MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-third Session
March 27, 2025

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 3:33 p.m. on Thursday, March 27, 2025, in Room 2134 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4 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:

Senator Dina Neal, Senatorial District No. 4
Senator Julie Pazina, Senatorial District No. 12

STAFF MEMBERS PRESENT:

Destini Cooper, Committee Policy Analyst
Eric Robbins, Committee Counsel
McKenna Melvin, Committee Secretary

OTHERS PRESENT:

Annette Logan-Parker, Founder, Cure 4 The Kids Foundation; Chair, Nevada Rare Disease Advisory Council
Craig Vincze, Founder, Max Vincze Foundation
Sumit Gupta, Chair, Nevada Newborn Screening Advisory Council
Summer Webb
Stephanie Van Hooser, Administrative Director, Nevada State Public Health Laboratory

Jacqueline Nguyen, Nevada State Medical Association
Katrin Ivanoff
Ofelia Gentscheff, Statewide Coordinator, Newborn Screening Program, Nevada State Public Health Laboratory
Nicola Longo
Sydney Mitchell, Legislative Intern for Senator Pazina
Dan Musgrove, Nevada Donor Network
Warren Hardy, La Paloma Funeral Services; Life Science Anatomical
Taylor Avery, Vegas Chamber
Mark Fiorentino, Kaempfer Crowell
Blayne Osborn, President, Nevada Rural Hospital Partners Foundation
Allison Herzik, Dignity Health-St. Rose Dominican
Patrick Kelly, Nevada Hospital Association
Joanna Jacob, Clark County
Cadence Matijevich, Washoe County
Lisa Mead, CEO, Reno Orthopedic Clinic
Gerad Davis
Saju Joseph
Matt McCord
Sabrina Schnur, Nevada Psychiatric Association
Robert Purdy, Nevada Opioid Treatment Association
Douglas Geinzer
Wolfgang Gilliar, Dean, College of Osteopathic Medicine, Touro University Nevada
Mitchell Laughton, Owner and President, The Laughton Company
Alex Logan
Angie Wilson, Executive Director, Reno-Sparks Tribal Health Center
David Cherry, City of Henderson
Adam Plain, Insurance Regulation Liaison, Division of Insurance, Nevada Department of Business and Industry
Shelly Capurro, Nevada Association of Health Plans
Brett Scolari, Reno-Sparks Indian Colony
Christian Solomon, Nevada State Director, Rise Free
Yvonne Powers, Councilmember, Shoshone-Paiute Tribe; Duck Valley Indian Reservation
William Adler, Duck Valley Shoshone-Paiute Tribe; Pyramid Lake Paiute Tribe
Jon Pishion, Health Director, Fallon Tribal Health Center
Jshauntae Marshall, Chamber of Mothers
Troy Roques, Executive Director, Vegas for Athletes

Bayo Curry-Winchell
Naysha Isom
Catherine Nielsen, Executive Director, Governor's Council on Developmental Disabilities, Nevada Department of Health and Human Services
Jollina Walker
Kaleigh Mancha, Cofounder, Heart and Sol Collective
Adkin Kolade
Eric Wilcox, Chair, Nevada Commission for Persons Who Are Deaf and Hard of Hearing
Christina Hernandez
Sue Burtch, Executive Director, National Organization for Women, Nevada Chapter
Ryan Beaman, Professional Fire Fighters of Nevada
Damon Schilling, Intermountain Health

CHAIR DOÑATE:
We will go to a work session first because we have all the members here. Then we will do the bill hearings. I will open the work session on Senate Bill (S.B.) 43.

SENATE BILL 43: Revises provisions relating to environmental protection. (BDR 40-264)

DESTINI COOPER (Committee Policy Analyst):
I have a work session document (Exhibit C) that gives the history of the bill and describes the amendments.

SENATOR LANGE MOVED TO AMEND AND DO PASS AS AMENDED S.B. 43.

SENATOR TAYLOR SECONDED THE MOTION.

SENATOR TITUS:
I am going to be a no on this bill.

THE MOTION PASSED. (SENATOR TITUS VOTED NO.)

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CHAIR DOÑATE:
I will now open the work session for S.B. 138.

SENATE BILL 138: Makes revisions governing Medicaid eligibility and enrollment for certain infants. (BDR 38-580)

MS. COOPER:
I have a work session document (Exhibit D) that gives the history of the bill and describes the amendments.

SENATOR TITUS:
One of the things that I was very concerned with on this bill, although I absolutely support in concept the presumptive eligibility and enrollment in Medicaid for these NICU babies—I worried and asked the question during the hearing about the fact that if they didn't sign with Medicaid, it would be part of their licensure. I was very concerned about that mandate, and until I have a clear understanding of that part of this bill, I am going to have to be a no on it.

CHAIR DOÑATE:
Just as a quick response, from my understanding, the bill with this amendment would be drafted so, essentially, they would have escalation procedures, similarly to what we have done with other bills in terms of issuing corrective action and so forth, before it escalates to revocation of a license. But your sentiments have been heard, and I hope that answers your question.

SENATOR TITUS:
Thank you; I am still going to be a no. But you know, it is always fun to change your vote to a yes. I never have to argue with that if I see a better bill.

ERIC ROBBINS (Committee Counsel):
I wanted to note that this bill goes in *Nevada Revised Statutes* (NRS) 422.063, not NRS 449. It is not hospital regulation.

SENATOR TITUS:
Just to be clear during the testimony, I want to make sure I am talking about the correct bill. We are talking about S.B. 138? This is presumptive eligibility for infants. During the testimony, we did discuss whether or not the mandate was for the hospitals to make sure that they are signed up with Medicaid and make sure these infants are automatically enrolled under presumptive eligibility.

MR. ROBBINS:
Correct. Just to clarify, that part goes in NRS 422.063, and so the enforcement would be the ability of the hospitals to participate in Medicaid, not necessarily their licensure. However, there is this NICU Parent's Bill of Rights, which would go in NRS 449A.

So that probably would be subject to the NRS 449 penalties, which, as the chair said, do not normally start out with a license revocation. That is a pretty severe penalty; most of that is taken care of through corrective action plans and things like that.

SENATOR TITUS:
Thank you for the clarification. I am still going to be a no.

SENATOR STONE:
I share the same concerns as my colleague, but I am going to be doing the reverse. I am going to be voting yes because we had a commitment. I think the author was going to mitigate those concerns, and I believe that they may have been or will be. I will just reserve my right to change my vote on the floor.

> SENATOR TAYLOR MOVED TO AMEND DO PASS AS AMENDED S.B. 138.
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> SENATOR LANGE SECONDED THE MOTION.
>
> THE MOTION PASSED. (SENATOR TITUS VOTED NO.)

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CHAIR DOÑATE:
I will now open the work session for S.B. 185.

SENATE BILL 185: Revises provisions relating to Medicaid reimbursement for care of disabled or chronically ill children. (BDR 38-760)

MS. COOPER:
This bill was sponsored by Senator Angela Taylor and heard on February 18. As mentioned in the work session document (Exhibit E), S.B. 185 requires the Department of Health and Human Services to reimburse a family member of a

recipient of Medicaid for providing personal care services covered by Medicaid to the recipient in certain circumstances. There was an amendment, but I do want to note the intent on this because it wasn't necessarily carried out through the amendment but Legal intends to clarify the language.

The intent of the amendment included in the work session document, Exhibit E, is to clarify that the reimbursement for personal care services for family members will be provided under the same conditions as reimbursement for personal care services provided by other persons. The amendment requires Medicaid to provide reimbursements for personal care services, including, without limitation, personal care services provided by a qualified family member.

SENATOR TITUS MOVED TO AMEND AND DO PASS AS AMENDED S.B. 185.

SENATOR LANGE SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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CHAIR DOÑATE:
I will now open the work session for S.B. 207.

SENATE BILL 207: Requires the establishment of a program of all-inclusive care for the elderly. (BDR 38-763)

MS. COOPER:
I have a work session document (Exhibit F) that gives the history of the bill and describes the amendment to the bill.

SENATOR TITUS MOVED TO AMEND AND DO PASS AS AMENDED S.B. 207.

SENATOR STONE SECONDED THE MOTION.

SENATOR TAYLOR:
I just want to take a moment to thank Governor [Robert] List for being fully engaged in this process and being a part of putting the presentation together, making sure we came up with a bill that is really going to help Nevadans.

THE MOTION PASSED UNANIMOUSLY.

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CHAIR DOÑATE:
I will now open the work session for S.B. 244.

SENATE BILL 244: Requires Medicaid to provide coverage of certain treatments for obesity. (BDR 38-206)

MS. COOPER:
I have a work session document (Exhibit G) that gives the history of the bill, and there were no amendments.

SENATOR TAYLOR MOVED TO AMEND DO PASS S.B. 244.

SENATOR LANGE SECONDED THE MOTION.

SENATOR TITUS:
I have some concerns about some of these drugs for children. I'm worried about a medical environment change and what care is appropriate for youth in particular. I am worried about any mandates of coverage. I trust that this is going to go through a review process through Medicaid, however, it still has some hurdles to go through. So, I will be a yes to get this out of the committee but may change as things progress.

SENATOR STONE:
I regret that I am going to be a no vote on this again, because of these newer drugs and the studies in children. I know we are not a fiscal committee, but the price tag associated with this is high. So I am going to be a no for now, but I reserve the right to change my vote when we come to the floor.

SENATOR TAYLOR:
I just wanted to say, I will move this because I like what it does. There is a little more information that I would like, so I reserve my right to change if necessary. I am not sure that will be the case, but I wanted that to go on record.

THE MOTION PASSED. (SENATOR STONE VOTED NO.)

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CHAIR DOÑATE:
We have completed the work session for today and so now we will move on to the bill presentations, starting with opening the hearing on S.B. 348.

SENATE BILL 348: Makes revisions relating to health care. (BDR 40-123)

SENATOR JULIE PAZINA (Senatorial District No. 12):
I am presenting S.B. 348, which makes revisions relating to health care. I have with me today Annette Logan-Parker, Founder and Chief Advocacy and Innovation Officer of Cure 4 The Kids Foundation. I am going to hand it over to her to share some background on the bill, and then I will briefly walk through the sections.

ANNETTE LOGAN-PARKER (Founder, Cure 4 The Kids Foundation; Chair, Nevada's Rare Disease Advisory Council):
I have attended over 200 funerals for Nevada's children and that is not something I say lightly. I carry their stories with me every day. I can't help but wonder how many of them might still be here if they had been diagnosed sooner. Senate Bill 348 gives us the tools to act earlier, save lives and prevent the kind of heartbreak that happens far too often when life-threatening conditions in children are detected too late. Thank you for the opportunity to present this legislation which modernizes Nevada's Newborn Screening Program in four critical ways.

First, it ensures Nevada automatically adopts all federally recommended conditions listed on the recommended uniform screening panel, keeping our State aligned with national best practices. Two, it updates Nevada's newborn screening fee to a sustainable amount with modest inflation-based adjustments, to ensure the program can keep pace with rising costs and evolving technology. Third, it also strengthens our statewide infrastructure, ensuring newborns who

screen positive receive timely, in-state follow-up care including access to genetic services. Fourth, it establishes licensure for genetic counselors so families have access to qualified, compassionate professionals at a time when clear guidance matters most.

I want to take a moment to acknowledge the important work being led by Senator Lange through S.B. 189 that also addresses licensure of genetic counselors.

SENATE BILL 189: Provides for the licensure and regulation of genetic counselors. (BDR 54-69).

These two bills share the same goal, and we support aligning the language of those two bills. It is important to understand that S.B. 348 is not about starting something new, it's about bringing Nevada in line with national standards. At Cure 4 The Kids Foundation, we care for children across the State and the surrounding region. Many of them arrive at our clinic after months or even years of unexplained symptoms and no diagnosis. Families often tell us they've seen several doctors before finally being referred to us. Tragically, we have seen too many children whose conditions could have been treated far more effectively if they had been identified at birth.

Newborn screening is widely recognized as one of the most effective and cost-saving public health strategies. The CDC ranks it among the top ten public health achievements of the 20th century. It's fast; it's not invasive, and it's performed within 48 hours of birth. It detects life-threatening yet completely treatable conditions. It saves more than 13,000 lives annually in the United States.

This legislation has the power to prevent heartbreaking delays in care for dozens of Nevada families. These are newborns who under today's limited screening panel may go months or even years without a diagnosis, missing the critical window when early intervention has the opportunity to change things in a significant way. When even one child falls through the cracks, the consequences can be lifelong. Multiply that across our State; the impact both personally and financially is staggering.

From a fiscal standpoint, the return on investment is undeniable. By identifying just a few additional cases through expanded screening, Nevada stands to save

millions of dollars every year, not only through fewer NICU stays and reduced emergency interventions, but also through a lower demand for long-term medical and disability services for these infants. Every year, Nevada misses the chance to save lives and millions of dollars, not because we lack the science or the treatment, but because our system hasn't kept up.

There is recoverable revenue to be found in smart public health strategies, and newborn screening is one of the clearest examples we have. When we catch conditions early, we avoid costly crisis care, prevent prolonged hospitalizations and dramatically reduce reliance on lifelong support services. We're not asking for a blank check. We're offering a substantial return, a return measured not only in dollars saved, but lives changed.

This has the power of preventative public health done right, and that is the promise of this legislation. We also cannot overstate the importance of the Nevada State Public Health Laboratory (NSPHL) in this effort. They're the only lab authorized to process newborn screening samples in Nevada. This legislation ensures that it remains aligned with national standards, has the support needed to expand its capacity and modernize equipment.

I want to be extremely clear about the newborn screening fee. It is not a new fee or a tax. The proposed increase of $69 per live birth is a simple adjustment to an existing charge that has remained unchanged for over a decade. Despite rising healthcare costs and expanded testing capabilities, it's fully covered by insurance. More importantly, it is not billed separately to families. It remains embedded in the hospital's global labor and delivery reimbursement rate.

While Nevada's newborn screening fee has remained among the lowest in the country, our reimbursement rates for labor and delivery have steadily increased. Hospital fees for childbirth-related costs have risen in the last decade, though the newborn screening fee has not. Updating the screening fee simply aligns it with the economic reality the rest of the system has already recognized. Even with the long overdue adjustment, Nevada will continue to have one of the lowest newborn screening rates in the country. This modest increase ensures the program is sustainable, responsive and aligned with national standards.

This bill also prioritizes keeping families in Nevada by expanding access to clinical genetic services. It includes language to support genetic counselor licensure and provides essential resources to grow the specialized medical

genetics program at Cure 4 The Kids Foundation. By investing in local infrastructure and expertise, we help ensure families receive timely accurate diagnoses and counseling when they need it the most. This not only improves outcomes but also significantly reduces healthcare spending.

