MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Eighty-second Session
March 28, 2023

The Senate Committee on Health and Human Services was called to order by Chair Fabian Doñate at 3:33 p.m. on Tuesday, March 28, 2023, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, 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 Rochelle T. Nguyen, Vice Chair
Senator Roberta Lange
Senator Robin L. Titus
Senator Jeff Stone

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Patrick D. Kelly, President and CEO, Nevada Hospital Association
Tania Gonzales, Nevada Latino Legislative Caucus
John Hardwick, M.D., Northern Nevada Emergency Physicians
Todd P. Sklamberg, CEO, Sunrise Hospital and Medical Center
Luz Castro, Program Manager, Dignity Health–St. Rose Dominican
Jose Cucalon Calderon, M.D.
Maria Fernandez, M.D., Interim Medical Director, Community Health Alliance
Katherine Salkanovic, Director of Patient Experience, Cure 4 The Kids Foundation
Rico Ocampo
Samuel Cano, Student, College of Southern Nevada
Susie Martinez, Executive Secretary-Treasurer, Nevada State AFL-CIO

Jimmy Lau, Biotechnology Innovation Organization
Marc Ellis, President, Communication Workers of America, Local 9413
Paul Catha, Culinary Workers Union, Local 226
Erika Castro, Organizing Director, Progressive Leadership Alliance of Nevada
Maria-Teresa Liebermann-Parraga, Deputy Director, Battle Born Progress
Isabel Bento, Student, University of Nevada, Reno
Jose Macias
Guadalupe Guzman
Fabio Diaz-Ortega, Patient Experience Associate, Cure 4 The Kids Foundation
Maria Farmer, Patient Financial Counselor, Cure 4 The Kids Foundation
Paola Davila
Alyssa Cooley
Amber Williams-McGee, Cure 4 The Kids Foundation
Cyrus Hojjaty
Maya Holmes, Culinary Health Fund
Holly Welborn, Executive Director, Children's Advocacy Alliance
Casey Rogers
Janine Hansen, State President, Nevada Families for Freedom
Lynn Chapman, State Treasurer, Independent Nevada American Party
Joy Trushenski
Susan Roof
Julie Burke
Barbara Jones
Susan Proffitt
Lisa Partee
Bob Russo
Emperatriz Alvarez, Make the Road Nevada
Elizabeth Lopez, Make the Road Nevada
Victoria Ruiz
Jim DeGraffenreid, National Republican Party
Charlotte Stewart, Health Freedom Nevada
John Carlo
Elena Deniger

CHAIR DOÑATE:
Today, we have a presentation by Patrick Kelly, President and CEO of the Nevada Hospital Association.

PATRICK D. KELLY (President and CEO, Nevada Hospital Association):
A few weeks ago, I was here speaking about the status of hospitals in Nevada and was invited by the Chair to talk about uncompensated care. I have submitted my presentation (Exhibit C). In Nevada, 19 hospitals provided $1.26 billion in care that was not paid by government programs or the individuals who received the care. Who are these individuals who are part of the uncompensated care? We have Medicare, Medicaid, underinsured, uninsured and undocumented patients. This group represents about 75 percent of the care that is provided in these 19 acute care hospitals. It is a significant amount and, as you will see, each member of that group does not pay the full cost of the care received.

There is a difference between cost and charges. I am not talking about charges, I am talking about the base cost. If you have private insurance, you wonder why your health insurance is expensive. One big reason is cost shifting. You pay the cost of your care plus part of the cost of care covered by government programs. For example, a procedure costs the hospital $1,000 to provide. Medicaid will pay on average $530 for the procedure or about 53 percent of the cost. Some hospitals receive a supplemental payment from the government, but not all. Nationally, Medicare pays on average $870 or about 87 percent of the cost. Both groups pay less than the hospital cost to provide the service. The difference is made up by union members, small businesses, families and anyone with private insurance. These are the groups paying more than the cost of their care. The cost is shifted from government programs to patients with private insurance.

The cost shift is huge. Approximately 70 percent of the care provided by Nevada hospitals is to Medicaid and Medicare beneficiaries. Additionally, the cost of care provided to people who are unable to pay their medical bills is also shifted. In all, 75 percent of care is partially subsidized by the insured groups; that is a lot of shifting. Small businesses and families cannot continue to pick up the cost of these government programs as they are already paying too much. Government programs should pay at least the cost of the care provided.

Looking at the different groups, we will start with Medicare, Exhibit C, Slide 6. About 17 percent of Nevadans are Medicare beneficiaries and they are the largest users of hospital services in the State. They represent about 40 percent of the patients because they are older individuals who typically have a lot of health issues. Medicare is a federal program, and the State does not have a lot

of influence on it. Medicare is a cost shifter, because it must be considered in all this, but it is an area that the Nevada Legislature does not have much influence over. However, there are areas where the Legislature can have influence. About $1.1 billion in under-reimbursed care offered each year goes to these four groups: Medicaid, underinsured, uninsured and undocumented individuals.

About one in three Nevadans are Medicaid beneficiaries, Exhibit C, Slide 9. The number of Medicaid enrollees is expected to decrease when the public health emergency ends. There will be a reevaluation of whether people are still eligible to apply for and receive Medicaid. Our hope is that a lot of the people who lost their jobs during the pandemic and went on Medicaid have found jobs and will have some private health insurance. If not, they may be able to reenroll in Medicaid or be eligible for the Silver State Health Insurance Exchange and get their payments there. Medicaid represents a huge cost shift. It covers 51 percent to 53 percent of the cost, but the rest is shifted onto other groups, primarily commercial insurance.

This chart, Exhibit C, Slide 10, looks at the growth of Medicaid rates versus hospital costs. The bottom line is the Medicaid rate has not gone up dramatically since the 1990s. The hospital cost, however, has gone up dramatically and the gap is about 50 percent. In the last 20 years, there has been about a 5 percent increase in Medicaid rates paid to hospitals. That is not 5 percent per year, but 5 percent over 20 years. This graph, Exhibit C, Slide 11, identifies the contributions made by three different entities toward hospital Medicaid costs. In 2021, hospitals funded more of the cost to care for Medicaid patients than the federal or State governments. The State contributed 14 percent, matched by the federal government at 37 percent. Hospitals made up 49 percent of the contribution, which is much larger than any of the groups.

There is a category called dual-eligible and these are people eligible for both Medicare and Medicaid. We have about 78,000 Nevadans who fall into this category. Medicare is the primary insurer and Medicaid comes in with the copays and deductibles. When it comes to hospital care, Medicaid in Nevada does not pay copays and deductibles. That cost is absorbed by the hospitals.

Some insurance plans also have an impact. When we have high-deductible plans, people get plans they cannot afford and hope they do not get sick. The IRS defines a high-deductible plan as $1,400 for an individual and $2,800 for a family, Exhibit C, Slide 13. It is not unusual to see $5,000 deductibles under

these plans for a family. This is a substantial burden for a working family because they do not have $5,000 sitting around if they have a medical emergency. About 45 percent of Nevada's workers are enrolled in these high-deductible plans. When an emergency happens and they cannot pay the $5,000, that is another cost that hospitals absorb. Because these plans are becoming so popular, there is a lot more expense in that category.

Another health plan that is a concern is the high share plan, Exhibit C, Slide 14. This is where an insurance company will pay 70 percent or 80 percent of a hospital bill, but the policyholder is required to come up with the other 20 or 30 percent. That is a huge amount of money for many working families and, because they cannot pay that, it is another cost that the hospital absorbs.

About 13 percent of Nevadans are uninsured, Exhibit C, Slide 15. An interesting study was done by a company called Manatt about the public option and uninsured Nevadans. They found that 83 percent of uninsured Nevadans were eligible either for Medicaid or the Silver State Health Insurance Exchange, but they were not taking advantage of either one. This is an opportunity to try to get these individuals insured.

Every acute care hospital has a charity care policy, and it is usually based on federal poverty guidelines, Exhibit C, Slide 16. If you meet federal-poverty level requirements, the care can be free in certain circumstances. If you do not, there is a discount policy that applies. If you pay cash at a hospital, you get a 30 percent discount.

We do not have statistics on undocumented individuals because we do not track them at the hospital. A part of Medicaid provides for emergency medical care, but it is limited to acute emergency medical conditions, labor and delivery, and outpatient dialysis services. It is limited in what it covers, but it does not pay for care after the patient is stabilized.

This chart in Exhibit C, Slide 18, demonstrates the trends of where uncompensated costs are headed. The statistics start with the year 2015 with the rate of uncompensated care for Medicaid increasing while the uninsured rate is slightly decreasing. There is a definite trend with respect to Medicaid. The Committee Chair asked me what the Legislature could do to help eliminate some of this uncompensated care and what would be the benefits of closing the gap. The first is that individuals on commercial insurance plans should not be

subsidizing as much of the care provided to these groups we discussed. Over time, people would get better care and have access to care, so that when they are seen in the emergency room (ER), they are not in terrible situations. We hope to avoid that and not have those types of admissions. A lot of different things would help to fill the uncompensated care gap.

CHAIR DOÑATE:
The rising level of uncompensated care is something we must address because it is continuously increasing. How does this play out in terms of the actual spending on care that is delivered? Is there a law that requires hospitals to take care of everyone when they step into the ER? The reality is that we do have to pay for it in some way.

MR. KELLY:
Yes, in 1986, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA). When anybody arrives at an ER, they will receive care until they are stabilized regardless of their ability to pay. That is a strictly enforced law and all hospitals follow it closely.

CHAIR DOÑATE:
What I am hearing is that we are paying, regardless. The question is to whom is the burden shifted? Is it the hospitals and clinical providers?

MR. KELLY:
It is the hospitals who must absorb it and they hope they can shift that cost to the commercial payers, but they must negotiate with the commercial payers, so you cannot automatically shift everything to them.

SENATOR NGUYEN:
Uncompensated care is a huge problem. What is the dollar amount of uncompensated care within Nevada hospitals?

MR. KELLY:
It is $1.3 billion for the 19 acute care hospitals in Nevada and that includes Medicare; without Medicare, it is $1.1 billion.

SENATOR NGUYEN:
Obviously, we are talking about private hospitals. How are they managing uncompensated care? Are they writing that off as a tax loss, and how is that working?

MR. KELLY:
Some public hospitals are included in the 19 hospitals, so it is a mixture of public and private. Unfortunately, we have some hospitals that have significant losses. In the first three quarters of last year, over half the hospitals in the State had negative operating margins. They are not able to shift all the money they need to be shifting. In the last annual report, we have hospitals that reported $100 million in losses. These are significant issues, but they try to recoup the costs in other areas. If they were a for-profit hospital and had a loss, then they would be able to get a little tax write-off. However, that is certainly not the goal.

CHAIR DOÑATE:
My question is not about uncompensated care, but about the circumstances that our hospitals are encountering in the ERs. Are there situations, because of uncompensated care, where people cannot access health insurance coverage and are turning up in hospitals with more catastrophic outcomes? Does that lead to your ER being more crowded?

MR. KELLY:
We are seeing that people who do not have access to primary care services get sicker more often, and then show up in the ER. We are taking care of a sicker group of people. Because they do not have enough access to primary care, people are coming to the ER for care, and it is about the most expensive place to get primary care. But we take care of everybody who comes through the ER and, because of EMTALA, we try to help them, so they can return home. We need more access in so many different areas and primary care is one. We still need better access to specialty services.

CHAIR DOÑATE:
For clarification, is the $1.2 billion annually? I want to make sure I get it right.

MR. KELLY:
$1.26 billion annually.

SENATOR STONE:
Is the $1.26 billion for people that were in the ER with urgent situations that need to be stabilized? If the law were to be changed so that anybody can go to any doctor or hospital for any condition without insurance, what kind of a multiplier effect would you see for that $1.2 billion? Would you see it four or five times as much if people can go to the ER for a hangnail?

MR. KELLY:
I really do not know because it would be a huge multiplier effect. I worry if I said four or five times as much because that may be too small a number. If everybody starts using ERs as primary care centers, we will go crazy. We cannot manage the capacity with the current infrastructure.

SENATOR STONE:
How about the Medicaid system? What if we had a sudden influx of 500,000 people and they all had to go on Medicaid? How would we accommodate the existing Medicaid population? Would you see a dilution of services because there are only so many providers that can see these people? There is only a finite amount of money the State provides that receives the federal match. The State would obviously have to contribute a significant amount of money to accommodate this growth in the Medicaid population and receive the federal match, which is particularly important.

MR. KELLY:
The federal match is extremely important. The State would have to come up with more money to expand the programs. We need better access to care for people who are on Medicaid and a lot of other programs.

SENATOR STONE:
So, at a five-time multiplier, the State would be looking at $5 billion or $6 billion more in expenditures to accommodate the uninsured population for any kind of healthcare needs in the State.

MR. KELLY:
Yes, it would be a significant amount.

SENATOR LANGE:
You said that 83 percent of uninsured are eligible for insurance, but they do not take advantage of getting it, is that correct?

MR. KELLY:
The report said that 83 percent of the uninsured are eligible for Medicaid or for subsidies on the Silver State Health Insurance Exchange.

SENATOR LANGE:
You get these patients in the hospital all the time. Is there a program you have in your hospital to try to get them insured?

MR. KELLY:
Yes. A hospital representative works with them to find out if they have commercial insurance. If they do not have insurance, the representative asks questions to determine if they qualify for Medicaid. If they are eligible for Medicaid, the process for enrollment can be started at the hospital. The Silver State Health Insurance Exchange cannot be done right on the spot, but we can direct them to that area.

