deal that is appropriate for themselves.

Specifically, S.B. 329 (R1) has two primary provisions. The first provision provides important transparency into consolidation of our health care markets. The bill will require reporting on health care deals in Nevada involving hospitals and physician groups within 60 days after they have occurred. This is basic summary information that will be reported, and it is listed in the bill, but we do not expect this to add any significant administrative burden. This should all be easy and accessible information. Senate Bill 329 (1st Reprint) also requires the Department of Health and Human Services to post the information contained in the notices on an Internet website maintained by the Department. Connecticut already does this and has done so for several years. The Department of Health and Human Services will also prepare an annual report regarding market transactions and concentration in health care based on the notices and post the report on an Internet website maintained by the Department.

The bill's other major provision will make specific anticompetitive contract provisions unfair trade practices. Prohibited provisions will be void and severable. The prohibitions will also only apply to new and not existing contracts, so it will not disrupt existing agreements. The specific contract provisions between hospitals, health systems, providers, and health plans that will be prohibited as unfair trade practices are anti-tiering and anti-steering provisions. The antitrust language we want this bill to end prohibit flexibility to promote programs that help patients find the lowest-cost and highest-quality care in the network based on patient choice and priority. Our plans want to keep all facilities contracted but be able to have a lower copay for places with a higher-quality program like knee surgery or prenatal care which cost the patient and the plan less money. That is what steering does in plan design. Instead of forcing us to treat every hospital the same, which is what the monopoly-like language does, we now have to contract with all hospitals the same way regardless of the rates they are charging or their quality. This prevents plans from educating, directing, or incentivizing patients to utilize lower-cost, higher-quality care.

The other provisions that would be prohibited are all-or-nothing contracting. These clauses are when a hospital system refuses to contract with our plan unless all hospitals in their system are included in the contract. We usually want this, too, so patients are not confused about where to go in a network, but when a hospital system controls the majority of beds in a community and they force this provision into the contract, we cannot negotiate on an even playing field. If we need our members to have access to hospitals near them, we have to take all the hospitals the company controls, even if one has quality problems, even if it drives up health care cost or is a lower-quality facility. Forcing plans to include higher-cost, lower-quality facilities and providers is the opposite of value-based care and undermines efforts for truly successful coordinated care.

Senate Bill 329 (1st Reprint)'s prohibitions on anticompetitive contracting provisions like anti-tiering and anti-steering and all-or-nothing will not limit the ability of a hospital, providers, or plans to negotiate networks or what those networks will look like. It will simply affect language that restricts the ability of plans to communicate with, educate, direct, or incentivize their members to utilize lower-cost, higher-quality care which benefits the patients and the plans. Now, Katherine Gudiksen will discuss what is happening in other states.

Katherine Gudiksen, Private Citizen, Piedmont, California:
[Katherine Gudiksen presented a PowerPoint, Exhibit R.] I work at The Source on Health Care and Competition, and I need to say that I am speaking only for myself today. Anything I say does not represent the views of University of California, Hastings College of the Law, The Source on Health Care Price and Competition, or their funders.

In our research, we looked at what other states are doing, as Ms. Holmes described [page 2, Exhibit R]. There were two lawsuits alleging anticompetitive use of anti-tiering or anti-steering clauses. After those lawsuits were settled, after much time and expense, many states have taken the mantle and asked what they could do to prevent some of this legislation as well. As you can see from my map, Massachusetts is the only state that has banned these provisions in statute, and their law passed more than two decades ago. At the federal level, Congress considered banning these provisions in a couple of bills last year, and one in the proposed Lower Health Care Cost Act of 2019 came close to passing. The Congressional Budget Office issued a report about that bill and found that nationwide, if there was a ban on any anti-tiering, anti-steering clauses, the country would save over $1 billion over ten years.

The interest in these clauses is starting to pick up, partly because of those lawsuits in the congressional bills. So far this session, seven states have introduced bills to prohibit anti-tiering or anti-steering clauses—similarly for all-or-nothing clauses, the other clause that S.B. 329 (R1) would prohibit [page 3, Exhibit R]. Massachusetts is the only state that has a restriction, and it is a pretty narrow restriction. It only applies in narrow-network or tiered-network plans, but this clause was considered in that lower health care cost act in Congress. So far this year, six states are considering banning these provisions.

In summary, there are eight states that are considering bills to restrict anticompetitive practices, and it seems to be a subject of growing interest [page 4]. I helped write some model legislation for the National Academy for State Health Policy because they were getting interest from states to ban the use of these clauses in most insurance contracts. There is growing interest in the ways that state laws can support antitrust enforcement by banning specific provisions that have been used to drive up prices by dominant health firms.

Chair Nguyen:
Are you ready for questions at this time? I will start with Assemblyman Hafen.

Assemblyman Hafen:
Under the current law, a hospital and doctor groups are covered under one plan. It is one negotiation, and what we are trying to do is split that up. I think the term you used was "monopoly." Is that correct?

Bobbette Bond:
There are two things going on. One thing we are trying to do in this legislation is to start tracking transactions when a group is buying a group. The second thing we are trying to do is, we have contracts with monopoly language in the contracts. It is not a monopoly between a hospital and a doctor right now so much that we are talking about today; it is a hospital system that has created a monopoly in the area. They have over half the hospital beds, so they insert language into the contract that requires you to not do any of these other creative things about [unintelligible] a physician group that is not their physician group or a hospital that is not in the system that has a great women's health program. They call that anti-steering when we tell our patients there is a better place to go, they call that steering the patient so contracts with one hospital system do not allow that. Because it does not allow it in one system, it is impacting all the systems because we cannot do it anywhere. We are not the only ones that face this issue, but we are the ones bringing it to the Legislature today.

Assemblyman Hafen:
I fully understand that the way insurance and hospital systems work is very confusing. I struggle to figure out where I can go and where I cannot go, but my concern is that right now under the current system, I have a fairly comfortable way of navigating when I go to the hospital that some of these things are going to be covered. It appears under this bill the intent is to actually break that up. If I end up at a hospital that is not in my plan, the radiologist group may or may not be covered under this plan, and that draws some very serious concerns to me. Maybe you can address why that is a benefit. I look at a one-stop shop as being of much more benefit to the patient, including myself, than having to go to a hospital, check in, and then be sent to a radiologist group clear across town or, in my case, possibly to another town.

Bobbette Bond:
That is not where this bill is intending to go. Where this bill is intending to go is if you are in negotiations with a hospital and you know the quality scores or the price at that hospital is higher and lower in quality than other hospitals, then you want to be able to negotiate a rate with that hospital that takes that into account, or you can negotiate a different rate for one hospital than for another. That is one thing we would like to do in our contracts, so that is why we talk about it in monopoly terms. The language that is being [unintelligible] into contracts does not let us do that. We are not trying to eliminate the hospital from the contract, we are trying to be able to steer people to it in different ways. If it is the most expensive contract we have, then we would tell our patients that they can go to the other two places for less money. We would tell them, This is your cost share; it is lower

somewhere else, or it is better quality; or you would be able to work with one hospital and their special women's health program. That is a real example we are dealing with right now. It is not about breaking up the hospital and doctors at all. It is more that we want to eliminate the language that does not allow us to send a patient to one hospital with their radiology group at a lower cost than the other hospital, because that is called steering. We are not trying to break up the radiologists from the hospital at all.

