MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-third Session
May 31, 2025

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 4:59 p.m. on Saturday, May 31, 2025, in Room 2134 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 7 of the Nevada Legislature Hearing Rooms, 7120 Amigo Street, Las Vegas, Nevada. Exhibit A is the agenda. Exhibit B is the attendance roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Fabian Doñate, Chair
Senator Angela D. Taylor, Vice Chair
Senator Roberta Lange
Senator Robin L. Titus
Senator Jeff Stone

GUEST LEGISLATORS PRESENT:

Assemblymember Natha C. Anderson, Assembly District No. 30
Assemblymember Shea M. Backus, Assembly District No. 37
Assemblymember Gregory S. Koenig, Assembly District No. 38

STAFF MEMBERS PRESENT:

Destini Cooper, Committee Policy Analyst
Eric Robbins, Committee Counsel
Norma Mallett, Committee Secretary

OTHERS PRESENT:

Blayne Osborn, President, Nevada Rural Hospital Partners
Sarah Adler, National Alliance on Mental Illness-Nevada Chapter; American College of Obstetricians and Gynecologists, Nevada Section; Nevada Nurses Association
Jacquelyn Nguyen, Nevada State Medical Association
Lea Cartwright, Nevada Psychiatric Association

Joseph Adashek, President, Nevada State Medical Association
Adam Plain, Insurance Liaison, Division of Insurance, Nevada Department of Business and Industry
Cari Herington, Executive Director, Nevada Cancer Coalition
Shelly Capurro, Nevada Association of Health Plans

CHAIR DOÑATE:
Let's start first by opening our bill hearing on Assembly Bill (A.B.) 326.

ASSEMBLY BILL 326 (2nd Reprint): Revises provisions relating to the designation of hospitals as centers for the treatment of trauma. (BDR 40-153)

ASSEMBLYMEMBER GREGORY S. KOENIG (Assembly District No. 38):
This bill would allow the emergency rooms of rural hospitals to be designated as category [level] IV treatment centers. This is something done by every other surrounding state but not yet in Nevada.

BLAYNE OSBORN (President, Nevada Rural Hospital Partners Foundation):
Assembly Bill 326 in the second reprint allows for the State Board of Health to do regulations, giving them the ability to recognize trauma level IV in Nevada. Currently, Nevada only recognizes trauma levels I through III. This would allow for a level IV, and it would limit that designation only to critical access hospitals that are more than 80 miles away from a county with two or more trauma centers.

Right now, the only county that has that many trauma centers is Clark County. This bill has no fiscal note, no appropriation and no impact on Clark County or the Southern Nevada Health District.

SENATOR TAYLOR:
I do not know what category IV is so could you explain that? Then, what is the advantage of that in plain language?

MR. OSBORN:
Level IV trauma centers have demonstrated an ability to provide Advanced Trauma Life Support to patients prior to the transfer to a higher level trauma center. They provide evaluation, stabilization and diagnostic capabilities for injured patients.

Basically, our goal with this is to allow for this designation. We have one critical access hospital currently that is ready to pursue this license. And with that, we hope to see more resources, better transfer protocols, standardized procedures and more of a trauma system working together—particularly in Northern Nevada.

ASSEMBLYMEMBER KOENIG:
This is something that we brought up in our last presentation. It gives the staff more training and resources and the treatment time goes down. They are able to save lives quickly because they are better trained. Overall, it makes things more efficient.

CHAIR DOÑATE:
Thank you so much, any closing remarks?

ASSEMBLYMEMBER KOENIG:
I call this bill my roller coaster bill. It started as a mandate, got turned into a study, turned back to where it was and, with the help of Senator Doñate, we were able to get it to where it is today. And I think he actually wanted to cosponsor this bill, so thank you so much.

CHAIR DOÑATE:
I would add myself as a cosponsor, but I do not want to jeopardize your bill going through the amendment process again, especially in the last few days. Also, thank you for not doing a study. I think sometimes we don't need to study things; we can just do it now. I will now close the hearing on A.B. 326.