SENATOR LANGE:
Have you had success with that program?

MR. KELLY:
Absolutely.

SENATOR LANGE:
So, the costs would be more if you did not have that program?

MR. KELLY:
Yes. At least we get some reimbursement, which is about 53 cents on the dollar; it is not enough, but it is better than nothing.

SENATOR TITUS:
At what point does it become unsustainable? Health care is not like the big-box store model where you can buy a bunch of batteries, pay pennies on the dollar for them, and if you sell millions of batteries, you eventually make a profit. If you continue to get 53 cents on the dollar and think you can charge private insurance companies to compensate for that, at some point the private insurance will be unable to reimburse enough to keep the doors open. Did you say 75 percent of the costs are now shifted to Medicare or Medicaid in Nevada?

MR. KELLY:
I said that 75 percent of our patients are subsidized by commercial insurance.

SENATOR TITUS:
How long is that sustainable for commercial insurance to subsidize 75 percent of our population?

MR. KELLY:
That is why people get frustrated because they see their health insurance premiums going up and it is because these programs are covering the costs.

SENATOR TITUS:
We use the term "underinsured." I have patients who have insurance, but they cannot get health care because they are waiting three months for health care. They cannot get into a doctor's office or, even worse, they have a $5,000 or a $10,000 deductible. These folks have insurance, but they do not have care.

We are tipping the balance to a point where we will not have any health care in Nevada because no office can stay open. I used to tell my Medicare patients that it is cheaper for them to stay home than to see me in my office. Or I would tell them to call me on the phone or come by my house because if they walk into my office, it costs me money. They would get that "aha" moment about what that disparity is. What percent of folks were assisted in the hospital with insurance, who were eligible for Medicaid or the Silver State Health Insurance Exchange that had never applied?

MR. KELLY:
It was 83 percent of uninsured Nevadans who were eligible and did not apply for whatever reason. A lot of time it is because they are young, healthy people.

CHAIR DOÑATE:
I work in health administration and keep track of utilization management and the delivery of healthcare services. You work with hospital executives every day. Would you agree that the best possible scenario for many of these patients that go to the ER is to get them access to preventive health care, so they do not have to go to the ER? Is that the outcome that would make the most sense for uncompensated care?

MR. KELLY:
If you are looking to save money, that makes absolute sense.

VICE CHAIR NGUYEN:
I will open the hearing on Senate Bill (S.B.) 419.

SENATE BILL 419: Makes revisions relating to public health. (BDR 40-748)

SENATOR FABIAN DOÑATE (Senatorial District No. 10):
Senate Bill 419 is an expansive piece of legislation that will make various reforms to our healthcare system. Today's presentation (Exhibit D) is historic. Over the last few years, many of us in the healthcare community have worked and dreamed about this moment. It is a moment that has taken too long to address the challenges that we face in society. No Nevadan is left behind, no one is forgotten.

In the first week of the Legislative Session, I mentioned my intent to introduce legislation that would reform our healthcare system to better reflect and serve the individuals of this State. For too long, we have heard the horror stories in our community from the folks that have consistently been denied care. We heard there are not enough doctors, they cannot get on a doctor's schedule, they have to travel out of State to receive the needed care, health care is too expensive or they lost their home because of the bills for health care.

Today, community leaders, physicians, executives and I are embarking on a piece of legislation that will shape the future trajectory of health care in our State. This bill can establish a simple vision that everyone deserves access to care regardless of who they are, where they come from or their immigration status. I am joined by Ms. Tania Gonzalez, a fellow with the Nevada Latino Legislative Caucus and members of our clinical workforce. We will talk about the bill in its conception and explain the Medicaid expansion piece.

The first part of the presentation that I want Committee members to look at is this powerful photo (Exhibit E contains copyrighted material. Original is available upon request of the Research Library.), that was taken when the Las Vegas Strip closed for business during the COVID-19 pandemic. As you look at this photo, think about the words that come to mind and how this visual makes you feel. I will say shocking, absurd, confused, worried, frustrated, desperate, sad, depressed and hopelessness. Every day that I am in this building, I think about

this photo. I think about the thousands of workers who were laid off because of our broken public health system. I think about filling out my dad's and uncle's unemployment forms, refreshing the webpage repeatedly on Sundays, hoping that the system would work. Otherwise, we would not know how to survive.

I think about our State and what we could have done and should have done to prevent this. I think about our Country and what we could have done to bolster our public health system with the right tools to prevent disease transmission. I think about the Nevadans that lost their lives, the families that unexpectedly found themselves having to bury their relatives because we did not have the courage to build the right capacity or fund the resources to prevent this. I think about our healthcare workers and the indentations left around the sockets of their eyes from the surgical masks they wore for hours because we could not dispose of them; because we did not have had the resources to replace them.

I think about this photo all the time. It is keeps me up at night wondering where we went wrong and where we could go next. We have seen the statistics. We know that there were people in certain communities in this State that were left behind, including my family members that were not treated equally, whether it was in the dissemination of health information or even something as basic as healthcare coverage, people were left behind. We continue to ignore the hardworking families that call this great State their home. This photo reflects how we failed.

Part of today's bill hearing is to never repeat this ever again. For too long, residents in my district have pleaded for help. Archaic policies, both in this State and federally, have denied people the right to live and access health care. This bill is an appropriate way to repair our broken system and this is how we will get it done. If you are like me, you were probably wondering in July 2021 what we can do to fix our healthcare system. Like any normal human who is a health administrator, I created an analysis of the strengths, weaknesses, opportunities and threats in our healthcare system. I will walk through some of the things that I visualized in Exhibit D, Slide 2.

What does Nevada do right? When it comes to our healthcare system, we have strong tax bases and incentives to encourage people to move into the State. That is something that has always attracted folks to Nevada. Commercial insurance plans in our State have a strong base, too, given that many of our residents are unionized. We are approaching a level of maturity where our

healthcare system is beginning to become more innovative. We see this with the coordination between our two schools of medicine and the community support gathering for health care.

What does Nevada lack and what do we not do well? First, we lack sustainable public health funding. We have seen the statistics and our State ranks last for public health spending. That is part of the reason my classmates and I could not find public health jobs upon graduation because most of our healthcare providers are for-profit. You can argue that our current systems are siloed, but I do not want to get into that debate. The reality is we have failed to deliver on multiple things like interoperability with the structure that exists today. Increasing our Medicaid reimbursement rate is an issue that needs to be addressed immediately to find sustainable funding models.

What are the threats that could potentially leave permanent damage to our healthcare system which is already so fragile? We have a rising level of uncompensated care because of the nature of our federal government. There are folks that have lived here for years, decades, who have been denied adequate care. There is no clear strategy to bolster our healthcare capacity, which has resulted in workforce shortages in our healthcare system. We are always shorthanded. We look at placing bandages on our wounds instead of preventing the injury in the first place.

As a healthcare administrator that worked on the east side of Las Vegas, I have interacted with patients who have been denied basic preventative services. Our undocumented immigrant population, including my family members, has been denied adequate health coverage due to the lack of access to care. We deserve a system that takes care of everybody. However, if we continue on this path, the problem will worsen, and more lives will be lost. It is as simple as that.

One part of this analysis excites me the most: we can go to the digital frontier. We can reform our payment models to incorporate technology into medicine and build the infrastructure to review, finance and invest in the future products of tomorrow. The race for digital health is a national conversation that can pivot our State as an international leader. That is why we spent time earlier this Session speaking with the Healthcare Information and Management Systems Society (HIMSS) (Exhibit F and Exhibit G).

An effort to help diversify our economy is to attract more researchers to the State that could invest in biotechnology. If we build the right infrastructure, Nevada can be a leader in producing the cures of tomorrow. Last, but not least, we need to do our part to invest in graduate medical education and clinical programs. This is the opportunity that we have before us, and we need to do a better job of financing these initiatives once and for all.

Let me leave you with one thought; how do we do it all? How do we address the shortages, cover folks who need help the most, build on our interoperability and pave the way to expand health care to people who have been denied? That is the Nevada Health Opportunities Planning and Expansion Act of 2023 (HOPE Act). That is why we are here today. The HOPE Act is a bill that brings forth the necessary changes in our community to provide preventive services and reduce the level of uncompensated care. It is an innovative bill that looks at the economic development trajectory of our State to build on our healthcare capacity and incorporate health information technology like never before.

This bill will set our State up for future generations to come. It is a bill that I am most proud to introduce as your colleague, but also as a resident that believes in a State that I so dearly love, a State that deserves endless support and admiration. That support and admiration must come with a commitment to change. The Nevada HOPE Act aims to do the following.

First, align our health systems to be a leader in the twenty-first century. Patients deserve access to their data anytime and that is what we will be covering today.

Second, shape the future jobs of tomorrow. I mentioned my intent to help modernize our public health system. We know that this has been a request for many folks throughout this community. We also must find new innovative ways to collaborate with one another. We will talk later today about the Nevada Innovation Hub, which is going to be a State-run entity that can help with the alignment of public health data that the government already collects and make sure we are not duplicating services. Further, we should have a conversation as to what digital health reimbursement looks like.

Third, build our healthcare capacity. Nevadans should not be forced to go out of State to receive the care they need. We need more doctors and more facilities. Investing in healthcare jobs is a good financial investment for the long-term

sustainability of our State. This bill introduces a new tax abatement program to allow medium and large health industries to move into Nevada and support our general infrastructure.

Finally, expand access to health care for all Nevadans. Historically, we know that people have been left behind and each of these initiatives is reflected in the bill context. We will break it down for you, so it makes it easier to follow throughout the bill.

Exhibit D, Slide 5, discusses aligning our healthcare delivery systems. Senate Bill 419, section 6, establishes two principles—building our capacity for data interoperability and aligning ourselves toward a Trusted Exchange Framework and Common Agreement (TEFCA) (Exhibit H). As drafted, it would require the Nevada Department of Health and Human Services (DHHS), in consultation with our healthcare providers and third parties, to prescribe a framework for the electronic maintenance, transmittal and exchange of health electronic records, prescriptions and health-related information.

This is an item that was mentioned earlier in this Session by the HIMSS during their presentation. It is part of the work being fulfilled by the Office of the National Coordinator (ONC) for Health Information Technology. Under the 21st Century Cures Act, the National Coordinator of ONC is charged to develop a TEFCA for health information networks (HIN) nationally. In January 2018, 0NC released the first draft of what we know today as TEFCA.

The goal is to establish a universal floor of interoperability across the Country under guidelines established by TEFCA. A few principles TEFCA seeks to accomplish are outlined in Exhibit D, Slide 7: the standardization of health data; openness and transparency; cooperation and non-discrimination; privacy, security and safety; and access and equity.

In 2019, the ONC issued a Notice of Funding Opportunity and awarded a cooperative agreement to The Sequoia Project to serve as the recognized coordinating entity (RCE) that providers will use to develop, update, implement and maintain the Common Agreement. The RCE is also responsible for soliciting and reviewing applications of qualified HINs. Qualified HINs (QHINs) are networks that agree to the common terms and conditions of exchange with each other, as specified in the Common Agreement, and to the functional and

technical requirements for exchange, as specified in the QHIN Technical Framework, Exhibit D, Slide 8.

The QHINs will be the central connection points within the TEFCA ecosystem. They will route queries, responses and messages among entities and individuals sharing information and help close out any potential questions that may arise. This creates a Common Agreement, which is a document that will provide the governing approach necessary to scale a functioning system of interconnected QHINs throughout our Country. The Common Agreement will allow healthcare providers to coordinate with one another and build our interoperability of data, Exhibit D, Slide 9. Federal standards will begin to require alignment and Nevada's participation will position our State as a model of implementation for this conversation. Senate Bill 419 allows DHHS to begin prescribing regulations on the items set above, including the necessary requirements to align toward federal standards and bring together our local health providers.

To clarify, my intent in section 6 is not for the State to create its own standards of interoperability; that would be counterintuitive to this process. My goal is to ensure our State is aligned toward what is being done federally with TEFCA. We should not be creating more regulatory burdens than already exist and instead prioritize the initiatives of our federal government.

We have a conceptual amendment to the bill that makes conforming changes to various sections, including sections 1 and 6 regarding jurisdictions and compliance. Exhibit D, Slide 13, provides a graphic to introduce what a QHIN looks like and how the information is distributed amongst institutions. The Sequoia Project is the main entity facilitating the transmittal of digital health information. The QHINs are the mediators between different regions across the Country. Participants in the QHINs can be central State-based repositories, health information exchanges or State-based data utilities. Secondary participants can be individual entities like the University Medical Center (UMC) in Las Vegas or other hospital systems than operate in multiple jurisdictions but need to flow data to one centralized QHIN.

Further, S.B. 419 establishes requirements for electronic health records (EHR) integration. To continue our commitment to prioritizing the interoperability of health information, sections 6, 28, 29, 45 and 63 of this bill will require government entities, health providers and administrators to maintain, transmit

and exchange health information within the EHR system. The deadlines are listed on Exhibit D, Slide 14.

Requiring providers to integrate within the EHR is not only a good practice to assist patients in retaining their health data, but also a cost-saving measure that can reduce the duplication of procedures. Section 57 will appropriate general fund dollars to help smaller providers and doctors comply with this EHR requirement. Section 6 of the bill establishes a waiver to help healthcare providers that may have trouble with the interoperability requirements set forth in this provision.

