MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON COMMERCE AND LABOR

Eighty-Third Session
April 23, 2025

The Committee on Commerce and Labor was called to order by Chair Elaine H. Marzola at 12:03 p.m. on Wednesday, April 23, 2025, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 1 of the Nevada Legislature Hearing Rooms, 7120 Amigo Street, Las Vegas, Nevada. Copies of the minutes, including the Agenda [Exhibit A], the Attendance Roster [Exhibit B], and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/83rd2025.

COMMITTEE MEMBERS PRESENT:

Assemblymember Elaine H. Marzola, Chair
Assemblymember Sandra Jauregui, Vice Chair
Assemblymember Natha C. Anderson
Assemblymember Max E. Carter II
Assemblymember Lisa K. Cole
Assemblymember Melissa R. Hardy
Assemblymember Heidi Kasama
Assemblymember Brittney M. Miller
Assemblymember Daniele Monroe-Moreno
Assemblymember PK O'Neill
Assemblymember Erica P. Roth
Assemblymember Selena Torres-Fossett
Assemblymember Toby Yurek

COMMITTEE MEMBERS ABSENT:

Assemblymember Steve Yeager (excused)

GUEST LEGISLATORS PRESENT:

Senator Roberta Lange, Senate District No. 7

STAFF MEMBERS PRESENT:

Marjorie Thomas, Committee Policy Analyst
Sam Quast, Committee Counsel
Daniel Peinado, Committee Counsel
Logan B. Service, Committee Manager
Julie Axelson, Committee Secretary
George Whalen, Committee Assistant

OTHERS PRESENT:

Vishisht Mehta, M.D., Director, Interventional Pulmonology, Lung Center of Nevada; and Chair of Pulmonology, MountainView Hospital, Las Vegas, Nevada
Sasha Sutcliffe-Stephenson, representing Nevada Oncology Society
Chivonne Harrigal, representing Nevada Cancer Coalition
Cari Herington, Executive Director, Nevada Cancer Coalition
Jacqueline L. Nguyen, Policy Director, Nevada State Medical Association
Annie Millard, representing Nevada Cancer Coalition
Jennifer Atlas, Government Relations Director, American Cancer Society Cancer Action Network
JoAnna Strother, Senior Director of Advocacy, American Lung Association
Adam Plain, Insurance Regulation Liaison, Division of Insurance, Department of Business and Industry
Shelly Capurro, representing Nevada Association of Health Plans
Pamela L. Zielske, Western Region Advocacy Director, Dialysis Patient Citizens
Charles Lizer, Private Citizen, Winnemucca, Nevada
Dan Musgrove, representing Nevada Donor Network
Paige Barnes, representing Fresenius Medical Care
Dean Marcoccia, State and Local Government Affairs Lead-West, Public Policy and Government Affairs, Biogen
Jimmy Lau, representing DaVita
Ernesto Molmenti, Private Citizen, Reno, Nevada
Diana Arevalo, Managing Director, Advocacy, ALS Association
Josie Gamez, Associate Director of State Policy and Advocacy, American Kidney Fund
Jim DeGraffenreid, Private Citizen, Minden, Nevada
Tray Abney, representing America's Health Insurance Plans
Jason Casey, Private Citizen, Sparks, Nevada

Chair Marzola:
[Roll was called, and Committee rules and protocols were discussed.] Welcome to everyone who is here with us in Carson City, in Las Vegas, and tuning in over the Internet. Today, we will hear three bills: Senate Bill 246, Senate Bill 292, and Senate Bill 387 (1st Reprint). I will not be taking those in order. With that, we will move to our first agenda item. I will now

open the hearing on Senate Bill 387 (1st Reprint). This measure revises provisions relating to the prevention and early detection of lung cancer. Welcome, Senator Lange. You may begin when you are ready.

Senate Bill 387 (1st Reprint): Revises provisions relating to the prevention and early detection of lung cancer. (BDR 57-68)

Senator Roberta Lange, Senate District No. 7:
Thank you so much for taking these bills out of order, as the doctor needs to get back to his patients. Today, I am going to present Senate Bill 387 (1st Reprint), which is a critical piece of legislation to improve the prevention and early detection of lung cancer. With us on Zoom today is Dr. Mehta, who is the director of interventional pulmonology at the Lung Center of Nevada and is also the department chair of pulmonology at MountainView Hospital, both in Las Vegas.

Lung cancer remains a significant health concern in the United States with an estimated 226,650 new cases expected in 2025, according to the American Cancer Society. It is the second most common cancer, both in men and women and, tragically, is the leading cause of cancer deaths. According to the Centers for Disease Control and Prevention (CDC), early detection of lung cancer is crucial for improving survival rates. When lung cancer is found at a localized early stage before cancer cells spread within and around the lung and other parts of the body, treatment is more effective and there are more treatment options available. Research shows patients with early-stage lung cancer have a high five-year survival rate, exceeding 75 percent, while the survival rate for stage 4 lung cancer is less than 10 percent in the same span.

This brings us to S.B. 387 (R1). Requiring health insurers to cover lung cancer screenings improves early detection and treatment, similar to prostate cancer or colon cancer screenings we already require in statutes. Medicare, for instance, already covers annual lung cancer screening for qualifying high-risk individuals. At this point, I would like to hand it over to Dr. Mehta for additional background information.

Vishisht Mehta, M.D., Director, Interventional Pulmonology, Lung Center of Nevada; and Chair of Pulmonology, MountainView Hospital, Las Vegas, Nevada:
I strongly support this bill because it has the potential to save lives by increasing access to lung cancer screening. Lung cancer is the leading cause of cancer-related death in the United States and Nevada for men and women. It is curable if caught early. The two-year survival for stage 1A1, which is the earliest stage, is 97 percent, but for stage 4B, the latest stage, it is 10 percent. Unfortunately, most cases are diagnosed too late, and options are limited. The best tool we have in this regard is low-dose CT [computed tomography] screening. It has been proven to reduce lung cancer-related mortality by up to 20 percent in high-risk patients. It helps us identify cancer early. The scan is quick, painless, and requires no needles and no contrast dye.

