MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Sixth Session
February 25, 2011

The Committee on Health and Human Services was called to order by Chair April Mastroluca at 12:04 p.m. on Friday, February 25, 2011, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, 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/76th2011/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:

Assemblywoman April Mastroluca, Chair
Assemblywoman Peggy Pierce, Vice Chair
Assemblyman Elliot T. Anderson
Assemblywoman Teresa Benitez-Thompson
Assemblyman Richard Carrillo
Assemblywoman Lucy Flores
Assemblyman Jason Frierson
Assemblyman Pete Goicoechea
Assemblyman John Hambrick
Assemblyman Scott Hammond
Assemblyman Pete Livermore
Assemblyman Mark Sherwood

COMMITTEE MEMBERS ABSENT:

Assemblywoman Debbie Smith (excused)
Assemblyman Steven Brooks (unexcused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Allison Combs, Committee Policy Analyst
Kirsten Coulombe, Committee Policy Analyst
Risa Lang, Committee Counsel
Mitzi Nelson, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Michael J. Willden, Director, Department of Health and Human Services
Cliff King, Chief Insurance Examiner, Life and Health Section, Division of Insurance, Department of Business and Industry
Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services

Chair Mastroluca:
[Roll was called.] We have one presentation on the agenda today. We are going to hear an overview of federal health care reform as it pertains to Nevada. This is important because we will be receiving quite a few bills from the Senate regarding this issue in the coming weeks. We want to take this opportunity to make sure that everyone is prepared.

Michael J. Willden, Director, Department of Health and Human Services:
I am the Director of the Department of Health and Human Services (DHHS). With me at the table to help answer questions are Charles Duarte, Administrator of the Division of Health Care Financing and Policy (DHCFP), which most people know as Medicaid and Nevada Check Up, and Cliff King, with the Division of Insurance in the Department of Business and Industry. As the Committee will recall, we gave an overview on health care reform on February 9. In today's presentation, we will try to provide more in-depth information on this subject. I have provided a document on health care reform (Exhibit C), identical to the one provided February 9, as well as a letter regarding the medical loss ratio (MLR) addressed to Secretary Kathleen Sebelius of the U.S. Department of Health and Human Services (Exhibit D). We have also provided a document regarding the Pre-Existing Condition Insurance Plan (PCIP) in Nevada (Exhibit E), which is one of the issues we have dealt with over the past year. Finally, we have provided an unofficial copy of a bill draft request (BDR) (Exhibit F), dealing with Nevada's health insurance exchange, which will be formally transmitted by the Office of the Governor today to meet the statutory deadline for BDR submissions.

I will walk through the health care reform document again. Page 2 includes a simple pie chart that breaks down how Nevadans are currently insured. In summary, about 20 percent of Nevadans are uninsured. The basic intent of health care reform legislation is to help uninsured Nevadans gain access to health care through their employer, the state health insurance exchange, the individual market, or the proposed Medicaid expansion. Page 4 includes a list of 29 white papers that have been created by the DHHS regarding the Patient Protection and Affordable Care Act (PPACA). Two that would be most interesting for your review are titled "Health Insurance Exchanges – Goals for the Health Insurance Exchange" and "Section 1202 Payments to Primary Care Physicians." Additionally, the paper titled "Sections 1311 & 1413 Establishment of the Eligibility Engine" explains the required automation that will aid the uninsured in gaining access to Medicaid and Nevada Check Up and other available subsidies. There is also information about prescription drug rebates and fraud, waste, and abuse. There is a white paper available for just about every subject involving health care reform.

I would like to spend time reviewing actions the DHHS has taken since health care reform legislation was passed. Page 6 lists the implementation timeline from the Henry J. Kaiser Family Foundation website, which is a valuable tool. There are approximately 92 trigger points that must be met during the next six or seven years. Page 7 lists deadlines that were required to be met in calendar year (CY) 2010.

Since passage of the health care reform legislation last March, DHHS has established an internal working group that includes various state executives. My associates here today, Charles Duarte and Cliff King, and I are members of this working group. Additional members are Darrell Faircloth from the Office of the Attorney General; Karen Caterino, Administrator, Risk Management Division; Kateri Cavin, from the Nevada Public Employees' Benefits Program; Marilyn Wills, who is the Interim Director of the Office for Consumer Health Assistance; and Romaine Gilliland, Administrator, Division of Welfare and Supportive Services. Brett Barratt, Commissioner of Insurance, and Glenn Shippey and Jackie Rombardo, also from the Division of Insurance, are members of the working group as well. Consultants and other staff are brought in as needed. We meet two to three times per month to handle issues as they arise and make recommendations to the Governor. There are several federal planning grant opportunities which we have taken advantage of to hire consultants to help us with the process. Specifically, we have contracted with Bob Carey of Public Consulting Group for this purpose. In my opinion, Mr. Carey is one of the more knowledgeable authorities in the nation regarding insurance exchanges and health care reform. He is a valuable resource who

participated in the enactment of the 2006 Massachusetts Health Care Reform Law. He has helped the Department with estimating costs and aided in the decision processes.