Senate Bill 419 will help DHHS understand where providers stand with the facilitation of their established health records to get a lay of the land. This will help us understand where to spend future dollars on broadband and interoperability, should federal grants become available with TEFCA and other pieces of legislation.

Throughout the COVID-19 pandemic, our State fell behind regarding health information technology. Earlier this Session, you heard our public health professionals say that in the initial stages of the pandemic, everything was being tracked on a spreadsheet. As a State, we can do better. We deserve data points that work. The reality is we are already doing this work. That is why, to build the future health jobs of tomorrow, we need to enable the full reimbursement of digital health and begin to modernize our outdated public health systems.

Under the provisions of this bill, the Joint Interim Standing Committee on Health and Human Services will begin to explore the full reimbursement of digital health. Earlier this Session, our Committee held presentations on health information technology and where our sector is going in the future. Artificial intelligence (AI) is already mainstream in health care. In a peer-reviewed research study, the Centers for Medicare and Medicaid Services (CMS) is already beginning to establish a national payment amount for an authorized AI system that can help make clinical decisions and support the expansion of healthcare delivery. We will increase the use of AI in virtual reality. The American Medical Association has already unveiled new current procedural terminology codes for these services, including AI and virtual reality.

Senate Bill 419 requires the Joint Interim Standing Committee on Health and Human Services to review the feasibility of the full expansion of digital health, including remote patient monitoring and digital therapeutics. As someone who has worked in this space at other leading institutions, Nevada can begin revising payment models to be more inclusive of technology. Nevada can lead the way for innovation and begin to build an infrastructure cycle of research, qualification, verification, investment and commercialization.

Time after time, we have heard from constituents and public health officials, about the lack of capacity that our State carries for the transmission of public health data. This data is already being collected by different State agencies and departments, but because we work in silos, the systems fail to connect with one another into evidence-based strategies to address social determinants.

Sections 22 through 24 of this bill will establish the Nevada Innovation Hub within DHHS, modeled after the Indiana Management Performance Hub and facilitating data-driven innovation as noted in the handout (Exhibit I). The Nevada Innovation Hub will work to align our governmental public health systems to better work alongside and with one another. This bill addresses the feedback collected by a COVID-19 study, which emphasized the lack of coordination between jurisdictions and entities. The Nevada Innovation Hub can become a home for public-private partnerships to be established and eliminate the disparities that have resulted from the social determinants of health.

To clarify, my goal is to delineate the outcomes of this Hub toward public health data, not healthcare-related data. The Hub should be a resource that can provide coordination between different agencies and jurisdictions to improve outcomes. It coordinates the data points that our State already collects for varying reporting requirements.

For instance, I see the Hub taking on issues like the opioid epidemic or collaborating with the Nevada Department of Education to address social determinants with support of income data generated by school forms. We can work together to solve major systemic issues with the data already collected by our government. The goal should be not to work in silos but to provide an enhanced strategy. This is not a Hub for healthcare-related data on the prescriptions you are taking or how your physical went. That is a separate conversation for another session.

Most importantly, the Hub must align toward the identifiable data points. We want to ensure that patients continue to have their privacy secured and that we adhere to the federal HIPAA requirements, which is why this bill aligns the language toward this initiative.

Lastly, here is my vision for why this Hub is necessary. Throughout the COVID-19 study, we heard from many stakeholders about the failure to coordinate between different jurisdictions and State agencies. The reality is that most of this will come down to money and resources, but we deserve health officials in this State that can help provide some level of strategic direction to bring everyone together for public health-related data.

We want to ensure that Nevada is positioned to receive grants from the Centers for Disease Control and Prevention and other national groups to pilot new initiatives to modernize public health reporting structures in a scalable, sustainable way. Nevada can lead the way, rather than creating a singular solution. It will set us up to eventually succeed because public health data on patients should cross boundaries and our systems should work together.

Section 59 is one of the most important portions of this bill. Throughout the COVID-19 pandemic, the DHHS staff has been relentlessly serving our population to help navigate this public health emergency. Now that we are in the recovery stage, it is time for DHHS to begin a study that determines, adds, eliminates, reclassifies or revises the salaries for positions to increase the effectiveness and efficiency of agency operations.

Throughout the campaign cycle, voters told me about their frustration with the coordination of our healthcare system and the lack of providers. We can do a better job to attract more companies to the State. Investing in bioscience can help drive Nevada's economy forward as noted in the best practices report (Exhibit J) by the Council of State Bioscience Association.

We anticipate this bill will be referred to the Senate Committee on Finance to review the contents of tax abatements. I will go over some of the adjustments we made in this bill. Sections 31 through 38 of this bill allow the abatement of sales and use taxes for property that provides health care or conducts scientific research, certain property taxes imposed on businesses, and excise taxes on wages paid to employees performing services directly related to critical medical and scientific needs. With an ever-changing pandemic, Nevada has shown its

resilience in countering public health disasters. Now, more than ever, Nevada needs to diversify its economy. Senate Bill 419 will enable the Nevada Governor's Office of Economic Development to attract new health startups and businesses seeking to find the next cure.

TANIA GONZALES (Nevada Latino Legislative Caucus):
I will speak to you about the lessons we have learned since the onset of the COVID-19 pandemic and the strategies other states have taken to combat the lack of access to healthcare issues. I will go over expanding access to health care to all Nevadans, the impact of COVID-19, similar legislation in other states in tandem with their outcomes and conclude with a holistic bill summary. I have provided a document (Exhibit K) outlining the background, solution and key bill proposal data.

The Nevada HOPE Act, S.B. 419, is an act that relates to all Nevadans. Expanding access to health care is more than fiscal responsibility, it is the right thing to do. Through Nevada's HOPE Act, we are introducing legislation for Medicaid expansion for all Nevadans regardless of their citizenship status. As such, it will become Nevada public policy that each resident of the State who would otherwise be eligible for Medicaid, if not for their non-citizenship status, may enroll in Medicaid. Sections 39 to 49 pertain to this.

It is indisputable that Nevada took a hit from the COVID-19 pandemic as detailed in the report (Exhibit L). The uninsured crisis left Nevada uniquely vulnerable to the pandemic. As a result, communities of color were disproportionately affected. Nevada's racial and ethnic minorities were among the hardest hit by the pandemic in terms of infection, hospitalization and mortality rates.

According to a study conducted by the National Center for Coverage Innovation at Families USA, Exhibit L, 40 percent of COVID-19 deaths and more than 50 percent of all COVID-19 infections in Nevada were linked to health insurance gaps. This is a shocking statistic because it means that those deaths could have potentially been prevented if access to care had been more accessible.

Nevada has an estimated 330,390 uninsured individuals or 10.6 percent of the total State population. This data is from the recently published Nevada Department of Business and Industry, Division of Insurance, *2023 Insurance Market Report*, Exhibit D, Slide 30. In 2019, of the uninsured, 27 percent were

ineligible because of their immigration status. The following year, in 2020, the percentage of uninsured increased to 34.9 percent.

A visual display adds to that information in Exhibit D, Slide 33. The total number of native-born citizens in Nevada is about 241,000 people, which represents 60.6 percent of the uninsured population. The 7 percent foreign-born population, combined with natural-born Nevadans, amounts to 67.6 percent of the uninsured. That means that one in three uninsured individuals in Nevada is a foreign-born noncitizen. While 10.5 percent of the total Nevada population is uninsured, almost half or one in two noncitizens, are uninsured. This is where the 44.2 percent comes from. Using this data, we estimate the Nevada HOPE Act will enroll 95,000 to 110,000 Nevadans.

Exhibit D, Slide 34, illustrates the U.S. states that have passed legislation as of 2022 to expand and commit to health equity. This is not including the recent bill passage in Colorado. Currently, nine states provide comprehensive state-funded coverage to all income-eligible children regardless of citizenship status. Those states are California, Illinois, Oregon, Colorado, Maine, New York, Rhode Island, Vermont and Washington, D.C. Another ten states have used the federal Children's Health Insurance Program to expand access to children. Some states have expanded to include pregnant women.

A timeline of the Healthy Illinois Campaign indicates that seven years ago, Illinois first guaranteed coverage to all children up to age 19. In 2020, Illinois expanded coverage to non-citizen seniors aged 65 and older. Each year after that, Illinois expanded coverage to more groups; ages 55 through 64, ages 42 to 54, and in 2023, Illinois closed the gap ensuring noncitizens ages 19 to 41.

In 2016, California's timeline was the same as Illinois. It established its Medi-Cal program guaranteeing coverage to all children who are noncitizens up to age 19. Like Illinois, California expanded coverage for noncitizens ages 19 to 26. In 2022, coverage was expanded to noncitizens aged 50 and over and expanded coverage for the remaining ages of 26 to 49. California closed all health insurance gaps last year.

Oregon first guaranteed coverage to all children who are noncitizens up to age 19 as well. A couple of years after its implementation, it expanded to young adults ages 19 through 25 and seniors 55 and older, the details of which are

covered in an implementation report (Exhibit M). Oregon, like other states, experienced a steady increase in enrollment month by month. Those enrolled sought a wide range of health care, starting with primary care and specialty care followed by dental care, pharmacy and so on.

The last state I will cover today is Colorado. Last year, it too began covering income-eligible children who are noncitizens. At the same time, it expanded coverage to women who are pregnant and up to 12 months postpartum. They targeted the significant healthcare disparity between Hispanic/Latinx women and non-Hispanic white women. Exhibit D, Slide 44, displays a multiplier effect that Colorado assessed and is applicable to other previously mentioned states. The idea is that if money is injected to expand Medicaid, it will continue to increase new economic activity.

By now, you can see a trend among these states and the strategy taken to combat the lack of access to care issues. This strategy helps reduce health disparities. The states I spoke about earlier have seen healthier birth weights with lower risk of infant mortality, reductions in maternal mortality rates, higher rates of adolescent immunizations, lower rates of ER visits, fewer admissions for preventable health issues that could have been prevented and simply just more preventative care.

Sections 6, 28, 29, 45 and 63 require the establishment of a framework for the interoperability of health systems and mandate the commencement of usage to be July 2024 and July 2025.

Section 57 appropriates grants to assist with such compliance. Section 60 requires the DHHS Director to establish an advisory group. Sections 1, 2 and 6 mandate a notice of failure to comply and sets an opportunity to be heard. It is important to know that this would not be a misdemeanor.

Sections 9, 17, 45, 47, 50 and 53 have been stricken; they required the suspension of a credential upon the notice of failure to comply. Sections 15, 49 and 54 established that the suspension is not subject to procedure as the suspension of licenses. Some of this also has been stricken. Sections 1, 17, 19, 45, 47, 50 and 53 prescribe a similar process to reinstate a suspended credential if the holder complies. Here again, some language has been stricken.

Section 4 authorizes the DHHS Director to establish a Statewide health information exchange. Section 7 expands healthcare immunity from liability to providers who use the interoperability system. Section 8 establishes the exchange of electronic health practice is not an unfair trade practice. Sections 22 through 24 establish the Nevada Innovation Hub within the DHHS. Section 23 creates the position of the chief data officer to serve as an executive of the Hub and to advise public health agencies. Section 24 requires the Hub to establish and maintain its activity. Additionally, sections 24 and 27 require that the confidentiality of personally identifiable information be maintained by the Hub for which disclosure is prohibited.

Section 61 also has been stricken. It required the chief data officer to submit a report to the Joint Interim Standing Committee on the Hub's policies and procedures. Section 31 authorizes partial abatement of health care and scientific research and certain taxes. It also requires the applicant to obtain the approval of a supermajority from the Nevada State Board of Economic Development. Sections 35, 36 and 37 establish the duration and amount of the abatements. Section 38 authorizes abatements on certain machinery. Section 39 requires the DHHS Director to authorize Medicaid in the State plan for any person who otherwise qualifies, regardless of their citizenship status; but it has been amended to require the State to first seek waivers from the federal government to seek financial participation.

Section 43 removes the requirement that a person who is not a citizen must be allowed by federal law to receive Medicaid. Section 41 creates the Medicaid Outreach Advisory Committee within the Division. Section 42 requires the Committee to advise the Department and publish a report of its activities. Section 59 requires the Department to assess workforce development and submit a legislative report.

Last, but not least, I am presenting Senator Doñate's three conceptual amendments (Exhibit N) to S.B. 419 and will briefly review them. Any licensure revocation penalties have been completely stricken. Any licensee who fails to comply with the interoperability regulations and standards is instead referred to an appropriate regulatory body of the State. The requirement that the chief data officer submit a report to the Joint Interim Standing Committee on the Hub's policies and procedures is also stricken. The Director is newly required to first apply for any federal waiver or take any other action necessary to obtain federal financial participation for the Medicaid expansion.

The Nevada HOPE Act will provide reforms on the interoperability of health data and provide incentives to build our healthcare capacity, which includes the full Medicaid expansion of Nevadans who would otherwise qualify. It is the right time to do so and the right thing to do. Please help us pave the way for Nevada to be a national leader in the space of health infrastructure and access to care.

SENATOR DOÑATE:
I have other presenters that will touch on some of their firsthand experiences as health professionals in our State. There is broad Statewide support for this proposal. Nevadans are already taking a stand on the bill as the levels of uncompensated care continue to increase. Rather than hearing it from me, I want you to hear from our healthcare providers.

