MINUTES OF THE
SENATE COMMITTEE ON COMMERCE, LABOR AND ENERGY

Seventy-Seventh Session
March 27, 2013

The Senate Committee on Commerce, Labor and Energy was called to order by Chair Kelvin Atkinson at 1:30 p.m. on Wednesday, March 27, 2013, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412E 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 Kelvin Atkinson, Chair
Senator Moises (Mo) Denis, Vice Chair
Senator Justin C. Jones
Senator Joyce Woodhouse
Senator Joseph P. Hardy
Senator James A. Settelmeyer
Senator Mark Hutchison

GUEST LEGISLATORS PRESENT:

Senator Barbara K. Cegavske, Senatorial District No. 8

STAFF MEMBERS PRESENT:

Marji Paslov Thomas, Policy Analyst
Dan Yu, Counsel
Wayne Archer, Committee Secretary

OTHERS PRESENT:

Michael Edwards, M.D.
Michael Hackett, Nevada State Medical Association; International Myeloma Association
Bill Welch, Nevada Hospital Association
Denise Selleck Davis, Nevada Osteopathic Medical Association
Lesley Pittman, Nevada State Society of Anesthesiologists

Allison Copening, Cover Up Nevada
Cari Herington, Nevada Cancer Coalition
Gary Milliken, American Suntanning Association
Tom McCoy, American Cancer Society Cancer Action Network
Lindsay Eaton, Nevada Justice Association
John Carpenter
John Ellerton, M.D.
Carla Brutico, R.N., Oncology Nursing Society
Shannon Hogan
Bob Ostrovsky, Nevada Association of Health Plans
Liz MacMenamin, Retail Association of Nevada
Josh Griffin, Health Services Coalition; MGM Resorts International; Med-Care Solutions
Adam Plain, Insurance Regulation Liaison, Division of Insurance, Department of Business and Industry
Rusty McCallister, Professional Firefighters of Nevada; Las Vegas Firefighters Local 1285
Laurie Squartsoff, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Yvanna Cancela, Culinary Workers Union Local 226
John Sande IV, Express Scripts Holding Co.
John D'Angelo, M.D., Banner Churchill Community Hospital
Robert Groves, M.D., Banner Health
Alfredo Alonso, Banner Health
Keith Lee, Board of Medical Examiners
Joan Hall, Nevada Rural Hospital Partners Foundation
S. Paul Edwards, General Counsel, State Board of Pharmacy
Steven Valenti, Med-Care Solutions

Chair Atkinson:
I will now open the hearing on Senate Bill (S.B.) 211.

SENATE BILL 211: Requires certain health care practitioners to communicate certain information to the public. (BDR 54-14)

Senator Barbara K. Cegavske (Senatorial District No. 8):
Senate Bill 211 promotes truth in advertising for health care services. Patients are bombarded with advertisements and claims for health care services provided by physicians and nonphysicians. Health care providers must be truthful in how

they market themselves, but the Internet gives limitless ability for anyone to say anything. Senate Bill 211 ensures health care providers will promote only those services they are legally allowed to provide. To provide increased clarity and transparency, S.B. 211 will ensure patients know the education, training and licensure of their health care provider. This measure does not increase or limit a practitioner's scope of practice. Instead, it increases transparency so patients can make informed decisions about who provides their care.

Section 1, subsection 1, paragraph (a) of S.B. 211 requires advertisements for health care services to include the type of license held by practitioners named in the advertisement. Advertisements must not contain any deceptive or misleading information.

Section 1, subsection 1, paragraph (b), subparagraph (1) of S.B. 211 requires health care practitioners to display conspicuously a written patient disclosure statement identifying the type of license they hold. Section 1, subsection 1, paragraph (b), subparagraph (2) of S.B. 211 requires health care practitioners who wear a name tag to identify on their name tag the types of licenses they hold.

Section 1, subsection 1, paragraph (d) of S.B. 211 prohibits physicians or osteopathic physicians from using the term "board certified" unless the physician discloses the full name of the board by which he or she is certified. The board must be a member of either the American Board of Medical Specialties or the American Osteopathic Association.

Section 1, subsection 1, paragraph (f) provides that a health care practitioner who violates any provision of this section may be subject to professional discipline.

Section 1, subsection 2, paragraph (a) of S.B. 211 exempts veterinarians and other individuals licensed by the State Board of Veterinary Medical Examiners.

Michael Edwards, M.D.:
I support S.B. 211 because it would provide clarity and transparency for patients. Senate Bill 211 will help alleviate the "white coat confusion" that exists in health care settings. Patients often mistake nonmedical providers for medical doctors. A telephone survey conducted by the American Medical Association in 2010 showed 68 percent of respondents erroneously believed

podiatrists are medical doctors. The same survey reported 43 percent of respondents erroneously believe otolaryngologists are not medical doctors.

Patients deserve to know precisely whether the professional treating them is a physician, physician's assistant, advanced nurse practitioner, nurse, medical assistant or technician. Uninformed choices can lead to unintended consequences or adverse outcomes. Patients should be informed of the specific training and credentials of their health care provider.

There are virtually no restrictions on how health care professionals focus their practices within their specialized field of care. Senate Bill 211 would establish clear parameters for which health care practitioners can use the term board certified. The term board certified is not sufficiently specific for patients to understand the type of training their health care providers have completed. As a board certified plastic and general surgeon, I could open a Laser-Assisted in situ Keratomileusis, LASIK, clinic, and advertise myself as board certified without stating the qualification that my certification is not in ophthalmology. This is but one example of how the public can be misled. Requiring physicians to note the full name of the board from which they receive their certificate would provide additional transparency.

The public should be confident advertisements for health care services are clear and informative, not misleading or confusing. The survey I referenced earlier reported less than half of respondents felt confident health care professionals only advertised services for which they are properly trained. Patients deserve to know their physicians have completed the requisite training and education necessary to provide the specialty care they are seeking.