On average, out-of-state care for genetic services can cost Nevada between $15,000 and $25,000 per patient annually when factoring in medical expenses, travel and lost productivity. By localizing care, the State can save resources while keeping families closer to home during some of the most difficult moments of their lives. Early detection also relieves pressure on our overstretched healthcare workforce. In a state facing serious pediatric and pediatric specialist shortages, preventing advanced illnesses through early screening means fewer emergency room visits, shorter NICU days and less strain on care teams. It helps Nevada make the most of the resources that we do have by acting early rather than reacting too late.

The benefits of newborn screening extend well beyond healthcare. Misdiagnoses often lead to greater reliance on special education programs, behavioral interventions and long-term disability services. When conditions are caught early, we give children a better chance at school. We also reduce the burden on school districts and Medicaid-supported services. This bill is a win for every sector that touches a child's life.

Importantly, newborn screening is not a partisan issue. It is one of the rare policies that brings Legislators together because it saves lives, lowers costs and represents the kind of thoughtful, proactive government that we all want to see. I have walked beside families navigating the most unimaginable circumstances, including parents who have exhausted every resource, seen a dozen doctors and still had no answers. I have also seen the power of early diagnosis, the relief it brings, the hope it restores and the outcomes that are only possible when we catch a life-threatening condition in time.

I started today by telling you I have attended over 200 funerals for Nevada's children. I will end by telling you this: I know without question some of those children would still be here today if their conditions had been diagnosed earlier. Before I close, I would like to share a powerful statement from a letter of support (Exhibit H) submitted by the Southern Nevada Health District, the largest public health authority in the State serving more than two million Nevadans.

> We recognize that early detection and prevention are crucial for improving health outcomes and reducing long-term costs. Newborn screening is one of the most effective public health measures available. It's quick, safe, and can detect a wide range of serious yet treatable conditions within days of birth, often before symptoms emerge.

Senate Bill 348 is a lifesaving bill with a cost saving return, and on behalf of the families we serve today and the thousands of babies yet to be born in Nevada, I respectfully urge your support.

SENATOR PAZINA:
Recognizing time is of the essence and presentation times are probably limited, I am happy to skip going through a review of the bill because I believe everyone's already read it. The reason I felt like this bill was so important and that I worked with Ms. Logan-Parker was that I had the opportunity in 2019 to work alongside a previous Senator who was just announced to the Hall of Fame today, Joyce Woodhouse, on S.B. No. 315 of the 80th Session which created the Rare Disease Advisory Council.

That was brought about by a current constituent of mine, formerly a constituent of Joyce Woodhouse, who lost a son at the age of six to undiagnosed childhood cancer within 48 hours of diagnosis. The importance of early diagnosis can't be emphasized enough. That is why this bill is so important and why I am so happy we are able to bring it today.

SENATOR TITUS:
I appreciate you bringing the bill forward, and I appreciate your engagement. I have a number of questions. First, I have been on the Health and Human Services Committee in both houses now. We have certainly expanded the list of tests that we do on our newborn screening. I do not see anywhere in the bill that expands the tests that we are doing.

MS. LOGAN-PARKER:
What we are referencing is keeping Nevada's newborn screening panel consistent with the federally recommended universal screening panel. Right now, Nevada does not meet all of the conditions listed on that panel.

SENATOR TITUS:
So, for clarity then, if we adopted this and if Nevada doesn't do it already, it would mandate that they increase the number of tests that we are currently doing?

MS. LOGAN-PARKER:
Correct.

SENATOR TITUS:
Is the state lab prepared to do that with the current machines that they have?

MS. LOGAN-PARKER:
No, part of this bill includes resources to expand the laboratory capabilities.

SENATOR TITUS:
So, you said it is just a modest increase, but in reality, it is almost 100 percent. Not quite because the current fee is—you said it is going to increase by $69 up to $150. That is not just a modest increase in fees; that's a dramatic increase in fees. When you mentioned that patients will not have to pay for it, somebody pays for it.

You said it is included in the global rate. One of the problems on global rates is when you get reimbursed as a provider, you get reimbursed for a delivery. They give you X amount of dollars globally for that delivery. But now there's an increase in charges for that delivery. They do not reimburse you for sutures that you might need, episiotomies and a blood transfusion, even if they bleed—all of those things they do not reimburse you for because it is a global rate. Now you are adding to that an additional fee. Is that correct?

MS. LOGAN-PARKER:
Yes, so the hospital would be responsible for the difference.

SENATOR TITUS:
Correct, that is what I am getting at. Even though you said it is not a big fee and nobody pays for it, somebody pays for it. Again, that is where some of the costs come from. I know we are not a money committee, but that is just part of the reality of these things.

One more question: you are putting a genetic counselor in the definition of healthcare provider. I certainly believe in genetic counselors. Literally just three months ago, I lost a great nephew; he was three months old—no history, no problems. My niece had him maybe a week late, and then he was perfect. They went home for a week, and then suddenly he couldn't breathe; he had a very rare genetic disorder. He just died recently after they did all they could for three months; there was no test that could have predicted this. These things, these tragedies happen to families across the board, across the world, frankly.

I know your passion. You have been in this realm, and you have seen things that you have diagnosed, or you know if they could have been diagnosed. But again, a genetic counselor can just offer information to parents assuming they have these tests. For me, it's information as opposed to somebody who is actually a healthcare provider.

Putting the genetic counselor under the definition of a healthcare provider has me some somewhat concerned because they are just a provider of information, and perhaps in the long run that is ultimately health care. But for me, it's just a stretch of the definition of a healthcare provider. It's more of a purveyor of information than a healthcare provider. So that is just something I have a concern about. I didn't know if other states have them included in their definition of healthcare provider. Can you tell me how many states?

MS. LOGAN-PARKER:
I don't have the exact statistics available for you right now, but I am happy to follow up with you. There are several states. I just do not know the exact number of states.

CHAIR DOÑATE:
Thirty-four states.

SENATOR TITUS:
So, if they're designated as healthcare providers …

MS. LOGAN-PARKER:
I also want to say I am so sorry for your loss.

SENATOR TITUS:
I appreciate that. If genetic counselors are designated as healthcare providers, is that something then Medicaid could charge? Will they be given a National Provider Identifier number and then charge for their services and be reimbursed through the Medicaid office for insurances?

MS. LOGAN-PARKER:
Yes.

SENATOR TITUS:
These other states where [genetic counselors] exist, are they currently reimbursed?

MS. LOGAN-PARKER:
Many of them are.

SENATOR TITUS:
Some are, but you do not know that they all are?

MS. LOGAN-PARKER:
I do not know that they all are.

SENATOR TITUS:
I am just wondering about premium rate costs. And again, we are not financial, but the reality of the decisions we make here will ultimately end up over in that committee. So anyways, I appreciate all the questions, and I appreciate you bringing the bill forward.

CHAIR DOÑATE:
My understanding of the rationale to get them licensed is because there is a level of credibility in terms of them having to get their master's degrees and so forth. But there's nothing in state law right now prohibiting someone to say they are a genetic counselor. There are no reporting requirements in terms of a person not being authorized to actually be giving this advice, because either they are not qualified, or they are giving wrong advice. This bill would establish the pathway to do that, right?

MS. LOGAN-PARKER:
Correct.

SENATOR LANGE:
Currently, there's no licensure for genetic counselors. Just to clarify for your bill, you want to get them licensed because then they can bill the insurance for their services. Is that correct?

MS. LOGAN-PARKER:
That is correct.

CHAIR DOÑATE:
I know we're not a money committee, but I just wanted to know the intention because it obviously deals with the policy with the NSPHL—to stand up the construction of expanded laboratory space. Didn't we already give them funding to do this? Didn't they just open a new facility, or they are about to open a new facility? I am wondering, is this for Southern Nevada? Or what's the purpose of that?

MS. LOGAN-PARKER:
The purpose is to expand the current laboratory even more than it already has expanded. A lot of the resources are for the laboratory equipment itself and the space required to house that laboratory equipment.

CHAIR DOÑATE:
Would that be in Northern Nevada or in Southern Nevada?

MS. LOGAN-PARKER:
Northern Nevada.

CHAIR DOÑATE:
Got it. I am just saying, we should probably look at building facilities down south.

CRAIG VINCZE (Founder, Max Vincze Foundation):
I am here today in strong support of S.B. 348. I am the founder of the Max Vincze Foundation, but I am also the father who lost his son to a rare cancer. In 2021, my 22-year-old son Max died 90 days after diagnosis from a cancer called NUT carcinoma. This is an aggressive cancer that strikes predominantly in young people. Those 90 days revealed not only the devastation of his diagnosis for him and our family, but also the fragmented system of care for rare diseases in Nevada.

Senate Bill 348 creates a critical pathway for faster and more accurate diagnoses by integrating genetic expertise into our local care system for aggressive cancers like my son's and others that predominantly affect young people. Every day is a difference between life and death. As was previously discussed, this bill modernizes Nevada's Newborn Screening Program. I see the true value lies in building a comprehensive infrastructure for rare diseases throughout an entire citizen's lifetime. This is especially vital for adolescent and young adult cancer patients like my son, Max. They are actually in a severely underserved category just by virtue of their age.

One of the biggest tragedies of Max's journey was the weeks it took to get genetic testing for his tumor. Doctors could not even start treatment because they did not know what kind of tumor they were dealing with. We waited three weeks to get the answer. Now, when you have 90 days to live and you wait three weeks for an answer that in other cities and states they are getting in two days, we can do better.

This bill would strengthen the foundation for improving genetic testing and care. A lot of the same disciplines are needed between the newborn screening and what they need to find tumor genetic information. I urge you to vote in favor of this, not just for Max's memory but every Nevada family facing the nightmare of a rare disease diagnosis and those who will. I submitted a letter of support (Exhibit I) for S.B. 348.

CHAIR DOÑATE:
Thank you so much for sharing your story. We're sorry for your loss.

SUMIT GUPTA (Chair, Nevada Newborn Screening Advisory Council):
I practice pediatric hematology oncology here in Las Vegas. I am here today to speak in strong support of S.B. 348, which represents a critical step forward in modernizing Nevada's Newborn Screening Program. Newborn screening is one of the most impactful and cost-effective tools in public health. It allows us to detect serious treatable conditions before symptoms appear, giving children the best possible chance at a healthy start and preventing the need for costly lifelong care.

One of the clearest examples of the impact is cystic fibrosis. Before screening, children were often diagnosed only after irreversible damage had occurred. When cystic fibrosis was added to the federal screening panel in 2006,

outcomes improved dramatically. But Nevada did not adopt cystic fibrosis screening until 2009, meaning families here missed out an early detection for three critical years. Another example is spinal muscular atrophy in which children die before their second birthday if they do not get treatment on time. We added this in the screening panel in 2024, being the forty-ninth state in the United States to do so.

Senate Bill 348 ensures that will not happen again; this bill allows Nevada to automatically adopt federally recommended screening conditions. It also invests in NSHPL, supports in-state follow-up care and updates the long-outdated screening fee, so we can keep pace with modern standards. Early detection saves lives and every $1 invested in newborn screening yields an estimated $4 to $10 in savings by preventing costly emergency care, long-term treatment and social service needs. Senate Bill 348 is a smart evidence-based investment that is both urgently needed and long overdue. I have submitted a written letter of support (Exhibit J). Thank you for your time and your commitment to the Nevada children.

SUMMER WEBB:
I am the mother of a child with Infantile Onset Pompe Disease. I support S.B. 348. Two years ago, my three-year-old son was hospitalized for a respiratory infection. Although he had been cured of the original virus we came in for, something was still wrong. As time went on, he became worse, having to be intubated and placed on life support. All his organs were in distress, and he was in a coma fighting for his life. He lost all muscle tone and became 0 months old. Our smart beautiful boy lost his ability to talk, walk, hold his head up, hug and kiss us … etcetera. The doctors and medical staff exhausted their resources and told my husband and I they could do no more.

They said we would need to go to Utah or LA for help. We airlifted our son to Utah in a snowstorm, on life support, leaving our minor children at home. We are originally from Los Angeles and have no family in Las Vegas. Family members had to alternate coming to our home to watch the kids for 5 months as we went from Utah and then to UCLA [University of California, Los Angeles] to get diagnosis and begin treatment. I lived in the ICU with my son, never leaving. This took a real toll on my family during an already traumatic situation.

Nevada is one of the few states that did not screen for Pompe Disease on the newborn screening. We found out that our son was born with Infantile Onset

Pompe Disease and there is no cure. His body doesn't produce the enzyme needed to break down the sugar in his body, so it stores and builds up in his muscles, causing damage. This means that since birth, then sugar was storing and building up in his muscles, creating scar tissue around all his muscles until every muscle in his body either gave out or almost gave out. His heart was enlarged, kidneys almost failing, lungs on a ventilator and no longer able to do anything. Most children with this disorder don't live past the age of two.

Now my son gets life-saving enzyme replacement infusions every week and is fighting every day to live, but twice as hard because of all the irreversible damage that was done before he received treatment. I am originally from California and have been living in Las Vegas for ten years now. I am the VP of a finance company here in Nevada and on the executive board of the Women's Chamber of Commerce in Nevada and hold several board positions for charitable organizations and support our community.

Although I love living in Las Vegas and raising my family here, I can't help but regret moving here and having my child here, because California does check for Pompe Disease, and if I would have had my son in California, he would have been screened for Pompe at birth and would have been monitored and receiving treatment sooner. This could have prevented him getting so far gone before getting a proper diagnosis and treatment and saved our family so much devastation. I urge you to pass this bill because time is everything with these rare diseases. I have submitted my written testimony (Exhibit K).

STEPHANIE VAN HOOSER (Administrative Director, Nevada State Public Health Laboratory):

In July 2014, the Nevada State Public Health Laboratory began conducting newborn screening in state, transitioning from the prior practice of out-of-state testing. At implementation, the screening panel included 28 of the 36 core conditions recommended by the Health Resources and Services Administration (HRSA) through the Recommended Uniform Screening Panel (RUSP). Since that time, the Laboratory has successfully expanded RUSP to include severe combined immunodeficiency, spinal muscular atrophy and X-linked adrenoleukodystrophy, all was supported by funding from HRSA and the American Rescue Plan Act.

Since 2014, the laboratory has maintained a newborn screening fee of $81 per birth, which includes both the first and the second screen. This fee is one of the

lowest in the nation. Currently, five core conditions recommended by the RUSP have yet to be implemented in Nevada. Establishing a modernized, sustainable fee structure is essential for the Nevada State Public Health Laboratory to maintain its current testing capabilities and expand the state's newborn screening panel in alignment with the RUSP.

I respectfully urge your support of S.B. 348, a critical measure aimed at strengthening Nevada's public health infrastructure and improving health outcomes for the state's newborns and their families. I have submitted my written testimony with further information (Exhibit L).

JACQUELINE NGUYEN (Nevada State Medical Association):
The Nevada State Medical Association (NSMA) had worked on amendments and supported S.B. No. 189 of the 83rd Session and really appreciate that the language here will be aligned to that. This bill will bring improvements to Nevada's Newborn Screening Program by expanding access to early detection of rare but treatable genetic or metabolic conditions. We know that early intervention can lead to better health outcomes, reduce long-term healthcare costs and, most importantly, help reduce heartache for patients and their families. Thank you; NSMA is in support.