JOHN HARDWICK, M.D. (Northern Nevada Emergency Physicians):
I am here to add context to the conversation and provide additional comments to the written testimony (Exhibit O) I submitted. I worked today, got off my shift, and immediately came here because this is an incredibly critical issue that needs to be addressed. As emergency physicians, a lot of us went into this because we want to care for the sickest and most vulnerable in our community. It allows us to be a safety net when the system is broken. The current paradigm of healthcare reimbursement results in multiple consequences when it comes to the underinsured and uninsured. One that has already been addressed eloquently is that patients seek primary care at the ER.

For example, someone comes in and they have a history of diabetes. When they come in, they may not know they have diabetes, and we diagnose them with that in the ER. I might be able to start them on some oral medication, but my ability to offer longitudinal care is difficult. Longitudinal care, especially in chronic illnesses, is incredibly important because that disease should be monitored. How is that disease progressing? How are they responding to the medication? Without monitoring the disease, overwhelmingly, these patients cannot maintain decompensation about their disease. It leads to a worse outcome for that patient and more expensive care.

Let us say you have a diabetic patient who does not seek care, does not have follow-up care and develops a diabetic foot ulcer. The diabetic foot ulcer ends up becoming infected and the patient loses a foot. That is an expensive procedure and hospitalization. You now have someone who is outside of the workforce and can no longer work.

Senator Stone, you made a comment about treating someone in the ER for a hangnail. What happens if we must treat every hangnail that came to the department? Currently, we do have to treat every hangnail that comes to the ER, and we are happy to do it. As mentioned earlier, it is an incredibly expensive and inefficient way to provide care. Earlier this morning, I took care of an ingrown toenail, and I am happy to do it, but it would have been much better through a primary care physician. They came to the ER because they were unable to get that care at an urgent care or at a physician's office because they do not have insurance.

When we talk about the cost of these things, there is some talk about parity. If we are already paying for this in the ER, it justifies the cost. We are not only paying for it, but we are also paying more right now. We are paying significantly more because these diseases progress and these patients' diseases progress to a point where the care costs significantly more. It is significantly better to intervene in that chronic disease early before it progresses. Another thing that happens is patients avoid care altogether because they are worried about the cost associated with it. People want to pay their bills and they are worried about going to the ER because of the costs associated with the ER if they are underinsured or uninsured.

What happens in those cases? I recently saw a tragic case. A gentleman came in and had squamous cell carcinoma, which is a simple skin cancer that many people have and is treated by doing a quick excision of the lesion. This gentleman did not have a primary care doctor, he did not seek care and the lesion got worse. By the time he saw me in the ER, that lesion had invaded his entire orbit, he lost his eye and was having intractable seizures in the ER. He was in a coma, he was intubated and placed in the Intensive Care Unit (ICU). You can imagine the cost associated with that. Not only the societal cost and the cost for that individual, but also the monetary cost of that patient and not having a system in place where the patient was able to seek reliable care.

Another issue is that without reliable reimbursement for ER costs and as our undocumented population grows, that cost is passed through to other payers including the State Medicaid program. We are paying for it anyway, as a State. Hospitals must address this. They cannot go insolvent. They have and want to serve the community, but that means they must cut staffing and services. That means more physician burnout, which means more provider burnout. That

means fewer services available for mammograms and routine care. It is this kind of self-perpetuating cycle that gets worse if we do not intervene early.

Lastly, it leads to us not being able to provide meaningful follow-up for specialty services. Say we have a patient come in and their heart rate is going super-fast out of nowhere. This is known as supraventricular tachycardia (SVT). We can treat that in the ER with medications or cardioversion. Those medications or procedures are not cheap and monitoring those patients is not cheap. For those patients with SVT, there is a simple fix, which is an ablation that happens as an outpatient. An ablation procedure is where a cardiologist can go in and burn that area of tissue in the heart that is a little hyperactive. But without that ablation, the patient is discharged from the ER and does not have a reliable means of follow-up. They repeatedly come back to the ER. This problem could be fixed with one visit to a specialist, but they are unable to see that specialist. Therefore, the ER recidivism is constant, and this is a cost that perpetually increases.

TODD P. SKLAMBERG (CEO, Sunrise Hospital and Medical Center):
I have had the privilege of being the CEO of Sunrise Hospital and Sunrise Children's Hospital for the last 15 years. We are excited about advancements in the interoperability of patient health records aligned with the national standards. We commend the Senator for opening this important conversation on the expansion of access to care.

Sunrise Hospital is the State's largest acute care hospital with 834 beds. We treat over 250,000 patients each year with 175,000 coming through our ER, and about 40,000 admissions. We also have the privilege of being the State's largest Medicaid provider. One in five Medicaid recipients in Nevada received their hospital-based care at Sunrise Hospital. One in four in Las Vegas received their care at Sunrise Hospital and we are committed to all patients regardless of their ability to pay and their residency status. We care for the entire community. An hour ago, when I contacted the hospital, we had 850 hospital-admitted patients and 200 in our ER. We care for over 2,000 undocumented patients each year coming through our hospital.

Many of you have had the opportunity to tour our hospital and spend time in Sunrise Children's Hospital, specifically our neonatal ICU. There is no better place to understand the impact of preventative care and access to health care than touring our neonatal ICU. Last week, when I was in the unit, I had the

opportunity to visit a 500-gram baby, which is about a pound. Think about four sticks of butter, which is about a pound. That baby was born at 22 weeks with no coverage. The mother did not have any prenatal care. As we think about access to care and the provisions we are talking about today, that ounce of prevention can provide significant enhancements. For that baby, instead of being in the neonatal ICU for 15 weeks, that individual would potentially lead a healthy life. Access to primary prenatal care and obstetricians will help reduce admissions to one of the most costly and acute settings in a hospital, the neonatal ICU.

As you contemplate the bill, please keep in mind that expanding coverage to include more of the uninsured is a strong investment. Most importantly, it increases access to preventative care, promotes overall wellness, and significantly improves the quality of life. Today's hearing is the first step in a voyage of expanding healthcare access and services. We look forward to collaborating with you as this bill moves forward.

LUZ CASTRO (Program Manager, Dignity Health–St. Rose Dominican):
My presentation (Exhibit P) is on our responsible early detection (R.E.D.) Rose Program and our work with the undocumented population of southern Nevada. Dignity Health-St. Rose Dominican started in 1947 after World War II. Seven Adrian Dominican sisters of Michigan traveled to Henderson, Nevada, with Bishop Gorman to purchase the hospital for $1 a year for 25 years. The hospital purchased is today known as the Rose de Lima campus. We are the only not-for-profit faith-based hospital system in Nevada. Our mission is to make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all. We serve our most vulnerable population, especially the uninsured, underinsured and undocumented. They have three main campuses and four neighborhood hospitals.

At St. Rose, we serve all vulnerable populations. The R.E.D. Rose Program is just one example of the type of care we provide to the undocumented population. The R.E.D. Rose Program began in 2001, founded by Sister Monica Stankus. She wanted to ensure that women without adequate insurance received the treatment they needed in their fight against breast cancer as well as financial support if they cannot hold down a job while receiving treatment. In 2018, the R.E.D. Rose Program received a transformational $10 million donation from the Las Vegas-based Engelstad Foundation to

continue this important work. The program was rededicated as the Engelstad Foundation R.E.D. Rose Program. The R.E.D. Rose Program supports vulnerable women and men with free breast health services if they are low-income, uninsured or undocumented. These services are clinical breast exams, mammograms, ultrasounds, biopsies, follow-up consultations and surgery.

Since its inception, the R.E.D. Rose Program has cared for over 7,500 patients providing 4,336 mammograms, 3,739 ultrasounds, 867 biopsies and 130 breast cancer diagnoses. Ninety percent of our R.E.D. Rose clients are undocumented. Unfortunately, there is a lack of preventative healthcare services for the undocumented community in Nevada. Uninsured women with breast cancer need to pay out of pocket for treatments like chemotherapy or radiation. These out-of-pocket costs are $600 to $1,000 per treatment. This causes a financial burden for our clients and their families, forcing them to travel out of State in search of free or affordable treatment. Our clients have expressed other health-related issues to our hospital navigators, and we strive to connect them to free programs at Dignity Health. It has been challenging to find more community resources to support their needs. By expanding Medicaid to the undocumented community, we are not only giving them access to a better quality of life, but it can mean saving someone's life. At Dignity Health, we believe that health care is a basic human right for everyone.

SENATOR DOÑATE:
Folks ask why federally qualified health centers (FQHC) are not able to cover this. We have Dr. Jose Cucalon Calderon and Dr. Maria Fernandez, who are with the Community Health Alliance, an FQHC in northern Nevada who can respond to this question.

JOSE CUCALON CALDERON, M.D.:
I am a general pediatrician practicing in northern Nevada for six years. I am going to speak about stories that I encounter daily and that became more frequent during the initial years of the pandemic. There is a history of families coming to my establishment to talk about family situations that lead to loved ones having either critical illness or death. I will speak of stories of my patients being unable to access healthcare services, including the parents of my patients. As a pediatrician, I see patients from birth until they are 21 years old. That is a long continuum and relationship that I have established with these families since I have been seeing their children for close to six years.

As one of the few Spanish-speaking physicians, especially as a pediatrician, families ask me what are good choices for the growth and development of their children. How can they help them thrive? One of the more common answers that I give is making sure that the parents are taking care of themselves, being able to contact services, and getting a colonoscopy and mammogram on time. Frequently, they say, I do not have a physical care provider, I do not have access to that, and I am undocumented.

I also run an extremely busy newborn nursery in northern Nevada where the care that we deliver to these newborns is affected. Most are not for the better because of the lack of prenatal care during pregnancy. This can lead to significant health consequences as was mentioned previously. Primary care is life. It can mean the life of your family. It can mean the life of multiple families. Access for everybody is necessary, not only for all the right reasons, but because it is going to be cost-effective. It is going to end up expanding access to care for everybody in the State as well as allowing people to practice the best medicine available, which is preventive care.

MARIA FERNANDEZ, M.D. (Interim Medical Director, Community Health Alliance):
Community Health Alliance is an FQHC in northern Nevada. I come here in support of this bill. As a family medical doctor, I see patients from newborn all the way to their nineties. Having access to insurance means that patients will seek medical care before they end up in the ER. As our ER doctor shared, I see hospital discharge patients after they have had a leg amputation because of uncontrolled diabetes. I can control their diabetes and work with them, but the damage has been done. They entered the ER because they had other priorities such as paying for food and supporting their family.

So, absolutely as an FQHC, we provide services, screenings and a lot of grant programs. Because they do not have insurance, many people do not come to see us early enough. Often, when they come in and have not been screened for cervical cancer, they are diagnosed with cervical cancer. I would encourage you to think about this bill and the possibility of covering people with insurance and how much that would prevent in terms of complications. I could plug them into specialist services without them going bankrupt due to the cost. I take care of my patients as if they are my family members. Our Nevada community absolutely deserves to get access to health care and deserves insurance.

SENATOR DOÑATE:
I am honored to be joined by the team from Cure 4 The Kids, as they will talk about some of the extreme cases that we see with our kids in the Las Vegas Valley. Ms. Annette Logan-Parker, Founder and CEO of Cure 4 The Kids Foundation, was scheduled to speak via Zoom; however, due to technical difficulties, she was unable to make her presentation. She submitted written testimony (Exhibit Q).

KATHERINE SALKANOVIC (Director of Patient Experience, Cure 4 The Kids Foundation):
The reason I am here today is a personal one. Our job as a parent is to keep our children safe, to ensure that they are happy and healthy. What if in your search for a better life, you get thrown a curveball and you get sick? You want to survive but the odds are stacked against you because you are undocumented, uninsured and to top it all off you do not speak English.

This situation happened to my own father. He arrived in this Country with hopes and dreams, and tragically within months, we learned that he had an aggressive form of kidney cancer and needed surgery. Being undocumented and uninsured in Nevada means that you are alone with nowhere to turn. We were told to go to the hospital, they cannot turn you away, but it turns out they can, and they did. My dad ended up having surgery months later, but only after we agreed to pay cash up front. We were forced to borrow money from friends and family, and we came up with the required $5,000 to schedule the surgery. Unfortunately, we were too late. He died the day after the surgery. How can he continue to keep us safe? This happens every day in Nevada.

After losing my dad, I was determined to help families like mine. I am now the Director of Patient Experience at Cure 4 The Kids Foundation. I see families like my own every day. Our organization provides treatment and care for children battling cancer and other diseases. Do you know what happens when a child is diagnosed with cancer and the child and parents are undocumented and uninsured? Imagine for a second, the thought of your child dying because you cannot afford the treatment to keep them alive. It is heartbreaking to know that our State cannot provide them with one of the most basic needs, which is health care.

I want to share the story of an 18-year-old young lady named Azul. I first met Azul when she was diagnosed with myelodysplastic syndrome, which is a rare

form of blood cancer, when she was only 13 years old. Her mom recalls hearing Azul's diagnosis and thinking, this is going to be hard, but we got this. As they navigated a broken healthcare system, she soon realized that the hope of keeping her daughter alive was quickly fading. Being uninsured brought problems that they were not expecting. At every hospital visit, the social worker would have them re-apply and re-apply for emergency Medicaid. Every denial broke her heart all over again because cancer is not emergent enough to qualify for emergency Medicaid. She set a payment plan and paid as much as she could.

One day the unthinkable happened. They were denied entrance to the hospital for their inability to pay the full balance for her treatment. She was just three cycles away from finishing her chemotherapy treatment. Her family knew that stopping the chemotherapy early would tremendously increase her chances of not just relapsing but dying. Her mom was desperate to save her daughter. She called TV stations, radio stations and even the Argentinian embassy in California, but no one could help her.