This bill will bring greater awareness to lung cancer, ensuring more patients and providers understand the importance of screening and improve access. As a physician, I see firsthand the devastating impact of late-stage lung cancer. I have also seen the power and benefits of early detection: patients whose cancers are found early, treated effectively, and whose lives were saved because of access to screening. I urge your support, and I am happy to answer questions based on my professional capacity related to the medicine and science of this process.

Senator Lange:
With that, we will answer any questions you might have.

Chair Marzola:
Are you able to go through the bill for us?

Senator Lange:
We made an amendment in the Senate. I am going to go over that amendment. I think you have the reprinted version, but I want to be clear about the process we went through in the Senate. We had a conceptual amendment. The amendment removed the new requirements concerning lung cancer screening. We removed sections 1, 3, 4, 6, and 8 through 11. Instead, it requires commercial health insurers with policies of health insurance or health plans provide coverage for lung cancer treatment and to also provide lung cancer screenings in accordance with the guidelines for such screenings published by the American Cancer Society. Other guidelines are reports concerning lung cancer screenings from nationally recognized professional organizations, which include current or prevailing supporting scientific data. This is consistent with existing requirements in state law concerning colorectal and prostate cancer screenings; for example, *Nevada Revised Statutes* (NRS) Chapter 689B.

Section 5 refers to section 4, which I proposed to amend and, therefore, section 5 will have the same requirements as set forth in the conceptual amendment. Sections 2 through 10 authorize the Commissioner of Insurance to require certain policies issued by domestic insurers for covered individuals in another state include the amended language coverage requirements and suspend or revoke the certificate of authority issued to a health maintenance organization or certain other insurers who fail to comply with these screening requirements.

Further, the amendment to deleted section 13, which would have required the Governor to annually proclaim lung cancer awareness month and lung cancer screening day. It replaced references to the United States Preventive Services Task Force in section 17. It now requires the Department of Health and Human Services to conduct a study to determine if lung cancer screening criteria, adopted by the American Cancer Society, creates inequities in access to screening for lung cancer based on sex or gender identity or expression, and submit a report on its conclusions and any recommendations for expanded criteria to increase access to screening for lung cancer to the Joint Interim Standing Committee on Health and Human Services. With that, we will answer questions.

Chair Marzola:
My father died of lung cancer, and I saw what he went through, what happened, and it was not caught soon enough. I will go to Committee members. Are there any questions? [There were none.] That is what happens when you have a very good piece of legislation. We will move to testimony in support of S.B. 387 (R1). Is there anyone wishing to testify?

Sasha Sutcliffe-Stephenson, representing Nevada Oncology Society:
We are fully supportive of this bill.

Chivonne Harrigal, representing Nevada Cancer Coalition:
I am a local radiologist who specializes in cancer imaging. I have lived and worked in Nevada for more than ten years, and I am in support of this bill. In many people, we find lung cancer when it is very advanced and at a very late stage, after it has already spread to the brain, to the bones, or to the abdomen. Fortunately, lung cancer screening is a tool that has been found to save lives through earlier detection, giving people a better chance to survive.

One of the barriers many people face in getting this test is their insurance companies do not cover it or they require high copays. Medicare already covers this test without a copay, and these insurance companies should do the same. Early detection saves lives from cancer. You have the ability to save many lives from cancer by passing this bill, S.B. 387 (R1). You would also be helping thousands of families in Nevada by reducing the financial burden that comes with lung cancer screening, a test insurance companies should already be covering.

Cari Herington, Executive Director, Nevada Cancer Coalition:
We are your nonprofit partnership of both private and public health care providers across the state. We are working together to reduce the burden of cancer. As you can imagine, reducing the burden of late-stage lung cancer is a top priority for us. A huge thank you to Senator Lange for bringing this bill forward, and her steadfast dedication to ensuring access to cancer screenings for all Nevadans. We concur with everything shared so far, and we strongly support S.B. 387 (R1). [Submitted testimony in support, Exhibit C.]

Jacqueline L. Nguyen, Policy Director, Nevada State Medical Association:
The Nevada State Medical Association is the oldest and largest organization representing physicians in our state. Those ages 55 to 80 with a history of smoking or other risk factors are at a higher risk to develop lung cancer. Lung cancer is usually discovered in later stages because symptoms do not present in earlier stages. Early detection through screening offers more options for medical intervention and significantly increases chances of successful treatment. Therefore, our physician members are in strong support of S.B. 387 (R1).

Annie Millard, representing Nevada Cancer Coalition:
I am a board member of the Nevada Cancer Coalition. I am also a retired nurse with 12 years in oncology. I have seen so many devastating deaths from lung cancer that was caught too late and so many successes from seeing lung cancer that was caught early. Many survived that five years that was presented earlier. I encourage you to please pass this bill, which will save lives.

Jennifer Atlas, Government Relations Director, American Cancer Society Cancer Action Network:
The American Cancer Society Cancer Action Network is the nonpartisan, nonprofit advocacy affiliate of the American Cancer Society (ACS). We advocate for evidence-based public policies to reduce the cancer burden for everyone. The American Cancer Society Cancer Action Network advocates for all insurance plans to provide a comprehensive benefit for lung cancer screening, including all follow-up testing according to recommended guidelines, without cost sharing or other barriers. We would like to thank the sponsor for adopting ACS guidelines.

JoAnna Strother, Senior Director of Advocacy, American Lung Association:
The American Lung Association supports S.B. 387 (R1). This bill aims to reduce barriers to lung cancer screening and diagnosis and addresses potential inequities in excess. This bill would add lung cancer screening to low-dose CT to Nevada statutes to align lung cancer screening coverage with coverage for other screenable cancers. Cancer continues to be a significant burden on the people in our state and across the U.S. About every two minutes, someone in the U.S. is diagnosed with lung cancer, and every day lung cancer takes the lives of more than 361 people. Lung cancer is the leading cause of cancer death here in Nevada and across the U.S.

Detecting lung cancer in early stages versus late stages is often the difference between life and death. Screening for lung cancer with low-dose CT scans among those at high risk can reduce the lung cancer death rate by up to 20 percent by detecting tumors at an earlier stage, when they are more likely to be curable. Currently, screening rates are very low among those at high risk. If lung cancer is found before it spreads, the likelihood of surviving five years or more improves to nearly 64 percent. With that, we would like to thank the sponsor and thank you, Chair and Committee, for hearing this bill.

[Letters in support, Exhibit D, were submitted but not discussed and will become part of the record.]