Senator Jones:
I am concerned the posting requirement in section 1, subsection 1, paragraph (b), subparagraph (1) of S.B. 211 does not make sense for doctors in a hospital setting. Would you oppose an amendment to exempt doctors who practice in a hospital setting?

Senator Cegavske:
I would not oppose such an amendment. It is my understanding the credentials of all the doctors practicing in a hospital are posted already.

Dr. Edwards:
Hospitals have credentialing committees who vet physicians prior to issuing them privileges. I would have no problem with an amendment.

Senator Hutchison:
I agree with Senator Jones' comments. I am also concerned about the visibility requirement for the written disclosure in section 1, subsection 1, paragraph (b), subparagraph (1) of S.B. 211. How will this provision be monitored? Will the Board of Medical Examiners establish some set of criteria?

Dr. Edwards:
I will check to see how this has been addressed in other states. The Board of Medical Examiners could recommend specific signage, just as the State Board of Pharmacy has done with regard to prescriptions. The enforcement process is driven by complaints, and it may have to rely on an honor system. The Board of Medical Examiners does not have the ability to perform spot inspections.

Michael Hackett (Nevada State Medical Association):
The Nevada State Medical Association (NSMA) supports S.B. 211. The NSMA has proposed an amendment to section 1, subsection 1, paragraph (d) of S.B. 211 (Exhibit C). A national medical specialty group advised the NSMA the language in S.B. 211 failed to identify the specialty certifications options correctly. The proposed amendment was developed with this group to address this specific concern.

Bill Welch (Nevada Hospital Association):
The Nevada Hospital Association supports S.B. 211, but it shares Senator Jones' concern about doctors practicing in hospitals. We have spoken with Senator Cegavske and have submitted an amendment to section 2 of S.B. 211 (Exhibit D). The proposed amendment would insert a new paragraph exempting health care services provided in medical facilities licensed under *Nevada Revised Statutes* (NRS) 449 or 450.

Denise Selleck Davis (Nevada Osteopathic Medical Association):
The Nevada Osteopathic Medical Association supports S.B. 211. Transparency is vital for patient safety.

Leslie Pittman (Nevada State Society of Anesthesiologists):
The Nevada State Society of Anesthesiologists supports S.B. 211.

Senator Cegavske:
I support the amendments proposed by Mr. Hackett and Mr. Welch.

Senator Denis:
I will close the hearing on S.B. 211 and open the hearing on S.B. 267.

SENATE BILL 267: Establishes provisions governing tanning establishments. (BDR 52-958)

Senator Joyce Woodhouse (Senatorial District No. 5):
I sponsored S.B. 267 because cancer prevention is an intensely personal issue for me. I will read my written testimony (Exhibit E).

Senator Hardy:
Section 8, subsection 1, paragraph (a) of S.B. 267 requires a parent or guardian to be physically present at the tanning establishment. I understand this to mean the parent or guardian has to be present to provide written consent, but need not be present for the tanning.

Senator Woodhouse:
Yes, that is my intent.

Senator Settelmeyer:
How does the fine set in section 12 compare to the fines imposed by other states with similar restrictions?

Senator Woodhouse:
I will research fines in other states and get back to you.

Allison Copening (Cover Up Nevada):
I support S.B. 267 because it protects children with virtually no expense to the State. As a small business owner, I am sensitive to legislation that impacts businesses. Senate Bill 267 will have little impact on businesses, but it will have a huge impact in the fight to protect children against skin cancer.

The *Las Vegas Review-Journal* recently selected its favorite tanning establishment based in part on the fact it offered sunless tanning options. It is refreshing to see mainstream media recognize the dangers tanning beds pose. Most parents do not want their children to use tanning beds, and they are

probably not aware their children are using them. Senate Bill 267 will allow parents to have more involvement in the lives of their children, and it will give parents greater control to guide them to safer alternatives.

Senator Hutchison:
Are you aware of any litigation demonstrating the dangers of tanning?

Ms. Copening:
I am not aware of any such litigation. This effort is based on the overwhelming science linking tanning to cancer.

Cari Herrington (Nevada Cancer Coalition):
The World Health Organization includes the radiation resulting from ultraviolet tanning in the same category as plutonium and cigarettes. Dermatologists are diagnosing thicker tumors in younger women as well as in areas that are not usually exposed to the sun, such as the breasts and genitals. These areas are often exposed in ultraviolet tanning booths. While melanoma tumors are curable if diagnosed and treated early, melanoma is an aggressive cancer that can spread quickly.

Thirty-three states regulate indoor tanning for children under the age of eighteen. California and Vermont have banned the use of tanning devices by minors. Twenty-one states are considering similar legislation. To make this legislation as effective, we encourage the Committee to ban those under the age of 18 from using tanning devices. The State protects children from the dangers of smoking, drinking and driving before they fully understand the risks. The State should do the same for tanning devices.

Gary Milliken (American Suntanning Association):
The American Suntanning Association is concerned about section 8 of S.B. 267, which relates to parental identification and consent. Other states requiring parental consent have proscribed universal consent forms. I have submitted such a form for the Committee's review (Exhibit F). Tanning operators do not want minors using tanning booths without parental consent, and a general form will help operators comply with the requirements of S.B. 267.

Our other concern relates to the fines imposed under section 12, subsection 2 of S.B. 267. In response to Senator Settelmeyer's question, the

fines for violating consent requirements vary among the states. I will work with Senator Woodhouse to provide the Committee more information on the fines other states impose.

Senator Hutchison:
How do you feel about the provision in section 12, subsection 2 of S.B. 267, which requires courts to award court costs and attorney's fees? Do you know what other states do?

Mr. Milliken:
I addressed this issue with Senator Woodhouse, and I will research how other states have addressed it.

Senator Hardy:
The document you have submitted is copyrighted. Will the Committee have to come up with its own?

