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

Seventy-Fifth Session
March 23, 2009

The Committee on Commerce and Labor was called to order by Chairman Marcus Conklin at 1:35 p.m. on Monday, March 23, 2009, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/75th2009/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblyman Marcus Conklin, Chairman
Assemblyman Kelvin Atkinson, Vice Chair
Assemblyman Bernie Anderson
Assemblyman Morse Arberry Jr.
Assemblywoman Barbara E. Buckley
Assemblyman Chad Christensen
Assemblywoman Heidi S. Gansert
Assemblyman Ed A. Goedhart
Assemblyman William C. Horne
Assemblywoman Marilyn K. Kirkpatrick
Assemblyman Mark A. Manendo
Assemblywoman Kathy McClain
Assemblyman John Oceguera
Assemblyman James A. Settelmeyer

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblyman David P. Bobzien, Washoe County Assembly District No. 24

STAFF MEMBERS PRESENT:

Dave Ziegler, Committee Policy Analyst
Andrew Diss, Committee Manager
Karen Fox, Committee Secretary
Sally Stoner, Committee Assistant

OTHERS PRESENT:

Paul V. Townsend, Legislative Auditor, Audit Division, Legislative Counsel Bureau
Trevor Hayes, Las Vegas, Nevada, representing Health Management Systems, Charlotte, North Carolina
Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Tom McCoy, representing American Cancer Society-Cancer Action Network, Reno, Nevada
Carla Brutico, RN OCN, State Health Policy Liaison for Nevada, Oncology Nursing Society, Carson City, Nevada
Robert A. Ostrovsky, representing Health Plan of Nevada, Inc., Las Vegas, Nevada
Leslie A. Johnstone, Executive Officer, Public Employees' Benefits Program, Carson City, Nevada
Erin Russell Hayes, Las Vegas, Nevada, representing Aflac, Columbus, Georgia
Lea Tauchen, representing Retail Association of Nevada, Carson City, Nevada
Sherri Rice, Executive Director, Access to Healthcare Network, Reno, Nevada
Lawrence P. Matheis, Las Vegas, Nevada, representing Nevada State Medical Society, Reno, Nevada
Elisa Maser, representing Nevada Advocates for Planned Parenthood Affiliates, Reno, Nevada
Jeanette K. Belz, representing Nevada Psychiatric Association, Reno, Nevada
Lesley Dickson, M.D., Nevada Psychiatric Association, Las Vegas, Nevada

Chairman Conklin:
[The roll was taken.] We have a quorum. The first order of business is that I have three more bills to introduce.

BDR 53-278 - Provides provisions governing coverage for cancer as an occupational disease of firefighters. (Later introduced as Assembly Bill 521.)

ASSEMBLYMAN ATKINSON MOVED FOR COMMITTEE INTRODUCTION OF BDR 53-278.

ASSEMBLYMAN MANENDO SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYWOMAN BUCKLEY WAS ABSENT FOR THE VOTE.)

BDR 54-773 - Implements the federal secure and fair enforcement of mortgage licensing act of 2008 (The Safe Act). (Later introduced as Assembly Bill 523.)

ASSEMBLYMAN ANDERSON MOVED FOR COMMITTEE INTRODUCTION OF BDR 54-773.

ASSEMBLYMAN MANENDO SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYWOMAN BUCKLEY WAS ABSENT FOR THE VOTE.)

BDR 58-1139 - Makes various changes relating to energy. (Later introduced as Assembly Bill 522.)

ASSEMBLYWOMAN KIRKPATRICK MOVED FOR COMMITTEE INTRODUCTION OF BDR 58-1139.

ASSEMBLYMAN ARBERRY SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYWOMAN BUCKLEY WAS ABSENT FOR THE VOTE.)

At this time we will open the hearing on Assembly Bill 399.

Assembly Bill 399: Establishes provisions for the primacy of health care plans. (BDR 57-964)

Assemblywoman Heidi S. Gansert, Washoe County Assembly District No. 25:
This bill was one of the last to come out of drafting so it was not what I was expecting it to be. Legal did not have time to put together an amendment today, but it may be ready next week. I have, however, given you a conceptual amendment and a handout (Exhibit C) that reviews the objectives of what the

bill intends to accomplish, what the current system is, and what we need to change. The objective of this bill is to make sure that Medicaid is the payer of last resort, which is a federal requirement.

Included in the handout distributed to you today is a Government Accountability Office (GAO) report and a study stating that, on average, 13 percent of respondents in the survey had other coverage in addition to Medicaid. The question is, are we picking up all the third party payers before Medicaid is the payer of last resort?