Chair Marzola:
Is there anyone else wishing to testify in support? [There was no one.] We will move to testimony in opposition to S.B. 387 (R1). Is there anyone wishing to testify in opposition? [There was no one.] We will move to neutral testimony. Is there anyone wishing to testify in neutral?

Adam Plain, Insurance Regulation Liaison, Division of Insurance, Department of Business and Industry:
The Division of Insurance is neutral on S.B. 387 (R1). We evaluate the mandate as providing the same sorts of benefits as the U.S. Preventive Services Task Force Grade B recommendation for lung cancer screening. Meaning S.B. 387 (R1) would not trigger federal defrayal provisions as currently constituted. I did provide some written testimony [Exhibit E].

I also note evaluation is potentially contingent upon the outcome of the federal court case, *Braidwood Management Inc., et al v. Robert F. Kennedy Jr., et al*, formally docketed as *Braidwood v. Becerra*. That court case was heard on Monday before the U.S. Supreme Court. If you are the type who likes to look at professional or amateur Supreme Court blogs and figure out what is going on, you may do so and figure out where that court case may be headed. The gist of it is, should the plaintiffs in *Braidwood* prevail and the U.S. Preventive Services Task Force provisions be struck down as unconstitutional, then S.B. 387 (R1) would likely be determined to be a mandate in excess of essential health benefits and trigger defrayal. If the defendants are successful, then the U.S. Preventive Services Task Force recommendation stays in place, and it would not trigger defrayal. I would be happy to answer any questions the Committee may have.

Chair Marzola:
Committee members, are there any questions? [There were none.] I appreciate the update. Is there anyone else wishing to testify in neutral? [There was no one.] Senator Lange, would you like to give any closing remarks? [Senator Lange indicated no.] I will close the hearing on S.B. 387 (R1). I will now open the hearing on Senate Bill 246. This measure revises provisions relating to health insurance coverage for gynecological or obstetrical services.

Senate Bill 246: Revises provisions relating to health insurance coverage for gynecological or obstetrical services. (BDR 57-205)

Senator Roberta Lange, Senate District No. 7:
I have the honor today to present Senate Bill 246. This legislation increases access to gynecological and obstetrical services for women, removing unnecessary barriers set forth by their health insurance plans. I will give you a little bit of background information. While prior authorization aims to reduce unnecessary care, it may limit or delay medically necessary care. Health insurance routinely uses prior authorization or referrals which can create significant barriers to timely care.

This is particularly concerning in fields such as gynecological oncology where delays can impact survival rates. Studies show prior authorization can result in an average delay of two weeks for cancer care with over one quarter of patients experiencing such delays during the treatment. In another large cohort study on the use of prior authorization in gynecological oncology care, researchers found insurance in racial disparities occurred in prior authorization. Specifically, the findings show female patients with Medicare Advantage plans had a 76 percent increased risk of experiencing prior authorization, and female patients of Asian descent had a 60 percent increased risk.

Further, the prior authorization process can be opaque and unpredictable, complicating decision making for both patients and physicians. Senate Bill 246 seeks to address these issues by expanding the requirements for direct access to gynecological and obstetrical services (OB/GYN).

Chair Marzola, with your permission, I will briefly go through the bill. In Nevada, we have statutes requiring certain public and private health insurers to directly authorize gynecological or obstetrical services with prior authorization or referral from a primary care physician. Sections 1 through 6, 8, and 9 additionally apply these requirements to health plans that provide medical care to certain private sector employees of small employers and their dependents—benefit contracts issued by fraternal benefit societies, managed care organizations, the Public Employees' Benefits Program, and Nevada Medicaid. Section 7 makes a conforming change, and section 10 makes the bill effective on January 1, 2026.

By eliminating the need for prior authorization or referrals for these critical services, we can improve health care outcomes and reduce disparities in care. Therefore, S.B. 246 is an important step toward expanding access to timely and equitable care for all women in our state. I might add, if you have a PPO [preferred provider organization] insurance plan, you do not have to get a referral from your primary care doctor to go to a gynecologist. If you have HMO [health maintenance organization], and those insurance policies are generally for people who cannot afford a PPO, you have to go to your primary care doctor to get a referral to go to a gynecologist; therefore, costing you more money upfront. This bill would make that go away so no one needs a referral. You can go straight to the gynecologist. This completes my presentation, and I am happy to answer any questions.

Chair Marzola:
You actually answered my question regarding PPO and HMO and how that would work. Committee members, are there any questions?

Assemblymember Kasama:
I like this. This is also good. I noticed in the Senate hearing there was concern a woman cannot designate their OB/GYN as a primary care physician. It looked like there was maybe some talk about fixing that, and I see it is still in section 2, subsection 2. I am wondering if you had found out you could not do that or what you could share on that.

Senator Lange:
That was a question, and I should have brought that up. There are women who want their gynecologist to be their primary care doctor. I have talked to some stakeholder groups, and they would like that to be changed. I have discussed it with the Senate caucus and, frankly, I do not have the votes to be able to change the language because people think it is bad policy, and you should keep your primary care doctor to deal with primary care situations. I would love it, Chair Marzola, if you could ask Legal, because what I am concerned about is if the Affordable Care Act (ACA) says it would be okay because I have heard conflicting messages that they could or could not be a primary care doctor. I just do not know.

Sam Quast, Committee Counsel:
I do not know the answer to that. What I do know is the provisions in this bill that prohibit that are consistent with the provisions in existing law where this already exists that say you cannot designate them as a primary care physician, but I do not know the implications of the Affordable Care Act. I can look into that and get back to you.

Chair Marzola:
We will look into it, and then I will provide all the information to you, Senator, and to all the Committee members.

Assemblymember Cole:
You had mentioned the HMO and PPO difference. I am sure you know this, but the cost for premiums on PPO is much higher than anything on HMO. I do not know how much of that is attributed to the fact you do not have to go through and get the referrals and everything else. Is there any concern there will be an increase in premiums for those on HMOs to deal with this?

Senator Lange:
I have talked to the insurance companies, and no one has mentioned there would be a price increase for this. I cannot answer that question any further. Maybe during testimony one of them will be able to answer that.

Chair Marzola:
Assemblymember Cole, you may want to take that question offline to some of the different stakeholders.