Chelsea Capurro:
This bill does not do anything to address our current contracts. This is only for things going forward. I would also point out that the biggest thing is that we just want to be able to communicate to our members what options are out there and what the costs are and what the quality is. This is not going to change our saying you cannot go to this radiologist; you have to go here. It is saying that you can have all these choices. If you go to radiologist A, it is going to cost you this; if you go to radiologist B, it may cost you this. Some of our contracts restrict us from even giving information about cost—what different hospitals may cost if we go there or if a member says, How much will this knee surgery cost us? We struggle with being able to direct them and tell them, If you want to go to hospital A versus hospital B, here is what that price difference is going to be.

Bobbette Bond:
To follow up, I think it is important to say that we think fixing this will impact the networks much better because right now, our only alternative is to eliminate this hospital system from our network. We do not want to do that. We want people to have choice, but we want the members to drive that choice. We want them to be informed about which hospital they want to go to. If you want to go to the great women's hospital because it has high-quality good care around deliveries, then we want to be able to say that information. If you want to go to whatever hospital your favorite obstetrician is practicing at, then they should be able to do it, but this is going to be the price difference. We cannot do that right now.

Assemblyman Hafen:
I am not following, maybe because I am not an insurance provider or doctor. First, we want to split up the monopolies, and now we, as the insurance provider, want to steer patients to one hospital or the other. I am really confused now about what it is we are actually trying to do here. Are we trying to allow the insurance companies to steer to certain hospitals and away from other hospitals? Are we trying to break up a "monopoly" and get rid of the one-stop shop?

Chelsea Capurro:
This is not about breaking up monopolies; this is about having the opportunity and the ability to provide our members, the patients, your constituents, with information about their health care. If it is helpful, I can follow up with you offline.

Assemblyman Hafen:
I keep getting conflicting answers, so I am trying to figure out where we are actually going with this. Thank you for the answer.

Assemblywoman Summers-Armstrong:
I had a high-risk pregnancy many years ago and my obstetrician (OB) really wanted me to go to a particular hospital where I could receive good care for the delivery of that child. That hospital was not in my group plan. Are you saying that this would allow me to ask my insurance people if I could go to another hospital and I would be able to go there? Or would it allow you to have that hospital as an option because you looked at your group of insureds and saw that you have older patients and that there might be a need for a place for women to go for high-risk pregnancies? Maybe the group you have a contract with does not have such a facility and you could add another hospital into the options for that group.

Bobbette Bond:
Assemblywoman Summers-Armstrong, I think it is the second sentence you said. It would allow the insurance plan flexibility to create opportunities for you to go to the hospital. You might pay a different amount for that, though, and that is called steering. Alternatively, the insurance plan would not put that hospital in network, and then you would not have the opportunity to go there at all. Our perception of this is that it is a way to keep all of the hospitals contracted but have options that are more or less expensive depending on the cost and quality of that hospital. That would be a decision you could make with your doctor. It increases the decision making you can make with your doctor.

Assemblywoman Gorelow:
Throughout the presentation, you have been mentioning quality scores. Could you elaborate more on how the quality scores are determined and who determines the scores?

Bobbette Bond:
At the Health Services Coalition, we follow a series of scores. Some of them are built into our contracts. For example, what the rate of sepsis is that a hospital would have or how many readmissions the hospital has. Those are numbers we collect, but it is also public record. There are public databases that are created. The Centers for Medicare and Medicaid Services has a set of scores that they use to compare every hospital in the country. There is a company called The Leapfrog Group that has a national set of scores where they compare quality. There are other tools out there, but those are the two biggest ones—the most commonly used ones. They allow you to see how hospitals are doing across certain factors, then you can bring that into the way you want to contract and the way you want to educate your membership.

Assemblywoman Gorelow:
How would that work with, say, a hospital with multiple departments? Maybe their OB department is really good, but their radiology department might not be so good. How would that work in that case?

Bobbette Bond:
That is exactly what we are trying to get to. If their OB department is really great, we would like to be able to highlight that in the way we structure the plans. Every plan is going to structure the way it works best for their members. There is not just one structure, but if anyone is contracted and we can tier or steer, we could design a plan that says, this hospital has the best OB scores, so we are going to have the lowest rates to go to this hospital because they have the best outcomes. We are not going to tell you that about the radiology program. We are going to tell you what we know about the radiology program—those scores that we can get. It is to help us develop some consumer tools and some patient choice while keeping all the hospitals contracted. What we have to do to do that is remove this language in the contract that does not allow us to do it.

Assemblywoman Gorelow:
Thank you. I would like to follow up later offline about some more questions because I am afraid it might take a little while to get some more clarification.

Assemblyman Matthews:
I have a question about the economics of this. Regarding section 20.9, subsection 1, paragraph (c), it is my understanding that a hospital's firms are able to provide contractually lower prices when they are assured of higher volumes. Assuming that is the case, when you have the forced fragmentation under this, which I think is what Assemblyman Hafen was getting at, how would this lead to anything but higher prices? It seems to me that paragraphs (c) and (d) would work together to make health care more complex and more expensive for patients.

Bobbette Bond:
We negotiate our contracts in cycles of three to five years. Our rates and our programs are set on what the quality scores are, how much pain a patient experiences, and what the outcomes are. For section 20.9, subsection 1, paragraphs (c) and (d), I think what would actually change is instead of us having to just pay a blanket rate for contracts, we would be having a conversation with the hospital to say, We do not really see the quality in this hospital for this procedure. We would like to talk about different rates. It is possible, as you are suggesting, that the rate at one hospital would go up for us, not for our members, but for us to pay that rate. However, on others it would go down, and then you would look to steer people to the best care for them for that procedure they need and that will help us manage costs and outcomes. I think we did get good value out of a rate, of having all the hospitals contracted, but there is no flexibility in this steering language; if they removed that anti-steering language, anything else is handled in the contract. If the hospitals want to charge us more because we are now able to steer our patients, that is a negotiation point with the hospitals instead of just a prohibition.

Assemblywoman Titus:
Thank you, Senator Lange, for bringing the bill forward. Your concerns about health care costs are accurate as far as the health care costs rising and what we are doing to lower health care costs. Having had to give up private practice after 15 years and go to work for a local hospital because I could not afford to be a private practitioner any longer, I am acutely aware of the problems in health care and cost. However, I have concerns about what this bill does and that it may lead to the opposite of what you are trying to solve. As an insurance provider, or payor, as the Culinary Union is, I see you as being almost as guilty of the very thing you are trying to say physicians or providers are. Do your Culinary Union members have the option of another insurance plan other than what you offer them?