Right now we use a contractor called Health Management Systems (HMS) who uses two different methods of examining this challenge. One of the methods is pay and chase, in which we pay and then attempt to determine later if the claimants had additional insurance or not. The second method is cost avoidance, where HMS tries to identify the carrier in advance to determine whether there is coverage other than Medicaid. Health Management Systems has informed me that it is difficult to get updated information from insurance companies. Some insurance companies are very good at providing information fairly frequently, some provide part, but not all of the data, and some stall. The key is to have a very strong and current data base to be able to check whom the appropriate payer is. Health Management Systems also shared that the state does not have any teeth requesting information. Currently there is no penalty if a payer does not provide information and it is not being gathered in a comprehensive or timely manner. We need to ensure that policyholders' information, for those covered through insurance companies, is matched at least monthly, and perhaps nightly or weekly. Additional information should be included in the database including third party administrator, (TPAs), and pharmacy benefit managers (PBMs). We also need to make sure when they send this information, we do not get bad information, we define the characters, make sure it is the information we need, and that we provide penalties if information is not provided.

The GAO report suggests that we are collecting less than 1 percent of what we should be. They estimate that 12 percent of individuals have third party insurance. For each 1 percent that Medicaid does not pay, the state could save $13 million.

Improving this system is extremely important so Medicaid meets the federal guidelines and becomes the payer of last resort. There are a number of states that are in the process of putting this type of legislation together. Something that we have that other states do not have is the provision of the False Claims Act, under which Nevada can go back for six years to collect if they find out that, in fact, there was another insurance carrier that should have paid before

Medicaid. I provided an audit highlight in the handout and also have asked the Audit Division to speak to you.

Chairman Conklin:
Did you provide a conceptual amendment to the bill?

Assemblywoman Gansert:
Yes, our staff prepared that.

Chairman Conklin:
Are these the documents you have been working from?

Assemblywoman Gansert:
The one I just went through is the one that starts out with A.B. 399 which includes the audits, spreadsheets, and portions of the GAO report. Mr. Ziegler was kind enough to put together some conceptual amendments to this bill.

Chairman Conklin:
Are there any questions from the Committee?

Assemblywoman Gansert:
The information concerning confidentiality, this information is being uploaded now. We just need to refine it to make sure it is accurate and current.

Chairman Conklin:
What amount do you think we are currently missing and could recover by implementing this bill?

Assemblywoman Gansert:
We can go back six years. The GAO report states that they expect 12 percent of claims paid involved claimants who had third party coverage that was not recognized. There is a big gap between what the GAO believes we should have as far as third party payers versus what we are recognizing within our system.

Chairman Conklin:
Do we have an extrapolation of how much money that might be?

Assemblywoman Gansert:
Each percentage point is $13 million. So 10 points would be $130 million. This information is being uploaded to HMS, who has informed me the exact amount is difficult for them to get. If there are no teeth to it, they feel if they ask too many times, they may not even get the information because the insured

does not have to provide it, although some of the major insurers in our state are providing it. We need to do a better job.

Chairman Conklin:
So we could potentially save $150 million.

Assemblywoman Gansert:
Yes, potentially.

Chairman Conklin:
Are there any questions from the Committee? There are none.

Paul V. Townsend, CPA, CIA, Legislative Auditor, Audit Division, Legislative Counsel Bureau:
I have provided you a handout (Exhibit D) that includes the Division of Health Care Financing and Policy (HCF&P) audit issued in February 2008. The primary objective of the audit was to determine if the HCF&P compliance unit had sufficient procedures to identify fraud, abuse, and overutilization to ensure control over medical payments. One of the issues we found was in some Medicaid paid claims should have been paid by Medicare. On the bottom of page 24 of the handout, under the heading "Payments from Other Liable Parties Not Always Recovered," we discuss this issue. We found a number of paid claims for services on recipients who were covered by Medicare, which resulted in thousands of dollars not being properly recovered or being paid needlessly because Medicare should have covered the majority of the cost.

Page 25 gives background on this issue and indicates that certain recipients are covered by insurers other than Medicaid, which many instances is Medicare. Recipients covered by both Medicaid and Medicare are known as dual eligible recipients. For persons enrolled in both programs, Medicare pays for services covered by their plan before payments are made by Medicaid. As mentioned previously, Medicaid is always a payer of last resort. Requiring a Medicare payment is significant because Medicare pays 80 percent of covered services.

Our review focused on end-stage renal disease claims since they are high-risk claims. We found there were some dual eligible recipients enrolled in Medicare retroactively that were not always identified. Two of the fifty recipients we reviewed fell into that category. If the Division had established controls to identify the two recipients in our sample and required providers to bill Medicare, we would have recovered approximately $90,000 on those two claims alone.