Again, page 7 lists some of the issues that we have tackled over the first year, such as reviewing health plan premium increases. We received a $1 million grant from the federal government which has enabled the Division of Insurance to hire two full-time equivalents that have contract dollars for actuarial review which are good through September 30, 2011. The grant has gone through Interim Finance Committee review and is off and running. We have also dealt with issues of lifetime limits on insurance policies, adult dependent coverage up to age 26, and the PCIP. Although federal money was made available to the states to establish the PCIP, Nevada opted to defer this program to the federal government. We felt the amount of money available versus the number of Nevadans who had preexisting conditions would be overwhelming. However, the PCIP has actually been "underwhelmed." The PCIP is administered by the Government Employees Health Association for the approximately 125 Nevadans who have taken advantage of this program to date. I am not sure if the low participation rate is due to lack of awareness of the program or whether it is an affordability issue. The last page of the PCIP handout (Exhibit E) lists the 2011 monthly premium rates for Nevada, by the age of the enrollee. We are continuing to work through our public information outreach efforts to make sure that that Nevadans know the PCIP program is available.

We also have a number of public workshops planned over the next six months to discuss health care reform. The first one was held February 2 to engage the public in the process. We were overwhelmed at the level of interest shown during the first meeting by the public, insurance carriers, agents, and brokers. Additional meetings are scheduled to be held February 29 and 30. We are also holding a meeting in Reno on March 1 at the Grand Sierra Resort and March 2 at the Cashman Field Center in Las Vegas. We have gone from scheduling the meetings in smaller, governmental rooms to larger venues in order to get more broad scale input on the various issues involved. A series of meetings is scheduled from the end of March through the end of May to ensure the public understands the issues Nevada must tackle and to gather as much input as possible. We want to do this not only because it makes good sense, but also because gathering this type of information is a requirement of our planning grant.

The next item we must deal with is the minimum medical loss ratio (MLR) for insurers. This is a big issue in health care reform that requires insurance

carriers, brokers, and agents to reduce their administrative costs to a set ratio. Nevada just applied for a waiver on the MLR. I would like Mr. King to address this issue.

Cliff King, Chief Insurance Examiner, Life and Health Section, Division of Insurance, Department of Business and Industry:
The MLR program was established by the PPACA to ensure that a greater proportion of the dollars received by an insurance company in the form of premiums are paid out on medical issues rather than as administrative costs, bonuses for executives, or any other reason. The purpose is to make sure that premium dollars are directed back to the patients who pay them.

There is a two-pronged approach in the PPACA to keep insurance affordable. The first prong involves rate review provisions which require the insurance carrier to file proposed rate increases with the Division of Insurance to ensure that the increased rate is justified and reasonable. We have received a $1 million grant to enable us to establish this program to review the rate filings. The second prong involves a rebate that is paid to the policy holder by the carrier who does not achieve an 80 percent MLR. The rebated amount would be calculated as the difference between the mandated 80 percent ratio and the carrier's actual loss ratio.

As previously mentioned, Nevada has filed for a one-time waiver for CY 2011, in the individual market only, requesting that the MLR be reduced to 72 percent. An insurance premium is based upon expected losses and loss adjustment expenses. The policies that were issued and will be collected upon during CY 2011 were based upon data from CY 2009, when the expected or target loss ratio in the industry was 65 percent. Suddenly, by virtue of this act, the loss ratio for CY 2011 has been bumped up to 80 percent, which is a somewhat murky figure. The loss ratio is calculated by removing premium taxes and fees plus a credibility factor for insurers who insure fewer than 75,000 lives. As shown on page 2 of Exhibit C, as of September 1, 2010, there were 87,309 Nevadans covered by individual policies. No single carrier in the individual market covers 75,000 lives in Nevada, which means carriers in this market will receive a credibility adjustment. In reality, using 2009 figures, 72 percent is a realistic loss ratio target.

Why does it take so long for a premium rate increase to be collected? For example, if a rate change is approved on January 1, 2010, and a policy is renewed on December 31, 2010, the rate change will not actually go into effect until December 31, 2011. Therefore, the insurance agency will not see the benefit of the rate change until 2012. The policies that were issued for CY 2011, on average, had a rate change on July 1, 2010 before the MLR was

firmly established. Now, it is true that the MLR was established in the PPACA on March 23, 2010, but the details did not become finalized until the regulation was issued, effective December 1, 2010. Even at that, it was an interim final regulation, meaning it was not effective until at least 60 to 90 days later, when it was officially adopted by the U.S. Department of Health and Human Services. In essence, we requested an amendment and adjustment to the 80 percent MLR for CY 2011. The MLR would increase to 80 percent for CY 2012 and CY 2013. Beyond that date, the insurance exchange would take effect. I would be happy to answer questions.