KATRIN IVANOFF:
I urge you to vote for this bill to make needed changes and think of out-of-the-box solutions. Somebody mentioned maybe building another app in rural Nevada, where it's going to be cheaper and help create more jobs there. Or [we could] cut some other spending like the Christmas view where we are giving money to nonprofits. I love nonprofits, but nonprofits should be financed by private people, not by our tax money. They could have used this money to support views like this where it is affecting everybody, regardless of their political views or color or anything, anything that can be screened and detected early.

We all know early detection is very important for preventing death, and [I am] fortunate enough not to be in the situation of the people that are presenting this view. I have not lost a child or something like that, thank you Lord. However, I am a parent, and my heart goes out to any parent who lost a child. I do not care what views or political agenda they have. This bill would help everybody.

One of the Legislators had to leave the Legislature because she went to work for the nonprofit that they voted $250,000 for. Her salary was $250,000 in that same nonprofit with three people working in it and probably all the money going for salary …

OFELIA GENTSCHEFF (Statewide Coordinator, Newborn Screening Program, Nevada State Public Health Laboratory):
Each year, we screen more than 33,000 Nevada newborns for serious but treatable conditions. Our work is time-sensitive, even delays of a student can result in irreversible damage or missed opportunities for treatment. As the federal government continues to expand the list of recommended screening conditions, we must also expand our capacity. This includes modernizing our equipment, hiring and training more laboratory staff and maintaining rapid turnaround times for lifesaving results.

Senate Bill 348 directly supports this need. It ensures that Nevada not only adopts all federally recommended screening conditions but also has the laboratory infrastructure to implement them effectively. Right now, we're at a tipping point. Our laboratory team is dedicated, but we cannot do more with the same resources. Senate Bill 348 gives us the tools to keep pace with science and serve families statewide with accuracy, speed and reliability.

I respectfully urge your support for this important bill and for the laboratory capacity that makes newborn screening truly work. Thank you for your time and dedication in promoting public health and the needs of our most vulnerable population. I have submitted my letter of support (Exhibit M).

CHAIR DOÑATE:
That concludes our time allocated for support testimony, we will now move on to testimony in opposition. There being no testimony in opposition, we will move on to neutral testimony.

NICOLA LONGO:
I am a clinical and biochemical geneticist from the University of California, Los Angeles (UCLA). I have been coming to Las Vegas to see patients with metabolic disorders for a long time. I believe it is important that Nevada has the opportunity of finding and hiring their own metabolic geneticist to identify and treat patients with metabolic disorders. These children are identified by newborn testing and need to go out of state. They come to see us at UCLA, or they go

to the University of Utah, where I worked until last year, to receive care. I think that there needs to be a provision to allow a physician in Nevada to stay in Nevada and to care for these patients. I hope that with the expansion of this bill, there will be a sufficient amount of money for the newborn screening program to accomplish all of the goals that are part of the two programs, not just a screening test. I submitted my letter of support (Exhibit N).

CHAIR DOÑATE:
We're going to close this testimony. We do have a proposed amendment from Senator Pazina and Annette Logan-Parker (Exhibit O), support documents from Ms. Logan-Parker on behalf of Cure 4 The Kids and Nevada Rare Disease Advisory Council (Exhibit P) and 42 letters of support (Exhibit Q) that I will submit. I will close the hearing on S.B. 348 and open the hearing on S.B. 349.

SENATE BILL 349: Revises provisions relating to anatomical gifts. (BDR 40-543)

SENATOR JULIE PAZINA (Senatorial District No. 12):
I am going to introduce my wonderful hardworking intern from the University of Nevada, Las Vegas (UNLV), who's going to help present S.B. 349. She will work with the Nevada Donor Network and Dan Musgrove on that presentation. Sydney Mitchell has been serving as my legislative intern during the session. She was born and raised in Nevada and is currently a third-year student at UNLV studying political science with a minor in Spanish. Sydney currently aides at Brookings Mountain West and the Lincy Institute with their data hub project, a think tank on public policy in the Mountain West region. She comes by her love of education honestly, because her dad is a public school teacher in Clark County.

SYDNEY MITCHELL (Legislative Intern for Senator Pazina):
I am presenting S.B. 349. I am going to give a small piece of background before I turn it over to Dan Musgrove. I think there are some important things to note. According to an investigation from the Kaiser Health Foundation, between 2014 and 2019, roughly 170 organs could not be transplanted. Almost 370 were near misses due to delays from transportation issues. With over 113,000 people on the waitlist desperately waiting for a life-changing organ, there are many missed opportunities due to transportation wait times. This is something to keep in mind throughout this presentation. With that, I will now be turning the presentation over to Dan Musgrove.

DAN MUSGROVE (Nevada Donor Network):
I am going to walk you through the amendment (Exhibit R), which changes a couple of portions of the bill in response to work that we have been doing with both the funeral and mortuary folks, as well as coroners from Clark and Washoe Counties. They are crucial partners to the Nevada Donor Network (NDN) in the work we do. It was important for us that they felt comfortable with what we are trying to accomplish. The idea of transportation of the deceased is, from what I understand, a bit silent in NRS. What we want to do, especially in Southern Nevada, and hope to do in other areas of the State is creating what is called a donor care unit (DCU). We are at the mercy of hospitals and sometimes the funeral homes for our ability to procure organs for lifesaving transplants.

As you may be aware, there is a very finite window of time in which organs are viable. It is very crucial for us, as Ms. Mitchell described, to make sure we are within those guidelines so that those organs can become viable and be given for lifesaving transplants. We wanted to make sure that we're creating this DCU, which will be an off-site facility. Normally this happens in a hospital but, as you can imagine, sometimes hospital ORs are very busy. Sometimes mortuaries and funeral homes are very busy, and so we are at their mercy. We wanted the ability to transport to our DCU so we can begin that procurement process.

This bill does a couple of things. It allows the county coroner to prescribe a procedure allowing for the procurement organization—someone like NDN—to arrange for transportation within the State to get that body or part for transplantation. The second thing we did was ensure to only transport when we need special medical equipment to make sure that the transport is safe and ensures viability. That was the second half of our amendment. It's so crucial that we have this opportunity because one person, one organ donor, can save the lives of eight people. The tissue and other stuff can impact, prolong and help people beyond that.

SENATOR LANGE:
As you know, Renown is opening a transplant center, and they are going to do kidneys now and move to livers. I am just wondering, in this bill, if you have thought ahead about a provision to do this in Reno?

MR. MUSGROVE:
It allows for that. It is open enough so it can be done statewide. There is a county coroner in Clark and in Washoe County. We work tremendously well

with Dr. Laura Knight. At this point, we don't immediately envision the need to have a DCU because of the sheer volume. Renown, they or the other hospitals, will be able to help us. But absolutely, if we feel that the need is great enough, then we would create a DCU up here in Reno. Then we would work with the Washoe County Coroner and the bill allows for that.

SENATOR LANGE:
So, my question then is if the need was there to be able to have this in Reno, how long would it take to set it up?

MR. MUSGROVE:
I will get that information for you.

SENATOR TITUS:
I appreciate the conversation we've had and, Senator, I appreciate you bringing stuff forward like this. I have a number of questions really. Currently, if you are looking at moving a donor who has been determined no longer living, you're going to be able to transport that body to harvest organs at a different location or are you looking at just pieces?

MR. MUSGROVE:
The Nevada Donor Network is working right now to build a DCU, which would be an off-site facility. It would essentially have an operating room where our doctors and staff could then take the deceased and procure the organs. Like I said earlier, we are sometimes at the mercy of hospitals and using their emergency rooms to do that right now. They certainly want to be helpful, but sometimes they need those rooms, and we certainly do not want to miss our window of time.

SENATOR TITUS:
So, you are looking at picking up the donor from a location where they've been declared and then transporting them to a specific location where you would then harvest whatever there is to harvest. Then you will ask the coroner to come and get the …? Give me a process here.

MR. MUSGROVE:
The funeral folks might be able to add some additional color to that. We would go with whatever the family's wishes are. Normally, at that point, the funeral

home will pick up the deceased and begin that normal process of whatever the family's wishes might be.

SENATOR TITUS:
When you have a transport, I understand that they may be on a ventilator still, so they are going to have some medical equipment. Who will regulate it? Will they be subject to the same regulation as the ambulance paramedics—those folks who deal with ventilators and deal with emergency vehicles?

MR. MUSGROVE:
I would like to get a more advanced answer to you. But my belief and from what I understand is because the individual is deceased, has been declared dead, there isn't quite a strict regulation that is in place as far as I know. But we would basically have a vehicle that has that equipment on it to preserve the viability of the organs. That is our sole intent of having that medical equipment because, again, the person in the hospital has been declared deceased.

SENATOR TITUS:
Is the attendant in that vehicle going to be a licensed paramedic? Or are they going to understand how you operate in intubation? How do you operate perhaps cardiac compressions? Who will be attending, what license would it be and then liability?

MR. MUSGROVE:
I think we would be assuming the liability at that point in that our staff deals with these individuals who have willingly become an organ donor, the requisite training and certifications. But I will get you a specific answer as to who we envision in the vehicle that we transport. I imagine that would be done in regulation or by whoever has the jurisdiction. This is probably not in NRS, but I will get that information for you.

SENATOR TITUS:
Right, I think there's a whole licensure component to a transport vehicle essentially with medical equipment on board. It's not an ambulance per se; you're moving a body that you're continuing to keep some viability to it, as you testified. There's a lot of logistics and a lot of pieces to that, literally. The concept is great, and I understand the problem. In my area, rural Nevada, when I would pronounce somebody and have to contact the donor network and all of the above, there could be delays. Certainly, we want to maximize if somebody

did wish to donate, that could certainly be part of their wishes. I am concerned about the logistics and what really has to happen here. Although the concept sounds great.

CHAIR DOÑATE:
I think the concern that I had was more in terms of what it would take to become a procurement organization and what the requirements and standards are if there is an effort of malfeasance and they are not transporting correctly. I know last session, we talked about the influence of a black market, if there was one. I know that is not the case, but I wanted to see what the reporting requirements are if you know there was a sign of negligence, and I think that is what Senator Titus was kind of hinting at, right? How do you go after someone that makes an error? Is it the technicians themselves? Is it the entity? Is it the organization? I believe, from my understanding, that you have the Centers for Medicare & Medicaid Services (CMS) designation. It would be CMS that would essentially revoke your license to practice.

MR. MUSGROVE:
You hit it on the head, it is CMS. There are 56 designated Organ Procurement Organizations (OPO) across the country, and they have to meet a very high level of standards to be considered one of those OPOs.

CHAIR DOÑATE:
The only thing I would recommend in the amendment, just to tighten it, is perhaps in the regulations that the coroner's office would prescribe some issuance of revocation, as well, at the local level if they notice complaints. So, we do not have to wait for CMS, because we know the magnitude of CMS and sometimes it is delayed and so forth. I am just saying that as more of a long-term thing.

WARREN HARDY (La Paloma Funeral Services; Life Science Anatomical):
We do appreciate our partnership with the NDN; they are our OPO in Nevada, and we are grateful to have them. We are grateful for the work they do. We're also grateful to Senator Pazina, the sponsor of the bill, for her willingness to hear our concerns. I am encouraged by the conversation that has occurred before the committee because this is an area that there's not a lot of direction and protections and we need them, so we get very concerned. We are very concerned, obviously, because most of the protections that do exist in the State

reside with the funeral directors and the funeral homes that are traditionally the ones that pick up these decedents.

What the NDN and Senator Pazina have identified here is a need. There are a few of these transports where it actually requires medical equipment to protect the viability of the organ. We are not interested in taking on that liability or investing in the equipment necessary to do it. So, the language drafted is fantastic for us. We appreciate the sponsors and the proponents working with us on this bill.

TAYLOR AVERY (Vegas Chamber):
The Vegas Chamber is in support of S.B. 349. We appreciate the bill's intent to allow procurement organizations, which effectively operate as middlemen, to transport anatomical gifts to facilitate effective and speedy organ donations. This ensures a donor's last wishes are honored and precious anatomical gifts don't go to waste.

MARK FIORENTINO (Kaempfer Crowell):
We represent the Davis Funeral Home, and I will say we mostly say ditto to former Senator Warren Hardy's testimony. We're very grateful to Senator Pazina for working with us and the other stakeholders to get into the position of where it is at. We are supportive.

BLAYNE OSBORN (President, Nevada Rural Hospital Partners):
For the record, full disclosure, I am a board member of the Nevada Donor Network. I think this is a very good bill and happy to be here in support.

ALLISON HERZIK (Dignity Health-St. Rose Dominican):
We are in support.

PATRICK KELLY (Nevada Hospital Association):
We support organ procurement efforts.

JOANNA JACOB (Clark County):
I'm here today on behalf of Clark County in the neutral position. They want to thank Mr. Musgrove and Senator Pazina. The amendment that was before you referencing coroners was something that worked on with the bill proponents. What we really envisioned with that, after the discussion today, might need some more work. From what we heard from the committee, we envision that

would be a process whereby we would ensure that the coroner would be notified if there was a transport, particularly if there's an investigation that is ongoing, and that was kind of our intent there. We certainly will continue to work with the NDN, as we did last session and as we have traditionally done, to tighten up the language to hopefully bring it back to you for consideration for work session.

CADENCE MATIJEVICH (Washoe County):
I will ditto the comments from Ms. Jacob; I don't think we envisioned that coroners would be establishing regulations that had to do with the actual procurement. I think that is a little outside of the scope of what they do. We look forward to working with Senator Pazina on that, and perhaps there might be another entity that is more appropriate to establish those regulations. We're not sure that it is the medical examiner or coroner.

MR. MUSGROVE:
I just wanted to thank this committee because of S.B. No. 109 of the 82nd Session. Because of the work that you made us do on that bill, 20 people have qualified, and 80 lives have been saved.

Here's a story, an unintended wonderful consequence. A young 15-year-old got into an argument with his parents and left his house on his bicycle, had no ID, no identification, no cell phone and was tragically hit in a car accident. They could not identify him, but because of S.B. No. 109 of the 82nd Session, we went through a laborious process of trying to find out who he might be related to. We found his mother and father. She had the chance to say goodbye to her son in the hospital rather than in the coroner's office. That is the impact of the legislation that you do on a daily basis.

CHAIR DOÑATE:
I will now open the bill hearing for S.B. 337.

SENATE BILL 337: Revises provisions relating to opioids. (BDR 40-204)

SENATOR ROBERTA LANGE (Senatorial District No. 7):
Today, I am presenting S.B. 337, which revises provisions related to opioids. I will have my experts speak to you. Then I will go over the sections of the bill because it is a lengthy bill, and I think that is probably a really good thing to do.