Assemblymember Torres-Fossett:
I appreciate this legislation because I know to get an appointment with an OB/GYN in southern Nevada can be more than six months. I had an appointment that had to be canceled in September, and I was not able to reschedule it until January. Then I had budget briefings so I was not able to reschedule it until June. Unfortunately, that is something that happens far too often. Can you talk a little bit about some of the benefits to patients in being able to immediately see their OB/GYN? There can be a number of reasons why a patient might need to see an OB/GYN. Can you talk about why they might need to see an OB/GYN instead of their primary care physician?

Senator Lange:
I think there are a number of things. I am mortified it would take you that long to see your OB/GYN when women have pressing issues they need to have taken care of. When you have to wait that long, it could be a domino effect in your health care. Women go to gynecologists because they are having babies, have infections, or something going on in their women parts of their bodies. It is important we have access. We know the time to get into your primary care doctor is a long time. Being able to go straight to your gynecologist to deal with it and not have to pay that additional copay is really important because they are the people who can least afford it.

Assemblymember Torres-Fossett:
Do you have any information about how long it generally takes to get an appointment with our primary and our OB/GYNs? Maybe somebody else in this room would be able to help answer that because I know to get into my primary, it is at least six weeks. I am wondering what the timeline looks like for a patient who is trying to get this care.

Senator Lange:
I am not sure how long it would take to get this care. As you know, in Nevada, we have physician shortages in all areas. It does not say you cannot go to your primary care doctor. It says if you feel like you need to go to your OB/GYN, you can go without getting a referral.

Chair Marzola:
Committee members, are there any additional questions? [There were none.] We will move to testimony in support of S.B. 246. Is there anyone wishing to testify in support?

Jacqueline L. Nguyen, Policy Director, Nevada State Medical Association:
I was texting my doctors furiously asking about what the turnaround time is. Hopefully, they will answer me, but I am sure they are in with patients. Prior authorization reform is a top priority for all Nevada physicians and is our advocacy priority this session on behalf of patients, physicians, and other providers of health care. Particularly with S.B. 246, OB/GYN services should be provided for all patients as standard care that should not require prior authorization or referral as it is essential health care services for women. With essential medical services, requiring prior authorization can create delay and unnecessary administrative burdens, which delay care and add cost to not only physician practices but also, and most importantly, to patients.

I really appreciate the question, Assemblymember Kasama. We know in the prior hearings there was discussion about opening the statutes and proposing language that would allow for one to designate an OB/GYN as a primary care physician. In speaking to our OB/GYN members and our primary care members, we would be in full support of that amendment.

Chair Marzola:
Is there anyone else in Carson City wishing to testify in support? [There was no one.] We will move to testimony in opposition. Is there anyone wishing to testify in opposition?

Shelly Capurro, representing Nevada Association of Health Plans:
I actually signed in as neutral because I was going to clarify, as I did on the Senate side, the intent of this bill was to not have a member be required to go to their primary care in order to go to their OB/GYN. We are neutral on that. In this presentation, it started to look more like a prior authorization bill. That is why I am in opposition. We are going to need to have further conversations with the sponsor, but she is amazing in having conversations with us, and we will figure out where we are at on this.

Chair Marzola:
Is there anyone else wishing to testify in opposition? [There was no one.] We will move to neutral testimony. Is there anyone wishing to testify in neutral?

Adam Plain, Insurance Regulation Liaison, Division of Insurance, Department of Business and Industry:
We submitted written testimony talking about defrayal [Exhibit F]. This is not a defrayal item to our understanding. I wanted to use my time, though, to talk about some of the

questions. To clarify, under the Affordable Care Act, plans subject to those provisions must allow an OB/GYN to be designated as a woman's primary care physician. Additionally, health plans, regardless of whether it is PPO, HMO, point-of-service, or EPO [exclusive provider organization], it does not matter. They are not allowed to require prior authorization before a woman sees their OB/GYN, regardless of whether they are the primary care physician or not. I would be happy to work with Committee staff to get those citations. I do not have them handy right now, but we can work through that. It is an essential health benefit under the primary care essential health benefits, so that is why it trickles through that way.

If you reference the handy market guide the Division of Insurance published at the beginning of session, on page 20 there is a nice pie chart we produced talking about the premiums by line of business. The market we regulate, the fully insured marketplace, the ones we can say are subject to ACA provisions in this matter are the large group, individual, and small group market is 18.5 percent of Nevada's population. So, 81.5 percent of Nevada's population are not subject to Division of Insurance regulation and potentially not subject to these provisions of the Affordable Care Act because they are Employee Retirement Income Security Act of 1974 (ERISA) self-funded plans, on Medicaid, Taft-Hartley plans, or uninsured. Existing provisions do not apply to them and potentially the provisions of the bill would not apply to them either because the state cannot regulate ERISA plans and whatnot. I wanted to put that on the record to clarify. I am happy to answer any questions.

Chair Marzola:
Can you provide the citations to the committee secretary so I can provide it to all the Committee members?

Adam Plain:
Certainly. Off the top of my head, it is something like 45 CFR 145.104. Do not hold me to that because the federal regulations bump around between 45 and 42 as the chapter, and I cannot keep them straight, but it is in that general area code.

Chair Marzola:
We will wait for your email. Is there anyone else wishing to testify in neutral? [There was no one.] Senator, would you like to give any closing remarks?

Senator Lange:
I think that is good news, and I look forward to updating the bill with an amendment and getting it back to the Committee.

Chair Marzola:
I will close the hearing on S.B. 246. I will now open the hearing on Senate Bill 292. This measure revises provisions relating to Medicare supplemental policies.

Senate Bill 292: Revises provisions relating to Medicare supplemental policies. (BDR 57-1069)

Senator Roberta Lange, Senate District No. 7:
I have the honor to present Senate Bill 292 today. This legislation increases access to Medicare supplemental health insurance policies for Medicare beneficiaries under the age of 65. Before I begin my presentation, I do not often share personal stuff, but I am a kidney patient. I am in stage 5 renal failure. I am getting a transplant in the fall. Lucky for me, I am over 65 so I have the benefit of Medicare and a medigap policy that will cover the entire transplant. Today, I am going to talk to you about patients who are under 65 who are granted Medicare coverage, but they do not have a medigap policy to cover the additional amount, which makes having a transplant unaffordable. For them, it is life or death. I want to talk to you about what other states are doing and how I think we can help the thousand patients in Nevada who need this coverage.