An additional error was that providers were not billing on the proper form. An edit in the system allowed claims to be paid on dual eligible recipients without

the prior Medicare payments. Therefore the claims payment system allowed payments for services on improper forms which resulted in Medicaid paying 100 percent for services rendered, instead of the 20 percent co-payment amount.

Page 26 is an example of four claims that were paid for one recipient without the proper Medicare processing. This example also includes other errors of overpayments and inappropriate billings, which resulted in an overpayment of more than $600,000. The contractor, Health Maintenance Services, who gets a 12 percent recovery fee, would have collected $75,000 for their services.

The scope of the audit was from 2006. In September 2007, HCF&P provided information indicating they had initiated recovery of over $6.6 million and by late last year, they had recovered over $10 million.

The top of page 27 is a general statement: ensuring that primary payment is obtained from other insurers is necessary to contain costs in the Medicaid program. The Division can significantly reduce payments for recipients covered by other programs. Therefore, sufficient controls are necessary to ensure dual eligible recipients are identified, as well as the related medical services covered by those programs. Furthermore, controls should ensure that Medicaid only pays the portion of the claim for which it is liable.

Since this audit came out, the Division has made a number of improvements in this area, and I think they are also working on some programming changes as of the end of last year.

Assemblyman Horne:
Does any of your data include Medicaid fraud?

Paul Townsend:
Because the numbers were so large, at the time the audit was conducted, we made a referral to the Medicaid Fraud Control Unit at the Attorney General's Office, and I have not heard back from them since I made the referral.

Assemblyman Horne:
It is one thing when someone files for assistance and gets confused about who the appropriate payer is, but another thing when someone is gaming the system and needs to be referred to the fraud unit. Because these numbers do not reflect that, I would be interested in the breakdown.

Chairman Conklin:
Are there any questions from the Committee? There are none.

Trevor Hayes, Las Vegas, Nevada, representing Health Management Systems, Charlotte, North Carolina:
Health Management Systems (HMS) is the national leader in helping the government to avoid costs and reclaim costs in government-sponsored health care programs. We were opposed to the bill as written, however, we have been in contact with Assemblywoman Gansert and support the amendment she has proposed. Since we operate in 40 states, we have been able to provide her with some of the best practices we have seen. Since 2004, HMS has saved the state over $130 million, which includes $100 million in up-front cost avoidance and $30 million in the recovery of payments. Health Management Systems contract is through First Health which has the main contract with the state, and we are subcontracted through them.

Chairman Conklin:
There probably will not be a subsequent hearing.

Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
Before I give my written testimony, I wanted clarify a couple of things. I do not want the Committee to think there are hundreds of millions of dollars of potential savings that may be available. We have been working for four years with HMS on developing our Third Party Liability (TPL) recovery issues. They have done a very good job assisting the state.

Currently, 22 percent of Nevada's Medicaid recipients have a third party liability. It is significantly higher than the 12 percent noted in the 2004 GAO report. It has been through the efforts of HMS and our fiscal agent, First Health, that we have been able to accomplish that.

The second thing I want to clarify is that Medicare claims are not issues that will be resolved by fixing the reporting requirements for Medicare through a company similar to HMS. Those issues had to do with individuals who were eligible but did not apply for Medicare. When we identified they were eligible for Medicare, our system had some problems that did not allow us to retroactively collect on those claims. It was not something that HMS could have resolved through their efforts.

We are grateful this amendment is being presented. It would be beneficial to revise the bill in a manner that would allow us to have more teeth to collect eligibility information from the Medicaid program. We have 136 resident insurance carriers that HMS works with. We collect information through HMS from each of those carriers on a daily, weekly, monthly, and sometimes

quarterly basis. Having more authority for the state or a subcontractor to collect information would be helpful.

[Spoke from written testimony (Exhibit E).]

Assemblywoman McClain:
My first concern is The Health Insurance Portability and Accountability Act (HIPAA) compliance. When did we first get First Health?

Charles Duarte:
First Health started as the state's fiscal agent in October 2003. Health Management Systems as a subcontractor in July 2004.

Assemblywoman McClain:
I remember all the problems we had.

Charles Duarte:
They were significant.

Assemblywoman McClain:
My concern is that we are looking at a 2006 audit to base this legislation on. Could you please explain the HIPAA compliance rule?

Charles Duarte:
We have requirements under the Medicaid act as well as HIPAA to protect the confidentiality of client and health information. I think the bill, as originally proposed, created some challenges, not just for Medicaid as a program, but for other insurers in terms of protection of personal health information. I think the amendment Assemblywoman Gansert has proposed will resolve those issues.

Chairman Conklin:
Are there any questions from the Committee? We will close the hearing on A.B. 399 and bring it back to Committee. We will open the hearing at this time on Assembly Bill 268.

