MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-first Session
May 4, 2021

The Senate Committee on Health and Human Services was called to order by Chair Julia Ratti at 3:35 p.m. on Tuesday, May 4, 2021, Online and in Room 2134 of the Legislative Building, Carson City, Nevada. Exhibit A is the Agenda. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Julia Ratti, Chair
Senator Pat Spearman, Vice Chair
Senator Dallas Harris
Senator Joseph P. Hardy
Senator Ben Kieckhefer

GUEST LEGISLATORS PRESENT:

Senator Nicole J. Cannizzaro, Senatorial District No. 6
Assemblywoman Lesley E. Cohen, Assembly District No. 29

STAFF MEMBERS PRESENT:

Megan Comlossy, Policy Analyst
Eric Robbins, Counsel
Norma Mallett, Committee Secretary

OTHERS PRESENT:

Katie Keith, J.D., M.P.H., Associate Research Professor and Adjunct Professor of Law, Georgetown University
Shenakwa Hawkins, Care With Purpose Medical Center LLC
Randi Lampert, M.D.
Stacie Weeks, Aurrera Health Group
Annette Magnus-Marquart, Battle Born Progress
David Goldwater
Priscilla Maloney, American Federation of State, County and Municipal Employees, Retirees Nevada Chapter 4041

Sarah Adler, Nevada Advanced Practice Nurses Association
Eric Jeng, One APIA Nevada; Asian Community Development Council
Christine Saunders, Progressive Leadership Alliance of Nevada
Quentin Savwoir, Make It Work Nevada
Barry Gold, AARP
Katie Robbins, Planned Parenthood Votes Nevada
Jim Sullivan, Culinary Workers Union Local 226
Evan Louie
Daniel Corona, Mayor, West Wendover
Philip Malinas, M.D.
Theresa Bohannan
Ender Austin III, Faith in Action Nevada
Tom Clark, Nevada Association of Health Plans
James Wadhams, Nevada Hospital Association
Jaron Hildebrand, Nevada State Medical Association
Michael Hillerby, Renown Health; Hometown Health
Susan Fisher, Nevada State Society of Anesthesiologists
Ann Silver, Reno + Sparks Chamber of Commerce
Scott Muelrath, Henderson Chamber of Commerce
Connor Cain, Hospital Corporation of America; Sunrise Hospital and Medical Center; Mountain View Hospital; Southern Hills Hospital and Medical Center
Mary Beth Sewald, Vegas Chamber
Peter Guzman, Latin Chamber of Commerce
Marcos Lopez, Americans for Prosperity Nevada
Cyrus Hojjaty
Nancy Bowen, Nevada Primary Care Association
Amber Federizo, APRN, FNP-BC, Hemostasis and Thrombosis Center of Nevada
Trey Delap, Director, Group Six Partners LLC
Margot Chappel, Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services
Anthony Yarbrough, Veterans of Foreign Wars

CHAIR RATTI:
I will open the hearing on Senate Bill (S.B.) 420.

SENATE BILL 420: Revises provisions relating to health insurance. (BDR 57-251)

SENATOR NICOLE J. CANNIZZARO (Senatorial District No. 6):
I will read from my written presentation on S.B. 420 (Exhibit B) and have submitted a conceptual amendment (Exhibit C).

KATIE KEITH, J.D., M.P.H. (Associate Research Professor and Adjunct Professor of Law, Georgetown University):
I am speaking on S.B. 420 regarding additional health insurance coverage expansion in Nevada. I have submitted my written presentation (Exhibit D) and supplemental documents (Exhibit E).

SHENAKWA HAWKINS (Care With Purpose Medical Center, LLC):
I am in favor of S.B. 420 and will explain why this bill is needed. I am a health care provider, small business owner and advanced practice registered nurse (APRN). I run the Care With Purpose Medical Center in Las Vegas. We serve communities of color and low-income communities including a large homeless population. I know what it is like to lose your job along with your health insurance. I lost mine at the start of this pandemic when the clinic I worked for shut its doors. Our practice at Care With Purpose Medical Center treats many people who are in the same situation I was in. I have been a nurse for over 20 years, including in emergency rooms and trauma centers. If people had been able to afford health insurance and were treated proactively, they could have avoided expensive emergency care. I see this far too much, and it is heartbreaking and frustrating. Anything we can do to make health insurance accessible and affordable will help many people and S.B. 420 will do just that.

As an APRN, the pay parity provision of the bill will allow me to keep my clinic open. There is so much healthcare inequality in our existing system, and that is part of what inspired me to open the practice and help historically underserved populations. We are providing the same level of care with preventive medicine and management of chronic diseases, such as hypertension, diabetes and high cholesterol, which are dominant medical conditions in communities of color.

Cost of insurance is a major factor. This bill will help bring costs down and help communities like the ones I serve in my clinic. I ask this Committee to help us and pass S.B. 420.

RANDI LAMPERT, M.D.:
I am a pediatrician practicing in Las Vegas, and I support a Nevada Public Option. I have seen too many people go without health care or medical treatment. My written testimony has been submitted (Exhibit F).

SENATOR CANNIZZARO:
This bill is personal to me. While I was in college, I injured myself badly after losing my health insurance. Because I did not have access to health care, the medical bills followed me after law school as I was seeking to become an attorney, and it took years to pay the medical bills.

I cannot imagine what it must be like to wonder if your baby is okay, or the person carrying your child is going to be okay. Doing nothing is not a solution. Senate Bill 420 will help get us there. I will now read from my written remarks, Exhibit B, with a summary of the Public Option.

SENATOR KIECKHEFER:
Will the Public Option be open to anyone living in Nevada? What waivers to the rules as part of the State Innovation Waiver in section 11 will you be requesting to obtain federal financial support for the Public Option?

SENATOR CANNIZZARO:
The Public Option would not be available to individuals who are covered under their employer-paid health plans, especially large employers from multiemployer health plans. We are talking about the individual and small-group market, and that is what this product is designed to capture.

We will work with the Department of Health and Human Services (DHHS) to look at what waivers are available. We have also looked at the Affordable Care Act (ACA) 1332 waiver. We want to make sure there is enough built-in flexibility and innovative capacity to get funds to help buy down the costs of premiums.

SENATOR KIECKHEFER:
Sixty-five percent of individuals in our State are eligible for Medicaid or subsidy eligible under the ACA. A substantial portion of the rest of that population are undocumented individuals and not eligible for subsidy under the Silver State Health Insurance Exchange. Who are we targeting or bringing into this market?

Are we going to disrupt the small-group market so massively that it brings people in? I am trying to understand who is going to sign up.

SENATOR CANNIZZARO:
There are many individuals who are uninsured and do not qualify for subsidies, and affordability is a barrier with respect to the Exchange.

STACIE WEEKS (Aurrera Health Group):
Out of 350,000 individuals in the small-group category, 37 percent are eligible for Medicaid but have not yet enrolled. Affordability challenges today in the Exchange are experienced by 17 percent. The Public Option would be available to those individuals, and if they are eligible for the Exchange, could purchase the product. Immigration status is a barrier for 27 percent of individuals; however, it is not always the undocumented individuals. It could be individuals eligible for Medicaid who are barred by the five-year residency rule. If individuals have not lived in the U.S. for five years, they cannot purchase Medicaid. Many immigrants struggle with this barrier because they are low-income when they first move to the U.S. This product would be available to that 27 percent outside the Exchange. This product would also be available to the 19 percent who are eligible for Nevada Health Link but are not enrolled.

SENATOR KIECKHEFER:
For the 17 percent who have affordability challenges, there was a significant expansion of tax credit subsidy and support through the American Recovery Plan, including increases beyond 400 percent of the federal poverty level. Does that address some of the 17 percent?