LISA MEAD (CEO, Reno Orthopedic Clinic):
I am a proud Nevadan and here as both a mother and the CEO of Reno Orthopedic Center. I have dedicated 40 years to healthcare administration, hospitals, medical schools and private practice. In that time, I have witnessed firsthand both the power and the peril of pain management. For surgeons, including the 35 I work for, opioids were once the gold standard for post-surgical pain relief. We are trained to use them as a primary tool, but we have also seen the unintended consequences.

Patients who once came to us seeking relief from pain have instead found themselves trapped in a cycle of dependence. I have seen it professionally in the patients we serve, and I have experienced the devastation of opioid addiction after a legal prescription within my own family. Even with my direct knowledge and access that led us to one of the best and only physicians in the world performing a rare procedure at one of the most prestigious facilities in the world, I could not predict, prevent or fix my son's subsequent addiction to opioids. A miraculous surgery that restored the use of his arm took away seven years of his life.

Can you imagine what it must be like for those seeking treatment? Armed only with a hope to relieve their pain and little to no education, to make a choice of how that pain is relieved. We can both relieve pain and prevent addiction by removing barriers addressed in this bill. Seventy percent of those addicted to opioids start with a legal prescription, often after a surgical procedure. If this entire committee went into surgery where opioids were prescribed, and if you use those opioids for more than five days, at least one of you would have a 50 percent chance of becoming addicted. Yes, it only takes five days for addiction to take hold as recent studies have shown.

It is like a game of Russian roulette. There is no way to know who gets that devastating bullet. We must do better. There are many tools in the pain management tool chest; some are combinations of readily available non-addictive drugs and therapies; even more promising are several new nonaddictive drugs that are proving to be highly effective in managing pain but unfortunately come with a very high price tag to either the facility or the patient. The new FDA-approved sodium channel blockers are not yet covered by insurance, and patients are charged $15 per pill. By comparison, a ten-day prescription for hydrocodone will cost most insured less than $5 for the entire prescription.

One of the most critical pieces of this legislation is coverage for nonaddictive medications by insurers operating in our State to give doctors and patients choices that are affordable and safe. It's why we at ROC [Reno Orthopedic Center] have made it our mission to do our part to prevent a possibly devastating outcome from surgery like my son's. A few months ago, we became the first ambulatory surgery center in the State certified to give patients the option to choose to have their surgery opioid-free or opioid-sparing. We were lucky enough to be connected with Dr. Matt McCord who is doing this work in Michigan. He set us on the course, giving our doctors the tools to offer this option. We call it Opioid-Sparing Care and Recovery (OSCAR).

Our very first OSCAR patient came to one of our surgeons after suffering hip pain for seven years, avoiding surgery because of the debilitating effects of opioids she had experienced in a previous medical issue. She was unable to work, exercise, travel or enjoy life because of her very treatable hip pain. Conservative treatment had failed, so she suffered because she did not think she had a choice.

Patients can avoid necessary procedures by living in pain for years, not out of fear of surgery itself but out of the fear of what the medications they would need afterward could do to them. That should never be the case. Some suffered debilitating side effects. Some had witnessed the addiction of a family member or friend. Some have beat addiction and need a safe place to have surgery where they will not risk a relapse. We need to give them that place. More importantly, we need to support doctors with education and implore facilities to find a better way so that there are no more preventable tragedies in our State.

Senate Bill 337 is a step forward in ensuring that patients and providers alike have access to better, safer pain-management solutions. It is about giving people a choice, a choice for effective pain relief without the risk of addiction, a choice for a future where surgery is no longer a fear of dependency. Nevada has that opportunity to lead this effort. We can show the country that innovation in pain management is not just possible, it is happening right here. I urge you to support this bill and stand with us in this critical fight against the opioid crisis.

GERAD DAVIS:
I stand before you today not just as a citizen of Nevada but someone whose life was profoundly altered by a single prescription. I am also speaking to you as a certified alcohol and drug counselor who works on the front lines of the battle

against addiction. I've witnessed firsthand the devastating consequences of opioid dependency every single day. In 2011, I was involved in a serious motorcycle accident that shattered my jaw and left my right arm paralyzed after I collided with a tree. The physical pain was unimaginable, and in trying to manage it, I was prescribed a high-powered opiate—a decision that would unknowingly change the course of my life. At the time, I was unaware of the addictive nature of these medications or the brutal withdrawal symptoms that would follow.

No one told me that my treatment for pain could lead to years of suffering addiction and loss. What started as a doctor-approved pain management tactic, turned into a seven-year battle with addiction—one that led to multiple failed attempts at sobriety; the dismantling of relationships with my family, friends and community; and the loss of nearly everything I had worked for. The very medication meant to help me recover ultimately took away my ability to function as a productive member of society.

But my story is not unique; unfortunately, this problem touches millions of lives, not just the individuals who suffer from addiction but also the families who endure the pain of watching their loved ones struggle, lose hope and spiral into a cycle of dependency they never saw coming. Today, the crisis is worse than ever. As a counselor, I continue to see the devastating effects of opioids, which has now evolved into something far deadlier: fentanyl. What started as an epidemic of prescription opioid addiction has morphed into a full-scale public health emergency.

Fentanyl is now the leading cause of overdoses in this country. It is 50 times more potent than heroin and is increasingly found laced in counterfeit pills and street drugs, putting even casual or first-time users at an extreme risk of a fatal overdose. I work with people every day who, like me, started with a legitimate prescription but ended up losing everything. Many of them never intended to become addicted, they simply followed their doctor's orders. But once that prescription ran out, their bodies craved more. Some turn to illegal opioids; others unknowingly use substances laced with fentanyl. The result is lives lost too soon, families destroyed and communities left reeling.

This is why S.B. 337 is so critical. This bill introduces something I desperately wish I had back then—the choice for opioid-free surgery and comprehensive patient education about the risks of opioids. Had I been informed of an

alternative pain-management option and been given the chance to make a different choice, I could have spared myself the devastating consequences that followed. Senate Bill 337 ensures that future patients will have that choice. We are in the midst of a national opioid crisis, one that in many cases begins with well-intended prescriptions.

Nevada has the opportunity to be the leader in preventing addiction before it starts by ensuring that patients receive clear, transparent and informed options when it comes to post surgical pain management. By passing this bill you are not just changing policy, you are changing lives. You are giving people like me a chance to avoid addiction before it ever begins. You are giving families the ability to keep their loved ones safe, and you are protecting communities from the ripple effects of opioid dependency. I urge you to support this bill not just for me but for the thousands of Nevadans who deserve a future free from opioid dependency.

SENATOR LANGE:
Thank you for that. On CNN, they did a huge documentary on the opioid crisis in the United States. If you have not seen it, it is worth your time. It will knock your socks off with what they say and what happened. It has changed how I think about this, which is why I wanted to do this bill so much. I think we have to make changes in our society and positive changes [toward] an opioid-free alternative. Before I walk through the sections of the bill, I would like to pass it over to Dr. Saju Joseph from Las Vegas to give a bit of background and explain how this bill was brought about.

SAJU JOSEPH:
I am a board-certified general surgeon and surgical oncologist. I spent my career in academic surgery and moved here in 2017. In my academic practice, I have trained surgery residents, medical students, conducted research, and I continuously tackle some of the most complex surgical cases. I moved here to start the general surgery residency program at Valley Health System. I had been involved with that program up until I founded my own practice with some specialty physicians in 2022.

There I focused on providing opioid-free and sparing surgical techniques. Because of my past academic practice and watching this crisis occur in front of me, I felt this was a very important pivot that I needed to make. Since that time, I have had phenomenal results. I am proud to say I have presented my

own outcomes and research of over 250 opioid-free surgeries, specifically hernia surgeries, caring for working and labor employees. I presented at the National Alliance of Healthcare Purchaser Coalitions as well as at a major surgical conference. In that experience, of the 250 patients that I have operated on, only 4 patients took opioids at all and only 1 of them took it for more than four days—they took it for five. More importantly, and the reason this became important to the payer side, I was able to get all those patients back to work within 4.5 weeks, compared to the standard 12 weeks. And for people like the Anheuser-Busch distributors, United Auto Workers and other labor union employees, this is a major financial impact for them.

The reason I got turned on to this and was very interested in supporting S.B. 337 was because it is important to recognize the opioid crisis on multiple levels. One is very important, and that is taking care of the addicted patient who's actively overdosing. I don't think anyone in health care would disagree that this is an important thing to do to save lives. However, I also will tell you that I am very focused on what I call turning off the faucet. Taking care of a patient who is overdosing is only mopping the floor until we turn off the faucet. And [until we] stop these addictions from occurring, we are not helping this community.

It's important to recognize that we have lost 1 million working Americans to an opioid overdose. We lose 1.4 million workers from the workforce. If you look at labor jobs, 25 percent of the people working are chronically addicted to opioids. If you go to the United Auto Workers and look at the people working on the line building our cars, that number goes up to 30 percent. Of the patients who are addicted in that subset, [there is a] 60 percent [chance] their sentinel event is a surgical one—shoulder surgery, orthopedics, general surgery, accidents. They start their addiction through a doctor that is trying to do their best. I am not faulting the doctors. I practice and I see patients who need these medicines; it is important. But most of them, if you give them an alternative, they will jump at it because they want to get back to work.

This is an important step, and this is a state that needs it. Today the economic impact [derived from the] last set of data showed it was a $1.5 trillion problem in 2020, a 37 percent increase from 2017. Addictions have only increased. Even though we recognize as a healthcare community where these problems lie and where they are going, the problem is multifold. The moment someone becomes addicted, we all know what happens: it becomes a problem that falls

onto our State. They begin with absenteeism at work; they are more likely to be admitted to a hospital; they will lose their jobs; they will end up on state Medicaid or on state aid programs and, ultimately, being homeless. And they have overwhelmed our criminal justice system.

I want to reemphasize the most important point: You will hear a lot about treatment and prevention; I draw a very important line between prevention of death, prevention of an overdose and prevention of the addiction starting. Senate Bill 337 focuses on the prevention of the addiction ever starting. It is important for us to do, and I hope that this bill will make Nevada the gold standard in addressing the opioid crisis.

SENATOR LANGE:
I will go through the sections of the bill really quickly if that is okay?

CHAIR DOÑATE:
Senator Lange, we have reached the 15-minute mark. Are you comfortable just going straight to questions?

SENATOR LANGE:
We have a couple of proposed amendments, and I think it will make the questions go better.

CHAIR DOÑATE:
Go for it.

SENATOR LANGE:
We have met with the nurses. There are a couple of places in the bill, like section 36, that talks about nurses and their role in this. In Nevada, nurses can't do the kinds of things that are in the bill, so we are going to be amending that out. The second thing is the Nevada Justice Association attorneys have talked to us about the immunity clause that we have in section 21 of the bill. Because we negotiated that last session and they have a ten-year agreement, we're going to update that and change it to NRS 41A.045, and they've agreed to that.

We have also met with the hospitals and insurance companies; they have told us that they need time to implement this, and they've asked us to move the start date back, so we have moved it to July 1, 2026, to allow them to get

things in order. We'll continue to meet with stakeholders, and hopefully before the work session, we'll be able to bring back the amendments so we can move forward.

I think we have Matt McCord on Zoom to answer questions. This bill passed in the State of Michigan unanimously by both parties. Matt will be able to get some background information if you need it.

SENATOR TITUS:
That is exactly where I was going. My question is what other states have already passed this? What kind of outcome data do they have to share that it made a difference with the opiate overdoses?

MATT MCCORD:
I think Michigan was the eighth or ninth state to have passed this legislation. One of the other states was West Virginia, [as well as] others. Michigan passed this in 2018. In 2022, we actually added more teeth to the legislation to make it more meaningful and transparent for employers; we are just now seeing the benefits of that. The Nevada law incorporates most of those changes that we thought were important to enhance adoption. It is still early for the state of Michigan.

SENATOR TITUS:
You said you started in Michigan in 2018, and you did not see any improvement, so you changed your law or made additional changes to it that we are seeing in the Nevada proposal?

MR. MCCORD:
Yes. For example, we recommended that it be included in the open enrollment health insurance paperwork in Michigan for companies that are domiciled in Michigan; that helped make it more apparent for those employees. They knew they actually had and are empowered now to have this advanced directive.

They can at least put a stake in the ground and ask providers to provide the information they need to make more informed decisions on whether they receive opioids for acute pain.

SENATOR TITUS:
Just for clarification, you're saying that since you changed this in 2021, you are seeing better outcomes. Does that mean you are seeing less overdoses or addiction, or you are seeing more compliance?

MR. MCCORD:
Still yet to be measured. I have to emphasize, because we are doing this mostly with large union partners, they keep some of that information to themselves. But they have a significant opioid problem. I wasn't able to make a presentation, but I will say that our problem—let's be clear here, we do not have a pain crisis in America, we have an overprescribing crisis, and we are addressing that with this legislation.

SENATOR TITUS:
I am anxious, and maybe, Senator Lange, you have somebody because I know I have sat in this building for six sessions now and every session we have more regulations on providers and overprescribing. I have seen data that truly shows that providers have prescribed less. We now have multiple layers of mandates that we are required to sign an agreement with the patient before we prescribe narcotics. I have to sign on to the physician … periodically to make sure that this person's not seeking drugs, that they are not getting [a significant] amount of prescription. I am reviewed on what I prescribe.

We have all these protections in place in Nevada, yet our overdoses continue to rise based on fentanyl and other drugs. Again, if we can get in front of the addiction problem, I absolutely agree. But I have yet to see all the mandates that go on the providers make any difference in the number of overdoses. I certainly like the alternative. I certainly hear that if I prescribe past five days, which we do not try to, those are the rules that it can risk addiction. I hear all of that. But again, we are putting the onus on the provider in the hospital which I have seen every session, and yet we are seeing more overdoses.

SABRINA SCHNUR (Nevada Psychiatric Association):
We think this bill is a great way to help folks who live with substance-use disorder or who may be at risk of substance-use disorder to have a plan in place before hospitalization. The Nevada Psychiatric Association encourages patients to have plans such as this and psychiatric advanced directives in place.

ROBERT PURDY (Silver State Government Relations; Nevada Opioid Treatment Association):
The Nevada Opioid Treatment Association is a coalition of providers of medication for opioid use disorder (OUD) who treat the terrible downstream effects of not having enough non-opioid directives in place throughout Nevada's healthcare system. Our clinics do not have enough capacity to treat the Nevadans who need us. We really need to attack the faucet on this crisis; it is a silent killer in our society that affects my family. I assume it probably affects a lot of yours too. We need to do something about it.

DOUGLAS GEINZER:
I come before you today as a Nevadan for 32 years, a father, a husband and a veteran. Sadly, we all have personal stories similar to what you have heard today. I hail from Western Pennsylvania where the opioid epidemic has taken several family members, friends, fraternity and military brothers from me. I suspect the same is true with every single person in this room today. I want to share with you a very powerful metaphor. Bishop Desmond Tutu said, "There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find why they are falling in."