Assembly Bill 268: Requires certain policies of health insurance and health care plans to provide coverage for certain types of chemotherapy. (BDR 57-1007)

Assemblyman Chad Christensen, Clark County Assembly District No. 13:
Assembly Bill 268 involves the topic of cancer which has affected my family profoundly the past two years. My uncle, who lived in a very rural area in Utah, passed away from cancer had to travel to get treatment. My intent today is to

open the dialogue on this subject and let the experts discuss what we can work out. As a legislator, I am always sensitive to placing mandates on non-public-sector companies. At the same time I am very sensitive to helping cancer victims who are experiencing their little piece of hell on earth as they go through a very difficult time.

For years the treatment plan for cancer has been to get plugged into an intravenous (IV) therapy with other patients in a room at a medical facility. Medications have come a long way, and now chemotherapy treatments can be taken orally.

I am concerned about a patient who has been diagnosed with cancer, and in many cases does not know how long he has to live, while being in this financial crunch and economic crisis where people are concerned about their jobs, and has to leave work to get treatment at a doctor's office. I also think about patients who live in rural districts, who have to drive long distances for IV treatments. I believe oral treatment can be a significant help to those patients. There is a significant cost to insurance carriers to have claimants go to a doctor's office for IV treatment. My understanding is there can be a significant cost reduction through the pharmaceutical application of taking a chemotherapy pill versus going for IV treatment at a medical facility.

Chairman Conklin:
Is there someone who you would like to speak first?

Tom McCoy, representing American Cancer Society-Cancer Action Network, Reno, Nevada:
The byproducts of the work of a research doctor had been approved by the Food and Drug Administration (FDA), and IV cancer chemotherapy began its widespread use in 1962. Oral chemotherapy, which Assemblyman Christiansen mentioned, can be taken as a pill, capsule, or liquid and has been around for quite some time. In the past five years there has been a dramatic increase in the development of oral anticancer drugs. Twenty-five percent of all new cancer drugs being developed today are oral, and this will continue to increase due to the advantages to patients. The oral drugs can be taken at home unlike injected drugs that have to be administered at a medical facility, and the side effects of oral drugs are often less severe. If there is an oral drug equivalent to an IV drug, patients prefer to take the oral drug. The oral therapy means less hospital time and less costly medications for side effects. One study I reviewed showed a patient taking oral medications made eight hospital visits, and the IV user taking the same types of drugs made 30 hospital visits. This translates to cost savings per the insurance industry as there is less need to be treated by the oncologist.

There is a disparity currently in Nevada as a cancer patient getting treatment through an IV might pay a $15 co-pay because it is coded as a medical benefit procedure, while another cancer patient taking the same drug orally will pay a co-pay of $400 to $500 because it is considered a prescription drug. Some oral therapies run up to $9,000 per month, which can quickly devastate a family's finances. Because of our current economic state, some patients do not take the recommended oral dosage so they can stretch the medications to save money.

The Medicare model is what we see as an answer to this problem. If there is an equivalent oral drug, it should be treated the same from a financial standpoint as an IV drug. Access to treatment is a serious consideration in our state. The hundreds of miles of travel often required by our rural cancer patients for standard IV treatments might be extremely burdensome, but the patients may not be able to afford the alternative oral drugs due to the lack of parity in their health policy at the present time.

The American Cancer Society sees this bill as a quality of life issue for cancer patients in each of your districts. Last year over 11,000 Nevadans were told they had cancer. When someone has to deal with the physical and emotional affects of fighting cancer, the one thing that is not needed is to deal with conflicting financial insurance policy issues. Hard decisions have to be made impacting treatment, quality of life, and survival. We believe the passage of A.B. 268 will benefit the state's healthcare system, health insurance carriers, and most importantly, Nevadans who are diagnosed with cancer.

[Distributed statement (Exhibit F).]

Chairman Conklin:
Are there any questions from the Committee?

Assemblyman Anderson:
While the cost of oral medication is dramatically higher than comparable treatment in the hospital, will the passage of this bill give the patient an opportunity for home therapy?

Tom McCoy:
There should be a financial offset for everybody involved. The patient can often maintain their work schedule and family life by taking a pill at night, while they are sleeping. It will make a significant impact.

Assemblyman Anderson:
The real importance of this bill is the fiscal impact to the patient, so that they may be able to get the dosage for their cancer treatment at a more realistic cost rather than taking time from work to go to a hospital for an IV, and the out-of-pocket expense.

Tom McCoy:
It would be treated as a co-pay for an IV.

Chairman Conklin:
Are there any questions from the Committee? There are none.

Carla Brutico, RN OCN, State Health Policy Liaison for Nevada, Oncology Nursing Society, Carson City, Nevada:
[Spoke from written testimony (Exhibit G).]