Bobbette Bond:
Our insurance plan gives them a comprehensiveness of coverage and a large network in all the hospitals contracted, and that is just us. Stacie Sasso with the Health Services Coalition can talk more about the other 24 plans that are in the Coalition.

Assemblywoman Titus:
When you have a contract, as a provider, I know many years ago something called the Stark Law [Physician Self-Referral Law] came out. In the interests of lowering costs, the federal government recognized that providers should not own the X-ray equipment that they then refer their patients to. There were national concerns about that increasing the cost of health care, so there have been regulations already to help lower the cost. For me, what I see the Culinary Union do, or your insurance plan do as other insurance plans do, is you negotiate certain rates with hospitals. It is not about cost reimbursement. Your wanting to know what the true cost is of doing business I think would be ideal. If you paid and reimbursed the providers—all providers—their costs, you might be surprised that health care rates would come down because they would not be charging the extra fees for those who are not getting reimbursed at all for the care they give.

I think the concept and the solution would be if we truly did know and ask all across the board what the actual cost of doing business was. That, for me, would be the solution to cost reimbursement. I am not sure you are asking the providers the right questions as opposed to preventing them from joining. I had to join something else because I could not stay in business. You are going after the providers and even making it a felony—in section 20.9 it becomes a felony, but we are trying to stay alive. Most of these mergers are happening, not because they want to make more money, but, frankly, they want to stay in business. They cannot survive. A small group of five, for instance, cannot survive because they do not get reimbursed enough.

I would support efforts along your line to find out what the true cost of doing business is and then make sure you cover the cost of doing business. Then there would not be the winners and losers I am seeing right now. You, then, would be in the driver's seat of negotiating these contracts. For me, this does absolutely the opposite of the problem I am hearing you are trying to solve—which is allow your members to know where they can go and what those costs genuinely are and then direct them—if you go to this hospital, the cost is this. I do that

now in health care. I have my patients call the radiology department and find out what it is going to cost to have a CAT scan, especially for a cash payor, and negotiate the cost. I think that is the solution, and I am very concerned that this bill does absolutely the opposite of what you are trying to do.

Bobbette Bond:
We agree with you that more transparency is needed. We spend a lot of time as a coalition on health care transparency. The issue you are raising about section 20.9, the felony, is not about the merger. If it makes it prohibitive to have this language in the contract that does not allow us to tier and steer, that is what is being [unintelligible]. That language no longer can be used in contract to prohibit us from doing the tiering or steering we are talking about. That is what we are trying to stop. The reason it is a felony is that is the way the state law is written about what happens in a situation where you are dealing with this antitrust agreement.

Assemblywoman Peters:
I have clarifying legal questions about section 1. There were a couple of concerns about the breadth which this section would cover—mergers and acquisitions. As we know, not every hospital or provider in the state is isolated to the state of Nevada. In this language, would this pertain to only mergers and acquisitions in the state of Nevada? My second question involves the fact that when we talk about other affiliations between physician group practices, we talk about physician group practices and hospitals. Does this pertain to situations in which we have an insurance company that is a part of a health care provider/hospital entity that may be acquiring new facilities or partners under their umbrella?

Bobbette Bond:
I know what the intent of the bill is, and the answer to your second question is, yes, it would capture those. The answer to your first question—would this cross state lines—would be, no, because it is a state statute. HCA Healthcare has three hospitals in Las Vegas; it should only impact them in Las Vegas. It would not impact them in Arizona.

Assemblywoman Peters:
I would ask our legal counsel to weigh in on what this language does say and ensure that is being covered under this language.

Karly O'Krent, Committee Counsel:
I will take the questions one at a time, starting with whether this applies to providers that have groups in other states. It is possible that this bill would apply to providers that have groups in other states if those groups merged with groups in this state. The Committee, if it so chose, could amend the bill to make the bill only applicable to provider groups in this state. The Committee would need to specify exactly how that would look. With regard to the other question, section 1 of the bill does not apply to insurers. I am not sure if that addresses your concerns, but that is how the bill works as it is currently drafted.

Assemblywoman Peters:
My question was related to groups such as Optum that have provider umbrellas also under their insurance network. As they purchase those providers under their umbrella, would that scenario be captured under the data collection described in section 1, or would it be excluded because Optum is an insurance company?

Karly O'Krent:
As it is currently drafted, it would be excluded from section 1 because Optum is an insurance company.

Assemblywoman Peters:
Thank you for that clarification. If I may, Chair Nguyen, I have additional questions related to section 20.9. I am not familiar with contract language in your negotiated contracts with health care providers. As I read some of this, I got concerned about situations in which you would want to have those hospitals and their attached groups in the same coverage, if that was your only option, which is one of the scenarios in northern Nevada—we have two major hospital groups. Often, patients prefer to use those network groups because they know they are covered under their insurance or they are connected by the way they share data or bill or whatever. When you are talking about the language that restricts these different points, these paragraphs in section 20.9, subsection 1, what does that language look like? Would it be if I saw a contract that said, We are contracting with this group and its subgroups? Would that qualify as this "Requires the third party to place all providers of health care affiliated with a business entity in the same tier," as stated in section 20.9, subsection 1, paragraph (c), or is there separate language in the contract that says, Upon contracting, we limit you to only our groups under our network umbrella and they are listed below?

Bobbette Bond:
I think what we would do is your second example, but I want to make sure I understand what you are saying.

Assemblywoman Peters:
Can you give us an example of the language in your contracts that restricts you from steering and tiering that you are trying to eliminate with this language?

Bobbette Bond:
There is language in some of our contracts that we have been unable to remove through contract negotiations that say we are not allowed to tier or steer in any way. When we say what we want to do is start the program where we can provide special benefits inside our funds or inside our coalition to allow, for example, someone to go to a women's health program that is only at one hospital. We want to make a separate price for that, we want to have our maternity patients go there, and that is called tiering, that is called steering. We are not allowed right now to do it because of that one sentence in our contract that prohibits tiering and steering. That is all we are trying to do is remove that one sentence and allow the rest of the contract to flow as a contract would.

Assemblywoman Peters:
In this bill, why is there not just a line item that says contracts cannot include clauses that prohibit steering and tiering? Instead, there are these descriptions of restricting, requiring, and prohibiting.

Bobbette Bond:
I think the language is nationally established language that was suggested by our consultant to make sure we capture the issues that steering and tiering are. It became a more specific explanation, but the intent is what you just said—that is where you go; that is what you get.

Assemblywoman Peters:
I do not want to have a scenario come up where an insurance provider has a contract with a health provider that inadvertently puts them in a situation where they have restricted their network to only that provider umbrella and then put them in this category. That is my concern, and I want to get on the record that the intent is not to capture those scenarios. In that good-faith negotiation, those situations can happen, but what this is really trying to get at is that anti-steering, anti-tiering clause that prohibits you from doing those things within your member groups.

