MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Seventh Session
February 28, 2013

The Senate Committee on Health and Human Services was called to order by Chair Justin C. Jones at 3:30 p.m. on Thursday, February 28, 2013, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Justin C. Jones, Chair
Senator Debbie Smith, Vice Chair
Senator Tick Segerblom
Senator Joseph P. Hardy
Senator Ben Kieckhefer

STAFF MEMBERS PRESENT:

Marsheilah D. Lyons, Policy Analyst
Joyce Hinton, Committee Secretary

OTHERS PRESENT:

Bobbette Bond, Project Officer, Nevada Health CO-OP
Barbara Smith Campbell, Chair, Silver State Health Insurance Exchange
Jon M. Hager, Executive Director, Silver State Health Insurance Exchange
Damon Haycock, Finance and Research Officer, Silver State Health Insurance Exchange
Cadence Matijevich, Assistant City Manager, Office of the City Manager, City of Reno,
Tracy Chase, Chief Civil Deputy, City Attorney's Office, City of Reno
Mike Cathcart, Business Operations Manager, City of Henderson
Lisa Foster, Nevada League of Cities; Saint Mary's Health Plan
John Slaughter, Director, Management Services Division, Washoe County
Rusty McAllister, President, Professional Fire Fighters of Nevada

John R. McCormick, Rural Courts Coordinator, Office of the Court Administrator, Supreme Court
Melissa A. Saragosa, Justice of the Peace, Las Vegas Township, Clark County; Nevada Judges of Limited Jurisdiction
Donald Farrimond, M.D., Nevada Academy of Family Physicians
Larry Matheis, Executive Director, Nevada State Medical Association
Nancy E. Hook, MHSA, Executive Director, Great Basin Primary Care Association
Elisa P. Cafferata, Nevada Advocates for Planned Parenthood Affiliates
David A. Johnson, M.D., Nevada Academy of Family Physicians

Chair Jones:
We have some presentations before we start hearing the bills.

Bobbette Bond (Project Officer, Nevada Health CO-OP):
I will give you an overview of how Nevada Health CO-OP (CO-OP) originated and how we work with the Silver State Health Insurance Exchange (Exchange).

The CO-OP is part of the Affordable Care Act (ACA) that passed in March 2010. It is an exciting segment of the ACA that will bring new money into each state with a new type of health care plan.

It is extremely difficult for an insurance company to start in any state. The amount of reserves needed to make sure a company stays solvent and the amount of guaranteed income needed makes it difficult for insurance companies trying to launch a business. This is a seeding program the federal government created to provide new competition for the Exchange. It also created a model that will allow not-for-profit health plans to grow. There are not many of them left in any states. It is a valiant objective, and we are happy to be involved.

On the second slide, "CO-OP Awardees," (Exhibit C), I would like to show you where we are compared to the rest of the Country. The green states were able to receive co-op funding under the ACA rules. The ACA calls for the creation of a co-op in every state. Submitting an application is a complicated process. The funding is all regulated by the Centers for Medicare and Medicaid Services (CMS). All the milestones achieved and everything monitored is based on CMS modeling.

The first funding cycle in which an application could be submitted was October 2011. We filed our application for Nevada December 2011. We spent spring 2012 having our application reviewed by CMS through a third party. Our application was probably 400 pages, and we received a detailed interview. We needed an extensive business plan to show we knew how to be state licensed. We demonstrated community need and the community resources available. We created a comprehensive provider network to include state safety-net providers with the ability to expand statewide and not in just one region. We had to anticipate how the exchanges are going to look by 2014.

We had to be able to integrate enrollment systems, claims systems and medical management systems. It is similar to starting a new insurance company from the ground up. A National Committee for Quality Assurance (NCQA) accreditation is required to be on the Exchange. Our co-op will go through the NCQA accreditation process.

We must make a detailed feasibility study with a 15-years pro forma of how we would make enough money to pay back the co-op grant. It is called a co-op grant, but it is a loan. I will review all the information with you.

We received our award for the CO-OP in May 2012. There are tight timelines, which are not dissimilar from what is going on with the Exchange. We have to be able to meet the timelines and to provide people the ability to enroll in the CO-OP by October 1, 2013. We have to be an established provider by January 1, 2014. It is an aggressive timeline.

The ACA had every state provide a competitive application for a new entity. Once we got this far, we were in the second round. Several states followed, but because of the "fiscal cliff" negotiations, the funding has been cancelled. There are only 24 co-ops. We are safe. Our money is secured, and it is a loan that cannot be renegotiated. In the Intermountain West, Utah, Arizona, and Oregon were also co-op awardees. Washington, Idaho, Wyoming and California did not receive co-op grants. It is a great asset for Nevada that we were 1 of 24 states that did receive a grant.