MS. WEEKS:
That subsidy amount is temporary and would not be long-term to address the issue.

SENATOR HARDY:
Will this work, and is this going to be revenue neutral by using other practitioners such as doulas?

CHAIR RATTI:
We will have general discussions about the cost and then a deeper conversation with the Senate Committee on Finance. We have a fiscal note posted.

SENATOR CANNIZZARO:
The Public Option is separate from Medicaid eligibility. The overall goal of S.B. 420 is to help increase access to affordable care. We have been talking with DHHS and the Exchange with respect to pregnant women in those populations and some of the surrounding prenatal and postpartum care. In S.B. 420, there is the inclusion of eligibility for some of these services, which would not be revenue neutral. There is a fiscal note associated with it and there are federal funds that would accompany those as with many Medicaid and federal matching dollars. The waivers and Public Option Trust Fund is about health insurance as a whole. Some of the Medicaid pieces would cost the State money, which we will discuss with the Senate Committee on Finance. Overall, bringing in federal dollars will help with savings in terms of more acute care for those patients.

SENATOR HARDY:
How are we motivating insurance companies or hospitals to cut their costs when the reality to provide coverage will increase from 5 percent to 15 percent in 4 or 5 years?

SENATOR CANNIZZARO:
Individuals looking at the Public Option are uninsured and uncompensated at this point. When hospitals or providers see those individuals, they are providing that care for the uninsured. Those built-in costs are distributed among other people who are paying for health insurance. The Public Option is a premium-based plan. Our goal with this is to create something that is more affordable so people can actually afford it. People may be eligible to get health care, but if they cannot afford it that eligibility is meaningless. When individuals are covered, even though it may be a lower-cost plan, that is something that is far more than what hospitals and providers would be getting for individuals who are on uncompensated care. The motivation is to get more people insured so you are not facing the prospect of them coming in for medical services and being completely uninsured.

SENATOR HARRIS:
This is a great bill, and I am happy to see it here in Nevada.

CHAIR RATTI:
Access to insurance does not always equal access to care. It depends on how skinny that network might be and the provider list, and whether that provider

list has waitlists, or depending on the number of available providers, or if we have the specialists we need in the network. How does the bill approach the question of network adequacy making sure that just because you have insurance also means you have care?

SENATOR CANNIZZARO:
If someone is eligible for insurance and cannot afford it, that is akin to being ineligible for insurance. Similarly, if someone is on a plan that either does not provide the basic level services he or she needs or, the individual does not have access to see a provider, then that is akin to having no care at all. Senate Bill 420 has a couple of things in it that address that issue. We are requiring groups bidding on those contacts to also bid on the Public Option to make a good-faith bid for that product. If you take Medicaid patients, you are also accepting the Public Option. This is similar to workers' compensation and the Public Employees' Benefit Plan. We are creating a network of providers Statewide that will see these patients and will accept that insurance to hopefully address the adequacy of care issue. We are also talking about this being a Statewide product where you will see the continuity of care even if people were to move, or if they were unqualified individuals or did not have employer-based health care, that they could also have that flexibility to stay with their providers and make sure they could continue having that access with this particular product.

CHAIR RATTI:
If I understand the bill correctly, the insurance companies are required to bid on the Public Option if they want to bid on Medicaid. Do providers who accept Medicare or Medicaid also have to accept the Public Option?

SENATOR CANNIZZARO:
That is correct. It also includes workers' compensation, in particular, the State workers' compensation and Public Employees' Benefit Plan (PEBP).

CHAIR RATTI:
So we have had some challenges with providers choosing to opt out of our Medicare and Medicaid systems because of the rates. Do we have any experience with similar models in other states? Are we concerned about the potentially unintended consequence of losing providers who choose to get out of the whole public space?

SENATOR CANNIZZARO:
This bill will ensure there are providers who will accept the Public Option so people can get access to services. The populations sought to be served with the Public Option are individuals who are not insured because they do not qualify, or they are not insured because they are having affordability issues, either through their small-group employers that are not providing insurance or because these individuals simply cannot afford what is offered.

We are not increasing eligibility for Medicaid rates and demanding those eligible are covered at the Medicaid rate. Individuals will choose an insurance plan and pay the premiums based on the rate. Our goal is to provide a Public Option with negotiated rates that would incentivize providers to accept clients that are underinsured and provide them with coverage paid for through the system.

We have not seen other states that have implemented this type of model. One of the important key aspects about this bill is there is built-in time to allow DHHS to help implement the Public Option. There is also time to consult with the Exchange and insurance commissioner to ensure we are getting those price points correct and making the right decisions on how this would be implemented. Additionally, we are going to take time to look at the data and make sure what we are doing does not inadvertently price out other providers or result in a loss of providers. The goal is to ensure there are individuals who would be accepting the Public Option and create a network of providers.

MS. WEEKS:
Minnesota has a similar provision for its Medicaid program, public employee program and workers' compensation. It is called Rule 101 in Minnesota, and it works well there. There are robust networks of providers in Minnesota because of that rule. Since you are tying it to Medicaid in many ways and doing a procurement together, you are going to be incentivizing plans if providers want to offer the product and obtain the money Medicaid can bring as well as this market. We know the contracts to managed care are close to $2 billion. If insurance companies want that, it would incentivize them to do better by providers to make sure they are in their networks to offer and incentivize those plans to come forward, and work with providers in a way that maybe they are not today.

CHAIR RATTI:
Please walk me through the timeline. I want to make sure it is clear on the public record that this is not effective July 1, for people would think they have access to insurance in the next year.

SENATOR CANNIZZARO:
In the proposed conceptual amendment, Exhibit C, on page 2, item 9, we revised it to be available for the coverage year beginning January 1, 2026 to allow for alignment of procurement. This is not something that would be implemented July 1. Our goal is to build in that lead time so there is enough space for DHHS in consultation to provide for that procurement—also, time for us to get the data in the interim through actuarial studies to ensure we are putting it in a good spot. By building in that time and allowing this to become a plan year effective in 2026, it allows the flexibility that is needed. It is also encouraging creativity on our part, as a State, to come up with a way in which to implement this, resulting in savings to Nevadans.

SENATOR KIECKHEFER:
The bill recognizes this could be a problem due to the fact we are going to allow PEBP and Medicaid to opt out of that requirement. We are saying in section 13, subsection 2 of the bill, that if we are going to disrupt access for our people through Medicaid and PEBP, or if they are going to have difficult access to covered services, we are going to allow them to waive this requirement for commensurate access.

In section 10, is it stating there have to be at least two plans, a gold and a silver option offered?

SENATOR CANNIZZARO:
Yes, there would be a gold plan and silver plan.

SENATOR KIECKHEFER:
How should section 10, subsection 5, as amended in your conceptual amendment, Exhibit C, regarding costs, be interpreted? Is it that over four years the costs of these plans will be 15 percent less or the average costs of all health insurance plans will be 15 percent less?

SENATOR CANNIZZARO:
This is applicable to the Public Option only, not to plans across the State.

SENATOR KIECKHEFER:
The targeted price reduction of health insurance is not a downward pressure on all plans in the State to try to reduce premiums. It is specific solely to these two Public Options. Is this correct?

SENATOR CANNIZZARO:
Yes.

SENATOR KIECKHEFER:
In the amendment, Exhibit C, bullet point 6 as it relates to the Culinary Workers Union Health Fund, is the idea it would be subsidy eligible if it is offered on the Exchange. Would it be able to enroll people who are not members of the group? If an association health plan would fit this category, could it enroll people who are not part of the association?