My other question had to do with how this language you are presenting here in section 20.9 compares to the language that was referenced in Maryland.

Katherine Gudiksen:
I think you meant Massachusetts. The language is quite similar. I think the anti-tiering, anti-steering is the same, but I would have to go back and read it. I can get the statute and citation for the Committee; it is very similar to Massachusetts' language.

Assemblywoman Peters:
If you would follow up with the Committee with that information, that would be helpful.

Assemblywoman Benitez-Thompson:
In section 20.9, section 1, there are five things—five "shall nots"—paragraphs (a), (b), (c), (d), and (e). What gets negotiated and what gets contracted are read or seen by people, because I imagine some of these things are probably proprietary, so there is not a bunch of contracts lying around that we can read. What might be helpful is clarity on the "shall nots." We have been focusing on paragraph (a)—the incentives, steering. Could you give us an example of what the "shall not" is, and, if enacted, what the "will allow" is? That way we could hold an example of each one of those things in our heads. I heard a reference to a women's clinic, but I do not think I have it quite contextually. That might be helpful and also good for the legislative record on concretely where we are on the status quo on paragraphs (a) through (e), and then where the bill will lead us with (a) through (e). For example, paragraph (a) mentions incentives. Do we have "incentives" defined somewhere? When we think of incentives, is it like a bonus in a health savings account? Is it a lollipop? That is what I am looking for. Take your example down to a little bit more pedestrian level and outside of contract law.

Bobbette Bond:
It restricts a third party from offering incentives. We want to remove that so that we can offer incentives for our covered persons using a specific provider. We could make a lower copay. That would be an incentive. They would have a lower copay to go to a specific provider. Right now, that is prohibited but would be allowed under section 20.9, subsection 1, paragraph (a).

It restricts a third party from assigning providers in health care into tiers. Now we have to have all our hospitals have completely equal communication materials, copays, deductibles, listing in our directory—everything has to be exactly the same among our providers. If there are tiers, we could say, Okay, for knee surgery at this hospital—and we did this in our benefit design in our contract—it is going to cost you, the patient, $250 to go to hospital A. However, because of the quality scores and the cost to us, it is going to cost you $125 to go here. That is tiering. That is in section 20.9, subsection 1, paragraph (b). I will need help with defining paragraph (c).

Katherine Gudiksen:
Section 20.9, subsection 1, paragraph (c), would be if a health system said you need to put all our clinics in the same tier at the same cost-sharing. For example, if you wanted to put our women's health at the lowest cost pay, you have to also put our radiology group and our MRI machines at that same rate. It prohibits a health system from saying that everyone has to be at the same tier and gives the insurer or payor the flexibility there.

Paragraph (d), the fourth item, requires a third party to contract with a business entity affiliated with the provider as a condition of entering that contract. For example, if an insurer wanted to only contract with the main hospital and not all of that hospital's affiliated clinics that they felt were of lower quality, this would prevent the health system from only offering a contract that was for all of those systems. The insurer has to be given the right to contract with just one of those entities.

Paragraph (e) prohibits the third party from contracting with a provider of health care that is not a party to the contract or a third party from entering into such contract. That one is more about exclusive contracting. That one is where the provider prohibits the third party from contracting with someone else. If you want to contract it with us, we are the only ones who can provide that service.

Assemblywoman Benitez-Thompson:
Pieces of the audio were not great, so I had difficulty hearing. Section 20.9, subsection 1, paragraphs (b) and (c) are talking about tiers; one is tier restrictions and the other talks about tier clumping, right? I think I heard the example that it would be a lower copay for the insured person to be able to say one hospital will cost $250, but if you go to this other hospital, it will cost $125. That is where you would see that tiering—price tiering. It is not necessarily categorical tiering. That would be the same for paragraph (c)—pricing in different tiers versus all groups, the women's clinic and MRI groups, all having to be one cost to the insured person.

Bobbette Bond:
What she is saying in the last part of her sentence, I am not sure that is what that is.

Katherine Gudiksen:
On paragraph (c), it would depend on how the insurer has structured those tiers. Typically, they are different costs—either copays or cost sharing—but it would be up to the insurer to determine what it would mean to be in tier 1 versus tier 2. The language there prohibits the health system from requiring everything to be in the same tier with that same cost sharing or copay, however those tiers have been structured.

The restriction on paragraph (b) is just a restriction to even be putting them in tiers. Some of these contracts do say that if you want to contract with us, you cannot have a tiered network. Paragraph (b) just requires the health system to allow the insurer/payor to have a tiered network to begin with.

Assemblywoman Benitez-Thompson:
Is this the normal course of business? The way the contracts are coming out across the board, no matter where you go to contract, you are going to run into these tier restrictions and the networking, contracting to contract, paragraph (d), contracting with affiliates. For instance, if you are going to contract with me, you need to have the whole kit and caboodle. Am I correct in assuming that those types of pieces are probably boilerplate for most insurers when they are negotiating contracts with hospitals? Or is it a uniquely Western trend or a uniquely Nevada trend?

Bobbette Bond:
I do not know how unique it is, and we do not do it now. We do not do it now because if it were held up in one contract, it would be held up. We cannot do any tiering or steering, so I do not know how common the tiering or the steering is in plans. We just do not do it and the Coalition does not do it. What we would like, in order to make sure we keep all of our hospitals contracted, is the ability to do it when we feel like we should be able to do it. I do not know how widespread it is, though. It would all be negotiated in contracts, so we would just be removing the language that prohibits us from doing it and then negotiating it in a contract.

Assemblywoman Benitez-Thompson:
It sounds like de-aggregating and then negotiating all of these pieces out. We are in *Nevada Revised Statutes* (NRS) Chapter 598, so we are in the chapter on unfair trade practices. As I read the chapter, and this is general law, applicable law, there is nothing really targeted toward health care in here right now. I understand that the chapter has been applied toward health care, so we have some case law out there on some of these things I would imagine such as the noncompetes, which I think section 20.9, subsection 1, paragraph (d), would be interpreted as—the contract with our affiliates—but I do not see anything in here. It may have been a piece of Assemblywoman Peters' question, but that is

already inherently illegal, right? The exclusivity, contractor exclusivity—if you contract with us, you cannot contract with anyone else for provider groups. Am I correct in that assumption as well, that NRS Chapter 598 gets used as a tool in health care? I would guess from these "shall nots," not as frequently as we might think, or it is an arduous process, or it feels like it. When it comes specifically to conversations about these contracts, the level is different than it might be for investigating other types of acquisitions and such.

Bobbette Bond:
What I understand from what you are saying is the unfair trade practice language. That language was just referenced in statute because we want it to be unfair; we do not have any extra hooks on this; we do not have any other way to prohibit; we do not have a fine; and we do not have a way to otherwise penalize a contract that has this in it. I think what is going to happen is we just will not have this language anymore. That section will be out of our contracts because no one wants to commit an unfair trade practice, but the rest of the language in here that is referencing this is related to the state statute now; it is not specific to this bill.