We are now creating our CO-OP to focus on the uninsured. Nevada has 545,000 uninsured persons. We have one of the highest rates of uninsured persons in the Country. We have a great opportunity to work with this large population. We are also trying to stay true to what a co-op is supposed to be.

The reason the groups that sponsored a plan did so is their long and strong history in member engagement, consumer protection, consumer interest, health care quality, health care improvement and cost containment. The CO-OP serves the mission of the two organizations that are the founding sponsors. They are the Health Services Coalition in Las Vegas and The Culinary Health Fund.

"Sponsor" in the legal definition of the CO-OP is a very loose term. Sponsors are able to provide everything from a temporary home to member support inside their coalition. The help from our two sponsors is making a lot of our work possible.

The CO-OP will have a small board at first. The board now consists of myself; Kathy Silver, formerly of the University Medical Center hospital; Jeff Ellis, human resources for MGM companies in Nevada; Danny Thompson, AFL-CIO, who will replace D. Taylor; and Tom Zumtobel, who works on Nevada care delivery and network building. Tom is in northern Nevada right now building a network for us. We will be expanding our board by two new members in March, so the formation of the board is being settled.

The CO-OP is a consumer-oriented and operated health plan. It is modeled so all resources go into this entity, and the members share it. The formation board will eventually turn into a permanent board by the end of 2015. We will have a member board that are CO-OP users. They will manage the CO-OP and have representation as consumers. All the resources that go into and out of the CO-OP are controlled by the CO-OP only. The CO-OP can never be privatized, never become a for-profit organization, never be sold and never be absorbed by another entity. It has to stay true to its mission.

Oversight of the CO-OP by the CMS is significant. The funding that comes into the CO-OP is heavily regulated by a 5-year project plan we created. The plan is followed by a disbursement schedule. Milestones must be completed as they are funded. Once the milestones are completed, we have to "pull down" the next disbursement of funding to keep operating. We do not receive money until we meet our milestone. We have weekly calls with the CMS and have a full-time CMS account manager.

The Division of Insurance (DOI), Department of Business and Industry, also regulates us. We have to be state licensed to be a co-op in Nevada, and we have to be state licensed to be on the exchanges. We have built a good

relationship with Scott Kipper, Commissioner of Insurance, and the DOI. They have given us direction about how to get our early certificate of authority.

In Clark County, we have been able to get our network adequacy requirements as set by the State Board of Health (BOH), Health Division, Department of Health and Human Services (DHHS). In April, we will have our network adequacy in the north. These are key pieces for our Certificate of Authority. The DOI will oversee our process, and we will have to be accountable to them just like any other insurance company in the State.

We are also accountable to the BOH because they have the network adequacy requirements in the State. You should be receiving a bill regarding this. It is unusual for a board of health to oversee the network adequacy for all the insurance companies in a state, and then to have a division of insurance to oversee everything else.

We are also responsible to the Nevada Attorney General who has the ability to inspect and audit any nonprofit organization in the State.

We also must accomplish the NCQA accreditation which requires that we do consumer surveys. We have to meet quality standards to document our progress and assure we have medical case management in place. It is significant work to stay on top of all this. We have many masters.

This Committee should be most aware of our unique financing issue. The CO-OP program uses no State financial resources. The State has been helping us in other ways. The Exchange, the DOI and the BOH have all been helpful to us. The grants are set up as two loans. We have a solvency loan where we received most of the money from the federal government. The solvency requirements are the most difficult to meet as a start-up. We have about $46 million in reserves to meet the DOI requirements for solvency. The solvency is reserved so our members who end up with high-claim costs do not get stuck if we get in trouble, making sure the consumers are always protected. This is a 15-year loan.

The other loan is a 5-year loan of $17 million for our capitalization. Both of these loans bring money and jobs into Nevada. They will also eventually bring tax revenue into the State, without any outlay from the State. This is a great asset for the State, and we are excited to be participating in it.

Our vision is to provide a new option that is attractive to people who have never been insured. The Exchange and the ACA will now allow them to have insurance. We also hope to attract people who have had insurance in the past but are interested in the nonprofit model, or the member-focus model.

We are starting in southern Nevada. We will have Clark County and Washoe County areas ready for the Exchange in 2014. We will need another year to "build out" the rest of the State. We will start the rural areas in 2015. Working with health care in the rural areas is a challenge. There are not many resources. We will have to work with the Native-American tribes carefully to determine how to create as much access as we can. We are working on a good relationship with the Nevada Rural Health Group and the hospitals. The hospitals are actively working on bringing a telehealth model to the State. We want to participate in their efforts; this is an important step for the rural areas.