Looking at the people in this room, I estimate there are over 100 people here today. What does that mean? If all of us had a surgery today, by tomorrow at least ten of us would become addicted involuntarily to opioids. Senate Bill 337 helps correct this by giving citizens of Nevada the opportunity to opt out of opioids through the simple use of an advanced directive just like we have an advanced directive for do not resuscitate and do not intubate. This would allow us to stop opioids from being prescribed in the first place. It simply informs doctors of your desire not to be given an opioid unless absolutely necessary.

As several of the doctors before me testified today, opioids are not needed in 90 percent of the surgeries done today. I want to touch on an extremely vulnerable population when it comes to opioids—our U.S. veterans. A rear admiral in the U.S. Navy, Dr. Lou Tripoli, was supposed to testify today but was unable to. He has seen firsthand, as have I, how the opioid crisis has destroyed retired and inactive military personnel. Opioids were once used as the first line of defense for not only physical pain but also mental pain that was disguised as physical.

The veteran addiction rate is higher than any other population out there, and we lose 22 veterans a day to suicide, many of which started with an opioid addiction. The indirect cost of the opioid crisis wreaks havoc on Nevada's Medicaid budget. Medicaid is the final safety net before an addict falls into the river, as quoted in the earlier metaphor. When one of our brothers, sisters, daughters are … I will give one stat that I was reading last night on just the Medicaid management of an opioid disorder. In 2013, the national Medicaid budget spent $9.4 billion on OUD. By 2019, that rose to $23 billion. In 2023, it's now $29 billion. That is a 300 percent increase.

WOLFGANG GILLIAR (Dean, College of Osteopathic Medicine, Touro University Nevada):

I am the dean at the College of Osteopathic Medicine at Touro Nevada. There are many bad lessons in the story of the opioid crisis. One class of drugs, from OxyContin that was actually not introduced until the 1990s to the illegal synthetic opioid fentanyl—opioids have turned the health system and our community's upside down with devastating consequences. The current opioid crisis ranks as one of the most devastating public health catastrophes of our time.

One major conclusion is that the opioid crisis represents a multisystem failure of regulation. Driven by our medical students, our faculty and many horrific patient stories, this one central question arose: What can we do at the college of medicine to mitigate against and to prevent these horrendous detrimental effects and unacceptable adverse outcomes? I am pleased to report to you that we developed an innovative standalone curriculum that is actually two-pronged to lead to better and safer pain control and prevention.

First, we need to prevent this from happening again. Our medical students will be educated about the lessons we have learned and the failure of the medical system and others. Then we are teaching about the specific alternatives to opioids. This includes osteopathic principles and practices, including multidisciplinary approaches, physical therapeutic ways and state-of-the-art pain management. This curriculum is meant for all incoming medical students, and we are looking to make this a certificate course. We would be happy to share this curriculum with any other medical school or other programs simply to enhance the education and prevention.

The role of a Legislator is either to prevent bad things from happening or to correct the course of things that were bad and try to prevent them from recurring again. We support S.B. 337 and thank you for paying attention to this bill.

MITCHELL LAUGHTON (Owner and President, The Laughton Company):
I am a second-generation Nevadan. My business has been in employee benefits consulting for over 50 years in the State. The reason I am coming here in support of this bill is I feel that this is a way we can finally get our employer groups—they want to prevent addiction; they do not want to manage it. They do not need another thing, as an employer, to manage and something to do. This bill provides an easy way for employees to make an election and opt out of opioids through an open enrollment process.

For anyone who's intimately involved with the open enrollment process, we can easily put the election form online, or we can do a paper enrollment for people. It would not take very much time or labor for them to do it. Employers spend over $2.6 billion per year treating opioid addictions. We feel as though the best way to be able to avoid that cost is to prevent it up front. Businesses can lower their healthcare costs by over $5,300 per person addicted if they can just prevent that person from becoming addicted. I am in support of S.B. 337. I believe an ounce of prevention is worth a pound of cure.

ALEX LOGAN:
I'm just representing myself, but I have been a firefighter in Clark County for 17 years. Seven of those years I worked on the Las Vegas Strip. I can say that I have run an overdose [call] almost every single day for the last 17 years. The problem has gotten so bad that every single fire engine and fire truck in the county has a box of Narcan. We can run an overdose call, treat the patient and then when we are ready to leave, we hand them Narcan for when they overdose again in the future. Anything we can do to stop opioids getting into the public is something that I support. I support this bill.

ANGIE WILSON (Executive Director, Reno-Sparks Tribal Health Center):
I am the director for the Reno-Sparks Indian Colonies Tribal Health Center, the largest tribal health center in Nevada. I would be amiss to not say that for American Indian and Alaska Native people, the drug overdose rates in our communities is devastating. There was an Office of Inspector General report that in American Indian communities, this death rate rose by 291 percent across

Indian Country. We do know that for our American Indian and Alaska Native folks, in both 2021 and 2022, the rates increased another 15 percent from 56.6 deaths per 1,000, to 65.2—the highest death rate in any other ethnic population. I think that any step Nevada can take to curb this issue in Indian Country is significant.

For the fellow folks who were up here, I too have to administer Narcan—even for folks that are not eligible for our services that are passing through the Truckee River where our clinic is located. There have been multiple times that our staff has had to administer Narcan repeatedly. I think it is a big issue. It certainly is for the tribal communities that we serve.

DAVID CHERRY (City of Henderson):
We all recognize that the opioid crisis has affected our community. The City of Henderson has been working to raise awareness among our young people through our Don't Risk It All with Fentanyl campaign. We also look at this issue through the lens of a self-insured employer that provides healthcare coverage to our workforce, and we see the benefit of S.B. 337. When it comes to opioid alternatives, the bill offers options to patients. Finally, as the previous speaker mentioned, our firefighter paramedics and EMT see the effects of opioid misuse on a daily basis as does our police force. If we can address the addiction issue by preventing folks from being exposed to these and becoming addicted, we see the benefit to our community and all communities in Nevada.

MR. KELLY:
I just want to thank the sponsor for bringing this very important legislation and for spending time with us to address the implementation issues related to it. We look forward to continued discussions.

MR. OSBORN:
Ditto, we look forward to seeing the amendments.

ADAM PLAIN (Insurance Regulation Liaison, Division of Insurance, Nevada Department of Business and Industry):
Unfortunately, this is the first bill we have encountered this session where we are unable to reach a conclusive evaluation as to the effects of federal defrayal resulting from the bill. I provided an explanation of how the essential health benefits framework works for pharmaceutical benefits as opposed to pure medical benefits; unfortunately, the Division of Insurance just does not have the

staff resources available to fully evaluate how certain opioid and nonopioid medications fit into those various pharmacopeia categories.

So, we do not know whether a mandate to require non-opioid medications would exceed the current essential health benefits benchmark plan. We are open to working with any interested parties and partners that want to help us through that process. But again, at this time, we cannot conclusively evaluate this bill in terms of federal defrayal. I have submitted written testimony (Exhibit S).

SHELLY CAPURRO (Nevada Association of Health Plans):
We want to thank the sponsor for meeting with us earlier, and we just want to put a couple of things on the record. Regarding the non-opioid directive form, we will be required to provide this form online and to every enrollee. It is the understanding of the Association, as we read these provisions, that once a form is filled out and returned to the practitioner, medical facility or insurer, it immediately becomes a legally binding document—regardless of who receives the form and whether the directive is communicated to all parties that are legally bound by it. We'd like to ensure that liability protections are in place for all parties involved in this process.

The Association also has clarifying questions on the sections of the bill that seem to allow the State to reduce reimbursement rates or prohibit medical facilities and practitioners from receiving payments if they are not in compliance. Our members have provider agreements in place that include provisions on reimbursement. We'd like to have a further understanding of how we can carry this out. Again, we want to thank the sponsor for working with us and we look forward to working on these issues.

MS. IVANOFF:
I was not able to hear in the presentation of the bill. However, hearing a sentence aimed at reducing opioid use and promoting non-opioid alternatives, I wanted to express my appreciation for at least starting the conversation. When it comes to a view, I was not able to hear if there are some pros and cons so I can't really make a negative or positive determination, but I am happy that you guys are talking about that; I just wanted to express that.

MR. JOSEPH:
Senator Titus, I wanted to give you a brief answer to the question you had posed. I cannot give you state-level data because this is relatively new. I can give you data, again, that we presented in our compliance. That was with our Anheuser-Busch distributors, who did note a substantial drop since they've moved their surgical volume over to our practice in their opioid addiction numbers. Walmart also presented their data, and we are one of their larger surgical bundle providers in Las Vegas. As I said, we've done over 400 of these cases, so we do believe that there is a reduction in opioid addiction that has translated from the directive into practice.

SENATOR TITUS:
Just a comment to all, I appreciate all of this. There is a real segue with injured workers and addiction. I will tell you all to listen to a song by Jason Isbell called the "King of Oklahoma." If you have not heard that song, you need to hear it. An injured worker gets addicted and ruins his life.

CHAIR DOÑATE:
I will go ahead and close the hearing on S.B. 337, and we will move on to the next bill hearing, S.B. 312.

SENATE BILL 312: Enacts provisions relating to the health of American Indians, Alaska Natives and Native Hawaiians. (BDR 38-347)

BRETT SCOLARI (Reno-Sparks Indian Colony):
It is my honor to introduce Ms. Angie Wilson to you all. I know you have all worked with her; many of you worked with her in the interim on this bill. We just sincerely appreciate this hearing, and I will turn it over to her.

ANGIE WILSON (Executive Director, Reno-Sparks Tribal Health Center):
I am here on behalf of the Reno-Sparks Indian Colony. I would like to also mention that Chairman Gardipe really does appreciate having met with most of you. He could not be here today, as they're laying to rest a former chairman from Pyramid Lake and former National Indian Health Board Chairperson Vinton Hawley. Our condolences to the Pyramid Lake Paiute Tribe and to those of you who spoke on grief and loss issues today.

I just wanted to thank you so much for allowing me to have been working with you during the joint interim committee. As a result of that presentation, which

was historic for Nevada, we talked about a lot of things. We talked about how American Indians and Alaska Natives have lived under federal Indian policy and the impact of those policies as it relates to what health disparities look like in American Indian communities today, specifically here in Nevada. We talked a lot about how those health disparities have been impacted. We talked a lot about opportunities to improve mechanisms that we can work on together, as tribes and as a state, to strengthen the healthcare delivery system for American Indians and Alaska Natives. I am excited to follow up on that here today with a presentation (Exhibit T contains copyrighted material. Original is available upon request from the Research Library).

I just want to talk briefly about the importance of what I feel like really came out of this proposed bill, S.B. 312. I will talk a little bit about tribal sovereignty, federal trust responsibility, our government-to-government relationship and the complexities of the Indian healthcare delivery system. In addition to those federal requirements, obviously, we have talked and will talk a little bit about disparities, but also about the tribal expertise, our challenges and our concerns, and how S.B. 312 really helps to bring them all together with the Tribal Health Authority Council. I think it is probably really important to reiterate this today and for those of you who we have met directly, I just want to say thank you for giving us the opportunity to meet with you all.

Just as a reminder, especially with some of the changes happening at the federal level, that the U.S. government and federally recognized tribes operate on a government-to-government principle, meaning that we treat each other like a separate nation in most respects. Indian tribes exercise inherent sovereign powers over our members and our territories, and the U.S. Constitution contains a number of provisions that outline the federal government's relationship with tribes.

The federal government has a unique relationship with our Indian tribes, derived from the U.S. Constitution, treaties, Supreme Court doctrine, and federal statute. Recently, we know there have been DEI initiatives taking place under the new federal administration; I just want to address that. We all know that there is a tribal exemption to the DEI initiatives. That is partly because the Canadian Construction [Association] [adds] a unique trust responsibility between the federal government and Indian tribes. It is not a race-based relationship; we have a political relationship with the U.S. federal Government.

That is how the State comes into play when Indian tribes exercise our rights to health care and things along that line because the State does play a part in that. The State does get what we call 100 percent Federal Medical Assistance Percentage (FMAP), meaning [the State is] 100 percent reimbursed on behalf of American Indian and Alaska Native Medicaid beneficiaries who seek care in our Indian health, Tribal health or Urban Indian programs. We will talk a little bit about that here soon. But I did include for you the memorandum that came from the U.S. Department of Health and Human Services (HHS) that describes the Canadian Construction and reaffirms that relationship.

We have met with HHS Secretary Robert F. Kennedy Jr., the newest incoming secretary at HHS about ongoing issues related to the Indian Health Service (IHS) and everything that is Medicare and Medicaid services related as well. This was a picture of him recently meeting at the Secretary's Tribal Advisory Committee meeting. Of course, we have our government-to-government relationship between the 28 tribes in Nevada with our State, all of you, our leadership here and also with the Nevada Indian Commission. We value these relationships in a significant way, and we'll talk a little bit about how those relationships really play out.

In my additional duties, I serve on the CMS Tribal Technical Advisory Group representing all of the tribes in Arizona, Nevada and Utah. Yesterday, and this morning on Washington, D.C. time, we were meeting with the current administrators over CMS until Dr. Oz is confirmed; then we will be working directly with him. We did meet with Steph Carlton, the acting administrator and principal deputy administrator and chief of staff for CMS, and Drew Snyder, director of the Center for Medicaid and CHIP [Children's Health Insurance Program] Services and the deputy administrator on key issues specific to Indian tribes and how we obtain care. We also work directly with the Center of Consumer Information and Insurance Oversight, or CCIIO, on everything related to the federal [insurance] exchange and, of course, our State-based insurance exchanges. We meet directly with them on the success of those programs.

We have always had a really good working relationship with the State. We are very vocal about that when it comes to working on the national level. We often refer to the great tribal consultation practices that are exercised in this State. I am a California tribal member, and I can tell you, I use that example every single time I meet with the state of California, on how well Nevada has this under control and that they should [try to] attain to that.

We also work on things such as when Nevada had the whole body, whole dental, whole mouth, [section] 1115 waiver. It was held up with CMS for quite some time. We're able to champion that along at the national level and use our tribes' voices to push issues along for Nevada that impact our tribes but also impact Nevada overall. I serve as the tribal chairperson for CMS's Medicare and Medicaid Innovation Center where we talk about things like payment methodologies for states, improvement models and things along that line. So, we are excited to be your partner as we go through the process.

Obviously, we can talk a little bit about the complexities to the Indian healthcare delivery system, and of course, you know, our tribes have the ability to operate our tribal healthcare directly. We also have the right to retain any of those services with the IHS. There are some complexities on who's eligible for what service, and that all depends on a multitude of factors. That could be complex in itself. For Medicaid-covered services provided by our direct healthcare facilities or Tribal 638, like I mentioned, American Indians and Alaska Native Medicaid beneficiaries do not cost the State a dime. The State does get 100 percent reimbursement as long as those folks are getting care through our facilities.