We were able to help her. We put in the work and found a donor who was willing to donate the thousands of dollars needed to purchase the drug so we could give it to Azul. The mom saw firsthand that the simple fact that their family was undocumented and uninsured nearly killed her daughter. Life is precious. At our clinic, we fight every day to keep children with their families one more day. Please help us fight and give these beautiful children the opportunity to grow up and give back to their community like I did.

RICO OCAMPO:
I am here to tell you a personal story of how the current healthcare system in the U.S. failed my family, particularly my older brother, Carlitos. Our family's lives were forever changed in 2006 when Carlitos was rushed to the ER with severe abdominal pain. The doctors initially believed that he had kidney stones but, during his surgery, they discovered a tumor in his pancreas. The biopsy results confirmed that it was stage IV pancreatic cancer, and our world came crashing down. My brother was 17 years old. When the doctors told him about his diagnosis, he immediately looked at my parents and yelled "no me quiero morir, no me quiero morir," which translates to "I do not want to die, I do not want to die." It was a moment that will forever haunt me. Watching my older brother suffer and slowly deteriorate in front of our eyes was one of the most painful experiences of my life.

The weeks that followed were some of the most heart-wrenching for my family. My father lost his job and my mother pleaded with the hospital to save her son. We received financial aid due to the hard work of a social worker to pay off our mortgage and utility bills for the first month, but we did not qualify for Medicaid due to our immigration status, even though we were the ideal candidate. The healthcare system failed us, and we were left to bear the emotional burden of Carlitos' illness on our own. Our family watched as Carlitos passed away before he could make it to his high school graduation. He died as an undocumented person, a tragic reminder of how the Country that I call home will gladly receive the fruits of our labor but deny us our humanity.

After my brother's death, we were left with an overwhelming medical debt totaling over $300,000. To make matters worse, UMC put a lien (Exhibit R) on our house and took our home away. Members of the Committee, I am not sure if you have ever been in a situation where you have been stripped of your dignity, but this is one of those moments for me and my family. I am an undocumented person, and I am a human and believe that we deserve access to health care just like everyone else. We need to change the current healthcare system to provide support and hope to families that have experienced similar situations. I share my family's story, not to elicit empathy but to inspire action. Together, let us support the Nevada HOPE Act and create a better Nevada for our residents in Nevada where the American dream is a reality that is accessible to everyone regardless of immigration status.

SAMUEL CANO (Student, College of Southern Nevada):
I am an undocumented nursing student at the College of Southern Nevada and am here today to share my story and speak on behalf of all those who are facing similar struggles. I have been living in Las Vegas since I was four years old. Nevada is the only place I call home. As an undocumented student, I faced many challenges in my life, but I have always been determined to succeed. I have always been passionate about helping my community and that is why I decided to pursue a career in nursing.

My grandmother worked in a small clinic and her helping those in need inspired me to become a nurse. I knew that health care was the key to my success, and I worked hard to make that dream a reality. However, as an undocumented student, I am facing a huge obstacle because I cannot obtain any kind of health insurance, which is preventing me from getting the hands-on clinical experience I need to be a successful nurse. This is a major setback for me, and it is

preventing me from achieving my goals. It is heartbreaking to know that the only thing standing between me and my dream is something as basic as health care.

I have worked tirelessly to get to where I am today, and it feels like all my hard work has been for nothing. It is difficult to explain the frustration and sadness that comes with knowing that I am being denied access to something as essential as health care simply because of my immigration status. Despite these challenges, I am determined to contribute to this Country and to make a positive impact on the lives of those around me. I want to use my skills in education to help those in need and to give back to my community which has given me so much. I urge you all to support me and others like me who are facing similar struggles. We need access to health care to succeed in our careers and to continue serving our communities. No one should be denied health care simply because of their immigration status. Let us work together to make sure that everyone has access to the care they need and deserve.

SENATOR DOÑATE:
As you know, this is a working bill. It will go through multiple committees. We are all eager to talk about the financial piece of this legislation. However, this is a policy Committee and I want to reiterate that reminder for any questions you may have. There is a potential that the tax abatement portion of the bill could be referred to the Senate Committee on Finance.

VICE CHAIR NGUYEN:
There are a lot of different areas within this bill and we want to ensure we are given enough time to fully vet them within our Committee. You talked about other states that have implemented similar programs. The first thing that we looked at is how they all started covering children under 19, but then it clearly looks like they expanded coverage almost immediately to cover those other gaps. Can you explain why that happened and why people were not covered from the beginning as suggested in your bill?

SENATOR DOÑATE:
Yes. I have had many meetings during the last year with folks from different states. The reality is that it is incredibly difficult to financially project what the outcomes could be for this population. The presentation about uncompensated care communicated that it is hard for us to track how many of these folks live in this State because when they go to the ER or to doctor's offices, we do not

include citizenship status as part of any form that has to be completed. That is why it is incredibly difficult to track. What we have seen in other states, and Oregon is a good example, is that it was passed with bipartisan support. Originally, they started off with kids and pregnant moms, which is what they did in Colorado. The reason they did that was because you cannot project how many individuals would qualify or would enroll, so you do it in a strategic way where you do certain populations one by one.

There are certain states that have different legislation, but California is the one that has expanded it for everyone, and most of it comes down to state general funds as noted in its handout (Exhibit S). I contemplated whether I was going to expand it for everyone, which is what you have in front of you, or if I wanted to be strategic and start with kids and pregnant moms. I have family members that are impacted by this bill and I could not turn my back on them. They deserve access to care, too. That is part of the reason I got elected. There are people in this building that would be affected by this bill. There are residents in my district. I cannot turn my back on them. That was the reason I introduced the bill. I hope that within reiterations throughout this process, we can have a further conversation as to how that looks financially.

VICE CHAIR NGUYEN:
Does your bill contemplate, or do these other states have, a way to track the information so they can say it saved them money? We had a lot of supportive testimony from hospitals and maybe one of their representatives can answer the question of how they documented any savings and how health discrepancies were improved once they started covering people.

SENATOR DOÑATE:
I had the same question and said let us make sure that we measure the work we are doing. If the State changes its eligibility where you can keep the income threshold, but you change the application process, we can decide what requirements are necessary, whether you submit portions of the population or not at that point in time. If this bill passes, Medicaid can create a working group of health professionals, managed care organizations (MCO) and FQHCs that already have outreach groups to continuously monitor the enrollment and aggregation of data.

What if there is an instance where there is an increase in enrollment? We are not sure how to address that. Or the reverse, what if when we enact this

legislation, regardless of how many news articles are published, people still have a fear of enrolling as part of this Medicaid program? The bill covers the same thing that was introduced in Oregon, so there would be a work group for the facilitation and implementation to track the cost savings, enrollment, and other critical data.

VICE CHAIR NGUYEN:
Do hospitals in Nevada have internal measurements? Have decreases in the number of people going to the ER been seen in Colorado, Oregon or Washington?

MR. SKLAMBERG:
From a hospital standpoint, I have a limited ability to respond. You raise a good point of looking at that data in those states. Being part of a larger national organization that has a presence in Colorado, we could look at that data to see the impact. We also need to rely on the MCOs and the federally qualified or other primary care offices to help refine those numbers, including the number of new patients who are undocumented individuals who register through Medicaid and access primary care. That is going to be key in helping determine the success.

SENATOR STONE:
Before I get started, I want to say a few things. We have a bipartisan Legislature here and I have found in my experience it is important to collaborate with your colleagues and try to do things as best you can in a bipartisan way. That is why I was successful in my prior state. Senator Doñate, I applaud you for wanting to do something to enhance health care for everyone in Nevada. I only wish you would include us in your passion to deliver the same. You have a 55-page bill here today that revolutionizes the delivery of health care in this State, following what is hopefully going to be a federal model.

I saw this bill for the first time today at 9:00 a.m. My colleague saw it at the same time as well. While we have a Democratic Legislature, we have a Republican Governor who has made it clear that he wants to see us working together to try to produce bipartisan solutions in the best interest of every citizen in this State. I am disappointed that with an issue that is so important to you, which is so complementary to your healthcare background, you have excluded two of us who make up 40 percent of this Committee, when we want to be your partner. We do not want to be your adversary because we have

heard a lot of heart-wrenching stories here today. I do not want people to think that Republicans are heartless people that do not want to deliver health care.

We have hospitals that will deliver health care to anybody that goes there. We have FQMCs that will do the same. We all take an oath to want to help and cure people, but we have fundamental issues in Nevada that we need to address. I know this is not a financial committee, but I think we have done things in reverse. This should have gone to the financial committee first to find out what the cost is and then we can back into the policies and make sure we have a deliverable health system.

We have a lack of providers throughout the State. Our providers are burned out from COVID-19. Most physicians and clinics will not take Medicaid. Why? Because it is one of the lowest Medicaid fees in the Country. You cannot blame these doctors. They cannot keep the lights on in their offices to take Medicaid. Why are we not boosting our investment in Medicaid so that we can pay the doctors more and we can pay the hospitals more, so we do not have them subsidizing and on the brink of closing their doors, especially in some of the rural counties. To say that we do not have any struggling hospitals is a misnomer. We do have struggling hospitals here, especially in the rural areas, and I am sure my colleague will be happy to speak to that.

I have received several emails already from people, even though we did have this hearing and it was predicted this bill was going to show up this morning. I was hoping it would not, but it did. Many of the emails are saying we do not want to continue to subsidize more health care for people who are not here in this Country legally. That is whether we agree with the immigration policies of this Country or we do not. We have learned today that if we want to do the right thing and get everybody quality health care, including their hangnails, going to the ER is going to be a $5 billion expenditure at a minimum. Our budget in Nevada is not that gigantic and we only have a $2 billion surplus this year. We have a lot of needs including teachers and public safety.

I do not want to make this into a partisan event, but we have had the greatest influx of undocumented immigrants in this Country in the past three years. That is okay if we do, that is fine. But the federal government needs to issue a check so that we can appropriately take care of people. You can have open border policies, which is fine, but President Joe Biden should send us a check. If we have 400,000 undocumented people that are coming to Nevada in the next

biennium, then the federal government should give us the funds to take care of the healthcare costs for those 400,000 people. We should not have to depend on our citizens to subsidize and pay for the same at the expense of providing health care to our citizens who already have trouble accessing health care.

VICE CHAIR NGUYEN:
Is there a question about the bill here?

SENATOR STONE:
I think that the technological advances that Senator Doñate wants to make are fantastic. We tried it in California. You would be surprised how many hospital systems in California still operate with paper charts that do not have electronic charting. In the county hospital that I worked for as an elected official, it was a priority to get electronic charting, which saved us money, efficiencies and mortality because there were fewer mistakes made. I appreciate what you are trying to do and in conformance with the federal model. But we cannot be taken hostage to consideration.

VICE CHAIR NGUYEN:
I will remind this Committee that we are a policy committee. There is obviously a fiscal note that will be attached to the bill. So, it will go to the Senate Committee on Finance to determine the costs and if we can afford this as a State.

SENATOR STONE:
Mr. Ocampo, I appreciated your testimony, sir, and am sorry for your loss. I do not want you to think that Republicans are unsympathetic to the needs of you and your family. No one should endure what you have gone through, not only having to see your loved one pass away due to lack of care, but to have your house taken away from you to pay for the medical bills to take care of your loved one is appalling.

Ms. Logan-Parker, what a wonderful job you and your staff do at the Cure 4 The Kids Clinic which I toured. We need to get you on the 420(b) program. A wonderful program like this should be fully funded and allow you and the hospitals to have the necessary resources so no one is turned away. So, my challenge for Senator Doñate is, how are you going to communicate to people like me the importance of this program so that you can

engage me as an ally to try to deliver the same? If I am important to the process and to you, you are important to the process and me.

SENATOR DOÑATE:
Part of this conversation is offline. I do not want to take any more time on what the patients deserve to hear, which is the policy aspect of this bill. There are colleagues that sit on this Committee who have seen iterations of this bill before it came today. I recognize that the nature of introductions of bills is always difficult, but in the State that is just how things operate, and we have deadlines when we must pass these bills. The bill was shared with your leadership and the Office of the Governor, as well as with my leadership, my colleagues and the healthcare providers you see in this room today.

I do not want to take this any longer than we need to, but I will specifically answer your question regarding the costs. There will be conversations about what Medicaid provides and who is covered. It is important to curate for you that Medicaid expansion does not cover everyone. There are folks that will make too much money for Medicaid, and they could be undocumented, but they will not be a part of this bill. That is what separates us from other proposals that you see in other State legislation. The reason why we did that was because if you are not able to work, you should still have some level of safety net because it leads to the level of uncompensated care that we are seeing regarding our hospitals.

I will point you back to a slide on utilization management, a conversation that we have heard repeatedly. We already have a shortage of providers, and that is why my bill covers tax abatements. That is why I have worked to introduce legislation on other pieces of how to expand the pipeline of health care, and how to stabilize what we are experiencing on the front lines.

If you look back at this slide from state outcomes in Colorado, it shows that the direct effect of expanding coverage can lead to better indirect effects that reduces costs over the long term. It is easy to say that if there is going to be an enrollment of folks, there could be an increased cost of utilization. You heard from Dr. Hardwick today, the utilization already exists. We are already paying for it. We have seen in other states that this expansion can lead to a decrease in costs when enrollment happens. When you enact legislation, whether it is for kids or pregnant moms, what we see in Oregon is that they end up going to where we want them to go, which is primary and specialty care. That is the

outcome we desire for this instance. That is a conversation we can have, and I commit to that.