Chairman Conklin:
Did you talk to the bill sponsor about your proposed amendment?

Carla Brutico:
I did not, but I sent him an email with the amendment.

Chairman Conklin:
Are there any questions from the Committee? There are none.

Robert A. Ostrovsky, representing Health Plan of Nevada, Inc., Las Vegas, Nevada:
This mandate will apply to small and medium size employers that are not self-insured otherwise. This bill falls under the usual host of arguments that we have about mandates.

This bill states that oral medications, which are normally treated as a pharmacy benefit under a health insurance plan, would now be shifted to a major medical benefit. It would be paid in a different form than when paid as a pharmacy benefit. We have not had an opportunity to study this bill specifically on how it would impact insurers, but we did, however, look at a similar bill that Colorado has pending. Colorado did a study showing that in the course of one year you could treat 500 individuals who have colorectal cancer using an IV drug treatment system for approximately $187,000. The cost of treating those patients using a comparable oral drug regiment would be $9.3 million. There is a lot of money involved in the difference in cost between IV drug treatment and oral medications. The question is what portion does the insured pay. In one plan the IV treatments cost the patient $10 to $50 per day, per treatment. If

this is mandated to be paid as a major medical benefit for the same oral mediations, we will be paying a lot more money. The patient is still getting treatment. But the problem is if you have a choice between getting it through an IV or taking it at home orally, the difference in expense is dramatic.

Another concern for some of the medical advisors is when patients take the oral medication at home, the doctor does not have control over what time they take it, do they take the correct dose, do they skip a dose, or do they not take it at all if the patient is not feeling well.

This bill is not about limiting care. It is about how much we can afford to pay for the care when there are options. A patient can take the oral medication, but they are unfortunately going to pay a lot more out of their pocket. If the price of the drugs is reduced someday when they are not so new, perhaps there will be a better balance. Right now the cost is quite large. We feel this is not a good time to mandate a benefit that would be nice to have but is not necessary.

Chairman Conklin:
Are there any questions from the Committee?

Assemblyman Horne:
I did not hear any proposed suggestions. It sounds like you are saying if you get cancer, you will have to live with the rules, suck it up, and pay for it. I think that is offensive. I think this bill is trying to help cancer patients, and I would hope we find a way to work through it.

Robert Ostrovsky:
I did not mean to be offensive. There are issues in the rural areas that obviously need to be reviewed. I am not an expert on the rural areas, but I would be happy to talk with the sponsors of this bill. I suppose there are always circumstances that go beyond the rule, and we may be able to respond to those in some way. I would be happy to talk with the sponsors of the bill.

Assemblyman Goedhart:
Is the drug cost difference example you mentioned earlier normal? It seems counterintuitive. If you did not need to schedule an office visit time or doctor time, you would think that it would be less expensive to take the drug orally.

Robert Ostrovsky:
As with a lot of new drugs, the oral chemotherapy medications are expensive. Most of the IV treatments have been around for a long time so their cost has been reduced. The question is: is the oral drug equal to or even better than the IV drugs? There may be targeted drugs that are not otherwise available. We

are covering these as a pharmacy benefit. Other factors involved are how long the drugs have been around and whether the generic equivalent is available. Pharmaceutical research is very expensive. The pharmaceutical companies invest a lot of money in creating drugs for a relatively narrow market, such as specific drugs to treat a specific cancer.

Assemblyman Goedhart:
Would it be possible to come up with some compromise language that if the oral treatment was no more or less than the IV treatment for cancer, the oral drug would be utilized and paid through medical coverage versus the pharmaceutical benefit?

Robert Ostrovsky:
We will discuss that with the proponents.

Assemblyman Goedhart:
We know it has to be cost effective, but as someone who lives in a rural area, we have a lot of folks who have to drive 110 miles to Las Vegas for any type of IV medical treatment. An inordinate mandate will drive up the cost for everyone, but it would be our wish to see what you can do by working with the bill sponsors.

Chairman Conklin:
Are there any questions from the Committee?

Assemblywoman McClain:
Does this bill include government healthcare and self-funded policies? I know it exempts Medicaid.

Robert Ostrovsky:
I do not know what the bill sponsors intended.

Leslie A. Johnstone, Executive Officer, Public Employees' Benefits Program, Carson City, Nevada:
Speaking for the Public Employee's Benefits Program (PEBP), this bill specifically adds it to our statute as well. Currently, we cover oral medications as well as intravenous. I am not sure of the difference in cost in all cases. Our pharmacy program requires a $1 co-pay, so I would imagine it is comparable in cost to the intravenous. The bill specifically did add it to PEBP and local plans as well.

Chairman Conklin:
Are there any questions from the Committee? There are none.