I also want to mention that the Reno-Sparks Indian Colony championed the State Plan Amendment (SPA) several years ago for a new Tribal Medicaid Federally Qualified Health Center (FQHC) designation that now allows the State 100 percent reimbursement for services that are procured through our clinic. So, if we are referring to Medicaid specialty providers, those instances will now be extended to the State at 100 percent reimbursement.

That's part of the reason why collaboration between the tribes and the State is really important because there could be additional methodologies that not only support tribal healthcare in our communities, but also do the same to support reimbursement to the State. We do believe there's a federal trust responsibility that the State should not have to be paying for, so we can continue to work on that. For the provider enrollment and licensing exemptions, we have exemptions where healthcare professionals that are employed by tribal healthcare are exempt from the licensing requirements of the state in which the services are performed. That is as long as they are licensed in any state that is similar to how the Veterans Affairs does its licensing requirements.

Also, in regard to enrollment of insurance and the Federal Tort Claims Act (FTCA), our tribal health providers are covered by FTCA. The federal government does become responsible for negligence or wrong acts of tribal health providers unless it is an on-the-job injury, which is covered by workers' comp; a breach of contract rather than a tort claim; or acts performed by employees outside of the scope of employment.

Now, we have a little bit more difficulty when it comes to state-based Medicaid programs. When we look at Medicaid managed care organizations (MCOs)—and I know that Nevada is planning to expand to look at the entire State, rather than just having it at Washoe and Clark Counties—there are some very specific provisions in the law that MCOs must contract with the state and require the MCO to demonstrate sufficient Indian health, tribal health and Urban Indian (I/T/U) programs in networks for MCO-enrolled American Indians and Alaska Natives to have timely access to Medicaid-covered managed care services.

It also pays to our Indian health, tribal health and Urban Indian programs, whether we are contracted or not. That Medicaid-covered managed care service provided to MCO-enrolled American Indians is at a rate that's not less than the amount that would be payable to a contracted I/T/U provider. There is also a provision to make prompt payments—whether contracted with the MCO or not—to pay our clinics that are FQHCs, whether we are contracted or not for these services. If the amount paid by the MCOs to a non-federally qualified I/T/U is less than the IHS and counter rate, then the state Medicaid plan must provide payment for the difference between the MCO.

The Reno-Sparks Tribal Health Center is located in a managed care-required state, which is Washoe County. This is not a lone issue here for Nevada; it is across Indian Country. In every single state we run into similar issues, so much so that we did champion the tribal protections toolkit that went out to all states that operate Medicaid programs. It really goes into the laws and what they say, because there are so many issues when it comes to accessing care. This is how these partnerships or collaborations between the tribes and the State can really benefit each other to deter those.

There are exemptions for American Indians and Alaska Natives from cost sharing. Those cost sharings extend to Medicaid premiums. They are noted in the Code of Federal Regulations (CFR) there. Also, for the children's health insurance premiums and cost sharing, there are exemptions for American

Indians and, of course, for qualified health plan premiums and cost sharing under 45 CFR if household income is equal or less than 300 percent of the federal poverty level and there is verified membership in a tribe, or under section 1402 (d)(2) of the Affordable Care Act if they receive care through I/T/U programs or purchased and referred care.

There are American Indian and Alaska Native federal rights under Medicaid managed care, so we have the right to exempt ourselves from an MCO or a Primary Care Case Management program, unless that program belongs to an I/T/U program. American Indians enrolled in managed care have the right to select an in-network which includes our tribal clinics.

I want to quickly talk about tribal expertise and health care; this is really where S.B. 312 comes into play. We provide care within a maze; I am sure it's confusing to you; it's confusing to Indian people too. Believe me. Indian Health Service funding is subject to many different federal regulations which differ between programs and between tribes. It can differ between me as an enrolled member of California and as a Nevada tribal member on what we're eligible for. That could change if I start working for the tribe; there are so many caveats to that.

Also, creating and administering programs with limited funding [s a factor]. One of the biggest payers of third-party revenue across Indian country and across the entire United States is Medicaid. That's a significant issue for us and one that we are addressing with the new Secretary of HHS and with CMS. We appreciate Governor Lombardo's letter he penned in regard to the importance of Medicaid here in Nevada.

Community health programs are also important. When the Community Health Worker (CHW) program rolled out, this was already one of the longest standing programs in Indian country since 1969. Unfortunately, when the State rolled out the CHW program, there was not a consideration that there's been a longstanding, almost similar, Community Health Representative program. So that created additional barriers. Had we had better collaboration, we could have addressed issues those ahead of time.

There are social determinants of health, which all of the 28 tribes here deal with among their tribal members, addressing things like limited housing, food banks, food vouchers, energy cost, employment, education and case management.

Then, of course, there are culturally appropriate services that we really strive to provide in our tribal communities. We have various best practices and creative solutions with limited funding. You've heard about some of that with the SPAs. One of the things I discussed with you all during our interim time was the idea of our pharmacies being reimbursed at a higher rate or more open rate.

I am really happy to announce that we have worked really closely with the Division of Health Care Financing and Policy or Nevada Medicaid and with the Division of Welfare and Supportive Services. We pushed for a SPA that was accepted by CMS region nine. We just got word just a couple of weeks ago that the SPA has now been approved by CMS. This changes the relationship between the State and CMS, completely opening the door for the tribes to be able to bill for any type of medication for Medicaid beneficiaries. Extending that not only allowed an improved payment methodology to the tribes but now extends 100 percent FMAP to the State for millions of dollars in additional savings. We are excited about that.

Of course, there are challenges in Indian health care. We deal with a lot of the same things: provider recruitment and retention, common vacancies and concern about things like maternal infant health which is a big one for us, long-term care and remote areas with few healthcare options. I think I have stated before that in Nevada, it is not just about the Reno-Sparks Indian Colony; we look at all of Nevada, where most of our counties are frontier. That is a huge issue when it comes to our tribes as well as other Nevadans.

We also deal with things like cultural barriers, discrimination and mistrust; those are longstanding issues. Other challenges are communication, a lack of understanding of the Indian healthcare delivery system outside of Indian Country, and American Indian and Alaska Native health literacy. How can we help our patients better understand these processes?

We held a meeting with the Joint Interim Committee and presented on this in February. We had a follow-up presentation and appreciated your invite to come back and talk about access to behavioral health for tribal youth. That was really pivotal. We worked with you all on the collaboration of a bill draft request (BDR), [BDR 38-347,] to form a Tribal Health Authority Council; that was mirrored from the successful Washington State and Washington Indian Health Advisory Council initiative. It’s been very successful.

Today, we attended the work session with the BDR where the Tribal Health Authority Council BDR was unanimously passed by the Joint Interim Standing Committee on Health and Human Services. Just a quick summary, these are the items: Section 1 asked the [Nevada] Department of Health and Human Services (DHHS) to apply for federal authorization, allowing tribal benefit coordinators to determine Medicaid on site. Section 2 was to amend Nevada law to include new provisions regarding Medicaid eligibility determinations made by I/T/U programs. That is a benefit to the State because as long as we can keep people on, it passes the savings on to the State.

Sections 3 and 4 define the Tribal Health Authority Council as the official advisory body for Nevada American healthcare matters. Section 5 creates and defines the Tribal Health Authority Council, specifying its structure of voting members from I/T/U programs, the legislative representatives and non-voting members such as all of the tribal liaisons with our state agencies. Section 6 outlines the council operations, meaning quarterly meetings, the election of the chair, election of vice chair, and rules for quorum and voting.

Section 7 establishes a coordinator of the Council, appointed by the executive director of the Department of Native American Affairs. Department staff must provide staff facilities and resources to support the Council. Section 8 assigns responsibility to the Council, including assessing Native American healthcare needs, developing plans to improve healthcare access, and identifying barriers and proposing solutions.

Section 9 creates the Account for Tribal Health, a dedicated state fund to support the Council's activities, which would allow the Department to receive federal and private funding. Section 10 allocates $224,000 to the Department of Native American Affairs for the Council's operations; I believe that is for a staffer. Any unused funds would be returned to the State by September 2027.

Section 11 requires the DHHS to work with the Council to develop a Medicaid reinvestment proposal—again, that is from the new SPA where we extend additional savings for services that are provided through our clinics—and to submit recommendations to the Legislature by June 30, 2026. Lastly, section 12 establishes timelines for appointing council members and enacting the bill's provisions. That’s just the general overview.

I want to just say how much I appreciate this opportunity. I will say, this has been big news in the tribal healthcare world. Being invited to the joint interim committee, the discussion of the BDR, the work session and, of course, meeting with all of you. I genuinely think it gives us the opportunity between the 28 Tribal Nations and our State to have a better long-term collaboration on things that we can do here in our State.

CHAIR DOÑATE:
It is always a pleasure to have you here. I know we have worked extensively behind the scenes and if there are things to change in the bill, we'll work in terms of the technicalities and the semantics. But obviously, it's about building the infrastructure so that we can address the longstanding barriers. I just want to thank you for that.

SENATOR TITUS:
Great discussions about these needs and hopefully this will help. I do have some questions about the way the bill is written. So tribal members, if they're Nevada residents, can already apply for Medicaid based on the same criteria that every other Nevadan has to apply for Medicaid. This bill, if I am understanding it, does not create [a way] that they suddenly can apply; it's helping them have a Tribal Coordinator to look at who can apply and encouraging them to apply.

MS. WILSON:
Correct.

SENATOR TITUS:
I just wanted to get that on the record. My question is actually on section 5 and the Council. I have sat on a lot of different interim committees, and I do not know if they are supposed to serve without any reimbursement. One of the issues—especially when we had one person appointed by each Indian tribe in this State, and there are potentially 28 nations—was we could not get a member to serve because they could not get to these meetings. They did not have access; they could not travel; they wanted to help, but they could not get there. I worry about not having any source of helping them.

I know that the director will appoint the coordinator; the coordinator will get paid, but it's not clear on how that works. You have somebody coordinating this group. I just worry about this volunteer group—the actual participation and

if they are able to participate. I just worry that some of these tribes that need so badly to be a participant won't be able to participate.

MS. WILSON:
Yeah, I think that's good comment. One thing I would just say to that is currently, we hold quarterly consultation meetings with the divisions of DHHS here—from the office of the DHHS director to Nevada Medicaid to the Division of Welfare and Supportive Services, Aging and Disability [Services Division] and Child and Protective Services—a number of different folks we meet with once a quarter. I think what happens though—it is something that we do look at in regard to participation—we have tried to actually host them in Indian country. So, sometimes, we'll host them from my clinic at Reno-Sparks. We'll also allow for participation via Zoom or Teams for better participation.

SENATOR TITUS:
That's where I was going with this. I do not really see it mentioned that it had to be in-person meetings. I know we are working hard to get communications satellite and internet availability, but I think it is really important that they allow like a Zoom component to it.

CHAIR DOÑATE:
Senator Titus, just to answer that question, I think that is the meeting that we have scheduled for tomorrow, post-hearing. It is more to tighten up whether or not it is feasible for all these members to be represented. I think we are going to look at what the rotations would look like, or maybe it is their preference if they have a tribal health like an FQHC already established and so forth. We are going to talk more of the semantics of lowering it, but if there's a recommendation to make sure that they are paid and so forth, so it's more of a commission.

SENATOR TITUS:
It's access and participation.

MS. WILSON:
I would also say that the 28 tribes are represented by the 12 I/T/Us. Even though it wouldn't be all 28, it would be the 12 I/T/U programs. We represent all of tribal healthcare for all of the tribes. It's not as many as 28 people, but it is the I/T/Us that represent those tribes that we serve—and service delivery area.

CHRISTIAN SOLOMON (Nevada State Director, Rise):
I am speaking in favor of S.B. 312 as a proud Native Hawaiian and am in full support of expanding and streamlining access to healthcare resources for our Indigenous and Native Hawaiian community, placing the power to do so directly in the hands of the community. I am looking forward to seeing this bill establish the Tribal Health Authority Council, taking on the responsibility of improving the health of our Indigenous brothers and sisters in our State. Thank you so much for your consideration, and please support S.B. 312.

YVONNE POWERS (Councilmember, Shoshone-Paiute Tribe, Duck Valley Indian Reservation):
I just want to say that we are in support of this bill.

WILLIAM ADLER (Duck Valley Shoshone-Paiute Tribe; Pyramid Lake Paiute Tribe):
I am usually with Duck Valley Shoshone-Paiute and Pyramid Lake Paiute tribes, but I would love for them to speak for themselves. For the Pyramid Lake Paiute tribe, we want to say that this bill brings forth a lot of focus where there is not focus today on tribal health issues. Bringing forth the Tribal Health [Advisory] Council could actually help facilitate additional benefits or knowledge around benefits that are available for tribal members through the Medicaid programs and other programs out there. Really, it is a lack of knowledge and facilitation, and this bill could actually fill that gap. Thank you for bringing this forward, and any funding that is required is in the best place.

JON PISHION (Health Director, Fallon Tribal Health Center):
My health center serves pretty much all of Central Nevada, including the tribes of Lovelock and Yomba, as well as for Pershing County, Humboldt County and a few other counties we serve. I have been working with Ms. Wilson on this, trying to create some type of advisory board to help work with tribes. One of the biggest issues that we have faced is coordinating with all the tribes on health issues. I believe S.B. 312 would be a great benefit to tribes out here in Nevada to help us better coordinate healthcare services for our members.

MS. WILSON:
I would just like to say thank you all for allowing us to speak and we look forward to the meeting tomorrow.

CHAIR DOÑATE:
I am going to go ahead and close this hearing on S.B. 312 and move on to our final bill, S.B. 192, opening the hearing.

SENATE BILL 192: Revises provisions relating to public health. (BDR 40-86)

I will go ahead and pass the gavel to our Vice Chair.

VICE CHAIR TAYLOR:
Thank you, Chair. And as you said, we are going to now going to open the hearing for S.B. 192. Our Chair is coming forward and will present this bill.

SENATOR FABIAN DOÑATE (Senatorial District No. 10):
Thank you for the opportunity to present S.B. 192 today on behalf of Senator Neal. I want to go over the provisions of the bill. I do have copresenters in Las Vegas and on Zoom who will provide brief remarks in terms of the rationale, or what they were working on with Senator Neal for the bill. We will try our best to answer questions; just understand that we may have to follow-up offline.

Section 1 of the bill requires a hospital or a freestanding birthing center to provide a qualified sign language interpreter to a patient who is at the hospital or freestanding birthing center for the purpose of giving birth. Section 1 also requires the hospital or freestanding birthing center to allow a patient's family member or a doula to be present in the room with the patient during the birthing process.

Sections 2 to 6 of this bill make conforming changes relating to the applicability and enforcement of section 1.

Sections 17, 18, 43, 46, 48, 50, 51, 53, 55, 56 and 61 require various other public and private insurers to cover maternity care, to cover doula services and to include doulas in their networks of providers.