As most of you know, Medicare is a federal health insurance program for seniors who are 65 years of age or older. A lesser known fact is millions of individuals younger than 65 years can also enroll in Medicare because they suffer from end-stage renal disease (ESRD) or certain qualifying disabilities. You may also know seniors enrolled in Medicare choose to sign up for a Medicare supplemental policy, also called medigap insurance, because it covers payments for coinsurance and copays as well as certain deductibles and adds certain health benefits. However, federal law does not require insurers to offer medigap policies to Medicare beneficiaries under the age of 65, leaving a substantial portion of the Medicare population vulnerable to high out-of-pocket medical costs.

Research has consistently shown that younger Medicare beneficiaries face unique challenges. They are more likely to have low incomes, poor health, and severe chronic conditions. They also experience higher rates of access and affordability issues compared to older beneficiaries. A Kaiser Family Foundation study found beneficiaries under 65 with disabilities reported worse access to care, more cost concerns, and lower satisfaction than with the care that seniors receive.

Currently 36 states require medigap insurers to issue at least one kind of medigap policy to beneficiaries under the age of 65, typically through an individual open enrollment period. Unfortunately, Nevada is not part of those 36 states. The lack of access to medigap policies can have severe financial consequences. For instance, this financial burden can potentially jeopardize a Medicare beneficiary's chance to get a kidney on the kidney transplant list, which as you know, as I shared, is very personal to me. For these reasons and others, the American Kidney Foundation, an advocacy organization for people suffering from end-stage kidney disease, urges states to pass legislation that would require insurance companies that offer medigap coverage to make it available to Medicare beneficiaries under the age of 65—the same premiums, conditions, and services offered to those beneficiaries over 65 years of age. Senate Bill 292 is aiming to fix this issue.

With your permission, Chair, I will briefly summarize the key provisions of the bill. Section 2 establishes applicability of the definition "Medicare supplemental policy." Section 4 is a key section of the bill where I will briefly summarize its subsections. Subsection 1 requires a health insurance offering a Medicare supplemental policy to allow eligible individuals less than 65 years of age who are enrolled in Medicare due to a disability or end-stage renal disease to purchase any Medicare supplemental policy that an insurer offers to new insurers who are 65 years of age or older.

Section 4, subsection 2 prohibits such insurers from imposing any limitation, term, or condition relating to coverage benefits, protections, policies, or procedures with respect to a Medicare supplemental policy issued to an individual under 65 years of age, unless they also apply to an insured who is 65 years of age or older. Subsection 3 requires insurers to offer a supplemental policy at the same premium rates to an eligible individual as they would charge individuals who are exactly 65 years of age for such policies.

Section 4, subsection 4 sets forth that an insurer must establish an open enrollment period to purchase Medicare supplemental policies during a six-month period commencing the first day of the first month, which individuals less than 65 years of age are enrolled in Medicare part B coverage. Lastly, subsection 5 prohibits an insurer from taking certain actions during the open enrollment period set forth in subsection 4, including, but not limited to, imposing an exclusion of benefits during that open enrollment period based on preexisting medical conditions.

Sections 5 and 6 make certain conforming changes. Sections 7 through 9 apply to the provisions of section 4 to a hospital or medical services corporation and state and local governments that offer insurance to employees. Regarding the effective date, section 10 requires insurers to establish an open enrollment period for individuals who become eligible for Medicare supplemental policies if this bill passes. The period commences on October 1, 2025, and remains open through April 1, 2026.

With me today I have Pamela Zielske, who is the western regional advocacy director for Dialysis Patient Citizens, and she will give a little more in-depth information about the cost and how this works.

Pamela L. Zielske, Western Region Advocacy Director, Dialysis Patient Citizens:
We are the largest nonprofit patient advocacy organization in the country that works on behalf of end-stage renal disease patients. I am here testifying in support of S.B. 292. As Senator Lange mentioned, 36 states require insurers to sell at least one medigap plan to eligible individuals who are under the age of 65. Seventeen of these states have already passed laws like S.B. 292 that provide premium protections to ensure these plans are affordable for patients. By doing so, these states are making sure the playing field is even, and people are not penalized for getting sick while they are young. Nevada's neighbors, Oregon and Idaho, are among those states that already have affordable medigap laws on the books, and we are seeing more states pass laws each year. Indiana just passed affordable

medigap for the under-65 population last year. The states of Kentucky and Virginia passed medigap legislation in 2023.

Senate Bill 292 uses the proven same-as-age-65 premium protection formula that has been used in the state of Kansas since 1999. This is a well-tested model and it works. In fact, this year Kansas has 43 different insurers selling medigap plans to the under-65 market, and the average monthly premium there, regardless of age, is $218 a month. It is also worth noting that Kansas has a roughly similar population size as the state of Nevada.

Right now, a 65-year-old Nevadan has access to all ten lettered medigap plans, plans A through N, but if a person is diagnosed with ESRD when they are younger than age 65, they cannot purchase a medigap policy in the state of Nevada because they simply are not available. This explains why so many dialysis patients spend down their assets into poverty so they can become eligible for Medicaid.

In addition to providing patients with financial security, this bill also provides a pathway to a lifesaving kidney transplant, as Senator Lange mentioned. Most transplant centers require supplemental insurance coverage or adequate savings to ensure a patient can keep their new kidney healthy posttransplant. I do want to mention a kidney transplant can extend adult life expectancy by 8 to 12 years, and even longer with a living donor transplant. Access to a transplant also means people can lead the life they want to lead without dialysis. In many cases, it means they can return to work.

Before I close, I would like to mention a few things about cost. The report from Health Management Associates (HMA), which is a part of the record [Exhibit G], explored this issue of cost. Health Management Associates, which is a well-respected independent actuarial firm, evaluated Medicare fee-for-service claims data and determined if medigap carriers in Nevada were required to offer policies to those under 65 with ESRD and set premiums at the same rate a 65-year-old patient is paying, it would result in an increase for the overall pool of 0.9 percent or about $2 per month. This is because the pool of individuals who purchase medigap plans as a result of the bill would be very small. There are only about 1,500 ESRD patients in the state of Nevada who are under age 65, and of this group, 991 of them are considered nonduals. They are on Medicare, but they are not eligible for Medicaid. There are over 140,000 Nevadans who have medigap plans. If S.B. 292 passed, absorbing some of these 991 ESRD patients who are not eligible for Medicaid would represent a de minimis amount of the overall pool.