We want to be in Nevada to improve coverage and quality of health care and to be in a position to help people get into the right program at the right time. We also want to improve the quality indicators in the State. We can all agree our health status indicators are not where they need to be in Nevada. The CO-OP is a long-term asset and tool for improvement.

Chair Jones:
If I am the average consumer, what is the difference between the CO-OP and the Exchange?

Ms. Bond:
Mr. Hager and the Exchange have to build an exchange for all the qualified health plans in Nevada. The health plans have to be approved to be on the Exchange. They have to jump through the same hoops as we have to be accredited and build their plans to get approved by the DOI. We are one of the qualified health plan entities in Nevada; the rest will be commercial insurance companies. We will be one of many offerings on the Exchange.

Chair Jones:
Based on your experience, are there additional opportunities for Federally Qualified Health Centers (FQHCs) in southern Nevada?

Ms. Bond:
We are interested in that topic. We would like to see more clinics there. We know the FQHC formula is complicated. Each center has to be approved as a stand-alone facility. There must be enough "body count" in each neighborhood without being "picked off" by another FQHC. The placement of the FQHC must be carefully planned, but more access would be great. We are also interested in the patient-centered medical home (PCMH) program.

Senator Kieckhefer:
Is the CO-OP an insurance product?

Ms. Bond:
Yes.

Senator Kieckhefer:
If it is an insurance product on the Exchange, what is the unique benefit of being a co-op? Are the savings obtained through the lack of profit margin and lack of potential overhead?

Ms. Bond:
Yes.

Senator Kieckhefer:
You have a $45 million loan from the federal government that you will have to pay back over 15 years—right? Would you not have to increase premiums over the period to build up a stabilization reserve, and would it not undercut the savings?

Ms. Bond:
We can start repaying the loan as soon as we want. We do not have to build up reserves to do that. Any profits the CO-OP receives must stay inside the CO-OP, so we would only be using them to pay off reserves, improving benefits and increasing outreach. It is true we have a loan that many health plans will not have. We also do not need to produce a 12 percent to 15 percent profit. The loan rate is low at 2.5 percent simple interest. Our 15-year business model supports the repayment.

Senator Kieckhefer:
Do you have projections on what your premiums will be compared to other options on the Exchange?

Ms. Bond:
We are competing with United Healthcare, Anthem and other well-established plans that have a lot of money held in reserves so they will open strong on the exchanges. We are the underdog, but we have a lot of experience in health care delivery. We are going to have a competitive plan. We cannot be successful if we are not competitive on price. Our consultant helping us on our plan building is Milliman. We are also working with 23 other co-ops on ideas how to manage cost as effectively as possible.

Chair Jones:
Does the CO-OP replace the Culinary Health Plan? Is it a different layer? How does that work?

Ms. Bond:
No, the CO-OP is not going to replace the Culinary Health Plan. The founders did this because they thought it was important to expand access to nonprofit health care in the community. The CO-OP is not available to people who already have insurance. The CO-OP will be available to people who do not have culinary benefits. It will attract brand new markets. We are strongly going after the 545,000 uninsured persons. The Culinary Health Plan will continue to be its own entity. They are just helping build the backbone for us because they had the skill set. We will not have culinary members at all. We will have to spin off to be a completely separate entity in the end. We are independent from them.

One of the unfortunate consequences of the ACA is that it will increase part-time work. There is not a penalty for employers if employees work less than 30 hours a week. We are very concerned as a fund and as a community partner about people who had coverage and will not have it now. That is another target group we can serve.

Senator Hardy:
Does your board have a medical person?

Ms. Bond:
Yes, we have a chief medical officer slot for which we are recruiting right now.

Senator Hardy:
Regarding your network adequacy—do you already know who will be your providers in the south, the north and the rural areas?

Ms. Bond:
We are in the middle of that. In the south, we are figuring that finite piece as we design our plans. We are just getting started in the north. It is a secret until we get everything finished. We are trying to model our network along the PCMH model and have neighborhood hubs. We are doing network and plan design together.

Senator Hardy:
You are taking uninsured people who are not in a group and creating a group. Theoretically, you save money by expanding your coverage to as many people as you can.

Ms. Bond:
Yes, the philosophy is that all these individuals will be able to combine and have more affordable care than they could individually.