VICE CHAIR TAYLOR:
We are now opening the hearing on A.B. 514.

ASSEMBLY BILL 514 (2nd Reprint): Makes revisions relating to mental health care. (BDR 38-350)

SENATOR FABIAN DOÑATE (Senatorial District No. 10):
This bill came from the recommendations that the Joint Interim Committee on Health and Human Services brought forward. We have had extensive discussions in the interim about how we wanted to improve the mental health delivery system in our State, and this was one of the bipartisan recommendations that we developed.

The bill pretty much says that, to the extent that federal financial participation is available, the Medicaid director can establish a method to provide coverage for rehabilitative residential mental healthcare treatment. When we looked at what was missing for individuals seeking care, we noticed that rehabilitative residential mental health care is something other states have invested in while we haven't. We believe this is a gap that has been needed to be addressed.

VICE CHAIR TAYLOR:
You said, "other states." Are we the only state that does not have this?

SENATOR DOÑATE:
No, there are some states that do not offer this as well. But when we were looking back at what parts of our mental health delivery system were missing, this was something that came forward. It was a recommendation actually from DHHS [Department of Health and Human Services] themselves in terms of what we can do to improve the delivery system. It was brought forward in one of the presentations that we did during the interim.

SARAH ADLER (National Alliance on Mental Illness-Nevada Chapter):
We could not agree more with the need for this bill. Last session, I carried a bill for the National Alliance on Mental Illness (NAMI). Senate Bill No. 6 of the 82nd Session sought to create a revenue stream to really stand up supportive housing, which is part of the housing that folks with mental illnesses need.

This bill is really going to assist many Nevadans who live in challenging and unstable conditions, so, NAMI is in full support and appreciates the sponsor and all the work during the interim.

SENATOR TITUS:
How many Medicaid waivers do we have out there right now? I was wondering how long the process is. What is it looking like in this current atmosphere? How long does it take to get these waivers approved?

SENATOR DOÑATE:
In the interim there were about four or five waivers that we were waiting on. Traditionally, they take about two years before the federal government approves them.

VICE CHAIR TAYLOR:
If I may add in, I have a couple of Medicaid bills that require waivers and it's very similar to what Senator Doñate said. Stacie Weeks and her team told me about 18 months is the earliest that we can expect it. I will now close the hearing on A.B. 514.

CHAIR DOÑATE:
I am going to go ahead and pivot to A.B. 463.

ASSEMBLY BILL 463 (2nd Reprint): Revises provisions relating to prior authorization. (BDR 57-825)

ASSEMBLYMEMBER SHEA M. BACKUS (Assembly District No. 37):
This is a prior authorization bill. We wanted to make sure that there are some key treatments that will automatically be authorized and don't require going through the prior authorization process.

We shared some good stories on the Assembly side like with Dr. Steven Adashek, an obstetrician-gynecologist specialist who needed to get prior authorization for diabetes test strips. I don't know if Dr. Titus ever had to do this when she had a diabetic patient, but I feel that this is a unique problem.

The bill is divided in two parts. The first part addresses private insurers. I want to thank the private insurers for coming together to work on something that worked for them. In the bill, there's a timeline on the responses for prior authorization requests. It would require a response within two business days, unless already established by the Council for Affordable Quality Healthcare (CAQH) to have a deadline of seven calendar days. Section 19 goes over what the insurers are prohibited from requiring a prior authorization on. This is analogous to what is set forth in section 48.

SENATOR TAYLOR:
What does the bill do?

ASSEMBLYMEMBER BACKUS:
The bill basically does this. On the Assembly side, I shared my personal story—and the bill may not necessarily do this—where both my moms went in to their doctors, both were prescribed to have an MRI [magnetic resonance imaging] for different conditions. My birth mom had some weird chronic pain up

and down her jaw and after undergoing imaging and a panoramic exam, an MRI was ordered. For my stepmom, she had a lot of stomach issues which led to an MRI.