Mr. Milliken:
The document was only intended as an example of the type of form the Committee could proscribe. The tanning industry would prefer to have a standard form every establishment can use.

Tom McCoy (American Cancer Society Cancer Action Network):
The American Cancer Society Cancer Action Network (ACS CAN) opposes S.B. 267. Nationally, 12,000 people die from skin cancer each year. Of those, 9,000 result from melanoma. In Nevada, someone dies from melanoma cancer every 3 days.

But for the fact S.B. 267 permits minors to use tanning devices with parental consent, I would not be opposed to S.B. 267. The facts presented to you today show how S.B. 267 misses its goal. The risks of tanning do not disappear because a parent signs a permission slip. The radiation from tanning devices is 15 times greater than noontime sun.

Texas, one of the first states to require parental consent, has observed compliance rates as low as 11 percent. There is no nexus between parental consent and measurable decreases in indoor tanning.

The U.S. House Committee on Energy and Commerce conducted spot inspections at 300 salons across the Nation, including 3 in Nevada. Nearly all salons denied the risks of indoor tanning to investigators. Four out of five falsely claimed indoor tanning has positive health benefits. Several salons claimed tanning prevents cancer and that it would help remove cellulite.

The Legislature has imposed prohibitions to protect children from harmful substances and behaviors, such as alcohol. The dangers of indoor tanning should be viewed in the same light.

Senator Hutchison:
Can you explain Texas' compliance rate?

Mr. McCoy:
The compliance rate refers to tanning establishments complying with the parent consent requirements.

Senator Hutchison:
Does that mean minors are able to use tanning devices in 89 percent of spot inspections? Are you saying the parental consent requirement is not working in Texas?

Mr. McCoy:
The parental consent requirement is not effective in Texas. Many of the states that have passed legislation requiring parental consent are moving towards outright bans because it has not proven effective. If S.B. 267 did not allow minors to tan with parental consent, I would not be in opposition to it.

Lindsay Eaton (Nevada Justice Association):
The Nevada Justice Association is neutral on S.B. 267. I want to clarify that the immunity provision in section 12, subsection 4 of S.B. 267 only applies to the consent to tan. It does not extend to any other cause of action arising from negligent conduct on behalf of the tanning establishment or an employee thereof. The consent form should not immunize tanning operators from negligent conduct beyond that described in section 12, subsection 4 of S.B. 267.

Senator Hardy:
How much does a tanning treatment cost? I suspect the cost is such that children receiving these treatments likely do not pay for them with their own money. Rather, I think their parents are likely to be the ones paying for the treatments.

Senator Woodhouse:
I do not know how much the treatments cost. I will research the cost and get that information to you. I will also work to address the concerns of those who are opposed to S.B. 267.

Chair Atkinson:
I will close the hearing on S.B. 267 and open the hearing on S.B. 266.

SENATE BILL 266: Requires certain policies of health insurance and health care plans to provide comparable coverage for orally administered chemotherapy. (BDR 57-879)

Senator Moises (Mo) Denis (Senatorial District No. 2):
As cancer therapies have advanced dramatically in recent years, many insurance policies have not kept pace. Although the majority of chemotherapy is still administered intravenously, many cancer treatments can now be administered orally. For some types of cancers, the primary form of treatment is oral chemotherapy. Unfortunately, the cost of oral chemotherapy is substantially higher than intravenous administration.

Senate Bill 266 ensures Nevadans diagnosed with cancer can receive the best treatment available by making the out-of-pocket costs for all cancer treatments the same regardless of administration. For those insurance companies that elect to provide coverage for cancer treatments, Senate Bill 266 would require insurance companies to charge the same co-payment for drugs administered orally as for ones administered intravenously. The intent of S.B. 266 is to ensure the course of treatment is a medical decision and not a financial one.

Mr. McCoy:
Senate Bill 266 ensures cancer patients have a level "paying" field with regard to out-of-pocket expenses for treatments. Carriers generally cover intravenous chemotherapy under a health plan benefit, whereas orally administered treatments are covered under a pharmacy benefit. Intravenous treatments are

subject to a co-payment, but orally administered treatments are subject to high out-of-pocket expenses under cost-sharing schedules.

In addition to my written testimony (Exhibit G), I have submitted an information packet prepared by Dr. James Cohen of the Renown Institute for Cancer (Exhibit H). The information packet includes the monthly cost of various types of cancer treatments under cost-sharing plans. On page 2 of Exhibit H, the cost per patient, per month for medications to treat myeloid leukemia could exceed $13,966 under a 25 percent coinsurance plan.

Senate Bill 266 would bring dispensing parity to cancer patients, and would preclude an increase in patients' deductibles, co-pays and coinsurance. It also prohibits insurance companies from reducing monetary limits to achieve compliance with S.B. 266. No new coverage is mandated by S.B. 266. Instead, S.B. 266 only addresses disparity in plans that currently cover cancer treatments.

The ACS CAN estimates 13,000 Nevadans will be diagnosed with cancer this year. Nearly 20 percent of those diagnoses will require orally administered medications. As cancer treatments advance, this trend will increase. Senate Bill 266 will equalize out-of-pocket costs, which will reduce the financial barriers to treatment for cancer patients. A few carriers have already taken steps to reduce the disparity, but S.B. 266 will continue that process. Twenty-two other states have passed similar legislation, and claims that premiums would increase have been proven wrong.

Chair Atkinson:
You testified that premiums have not increased in states that have enacted similar legislation. Is that correct?

Mr. McCoy:
Our research has shown that premiums have not increased. In fact, cost-sharing plans increase the cost to insurers because patients often do not take the full dose due to the high cost of the pills.

Senator Settelmeyer:
This would be a tremendous benefit in rural Nevada, where it can be difficult for patients to travel to a hospital for intravenous chemotherapy. The side effects of chemotherapy, regardless of administration, are painful. Have other states

found that patients skip doses due to the side effects, since it is harder for patients to skip intravenous chemotherapy treatments?