SENATOR CANNIZZARO:
This is not specific to any particular group. We have many multiemployer plans in our State. Individuals may find themselves in a situation where they have lost their healthcare coverage because of loss of employment for a period of time. The goal is, with approval from the federal government for different waivers and subsidies the individuals might apply for, this is going to allow a structure in collaboration with DHHS to make sure these groups could continue coverage for the individuals who would otherwise have fallen off the group plans. The goal is to create continuity of care and ensure people can keep their health insurance even though they may have periods where they would not otherwise remain. Part of this is allowing flexibility and working with DHHS to create options and having approval with respect to waivers through the federal government.

SENATOR KIECKHEFER:
It is not open to the general public; would it only be people as part of the qualified group?

SENATOR CANNIZZARO:
Our intention is to make sure individuals who would still be qualified under that qualified group. If there were an indication it would be feasible to include individuals such as family members that potentially would have fallen off or would not be covered, they could potentially be covered. It is not as prescriptive as that in the language and how we are envisioning it.

CHAIR RATTI:
We have the intent of the bill on the record but would like our Counsel, Eric Robbins, to address the 15 percent for clarification.

ERIC ROBBINS (Counsel):
The bill provides the Director of DHHS may revise the performance targets provided the Public Option remains on target to reduce average premiums for health insurance in the State by at least 15 percent over 4 years in the conceptual amendment, Exhibit C, in which the Public Option is in operation. The text of the bill would go along with Senator Kieckhefer's initial impression that it would have to create downward pressure on all of the health insurance in the State and lower the average premiums of all health insurance by at least 15 percent. If it is going to carry out the intent expressed on the record today, the bill would need to be amended to reflect that intent.

SENATOR KIECKHEFER:
Just because we say a health insurance plan needs to have premiums that are 15 percent less, that does not reduce costs by 15 percent. It may actually increase costs and utilization, and there are a lot of different factors that could happen downstream. Who is going to pick up that cost?

SENATOR CANNIZZARO:
We are talking about getting individuals who cannot afford or are ineligible for health insurance. There are costs for uninsured, uncompensated care. It is more expensive to cover individuals through emergency services for more acute conditions, more often than not, or where a condition has gone untreated for a significant period of time. The treatment and mitigation of whatever the disease are far more expensive, intrusive and difficult to deal with and are not compensated. We are not talking about instances where individuals have health insurance and emergency services are what they are utilizing. We are talking about individuals who have much higher costs getting them insured so they have access to regular health care which, overall, will reduce their utilization of those emergency acute services. Also, there is compensation where there was none. Yes, there are costs associated with that, and we are trying to make it more affordable, but the other alternative is these individuals go without health insurance.

SENATOR KIECKHEFER:
Philosophically, I do not know if that is where we are going to be getting people from. If we are opening up the small-group market, I am concerned it is going to poach more people out of that than some of the categories we are talking about, like the 37 percent who are Medicaid eligible and go into a hospital with a significant problem. Those hospitals do everything they can to make sure the individuals are eligible or enrolled. If we make a plan 5 percent more affordable than the second lowest silver plan, but people have made the choice not to enroll even though they are eligible on the Exchange now, I am not convinced that will trigger them to sign up. I am concerned about where the cost shifts are going to happen to make up for some of this artificial pressure, and I think it is into large-group insurance, employer-based insurance and downward pressure on providers.

SENATOR HARDY:
In my experience when the ACA became effective, for instance, seeing patients who saved up all their illnesses and instead of one or two problems, we were dealing with five different diseases all at once. This same kind of thing is going to happen, so there would be an initial, quite expensive problem you would be facing. At the same time, that is the individual practitioner as opposed to the hospitals. In speaking with hospitals over the years, they do not make money on Medicaid or Medicare; they make up the difference on private insurance. What is it going to amount to for the practitioners in hospitals, hospitals themselves or the insurance companies that have done many things to invest in the community? That is one of the challenges we are going to see, the investment in the community while they are trying to push down to that 5 percent and eventually 15 percent.

ANNETTE MAGNUS-MARQUART (Battle Born Progress):
We support S.B. 420. My written remarks have been submitted (Exhibit G).

DAVID GOLDWATER:
I support S.B. 420. I am representing myself and the small business for whom I work. I have worked around health policy for almost 30 years. I have a disclaimer in that access to affordable health care is the right of all Nevadans. I am a partner in a small retail business that employs 35 people and also have a small consulting firm that employs 3 people. We pay for health insurance for our employees. If the Legislative building were open to the public, the line for small business owners would be out the door in support of this bill because health

insurance costs are such a big part of our budgets. Probably 10 to 15 percent of our health insurance cost represents 20 to 30 percent of total compensation to our employees.

We have an employer-based insurance program, and that is how we deliver health insurance, through our employer. That was not my choice nor anyone else's, but that is the one we have. Providers should be paid for their services. Those costs should be fair and not shifted between the insured and uninsured. The incentives for care should be aligned. The employer-based system, however, is particularly hard on small businesses. That is where the gaps are and where this bill fills those gaps. Small businesses do not have easy access to capital markets and therefore are generally undercapitalized. Additionally, most small businesses are the primary source of income. The dollars we pay for health insurance for our employees is felt by the owners. Those monies would otherwise go to our families and provide for our own well-being.

PRISCILLA MALONEY (American Federation of State, County and Municipal Employees, Retirees Nevada Chapter 4041):
We support S.B. 420. My written remarks have been submitted (Exhibit H).

SARAH ADLER (Nevada Advanced Practice Nurses Association):
We support S.B. 420. My written remarks (Exhibit I) and our proposed amendment to S.B. 420, section 30 (Exhibit J) have been submitted.

ERIC JENG (One APIA Nevada; Asian Community Development Council):
We support S.B. 420. My written remarks have been submitted (Exhibit K) as well as a letter of support signed by many Asian Pacific Islander American small business owners (Exhibit L).

CHRISTINE SAUNDERS (Progressive Leadership Alliance of Nevada):
We support S.B. 420. My written remarks have been submitted (Exhibit M).

QUENTIN SAVWOIR (Make It Work Nevada):
We support S.B. 420. My written remarks have been submitted (Exhibit N).

BARRY GOLD (AARP):
We support S.B. 420. My written remarks from AARP (Exhibit O) have been submitted.

KATIE ROBBINS (Planned Parenthood Votes Nevada):
We support S.B. 420. Nevada has one of the highest uninsured populations in the Nation, and the Public Option will provide higher quality, lower cost care to people across the State. The Public Option will also help address the disparities people of color face when trying to find affordable quality care for themselves and their families. Increasing access to health care, including reproductive health care, will make our State stronger and more equitable.

JIM SULLIVAN (Culinary Workers Union Local 226):
We support S.B. 420. We support the bill and conceptual amendment, Exhibit C, because health care is a human right. This is a good first step toward making sure all Nevadans get quality and affordable health care. Nevada has one of the highest uninsured rates in the Country, which this bill addresses by creating a Public Option for working families who are either not eligible for healthcare plans or cannot afford it. In addition, the conceptual amendment, Exhibit C, to this bill would allow the Culinary Workers Union Health Fund to participate in the program and continue to take care of participants if they were to lose healthcare benefits. This is important because it would allow union members and their dependents to continue to see their same doctors, not create a gap in much needed treatments, and have access to the same prescriptions and specialists instead of having to start over with a brand-new insurer if they were to lose coverage.

EVAN LOUIE:
I support S.B. 420. It makes sense to have insurance providers compete with the Public Option which will in turn provide lower premiums and expanded coverage. Nevada is forty-eighth in the Nation for overall health care and has the highest uninsured rate of the Medicaid expansion states.