Assemblywoman Pierce:
Does the loss ratio only apply to individual insurance policies and not group insurance?

Cliff King:
It applies to all types of insurance, but you can only request an exception for the individual market. The legislated MLR for large group insurance, greater than 50 employees, is 85 percent; small group insurance, 2 to 50 employees, is 80 percent; and individual coverage is 80 percent.

Assemblywoman Pierce:
Do group insurance plans currently have to meet the MLR legislated by the PPACA?

Cliff King:
The MLR is calculated by carrier, not by group or individual policies. For instance, Aetna has to have a MLR for their entire small group business of 80 percent or higher. In not, they have to issue rebates up to the 80 percent level.

Assemblywoman Pierce:
Is that rate effective now or is this one the regulations that must be met in CY 2012 or CY 2013?

Cliff King:
It is effective January 1, 2011.

Assemblyman Livermore:
Does the Division of Insurance control how aggressive the insurance carrier is in making arrangements with medical providers? Is it based upon loss or upon payments? Do you review their payment schedules or deductions from medical facilities?

Cliff King:
The Division of Insurance has regulatory authority over individual health benefit plans. We have rate authority over all health maintenance organizations (HMO), whether group or individual. We currently do not have regulatory rate authority over any business offering group health insurance. At this moment, Assembly Bill 74 is being heard in the Assembly Committee on Commerce and Labor. This bill includes a provision to grant the Division authority over group health benefit plans as well. However, we currently do not have authority over group plans, other than HMOs.

Assemblyman Livermore:
I would prefer to buy my insurance from a carrier that is aggressive in getting contractual discounts. I would hope that the Division would have oversight or directives to ensure carriers are in line with the market.

Cliff King:
I am not sure I know how to answer that question. Network adequacy is determined by the State Board of Health. Our Division does not have the expertise to determine network adequacy on the part of a carrier. I can tell you that the insurance market is very competitive in Nevada. We have ten carriers in the individual market with greater than 1,000 lives. A total of 28 carriers participated in a data call last fall, reporting their results in the individual market. Data collected for both the individual and the group marketplace appear to be very competitive. The group insurance market is already meeting the proposed loss ratios. Even though we do not have rate regulatory authority over the group insurance business at this time, it is a competitive marketplace. The marketplace is forcing the carriers to compete and that is a good thing.

Chair Mastroluca:
Mr. Duarte did you have something to add?

Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
Yes, I think Assemblyman Livermore is asking if there is significant transparency in the contracts that insurance companies have negotiated with their provider networks. Many consumers are interested in knowing if they are getting a good deal. I think that is an issue that will have to be addressed through the exchange, once it is established in 2014. The exchange will be a balancing act between aggressive oversight and purchasing. Will the exchange become a purchaser that aggressively manages the plans that are offered to make sure the consumer is getting the best deal or will it be a contract facilitator? It will probably be a blend of both. I know there is a lot of consumer interest to

ensure that our insurance companies are getting the best deal from the provider communities.

Michael Willden:
Before I leave this subject, I would like to highlight some items on pages 8 and 9 of Exhibit C that are in our budget, such as the Community Living Assistance Services and Supports (CLASS) Act. We have budgeted $50,000 to assess whether or not Nevada has an adequate infrastructure of personal care attendants to provide the services detailed in the CLASS Act. Other budgetary issues for which we have attempted to plan include funding the health insurance exchange, hospital acquired infections—we will no longer make payments beginning July 2011—and fraud, waste, and abuse.

We are holding the federal government's feet to the fire to 100 percent fund the planning and implementation of the state-operated health insurance exchange until 2015. We have already applied for a planning grant and staff. I should recognize Gloria Macdonald, who is part of the staff that is now in the second phase of planning and implementation, which we call the cooperative agreement phase. We will be putting in a request for additional federal funding as we proceed to the next steps of planning and implementation. However, beginning in 2015, Nevada will need to have a plan in place to ensure the exchange is self-funded or self-perpetuating.

There continues to be a lot of discussion regarding fraud, waste, and abuse. Mr. Duarte's budget has a significant number of requests dealing with this issue. Actually, dealing with fraud, waste, and abuse saves a substantial amount of money in the budget. Over the next two years, we have budgeted $1.5 million from the General Fund, which should save about $8 million over the next two years.