Mr. McCoy:
I do not have an anecdotal response, but I would say the responsiveness to treatments depends on the patient's relationship with his or her doctor.

Chair Atkinson:
I want to point out that New York, New Jersey, Kentucky and Vermont are also considering similar legislation.

Senator Hardy:
Do you have a breakdown of the cost for intravenous chemotherapy? More importantly, do you know how much the pills actually cost, as opposed to how much patients are charged?

Mr. McCoy:
I do not have access to the actual cost of these treatments. I can tell you from an administration standpoint there is a significant overhead cost to intravenous chemotherapy, but it is still treated as a health benefit with an appropriate co-payment. On the other hand, orally administered chemotherapy is covered under a pharmacy benefit with much higher coinsurance.

Michael Hackett (International Myeloma Foundation):
The International Myeloma Foundation supports S.B. 266. Twenty-two states have passed legislation requiring coverage for oral chemotherapy treatments. Oral treatments are available for a wide range of cancers. A standard course of treatment for myeloma includes two injectable anticancer treatments, two orally administered drugs and stem cell transplants. Myeloma is a recurring disease, so patients typically cycle through all of these treatment options to control the cancer. For this reason, it is critical cancer patients have equal access to all available treatments.

Senate Bill 266 does not mandate coverage. It only impacts plans that include chemotherapy as a benefit. Most insurers cover oral chemotherapy treatment, so S.B. 266 simply instructs insurers to apply the same cost-sharing rules to orally administered treatments as they do to intravenous treatments. The intent of S.B. 266 is to ensure patients receive care that is medically necessary. Oral chemotherapy drugs do not always have intravenous or generic

equivalents and are specifically indicated as the first and most-effective treatments for many types of cancers.

The first oral chemotherapy access legislation was enacted in 2008. Studies conducted in Indiana, Texas, Washington, Oregon and Vermont reported the legislation did not increase health insurance premiums. Nearly 30 percent of new cancer therapies in the research pipeline will be administered orally. Senate Bill 266 should cover treatments regardless of administration. In addition to my comments, I have submitted my written testimony for the Committee (Exhibit I).

Senator Joyce Woodhouse (Senatorial District No. 5):
I support S.B. 266 and want to share how oral chemotherapy helped my sister during her struggle with brain cancer. I will read my written testimony (Exhibit J).

Senator Settelmeyer:
I appreciate your story very much. Since your sister received oral chemotherapy, how did her doctors manage her white blood cells? Often patients need white blood cell injections which can cost $20,000.

Senator Woodhouse:
My sister Francie had to have her blood drawn every week while she was on the oral chemotherapy, but she did not have to receive injections.

John Carpenter:
I support S.B. 266 because of my daughter's painful struggle with breast cancer. It would be great if people suffering from this horrible disease could have access to oral chemotherapy. I attended some of my daughter's intravenous chemotherapy treatments. It is one of the most heart-wrenching experiences I have endured. It is a terrible experience with painful side effects. Although oral chemotherapy has its own side effects, they are nothing compared to those of intravenous chemotherapy.

I would like to have my written testimony submitted for the record (Exhibit K).

John Ellerton, M.D.:
Many of the advancements in cancer treatments have led to oral agents. Traditional cancer treatment is treated under the health benefits, while oral

therapies are treated under pharmacy benefits. As an oncologist, my concern is so great because the payments can be insurmountable. For example, intravenous therapies are covered under a fixed-price schedule. With oral medications, patients generally have a 20 percent coinsurance. For example, looking at Exhibit H, the monthly cost for Zytiga, a common drug used in the treatment of prostate cancer, is $6,983. Although some of the oral chemotherapy drugs are incredibly effective, some of them have limited benefits which makes the disparity even more confusing.

I have young patients who struggle to pay for these life-saving drugs. Although it is not their responsibility, I know many nurses who work to find alternate sources of funding to support these large co-payments for their patients.

Most of the intravenous therapies are generic and not very expensive. A whole course of treatment for some patients could cost as little as $100. Even with the costs of administering intravenous chemotherapy, the total cost does not even come close to the $6,000 for the prostate cancer drug I mentioned earlier.

I urge the Committee to include strong language to prevent the circumvention of these laws. Otherwise, insurance companies will try to find ways to get around the legislative intent.

Carla Brutico, R.N. (Oncology Nursing Society):
I am an oncology nurse, and I represent the Oncology Nursing Society. In the past, intravenous chemotherapy was the only therapy available to cancer patients. Today, oral chemotherapy drugs are becoming the standard care in cancer treatment. There has been an explosion in knowledge related to cancer research, and we know more about how cancer cells work. While these drugs are referred to as oral chemotherapy drugs, the drugs work in very different ways than traditional chemotherapy. Traditional chemotherapy is intravenous, using the blood as a pathway. This process kills cancer cells and normal cells, which is why traditional chemotherapy has many painful side effects. Oral chemotherapy works inside cancer cells, sparing normal cells with very few exceptions. No medication is without side effects, and oral chemotherapy drugs can cause fatigue, rashes and low blood counts. Since oral cancer drugs spare normal cells, more and more oral therapies will be developed. It is estimated between 25 percent to 40 percent of all new cancer fighting drugs will be orally formulated. Co-payments for traditional chemotherapy run from $25 to $45, while the coinsurance for oral chemotherapy drugs are thousands of dollars

under cost-sharing plans. The medications are not available from retail pharmacies because they are too costly to keep in stock. Patients must be registered with a special pharmacy and often receive the drugs by mail.

Patients receive intravenous chemotherapy through a regimen of specific cycles. Patients receiving oral chemotherapy stay on until their disease progresses, which could be years. Some patients who began taking these drugs in clinical trials 5 years ago are still taking them. The out-of-pocket costs have prompted patients either not to fill the prescriptions or skip doses. Either result decreases the efficacy of the treatment.