Katherine Gudiksen:
California brought up interstate antitrust law in their lawsuit against Sutter Health, against state antitrust law. At a certain level, this does rise to an antitrust violation that could be brought under state antitrust law. This basically eliminates the need for proving under the standards and geographic markets, et cetera, that are needed for an antitrust lawsuit. The Sutter case took a decade to reach settlement, and that is the reason for this law.

Chair Nguyen:
Do we have any other questions from Committee members at this time? Seeing none, I will begin testimony in support of S.B. 329 (R1).

Rusty McAllister, Executive Secretary-Treasurer, Nevada State AFL-CIO:
My first session lobbying was in 1999. I was a firefighter and also the chairman of a health insurance trust fund. I got to attend a subcommittee meeting and the subject was clinical psychologists trying to pass statutes that would make it so that the marriage and family counselors could not see certain patients. They had to go to a doctor first and not to the licensed counselors. I listened to the hearing and then was asked if I wanted to say anything. I asked if I could ask a question of the testifiers and was told, sure. My question was, If someone came to you and had a marriage problem or family counseling problem, would you refer that person to them? The answer came back, No, why would we? We are licensed to do that, so they were basically cutting them out of the business. I replied, All I know is this. If it costs $200 an hour to go see that person or $50 an hour to go see that other person, our members, if they cannot go there, they will not go there. They will not go see that person, and if they do not get the mental health care they need, bad things happen. The more things change, the more they stay the same. That was in 1999.

We are battling every day as the chairman of the health insurance trust fund, and I watch these people who run these health programs now. I had only 3,500 members in our trust fund. Assemblywoman Titus mentioned constantly trying to keep her head above water. That is what health trusts are trying to do—anything we can do to limit the ability of hospitals, networks, or providers to increase costs. There is only so much money—you cannot just go get more money and give it to them. The bottom line is, we are constantly trying whatever methods and techniques we can to limit our liability. We believe that S.B. 329 (R1) allows patients and health plans to shop for and get the best options available to them both in quality and cost. For those reasons, we are in support of this. Our 150,000 members and their families need techniques like these to try to limit the costs that are going out of their pockets every day.

Chair Nguyen:
Is there anyone else to testify in support of S.B. 329 (R1)?

Paul Catha, Political Organizer, Culinary Workers Union Local 226:
The Culinary Workers Union supports S.B. 329 (R1) because health care affordability, quality, and access are critical concerns for Culinary Union members. Consolidation in the health care industry drives up prices but not the quality of our health care. Senate Bill 329 (1st Reprint) will take important steps to understand how consolidation impacts our health care markets. In addition, S.B. 329 (R1) will stop anticompetitive contracting practices that prevent patients, employers, and plans from shopping for and getting the best deal. The Culinary Union urges the Nevada Legislature to support and pass S.B. 329 (R1).

Deanna Leivas, Secretary Treasurer, United Food and Commercial Workers Union Local 711:
On behalf of the 6,800 members of the United Food and Commercial Workers Local 711, I am speaking in support of S.B. 329 (R1). The bill will allow the state, policy makers, patients, payors, and other stakeholders to understand consolidation in our health care market and its impact on prices, affordability, quality, and access. It will provide vital information to guide decisions that protect competition and patient choice. Senate Bill 329 (1st Reprint) will also prohibit anticompetitive contracting practices at hospitals and health care providers with market dominance and demand because payors have to have them in their networks. This will prevent dominant market participants from exercising their market power to drive up prices and thwart competition based on price and quality. Anticompetitive contracting practices like all-or-nothing, anti-steering, and anti-tiering prevent health plans from directing or incentivizing patients toward lower-cost, higher-quality care. These provisions also prevent other hospitals from benefiting if they offer better deals or higher quality. They also stop patients and health plans from shopping for and getting the best deals. Senate Bill 329 (1st Reprint) will prohibit anti-steering and anti-tiering clauses which require health plans to treat all of the health systems' hospitals in the most favorable tier with the lowest cost sharing regardless of the rates they are charging or their quality. Thank you, and I urge you to pass S.B. 329 (R1).

Juston Larsen, Member, Culinary Workers Union Local 226:
I am testifying today in support of S.B. 329 (R1). I have had asthma since I was a child. I carry an inhaler everywhere I go just in case I have an asthma attack. I want to be an informed and empowered patient, so I need to have information to be able to better advocate for myself. I trust my Culinary Health Fund to help make sure I am going to the best quality of care for the lowest price. I wish that my Culinary Health Fund advocate could give me advice on which place is best for me to go: a place that is safe, a medical professional who is a good doctor, and a clinic that is the lowest copay for me. Right now, due to anti-steering and anti-tiering language in hospital contracts, my Culinary Health Fund is not able to give me complete information that I need and deserve, and that is not right. Removing the anticompetitive clauses from hospital contracts will allow my Culinary Health Fund to better give me the complete information so I can get my health needs met better. Please support S.B. 329 (R1).

Todd Ingalsbee, President, Professional Fire Fighters of Nevada:
We are here in support of S.B. 329 (R1). Managing our health care and its costs is a full-time job for us. We are constantly putting our lives and health on the line, from work-related physical injuries to heart and lung disease due to the cancer-causing carcinogens we are exposed to daily, it is vitally important that this piece of legislation pass. Without this, we have situations where we are unable to communicate to our members about where they can get the best care due to anti-tiering and anti-steering language that we are forced into with our hospital contracts. Our self-funded health trust needs to be able to educate our members, especially about where they can get the highest quality and lowest cost care. There are many times when we are prohibited from doing that, especially in a field that is so rife with injuries, disease, and, unfortunately, premature death. It is wrong that we are restricted from giving our members the basic information. This bill brings transparency about what is going on in the health care market in Nevada and allows us to educate our members about the best options out there for them. We ask your support for S.B. 329 (R1) to help our members so they are able to take care of themselves so we can take care of all our residents and guests in Nevada.

Chair Nguyen:
With no more callers in support, at this time we will begin testimony in opposition to S.B. 329 (R1).

George Ross, representing Sunrise Hospital and Medical Center; MountainView Hospital; and HCA Healthcare:
Do I have just two minutes, or may I use three minutes?

Chair Nguyen:
Go ahead with your testimony, and we may have some additional questions for you as well from Committee members.