Erin Russell Hayes, Las Vegas, Nevada, representing Aflac, Columbus, Georgia:
As you may know, Aflac sells individual, guaranteed, renewable health insurance policies which are designed and sold to provide supplemental benefits in the event of serious injury or hospitalization. Unlike comprehensive major medical or basic medical insurance coverage, they are payable in addition to and regardless of other coverage or insurance that is made. We have concerns with the bill as currently written. We do not think the bill was intended to include supplemental insurance and have brought this up with the sponsor of the bill and would like to continue to work with them on A.B. 268.

Chairman Conklin:
Are there any questions from the Committee? There are none.

Lea Tauchen, representing Retail Association of Nevada, Carson City, Nevada:
I would like to echo and add to the concerns made by Mr. Ostrovsky earlier. The Retail Association of Nevada is and always has been opposed to legislation that mandates a specific class of drugs and protects certain classes of businesses, such as pharmaceutical manufacturers. We feel this may create a more expensive insurance product and make it difficult for our small employers to insure their employees. Further, we think this is a manufacturer and insurance-provider issue that should be handled in a more businesslike manner between the entities involved and not at the Legislature.

Chairman Conklin:
Are there any questions from the Committee? There are none. We close the hearing on A.B. 268 and bring it back to Committee. We will open the hearing on Assembly Bill 438.

Assembly Bill 438: Requires a notice of noncoverage to be included in a policy of health insurance under certain circumstances. (BDR 57-885)

Assemblyman David P. Bobzien, Washoe County Assembly District No. 24:
Assembly Bill 438 addresses the proliferation of mini-med insurance plans that do not provide full coverage for the wide range of situations in which the purchasers may find themselves. We will be hearing testimony today about individuals who did not fully understand their policy and then found themselves in catastrophic situations which were not covered. This is a transparency measure which provides that if there is not coverage under the plan for certain conditions the plan should so note at the top of the plan so it is perfectly clear what is not covered.

The reports for each plan must be filed with the Insurance Commissioner as well as the Governor's Office for Consumer Health Assistance. Finally, once the

reports are received they also should be put on the websites of those offices. I have distributed a sample plan from Aflac (Exhibit H). Page one of the sample plan has a statement at the top that explains its limited nature. Under the new bill this statement would need to change slightly.

Chairman Conklin:
Have you gone over the proposed amendment?

Assemblyman Bobzien:
No, I have not. Ms. Belz will be presenting a friendly amendment to include other conditions.

Chairman Conklin:
Are there any questions from the Committee? There are none.

Sherri Rice, Executive Director, Access to Healthcare Network, Reno, Nevada:
I am here today in support of A.B. 438. We are the first nonprofit medical discount plan in the State of Nevada and in the United States. We are a partnership between Renown Regional Medical Center, St. Mary's Regional Medical Center, and over 500 local providers, who offer our members health care services at vastly reduced fees. Our mission, to make it simple, is access to care for the working-poor uninsured. Our members are only eligible if they are not on Medicare, Medicaid, Nevada Check Up, or employer-sponsored insurance. They have to show photo identification, live in the State of Nevada, and need to be between 100 to 200 percent of poverty level, which means a family of two makes anywhere from $1,000 to $2,800 per month. We base our criteria on family size.

We started the program two years ago. In the last year and a half we have put 3,000 uninsured northern Nevadans on our program and have been able to get them the health care they need, which includes open-heart surgery and bilateral knee replacements. We cover approximately 15 surgeries per month.

The reason I am here to testify for A.B. 438 is that about a year and a half ago we started to receive phone calls from people who had an insurance product, which was not going to cover what they needed. These are individuals who met our poverty guidelines and paid out of their pocket for an insurance policy that was not going to cover their cancer, outpatient services, or what they needed. Because our mission is to cover the gap for the uninsured poor to get access to care, our board of directors looked at how we could fill that. So now, when someone comes to Access to Healthcare Network and has, what Assemblyman Bobzien has called, a mini-med plan that will not cover their cancer treatment or life-saving surgery, we review their situation on a

case-by-case basis and put them into our program. Then they can get the care they need, and they pay a reduced fee, at the time of service. These are individuals who meet our income guidelines and have been paying on the previously mentioned product that does not take care of them in the way they needed at the time. We are here to support A.B. 438 so that there is more clarity for our members, who are the poorest of the poor and the working poor.

Chairman Conklin:
Are there any questions from the Committee?