Oral chemotherapy drugs are not a choice of convenience. Oral chemotherapy drugs may be prescribed in addition to intravenous chemotherapy, but they have no intravenous counterparts. The dosing schedules for oral chemotherapy drugs are complex and inconvenient. Patients must self-monitor and report to health care providers frequently. Although they are lifesaving, oral cancer drugs are not as convenient as many think them to be.

Senate Bill 266 is needed to bring insurance benefit design in line with medical innovation. The State should ensure all patients have access to the treatments most beneficial to them.

Shannon Hogan:
I am a member of the Board of Trustees of the Susan G. Komen for the Cure Northern Nevada Affiliate, but I am here my own behalf to support S.B. 266.

Ms. Herrington:
The Nevada Cancer Coalition (NCC) supports S.B. 266 which will increase access to cancer treatments. No one should have to choose between paying rent and paying for cancer medication. Unfortunately, that is what this inequity has forced. The NCC receives requests from many cancer patients seeking financial assistance. There are not many options for them. The Nevada Public Health Association, the Northern Nevada Children's Cancer Foundation and the Susan G. Komen for the Cure Southern Nevada Affiliate all support this bill.

Ms. Eaton:
If a health insurance plan offers insurance coverage for chemotherapy, it is only fair to extend the same coverage to all types of chemotherapy. Senate Bill 266 takes a proactive approach to achieve equal coverage. It protects Nevadans on

the front end, rather than having to hire attorneys to fight for equal coverage. Senate Bill 266 protects the public.

Bob Ostrovsky (Nevada Association of Health Plans):
Not all insurance companies treat intravenous chemotherapy and oral chemotherapy differently. For the most part, Nevada's health plans provide major medical benefits. We provide a pharmacy benefit that covers oral chemotherapy in tiers. Some of those have cost-sharing agreements and some have simple co-payments. There are many companies that provide low-cost oral cancer drugs. Our concern is finding a way to meld the pharmacy benefit with a major medical benefit. Under S.B. 266, an individual moving from a pharmacy benefit to a major medical benefit could actually end up having to pay more. For example, high deductible plans require a much higher out-of-pocket expense before insurers begin paying a major medical benefit.

I am concerned with the effective date. Insurers have submitted plans to the Silver State Health Insurance Exchange under the Affordable Care Act (ACA), which goes into effect January 2014. I do not know if the State is in a position to go back and change those submissions to get federal approval. We would like to discuss the possibility of submitting an amendment to delay the effective date.

Finally, I want to confirm patients can continue to use specialty pharmacies. If an oral chemotherapy drug is prescribed, a patient can get that drug filled twice at a regular pharmacy. Insurers then call and write patients directing them to a specialty pharmacy due to the high cost of the drugs. I will work with supporters on these issues because we support Senate Bill 266.

Chair Atkinson:
I hope you are sincere in your support for S.B. 266. I have a strong interest in seeing S.B. 266 pass. Many lobbyists insist they support legislation only to amend it in ways that end up killing it.

Mr. Ostrovsky:
We will work very quickly with Senator Denis, and we will not "love this bill to death."

Senator Hutchison:
Is this doable under the Affordable Care Act?

Mr. Ostrovsky:
This is doable, but the issue is how quickly the insurers can get it into place before the ACA goes into effect.

Liz MacMenamin (Retail Association of Nevada):
The Retail Association of Nevada believes everyone deserves the best access to health care. We do not believe S.B. 266 accomplishes this goal because it exempts certain health plans. I will work with Senator Denis to address my concerns.

Senator Hutchison:
Can you explain which health plans are exempted from S.B. 266?

Ms. MacMenamin:
A large portion of the underprivileged would be ineligible to receive this new benefit because the State's Medicaid plan is exempted from S.B. 266.

Senator Settelmeyer:
Will this cover State employees?

Ms. MacMenamin:
I cannot ascertain who will be covered and who will not be covered. Commercial health insurance providers are included. I represent some of the specialty pharmacies other testifiers have mentioned, and I can provide the Committee with studies they have conducted related to oral chemotherapy drugs.

Chair Settelmeyer:
You testified S.B. 266 exempted certain health plans. I am not aware S.B. 266 exempts any health plans. Am I missing something?

Ms. MacMenamin:
The State Medicaid plan is excluded.

Chair Atkinson:
You are incorrect.

Ms. MacMenamin:
I stand corrected. I am neutral to S.B. 266 then.

Josh Griffin (Health Services Coalition; MGM Resorts International):
The Health Services Coalition (HSC) is comprised of many health insurance providers, and it is neutral to S.B. 266. The HSC wants our members to receive the best treatment possible, but there are costs associated with S.B. 266. Even if mandates are imposed and premiums do not go up, other cost reductions may occur. I will work with Senator Denis to determine how the increased costs resulting from S.B. 266 can be spread out among those subject to its mandate.

It is difficult to say precisely which plans will be subject to the new benefit under S.B. 266. Some Employee Retirement Income Security Act (ERISA) plans are not governed by State law. However, some ERISA plans have contracts with commercial carriers. We want to ensure the costs are shared equally.

Adam Plain (Insurance Regulation Liaison, Division of Insurance, Department of Business and Industry):
As a matter of policy, the Division of Insurance is officially neutral to S.B. 266. The Division and the Silver State Health Insurance Exchange had some concerns about the cost to the State because the ACA requires the State to defray the cost of new mandates. After conferring with the U.S. Department of Health and Human Services (HHS), it does not appear there will be a cost to the State. We cannot guarantee that will be the case in the future, as HHS refused to put that in writing.

Senator Hutchison:
Do you have confidence in the interpretation of the HHS since they would not put it in writing? I fear the HHS would tell the State what it wants to hear right now but will change their mind in the future. If their interpretation changes, it could cost the State a lot of money.

Mr. Plain:
You are correct. The Centers for Medicare and Medicaid Services have generally tried to stick to it.