Senator Hardy:
Does CMS have adequacy ratios that you have to meet as far as requiring a certain number of orthopedic surgeons, anesthesiologists, primary care physicians, specialists, hospitals, etc.?

Ms. Bond:
The BOH does that in Nevada. In December, we attended the BOH meeting and demonstrated through our application process who our doctors will be. We had to meet the network adequacy requirements. We will have to do this separately for our network in the north. We will have to do this for every zip code in the State.

Senator Hardy:
Will you then make that information public so people will know whom they will have as potential physicians before they sign up with you?

Ms. Bond:
Absolutely. Mr. Hager will have a lot of insight about how networks will be shown on the Exchange.

Senator Hardy:
I read that the CO-OP is only allowed for Nevadans. We have border towns like Wendover and Laughlin. Will the program be based on a person's residence or workplace?

Ms. Bond:
That decision will be up to the DOI.

Senator Hardy:
Will that tell you what you need for the NCQA accreditation?

Ms. Bond:
The Exchange requires us to get our NCQA certification before we are considered to be a qualified health plan. We have to do it on our own. We have gone through the initial steps of filing with NCQA. What they have created for the co-ops and for the Exchange is an interim accreditation process. This requires the steps to be done in advance; then be surveyed midterm and surveyed late term. The Exchange is not helping us. It is a mandate.

Senator Kieckhefer:
Are the network adequacy requirements the same for co-ops as for commercial plans?

Ms. Bond:
I am sure they are, but we should confer with the DOI. The BOH only has one application process and one checklist.

Senator Kieckhefer:
I know through your presentation that you are focusing on the uninsured, but anybody can join—right? If I want to change my insurance when it is open enrollment, I could sign up?

Ms. Bond:
Yes.

Barbara Smith Campbell (Chair, Silver State Health Insurance Exchange):
We want to show you what we have done over the last 14 months. It has been a busy time for us. I think you will be pleased to see how far we have come and how far advanced we are in comparison to some of the other states.

Jon M. Hager (Executive Director, Silver State Health Insurance Exchange):
The statutes require no fewer than quarterly meetings. Last year the board had 42 publicly noticed meetings.

Slide 3, (Exhibit D) shows the description of an exchange. An exchange is a Web portal. Until about 15 years ago, we did not have the technology to show good side-by-side comparisons of health plans online. We now have that ability, and we have selected and implemented a Software as a Service solution. We are leasing the product and adjusting it for the requirements of the ACA. The Web portal allows an individual to select and enroll in health insurance. It will also aggregate premiums. An employer can allow its employees the ability to make a selection from a list of six carriers. The employer will then send us the premium on one check, and we will redistribute it to the carriers. The item that is new to state-based exchanges is that we will determine the eligibility for individual tax credit. The tax credit helps individuals afford coverage. We have been working with the board to develop policies that balance the needs of consumers, businesses and insurers.

On the next slide is a screen shot of an early development of our Web portal. You can see what the person in our example has selected. There will be a place to show the advance premium tax credit. There is a calculator to estimate what the cost might be.

Senator Smith:
Are these for primary coverage only or can a person buy secondary coverage through the exchange?

Mr. Hager:
A person can purchase secondary coverage on the exchange but would only be eligible for the advance premium tax credit if not eligible for employer-based insurance or a federal program. These will usually be used for primary coverage. A co-op is a health plan. The Exchange provides a mechanism to determine enrollment and eligibility. It allows people to enroll in coverage with one of the various health products.

We intend that our service areas match the rating areas established by the DOI. For individuals, the eligibility for coverage in a given area is dependent on where that person lives. If living in Incline Village, the eligibility would be on the Nevada exchange. If living on the California side, that person would have to go

to the California exchange. Many of the providers in areas like this will have a network that goes beyond the borders of the state. There can still be access to coverage, but a person would have to choose a product that is licensed where he or she is living.

For small employers with 50 or fewer employees there is the Small Group Health Options Program (SHOP) exchange. The eligibility for this is determined by the work-site location. If a person lives in California but works in Nevada that person would have to go to the Nevada Exchange. There are national networks for emergency coverage.

The BOH ensures network adequacies. The DOI intends to move network adequacies to its operation. The ACA requires all plans within the Exchange have an adequate network.

Slides 5 and 6, Exhibit D, are our connectivity diagrams. It is a challenge to unravel the "spaghetti" of the system. We have experts working on this issue. Slide 8 provides a few of our performance indicators. We have five goals; there is a link to our Web page if you are interested in knowing more about these.