As a personal story, my late wife was diagnosed with brain cancer four months after we were married and seven and one-half months pregnant with our daughter. I stopped running my business and lived in the hospital taking care of my wife and prematurely-born daughter. We could barely survive keeping up with COBRA premiums and healthcare costs because of severe income loss and cost of living. After my wife's passing, affordable health care is something for which I have become extremely passionate. As a small business owner, I know that competition drives innovation, but having more options is better for everyone.

DANIEL CORONA (Mayor, West Wendover):
We support S.B. 420. In the summer of 2017, it was announced Nevada's 14 most rural counties would have no insurance options due to the Exchange. Thousands of Nevadans, including myself, would not receive health insurance on the Exchange and simply be out of luck. Thankfully, at the last minute, State leaders were able to avert a disaster and secure health insurance for rural Nevadans. The threat of no available health insurance through the Exchange still looms yearly for rural Nevadans. However, there is potential for a long-term solution through S.B. 420. If passed, it would be one of the most comprehensive and robust public health insurance plans in the Country. For the first time ever, Nevadans in rural areas of our State would be guaranteed access to affordable coverage through a Statewide Public Option. This means rural providers and hospitals will also be guaranteed reimbursement for patients enrolled in the Public Option. This would be a game changer.

Rural hospitals provided nearly $30 million in uncompensated care in 2020 alone. Meeting those costs has been crushing Nevada's rural hospitals and is a major factor in why so many have recently closed their doors. This bill would also provide rural Nevadans with a Statewide network of doctors. They could receive in-network care even if those providers are outside the patient's home county. The Nevada Public Option will be offered to individuals, families and small businesses, providing health insurance through the Exchange. As the Mayor of West Wendover, a rural community that struggles yearly with access to affordable health care, I stand in strong support of S.B. 420.

PHILIP MALINAS, M.D.:
I support S.B. 420. I am a psychiatrist in Reno. As a medical professional, I support this bill and urge the policymakers to expand healthcare access by passing the Public Option. I have submitted my written remarks (Exhibit P).

THERESA BOHANNAN:
I support S.B. 420. I am a mother of two with a child who has a severe congenital heart defect. I have long been an advocate for a Public Option and to fix the problems the ACA was unable to address initially. Not having a Public Option was one of the main barriers to accessing affordable health care for everyone nationwide. As many of the previous speakers stated, the high number of uninsured people in our State would be helped by lowering costs. While addressing this bill, we also need to look at maximum out-of-pocket rates and deductibles; the cost-sharing for patients has been increasingly

unattainable. I am coordinating care for my son in Las Vegas and wondering how I am going to pay for airfare and hotel expenses. There are additional costs outside of the costs for health care which people are struggling to maintain. During the pandemic and when it was unsure how safe schools were, I looked at the option of leaving my job and looked at the Exchange. The out-of-pocket rates were incredibly high, about $13,000. As a parent of a child with special needs, I have met those maximum out-of-pocket costs with my son's care totaling over $2 million, and he is 5 years old. I know quite well the struggles that patients go through every day.

ENDER AUSTIN III (Faith in Action Nevada):
We support S.B. 420. I am speaking on behalf of many of our leaders across the State who have expressed reasons why they support this bill. This legislation allows for increased access, mobility and fostering equity in health care. Access to health care is a moral imperative. Access to health care allowed a mother who was dying to live a dignified life in her final days of life. It was important this mother maintain a state of normalcy even as her illnesses was progressing. Preacher David Ross spoke to me about the importance of health care when he faced a heart procedure that cost $250,000. If he did not have health insurance, he would have absolutely been put in debt that he would not have been able to take care of. Pastor Jo Harris spoke vigorously about the importance of health care for Black men who face unique health disparities exacerbated by a lack of access to health care. In 2021, if America catches a cold, Black America has the flu. Another leader spoke about the importance of her patients being able to keep their health insurance while they transition from job to job. Senate Bill 420 allows folks to carry their health insurance from one job to another, alleviating some of the challenges we have with racial disparities and ensuring there is a better quality of life for many others, as well as providing financial security.

TOM CLARK (Nevada Association of Health Plans):
We oppose S.B. 420, primarily the sections dealing with the Public Option. I represent the private insurance companies that operate in Nevada. The most important concern we have is cost—cost on implementation, creating and managing this new Public Option. The second biggest issue we have is access to care. When there are challenging things that occur within health care, we tend to find solutions. The healthcare system in Nevada is a system. When you look at insurance, it is broken down in a number of different ways. There are large-group, small-group and individual markets, self-funded plans, Medicare and

Medicaid. About 11 percent of the Medicaid folks are the uninsured. The reason I bring up those other kinds of insurance is because the system operates as a system. With the Public Option concept, if you set the rate and compress a portion of the market, the remaining areas in the system expand to cover and subsidize the costs of the compression. We contemplate that under this legislation, there will be a cost shift where you may see a set price under the Public Option, but those folks who are in those other elements of insurance will see an increase in the cost of their insurance.

There are 100,000 Medicaid eligible people who could enroll. There are about 80,000 people who qualify for zero-cost insurance through the Exchange. We need to work to get those people into that system.

This bill does not contemplate the increasing price of pharmaceutical drugs. We have done work as insurers for years to increase the number of providers we have, rural and urban and across-the-board disciplines, to bring them in. We fear the impact S.B. 420 will have on network adequacy will be detrimental. Under this proposal, the healthcare delivery system access will be impacted. Experience tells us a Public Option of this nature will be expensive, and healthcare costs for all Nevadans will increase while access will decline.

JAMES WADHAMS (Nevada Hospital Association):
We oppose S.B. 420. We support the notion of a Public Option; however, we have issues with this bill. The one element missing in the bill is a prerequisite for an actuarial study. This population needs to be analyzed and studied so the morbidity and healthcare characteristics can be understood. That should not be difficult if a portion of this population is already Medicaid eligible and is available to simply getting them enrolled. That will cut this approximately by a third to a half, depending upon how it is calculated. There needs to be an actuarial study so that both the insurers know what they are insuring, and the providers know what they are delivering service to.

One of the issues is that cost-sharing should not be an issue because it is already part of the system. Medicaid reimbursements are substantially below cost, and unfortunately, the Medicare reimbursements are also below cost. Using a Medicare or Medicaid system as a basis mandates the cost system will be less than the cost to prepare and deliver those healthcare services. That creates a problem; when costs exceed the revenues, then adjustments will have to be made. It is either passed on to the commercial market, that is, the

employers that are not eligible to participate will have to begin picking up that cost, or it can impact into the workforce and jobs, which is the largest cost factor in facilities and will have to be addressed. We tend to think it will erode the small group and individual plans, particularly those that are being put together by the Chambers of Commerce that have been so successful.

The ultimate problem as we find insurance for more people is that we have to be careful we do not decrease the access. The concern is that by mandating certain providers to participate, we may lose those certain providers from those other elements of care, for example, delivering care to the Public Employees Benefit Plan, injured workers and State Medicaid. For us in the hospital world, nurses and doctors are the lifeblood that flows in these facilities, and the adequacy of our workforce is critical to the delivery of care which was stressed so much in the last 15 months. Without those people willing to put themselves on the frontline and the facilities adjusting capacity, it would have been a problem.

As you review this bill, remember that costs come in different components. It is the out-of-pocket costs to the consumer, cost of insurance and ultimately the cost to deliver healthcare service by the providers. We have to be sensitive to where all of those costs go.