Lawrence P. Matheis, Las Vegas, Nevada, representing Nevada State Medical Society, Reno, Nevada:
Assemblyman Bobzien and I have the honor of serving on the board of the Access to Healthcare Network. The challenge of this issue is transparency and understanding the complexities of health care coverage. We would like to address the specific, immediate problem, but also build the capacity in the State of Nevada, at the Division of Insurance and at the Office for Consumer Health Assistance, to increasingly assist the public in better understanding what their insurance does and does not cover. People need to understand what they have in order to know if a policy has the value they think it does. Clearly, for example, a woman who came to the Access to Healthcare Network with insurance but no coverage for cancer, was confused and did not know the policy she purchased through a major consumer advocacy group did not meet her needs. She was sacrificing other things in order to afford the insurance policy. It turned out this was not a credible policy under Health Insurance Portability and Accountability Act (HIPAA).

There is an obligation for each of us to understand the policies and contracts we have. But if the last eight months have not taught us one thing as a nation, it should have. There is a certain opaqueness in what large companies sometimes tell us they are doing for us and we do not benefit from that. This is not to say they have done anything wrong or the broker was not forthright, but clearly the patient did not understand. This bill is trying to address this issue through disclosure requirements and by providing monitoring by other parties.

Concerning the conditions that are listed, I chose the top chronic conditions that Nevadans face. There are policies that do not cover one or more of these. I think we would be going in the right direction if went down the path of openness about coverage issues and what you have when you have a health policy.

We need to look at two other problematic areas for patients and consumers. One concern is health premiums on which other states have already taken

action. Other states have reviewed the cost of health insurance premiums. Most of us think premiums should go to pay for health care treatment. How much goes for other things, such as executive pay, or bonuses? As we are finding out with American International Group (AIG), sometimes the contracts can be so difficult to understand that you can be head of the Federal Reserve and not understand. It would be a big step for Nevada to post, on the Insurance Division's website, very clear guidance concerning where your money goes.

The last area would be to deal with silent or rental networks where consumers may think they will be covered under the policy they have, only to find out many months later that their claim was actually paid under another network and contract. As we learn from dealing with the transparency issue, of whether or not a policy covers major chronic conditions, during the next two years, we can see how we might better be able to inform people in the future. I would suggest that the Legislative Committee on Health Care, during the interim, meet with the Insurance Commissioner to make sure this is being pursued, and other consumer issues are identified, and we ensure more transparency in the health insurance market. I think the sponsor's intent is that this bill is a good way to start clarifying what is happening in the health insurance field, but it is only the start.

Chairman Conklin:
Are there any questions from the Committee? *Nevada Revised Statute,* Chapter 695B, titled "Nonprofit Corporations for Hospital, Medical and Dental Service," is listed in this bill. Who falls into that category?

Lawrence Matheis:
It used to be the Blue Cross plans. Long ago they stopped being nonprofit, I think now Hometown Health is the only nonprofit health services provider in the state.

Assemblyman Settelmeyer:
Do you know of other states that have a law similar to this, and if so, what illnesses have they left out?

Lawrence Matheis:
As far as I know, we are the first state that has dealt with this particular issue. Other states have dealt with the issues of health insurance premium transparency and the silent network. We are blazing new ground in terms of this act of clarity. Idaho has a law that deals with the issue of non-credible insurance under HIPAA. I will get that citation for your staff to review.

Chairman Conklin:
Are there any questions from the Committee? There are none.

Assemblyman Bobzien:
I want to call the attention of members of the Committee to a letter (Exhibit I) from Valerie Clark, President of Clark and Associates of Nevada, Inc., who is in support of the bill.

Chairman Conklin:
Are there any questions from the Committee?

Elisa Maser, representing Nevada Advocates for Planned Parenthood Affiliates, Reno, Nevada:
As you may know, we have five clinics in Nevada that offer reproductive health care to over 60,000 clients per year. We are very supportive of giving clients the information they need to make healthy decisions, and this bill is entirely consistent with our philosophy of treating clients as important partners in their health care. We would note that 80 percent of women in their child-bearing years use some form of birth control. As this bill goes through additional study in future years, we hope there will be some consideration of giving women some disclosure about what forms of birth control and family planning are and are not covered under the insurance plans.

Chairman Conklin:
Are there any questions from the Committee?

Jeanette K. Belz, representing Nevada Psychiatric Association, Reno, Nevada:
We are in support of this bill and offered the friendly amendment (Exhibit J) that Assemblyman Bobzien referred to earlier. Several months ago when Assemblywoman Leslie told me that this bill was going to be introduced, she and I talked about the confusion that exists in terms whether insurance policies cover mental illness and substance use disorders. We thought it would be appropriate to include them as additional conditions that would be elaborated on. In my amendment, after "stroke," we would include mental illness and substance use disorders, as defined in the most recent addition of the *Diagnostic Statistical Manual of Mental Disorders*.