SENATOR STONE:
That is the outcome that I certainly want as well. I understand we have a 16-week schedule here. I understand that things are condensed, but a 24-hour notice would have been great to at least get through the bill once and maybe see you with questions. California provides a vast array of services for undocumented immigrants, but they are also looking at a $40 billion shortfall this year and it is going to be interesting to see how they plug that.

VICE CHAIR NGUYEN:
As Senator Stone mentioned, the Legislature only meets every other year for 120 days. There were 110 bills that dropped yesterday. Unfortunately, they have to make their way out of committee by April 14, 2023, less than a couple of weeks away. This is a dynamic process as everyone knows. Bill sponsors are continually working on amendments and meeting with legislators, constituents, lobbyists and legal staff. I am sure, Senator Stone, the Chair will meet with you regarding any concerns you have on this bill.

SENATOR TITUS:
Senator Doñate, I appreciate your passion for your constituents in your district, recognizing that I am as passionate for my constituents in my district. As a medical provider, I cannot get my constituents and patients in to see doctors because there are not enough of us. I appreciate those of you who shared your families and your personal stories. I will share one of mine. My 56-year-old brother-in-law in Fallon had health insurance; he was a white healthy male who died of COVID-19 within 2 months of diagnosis and not getting care. I have a close friend who woke up Christmas Day with pain in his side and went to the ER, like everybody does because we cannot get them into a provider, even with insurance. Still, no providers could get him in. So, he goes to the ER, and a computerized tomography scan shows he has renal cell carcinoma and he died two months ago. It took a month to get him to the specialist for his diagnosis.

Access to care, or lack thereof, is not limited to any person, no matter how much you make, what your insurance is, where you are from, or whether you are documented. I would see anybody walking in my door and could not get them referred to a specialist because there are not enough. I tell people just because you have insurance does not mean you have health care. My concern is

with a potential of 95,000 additional folks on Medicaid, you are diluting an even more diluted system. Eventually, it may hurt everyone, the very people you are trying to help. How do you solve that access to care when we already do not have enough healthcare providers? When you use states like Oregon and Colorado and what the outcomes are there, what is their ratio of patient to provider?

In Nevada, we are the worst. We are at the bottom of the list of providers to patients across any state. In Colorado and Oregon, are they at the bottom or do they already have access to health care? I would appreciate my patients not having to go to the ER either, but I cannot get them in to see the specialist either, especially gastroenterologists (GI). I have a person waiting three months to get to see a GI specialist. They are fleeing our State in the north. We cannot find a GI doctor to see people. My own husband has had multiple appointments canceled because the providers left. None of this solves that. I see it adding to the problem.

I will ask all those fiscal questions in the future because I happen to have the advantage of having been on the Senate Committee on Finance. I will address that when that time comes. But this is really about the policy of care for the citizens of Nevada, my constituents who cannot get into care now. You are asking us to now dilute that system so your constituents can get in and see a provider. In all good conscience, this is not something that I can see as a pathway to access to care.

SENATOR DOÑATE:
I will touch on a few of your comments. Let us talk about the dilution, which is a difference of opinion. The utilization of these services already exists. They are already going to the ER. You came to the same point that I did, which is if we have an increase in enrollment, how does that impact our healthcare system? That is why I have other bills outside of this one to address our provider shortage and how we can engage folks from the health equity side. The proposals I have are not enough of what this bill does. The reason I included tax abatements is to cover exactly what you are mentioning. As Chair of this Committee, I have folks that come to me who are providers that want to move into this State. We know because of the external factors outside of this bill, for several reasons, that our State has failed.

Our Medicaid reimbursement rates, which is an issue that always comes up, is not being solved with this bill; that is a separate proposal. People ask me what else can this State do? I want to move here and have the employees and resources because I am in Arizona or Utah, or wherever. I want to come to Nevada but you have gaps, whether it is for mental health services or other areas, but I need help. Is there something else in this bill that your State can do? That is what the tax abatements do. The tax abatements look at healthcare capacity for individuals who want to move to the State for the equipment that they must purchase, for wages, for offices. That is something that will be covered if the bill makes it to the Senate Committee on Finance. When it comes to the dilution of services, we are already seeing the utilization.

Dr. Hardwick mentioned that people are already coming to the ER for simple scenarios when they could have gone to primary care, and this is coming from someone that also works in primary care. We can do a better job of coordinating with the companies that want to move here. We should because when they look at moving to our State, they always look at two things—education and health care. If they must go to Harry Reid International Airport and fly elsewhere to receive the services they need, this is not the way our healthcare system should be run. While a lot of them are my constituents for this bill, they are also everyone else's on this Committee. Undocumented immigrants live throughout our entire State. If you look at my Senate district demographics, about a quarter of the Latinos in my district are uninsured. The issue could be exacerbated more in the urban areas, but all of us suffer from the system, your constituents as well. In general, we want to make sure that they are covered because that is the right thing to do. It is also fiscally responsible in the long term.

SENATOR TITUS:
The next question I have is regarding insurance, the healthcare exchange and applying for insurance. You stated that many of these folks would not necessarily qualify based on their income. Are those folks able to purchase insurance on the Exchange? We have it because of the uninsured, because of Obamacare, the Affordable Care Act (ACA) and I am just going to get on my soapbox and say it was neither affordable nor about care.

As we heard in earlier testimony from the hospitals, insurance companies are now asking hospitals to cover a larger portion for the uninsured. What happens is those who do have insurance are now paying more for their insurance with a higher deductible. I have family and patients who avoid going to see a doctor

because our deductibles are now $10,000 and our costs are going sky high. We do not get care because we cannot afford it. What is it that prohibits a working person that comes to America to work, from buying insurance like the rest of us do on the Exchange?

SENATOR DOÑATE:
A lot of this is predicated on federal regulations. Undocumented immigrants are not eligible to enroll in the Children's Health Insurance Program (CHIP) or Medicaid or to purchase coverage through the ACA marketplaces under rules issued by CMS. Individuals with Deferred Action for Childhood Arrivals recipients, are not considered lawfully present for purposes of health coverage eligibility. Medicaid payments are for emergency services on behalf of individuals who are otherwise eligible for Medicaid. However, their immigration status disallows their eligibility.

When the ACA was passed, it forbids our State from enrolling undocumented people unless we apply for a waiver. You can see that Washington has a waiver (Exhibit T). They are the perfect example of applying for a waiver to allow folks to go into the marketplace. The deviation I make is that it can cover a certain portion of people for those who can afford the plans that are on the exchange. Not everyone will have to do the opportunity to afford that. If you are in the most vulnerable category, such as the children that we have before us today who are undocumented, you are forbidden from Medicaid. There are certain instances where you must stop working to take care of your child and that is where Medicaid coverage comes into play. That is often how federal legislation works.

The states must make an effort themselves to address this. We are in flux—we wait for the federal government to act, but we see this problem persisting. We still have an obligation to protect the people who live here, who call this place home. There are certain nuances that occur when looking at federal regulations and that is the reason we see the difference with waivers, such as a State Innovation Waiver, also referred to as section 1332 of the ACA waivers.

SENATOR TITUS:
Thank you for that clarification. I would just say that we have a lot of conversation to have afterward and am looking forward to further dialogue.

VICE CHAIR NGUYEN:
I have one last question. Obviously, we have seen some support and I anticipate there will be more support, not only from our healthcare providers but also from our hospitals. We heard the previous presentation on uncompensated care and those are enormous numbers that these private hospitals are seeing. Do they see this as a way to decrease those costs that are being incurred by them already under the current model?

SENATOR DOÑATE:
I do not want to speak for the hospital association or for the hospitals themselves; Mr. Sklamberg is here and can speak to that issue.

MR. SKLAMBERG:
I will focus the answer on access to primary and preventative care, which is where we will see the savings. The examples we heard today about having access and a broader network will reduce costs because we will keep patients out of the hospital and avoid the acute stages of medical needs.

SUSIE MARTINEZ (Executive Secretary-Treasurer, Nevada State AFL-CIO):
On behalf of over 150,000 members and 120 unions, the Nevada AFL-CIO supports S.B. 419, the HOPE Act, to ensure that every Nevadan has access to high-quality and affordable health care. The Nevada HOPE Act will close this gap in care and guarantee that every single worker that keeps our State's economy moving cannot only survive but thrive. The future of our State depends on the health of every single person in our community. By expanding Medicaid to all Nevadans, regardless of immigration or citizenship status, we can ensure that generations to come are happy, healthy and successful. I urge the Committee to support S.B. 419.

JIMMY LAU (Biotechnology Innovation Organization):
We are speaking specifically in support of the tax abatement and incentives package that is included in the bill. The Biotechnology Innovation Organization is a trade organization that represents thousands of members across the U.S. and other countries, mostly in the smaller and preliminary stages of biotechnology development. We thank Senator Doñate for approaching us for our viewpoints on how to encourage biotech companies to come to Nevada. This important piece in the bill is going to help bring in additional revenues and additional expertise to our State.

MARC ELLIS (President, Communication Workers of America, Local 9413):
We represent close to 700 workers at Saint Mary's Hospital and support this bill. Approximately 70 percent of innovative therapies that are developed in biotechnology spaces, particularly in precision medicine, come from small, early-stage companies. Attracting those into our State is a good thing for Nevada and a good thing for the folks who live here.

PAUL CATHA (Culinary Workers Union, Local 226):
The Culinary Workers Union, Local 226 supports the goals of S.B. 419, to expand Medicaid to all Nevadans and ensure people have easy access to their own health records, especially underserved populations that can have the most difficulty navigating the health system. Nevadans should be able to electronically access their health information quickly and easily and have the freedom to do what they want with their personal medical information. As the largest organization of immigrants in Nevada, many Culinary Union members reside in mixed-status households. When Nevadans are unable to access medical care and affordable rates simply because of their immigration status, it hurts immigrant workers, and it impacts the State.

The Culinary Union believes that everyone has the right to health care. When the State excludes Nevadans from Medicaid coverage, the State and our healthcare infrastructure are negatively impacted. Uninsured Nevadans will not seek preventative care and will increase the burden on local ERs. Culinary Union members have been heavily impacted by the provider shortage in Nevada and the Union supports efforts to bring high-quality low-cost health care to all Nevadans. We have not had time to fully review the amendment, but the Union plans to have more conversations with the Senator, and we support his intent.

ERIKA CASTRO (Organizing Director, Progressive Leadership Alliance of Nevada):
We support the HOPE Act, S.B. 419. We thank the Senator for bringing this legislation forward to help our State expand healthcare access for all Nevadans regardless of our immigration status or background. For the first two decades of my life, I was one of those uninsured Nevadans that they spoke about earlier and many of my loved ones continue to be. We are Nevadans like many of you. We also pay taxes for public services even when we do not have access to them.

In 2018, according to the American Immigration Council, immigrant-led households paid $3.1 billion in federal taxes and $1.1 billion in State and local

taxes. So, we are not asking for freebies. We are simply asking for our lives to be cherished with dignity and we will continue to invest in this Country, both culturally and financially.

I have lived here for 30 years, and my parents are getting older. I am constantly worried about how they will get the care they need if my brother and I are not able to pay for the healthcare needs out of pocket. My biggest worry was having my dad continue to work and risk his life while being diabetic and having no healthcare coverage. I urge you to support S.B. 419 to ensure that immigrants like myself and my family have access to health care.

MARIA-TERESA LIEBERMANN-PARRAGA (Deputy Director, Battle Born Progress):
We are in strong support of this bill. I am not just here representing my organization and standing together with the impacted people in this room and providers, but I also represent a little girl whom this bill would have helped. That little girl is me before I finally got coverage and citizenship. I am proud to be part of that influx of immigrants that make Nevada and this Country great. We need this basic coverage. I grew up undocumented and with that came growing up without access to much, especially medical care and coverage. It took many years of my childhood for my mom to find a job that could provide insurance for herself. When I finally became a citizen, I received insurance coverage thanks to the Culinary Union. A child or anyone should not have to spend years without access to important healthcare coverage. I missed a lot and know I am suffering from it. I urge you to please pass this bill.

ISABEL BENTO (Student, University of Nevada, Reno):
I am working to get my bachelor's degree in social work and hoping to get my master's degree in macro social work. This is my first time being in a legislative hearing and this is my first time speaking publicly. I am speaking as a person of privilege and that is being a natural-born citizen. While my father's side is Portuguese and Thai, my mother's side is Irish. We have been citizens of the U.S. for generations. Social workers have a code of ethics which you can find on the National Association of Social Workers website. These ethics include service, social justice, dignity and worth of a person, importance of human relationships, integrity and competence. These codes of ethics should not reside in just social workers but in all people of all professions.

Senate Bill 419 encompasses all the ethics and values I mentioned, and I stand behind this bill. The people who desperately need this bill are our neighbors,

friends, family and people in this room, including myself. I have been on government assistance all my life due to being low-income and just above the poverty line. My family has been uninsured all my life. Each parent works two or more jobs, working until they are disabled at the age of 40, and avoiding the ER at all costs.

My mom avoided going to the ER when she had extreme abdominal pain. It was not until she was pushed by her boss to go to the ER that she found out her appendix was about to explode. If she had gone any later, she would have died. My mom's story is not unique and, fortunately, she was able to get the care she needed. But this is not the case for thousands of people especially for those who are unrepresented, for those who are marginalized and for those who are the most vulnerable. I encourage people to think back on the code of ethics when thinking about these people in this community and when thinking about people like me and my mom and all the undocumented people of this Country. This bill will save the lives of all ethnicities and identities.