The bill can also help prevent cost shifting to the Medicaid program by preventing more patients from spending down their hard-earned assets to qualify for Medicaid. You will notice in the HMA report, it also estimated as many as one in four nondual Nevadans could annually avoid spending down their assets that lead to Medicaid eligibility and estimated a savings to the state of Nevada of roughly $900,000 over a five-year period. The impact of this bill would be both life-changing and lifesaving for Nevadans with ESRD who are under 65. I urge your support of the bill. I would like to invite Mr. Charles Lizer to share his story as a Nevada resident.

Charles Lizer, Private Citizen, Winnemucca, Nevada:
I am a kidney patient. I have been on dialysis for almost ten years, and I have been on the list for kidney transplant in Utah and now in Nevada for quite a while. In order for me to get a kidney transplant, I am going to have to come up with 20 percent up front, which I am being told is anywhere from $20,000 to $40,000. I have been saving, and I have some money saved up but nowhere close to that amount.

I currently work full-time, so I do not qualify for Medicaid. I am supporting this bill because this bill would help me tremendously. It would take a lot of the burden of that $40,000 I have to save off my shoulders, and it would improve my quality of life. Instead of being stuck on a machine four hours a day, four days a week, I could travel, I could do stuff, I could spend more time with my family, and I could go places I currently cannot do right now because I have to be tied to my machine every day. I guess that is about it.

Senator Lange:
That concludes our presentation. We would be happy to answer any questions.

Chair Marzola:
Thank you both for sharing. I think it gives a whole entirely different perspective when you have real life stories. I know it is tough but thank you for being great advocates. With that, Committee members, are there any questions?

Assemblymember Yurek:
I am really sorry to hear your story, but I appreciate you sharing it. I have a personal friend who is in end-stage renal failure. What a tough process that is. I definitely see the importance of this bill. I really like it. I have heard a lot of references to end-stage renal failure, its impact, and costs we are going to incur. Perhaps, as I was reading and looking at it, I may have missed it. As I understand, in section 4, it also makes reference to folks who are eligible for and enrolled in Medicare on the basis of disability. Is that a separate group of folks who would be eligible? [Senator Lange shook her head no.] That is directly tied to end-stage renal? [Senator Lange nodded yes.]

Assemblymember Cole:
My sister is the recipient of a kidney transplant from last year. I definitely feel the concerns and understand the issues. She has medigap, as she is in Pennsylvania, but I have also helped cover a lot of the costs that were not borne by those policies. You mentioned 36 states had at least one kind of medigap, and there is A through N, so there are a lot of options out there. Your language says any Medicare supplemental policy. Was there a distinct reason why you said any and it cannot be one or two options for people? Can you speak to that?

Senator Lange:
If we just did one medigap policy, it would mean the patient would still have to pay a lot out of pocket. Having multiple medigap policies available where a patient could sign up for any of those, it spreads it out. I do not know if Ms. Zielske might want to add a little bit more information, but I think it was more equitable doing it this way.

Pamela Zielske:
Yes, Senator Lange is correct. I believe 25 of those 36 states actually require all ten of those plans to be available. There are a few states I know of, and three that come to mind, that essentially say three plans have to be available and have different types of formulas from the others. A lot of it comes down to each of those ten lettered plans cover different things. By allowing patients to choose, they can make a decision about which plan is going to best meet their medical needs.

Chair Marzola:
The more plans available, the better options for the patients, essentially. Committee members, are there any additional questions? [There were none.] We will start with support testimony of S.B. 292. Is there anyone wishing to testify in support?

Dan Musgrove, representing Nevada Donor Network:
Our mission is to save and heal lives through organ and tissue donation. We are a part of that story you heard today. We think there are probably anywhere between 700 and 2,100 Nevadans who are going to need a kidney transplant. Because of the very reasons you heard today, a lot of that goes unreported because they do not have the ability to access the medical care they need.

Here is another perspective. Kidney failure has a disproportionate impact on people of color. Compared to White Americans, the likelihood of developing kidney failure is 4.3 times greater for Black Americans, 2.3 times greater for American Indians, 1.6 times greater for Asian Americans, and 2.2 times greater for people of Hispanic or Latino ethnicity. The very reason we need these coverages is to help those people access the medical care they need.

As you heard the gentleman who spoke very eloquently about his own personal circumstance, how do we all usually buy a car? We buy it on payments. We cannot come up with the down, we cannot come up with the big lump sum. Medigap insurance allows them to pay as you go to get an insurance policy that will cover that big gap. We ask for your support.

Jacqueline L. Nguyen, Policy Director, Nevada State Medical Association:
I did want to be three for three in support for Senator Lange day in Committee. We would like to thank Senator Lange for bringing forth this bill on behalf of patients. I shared before I had seen firsthand the medical difficulties and financial hardships patients face when I helped my own niece, Britney, through the long process of receiving her own kidney transplant just a few years ago. She is now thriving, but the cost of her care was a constant

worry for my family. Medicare supplemental insurance is sometimes a crucial resource for patients that can provide significant financial protections and access to care. Therefore, our physician members are in full support of S.B. 292.

Paige Barnes, representing Fresenius Medical Care:
We are a kidney health company providing dialysis along with other care in the state to Nevadans. We are here in strong support of S.B. 292. We really appreciate Senator Lange for sponsoring this bill and for everyone sharing their personal stories. We have submitted a letter of support for the record and urge you to review that [Exhibit H].

Dean Marcoccia, State and Local Government Affairs Lead-West, Public Policy and Government Affairs, Biogen:
We are a company focused on research and development of end-stage renal disease. We commend Senator Lange. This is your day today, and we strongly support this bill.

Jimmy Lau, representing DaVita:
DaVita is also a dialysis company provider here in strong support of the best interests of our patients and this bill. We would like to thank Senator Lange for her leadership on this issue and everyone who shared their personal stories as well.