George Ross:
I want to express our profound appreciation to the sponsor of the bill, Senator Lange. She met with us with an open mind and gave us a great deal of time to go over this bill. The most critical piece of this bill is the antitrust section—section 20.9, subsection 1. HCA Healthcare does not do section 20.9, subsection 1, paragraph (a). They do not do paragraph (b), and they do not do paragraph (e), so what we are going to focus on are paragraphs (c) and (d). With regard to paragraph (c), we believe that the provider should be explicitly permitted to offer incentives in the contract bargaining process to include those of its own entities in the contract or in the same tier. Proponents seemed to imply that they thought that to be the case, but the lawyers I have talked to who have read this believe that this may prohibit that from happening. We would like to have explicit language allowing the provider to offer such incentives. This would enable a higher volume of patients and thus enable a more discounted rate. It would also permit coordination of care. Hospital Corporation of America has consciously put together a system which enables the providers to get the patients to the right place for the needed treatment in a timely manner, thus seamlessly to the patient. We would like to explicitly know that is permitted, and why that is important is that, at the end of this bill, it says a violation of this section is a felony. This language is pretty vague. We have already had discussions about what it means. It is very important that a normal bargaining process not get you into a situation where you can be accused by an aggressive attorney or aggressive opponent of committing a felony.

With regard to section 20.9, subsection 1, paragraph (d), similarly, providers should be able to incentivize the payor to contract with affiliated groups. Those groups that provide your radiology treatment, your anesthesiology treatment, your hospitalists, having these together is essential to providing the continuity and coordination of care as well as preventing the difficult situation that can happen when a patient thinks he or she is going to an in-network hospital, and then wakes up after surgery to find out that the anesthesiologist or the radiologist or the hospitalist is in a different network, and all of a sudden they are paying out-of-network charges. Plus, when you do not have that connection, you have much less coordination, much less cooperation. We would love to see that section cut out altogether, but if not, it should be changed to explicitly permit the provider to incentivize the payor in the bargaining process to contract with affiliated groups as necessary for profit continuity, coordination, and integration of care. Without that, this puts the patient in a very difficult situation. It is my understanding that the [unintelligible] which was referred to, actually allows hospitals to ask for contracts with doctors providing services in that area or at that hospital for the reason of continuity of care.

Essentially, failure to fix section 20.9, subsection 1, paragraphs (c) and (d), as we are asking, will leave the patients in a very difficult situation. They would be facing a fragmented, disorganized, confusing medical environment in terms of both health care and figuring out their billing. I know there are certain payors, and we have heard from one of them extensively here today, who probably takes their patients almost by the hand and guides

them around, but the vast majority of Nevadans are not in that situation. They are left to do this on their own, and now that neither I nor my wife are as young as we used to be, we are doing a lot of health care. It is quite a confusing situation. Having everyone at least in the same network certainly would make life exceptionally easier.

Finally, antitrust violations should not constitute a felony. Antitrust cases are typically civil cases. The language in paragraphs (c) and (d) is ambiguous and open to very varied interpretations. To make trying to achieve a situation where the doctor groups serving a hospital are not in a payor's network a felony is a recipe for much worse and expensive care as well as a very anxious and confusing world for the patient. The beginning statements talked a lot about health care costs, and this is a way to bring down health care costs. But I think I have the right to say that the single most important thing this Legislature and the advocates of this bill could do to bring down their health care costs is to join together with all of us and convince the Legislature to increase Medicaid reimbursements to providers. The single reason why those costs are so high is because we have to shift such a large amount of cost onto the commercial and trust fund payors. It is very simple. Katherine Gudiksen talked about how much health care costs have gone up. Well, since 2001, hospitals have gotten one raise in Medicaid rates—2.5 percent—which was taken away from us last summer. That is all we have gotten. If you wonder why costs are going up, that is a very, very large reason.

Chair Nguyen:
Are there any follow-up questions?

Assemblywoman Benitez-Thompson:
Going back to the same question about section 20.9, subsection 1, and the "shall nots" and paragraphs (a) through (e), it looks as though paragraphs (a), (b), and (e) are off the table and we are focusing on paragraphs (c) and (d). Could you talk a little more about the practices that are allowed now that will become the "shall nots"? What it will allow from your perspective.

George Ross:
I cannot speak for any other company on that and I am not the negotiator on ours, but I can tell you that we do not require them all to be in the same tier, and we do not require them all to contract with all our entities. However, we would like to be able to incentivize them to do so if we chose to. If we could give them an incentive good enough for them to do it, we would love that.

Assemblywoman Benitez-Thompson:
Perfect.

George Ross:
Hopefully, they would find the lower price we could give them for that volume to be attractive as part of the bargaining process. We just want to make sure that the normal bargaining process, because of the way this bill is worded, is not suddenly becoming a crime.

Assemblywoman Benitez-Thompson:
I appreciate that. Again, going to incentives to make sure we are clear for the record: In the way we have been talking about it, it seems to mean financial incentives. Is that right?

George Ross:
Yes.

Assemblywoman Benitez-Thompson:
Therefore, section 20.9, subsection 1, paragraph (d), is contracting with affiliates. Obviously, if a hospital wants to say, Here is the hospital network we have built out. We have the hospital, we have the clinics, we have an urgent care, and we have specialties, so the idea would be to incentivize people to stay in the hospital network. That would be contracted and negotiated—the incentive to stay in, versus the way it is being talked about right now—the status quo. You are all in the hospital's network or you are not.

George Ross:
We do not mandate that, but we like to incentivize it. In terms of section 20.9, subsection 1, paragraph (d), the way we read that, it refers to affiliated entities. It is not necessarily the ones we own. In this case, we believe that means, the way our lawyers and negotiators write it, it is talking about the doctors' group that we made a contract with to do their radiology. The doctors' group we made a contract with to do the ER, and so on—all the places where you get a doctors' group to do it. It is a real mess when all of a sudden you have to pay out of network when you are in a network hospital. From a patient point of view, those are the kinds of things where a patient would say, What does this bill mean? Why do I have this? Why do I have that? It can drive you crazy. This will make life a lot simpler, a lot more organized, but more importantly, it will help coordinate care. When the hospitals work with these groups where they have contracts, they can interact and coordinate.

The best example I can give you of some of this is when I had an operation at MountainView Hospital on my elbow. I had my stitches out. The next morning there was a lot of blood in my bed. I got in my car and drove down the freeway to Southern Hills Hospital & Medical Center's ER. It took me about 10 or 15 seconds to get in there because all my information was right there in their computer system. They had everything they needed. It was very coordinated. They could see everything that happened to me right there. I respect what the proponents are trying to do here. They have a noble objective, but we want to make sure that our ability to provide the best possible care we can in a coordinated manner to the patients and give them as good an experience as possible is not inadvertently or advertently eliminated by the way this bill is worded.

Assemblywoman Benitez-Thompson:
I should clarify. When I was talking about the hospital and their network and I was referencing the buildings, we know that very few people are hospital employees. They have the brick and mortar then hire the physician groups to come in. You might have

administration—payroll and human resources and maybe some others tend to be direct employees—but maybe 10 percent of the people you see in a hospital are actually employees of that hospital and the rest are contract groups.

George Ross:
The nurses are all employees.