Given the financial risks of setting up a public option at Medicare baseline rates for physicians, the Nevada State Medical Association urges the Legislature to consider the impact and policy of the long-term sustainability of physician practices and ultimately the access to care for Nevadans. We ask the Legislature to refrain from using rates as the core of physicians' payments under this Public Option. Despite our concerns, there are some sections in the bill that we support, which are reflected in my written submission (Exhibit Q).

JARON HILDEBRAND (Nevada State Medical Association):
We oppose S.B. 420. Our membership consists of the majority of Nevada physicians, but we consider ourselves first and foremost as a patient advocacy organization. We do share the priority of approving access and affordability of healthcare insurance. Covering the uninsured and improving healthcare outcomes and affordability have a long-standing priority for the Nevada State Medical Association. We are not opposed to the Public Option but today we are in opposition to S.B. 420 as written. We have concerns with payment parity with respect to doulas, midwives and nurse practitioners.

The mandate in section 23 is another area of concern. We support physicians' freedom of choice when it comes to healthcare plan participation and therefore, we opposed the effort to require physicians' participation in the Public Option by tying it to the participation of other State-based programs. This mandatory participation provision overlooks the complexities of running a physician practice and in determining the capacity and ability of a practice to serve a patient mix. There are many reasons as to why a practice may not participate with the plan. Burdensome administrative policies, saturation of practice resources, physician time, engagement in alternative payment models, pending retirement and so on. It is critical that the physicians are able to weigh in on the contract options and make the decisions of what it is best for them, their practice, patients and staff.

The next issue we have are the Medicare reimbursement rates in section 14 of this bill that would establish provider payments using Medicare rates as a floor. We fear these rates will become a defective rate for all Public Option contracts. Medicare rates have not covered costs of providing care in the commercial market. According to data from the Medicare trustees and Medicare physicians, pay has barely increased in nearly two decades. Written testimony (Exhibit R) and supporting documents (Exhibit S) have been submitted by the Nevada State Medical Association.

MICHAEL HILLERBY (Renown Health; Hometown Health):
We oppose S.B. 420. While we support the concept of a Public Option focused on providing coverage for the uninsured, we do oppose this bill. We would like to work with you and others to design a program that works for Nevada without jeopardizing access to care or current options for coverage. We are acutely aware of the importance of the payer mix as we strive to manage costs and make the most efficient use of public and private dollars. When the number of patients increase in Medicaid, Medicare and other programs that reimburse below cost, or for those who are uninsured, the cost burden shifts to providers and private health insurance patients. That impacts the number of providers willing to enroll in these programs and see new patients.

Nevada ranks low in physicians, nurses and other primary care providers per capita. Nevada has among the lowest Medicaid reimbursement rates for hospitals in America. Our delivery system is fragile and sensitive to even small changes in the payer mix. The same is true for the private insurance market for businesses and individuals. We cannot implement a new Public Option before

we study and address the risk of losing providers in our system or making Nevada a less attractive place to practice medicine.

Senate Bill 420 seeks to address the large population of patients who are eligible but not enrolled in Medicaid or subsidized Exchange plans. There is a 37 percent population eligible for Medicaid and 20 percent or more for subsidized coverage on the Exchange. We should focus on these areas before implementing a new Public Option. We would like to work with you and the larger healthcare community to continue the work done through S.C.R. No. 10 of the 80th Session, the Patient Protection Commission and the Committee to Conduct an Interim Study Concerning the Costs of Prescription Drugs. If we are to build a Public Option that addresses the unique Nevada marketplace, work first needs to be done in the following areas: increase presumptive eligibility options to better capture more Medicaid eligible patients and help them complete full enrollment; explore expanded Exchange enrollment opportunities, for example, at point of care, and create something like Medicaid presumptive eligibility for the Exchange.

The actuarial study allowed in the bill must be mandatory if we are to understand the risk pool and the viability of any Public Option to avoid the results seen in the state of Washington. This is also reflected in the early years of our own Exchange and lack of coverage in rural counties. Also, remove the small-employer eligibility provision must be removed. This will exacerbate the cost shifting problem and create more uncertainty in a small, fragile private insurance market.

We must also address Medicaid rates, including the cuts made last summer. We need to align Medicare reimbursement with value-based care and patient outcomes, helping drive better access to the best care in the appropriate setting. This is a crucial step to deal with both access and the budget realities you face every day. We share your commitment to helping more patients access care with viable coverage and look forward to working with the Legislature to address the needs and best plan for the future in a way that encourages providers and payers the same.

SUSAN FISHER (Nevada State Society of Anesthesiologists):
We oppose S.B. 420. It was mentioned earlier that 35 percent of Nevadans eligible for Medicaid are not enrolled, and we need to figure out why. People are not signing up for Medicaid because physicians who can choose are not

accepting additional Medicaid patients. Unfortunately, we have physicians who cannot choose so they accept Medicaid patients and are losing money in their practices. I have submitted a letter from the Nevada Society of Anesthesiologists (Exhibit T) with details on our opposition to S.B. 420.

ANN SILVER (Reno + Sparks Chamber of Commerce):
We oppose S.B. 420. This bill would increase costs to our chamber businesses and their employees, reduce competition and choice for working Nevada families and possibly deter physicians from establishing much-needed practices in our State. We do support decreasing insurance costs and increasing availability. We are proud of the Reno + Sparks Chamber Association's health plan. We are able to offer affordable comprehensive vision, dental, medical and life insurance plans to any small business with between two and fifty employees. This plan covers thousands of lives across the State.

Senate Bill 420 would not reduce the high cost of health care in Nevada. It would, however, demand insurance premium reductions for a finite number of Nevadans and increase the cost to a larger proportion of the population. Your help is needed in creating incentives to medical residencies, encouraging and funding healthcare credentialing and refraining from establishing arbitrary government-set reimbursement rates. Your priorities should include encouraging doctors to work in our State and rewarding students who choose careers in health care. We ask that you rethink this bill and instead establish a task force to explore healthcare affordability and existing products in the Nevada market. We have enough choices without adding a distraction that will ultimately diminish the healthcare industry, leaving it without a chance to compete and succeed.

SCOTT MUELRATH (Henderson Chamber of Commerce):
We oppose S.B. 420. We have submitted our opposition testimony (Exhibit U).

CONNOR CAIN (Hospital Corporation of America; Sunrise Hospital and Medical Center; Mountain View Hospital; Southern Hills Hospital and Medical Center):
We oppose S.B. 420. In the last year, our hospitals have cared for nearly 10,000 Covid-19-positive patients and ensured that Nevadans, including those in vulnerable zip codes, had access to free, life-saving monoclonal antibody treatments all while sustaining difficult Medicaid cuts brought on by the pandemic's crushing impact to our State budget. We worry that the

Public Option proposal will not work for Nevada's unique healthcare environment and will have negative consequences for both patients and providers. At Sunrise Hospital, which is the largest provider of Medicaid services in our State, 15 percent of our patients are covered through commercial and managed-care insurance. Any shift in patients from commercial plans to a Public Option will reimburse at a far lower rate, threaten the ability of hospitals like Sunrise to offer services and lose vulnerable members of our community who rely upon us so heavily.

There are other ways to expand health insurance coverage in Nevada. First, over 50 percent of uninsured Nevadans are eligible for Medicaid or subsidies on the Exchange but not enrolled. We should increase efforts to ensure these people are enrolled. Second, Nevada has the highest share of those ineligible for coverage due to immigration status. If we truly want to expand insurance coverage, we as a State should ensure all those who would otherwise lack coverage are eligible for Medicaid. President Joe Biden is proposing a permanent extension of expanded pre-age subsidies available for private insurance in the public marketplace. The idea is to build in the ACA. We encourage you to support President Biden's approach to make health care more affordable. We hope this body will consider expanding coverage through enhanced enrollment efforts and coverage to otherwise ineligible Nevadans.