Senator Hutchison:
As a policy maker trying to figure out how much this will cost the State, that answer does not comfort me.

Mr. Plain:
After reviewing the Federal Register, there would be no cost to the State

because this is a new type of treatment and not a new mandate of treatment. The Division has heard from other states whose interpretations do not always hold up.

While it is true S.B. 266 would not mandate coverage of oral chemotherapy drugs, the ACA requires all insurers to cover at least one drug in every major pharmaceutical category. To the extent an orally administered chemotherapy drug is in a different pharmacopeia category than intravenous chemotherapy drug, insurers will be required to offer that drug.

With regard to affordability, a medical treatment is subject to a deductible, as well as an out-of-pocket maximum expenditure. Patients in a PPO may be responsible for out-of-pocket expenses until they hit their deductible. For example, a patient may be responsible for the first $2,000 of out-of-pocket expenses. After the threshold has been met, he or she would not have to pay anything out-of-pocket. On a pharmaceutical benefit, patients have first-dollar coverage, but out-of-pocket expenses are unlimited. The costs are not "apples to apples." With HMOs, patients have a single co-payment.

Senate Bill 266 does not address parity and administrative costs. Under PPO plans, patients receiving intravenous chemotherapy are billed separately for the drug, the office visit, the nurse and the doctor. Each one of those charges is subject to the PPO coinsurance. With an orally administered drug, that would not happen. Senate Bill 266 should make it clear whether parity includes the entire cost of the office visit for intravenous chemotherapy or the just the cost of the drug.

To achieve parity, S.B. 266 stipulates that the benefit level for oral chemotherapy drugs has to be increased to the benefit level of intravenous chemotherapy drugs. When the ACA becomes effective, most existing health plans will be noncompliant. The Division anticipates new health benefit plans will be created then. If every product in the market is new, there is no prior history to determine parity. The Division suggests the Committee clarify how parity will be determined when new products without comparable history come to market.

Rusty McCallister (Professional Firefighters of Nevada; Las Vegas Firefighters Local 1285):
The Professional Firefighters of Nevada are neutral to S.B. 266, and I will work with Senator Denis to minimize the effects on our small health insurance plan. Professional firefighters collectively bargain for their health care benefits, and every mandate results in cuts in services and benefits. The Legislature is considering at least five health care mandates this Session. Each of these mandates will have a financial impact. Additionally, there will be additional costs to our plans when the ACA takes effect in 2014.

Our plan covers oral and intravenous chemotherapy treatments, but we have to cut costs in other ways when we are mandated to control costs in a certain way. The average cost for intravenous chemotherapy under our plan is $1,000, whereas the least expensive oral chemotherapy drug is $5,000.

Laurie Squartsoff (Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
The Division of Health Care Financing and Policy has proposed an amendment to NRS 695G (Exhibit L). Senate Bill 266 is inconsistent in its application to our Medicaid vendors. Medicaid recipients are eligible for all chemotherapy services, including oral chemotherapy drugs. Section 6 of S.B. 266 exempts Medicaid health maintenance organizations, but section 8 of S.B. 266 does not exclude Medicaid Managed Care Organizations.

Yvanna Cancela (Culinary Workers Union Local 226):
I represent 55,000 workers and the 120,000 members our health care fund covers. While I understand the intent of S.B. 266, I am tremendously concerned about costs the fund would incur as a result of the mandate. Prescription drugs are expensive, and 80 percent of the cost of our pharmaceutical benefit is attributed to 20 percent of the pharmaceuticals. Senate Bill 266 could seriously jeopardize our ability to provide the best care for our members and their families. We want to work with Senator Denis to make sure those concerns are addressed.

Senator Hutchison:
Are you asking to be exempted from S.B. 266?

Ms. Cancela:
There are a number of ways we can work with the Senator Denis to find parity with regard to cost.

Senator Hutchison:
Short of exemption, do you see an opportunity for you to support this bill?

Ms. Cancela:
There is potential for a discussion that can lead to some solutions.

John Sande IV (Express Scripts Holding Co.):
Express Scripts Holding Co. is a plan benefit management company. We work with a number of providers to help them reduce the cost of health care. We are neutral to S.B. 266.

Senator Denis:
I will work to address the concerns raised during testimony on S.B. 266.

Chair Atkinson:
I will close the hearing on S.B. 266 and open the hearing on S.B. 327.

SENATE BILL 327: Revises provisions relating to health care professions. (BDR 54-772)

Senator Jones:
The State has a crisis in health care delivery, and it will only get worse as a flood of newly insured Nevadans come on board with the expansion of Medicaid and the implementation of the Silver State Health Insurance Exchange.

John D'Angelo, M.D. (Banner Churchill Community Hospital):
Banner Churchill Community Hospital (BCCH) is operated by Banner Health, a nonprofit health care system with 23 hospitals in 7 states. We are a 40-bed facility in Fallon, Nevada. Each year, the BCCH processes 2,200 admissions, 16,000 emergency visits and 37,000 outpatient visits. Of our 300 employees, 21 have completed "Stage 7," the final stage of adoption of electronic medical health records. We are the first hospital in the State to achieve this rating.

Banner Health is focused on innovation, and we became one of the first health care systems in the country to use Electronic Intensive Care Unit (eICU) technology. The eICU technology allows physicians to remotely monitor our ICU patients. However, State law limits our ability to provide this care to our patients at BCCH. Banner Health supports S.B. 327 because all of our patients should receive the same level of care, regardless of where they are located.

Robert Groves, M.D. (Banner Health):
Senate Bill 327 will improve access to quality care for Nevadans while reducing the cost of that care. My purpose is to give the Committee context to understand the service we provide. I have provided a slide presentation for the Committee to follow along (Exhibit M).