Assemblywoman Benitez-Thompson:
Yes. When I am talking about specialty clinics, urgent cares, it is the groups that are staffing those. In section 20.9, subsection 1, paragraph (e), it says they shall not do exclusive contracting, so those provider groups will be contracting with multiple entities as well, which I think they can do now because we have some case law on that.

George Ross:
That is correct. We have no problem with doing that; we do not stop them from doing that. We have no problem with that piece of the bill. If there is a group that wants to contract with two or three different hospital groups, fine.

Assemblywoman Summers-Armstrong:
This is really complicated, and our intent is to do the right thing for our constituents. This bill, if I am not mistaken when I listened to the earlier testimony, does not allow for there to be fines and fees if people do not comply. If there is no vehicle for fines and fees, and the only vehicle that is allowed here is a felony, what else can be done? I think we have seen enough corporate misbehavior. Often when people are fined, they continue poor behavior because they can afford to pay. It may seem egregious, but if you have a suggestion about how we can get people to comply, I would like to hear it.

George Ross:
You can always make it a misdemeanor and not a felony. Ideally, you could put fines in. You could put penalties in there but even then, we would think. If you just allow normal bargaining—because several times the proponents referenced that is part of the bargaining of the contract—if you can just put in here that we are allowed to incentivize those two items I talked about, we would not have any worries and we would not be worried about getting a felony because we would not be breaking the law. We do not do section 20.9, subsection 1, paragraph (a), we do not do paragraph (b), and we do not do paragraph (e). We just want to make sure that we can continue to provide coordinative, high-quality care that is good for the patient and puts the patient in a good place without committing a felony.

Chair Nguyen:
If I could just clarify, Mr. Ross, NRS Chapter 598 already has those violations go to district court. I believe that is existing statute.

George Ross:
I am not an attorney.

Chair Nguyen:
I will ask Ms. O'Krent because I believe that is already existing in the statutes, so this is not a new provision. Ms. O'Krent, can you clarify that, or do you need additional time?

Karly O'Krent:
That is correct.

Chair Nguyen:
I just wanted to make sure the record was clear that is language that already exists in NRS Chapter 598.

George Ross:
I have done a lot of health lobbying up here for two decades, and every time you change the health care law, it shows up in about one little blue line in about seven or eight very long paragraphs because there are all these different kinds. I am not a lawyer, but maybe we could put it in a different section and get rid of it that way. If that is what it requires, make a new section.

Chair Nguyen:
We have another question from a Committee member.

Assemblywoman Krasner:
Thank you, Mr. Ross, for being here. This is a complicated bill, but I do know that when people get sick or their loved one gets sick, they want the state-of-the-art hospital. They want the best doctors, but here in Nevada, we have one of the lowest Medicaid reimbursement rates in the United States. In the special session, we reduced Medicaid reimbursement rates an additional 6 percent. How will those factors, coupled with this bill, affect our state and health care for the people in our state?

George Ross:
I do not think it will help. If it passes as written, I think it will have a negative impact on how people receive health care and how people experience health care for the reasons I stated. The best thing we can do to improve health care in this state is to increase the Medicaid reimbursement rate. You need to pay doctors enough to take Medicaid patients. We are very low on medical, but when you drive through Henderson or you drive through parts of Summerlin, you are not seeing any shortage of doctors. Where you see the shortage of doctors is in east Las Vegas, North Las Vegas, and northeast Las Vegas. Where do the majority of the folks who are on Medicaid live? Those same places I just listed. You need to pay the doctors enough that they will take and see Medicaid patients, and similarly, if you pay the hospitals a somewhat fair rate—comparable to other states. I know it was said

earlier, but we have at least five entities that own hospitals in Las Vegas. It is fairly competitive when you do those contracts. It is one reason why someone apparently tries some of these other things to get an edge. It is quite competitive, so it will not take long if you start raising the Medicaid reimbursement rates when the cost-shifting gets less and the contracts to the payors go down. We do not like having to do that, but if you do not push those rates up, a hospital does not survive.

Chair Nguyen:
Mr. Ross, can I get you to direct this toward the contents of this bill? I know we have other people who want to testify here as well, so we will go to the lines for testimony in opposition to S.B. 329 (R1).

James Wadhams, representing Nevada Hospital Association:
I would like to thank Senator Lange for the time she spent talking openly to the sponsors of the bill. That has been a very open and robust discussion. The bill with its amendment is much improved. We do still have some concerns, and it is part of the reason we have been addressing these questions. There is not only a felony potential, but there is a private right of action, treble damages, and attorney's fees, so this element of section 20.9 is very serious. It has to be precise. Many of the Committee members' questions have drawn attention to the ambiguity, for example, in the phrase in what we have just been talking about in section 20.9, subsection 1, paragraphs (c) and (d) on business affiliates. Does that mean the affiliation of the in-house basic hospital services, such as lab and radiology and anesthesiology, or is that a reference to external, but affiliated, facilities? That needs to be clarified for all the reasons of the treble damages and the felony.

The other element is making sure of the language. If the Committee will look at section 20.9, subsection 1, I think there is a concern that there may be ambiguity in the way that language is written that a restriction on changing the incentives after the contract is entered into may be barred as well. I do not think it was the sponsors' intent nor, clearly, was it Senator Lange's intent; I do not think from what we have heard from the proponents that was their intent. I think the language needs to be clarified in that regard.

Finally, I think it would be worthwhile at least to have committee counsel take a look at the reference to a third party when we are actually talking about a hospital or a provider/physician provider entering into a contract with the payor. They are counterparties to the same contract. One is not an unrelated third party. The technical elements of this and eliminating antitrust provisions by themselves are not the problem that we have with this bill. It is making sure that it is clear and does not impede the open contracting that otherwise occurs in this highly competitive environment. Again, I appreciate the opportunity to testify and thank you, Madam Chair.

Katie Roe Ryan, System Director, Nevada Government Relations, Dignity Health-St. Rose Dominican:
Dignity Health-St. Rose Dominican is also in opposition to S.B. 329 (R1) for many of the reasons already cited by my colleagues. Anticompetitive practices are not an issue in the state, and if there are any health systems doing this, the Office of the Attorney General can deal with bad actors. St. Rose also does not mandate that payors contract with our entire network. The contracting restrictions piece of the bill in section 20.9 is severely problematic and will make navigating health care coverage even more difficult for patients while also creating access-to-care and quality issues by interrupting the continuum of care. This could also be harmful to health equity.

There is nothing in this bill that would prevent payors from making their members go to the cheapest place of care and not giving them a choice. How is this confusion and frustration better for the patient? This benefits the payor's bottom line, not the patient. That being said, St. Rose is willing to work with the sponsor on this bill in conjunction with the Nevada Hospital Association and hopes we can come to a resolution.