MARY BETH SEWALD (Vegas Chamber):
We oppose S.B. 420. We share the goal that every Nevadan should have access to affordable health coverage. This bill will not reduce healthcare costs, rather it will shift costs to other Nevadans. Mandating a State insurance plan to offer a rate 5 percent lower than commercial rates is another cost shift. Evidence from other states that have implemented similar programs confirm that insurance costs went up. An actuarial study should be conducted before this bill is passed. There are also concerns about requiring healthcare providers to accept government-set reimbursement rates. It will reduce providers to accept Medicaid, push doctors out and make it more difficult to find physicians. Let us expand on insurance coverage we already have, enroll more people into Medicaid, the State Exchange and Association healthcare plans. There are at least 30 percent of uninsured Nevadans who are Medicaid eligible. Enrolling them in Medicaid now would automatically reduce the uninsured population by more than 100,000 lives. Raising reimbursement rates and addressing shortages of healthcare providers are also solutions that will help cover more Nevadans.

PETER GUZMAN (Latin Chamber of Commerce):
We oppose S.B. 420. This bill is risky, overreaching and reckless legislation that will result in an increased cost of care to Nevadans who enrolled within employer-provided healthcare plans. This bill could reduce competition in the marketplace as well as consumer choice. Unfortunately, this is done with well intention, but there are unintended consequences for which people will pay dearly.

MARCOS LOPEZ (Americans for Prosperity Nevada):
We oppose S.B. 420. Our written testimony has been submitted (Exhibit V).

CYRUS HOJJATY:
I am in neutral on S.B. 420. I am confident this bill will reduce costs and bring competition to insurance plans. I would like more evidence on where similar ideas have been tried. I am concerned about immigration status and that an unequal situation could be created by noncitizens taking more than they actually paid back. The ACA has not lowered premiums; it has raised premiums. I would like to learn from other countries, particularly Europe, where they pay far less per capita for health insurance than we do here.

It is not just health insurance that concerns me. I want to make sure this bill understands why people are getting so sick. We have alarmingly high obesity rates. We need to understand what is causing these types of illnesses.

NANCY BOWEN (Nevada Primary Care Association):
We are neutral on S.B. 420. We support affordable quality health care for all Nevadans, and a Public Option could be an important tool to expand access to underserved communities. We appreciate that S.B. 420 establishes payment for our health centers on par with what they receive from Medicare or Medicaid. We support the expansion of Medicaid coverage to pregnant women above the current income eligibility level, and for doulas and community health workers to extend the ability of our health centers to provide care outside the clinic. We have long advocated for the expansion of managed care so our rural patients can access specialists in rural population centers.

We have concerns about the effects of S.B. 420 on the future of managed care in the State and on the viability of our hospitals and other referral partners. We have heard the concerns from these essential community partners, and we are

withholding our support until we understand more about the likely impact of this bill on them.

AMBER FEDERIZO, APRN, FNP-BC (Hemostasis and Thrombosis Center of Nevada):
We are neutral on S.B. 420. Managed Care Organizations (MCOs) in Nevada that cover Medicare recipients are not required to credential providers even if the provider is willing or if the provider is the only federally-recognized center of excellence for the treatment of bleeding disorders and clotting disorders in this State. For example, Smart Choice, Medicaid and Employee Retirement Income Security Act plans, such as the Culinary plan, continue to deny access to their members to the State's only federally-recognized hemophilia treatment center in Nevada, and their members continue to pay cash to access care. We have provided research to both of these payers that this specialized care delivered as a Health Resources and Services Administration program reduces mortality and morbidity by 40 percent at a cost savings. This data was published in a peer-review journal and has not made a difference.

This bill does not require MCOs providing care to Medicaid recipients or those who will be offering a Public Option a contract in good faith with all the providers who already contract for fee-for-service Medicaid. We have been willing to accept any contract made in good faith. We have been denied by some insurance companies stating they have an adequate network despite having no federally-recognized hemophilia treatment in their network. We look forward to the evolution of this bill to better address network adequacies.

SENATOR CANNIZZARO:
We have looked at and studied the Medicare buy-in since before the 2017 Session, and there were issues with that. There was additional analysis done in the last Legislative Session and proposed legislation which was not quite hitting the mark. We passed S.C.R. No. 10 of the 80th Session and did an actuarial analysis during the Interim that came out with data. We know who the people are who are uninsured, and now the question is how to get them insured. That is exactly what we are trying to do.

This bill, in contrast with bills in other states, provides for lead time for DHHS to put together a program that will work, and it provides the time to study the possibilities in the Interim and provides a procurement period that would take into consideration all of those points that have been made. We are past the point as to why we should not support S.B. 420 and we should continue to look

at this or figure out who these people are or figure out how we should study this more. We know who they are and I have talked to them at their doors. I would encourage you to knock on ten doors in your neighborhood and let me know how many people talk to you about the cost of health care. I am willing to state it is a fair number.

Cost shifts have come up a lot during testimony. When we are talking about the individuals who are qualifying for these of plans, most of them are uncompensated care right now. Those cost shifts are happening in the market right now. Yes, there will be cost shifts; we are dealing with health care. There are costs associated with multinational employer plans that are the best plans you can have that are paying premiums or your employer is helping you pay those premiums and providing that health care. You cannot say because there are costs associated with it we should do nothing to help these people who do not have care or accessing it. When we talk about cost shifts, which is the current reality of our system, there is money that is being made in the healthcare space. When we talk about cost shifts, what are we talking about? We are talking about people who are not accessing that care because they do not have health insurance. That is what S.B. 420 is getting at.

It is perplexing to me that the biggest argument is what we really should be doing is expanding people on Medicaid. To say that if we expanded people on Medicaid and eligibility for Medicaid and providers and insurers were provided those Medicaid rates, that this would be a better alternative to putting someone on a health plan where they are paying premiums, and if this bill passes as is, that floor is Medicare reimbursement. Adding people to Medicaid and saying they would take more Medicaid patients and get reimbursed at a Medicaid rate is what we should do instead of implementing health insurance, and in the same breath making the comment and argument about cost shifting, is perplexing because Medicaid rates are low. If we are talking about implementing something where you are getting reimbursed higher than Medicaid rates, I struggle to understand why that is a reason to oppose this bill.

A comment was made that the government is setting the Medicare rates and this is only Medicare compensation—this is not what S.B. 420 is. One of the concerns we had through the Interim and discussions with stakeholders was they would end up with Medicaid rates, so we tried to put a floor into the bill to provide reassurance they would not be getting the Medicaid rates. What this intends to do, and with the ability of the State's purchasing power and apply for

waivers and subsidies, the health insurers should be negotiating with providers for those rates knowing that is the floor. This is going to incentivize them to provide those value-based plans that are showing real health outcomes. This is not the government setting rates. It is not a State-run program being subsidized by the taxpayers. This is allowing the State to get creative and innovative. We cannot study this anymore. That time has come and gone. We have the studies and the data. Even so, provisions in this bill allow for actuarial analysis and the 1332 waiver will require that. If this gives people more assurance, I am happy to negotiate on the terms of the bill to ensure that does happen as this is our intent.