JOSE MACIAS:
I have been a longtime community leader working with the immigrant community in Nevada. I urge you to support S.B. 419, the HOPE Act. After the pandemic, we all learned the importance of being healthy and making sure that not just our families are healthy, but also our entire communities. If one of us gets sick, it is important to make sure we take the right steps to ensure no one else gets sick too. This bill will allow our State to expand health care for everyone. In times when silent killers like diabetes and high blood pressure are at an all-time high in our communities, we must make sure people have access to preventive care and not wait until it is about life or death.

I lived through this with my mother, who never had access to care or thought that health care was something she would be able to get. My mom was a hard worker. Unfortunately, because she did not have health care, she would go to work even when she was feeling sick. Sadly, when she finally checked into a hospital, it was too late for her. It has been nine years since she passed away from a stroke. Many families in Nevada are in the same shoes as my mom and my family. This Thursday, I will be putting my Aunt Rosa to rest who passed away last week from diabetes.

At this moment in Las Vegas, my dad is at home figuring out if he can make it to his chemotherapy appointment for cancer because he does not know if we

have enough cash to afford it since we pay hundreds of dollars out of our pockets to make sure he gets his healthcare needs met. No one should have to worry about having access to chemotherapy or to a checkup, or access to being healthy and living with dignity.

Life is not about blue or red, it is about human rights. Rosa Rivera is my aunt's name. I ask that you do not forget about her when voting for this bill. Tomasa Maria is my mom's name. I urge you to not forget about her when voting for this bill. Martin Macias is my dad's name, and he still has life. Please do not forget about him when voting for this bill. So many Nevadans are still counting on you. Please support S.B. 419 and pass the HOPE Act.

GUADALUPE GUZMAN:
I am reading my testimony (Exhibit U) in support of S.B. 419.

FABIO DIAZ-ORTEGA (Patient Experience Associate, Cure 4 The Kids Foundation):
I am a certified medical interpreter and patient experience associate at Cure 4 The Kids Foundation. I am reading my testimony (Exhibit V).

MARIA FARMER (Patient Financial Counselor, Cure 4 The Kids Foundation):
Our children not only need chemotherapy infusions, but they also need other specialty care such as physical therapy, dental care, and things they do not get because of their immigration status. We treat the whole child, not just a certain part. On behalf of Cure 4 The Kids, we ask you to please pass S.B. 419 and let us get the children, and future children of Nevada, the care they need. They have no choice where they go but end up with us. We try to take care of them and provide all the services that we can for them, but we really need your help.

PAOLA DAVILA:
I am a development specialist, and work in early intervention for Nevada and support S.B. 419. I have lived in Las Vegas for 18 years and am a resident of Assembly District No. 11 and Senatorial District No. 2. I am an immigrant and am lucky to have graduated from the University of Nevada, Las Vegas (UNLV). I am fortunate to work in early intervention and provide services and support for children with developmental delays and disabilities as well as their families. A lot of these families are uninsured immigrants and struggle to receive the help and care they deserve.

While benefits are provided by the State, children in early intervention benefit exponentially from private therapy since the first three years of their lives are the most important in development. In addition, some require therapy throughout their lives. Private therapy requires insurance, which creates a barrier that impacts children's development and quality of their life. Many of the immigrant families are hardworking Nevadans that want the best for our communities. Children of Nevada and their families deserve to have access to health care regardless of their status. I urge you to support S.B. 419 and change the life of immigrant families and their children, especially those with developmental delays.

ALYSSA COOLEY:
I am the managing attorney of the UNLV Immigration Clinic at the William S. Boyd School of Law. I am also a member of the Nevada Immigrant Coalition. For clarity, I am not speaking on behalf of UNLV today. I am expressing the importance of S.B. 419 for our clients and other undocumented folks. Imagine an asylum seeker whose government persecuted and tortured him, who fled his native land, leaving everything and everyone he has ever known behind to save his life, imagine that he presented himself to the U.S. and lawfully sought protection through asylum.

Now imagine that due to the ever-increasing backlogs in immigration court, not to mention the delays caused by a global pandemic, he will have to wait years for the adjudication of his asylum claim. If eventually granted, he will receive refugee benefits, which will include Medicaid. But contrary to popular belief, he will not receive any refugee or other public benefits while he waits. This is an asylum seeker who fled horrific torture in his home country and who is suffering.

He is suffering the physical and mental effects of state-sponsored abuse, but must wait years before he can receive medical coverage to treat those ailments. Meanwhile, his conditions are worsening to the point of requiring emergency medical care without access to medical coverage. He and other undocumented folks in our community are left to suffer from treatable conditions that could have been prevented with timely medical attention. Currently, all persons in Nevada are eligible for emergency Medicaid regardless of status and that treatment is expensive. Hopefully, we can all agree that preventative care is more cost-effective than treating serious or chronic conditions in the ER. I ask the Legislature to vote in favor of S.B. 419, not just for our clients and other

undocumented folks in the community, but for the benefit of Nevada as a whole.

AMBER WILLIAMS-MCGEE (Cure 4 The Kids Foundation):
Cure 4 The Kids Foundation strongly supports S.B. 419. In our business we understand the massive need for this type of reform as we see so many cases of undocumented children not receiving the lifesaving care that should be the most basic of human rights. All the organizations we heard from today take on the burden of this care which should be handled by the State. Cure 4 The Kids handles most of the care for children with rare diseases, but it is certainly not an option for the undocumented population. Daily, we see firsthand the damage that being uninsured does to our hardworking, undocumented families who are left alone to suffer.

Our State can do better. Our people deserve better. Let us change our State's reputation. Let us start to take steps to put Nevada on the map regarding health care for everyone's sake. The HOPE Act will inspire just that—bringing hope to thousands who have been living in fear.

CYRUS HOJJATY:
Today, I identify myself as an undocumented immigrant. I am certainly hoping that this health insurance is better than what my employer gives me. Please expand language services to Persians while you can, and tax the casinos, not the middle-class people. Also, extend Medicare for all because I think everybody should be covered.

MAYA HOLMES (Culinary Health Fund):
We are in discussions with Senator Doñate on a few aspects of the bill that we are trying to better understand. We absolutely support efforts to ensure medical record interoperability and patient access to their medical records. This will allow patients and their providers to seamlessly access, retrieve and send records where they need to go.

We agree with the intent of the legislation to align the State with national standards for interoperability so we can move away from siloed information that is not meeting the goals of health information, interoperability within the State, or nationally. We also support the Medicaid expansion to all residents of Nevada, regardless of their citizenship status, which will strengthen our healthcare system, improve the overall health of residents in our State and

ensure no member of our community is left behind and cannot receive the health care they need.

HOLLY WELBORN (Executive Director, Children's Advocacy Alliance):
We are testifying in support of S.B. 419. This is crucial legislation for expanding and encouraging access to care for Nevada's most vulnerable community members. I have a lot of statistics here but will focus only on a couple. Forty-two percent of eligible foreign-born children in the U.S. are ineligible for Medicaid or CHIP benefits and children who are eligible often do not get care because their ineligible parents are too afraid to access it. Furthermore, Nevada has one of the lowest participation rates for eligible children. We must change course. This is visionary legislation, and we applaud the Senator for his leadership. We encourage your support of S.B. 419.

CASEY ROGERS:
This bill feels like more of a power grab on the medical digital side of things with which I do not agree. There could be nefarious reasons for digital tracking which leads to digital dollars, which leads to digital humans, where you can turn on and off certain aspects of people's lives. This needs to be investigated. I echo exactly what Senator Stone brought up because everything he says carries immense weight. As much as people deserve medical care, taking from some and giving to others is not necessarily what this Country should be about. If I want to go into another country and do the same thing, would that be accepted by their citizens? It is something to consider.

JANINE HANSEN (State President, Nevada Families for Freedom):
We have several concerns about this bill. One is the issue of connectivity and networks. There is no guarantee of privacy or safety or security in government networks. This is supposed to be a State network. It is going to be connected to a federal network. Will it also be connected to the global World Health Organization? We have considerable concerns for privacy and health freedom in Nevada.

When the COVID-19 vaccines were mandated, we could show how some of these networks might be abused. People who refused to get the vaccinations lost their jobs, were retaliated against, and were denied health care, even life-saving health care. So, if your name is in a government database and they know what your healthcare decisions are, you could be retaliated against and

lose your opportunity for health care. We are concerned about that with this network that is going to be in this bill.

We are also concerned about the cost of paying for undocumented immigrants through insurance. The cost of insurance is bad enough, but using tax dollars is far more expensive, less efficient and creates more bureaucracy and more government jobs. We simply cannot afford it. According to the Institute for Policy Innovation in the U.S., the total U.S. tax burden including federal, State, local taxes and hidden taxes is equal to 56 percent of annual personal consumption spending. Fifty-six percent is more than a person spends on housing, food, health care, transportation, education, and recreation. How can people take care of themselves and their families when government takes 56 percent of our income? Government taxation is a major cause of family financial distress. No wonder, more people are slipping into poverty. We encourage you to reconsider this bill and defeat it.

LYNN CHAPMAN (State Treasurer, Independent American Party):
The $5 billion in startup money—that is a lot of money, especially for people like me who are on a fixed income. We have bills before our State Legislature for affordable housing, asking for higher property taxes. Schools want more money, higher taxes, and now, medical care for everyone who comes here. We the taxpayers cannot afford it. We just do not have enough money. Please vote no on S.B. 419.

JOY TRUSHENSKI:
First, I support legal immigration. However, I oppose S.B. 419 which gives taxpayer-funded Medicaid insurance to undocumented immigrants. Citizens are suffering due to high taxes for everything because of government-caused inflation. We cannot afford to give undocumented immigrants Medicaid along with welfare payments, housing, food, education and so much more. Giving free stuff will only encourage more illegals to come over our unsecured borders. This is a national security issue as people are not being vetted. I am opposed to a centralized government healthcare database of all health records, which includes whether you took the untested dangerous COVID-19 vaccines. This bill is communist and, like big brother, goes against freedom and personal privacy. Please vote no on S.B. 419 giving non-American citizens taxpayer-funded medical insurance along with everything else. This is unsustainable.

SUSAN ROOF:
I am deeply concerned that Nevadans cannot afford this legislation. Many people who are actual citizens of our State cannot afford their premiums due to Obamacare. They cannot afford their deductibles because the insurance companies must charge more to cover Medicare and Medicaid costs. The states of Washington and California have financial difficulties because of all their social programs. Unfortunately, life is not fair. I tell that to my daughter all the time. I know citizens who make daily decisions about taking their medications. We cannot afford this bill and I am asking you to vote no on S.B. 419.

JULIE BURKE:
I oppose this bill because there may be misconceptions about who has health care struggles. At one time, I was pregnant, needed health care, and was turned down by my first obstetrician because I did not have health insurance. Finally, I had another obstetrician and she required that I pay upfront before she would provide me with care. I also had a special needs granddaughter who needed a pediatrician. I called every pediatrician in Reno, Sparks and Carson City and finally found one in Carson City who would take Medicaid, but then he dropped her. I had insurance, but during Obamacare, the cost went up so high, and, as a single parent, it created financial difficulties for me.

Given the situation at the border currently, it is not a good time to pass this bill. The legal citizens in Nevada need to be a priority and this sounds extremely costly. Decisions have consequences and deciding to move to Nevada does not necessarily mean one deserves something. I also do not agree with the network aspect of the bill. I encourage your opposition to this bill.

BARBARA JONES:
I think of my own past. From 1984 to when I retired, I had no insurance working my whole life and not on welfare. For those who are sick and needing care, I sympathize with the need for help. But all my issues went to Jesus, to be honest, and I got healed of back trouble, carpal tunnel and breast cancer. With Medicare, I did not have to rely on Jesus as much. I did have two hospital visits because somebody was paying the bill, but I still had to pay my own bills. If we call on Him for those that are sick, I sympathize, it is not fun. But the mechanical aspect of this bill is so dangerous. The children whose data were put into a database the vendor sold to China. Your kids' information is in China, and you do not know what they have on you. It is the same thing with your health care, and it is the same thing with voting. Please vote against this bill.

SUSAN PROFFITT:
We have medical issues in Nevada, and they need to be addressed. I am the vice president of the Nevada Republican Club, and I am going to speak for myself today. I have heard a lot of emotion on the other side and in this case, I speak from experience. It has devastated my family to the point where we almost left the State. We do not have enough medical care for the people that are here. I do welcome the new people that are moving here. We need immigration, but we need it to be done in a legal manner. We have a lot of issues that can be addressed if you take the time to look at all the aspects that have added to the situation instead of producing this bill. This bill creates many more issues for countless people. Thank you for addressing this, Senators Stone and Titus, and for your astute understanding of the hot mess this bill will create.

I oppose S.B. 419 because it does not resolve the problem, it magnifies the mistakes of our government. When they forced Obamacare on Americans, they did not plan or implement it properly. It has created a nightmare for me, my family and many others. Socialized medicine sounds like a wonderful thing. The road to hell is paved with good intentions. I know you have good intentions and I do not mean to insult anyone today. But it is not helping our neighbors or new neighbors either. Nobody is going to benefit unless we change a few outdated laws and fix the problems created by a hastily planned and poorly executed medical system.