Slide 2 of Exhibit M, shows eICU technology is much more complex than the telemedicine with which you may be familiar. Slide 3 shows the demand for nurses and "intensivists" far exceeds the supply. This has contributed to a double standard in care. Patients admitted after hours have worse outcomes than those admitted during regular business hours. We also notice a disparity in care between urban centers and those in rural health care centers.

The traditional process by which we care for patients is wrought with hazard. Typically, nursing staff act as a surveillance mechanism for physicians. If a nurse identifies a problem, nursing staff must contact a managing physician. On a good day, this process can take 20 minutes. It can take up to an hour or longer on busier days. In this case, physicians are receiving secondhand information. The physician will then give orders based on this secondhand information. At each point, there is an opportunity for an error to occur.

Telemedicine is more than technology. It is not just hanging a camera in a patient's room. A number of processes and technologies must be implemented to do this effectively. While much of the care during this period is reactive, eICU allows physicians to monitor patients constantly and proactively. Sophisticated computer algorithms scan data streams to identify problems before they occur. Additionally, eICU specialists check on the most critical patients every hour. We have direct access to each patient's medical records and real-time vital signs.

A patient in an eICU can communicate directly with eICU specialists through the push of a button. This affords eICU physicians the opportunity to address minor problems before they become major complications. The eICU technology can be

especially helpful to family practitioners in rural Nevada who can receive consultative services from highly trained specialists to achieve the best outcome possible for their patients.

In addition to reactive care, eICU ensures evidence-based practice is being applied. This includes reliability science, intentional redundancy and tight feedback-control loops. A number of technologies help us achieve these goals, including intelligent independent alert screens which direct specialists to the patients in need. Computers are very good at identifying potential problems; human beings are not. Humans are excellent at solving complex problems and thinking on the fly, but computers are better at analyzing the minutia. I call eICU a "room with a view" because it gives eICU specialists the opportunity to see what is happening to each of our patients.

An example of how this has helped rural doctors is on slide 13 of Exhibit M. According to the CEO of Page Hospital in Flagstaff Arizona, their eICU allowed the hospital to care for many patients they would have had to transfer to other communities.

Senate Bill 327 has been written very broadly, and it will modernize State law so telemedicine can be used in a variety of applications. For example, stroke mortality can be reduced when patients can been treated remotely via telemedicine. Behavioral health specialists can effectively interact with and treat patients via telemedicine.

A chart titled "ICU Days Saved Beyond Predicted" is shown on slide 16 of Exhibit M. When a patient enters the ICU, physicians use a methodology called Acute Physiology and Chronic Health Evaluation to predict how long patients will remain in ICU. It also predicts their prognosis. Implementation of eICU technology has helped Banner Health increase the number of days saved from 1,427 in 2007 to 30,986 days in 2012. In addition to reducing the number of days spent in ICU, slide 17 of Exhibit M shows that eICU technology has helped Banner Health increase the number of non-ICU hospital days saved. Each day spent in ICU costs approximately $1,700. As you can see on slide 18 of Exhibit M, eICU technology helped save $83.9 million in treatments in 2012. The mortality numbers are equally impressive.

Banner Health supports S.B. 327 because it will improve the quality of health care, reduce costs and improve the patient experience.

Senator Hutchison:
It is my understanding S.B. 327 will only amend the definition of the practice of medicine. Is my interpretation correct?

Dr. Groves:
Yes. Senate Bill 327 will make it possible for physicians to use telemedicine to evaluate patients and prescribe treatments.

Senator Hutchison:
Can you comment on how many physicians are located outside of the United States?

Dr. Groves:
We have approximately 30 full-time physicians. Ten of those are based in Tel Aviv, Israel. Every single one of those physicians has been trained in the United States. They are licensed in Nevada, and they are credentialed and subject to peer review at the facility. They are disciplined in Nevada. Our experience has been extremely positive. Since 2006, we have established eICU units in Wyoming, Colorado, Nebraska and Arizona. We have not had any major challenges with this technology. Our malpractice claims are a quarter of what they were before we began this program. The cost is less than 20 percent of what it was before. In fact, Banner Health now pays more for legal counsel than we pay out for claims in the ICU.

Senator Hardy:
What are the qualifications of the specialists, and what are their roles compared to the attending physician?

Dr. Groves:
All of our physicians are certified by the Board of Medical Examiners as intensivists. Advanced practitioners would be duly licensed in Nevada, and would perform as any other advanced practitioner in Nevada. A "captain of the ship" is always present and responsible for patient care in the remote eICU. However, the physician at the bedside always has the last word.

Our experience has been that there is some resistance initially, but over time this turns to gratitude when the improved outcomes are seen. This is in part because it reduces our intensivists' stress. They are not constantly interrupted during the middle of the night for routine questions.

Senator Hardy:
In other words, there is a clear chain of command.

Dr. Groves:
That is correct. There are prescribed duties and escalation protocols, but the responsibility ultimately falls to the attending physician.

Senator Hardy:
Technically, it would not matter whether the individual monitoring the screen was located in Winnemucca or Tel Aviv.

Dr. Groves:
That is correct.

Alfredo Alonso (Banner Health):
Each section of S.B. 327 has been written to include telemedicine in the definition of the practice of medicine under the NRS. As a result, there is really no limit to the application of telemedicine. There has been some concern over section 14, subsection 5 of S.B. 327 as it relates to dispensing practitioners. While we do not want to remove this section completely, we are willing to discuss an amendment. We do not want to remove the ability of dispensing practitioners in rural Nevada to dispense prescriptions, but we also do not want individuals to dispense pharmaceuticals through telemedicine from another state.

Ms. MacMenamin:
The Retail Association of Nevada supports S.B. 327. I had planned on submitting an amendment related to pharmacies, but I have been advised by Committee counsel it is not germane.

Keith Lee (Board of Medical Examiners):
The Board of Medical Examiners has been working with Mr. Alonso during the interim on this legislation. The Board supports S.B. 327. Our main concern is that one must be licensed by and subject to discipline by the State to perform telemedicine services in Nevada. The Board has proposed a friendly amendment to allow the Board to serve letters and notices electronically (Exhibit N).