However, both of them were denied by their insurers who required prior authorizations before they could get the MRIs. As a result, my birth mom developed a bone infection before another doctor was able to help her get the MRI. Rather than waiting to jump through all the hoops, my stepmother decided to pay out-of-pocket for the MRI. They discovered a mass on her colon and took her into surgery.

This is what started the conversation. These are some simplistic things like when I think about diabetes strips and when you have pregnant women who potentially could develop gestational diabetes. Certain specialists will want to make sure they are testing their blood sugar but that requires prior authorizations.

In a nutshell, this bill may not exactly solve the problem my birth and stepmother ran into, but it will deal with little common things. Instead of having to get these prior authorizations, the insurers and Medicaid worked with me to develop a list of procedures and treatments that would not require prior authorizations.

JACQUELYN NGUYEN (Nevada State Medical Association):
The big thing about this bill is that currently in Nevada, insurers have up to 20 days to respond to prior authorization requests. This bill brings it down to two business days, unless there's preestablished exclusions from CAQH for a maximum of seven calendar days.

SENATOR LANGE:
I had a bill that passed and went to Governor Joe Lombardo's office that got rid of prior authorization for a woman to see a gynecologist. Preferred provider organizations allowed them to go without a referral, but HMOs did not.

In your bill, have you designated that it would be for both PPOs and HMOs? They work differently and what I found is that insurance companies use prior authorizations to control costs. If you have not put both in there, I think you have to designate that it's for HMOs and PPOs or it will probably only apply to PPOs.

ASSEMBLYMEMBER BACKUS:
I am a lawyer, but I think you've had that practical experience. I don't know if I am going to be able to hit this all the time, but I would assume by covering the insurance chapter of the *Nevada Revised Statutes* (NRS) that it would be okay, but I could stand to be corrected.

SENATOR TITUS:
To Senator Lange's question, it is a health maintenance organization or other managed care organization.

MS. NGUYEN:
As you know, prior authorization reform is the number one priority for us and our patients. Mandatory prior authorization causes delays in patient care, harming their health outcomes. It also creates massive administrative burdens for physicians.

We want our physicians in the rooms with their patients providing medical care, not doing paperwork and having to be on the phone. We are so grateful for this step forward and are grateful to all the stakeholders for this prior authorization bill.

LEA CARTWRIGHT (Nevada Psychiatric Association):
Sadly, board-certified psychiatric care was amended out of the bill. However, we are still in support of making changes to the prior authorization requirements. One of the reasons we became so heavily involved in this is when we attended the Executive Committee to Review the Death of Children and there were two cases that caught my eye.

One was a ten-year-old who was seen in the ER for asthma complications. They went to pick up the treatment at a pharmacy and were told that their insurance doesn't cover it. The child sadly passed from asthma emergency. The second child was 12 years old and similarly was seen in the ER for suicidal ideations. They were prescribed medicine, which was denied, and the child died from suicide.

Prior authorization reform has been on my mind for almost a decade now, and I am so grateful to this committee for hearing this legislation and moving this forward. We urge you to support A.B. 463.

MS. ADLER (American College of Obstetricians and Gynecologists, Nevada Section; Nevada Nurses Association):
Today, OB-GYNs join in the policy before you related to prior authorization and the nurses I represent will be able to spend more time with patients, not with paperwork. So, thank you very much for hearing this bill and both of those organizations are in full support.

JOSEPH ADASHEK (President, Nevada State Medical Association):
I would like to tell you that the bane of our existence is prior authorizations. There has to be a prior authorization for an obstetrician like me, a high-risk pregnancy doctor, to see a patient. Then when they see us, we have to get a prior authorization for an anatomy scan.

If we see birth defects, we need a prior authorization for amniocentesis. If we have to prescribe medications, we have to get prior authorization for the medications. For certain labs, we have to get prior authorizations as well. This is horrible for our poor patients to have to suffer through all of these prior authorizations. This is why we certainly agree with shortening the time to have a prior authorization approved.