Section 45 authorizes the Commissioner of Insurance to require certain policies of health insurance issued by a domestic insured to a person who resides in another state to include the coverage required by section 43.

Section 60 authorizes the Commissioner to suspend or revoke the certificate of a health maintenance organization that fails to provide that coverage required by section 55. The Commissioner is also authorized to take the same action against other health insurers who fail to provide the coverage required by sections 43, 46, 48, 50, 51, 53 and 61.

Sections 44, 47, 49, 52, 54, 58 and 64 cover the coverage of testosterone replacement therapy for menopausal women and any other type of hormone replacement therapy lawfully prescribed or ordered that has been approved by the FDA.

Section 20 requires Medicaid, including where benefits are not provided through managed care, to cover hormone therapy, including testosterone replacement therapy for menopausal women. It also requires the director of DHHS to apply for any waiver of federal law or amendment to implement the provisions of this section.

Section 16 makes conforming changes to require DHHS to administer the provisions of section 20.

Section 21 expands existing coverage of dental services under Medicaid and provides that, to the extent of federal financial funds available, the director shall include coverage for preventative diagnostic, periodontal and restorative services.

Section 42 prohibits certain health insurers from denying a request to include a provider of healthcare in a provider network because the provider of healthcare is a solo practitioner.

Section 19 of the bill additionally requires the board of trustees of each school district and the governing body of each charter school or university school for profoundly gifted pupils to adopt a policy concerning the prevention of sudden cardiac arrest during the participation of pupils in combative [competitive] sports sponsored by a school. Each policy must include that the pupils obtain an ECG screening conducted by a healthcare provider before participating in competitive sports.

Section 22 requires DHHS to provide an independent psychiatric evaluation of the child not more than six months before the child achieves a permanent

placement or transitions to independent living. This section provides that this requirement does not apply if a psychiatric evaluation conducted after the initial diagnosis has determined the child no longer has a mental or behavioral health condition. Additionally, if the psychiatrist who conducts a psychiatric evaluation of a child determines the child still suffers from the mental or behavioral health condition for which the child was previously diagnosed, and the condition has not improved, it shall be recorded in the child's medical record.

Sections 7 and 23 to 25 make conforming changes.

Section 26 prohibits a health carrier or health insurance administrator from providing healthcare services directly to patients; or operating or administering any entity that provides healthcare services directly to patients. Further, the Attorney General or any person injured by the violation of section 26 would be authorized to bring a civil action.

Sections 8 to 15 authorize the Attorney General to use money for certain fees which are currently used to support investigations of unfair trade practices, for the purpose of investigating violations of section 26.

Sections 38, 41, 57, 59, 62 and 63, make conforming changes regarding references to the direct provision of healthcare by insurers.

Section 27 provides that a noncompetition covenant may not restrict the provider of healthcare employed by or contracted with the hospital from providing medical services to another medical facility or office during or after the term of employment or contract as applicable. Section 27 also provides any provision of a noncompetition covenant that violates this prohibition is void.

Sections 29, 32 and 35 were part of the Board of Medical Examiners to adopt regulations concerning the use of race-based formulas and standards used by physicians and physician assistants.

Section 65 requires the Board of Medical Examiners, the State Board of Osteopathic Medicine, University of Nevada, Reno and the University of Nevada, Las Vegas to study disparities in healthcare access, the provision of healthcare and healthcare outcomes.

Sections 30 and 36 require a physician or provider to discuss with the patient upon diagnosis with arthritis, osteoarthritis or any other condition commonly treated using stem cell therapy the potential use of stem cell therapy to treat the condition.

Section 37 clarifies the requirements of NRS that do not apply to the prescribing or dispensing of a controlled substance in other circumstances and establishes a standard of care or grounds for disciplinary action against a practitioner when a controlled substance is prescribed or dispensed in other circumstances.

JSHAUNTAE MARSHALL (Chamber of Mothers):
I am testifying today in support of S.B. 192, which seeks to expand access to doula care and address the Nevada maternal health crisis. The United States continues to face a significant maternal health crisis. The U.S. maternal mortality rate is 23.8 deaths per 100,000 live births, according to the CDC in 2023. It is the highest among developed nations. In Nevada, specifically, the maternal mortality rate is approximately 16.7 deaths per 100,000 live births.

Rural counties face up to 40 percent higher rates of maternal complications due to limited access to care. One hundred percent of Nevada counties are classified as maternity care deserts with limited or no access to maternity care providers. Doulas helped to address and meet the educational and emotional needs of pregnant and birthing people who have limited access to perinatal providers. A 2023 study in the American Journal of Public Health found that states with Medicaid coverage for doula services saw a 15 percent reduction in maternal mortality rates among Medicaid recipients.

The current landscape of doula care in Nevada consists of 83 percent of doula supported births, which are women with private health insurance. Less than 5 percent of Medicaid recipients utilize doula services. Rural communities have extremely limited or no access to doula care. What S.B. 192 will accomplish for doulas and their birthing families is it will ensure that doulas are no longer considered a part of the family or the plus one, but rather an extension of the care team. It will also ensure that private health insurance coverage for doula services and care is available to the families.

Why does this matter? It matters because it will create approximately 100 new jobs annually for doulas who have been trained. It will potentially save an estimated 120 to 150 severe maternal morbidity cases per year. In conclusion,

every birthing family in Nevada deserves access to quality maternal support regardless of income, location or insurance status. Senate Bill 192 represents a critical step forward in making that vision a reality. I respectfully ask the committee to support S.B. 192.

TROY ROQUES (Executive Director, Vegas for Athletes):
I support S.B. 192. Sudden cardiac arrest remains the leading medical cause of death in young athletes today, with a survival rate of approximately 10 percent when it occurs outside of a hospital environment. The standard sports physical either misses or does not check the heart beyond the stethoscope, or for electrical or structural heart conditions that can be identified from a 16 second ECG test. Because of celebrity athletes such as Damar Hamlin and Ronnie James, sudden cardiac arrest has become a more prominent conversation. But here in Las Vegas, we have had our fair share of deaths and close calls. In 2023, Las Vegas lost three student athletes to sudden cardiac arrest.

Ashari Hughes was a 16-year-old who was playing flag football for Desert Oasis High School when she suddenly collapsed and died later at the hospital. Jordan Brister, an 18-year-old athlete from Amplus Academy was found dead in his high school bathroom after gym class. Ryan Keeler, a 20-year-old UNLV football player, was found [deceased] in his apartment due to hypertrophic cardiomyopathy. Since 2024, VFA [Vegas For Athletes] has screened 632 athletes, finding 23 with heart abnormalities and 7 with life-threatening conditions.

In August 2024, I met a 16-year-old from Foothill High School who suffered cardiac arrest at the Jerry Tarkanian gym. He was saved by a quick response with the AED but now lives with a pacemaker and can no longer play sports. Four months later in December 2024, I met the family of CJ Henley, a Coronado High School player who suffered cardiac arrest in his English class and now lives with the pacemaker and can no longer play sports. Two months later in February 2025, we've already experienced the death of another UNLV football player, Ben Christman, who was found in his apartment. The official cause of death was natural causes, but it is reported that Ben was having chest pains during practice that day.

An ECG does not directly prevent sudden cardiac arrest, but it is a crucial tool for diagnosis, risk, stratification and guiding treatment to prevent and manage

future episodes especially in athletes. Under Section 19 according to our firsthand testing results, we would find approximately 3,639 athletes currently playing sports with the heart abnormality and 11,008 athletes playing with a life-threatening condition. In a short time, VFA has gained the support of the Clark County School District as well as our professional sports organizations in UNLV. We are currently collaborating with the Las Vegas Aviators, the AAA team for the new Major League baseball team, the Las Vegas A's, for a pilot program to help protect the health of our future young champions.

BAYO CURRY-WINCHELL:
I am a family medicine physician, who's representing myself and as a health advocate, I am speaking today regarding the section [in the bill] about removing race-based protocols from healthcare. I would like to paint a picture because it can be really difficult to take in what that means. There's a current practice that if a Black individual has high blood pressure, there is a recommendation of two specific types of medications—that being a calcium channel blocker and a Thiazide medication. This is solely based on the fact that individual in front of that clinician is Black. I am here to highlight that form of thought process, as far as treating an individual based on the color of their skin, is harmful. I would like to go a little bit deeper on why that is impactful. Often many of us here who are listening have heard that Black individuals have a disproportionate rate of kidney disease.

Well, you can imagine, if you have a Black individual who is offered two specific types of blood pressure medications versus all of the other medications that are available to treat high blood pressure, you are going to be at a disadvantage from the start. So this practice is in play across the country, and it is harmful. We should not be practicing medicine based on the color of someone's skin. One last little point just to drive this home: race is not the same as genetics. So, treating an individual based on the color of their skin should not be happening in health care. It's harmful, and it prevents an individual from getting the best care possible.

NAYSHA ISOM:
I am a board-certified family medicine physician as well. I own a direct primary care and wellness practice right here in Las Vegas, and I am here to strongly urge you to support section 27 of S.B. 192. Non-competes are not just a business issue; they are a public health issue. These clauses restrict doctors from practicing within miles of their previous jobs for years at a time.

In a state like Nevada where we already face provider shortages, this leads to fewer doctors, longer wait times and disruptive care—especially in underserved and rural communities. Let me be really clear: non-competes don't protect patients, they protect corporations. They actually keep doctors locked in toxic jobs, afraid to leave even when systems are not serving them or their patients. When we do leave, we're forced to uproot our families or stop practicing altogether, just to avoid being sued. That's not how we solve the healthcare crisis at all.

As someone who has worked across the country, I have seen that when physicians are free to actually leave, we innovate, we stay in our communities, we build better models of care, and everyone wins. Removing non-competes would allow more physicians to stay in Nevada, open practices and provide the kind of care we all deserve. This is about access; it's about community, and it's about keeping good doctors in the communities they love.

SENATOR DOÑATE:
For the sake of time, I think we will just go to questions.

SENATOR TITUS:
I have so many questions, I am not even going to ask them because I promised you, I would be nice. There is one thing I do want to clarify and get on the record though. Again, this is a huge bill. I think it could probably be broken down into six separate bills because there are so many different subjects in here. Some good, some need work—that is just overwhelming for this type of a bill.

But I really want to clarify, in your definition, and this is specific to sections 35 and 36, it talks about the definition of a provider of health care. It says [in section 36, subsection 3], "As used in this section, 'a provider of health care'" means an osteopathic physician, physician assistant or group of providers of health care that includes an osteopathic physician or physician assistant. We have worked hard in this building to look at those many definitions and many bills, one we heard today that actually adds a genetic counselor as a provider of health care. We have social workers as a provider, counselors as providers, athletic directors.

I am just wondering, I think this is probably more for Legal Counsel, would it just be for this provision? It excludes nurse practitioners or other providers of

health care. I am wondering how that plays out. Let us say this bill passes, does that change in NRS? [Does it] change the definite provider of health care over all the things that we have worked hard to have as a provider of health care?

ERIC ROBBINS (Committee Counsel):
No, the definition is for a provider of primary care, not for a provider of health care here that you're referencing. But yeah, these definitions just apply in the particular sections of the bill. They would not affect anything else in NRS.

SENATOR TITUS:
It says, number [subsection] 3 [of section 36], "As used in this section: 'provider of health care' has the meaning …" But I would say provider of primary care—it doesn't include nurse practitioners?

MR. ROBBINS:
In this case …

SENATOR TITUS:
They would not be held to the provisions of this bill?

MR. ROBBINS:
I wouldn't say this bill but these particular provisions that are going in NRS 630.

SENATOR TITUS:
I guess it was an oversight of the drafters or a deliberate elimination?

MR. ROBBINS:
Actually, no, it would include them. Basically, the way these provisions are laid out, they go in the specific chapters governing different types of providers. In section 30, that one deals with allopathic physicians and "providers of primary care" are just defined to mean physicians or physician assistants in that provision because that is that particular chapter. That's what is regulated under that chapter. But if you go to section 33, [subsection 3, paragraph (b)], there's an identical section in the nurse chapter. For that, the "Provider of primary care" means an advanced practice registered nurse or a group of providers of health care that includes an advanced practice registered nurse. So that is where they would be covered.

SENATOR TITUS:
They're spelled out in every different section.

MR. ROBBINS:
Yeah.

SENATOR TITUS:
Okay. It just seemed to me that we are changing the definition after we talked about genetic counselors today being a provider of health care too.

MR. ROBBINS:
As I said, this is just a definition of provider of primary care. It's just for the particular sections where it is laid out.

SENATOR TITUS:
Thank you. I think we will have a long chat on this after, but not tonight.

SENATOR DOÑATE:
Do the committee members have any questions specifically for the presenters that are here? This would be the time in terms of the intent, and we could obviously talk offline.

I did forget to mention that we have not accepted any amendments on the bill, but you may see a few of them online on NELIS [Nevada Electronic Legislative Information System] (Exhibit U), (Exhibit V), (Exhibit W), (Exhibit X) and (Exhibit Y) to help us track the amendments. I just wanted to make that disclosure for folks.

DESTINI COOPER (Committee Policy Analyst):
I was just going to say that there are more presenters on Zoom that can answer questions. There was a doctor that just joined us as well.

VICE CHAIR TAYLOR:
Okay. That's probably the doctor you alluded to earlier.

SENATOR DOÑATE:
They can answer questions specifically on group practice and menopause. It is in case there were any provisions of the bill that they wanted to ask for more clarification on.

SENATOR STONE:
Senator Doñate said that there was a provision in there that hormones—progesterone, testosterone— can be prescribed. Is that prevented today? Does it need legislation to allow physicians and nurse practitioners to be able to prescribe those medicines?

SENATOR DOÑATE:
I am going to allow my copresenters to answer the second portion of it. But from my understanding of the bill provisions, it is more on the payment and reimbursement of the therapy.

SENATOR DINA NEAL (Senatorial District No. 4):
Dr. Braithwaite can't answer because she had to go deliver a baby, so I will answer the question. Currently, testosterone is not covered for women. So, if they are going into perimenopause or if they are starting their menopausal therapy, the average cost is about $400 a month out of pocket, and they have to pay when for a man it is covered. The goal was to allow the small dosage that women may need to be covered under the insurance.

SENATOR STONE:
I appreciate that explanation. Can you just elaborate a little bit more on the non-competition clauses and how they might affect some of our hospitals that have exclusive providerships?

MS. ISOM:
I would love to answer that. It pertains to the hospital systems here. We have basically two large ones that cover the entire valley. When you put physicians under a non-compete, then you actually take physicians out of the community, and we are already at a deficit. It's not really about protecting the hospitals; it's about protecting the communities and our patients.

SENATOR DOÑATE:
I actually do know a lot about the provisions regarding non-competitions. I think what we have seen in the market, specifically in Las Vegas, is there's been a growing influence of practices that have been administered in terms of recruitment of physicians. It's gone to an extent where, honestly, it has been very egregious. We have seen in the market where, for example, when we were recruiting physicians that they would have noncompetition agreements that would say you can't practice anywhere with the same specialty or same type of

provider group within a 15-mile radius. Well, that is essentially the entire Las Vegas Valley.