We have talked about the percentages of the premiums. In Colorado, after negotiations, there was an 18 percent reduction in premiums starting in 2022. We are giving lead time. We are at 15 percent over 4 years after the plan is enacted. That is worth consideration. With respect to provider participation requirements, those have worked in Minnesota. We have data that does work, and this is the right thing to do and something that will provide that additional piece. If the idea that there were enough choices and we do not need any more choices, then Nevada would not be seventh in the Nation for uninsured at a persistently high rate where we are the only State in that seven that did elect to do Medicaid expansion. That has to tell you a lot about whether there is an issue here, whether there are sufficient choices and what we should be doing about it. This does not affect employer-based health plans or association health plans. We are talking about how to provide affordable and accessible health care to Nevadans when we know there is an issue and this is a step in the right direction. We are still working with some people on amendments, and we will continue that work.

CHAIR RATTI:
I will now close public testimony on S.B. 420 and open the hearing on A.B. 205.

ASSEMBLY BILL 205 (1st Reprint): Makes various changes concerning the acquisition, possession, provision or administration of auto-injectable epinephrine and opioid antagonists by schools. (BDR 40-98)

ASSEMBLYWOMAN LESLEY E. COHEN (Assembly District No. 29):
I will present A.B. 205 and have submitted my written remarks (Exhibit W). Trey Delap from Group Six Partners will be presenting with me and has worked in behavioral health, addiction and recovery policy for years.

TREY DELAP (Director, Group Six Partners LLC):
I will provide background data for the Committee's consideration. The reason this is relevant at the moment is because there has been a substantial increase in overdose deaths in 2020, especially for young people under 17 years of age. All overdose deaths recorded in 2020 were unintentional opioid overdose deaths attributable to fentanyl. Overall, the State saw a 29 percent increase in the deaths by overdose of opioids in the adult population. Synthetic opioids account for two times the overdose deaths of heroin, and teen deaths are on the rise. The number of young people who die by overdose of synthetic opioids equals double the peak year of the opioid epidemic in 2011. The sum of opioid overdose deaths in 2020 alone in the 8- to 17-year-old population was one-third of the total number of the same population in the previous decade and a significant spike. Prevalence of opioids among young people is relatively high. Young people have access and are using illicit drugs. Approximately 35 percent of young people in Grades 8, 10 and 12 have used illicit drugs during their lifetimes. Of those, 27 percent have used drugs in the preceding year. An example is if youths reported they had used illicit drugs in the eighth grade, this means sometime between seventh and eighth grade they have used illicit drugs.

This gives us pause to look back at what the opioid epidemic has been and how it has evolved. In 1995, Oxycontin hit the market and the Fifth Vital Sign campaign urged healthcare providers to take pain as seriously as other vital signs. I was a junior in high school working in a hospital, and this was the change that was going on there. Also in 1995, the State Board of Pharmacy activated the Prescription Monitoring Program (PMP), one of the first in the Country. Between 1995 and 2015, an opioid epidemic erupted and the Nevada Legislature enacted the Good Samaritan Drug Overdose Act in 2015. The first thing the Nevada Legislature did in response to the opioid epidemic was to create a harm reduction and safe harbor encouragement for people to intercede when opioid overdose was occurring. In 2017, a comprehensive overhaul of prescribing occurred and the PMP became mandatory. Looking at opioids globally, the U.S. is the largest consumer of morphine, counting for 40 percent of the world's consumption of morphine. This is an indication we have a future

that will include opioids, and this is part of the connection we are looking at for schools.

The U.S. consumes 20 percent of the world's fentanyl. The public sentiment, about 51 percent of the population, regard the opioid epidemic as a serious problem. Sixty-seven percent of the public perceive there is lack of access or funding for treatment or mitigating services with regard to the opioid epidemic. Fifty-six percent of people agree that the opioid epidemic negatively impacted local economies and job growth. The number of overdose deaths from heroin between 1999 and 2019 dropped. Approximately 20 percent fewer deaths were from heroin, but those deaths were picked up by fentanyl overdoses which was 29 percent.

With regard to the specific impact on children, 2.2 million children are directly affected by parental opioid use or their own use. Approximately 2 million young people were affected primarily by parental use. They were either living with a parent with opioid use disorder, had lost a parent to an opioid-related death, had a parent in prison or jail because of opioids, or had been removed from their home due to an opioid-related issue. An additional 170,000 children had opioid-use disorder themselves or had accidentally ingested opioids. Young people have overdosed on opioids that were in the house. Of the 2.2 million children directly affected by the opioid epidemic, 41 percent are ages 5 or younger, 32 percent are between the ages of 6 and 11, and 27 percent are between the ages of 12 and 17.

Things have changed. In 2017, the PMP became mandatory. This was designed to target the first phase of the opioid epidemic which was overprescribing, and we have seen a drop in opioid prescriptions. The average daily morphine milligram equivalent per opioid prescription has decreased as well. The raw number of prescriptions have gone down, and the quantity and amount of potency have dropped.

Innovations, such as the online *JAVA* House of Medicine newsletter response to the opioid epidemic, is coprescribing naloxone and Narcan. The U.S. Department of Veterans Affairs (VA) has been doing this for a while. The VA writes prescriptions for opioids, Narcan and naloxone and will educate others in the household on its use. The top three prescribers by category writing prescriptions for naloxone are psychiatry, addiction medicine and pediatricians, which account for the third largest group of prescribers writing for naloxone. The

American Academy of Pediatrics (AAP) has identified this as part of the mitigation of harm and awareness of the impact of the opioid epidemic on children. The AAP has been engaging, analyzing and monitoring the impact of children going into the foster care system. The AAP published a number of articles about families affected by parental substance abuse. This connects to the availability of opioids in the house and children able to get access to them and also the strong market and demand.

The profitability of synthetic fentanyl is tremendous. If a drug dealer has one kilogram of the source material, the dealer has two choices, make a kilogram of heroin or 20 kilograms of fentanyl. A kilogram of heroin will yield $80,000 in revenue; 20 kilograms of synthetic fentanyl opioids will yield $1.6 million in revenue. There is demand in the prevalence, use and awareness and certainly a profit motive.

Nevada policy makers have seen this spike and are doing what they can with public education. Following the last Session, the Nevada Institute for Children's Research and Policy prepared a policy brief specifically addressing the availability of naloxone in public schools. All this information suggests we should do something. The opioid epidemic has been an all-hands-on-deck response. This is an important piece of legislation.

ASSEMBLYWOMAN COHEN:
The Health Department has reported the age range of use of opioids is falling to such an extent that the average age has fallen from 49 years old to 29 years old. The federal government, in an effort to stop the health crisis, has been giving out opioid antagonists to prevent overdose without qualification. The Nevada Osteopathic Medical Association, National Association of School Nurses, and Substance Abuse and Mental Health Service Administration of the U.S. Department of Health and Human Services have confirmed that Narcan is safe and can be given without harm. According to the Nevada Osteopathic Medical Association,

> Naloxone (Narcan) is a safe and effective drug for the treatment of suspected opioid overdoses … the drug is administered to a person who is not experiencing a narcotic overdose but other medical event, it will not cause harm.

Someone overdosing from an opioid will die without intervention. Often lives are lost waiting for the ambulance to arrive. The naloxone administered while waiting for the ambulance saves lives. It is safe and more benign than epinephrine and does not harm someone who is not overdosing.

At different times, naloxone kits have been distributed to different people in the building. These were purchased with money from the federal government. The Nevada State Opioid Response reports the distribution of 13,185 kits and reversals from the use of naloxone for 932 Nevadans who would have died if they did not receive naloxone. The kit I have from Partnership Carson City contains gloves, information on opioids, instructions and a couple of naloxone sprays. You do not have to have training to use the kit, you simply read the pamphlet and can save someone's life. Organizations such as Partnership Carson City provide free monthly training for approximately 30 to 60 minutes. The administration of naloxone itself takes about 10 minutes. The training also stresses calling for medical help.