The status of the development and the implementation of the Exchange are on slide 9, Exhibit D. We received conditional certification from Secretary Sebelius of the U.S. Department of Health and Human Services on January 1, 2013. The Board has approved 33 of 34 substantial recommendations of the advisory committees. The information technology implementation is on time. The eligibility engine is being built by Deloitte within the Division of Welfare and Supportive Services, DHHS. The Business Operations Solution, the Web portal, is being built by Xerox. We will be ready in October. Our marketing and outreach efforts have begun. We have had weekly, if not more, meetings to coordinate the efforts between the Exchange and the DOI.

On slide 10, Exhibit D, there is a visual picture of the milestones. The core areas and the critical path items are releases A, B and C. We are on or ahead of schedule on these. We are behind on a few items. We are working on a contract amendment for the implementation plan. The plan is done. We just need a contract amendment completed. We are working through the call center issue with Director Willden of the DHHS. We hope to come with a solution for the board after our meeting with the Governor's Office on March 14, 2013. We should be on track after a decision is made.

Chair Jones
Is that decision being made the consolidation you and I were talking about?

Mr. Hager:
Yes.

Damon Haycock (Finance and Research Officer, Silver State Health Insurance Exchange):
The finance and sustainability plan is discussed on slide 11, Exhibit D. We have received five federal grants for a total of approximately $75 million. Federal funding is available through December 2014. We cannot use the federal funds to pay for navigators. We cannot use the federal funds on operational reserves. Starting January 2014 a per-member, per-month fee will be charged to the carriers to fund the navigators and the reserve.

It is estimated that by January 2015, when the Exchange is required to be self-sustaining, the reserve will allow for a seamless transition between funding sources. There will not be a delay in paying obligations.

On slide 12, Exhibit D, we discuss "Bill Draft Request BDR 1285." The BDR was changed to BDR 57-1167. There are three parts to the BDR. The first part addresses interest and the operating reserve. In 2014, the reserve is forecasted to be approximately $2.7 million. The Exchange requests the addition of statutory language that would allow dispositive interest earned on these funds to be put into the Exchange budget account. The deposit of this interest will reduce fees charged to qualified health plans.

BILL DRAFT REQUEST 57-1167: Makes various changes to the Silver State Health Insurance Exchange. (Later Introduced as Senate Bill 454.)

Supplemental products are in the second part the BDR. We request authority to offer supplemental products relating to health insurance and employer benefits to qualified individuals. This would allow the Exchange to collect a per-member, per-month fee prorated to the premium for adult dental, vision and other supplemental products. Allowing the Exchange to collect additional revenue results in a lower per-member, per-month charge to the carriers, which is ultimately passed on to our citizens.

The third part of the BDR is the tax-exemption request. Carriers pay the State a premium tax equal to 3.5 percent for foreign carriers, or 1.75 percent for domestic carriers pursuant to *Nevada Revised Statutes* (NRS) 680B.027.

The Exchange fees charged to insurance carriers are new fees imposed by a State agency. The board has indicated that taxes should not be charged on fees charged by the Exchange. Based on this information the Exchange requests that the taxes imposed pursuant to that NRS do not apply to any fee charged by the Exchange.

The Governor's recommendation to expand Medicaid affects the Exchange by lowering the estimated population purchasing a qualified health plan. This population would now be eligible for Medicaid. The chart on slide 14, Exhibit D, shows the decrease in enrollment and the corresponding decrease in cost in Exchange operations. It should be noted that the lower enrollment in the Exchange causes a slight increase in per-member per-month fees to cover our fixed-cost expenses. The fees are only estimated for 2015 and beyond.

Our caseload projections are discussed on page 15 of Exhibit D. The numbers in this chart are provided to us by the DHHS. They include only individuals projected to participate in the individual Exchange. They do not include SHOP Exchange projections.

Mr. Hager:
In regard to our outreach and education plan, on slide 16, Exhibit D, is some information about our marketing and advertising campaign. We have $5.4 million set aside to fund that campaign. Phase 1 is the branding of the Exchange—making sure we have a name that is a little more appealing than Exchange. People do not understand what that means.

Phase 2 begins in July. This will be the education campaign. This will let people know "The Exchange is coming, be ready." It will help people understand an exchange. We may be called a marketplace or something else at that point.

Phase 3 is called "Action Up" and will begin in October. "The Exchange is ready, come and enroll for coverage effective January 1." The information we have found indicates that about 44 percent of enrollees will use the Exchange enrollment facilitators. This will come in the form of navigators, enrollment

assisters or certified application counselors. The plan for navigators, enrollment assisters and counselors is available on our Website.