Ernesto Molmenti, Private Citizen, Reno, Nevada:
I am a transplant surgeon. I came here to Nevada to change the lives of those in need. I am delighted to support Senator Lange's bill and also in support of all those who are in severe need. People with kidney failure are not only medically disadvantaged but, in most cases, financially and socially disadvantaged. To have access to a transplant, in addition to the financial resources, requires them to have social resources to help them recover from the surgery and financial resources to travel and bring their caregivers with them.

The mortality rate on dialysis is 60 percent at five years. After five years, half of those individuals on dialysis will be dead. I think it is our responsibility to act on behalf of them to give them a chance, irrespective of their age. Kidney failure is not something we induce on ourselves. It is something that comes along the way through many illnesses, both congenital and acquired. I think all these individuals who are disadvantaged, who are dying while going on dialysis, deserve a chance to be able to benefit from what we provide.

Kidney transplantation provides three main benefits: (1) improved survival; we live longer; (2) a better quality of life; when we have, for example, a three-day weekend, individuals on dialysis cannot say, I am going to go for a trip wherever I wish. When they are more than two days out of where the usual location is, they need to arrange for dialysis centers to be able to dialyze them, otherwise they would die, usually due to high potassium; and (3) from public health perspective, transplantation is cheaper than dialysis. We have to keep all those things in mind when we make a decision. That is a brief summary of what I think. Assemblymember Yurek, I hope your friend comes to see me so I can transplant him or her.

Diana Arevalo, Managing Director, Advocacy, ALS Association:
I speak before you on behalf of the brave individuals and families in Nevada who are facing the unimaginable reality of living with ALS [amyotrophic lateral sclerosis]. I speak before you with a simple and urgent request: please support S.B. 292. Amyotrophic lateral sclerosis is a devastating disease. It takes away a person's ability to walk, talk, eat, and breathe, and yet there is no cure.

For those living with ALS, every single day is a battle, not just against the disease itself, but against the overwhelming financial and logistical burden that comes with it. The cost of care can exceed $250,000 per year, forcing families to make heartbreaking decisions, draining retirement savings, taking on debt, and worrying about how to protect their children's futures.

One of the most pressing concerns for these families is health insurance. This bill offers a vital solution by ensuring people under the age of 65 who are living with ALS can access affordable medigap coverage. This would help close a dangerous gap in health care, giving patients and their loved ones peace of mind during an unbearable time. Most people with ALS qualify for Medicare as soon as their social security disability benefits begin, but Medicare alone is not enough. It only covers 80 percent of medical expenses with no cap on out-of-pocket expenses. For many, this means thousands of dollars in expenses just to access essential care.

Medigap coverage could be the difference between affording life-sustaining care or going without. Extending Medicare coverage is more than just a policy change; it is a lifeline. For all these reasons, I urge you to support S.B. 292.

Josie Gamez, Associate Director of State Policy and Advocacy, American Kidney Fund:
I am here today to testify in support of S.B. 292, which seeks to expand access to medigap coverage for kidney patients, providing them a better opportunity to live a healthier, longer life. Medigap coverage is especially critical for kidney patients in Nevada because Medicare only covers 80 percent of their medical expenses, leaving many patients with significant out-of-pocket costs for life-sustaining care. Additionally, having secondary insurance coverage, such as medigap, is a key requirement in the transplant evaluation process. Due to the scarcity of available organs, transplant centers require patients to demonstrate they have adequate insurance to cover their ongoing medical costs necessary in order for them to maintain a transplanted organ. Without medigap, many kidney patients face major barriers to receiving a lifesaving transplant simply because they lack sufficient coverage. By expanding access to medigap, S.B. 292 would help ensure kidney patients can afford the care they need, improve their chances of receiving a transplant, and ultimately enhance their overall health and quality of life. Thank you for the opportunity to testify and for your time and consideration.

Jim DeGraffenreid, Private Citizen, Minden, Nevada:
I am an independent insurance broker in Minden, Nevada. I am testifying today in support of S.B. 292 in that capacity. I have been an insurance broker in Nevada for almost 25 years. I am licensed in Nevada, California, Oregon, and Texas. Over the years, I have had many

clients fall into this situation where they are forced into Medicare. There has been a focus on end-stage renal disease today, but section 4 of the bill also covers those under 65 who are on disability and forced on Medicare after 24 months. Unfortunately, they are not able to purchase a medigap policy until they turn 65.

As Senator Lange pointed out earlier, this leaves these beneficiaries uncovered for significant out-of-pocket costs. In many cases, Medicare without a supplement is worse coverage than the insurance they had before the disability, but federal law forces them into Medicare. It is possible for these individuals to sign up for a Medicare Advantage plan, but these can be difficult to navigate due to limited networks and other restrictions. Senate Bill 292 fills the gap by allowing these beneficiaries to buy a full-service plan that will cover their medical needs without network limitations.

This is a bipartisan issue, which is why all 20 Senators present voted in favor of the bill earlier this month. I thank Senator Lange for bringing this bill forward, and we urge this Committee to support this bill to help Nevada citizens who have been forced onto Medicare before age 65.

[A letter in support, Exhibit I, was submitted but not discussed and will become part of the record.]

Chair Marzola:
Is there anyone else wishing to testify in support? [There was no one.] We will move to testimony in opposition of S.B. 292. Is there anyone wishing to testify in opposition?

Tray Abney, representing America's Health Insurance Plans:
We appreciate Senator Lange for bringing forth this issue. Our concern centers around cost. The under-65 population is also eligible for Medicare Advantage, which is heavily subsidized by the federal government. Should Nevada require coverage of ESRD for the under-65 population, we are concerned they represent a very expensive portion of the population that would be added to this risk pool.

On average, ESRD beneficiaries incur spending that is about six times greater than spending for beneficiaries ages 65 years and older without ESRD. Requiring carriers to include under-65 patients in the medigap risk pool, and restricting premium rates for these individuals to the lowest possible rate as this bill calls for, will result in increased premiums for the seniors for whom these policies were created. Many medigap enrollees are lower income and live in rural areas. Shifting the expense of the under-65 population onto seniors with medigap policies would add a significant burden to this vulnerable group, many of whom have been paying for medigap coverage for many years and are often on tight budgets.