This bill is enabling language and no mandate.

CHAIR RATTI:
I can see this bill is built on the work of former Nevada Senator Debbie Smith on the epinephrine legislation with a high level of confidence that this can save lives.

ASSEMBLYWOMAN COHEN:
This bill was also built on the work of Assemblyman John Hambrick in the last Session. The bill was not quite there at the end of the Session.

CHAIR RATTI:
I will now close the hearing on A.B. 205 and open the hearing on A.B. 96.

ASSEMBLY BILL 96 (1st Reprint): Revises provisions relating to emergency response employees. (BDR 40-96)

ASSEMBLYWOMAN LESLEY E. COHEN (ASSEMBLY DISTRICT NO. 29):
I am presenting A.B. 96 which came from my interest in peer support for first responders. I have submitted my prepared remarks (Exhibit X).

CHAIR RATTI:
We are seeing many bills this Session which have the language "within the limits of available money" or "as money is available." Is there anything we are doing out of the Nevada Office of Suicide Prevention or any of the behavioral health initiatives or anything along those lines which align with this bill? Are there other efforts the Committee should know about in terms of making sure our emergency responders have the behavioral support they need?

MARGOT CHAPPEL (Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services):
We are looking at the fees for license for our emergency medical services (EMS) folks, and the advisory committee will be given an opportunity to fund and increase those fees.

CHAIR RATTI:
There is a peer support line that is operating for EMS providers today?

MS. CHAPPEL:
Yes.

CHAIR RATTI:
The idea then is that the framework is built and there is someone already doing it, but if money could be found, we could expand on those efforts.

ASSEMBLYWOMAN COHEN:
There is a program in northern Nevada working on a program for southern Nevada. This program is about getting information out there. There is also a data collection piece to this bill to gather data about suicide attempts, and suicide and first responders.

CHAIR RATTI:
The data collection is also to the extent money is available. Hopefully, we can find a path to do meaningful work.

ASSEMBLYWOMAN COHEN:
I agree. There are also the pieces about getting the information out and having a place for the information to flow through. It is not just coming from

a not-for-profit, but the State is providing that information to people who might be looking for it.

ANTHONY YARBROUGH (Veterans of Foreign Wars):
We support A.B. 96. Many first responders who are law enforcement and firefighters come from the ranks of our military and veterans. For that reason, we recognize one of the biggest challenges we face today is a high rate of suicide among our members. There is a different world for an average civilian who has to deal with trauma, death and carnage, and the difficulty of actively performing their jobs on a daily basis. We recognize this could impact veterans, and we want to support that.

Suicide prevention is our No. 1 goal, and we recognize peer support is a proven foundation of success. It helps to identify the causation as well as the prevention. This is a good start since we have not been able to stop suicide—all we can do is try to prevent it. The peer support volunteers go through a combination of training, exercise, counseling and peer advocacy. Please support this bill.

SENATOR SPEARMAN:
The VA has trained peer-to-peer specialists to support veterans. To the extent money is available, we may be able to collaborate with the VA, and if not at the federal level, we should probably be able to do something with the Nevada Department of Veterans Services.

CHAIR RATTI:
I will now close the hearing on A.B. 96. The hearing on A.B. 217 is now open.

ASSEMBLY BILL 217: Requires training for unlicensed caregivers at certain facilities. (BDR 40-454)

ASSEMBLYWOMAN LESLEY E. COHEN (Assembly District No. 29):
I am presenting A.B. 217 which came out of the Interim 2019-2020 Legislative Committee on Health Care. I have submitted my written remarks (Exhibit Y).

MS. CHAPPEL:
During the pandemic, we witnessed quite a few citations in facilities where unlicensed caregivers worked. We saw people working in the kitchen who

prepared food without a mask and other violations performed by untrained, unlicensed caregivers.

CHAIR RATTI:
Many of us were on the Interim Committee that asked for this bill to be moved forward.

MR. GOLD:
AARP Nevada supports A.B. 217. Sometimes the State is good for these unlicensed personnel. These employees are fingerprinted, background checked and tuberculosis tested, but sometimes that is all that is required. I think it is important when people bring a family member, or they themselves go to facilities which have unlicensed staff with caretaking responsibilities, that the employees know what they are doing. A lot of these facilities, such as homes for individual residential care, have overnight staff, kitchen staff and caregivers. We are not sure how they are trained and tested. The licensed staff have established training regimens, which is great. This bill is the best way to ensure unlicensed personnel are trained and tested properly. We have to protect the most vulnerable people who live in or get treatment at these facilities.

SENATOR HARDY:
When this bill passes, or even before it passes, these facilities will take to heart what our intention is and not wait until January 1, 2022, to have regulations to force them to implement training for their unlicensed personnel.

ASSEMBLYWOMAN COHEN:
This is a modicum of regulations for training of people who are dealing with our most vulnerable population, whether it is infectious disease control or helping get someone on a bus without hurting the individual.

CHAIR RATTI:
I will now close the hearing on A.B. 217. Seeing no further testimony, this meeting is adjourned at 6:50 p.m.

RESPECTFULLY SUBMITTED:

Norma Mallett,
Committee Secretary

APPROVED BY:

Senator Julia Ratti, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Begins on Page**	**Witness / Entity**	**Description**
	A	1		Agenda
S.B. 420	B	1	Senator Nicole Cannizzaro	Bill Presentation
S.B. 420	C	1	Senator Nicole Cannizzaro	Proposed Conceptual Amendment
S.B. 420	D	1	Katie Keith / Georgetown University	Bill Testimony
S.B. 420	E	1	Katie Keith / Georgetown University	Supplemental Documents
S.B. 420	F	1	Dr. Randi Lampert	Support Statement
S.B. 420	G	1	Annette Magnus-Marquart / Battle Born Progress	Support Statement
S.B. 420	H	1	Priscilla Maloney / American Federation of State, County and Municipal Employees, Retirees Nevada Chapter 4041	Support Statement
S.B. 420	I	1	Sarah Adler / Nevada Advanced Practice Nurses Association	Support Statement
S.B. 420	J	1	Sarah Adler / Nevada Advanced Practice Nurses Association	Proposed Amendment
S.B. 420	K	1	Eric Jeng / One APIA Nevada	Support Statement
S.B. 420	L	1	Eric Jeng / One APIA Nevada	Support Statement
S.B. 420	M	1	Christine Saunders / Progressive Leadership Alliance of Nevada	Support Statement

S.B. 420	N	1	Quentin Savwoir / Make It Work Nevada	Support Statement
S.B. 420	O	1	Barry Gold / AARP	Support Statement
S.B. 420	P	1	Philip Malinas	Support Statement
S.B. 420	Q	1	James Wadhams / Nevada Hospital Association	Opposition Statement
S.B. 420	R	1	Jaron Hildebrand / Nevada State Medical Association	Opposition Statement
S.B. 420	S	1	Jaron Hildebrand / Nevada State Medical Association	Opposition Supporting Document
S.B. 420	T	1	Susan Fisher / Nevada State Society of Anesthesiologists	Opposition Statement
S.B. 420	U	1	Scott Muelrath / Henderson Chamber of Commerce	Opposition Statement
A.B. 420	V	1	Marcos Lopez / Americans For Prosperity Nevada	Opposition Statement
A.B. 205	W	1	Assemblywoman Lesley E. Cohen	Presentation
A.B. 96	X	1	Assemblywoman Lesley E. Cohen	Presentation
A.B. 217	Y	1	Assemblywoman Lesley E. Cohen	Presentation