Navigators cannot be paid with Exchange establishment grant funds, so that budget is slightly lower. The enrollment assisters will cover a lot of that functionality for the first couple of years. The certified application counselors will be volunteers. If you go to a hospital and you do not have insurance, they will assist you in obtaining coverage so the next time you will be covered.

Chair Jones:
Can you explain the difference between a navigator and an enrollment assister? Are they both employees of the Exchange?

Mr. Hager:
The navigators are required by the ACA. They are sub-grantees of the Exchange. The difference between the navigators and the enrollment assisters is the ACA does not allow funding navigators with the establishment grant funds. Other functions of the Exchange are allowed to be paid with establishment grant funds. Navigators are charged with enrollment and education outreach. Anyone who does these functions together cannot be paid with establishment grant funds. Enrollment assisters only provide enrollment. They do not provide education and outreach so we can utilize the establishment grant fund to pay them. This budget is sufficient to cover the 44 percent of the enrollees that we expect to go through the Exchange. We have had discussion at the board level about the budget. We want to make sure the budget is sufficiently robust to hire enough people to get the word out. The ACA allows but does not require the use of brokers and agents. The board had indicated that we should use them. They will be allowed to enroll people in the Exchange. We are not getting in the middle of the commission structure. They will get paid by carriers. The Exchange expands the producer's ability to make a living by having more people enroll and receive commissions from them. The Web portal will be used by 34 percent of people who contact us, whether or not they use the call center.

Slides 17 and 18, Exhibit D, are items that are not Exchange issues; however, network adequacy is at the forefront of everyone's mind. All plans in the Exchange must have network adequacy. There is concern of adverse selections inside and outside the Exchange. We have had a discussion with the commissioner of insurance, and he has indicated he would like to expand the network adequacy to the entire market. The difficulty is getting legislation

passed now and going through the regulatory process to create the standards. There is not enough time for the carriers to meet the new standards. We have decided that we need to use the authority of the ACA to create network adequacy standards in consultation with the DOI. The standards will apply specifically to qualified health plans in the Exchange.

The biggest difficulty we have is the rural areas where it is difficult to maintain a network. The challenge for this State will be to set standards that protect consumers, but that are not so stringent we would not have any carriers providing coverage in the rural areas.

Access to care is another issue. We estimate a 6 percent to 8 percent increase in demand for providers, which will be higher in the first half of 2014. Suddenly the uninsured will be able to receive the medical care they need. It will be difficult to increase the supply to meet the demand. Every state in the Country is trying to attract new providers. "Growing" doctors takes nearly a decade. What we will see is a shift in health care delivery. We will see advances in telemedicine. The doctors will become the coaches of the team instead of the stars of the team. The team will have physician assistants and registered nurses (RNs). A patient may not see a doctor every visit. We will also see an expansion of weekend and after-hour clinics.

The tax implications are presented on slide 19, Exhibit D. The Exchange will calculate the tax credit enabling the consumer to calculate the amount of the premium. On page 21, Exhibit D, the various tiers and estimates of deductibles are shown. This plan will step a person out of Medicaid. Medicaid is a fully subsidized product. As income increases, a person will have larger premiums and larger cost sharing of out-of-pocket expenses. There is an example on pages 22 and 23, Exhibit D, of individual subsidies for a plan in Reno and Las Vegas. The tax penalties are outlined on slide 24 of Exhibit D. The penalties for not having insurance will be less than the total premium. These are yearly amounts. If a person pays for a tax penalty, he or she will get nothing in return; if that person pays an insurance premium, he or she will receive insurance. Slides 26 and 27 of Exhibit D show the tax implications for businesses.

Chair Jones:
I want to thank you, Mr. Hager, and your entire team for getting everything up and running so quickly. You provided an enormous amount of information to us in a short amount of time.

A certain chamber of commerce had expressed concern that you were trying to compete with them. Is that a valid concern?

Mr. Hager:
I am not trying to compete with anybody. I am trying to implement the ACA in the most efficient way possible. I can understand the concern of an organization that has a group plan mostly for small businesses. The way the ACA is designed, a person is only eligible for the advance premium tax credit if he or she is in the SHOP Exchange. There is nothing we can do about that. If an employer has more than 25 employees, there is not a huge incentive to join the exchange. We are going to provide the best value we can possibility provide. Any other organization that provides insurance can provide the best value they can to the citizens of Nevada. The competition would help Nevada.

Senator Kieckhefer:
Will the large group exchange be in effect in 2017?