I am a handicapped senior citizen on a fixed income. I paid $500 a month for insurance, and it rose to $24,000 a year by the time I was old enough to get on Medicare, which I paid for all my life. When my husband got lung cancer, he was forced to wait a year in Nevada for surgery and he was spitting up blood the entire time. After having a third of his lung removed, the cancer returned. So, Senator Titus and Senator Stone, I really appreciate you fighting for us right now. My husband is going to die, and I have already lost my daughter to fentanyl, and our son to a sudden death syndrome that is going around now. I am a mad mother right now and I am mad at our government because they are not thoughtfully planning before they make these laws.

LISA PARTEE:
These stories of hardship are heartbreaking, but people who are here legally cannot get the health care they need, and they have insurance. Many of these stories would not happen if folks had come here legally. To give Medicaid to illegal people flies in the face of all Nevadans. We have been taxed to death to

pay for program after program for people who do not contribute. For those who are here against the laws of our land and for this Legislative Body to reward this lawlessness by making me and my family pay their way is an absolute insult.

The HIPAA law provides protection for all our health information to remain private. For you to want to voluntarily put us in a federal government database flies in the face of the Constitution. You are taking away our autonomy and our privacy. You swore an oath to protect our Constitution from all enemies, foreign and domestic, and now you want to give a handout to those who flaunt our laws? Are they, too, subjected to socialist treatment? I am all for people coming to this great Country, but come in through the front door, contribute to society and feel pride in your ability to do so like the rest of us. This is a socialist bill and is unconstitutional, anti-American and unsustainable.

BOB RUSSO:
I oppose S.B. 419, which would provide taxpayer-funded Medicaid for individuals residing in Nevada illegally. As I have said before, I have no issue with anyone who wishes to come to America provided they adhere to our immigration laws. Unfortunately, this bill would encourage more people to enter our State illegally to receive healthcare benefits. Given the shortage of doctors in our State, that would put a greater strain on our healthcare system and on insurance companies.

Additionally, this bill could end up being a financial burden to our State. Nevadans are already experiencing the strain of rising inflation, which is unlikely to reverse course in the near future. *The Nevada Globe* stated in an October 14, 2022, article that inflation in Nevada has reached 16 percent and is hitting Nevada households. The rising prices are costing Nevada households an additional $867 per month or $10,404 per year since January 2021. The *Daily Mail* reported that in 2021, Americans spent more on combined taxes than they did on food, clothing and health care.

Lastly, I have concerns that this bill would contribute to a centralized government health database that will violate the privacy of Nevadans and put bureaucrats between doctors and patients. Would this not violate the standard of confidentiality that exists between them? Could we see social credit scores to receive goods and services? It is for these reasons that I ask you to oppose S.B. 419. I want to thank Senators Titus and Stone for their interactions on this bill and the testimony they have provided.

EMPERATRIZ ALVAREZ (Make the Road Nevada):
I am reading from my written testimony (Exhibit W).

ELIZABETH LOPEZ (Make the Road Nevada):
I am here to talk about a topic that is important to me and to my community. Living without medical insurance has been a big challenge in my life. Being without medical insurance in the moment when you need it most has caused me to not have confidence or faith in the health system. When I must make a medical appointment, I must pay between $400 to $500 cash for my diabetes treatment. My income does not come out to more than $500. Sometimes I must decide if I pay for the consult, test or results, only one, and that is difficult for me. There are moments when time goes by, and I am not able to get my results because financially the cost is too much for me. The only thing I end up with is my medication.

It is difficult to go through this because this is not a luxury, it is a need. It is expensive to go to the doctor. When my child tells me, mom, it hurts here, or mom, it hurts there and I have to say it is ok, take a Tylenol and you will be fine. That pain, that desperation overwhelms you because you do not have insurance to go to the doctor. Believe me, it is difficult, and this is not a luxury, this is a need.

VICTORIA RUIZ:
I support S.B. 419 and want to ensure that it moves forward. As an immigrant woman who has called Nevada home since I arrived in the U.S. at the age of eight, I felt firsthand the effects of not having access to health care that I needed and have had to support others in my community during similar moments. You have heard several stories today illustrating the need for health care. No one should go without the necessary preventative care or medical treatment that they need over something like status, especially in a State where immigrants have been part of the State's fabric for decades and played a critical role in our economic recovery after the COVID-19 pandemic. There simply would be no recovery without immigrants.

The reality is that a person's immigration status has no relevance to a medical professional's ability to provide care. In addition, the social and health disparities amongst immigrants in this Country and State are by design as is the case for several other issues that disproportionately affect us. At this moment, you have

the power to do something about it and make good on your values of making health care accessible.

Immigrants across our State are just as much Nevadans as the next person. I have paid taxes since 1996 when the IRS figured out how to do that through individual taxpayer numbers. Immigrants are looking to you to deliver on this bill and recognize that our lives and wellness are worth taking definitive action. For many constituents, no matter what side of the issue we stand on, we want to see our elected officials spend precious time discussing real solutions and not on strategic colleague callouts that should be happening behind closed doors. Ideally, these conversations will remain productive and strategic.

JIM DEGRAFFENREID (National Republican Party):
We oppose S.B. 419. On behalf of the Nevada Republican Party, our platform specifically opposes government benefits or other special treatment for those who enter our Country illegally. Proponents spoke today about how similar legislation has reduced uninsured rates. As a health insurance professional, I know statistics are often meaningless. Being insured with a plan you cannot afford to use due to high deductibles is effectively the same as having no insurance. The ACA quadrupled health insurance premiums, increasing insurance company profits while passing most of the cost onto the taxpayers. Support for S.B. 419 from the hospital industry is reminiscent of those debates. This bill provides a huge financial benefit to medical corporations at taxpayer expense.

The discussion of how the pandemic exposed problems with healthcare delivery and payment is also disingenuous. Photos of an empty Las Vegas Strip do not have anything to do with healthcare delivery. Medicaid, which is the solution proposed in S.B. 419, was massively expanded during the pandemic. This increase has persisted well past the end of the so-called public health emergency and will not even begin to be addressed until April 1, 2023. The proposal to transfer the cost of care for noncitizens from hospitals to taxpayers through Medicaid has unintended consequences. Nevada encourages illegal immigration when we offer welfare benefits that other states do not. Nevada already has among the highest proportion of undocumented immigrants of any U.S. state even without this incentive.

It seems reasonable that the cost will be much higher than the estimated $78 million, potentially billions of dollars. In section 39, S.B. 419 incredibly

suggests that there may be federal funds available to help Nevada pay for this insanity. While federal law allows states to pass laws giving benefits to noncitizens, most of federal law is devoted to stating that aliens are not eligible for government aid. The chances of the federal government supporting this scheme to encourage more illegal immigration in Nevada are slim to none.

This bill is a major financial giveaway benefiting corporations at the expense of taxpayers. We should not discuss a single penny of taxpayer money going to aliens until every homeless veteran is sheltered, every American citizen in foster care has found their forever home with a loving family, and every Nevadan lives in a neighborhood free of crime. We urge this Committee to work for Nevadans and oppose S.B. 419.

CHARLOTTE STEWART (Health Freedom Nevada):
We are a nonpartisan grassroots all-volunteer organization representing approximately 5,000 Nevada families and we serve as the Nevada affiliate of both Children's Health Defense and Stand for Health Freedom, national organizations whose missions align with our own. Our founding principles include the right of every citizen, parent or guardian in the case of a minor child to true and fully informed consent to all medical and pharmaceutical interventions, religious freedom and parental rights in all personal healthcare decisions. Health Freedom Nevada strongly opposes S.B. 419. We are strongly opposed to the expansion of public health measures that have failed us miserably in the last couple of years. Please vote no on S.B. 419.

JOHN CARLO:
I have been in this meeting for over three hours just to testify and say that I am Hispanic. My dad was from Mexico; I speak Spanish and another Asian language. I am a union member also and want to thank Senators Stone and Titus for being the voice of reason.

Health care is not a basic human right. It is in the Bible, the godly and the ungodly suffer alike. Senate Bill 419 goes against union jobs. I have been struggling to find a job because there are so many undocumented immigrants taking construction jobs. I am against S.B. 419 because it is enticing the criminal act of illegal immigration to this Country. The Cornell Law School speaks to the unlawful employment of aliens. We are saying come to Las Vegas, we will take care of your medical needs. Instead, lower the cost of education and stop voting for federal senators who are funding wars on the

other side of the world. We are facing an unbalanced amount of power. We have a major border problem and hiring and referring undocumented immigrants goes against *Nevada Revised Statutes* (NRS) 232.521 and NRS 360.796.

ELENA DENIGER:
I oppose this bill about health care for illegals. There are too many people on the street. None of these people have healthcare insurance. I do not want taxpayers to have to pay for health care for illegals. You go into the doctors' offices and the ERs, and these places are flooded with them. Sometimes you cannot get care for 12 or more hours because these ERs are flooded with them. This is not fair. I have been a U.S. citizen all my life, well over 55 years, and I have never seen anything like what is going on right now. I oppose this bill.

VICE CHAIR NGUYEN:
I have 21 documents in support of S.B. 419 to put into the record (Exhibit X), and I have 2 documents opposing S.B. 419 to put into the record (Exhibit Y). I will close the hearing on S.B. 419.

CHAIR DOÑATE:
The last agenda item is public comment.

MR. HOJJATY:
It seems like there are a lot of unauthorized immigrants that are working on the Las Vegas Strip directly or indirectly and there are a lot of elected officials that have relatives who have not come here in the proper way. I am hearing a lot of people express pain and frustration over the COVID-19 period during the lockdowns and everything. Now I see the true colors. You are trying to portray yourself as a victim, you have job losses, financial turmoil, inflation.

Here is the sad truth. A lot of these paid activist organizations, and I can go on and on; there are so many out there; they are the ones who supported the lockdown, the mask mandate and the vaccines. A lot of people got harassed. There were a lot of politicians who continued to promote this stuff. Have we gotten a report regarding whether these efforts work or is this based on lies, deception and everything else? You use social justice; this system made a lot of wealthy white males incredibly rich. A lot of casino executives profited. We can see this is all part of the whole political machine of casinos, unions, and this political dynasty. You have exposed it, congratulations.

We see the global agenda, which is to destroy our traditional values, the middle class and promote foot soldiers. This is what we see from open borders. When are we going to get some accountability for all this? You see in casinos, taxes do not go up, and middle-class people must pay for this. The financial system is not crumbling. Nevada used to be the fastest-growing State with the lowest unemployment, and now it is no longer in the top ten. It is the fastest growing, but our unemployment is among the highest. We are clearly going in the wrong direction.

MR. CARLO:
I ditto what the previous speaker, Cyrus Hojjaty, said.

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CHAIR DOÑATE:
I adjourn the meeting at 7:26 p.m.

RESPECTFULLY SUBMITTED:

Norma Mallett,
Committee Secretary

APPROVED BY:

Senator Fabian Doñate, Chair

DATE:

SUMMARY				
Bill	**Exhibit Letter**	**Introduced on Minute Report Page No.**	**Witness / Entity**	**Description**
	A	1		Agenda
	B	1		Attendance Roster
	C	3	Patrick Kelly / Nevada Hospital Association	Presentation
S.B. 419	D	11	Senator Fabian Doñate	Presentation
S.B. 419	E	11	Senator Fabian Doñate	Photo – Las Vegas Strip During COVID-19
S.B. 419	F	13	Senator Fabian Doñate	Connected Health Handout
S.B. 419	G	13	Senator Fabian Doñate	Interoperability Handout
S.B. 419	H	15	Senator Fabian Doñate	Trusted Exchange Framework Handout
S.B. 419	I	18	Senator Fabian Doñate	Facilitating Data-Driven Innovation Handout
S.B. 419	J	19	Senator Fabian Doñate	Best Practices Report, Council of State Bioscience Handout
S.B. 419	K	20	Tania Gonzales / Nevada Latino Legislative Caucus	HOPE Act Handout
S.B. 419	L	20	Tania Gonzales / Nevada Latino Legislative Caucus	The Catastrophic Cost of Uninsurance: COVID-19 Cases and Deaths Report
S.B. 419	M	22	Tania Gonzales / Nevada Latino Legislative Caucus	Oregon Medicaid Expansion Implementation Report
S.B. 419	N	23	Tania Gonzales / Nevada Latino Legislative Caucus	Proposed Amendment

S.B. 419	O	24	John Hardwick, / Northern Nevada Emergency Physicians	Support Testimony
S.B. 419	P	27	Luz Castro / Dignity Health–St. Rose Dominican	Engelstad Foundation R.E.D. Rose Program Presentation
S.B. 419	Q	30	Senator Fabian Doñate	Cure 4 The Kids Testimony
S.B. 419	R	32	Rico Ocampo	Lien Hospital Property Rico Family
S.B. 419	S	34	Senator Fabian Doñate	California HHS Executive Summary Handout
S.B. 419	T	42	Senator Fabian Doñate	Washington State 1332 Waiver
S.B. 419	U	47	Guadalupe Guzman / Make the Road Nevada	Support Testimony
S.B. 419	V	47	Fabio Diaz-Ortega / Cure 4 The Kids Foundation	Support Testimony
S.B. 419	W	55	Emperatriz Alvarez / Make the Road Nevada	Support Testimony
S.B. 419	X	58	Senator Rochelle Nguyen	Letters in Support (21)
S.B. 419	Y	58	Senator Rochelle Nguyen	Letters in Opposition (2)