I think there's a question as to if we are facing such a shortage for certain provider groups or certain types of providers, why are we allowing corporations to hang this over their heads? This level of enforcement restricts them from being able to access care. There's a question of retention and whether or not they want to stay with their employer, but we should never be placing physicians in a position where they have to feel obligated to leave the State when we work so hard just to recruit them. And so that's why noncompetition agreements are starting to become problematic in the provisions of this bill. I believe that is what Senator Neal's intention was.

SENATOR LANGE:
Senator, regarding what Senator Stone brought up—I believe I did a bill on this for the Culinary [Worker's Union] two sessions ago that took care of this problem.

SENATOR DOÑATE:
My understanding of the bill that you are referencing is more about the acquisitions of physician groups, and it is more in terms of the integrations, unless Mr. Robbins wants to correct the …

MR. ROBBINS:
Senator Doñate is exactly right. There was a bill a couple of sessions ago, and I did not recognize it when Senator Lange brought it up just because it did not deal with this issue exactly. But, yes, that was more about consolidation of physician groups, and it did not really deal with non-competes in the way this bill does.

CATHERINE NIELSEN (Executive Director, Governor's Council on Developmental Disabilities, Nevada Department of Health and Human Services):
I am here to highlight the importance of language access for deaf and hard of hearing individuals during childbirth as it relates to S.B. 192. For individuals whose primary language is ASL, not English, communication barriers in healthcare settings can lead to miscommunication, medical errors and trauma. Too often deaf individuals must rely on untrained staff, inadequate technology or family members to interpret during critical moments, which compromises informed decision-making and safety. I know that a lot of the bill does not have

to do with this, but we are super excited to see that included in there. Access to qualified live ASL interpreters is something that we advocate for.

JOLLINA WALKER:
Thank you for this opportunity to support S.B. 192. I am here to highlight the critical role that this bill plays in advancing women's healthcare access in our State. Senate Bill 192 is a necessary step forward to ensuring families have access to comprehensive, preventable and equitable health care. Women face unique healthcare challenges, from reproductive health to maternity care.

This bill prioritizes policies that support their well-being. Senate Bill 192 addresses health disparities that disproportionately affect women, particularly those in underserved communities. It emphasizes access to care, ensuring that socioeconomic status, insurance coverage, geography and background do not serve as barriers to receiving high-quality preventative care. Importantly, this bill also recognizes the value of doula care in improving maternal healthcare outcomes, especially for Black women and women of color and those living in rural communities.

Comprehensive doula programs have demonstrated savings of $986 per birth in reduction of interventions and complications. This bill is more than just policy, it is a commitment to the health and dignity of women in our State. I urge the committee to support S.B. 192 and to help build a healthier future for women and their families. I want to thank Senator Neal for bringing this bill forward and my Senator, Chair Doñate, for carrying it forward. I ask that you support S.B. 192.

KALEIGH MANCHA (Cofounder, Heart and Sol Collective):
I am speaking in support of this bill in relation to the expansion of coverage for doula care. I am a licensed mental health therapist and certified doula, both roles I have held for 15 years. I am also cofounder of a local nonprofit that aims to reduce maternal health disparities in Clark County specifically. I want to quote some statistics that I think put a really poignant focus on why doulas are impactful for reducing maternal disparities.

The Policy Center for Maternal Mental Health (MMH) calculated the average healthcare provider spends 5.75 hours with a client or patient who is pregnant and postpartum versus doulas who spend an average of 76 hours during that same time frame during prenatal and postnatal care. I bring this up because the

Society for Maternal-Fetal Medicine reviewed CDC data from 2005 to 2022 and found that suicide and homicide are the number one causes of maternal deaths in the U.S. for pregnant women and women up to 42 days postpartum.

Doulas do many things, but I want to focus on the educational aspect. We educate families about the early signs and risks for pregnancy complications. We discuss maternal mental health needs and warning signs. We help families develop the skills to communicate with their providers. As a mental health provider, I know that it would be wonderful if we had screenings or other measures to reduce these numbers for maternal deaths. But the reality is that doulas serve as intermediaries between families and their providers, making sure they get the best care possible. Instead of burdening providers with doing more work, we are outsourcing it to people in the community who are skilled and trained to do this work.

I just want to point out that MMH found in a survey last year that 91 percent of doulas felt that mental health support was a critical part of their role. I support S.B. 192 in moving forward, enhancing people's access to [doula care].

ADKIN KOLADE:
I am a board-certified psychiatrist in child and adolescent psychiatry, for adults as well, and in addiction medicine. I support S.B. 192, specifically section 22.

ERIC WILCOX (Chair, Nevada Commission for Persons Who Are Deaf and Hard of Hearing):
I am a parent of a deaf child. The Nevada Commission for Persons Who Are Deaf and Hard of Hearing (NVCDHH) routinely hears complaints from the community that we represent about the difficulty in obtaining adequate sign language interpreters in healthcare settings. There really is an urgent need for a renewed commitment in Nevada to providing access to qualified interpreting, which should be afforded to deaf and hard of hearing individuals under the Americans with Disabilities Act—that is also including during childbirth, as provided for in this bill. Therefore, NVCDHH urges your support for S.B. 192.

CHRISTINA HERNANDEZ:
I would like to voice my support for S.B. 192. First, I would like to thank the sponsor of this bill. I sit on various maternal and child health coalition boards. I am a doula and am also a mom who utilized a doula during pregnancy. This bill will provide support for many more parents that currently could use a doula.

You've already heard the many benefits of a doula and how they can provide for families during pregnancy, labor and postpartum.

As we continue to hear about the high rates of maternal and infant mortality throughout this country and with the current cuts to maternal and child health, this bill will increase the much-needed access that our families deserve. This bill provides some of that relief. I would like to thank you for your time, and I urge you to vote yes on S.B. 192.

SUE BURTCH (Executive Director, National Organization for Women, Nevada Chapter):
We strongly support S.B. 192. It may be a huge bill, but it is a necessary bill, and we urge you to pass S.B. 192. I want to thank Senator Neal for bringing this bill forward and Senator Doñate for presenting it today. Thank you to all the presenters on this very, very important bill.

MR. KELLY:
I am with the Nevada Hospital Association. We're very happy to hear that Senator Neal's recovery is going very well, and we look forward to discussing our concerns with the bill when she returns.

MS. CAPURRO:
The Nevada Association of Health Plans, which is an organization comprised of ten health plans working in both the commercial and public markets. We appreciate the opportunity to express our concerns with S.B. 192. The bill restricts the ability of multiple healthcare companies from operating within the State and prohibits their ability to provide integrated and coordinated care. This would impact the treatment of hundreds of thousands of Nevadans. The health plans also have concerns within the bill over mandated treatments. We do look forward to working with the sponsor and coming to a resolution that upholds the care choices of Nevadans.

MR. OSBORN:
I think the bulk of Nevada Rural Hospital Partners' concerns center around section 1, subsection 1 and the real challenges that rural hospitals would face being able to comply with that provision. So, ditto to the other comments. We look forward to working with the Senator and the sponsors on this bill.

MS. JACOB:
Earlier this week, Clark County did have the opportunity, thankfully, to talk to Senator Neal. It was very good to hear her voice as everybody has expressed and thank you to Ms. Cooper and Senator Doñate for helping facilitate that conversation this week. We wanted to get our opposition on the record specifically only on section 22, which is the section requiring child welfare agencies to do a psychiatric evaluation of a child before they were to exit the system for permanency.

We have a couple of technical things that we have already discussed with Senator Neal. We really wanted to come up with language that is consistent with her intent, which as I understand is to make sure that the kids are getting an evaluation before they exit the system, and that evaluation should be independent. In order for us to do that, we wanted to work with her on the language of the bill to make sure that we could get an assessment maybe with other types of healthcare providers, particularly if it has to be an independent evaluation in Clark County. There are very few child psychiatrists, and we contract with all of them; it would be difficult for us to meet that requirement of the independence of the evaluation.

We are working on an amendment with Senator Neal. We do have children who exit to permanency in under a year. So, to do a second evaluation, we might run into some difficulties. We are working through some of those issues, and I think we are going to get there. We hope to get to neutral with the amendment, and we are going to talk to Senator Neal after the hearing today.

MS. MATIJEVICH:
I will concur in the comments that Ms. Jacob from Clark County made. We appreciate Senator Neal's understanding of our concerns and willingness to work with us. We look forward to addressing those concerns and coming forward in support of the bill in the future.

RYAN BEAMAN (Professional Fire Fighters of Nevada):
I appreciate Senator Doñate for meeting with us and trying to address our concern in one section of the bill. We'll continue to work with him and appreciate that.

DAMON SCHILLING (Intermountain Health):
We have not had the opportunity yet to speak to Senator Neal, but we do look forward to working with her. We're happy to hear her voice, and we wish her a speedy recovery. We look forward to working with her when she does return.

We are here today in opposition of section 26 of S.B. 192, which would prohibit a healthcare organization from also owning and operating an insurance company. This provision directly threatens Intermountain Health's integrated healthcare model, which is proven to improve patient outcomes, reduce cost and expand access to care in Nevada.

Intermountain Health has successfully operated both the healthcare system and an insurance plan, Select Health, in a way that prioritizes patient-centered care, affordability and efficiency. By aligning the financial and medical aspects of health care, we can reinvest savings into better services, preventative care and innovations that ultimately benefit patients and the communities that we serve. If S.B. 192 were to pass as written, it would force Intermountain to choose between providing care and offering insurance, effectively dismantling our ability to deliver value-based health care in Nevada.

This disruption would not only harm our patients but would also have devastating consequences for our clinics, primary care offices and the children's hospital we just recently announced which relies on our integrated model to secure sustainable funding, lower the cost of care and provide critical services for families in need.

Nevada already faces a shortage of healthcare providers and high costs for patients. Disrupting a system that is actively working to address these issues is limiting and harmful. Instead of dismantling successful integrated models like Intermountain, we urge the committee to support policies that encourage innovation, affordability and access to high-quality care. For these reasons, we strongly oppose section 26 of S.B. 192, and I urge the committee to remove or amend this provision to protect patients' choice and healthcare in Nevada. I have submitted supporting documents for our opposition (Exhibit Z).

MR. PLAIN:
The Division of Insurance is neutral on S.B. 192. As a matter of policy, we did note that we reviewed the two benefit mandates in the bill for federal deferral provisions for the purposes of doula services. It appears to us, by our

evaluation, that we are really just adding a new provider type and not really adding additional services. So, that would not trigger federal defrayal.

On the testosterone replacement therapy, the division notes that the existing statute NRS 689A.0415, sub[section] 1 currently requires coverage for any type of hormone replacement therapy, emphasis added on my own. We read that as [meaning] the testosterone replacement therapy for menopausal women would be a subset of that. Since we already require any replacement therapy, it's already covered. I'd say if there are consumers in the State under a fully insured commercial plan that are not experiencing that, they should probably contact our consumer services section. We can walk through the steps with them and see if maybe their coverage should provide that.

Additionally, we have had some communications with Senator Neal. We do have proposed amendments (Exhibit AA) on NELIS. It's our understanding that she is amenable, but I don't want to speak for her, obviously. But what we found is it looks like in the drafting, there are eight particular sections that may have inadvertently caught up some provisions in chapter 682A dealing with how real estate is owned by health insurers and in NRS 695C dealing with health maintenance organizations (HMO) employing physicians.

It's important to note that the investment of real property for insurers is a state accreditation item for the Division of Insurance. The proposed changes in the original bill would put us out of accreditation requirements.

It's important that we perhaps do not make those changes in the amendment. In NRS 695C, an HMO is by definition an amalgamation of physicians, so they need to be able to employ physicians. So those are suggestions, and we will work with Senator Neal.

VICE CHAIR TAYLOR:
We will now close the hearing on S.B. 192 and turn our meeting back over to the chair.

CHAIR DOÑATE:
Now that the bill hearing has been closed, we will move on to our last agenda item, which is public comment. Seeing none, we'll close public comment. That concludes the work of today. This meeting is adjourned at 6:50 p.m.

RESPECTFULLY SUBMITTED:

_____
McKenna Melvin,
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
S.B. 43	C	3	Destini Cooper/ LCB Policy Analyst	Work Session Document
S.B. 138	D	4	Destini Cooper/ LCB Policy Analyst	Work Session Document
S.B. 185	E	5	Destini Cooper/ LCB Policy Analyst	Work Session Document
S.B. 207	F	6	Destini Cooper/ LCB Policy Analyst	Work Session Document
S.B. 244	G	7	Destini Cooper/ LCB Policy Analyst	Work Session Document
S.B. 348	H	11	Annette Logan-Parker / Cure 4 The Kids Foundation	Southern Nevada Health District Support Letter
S.B. 348	I	17	Craig Vincze / Max Vincze Foundation	Support Letter
S.B. 348	J	18	Sumit Gupta	Support Letter
S.B. 348	K	19	Summer Webb	Testimony
S.B. 348	L	20	Stephanie Van Hooser / Nevada State Public Health Laboratory	Support Letter and Documents
S.B. 348	M	21	Ofelia Gentscheff / Nevada State Public Health Laboratory	Support Letter
S.B. 348	N	22	Nicola Longo / Cure 4 The Kids Foundation	Support Letter

S.B. 348	O	22	Senator Fabian Doñate	Proposed Amendment: Annette Logan-Parker / Cure 4 The Kids Foundation
S.B. 348	P	22	Senator Fabian Doñate	Support Letters and Documents: Annette Logan-Parker / Cure 4 The Kids Foundation; Nevada Rare Disease Advisory Council
S.B. 348	Q	22	Senator Fabian Doñate	41 Support Letters
S.B. 349	R	23	Dan Musgrove / Nevada Donor Network	Proposed Amendment Offered by Senator Julie Pazina
S.B. 337	S	41	Adam Plain / Division of Insurance	Written testimony
S.B. 312	T	43	Angie Wilson / Reno Sparks Tribal Health Center	Presentation
S.B. 192	U	61	Senator Fabian Doñate	Conceptual Amendment: Renee Ruiz / National Nurses Organizing Committee / National Nurses United
S.B. 192	V	61	Senator Fabian Doñate	Amendment
S.B. 192	W	61	Senator Fabian Doñate	Proposed Conceptual Amendment: Senator Dina Neal
S.B. 192	X	61	Senator Fabian Doñate	Amendment: Bayo Curry-Winchell
S.B. 192	Y	61	Senator Fabian Doñate	Conceptual Amendment: Ryan Beaman / Professional Fire Fighters of Nevada
S.B. 192	Z	68	Damon Schilling / Intermountain Health	Opposition Documents to Section 26
S.B. 192	AA	69	Adam Plain / Division of Insurance	Proposed Amendment to Senate Bill 192 and Testimony