Mr. Hager:
Yes. The requirements in 2014 and 2015 are for the SHOP program to open to employers with 50 or fewer employees. At its discretion, the State can increase that to 100 or fewer. That would require merging the two markets both inside and outside of the Exchange. I have not seen any legislation that is pursuing this.

We are required to open the Exchange to employers with 100 or fewer employees in 2016. In 2017, at the State's discretion, we could increase that to large employers as well. It would require a complete merge of the large- and small-group market. I am not sure that is healthy for either of those markets.

Chair Jones:
We will now open the hearing on Senate Bill (S.B.) 4.

SENATE BILL 4: Revises provisions governing the testing of a person or decedent who may have exposed certain public employers, employees or volunteers to a contagious disease. (BDR 40-265)

Cadence Matijevich (Assistant City Manager, Office of the City Manager, City of Reno):

There are two primary goals of S.B. 4. The first goal is to provide all public employees and volunteers of public agencies the ability to petition a court to order a blood test of a person or decedent who may have exposed them to a contagious disease. Under existing law, this ability is limited to law enforcement officers, correctional officers, emergency medical attendants, firefighters, county coroners, medical examiners and employees of agencies of criminal justice.

The City of Reno's position is that all of our public employees and volunteers are public servants. In the course of their job duties they may come into contact with members of the public, and they deserve the same protections that exist in the statute for the other employees.

The second goal is to shorten the time frame between exposure and court-ordered blood test being obtained. There are certain prophylactic drugs that when taken within a short time of the exposure, generally around 2-hours, may significantly increase a person's chances of not contracting the disease to which they may have been exposed. These prophylactic drugs can have severe side effects. It is crucial that a public employee be able to make an informed decision. The petition process in NRS 441A.195 makes it difficult for a public employee to obtain the results of the blood test within the 2-hour window.

To shorten the time frame, S.B. 4 provides that a public employee or volunteer for a public agency may give an oral statement under oath to a court. It would be in a manner similar to the procedure to obtain a search warrant in NRS 179.045. Senate Bill 4 will also allow a judge hearing the oral statement to orally authorize certain persons acting on behalf of the employer or public agency to sign the name of the judge or the justice of the peace on a duplicate order, which shall be deemed an order of the court.

Sections 2 and 3 of the bill expand the jurisdiction of justice and municipal courts to include any action seeking an order for a blood test of a person who may have exposed a public employee or volunteer of a public agency.

There may be concerns of confidentiality issues related to blood tests. Existing law contains confidentiality provisions. *Nevada Revised Statute* 441A.220 provides that all personal information is confidential and must not be disclosed

to any person, even pursuant to any subpoena, search warrant or discovery proceeding, except in certain situations enumerated in NRS 441A.220.

One of the enumerated exceptions is NRS 629.069, which specifies that a provider of health care shall disclose the results of any court-ordered blood test to certain persons including the person who was tested, the person who filed the petition or made the oral statement, and the employer's designated health care officer.

We were contacted by the Administrative Office of the Courts, Office of the Court Administrator, Supreme Court. They had concerns with the procedural provisions within the bill. We are most willing to address those concerns.

Senator Hardy:
Is a Good Samaritan considered a volunteer in this bill?

Ms. Matijevich:
We did not consider a Good Samaritan in this bill. It is our intent that a person working as a volunteer for a public agency be covered.

Senator Kieckhefer:
In section 1 of this bill it states " … in the course of his or her official duties." If an off-duty law enforcement officer is acting as Good Samaritan, as Senator Hardy indicates, that person would not necessarily be covered under this legislation. Under the normal course of duties as a law enforcement officer, that person would be covered. Is this legislation taking that person out of coverage?

Ms. Matijevich:
That was not our intent, to take that person out of coverage.

Tracy Chase (Chief Civil Deputy, City Attorney's Office, City of Reno):
Our intent in writing and drafting the bill was to cover public employees or volunteers of public agencies. I think the Good Samaritan nuance is an interesting one we would have to look at from a legal perspective to determine whether or not we could protect those individuals.

Senator Hardy:
It would be good to encourage Good Samaritan behavior, but I do not think any of us are looking to put a financial burden on the City.

Mike Cathcart (Business Operations Manager, City of Henderson):
We are in full support of S.B. 4. We do use volunteers throughout our organization including the public safety arena.

Lisa Foster (Consultant, Nevada League of Cities):
We support S.B. 4. It enhances protection for all of our members and employees.

John Slaughter (Director, Management Services Division, Washoe County):
Washoe County supports this legislation. The public employees we have thought about being covered with this legislation are our social workers and child protective workers. They often follow law enforcement into a home and may be exposed.