Secondly, what this bill does is prohibit insurers for requiring prior authorizations for certain preventative treatments. Having to wait for an authorization for a standard of care preventative test, like a mammogram, is just a waste of everyone's time. It wastes the patient's time, the doctor's time and the staff who is tasked with acquiring these prior authorizations.

We have had to wait on prior authorizations from normal preventative treatments, which get denied. I have had requests for diabetic test strips denied. It does not make sense to anybody, let alone the patient who has diabetes, for an insurance company to deny test strips.

ADAM PLAIN (Insurance Liaison, Division of Insurance, Nevada Department of Business and Industry):
The Division of Insurance is neutral on the bill as a matter of policy. I did want to address Senator Lange's question about HMO applicability. We do have two particular entity types in Nevada that are generally exempt from most of the other insurance codes. They are nonprofit hospitals, medical and dental corporations licensed under NRS 695B, as well as HMOs which are licensed

under NRS chapter 695C. These are explicit exemptions and you have to usually draw them in through the general clumping statutes, I think as they are called.

In this particular bill, section 28, subsection 2, draws in the nonprofit hospital, medical and dental corporations in NRS 695B.320. But I am not seeing that the HMOs are drawn in. They're explicitly exempt under NRS 695C.050, subsection 1. If you want to bring them in, I would suggest taking a look at NRS 695C.055 and adding the provisions of the bill to that clumping statute.

CHAIR DOÑATE:
I would like Mr. Robbins to respond back to that before we continue.

ERIC ROBBINS (Committee Counsel):
I actually disagree that HMOs are not covered in this bill. The definition of health carrier in the bill says, "has the meaning ascribed to it in NRS 695G.024…" If you go to NRS 695G.024, health carrier is defined as:

> … an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the cost of health care [services], including, without limitation, a sickness and accident health insurance company, a health maintenance organization, a nonprofit hospital and health services corporation or any other entity providing a plan of health insurance, health benefits or health care services.

The definition explicitly refers to a health maintenance organization. Therefore, they would be included.

MR. PLAIN:
I will happily defer to committee counsel.

SHELLY CAPURRO (Nevada Association of Health Plans):
We are in neutral on this bill. We have repeatedly said through the session that we would love the turnaround times on prior authorizations to be in line with the Centers for Medicare & Medicaid Service (CMS). In the current version of the bill, it looks like it's more in line with CAQH. Two days may be more acceptable in urgent situations, but in terms of non-urgent scenarios—we just want to get

it on the record—there shouldn't be a two-day turnaround. In terms of CMS guidelines and what we are looking for, we think we are neutral on the bill.

CHAIR DOÑATE:
Just to be clear, you are referencing the second reprint of the bill?

MS. CAPURRO:
Yes, the second reprint.

CHAIR DOÑATE:
We will now close the hearing on A.B. 463 and move on to A.B. 234.

ASSEMBLY BILL 234 (2nd Reprint): Requires Medicaid coverage for screening for certain forms of cancer. (BDR 38-893)

ASSEMBLYMEMBER NATHA C. ANDERSON (Assembly District No. 30):
The intent of A.B. 234 initially started off to protect access to cancer screenings for Nevada Medicaid beneficiaries. We wanted to increase access to all evidence-based colorectal cancer screening options to improve screening rates, decrease late-stage cancer diagnoses and ultimately save lives.

The American Cancer Society estimated that more than 17,000 Nevadans will be diagnosed and 5,450 will die of cancer in 2025. Early screenings can help prevent this risk of death from breast, cervical, colorectal, lung and prostate cancers. Basically, I was trying to get colorectal cancer screenings covered as they are not covered all the way. This is especially true for at-home testing, like Cologuard.

However, this triggered a significant fiscal note. We made a few changes and that is why you now have the second reprint. In this version of the bill, it codifies existing Medicaid practices and aligns our statutes with the federal Affordable Care Act. It is important to ensure that all Nevadans have access to the most effective cancer screening tools in order to find cancer sooner and start providing the treatment as early as possible.

When I talked with representatives of the Nevada Cancer Coalition regarding the budget issue that had happened, they understood that the funds just are not there. But they also believe that it's important for us to continue to think about

ways that we can possibly fund it in the future. It will continue to be a priority for us to expand the colorectal cancer screenings as much as we can.