Lesley Dickson, M.D., Nevada Psychiatric Association, Las Vegas, Nevada:
I want to support what Ms. Belz just said. We would like very much for mental illness and substance abuse disorders to be included in this list. I have looked at my insurance policy more than once to determine if it covers mental illness and it is very hard to figure it out. You have to call an 800 number to speak with someone to find out, since it is not in any written material I have been

sent. Mental illness is frequently not covered. Twenty to thirty percent of the population suffers from mental illness or substance use disorders at any one time, and I think they should know if they have coverage. We are in favor of both the bill and the amendment.

Chairman Conklin:
Are there any questions from the Committee? There are none. Is there any opposition? Is there anyone who is neutral on A.B. 438? We will close the hearing on A.B. 438.

> ASSEMBLYMAN ANDERSON MOVED TO AMEND AND DO PASS ASSEMBLY BILL 438.
>
> ASSEMBLYMAN ATKINSON SECONDED THE MOTION.

Is there any discussion?

Assemblywoman McClain:
Are there other major illnesses that should be included?

Chairman Conklin:
These are the major ones to get out first. Maybe we should get the bill out and then see how it works? We could list a bunch.

Assemblyman Horne:
If the Committee is interested in adding more, I would like to add sickle cell anemia and sickle cell trait.

Chairman Conklin:
We could add more illnesses, or we could consider it in the fashion the bill sponsor has presented it, to get it started.

Assemblyman Horne:
Sickle cell anemia is a disease that primary affects those of African or Mediterranean descent and often falls off the radar screen. It is a very serious disease, and I have the trait. It is something I have noticed that seems to always get overlooked. It is a devastating disease especially for young children.

Chairman Conklin:
Could Mr. Matheis and Assemblyman Bobzien come to the table? I know absolutely nothing about the disorder that Assemblyman Horne just mentioned, which is why I have never checked my policy for it. Is this a disorder that should be considered for this bill?

Lawrence Matheis:
It is a metabolic disorder that is extremely important in the African American community and for those of Mediterranean descent. It has a lot of consequences such as developmental delays and other issues. We were not trying to be exhaustive in the list and took the top chronic conditions that Nevadans face. If you have insurance and you are African American, sickle cell anemia and sickle trait should be part of your plan. It is more of an issue of benefits of coverage rather than of transparency about major disorders that are not there. I suspect most policies do not cover it.

Chairman Conklin:
Assemblyman Horne, do you have any questions for Mr. Matheis, since he is the only doctor in the room.

Lawrence Matheis:
Mr. Chairman, I am not a physician or an attorney.

Assemblyman Horne:
I am not trying to bog down Assemblyman Bobzien's bill at all, but I wanted to mention something that I thought should be included.

Chairman Conklin:
Assemblyman Bobzien, is that amendment acceptable to you?

Assemblyman Bobzien:
It is certainly a policy question. We are going for simplicity, but if it is felt that this is baseline information that we need, let us move forward with that.

Chairman Conklin:
I have a motion by Assemblyman Anderson and a second by Assemblyman Atkinson.

Assemblyman Anderson:
I would accept the amendment as friendly in its intent. And I would agree with the suggestion from Assemblyman Horne, being somewhat familiar with the medical condition, not personally having it but recognizing its propensity in a particular subset of the population. If it were a broader question, it would

indeed be one of the major health epidemics facing the nation, so I think it would be proper for it to be there.

May I withdraw my motion? We are missing several key members of the Committee, and I think it would be well for us to have everybody here for this bill, since it is a groundbreaking piece of legislation.

Chairman Conklin:
Assemblyman Atkinson is that acceptable to you?

Assemblyman Atkinson:
Yes.

Chairman Conklin:
We will withdraw the motions for A.B. 438 and take this bill back to Committee.

Assemblyman Bobzien, you might check with Assemblyman Horne, Assemblyman Manendo, and Assemblyman Settelmeyer for suggestions of what other illnesses should be on the list. We will take this matter up at another time. Is there anything else to come before the Committee?

[The meeting is adjourned at 3:03 p.m.]

RESPECTFULLY SUBMITTED:

_____
Karen Fox
Committee Secretary

APPROVED BY:

_____
Assemblyman Marcus Conklin, Chairman

DATE: _____

EXHIBITS

Committee Name: Committee on Commerce and Labor

Date: March 23, 2009 Time of Meeting: 1:35 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Sheet
AB 399	C	Assemblywoman Heidi S. Gansert	Conceptual Amendments and Supporting Documents
AB 399	D	Paul Townsend	Audit Report
AB 399	E	Charles Duarte	Written Testimony
AB 268	F	Tom McCoy	Written Testimony
AB 268	G	Carla Brutico	Written Testimony
AB 268	H	Erin Russell Hayes	Sample Insurance Policy
AB 438	I	Assemblyman David P. Bobzien	Letter from Valerie Clark
AB 438	J	Jeanette Belz	Proposed Amendment