Medigap issuers do not receive any additional state or federal funds to offset increased cost of covering an under-65 enrollee. The cost of the risk pool is paid solely by the patients in the former premiums. If a risk pool's costs increase substantially, premiums for future years will increase to cover the additional spending. In order to preserve senior Nevadans' financial

peace of mind, we would urge this Committee to not process this bill. Senator Lange, of course, is always wonderful to work with. We have submitted language. We talked about if there could be one plan that offers this and some premium flexibility so we can keep the cost a little bit more contained so it does not affect everybody in that entire risk pool. We will continue working with Senator Lange.

Shelly Capurro, representing Nevada Association of Health Plans:
I did sign in on opposition on this bill, and I would like to explain why. First, we would like to thank Senator Lange. We have had conversations with her, but we are still in opposition. Our members are very concerned with the cost implications of S.B. 292 since the bill mandates that insurers offer all Medicaid [*sic*] supplemental plans to individuals under 65, including those with ESRD. The plans must be offered at the same premium rate as those plans for individuals over 65. We would like to emphasize we are not requesting the removal of the option to enroll under-65 ESRD beneficiaries.

We are aware 36 states allow enrollment for under 65, and 21 of those 36 states have some requirement around premium rate methodology. We are okay with some of that. Only seven states mandate the same premium rate mandates that are in S.B. 292. Per data from the Kaiser Family Foundation, Nevada's average monthly premium rate is $221, and we are already above the national average of $217 a month. Kansas was referred to previously. We are already above Kansas, and this bill is not even in place.

Among the seven states that were referenced, Nevada already ranks second highest, with New Jersey being the highest at $228. We conservatively estimate this could be an increase to premiums of 5 to 10 percent with the mandates of this bill. This means a $221 monthly premium would now be anywhere from $232 a month to $243 a month. We know increases, no matter how small, can be cost prohibitive to Nevadans.

Therefore, we are asking for the flexibility that was mentioned in this hearing and by Mr. Abney, so we are in alignment with making Medicare supplemental plans successful and affordable to Nevadans, but we are looking for flexibility to make these affordable. We do hope to continue talking to Senator Lange on this.

Jason Casey, Private Citizen, Sparks, Nevada:
I am an insurance broker in Sparks, Nevada. I do Medicare. That is my principal business, and I have been doing it for 20 years. The reason I am in opposition to this bill is because I have seen throughout the years the rising costs of Medicare supplements within our own area as well as in the Las Vegas area. The problem becomes adding on to things. I am not in opposition to giving them to under-65, but I think we ought to do it to just certain plans or carve out these plans as other states do.

I would like to point out that a state next to us does not have under-65 rates and does not allow ESRD, even on their 65 plans. Now in Nevada, 98 percent of all people on Medicare, over and under 65, are eligible for Medicare Advantage plans. What about those 2 percent? I totally get it. That is why I think we ought to reduce this to plan A, which would take care

of all of their options. If we leave it open to all plans, believe me, people are going to only choose one or two of those plans. That is why I am in opposition without some amendments to this plan.

Chair Marzola:
Is there anyone else wishing to testify in opposition? [There was no one.] We will move to neutral testimony. Is there anyone wishing to testify in neutral?

Adam Plain, Insurance Regulation Liaison, Division of Insurance, Department of Business and Industry:
We submitted written testimony [Exhibit J]. I want to put on the record we do not see any issues from enforcement or any other standpoint for the Division of Insurance so we are neutral. I am happy to answer any questions.

Chair Marzola:
I do not believe we have any questions. Is there anyone else wishing to testify in neutral? [There was no one.] Senator Lange, would you like to give any final remarks?

Senator Lange:
To put it in perspective for these patients, it is the difference between life and death. If we cannot get them the help they need through insurance, you cannot fix the problem. We will continue to have conversations with insurance. In the research we have done, the premiums have not risen significantly, but we will continue to have those conversations and will get back with you. I encourage you to support this bill.

Chair Marzola:
I will close the hearing on S.B. 292. I will now open it up for public comment. Is there anyone wishing to give public comment?

Adam Plain, Insurance Regulation Liaison, Division of Insurance, Department of Business and Industry:
I am offering a mea culpa. I inadvertently misrepresented testimony on Senate Bill 246. The federal code 45 CFR§149.310(a)(3) relates to the specific provision that access to an obstetrician or gynecologist must be done without a prior approval. Subtitle (a)(1) relates to designation of a primary care physician. I said the Affordable Care Act (ACA) requires insurers to allow an OB/GYN to be designated as a primary care physician. That is incorrect. The ACA requires people to designate a primary care physician, and if their state defines an OB/GYN as a PCP [primary care physician], then they are brought in. Because Nevada does not currently define an OB/GYN as a primary care physician, that provision would not apply in Nevada currently. Carriers may permit an OB/GYN to be designated as a PCP but are not required to do so. I apologize for that inaccurate statement.

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Chair Marzola:
Thank you for that clarification. We appreciate it. Is there anyone else wishing to give public comment? [There was no one.] Are there any comments from the members before I adjourn? [There were none.] This will conclude our meeting for today. Our next meeting will be on Friday, April 25, 2025, at 12 p.m. This meeting is adjourned [at 1:25 p.m.].

RESPECTFULLY SUBMITTED:

_____
Julie Axelson
Committee Secretary

APPROVED BY:

_____
Assemblymember Elaine H. Marzola, Chair

DATE: _____

EXHIBITS

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
S.B. 387 (R1)	C	Cari Herington, Executive Director, Nevada Cancer Coalition	Testimony in support
S.B. 387 (R1)	D	Various individuals	Collection of letters in support
S.B. 387 (R1)	E	Adam Plain, Insurance Regulation Liaison, Division of Insurance, Department of Business and Industry	Testimony in neutral
S.B. 246	F	Adam Plain, Insurance Regulation Liaison, Division of Insurance, Department of Business and Industry	Testimony in neutral
S.B. 292	G	Pamela L. Zielske, Western Region Advocacy Director, Dialysis Patient Citizens	Article titled "Medigap Reform for Medicare Enrollees With ESRD Under Age 65 in Nevada"
S.B. 292	H	Maria Garcia, Senior Director, State Government Affairs, Fresenius Medical Care	Letter in support
S.B. 292	I	Tom McCoy, Executive Director, State Government Affairs, Nevada Chronic Care Collaborative	Letter in support
S.B. 292	J	Adam Plain, Insurance Regulation Liaison, Division of Insurance, Department of Business and Industry	Testimony in neutral