We talked earlier about enhanced payments to primary care providers that begin in CY 2013 and extend through CY 2014. These payments will be handled through federal reimbursement. The state will need to make a decision in CY 2015 if we will continue enhanced payments using state funds or roll back to the pre-2013 reimbursement schedule to primary care providers.

Chair Mastroluca:
Can we stick to policy issues?

Michael Willden:
Finally, the health care exchange must be operational by January 1, 2014. Our goal, through our BDRs and budgetary planning, is to roll out a Nevada-operated exchange by that deadline. However, the Secretary of the U.S. Department of

Health and Human Services can decide January 1, 2013 that Nevada is not making adequate progress and allow the federal government to take over the implementation process.

Chair Mastroluca:
Can you share with me why Nevada chose to create our own exchange and not partner with another state?

Michael Willden:
The only decision we have made so far is to not allow the federal government to run the exchange. We have not ruled out a partnership with another state; in fact, we have spent a considerable amount of time talking with Utah regarding this issue. As we work through the next two years of planning, we may eventually join a regional concept. We will decide if it makes better sense to form a collaboration with Utah or Arizona or another state. The direction we currently have received from the Governor and those involved in the planning process, including insurance carriers, is that we need an exchange that is run locally, not by the federal government.

Chair Mastroluca:
That is good to hear. Since Utah's exchange is almost set up, that might be a good place for us to watch and learn.

Michael Willden:
I would mention that Utah's exchange also has a long way to go in order to meet federal requirements.

Assemblyman Livermore
Would you be able to buy long-term care insurance through the exchange?

Michael Willden:
No, I do not believe there is any contemplation to broker long-term care insurance through the exchange.

Charles Duarte:
The CLASS Act sets up a voluntary, employer-based contribution insurance plan for people to purchase long-term care policies that have a limited dollar benefit. It is envisioned that the CLASS Act could potentially be expanded in the future to include a larger long-term care benefit. Right now, that act does not exist. It is going to be implemented, but it will be a voluntary employer-based program.

Assemblyman Livermore:
I asked that question because a large number of individuals do not have long-term care insurance. When they reach that age, it becomes a Medicare or state problem. If you are intelligent enough, you can shop for it in the market and get a good deal. I thought if long-term care were offered through the exchange it might save the state a lot of money in senior care.

Charles Duarte:
Right, Medicare is the long-term care plan for a lot of people.

Michael Willden:
In conclusion, we are on track to implement the exchange in 2014. It needs to be self-funding and viable by 2015. The last document I would highlight is our proposed BDR (Exhibit F), which should be transmitted from the Governor's office today. The bill will establish a health care exchange in Nevada called "The Silver State Health Insurance Exchange." It will be an independent public entity. We have discussed where the exchange should be housed, its governance structure, and whether it will be a 501(c)(3) nonprofit or an independent public agency. The Department does not believe it should be housed in Medicaid, the DHHS, or the Division of Insurance.

We have looked at other states' legislation to outline some of the duties and powers of the exchange, such as the provision to hire staff. We are recommending that the exchange be governed by a seven-member board of directors which must possess certain outlined knowledge, skills, and abilities. We have suggested that a number of exofficio, non-voting members also sit on the board. These are recent changes. Someone from the DHHS, Mr. Duarte or I, would take an exofficio seat because of our need to interface and provide expertise. The Director of the Department of Administration, Andrew Clinger or his appointee, as well as the administrators from the Department of Business and Industry and the Division of Insurance would also be exofficio advisors.

We hope that this legislation will be passed to establish the governance structure or model that will lead us through the next few years until actual implementation of the exchange. We have purposely left out how the exchange will be financed from 2015 forward. We do not currently have the answer to that question; we will need to do a lot of work between now and the next legislative session regarding that issue. However, the governance structure is needed now so that we can continue with the planning and implementation phase. I chair a work group that meets three times a month that would eventually transform into the health insurance exchange governance structure; hopefully that transition will begin this summer. There is more detail contained in the packet I have provided and I would be happy to answer questions.

Chair Mastroluca:
Are there any other questions? Are there any comments from the Committee? Is there any public comment? [No response was heard.]

This meeting is adjourned [at 12:43 p.m.]

RESPECTFULLY SUBMITTED:

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Mitzi Nelson
Committee Secretary

APPROVED BY:

_____
Assemblywoman April Mastroluca, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: February 25, 2011 Time of Meeting: 12:04 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
	C	Michael Willden	Health Care Reform presentation
	D	Michael Willden	Letter to Secretary Kathleen Sebelius re:MRL waiver
	E	Michael Willden	PCIP information
	F	Michael Willden	Copy of Nevada Health Insurance Exchange BDR draft