Dan Musgrove, representing Valley Health System:
I will not be repetitive. George Ross, James Wadhams, and Katie Ryan were excellent in their comments. Valley Health System has a number of hospitals in southern Nevada, and we are starting a second hospital in Reno. We currently have one in Sparks. As was discussed, there is something to be said for continuity of care, and I think Mr. Ross captured it correctly. There is an ability for us to go to exactly what Assemblywoman Krasner said. When someone shows up at our door in an emergency situation, they want the best of care. We save insurance systems money by not replicating or [unintelligible] throughout our whole system or other services where we can easily transfer them within our system and make sure they get the absolute best of care. Our concern, as has been said, is section 20.9, and we ask that you sincerely consider our suggested amendment. Thank you for the opportunity to testify.

Misty Grimmer, representing North Vista Hospital:
Thank you, Chair Nguyen, Committee members, and Senator Lange for having an open door to working with us on S.B. 329 (R1). North Vista Hospital is the only hospital in North Las Vegas and is in the oldest part of North Las Vegas. We echo the statements of the other hospitals you heard from today, especially Mr. Ross's comments about asking the Legislature to stop the cost shifting that happens from Medicaid to commercial payors by increasing Medicaid rates. We are a small hospital compared to others in Las Vegas and have just one location in Las Vegas; therefore, the ability to have as much flexibility with our contracting as possible is very important. Therefore, we, too, are in opposition to S.B. 329 (R1) as currently drafted.

Chris Bosse, Chief Government Relations Officer, Renown Health:
I am representing Renown Health in Reno. We appreciate Senator Lange and the representatives of the Culinary Health Fund for initially working with the industry on the bill and working to determine if there were unintended consequences that could be corrected in the bill language. We do, however, oppose S.B. 329 (R1) as amended as the majority of our concerns have not yet been addressed. Our primary concerns include the following: We believe payors and providers should be allowed to negotiate and mutually agree on contract terms. Senate Bill 329 (1st Reprint) prohibits parties from negotiating certain terms that may result in providers not being able to offer their best volume discount if they cannot confirm the payor's members will not be directed away from them. In addition, as an integrated delivery system, Renown Health provides value to its patients and those employer groups and payors we contract with by being able to provide high-quality care in the most cost-effective setting, including this past year during the COVID-19 pandemic where we provided care in the patient's home when it was appropriate.

Excluding or steering patients around the components of our delivery system has the potential of diminishing our ability to meet the patient's needs. By connecting the components of the health care delivery system, we are able to coordinate care, hold the components of the delivery system accountable to outcomes, and improve communication between levels of care and the patient. Senate Bill 329 (1st Reprint) undermines the components that, nationally, the Centers for Medicare and Medicaid Services has encouraged health care delivery systems to build through establishing accountable care organizations which have demonstrated the ability to improve quality and provide care most cost effectively. As stated previously, we oppose the bill and hope to be given the opportunity to work with Senator Lange and the Culinary Health Fund to address these concerns.

Chair Nguyen:
Is there further opposition testimony? [There was none.]

[Exhibit S, a letter in opposition, was submitted but not discussed and will become part of the record.]

Now I will go to neutral testimony on S.B. 329 (R1). [There was none.] I will call Senator Lange, our bill sponsor, back up to the table for any closing remarks.

Senator Lange:
We have heard a lot today, and you are all right: This is a very complex bill. We would not bring this bill to you if there have not been reasons for it. We continue to work with the hospitals who are the people who seem to have the most problems with the bill. We are going to work to amend the bill to include Optum and groups like that to make sure they have the same reporting requirements as other groups. Mr. Ross and I talked about that earlier in the week. We just wanted to make sure we could get the bill to you in a timely manner.

Today, you heard from legal counsel that the felony is not something we wanted to add in; it is something already in statute that is applicable to this language as well. We also know that the Office of the Attorney General deals with monopolies and can go after them. We want to be able to give the Attorney General some teeth into antitrust stuff that is happening or that could happen in our health care system in Nevada. That is why legislative language and [unintelligible] statute is so important in this bill. We are open to any questions you might have. If you are thinking about it at night and you come up with something, feel free to send me an email. I am happy to connect you with any of the presenters, and I thank you for your time.

Chair Nguyen:
Thank you, Senator Lange, and thank you, Committee. You were very patient and so attentive to the bills that were presented before us. With that, I will close the hearing on S.B. 329 (R1), and we will move to public comment. [There was none.] With that, I will close public comment and open up for comments from Committee members. Seeing none, I will adjourn today's meeting [at 5:21 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblywoman Rochelle T. Nguyen, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is the Work Session Document for Senate Bill 21 (1st Reprint), presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit D is the Work Session Document for Senate Bill 146 (1st Reprint), presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit E is the Work Session Document for Senate Bill 156 (1st Reprint), presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit F is the Work Session Document for Senate Bill 251 (1st Reprint), presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit G is the Work Session Document for Senate Bill 309 (1st Reprint), presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit H is the Work Session Document for Senate Bill 364, presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit I is the Work Session Document for Senate Bill 376 (1st Reprint), presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit J is the Work Session Document for Senate Bill 398, presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit K is a policy brief titled "Senate Bill 379 (BDR 40-457): Health Workforce Data Collection in Nevada through the Licensure Renewal Process," dated May 3, 2021, submitted by John Packham, Associate Dean, Office of Statewide Initiatives, University of Nevada, Reno School of Medicine, in support of Senate Bill 379 (1st Reprint).

Exhibit L is a copy of a PowerPoint titled "SB379: Improving Access to Care through Health Workforce Data Collection via Licensure Renewal," dated May 5, 2021, submitted by John Packham, Associate Dean, Office of Statewide Initiatives, University of Nevada, Reno School of Medicine, in support of Senate Bill 379 (1st Reprint).

Exhibit M is a letter dated May 6, 2021, submitted by Minette Galura-Boquiren, President, Nevada Dental Hygienists' Association, in support of Senate Bill 391 (1st Reprint).

Exhibit N is a letter dated May 6, 2021, submitted by Lancette VanGuilder, Legislative Chair, Nevada Dental Hygienists' Association, in support of Senate Bill 391 (1st Reprint).

Exhibit O is copies of emails dated May 6, 2021, submitted by various registered dental hygienists, in support of Senate Bill 391 (1st Reprint).

Exhibit P is copies of emails dated April 27, 2021 and May 4, 2021, submitted by various individuals in opposition to Senate Bill 391 (1st Reprint).

Exhibit Q is a copy of a PowerPoint presentation titled "Senate Bill 329: Presentation for Assembly Health and Human Services Committee, May 5, 2021," presented by Bobbette Bond, et al, Health Services Coalition, in support of Senate Bill 329 (1st Reprint).

Exhibit R is a copy of a PowerPoint presentation titled "Anticompetitive Terms in Health Care Provider Contracts," presented by Katherine Gudiksen, Private Citizen, Piedmont, California, in support of Senate Bill 329 (1st Reprint).

Exhibit S is a letter dated May 5, 2021, submitted by Kimberly Martin, Director, Government Affairs, DaVita, Inc., Denver, Colorado, in opposition to Senate Bill 329 (1st Reprint).