When you think about it, nationwide there are exactly five states that currently do not have this covered. Alabama actually just had this signed into law. It is time for Nevada to do so as well. But we also have to be aware of our financial issues.

SENATOR TITUS:
There are many different types of screenings recommended depending on the age, family history and various other factors. This bill is pretty broad. Are we just trying to mirror what is already standard practice? You mentioned Cologuard, which is an at-home test versus a digital rectal exam. There are low-dose CT scans versus blood tests. So, is this the language you choose? Is this what has been accepted? Where was your guidance?

ASSEMBLYMEMBER ANDERSON:
This is basically what the practice is at this time. This language was created between both the Nevada Cancer Coalition and DHHS to make sure that it reflects what the current language and practice is. It is simply codifying what the current practice is.

The stool sample that both of us brought up is not actually part of this. Initially, the plan was for the public to be able to utilize the at-home stool sample but that triggered a fiscal note. That is when we started having those other discussions. After revisions, this bill is putting the current practices into the NRS from what I understand.

SENATOR TITUS:
Thank you for bringing that up. I think health care morphs and changes, especially as studies come out on the benefits of blood tests versus biogenetic markers versus fecal occult blood tests (FOBT), which was my go-to on exams. You would do an FOBT any time you had the opportunity because it was good at cancer screening.

I'm glad that this bill is broad. When we put very narrow wording into statute, it makes me anxious because then we have to come back and change it again. [We are] using broad terminologies and then letting the Medicaid folks decide where that goes. I like the way this bill is going.

CARI HERINGTON (Executive Director, Nevada Cancer Coalition):
I represent the statewide nonpartisan nonprofit partnership of both public and private health care, working together to reduce the burden of cancer in Nevada. Thank you for hearing this bill and thank you to Assemblymember Anderson for working on this with us. We've also been working closely with Medicaid.

As you know, screening is available to help prevent risk of death from breast, cervical, colorectal, lung and prostate cancer. By detecting cancer early, treatments are more successful. Currently, the NRS provides protection and coverage for our insured patients for all these evidence-based cancer screenings. This includes the newest lung cancer screening, thanks to Senate Bill 387, which is just awaiting the Governor's signature as we speak.

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

While Nevada Medicaid currently provides payment for the cost of all of these cancer screenings just listed, only breast and cervical screenings are clearly stated in NRS for Medicaid.

To answer Senator Titus' question, Medicaid follows the Affordable Care Act, which have all the United States Preventative Services Task Force (USPSTF) screenings we mentioned, in addition to prostate screenings. Nevada Medicaid covers most screening options that are recommended through the USPSTF, but they are not able to pay for the [colorectal screenings] that Assemblymember Anderson had mentioned. We're working on that one but that's okay.

We're just happy that it will all be in code, providing parity for Medicaid beneficiaries with our otherwise insured Nevadans. It would just be equal. Guaranteeing all these recommended cancer screenings for Medicaid beneficiaries—who are sometimes more challenged with cancer related risks—improves early detection of cancer, ultimately decreases overall costs and saves more lives. As such, we are in support of this bill, alongside our members and partners across the State and we really appreciate your support as well.

CHAIR DOÑATE:
We are going to close the hearing on A.B. 234 and open a work session on some of the bills we have just heard. We are going to vote on A.B. 234, A.B. 326 and A.B. 514 as a consent calendar.

SENATOR TAYLOR MOVED TO DO PASS A.B. 234, A.B. 326 AND A.B. 514.

SENATOR STONE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR DOÑATE:
With that, this meeting is adjourned as of 5:42 p.m.

RESPECTFULLY SUBMITTED:

_____
Madison Zajac,
Committee Secretary

APPROVED BY:

_____
Senator Fabian Doñate, Chair

DATE: _____

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Introduced on Minute Report Page No.**	**Witness / Entity**	**Description**
	A	1		Agenda
	B	1		Attendance Roster