Joan Hall (Nevada Rural Hospital Partners Foundation):
The Nevada Rural Hospital Partners supports S.B. 327. Rural Nevada health care facilities need every tool available to meet the health needs of their communities. Telemedicine is an innovative application that helps meet these needs with a focus on access, value and improved outcomes. Senate Bill 327 increases the potential of specialty providers who would be allowed to provide telemedicine services to our rural community.

S. Paul Edwards (General Counsel, State Board of Pharmacy):
The State Board of Pharmacy opposes portions of S.B. 327. The United States Drug Enforcement Agency, U.S. Department of Justice, has identified Nevada as a key target for prescription drug abuse. Senate Bill 327 relaxes rules on the prescription of controlled substances and could result in further abuse. I do not see anything in S.B. 327 that would prevent a physician located overseas from prescribing, dispensing and shipping a controlled substance. I do not anticipate Banner Health's *iCare* system would violate such provision, but I am concerned about others who would push the envelope.

The State Board of Pharmacy is also concerned about the inspection of facilities. The Board inspects every facility licensed in Nevada. Under S.B. 327, the Board would not have the ability to inspect these facilities. If drugs can be prescribed and shipped to patients in Nevada, the State Board of Pharmacy does not have the opportunity to inspect the authenticity of the drugs. While we are not opposed to the expansion of telemedicine, the Committee needs to take a close look at S.B. 327 because it would allow additional controlled substances to circumvent the State's regulatory regime.

Senator Settelmeyer:
Can you point to a specific section that would allow telemedicine to be conducted from a pharmacy overseas?

Mr. Edwards:
Section 13, subsection 3 of S.B. 327 specifically authorizes registered pharmacists to engage in the practice of pharmacy electronically. The practice of pharmacy includes dispensing drugs. Section 13, subsection 4 of S.B. 327 is also problematic to that extent.

Senator Hardy:
Senator Jones has already indicated the sponsors are looking to remove section 14 of S.B. 327. I suspect they are willing to amend section 13 to alleviate any of the State Board of Pharmacy's fears. I also suspect the Committee will support those amendments.

Mr. Edwards:
The Pharmacy Board would like to be involved in the process more heavily than we have been.

Senator Jones:
I will be happy to work with Mr. Edwards. I will note there was not an attempt to contact me before this.

Chair Atkinson:
I will close the hearing on S.B. 327 and will open the hearing on S.B. 351.

SENATE BILL 351: Prohibits certain activities relating to liens for health care services. (BDR 54-847)

Senator Hutchison:
Senate Bill 351 addresses medical liens which are often created when someone without car insurance is involved in a car accident. Physicians treating these individuals will often refer their patients to other physicians for other treatments. Those physicians treat on the basis of a lien as well. The first physician will then create a proxy company to acquire the second lien.

Josh Griffin (Med-Care Solutions):
Med-Care Solutions supports S.B. 351.

Steven Valenti (Med-Care Solutions):
Med-Care Solutions is an "accounts receivable" finance company that purchases medical liens from personal injury cases where the individual does not have insurance or has been injured as a result of negligence of others. In these cases, the individuals have no way of paying for their own medical bills until they settle their legal claims against the responsible party. Since the personal injury settlement process can be lengthy, many health care providers are unable or unwilling to treat patients on a medical lien basis due to the risks of default and delayed payment.

Our medical lien funding service provides a means for patients to receive care. We compensate the provider in advance so the patient can get the care he or she needs. In exchange, Med-Care Solutions acquires the medical lien and receives payment if and when the injured party settles the legal case.

Unfortunately, some chiropractors and other health care providers have begun to create proxy companies to acquire the medical liens of the patients they refer. This creates a remarkable conflict of interest. It creates a financial incentive for prolonged and unnecessary treatment, and it can jeopardize the integrity of the initial legal case. Finance companies and medical providers must keep themselves at arms' length and should not commingle their revenues. Finance companies should not interfere or involve themselves in any health care related decisions. In fact, to ensure Med-care remains absolutely separate and independent for the medical treatment process, we never even meet with the patient.

I support S.B. 351 because it will prevent financial self-dealing in the health care industry and promote integrity.

Chair Atkinson:
How widespread is this problem?

Mr. Valenti:
The scope of the problem is unknown. Part of the problem is that most victims do not talk about the problem because they are embarrassed. We know of competitors and doctors who engage in this practice.

Ms. Eaton:
The Nevada Justice Association supports S.B. 351.

Chair Atkinson:
I will close the hearing on S.B. 351. The meeting is adjourned at 5:03 p.m.

RESPECTFULLY SUBMITTED:

_____
Wayne Archer,
Committee Secretary

APPROVED BY:

_____
Senator Kelvin Atkinson, Chair

DATE: _____

EXHIBITS				
Bill	**Exhibit**		**Witness / Agency**	**Description**
	A	1		Agenda
	B	6		Attendance Roster
S.B. 211	C	1	Michael Hackett	Proposed Amendment
S.B. 211	D	3	Bill Welch	Proposed Amendment
S.B. 267	E	5	Senator Joyce Woodhouse	Written Testimony
S.B. 267	F	2	Gary Milliken	Handout
S.B. 266	G	2	Tom McCoy	Written Testimony
S.B. 266	H	5	Tom McCoy	Information Packet
S.B. 266	I	4	Michael Hackett	Written Testimony
S.B. 266	J	2	Senator Joyce Woodhouse	Written Testimony
S.B. 266	K	2	John Carpenter	Written Testimony
S.B. 266	L	1	Laurie Squartsoff/DHCFP	Proposed Amendment
S.B. 327	M	22	Dr. Robert Groves	Slide Presentation
S.B. 327	N	1	Keith Lee/BME	Proposed Amendment