Rusty McAllister (President, Professional Fire Fighters of Nevada):
We also support this bill. The verbal authorization would speed up the process, and that is good for us.

John R. McCormick (Rural Courts Coordinator, Office of the Court Administrator, Supreme Court):
We have procedural concerns with this bill. We look forward to working with the sponsors to clear up those concerns.

Melissa A. Saragosa (Justice of the Peace, Las Vegas Township, Clark County; Nevada Judges of Limited Jurisdiction):
Our concerns with the bill have nothing to do with the policy behind it. Our concern was in the practicality of the implementation. Ms. Chase has likened it to the telephonic search warrant process. The difference in the search warrant process is the recording and transcribing the conversation. It is all done through the police department, not through the court. Ms. Chase and I have been in discussion today and are hopeful we can work out some language that will work for everyone. We have several concerns: Not every Judge has a court reporter, some just have a court recorder; what is the courts' responsibility to pay for the transcription of each one of the oral statements that will come through the court? In the very short window of 2 hours and at all times of the day and

night, how will the judges practically record such conversations? Who is going to be responsible? Will the judge have to carry a recording device at all times? Is an applicant going to be responsible for the recording? If the applicant is going to be responsible, who will transcribe it? These are some of the issues about which we are concerned. I think they are all issues that we can resolve. We are asking that you send this to a work session so we can have some time to work out those issues.

Chair Jones:
We will send this to a work session and ask that the City of Reno and anyone else who wants to be involved to please work with the Office of the Court Administrator and Judge Saragosa to find a solution that is reasonable.

We will close the hearing on S.B. 4. We will open the hearing on Senate Concurrent Resolution (S.C.R.) 4.

SENATE CONCURRENT RESOLUTION 4: Encourages the Department of Health and Human Services and the Commissioner of Insurance to work with health care providers and insurers to develop a patient-centered medical home model of care. (BDR R-507)

Senator Joseph P. Hardy (Senatorial District No. 12):
The interim Legislative Committee on Health Care heard testimony regarding Patient-Centered Medical Home (PCMH). This is a new way of looking at patient care. The resolution asks that the Secretary of State encourage the DHHS and the commissioner of insurance to work with health care providers and insurers to develop a PCMH model of care and to adopt these payment models.

The ACA has changed the landscape of medical care, and we now have Accountable Care Organizations and total risk models. These are designed to research how we can deliver better quality care and more health care. We want health care that is accessible, saves money, is available, keeps a personal physician, assists with the team approach, has family involvement, gives feedback and has a shift away from what we call the “fee for service” model.

We now have a model of the PCMH in Nevada with the MGM Resorts International. Forty-seven states work with this model. The doctor as a coach is an important concept. We are moving away from the doctor being star of the show or captain-of-the-ship approach and moving to the team approach in

delivering health care to people. With the ACA happening in the first part of 2014, we are going to have an increase in the number of people who want to receive the medical care they have been patiently awaiting.

Medical education will change as well. When we look at what is happening in the Nation, we see medical schools that have to provide a different model of teaching. We are going to see change not only in the delivery of care but also in how we teach the delivery of care.

Nevada Legislature's Committee on Health Care provided Bulletin No. 13-18, which characterizes the PCMH. I would be remiss if I did not have people who know more about this speak to this Committee. In full disclosure I am a physician, and I work for Touro University Medical School.

I have provided (Exhibit E) and (Exhibit F) for the Committee.

Donald Farrimond, M.D. (Nevada Academy of Family Physicians):
I am a board-certified family physician in Reno. I have been in practice in Reno since 2000. I also practice rural and emergency medicine in Nevada. I am currently serving as the secretary/treasurer for the Nevada Academy of Family Physicians (NAFP). The NAFP strongly supports S.C.R. 4. We are excited that we are having some discussion on this subject. Nevada is one of only two states that have not passed meaningful legislation related to the PCMH. In my experience in private practice, as a member of a large hospital based group practice and as an emergency physician, I have been able to witness the fragmentation within our medical community. I have seen the redundancy and waste in how we deliver medicine.

A single visit to an emergency room is paid in an amount greater than 50 visits to a family physician's private office. As an emergency physician, I see the same patients coming in repeatedly for nonemergency-related issues.

The NAFP has been proactive trying to get some discussion started. We have met with big business. We have met with John Socha, Director, Health Care Delivery, MGM Resorts International. There are 65,000 employees with MGM, and Mr. Socha is encouraged by initial results. We have met with Paul Grundy, M.D., Global Director of Health Care for IBM. Since they have implemented purchasing of PCMH services, they have saved billions of dollars. We have also been in discussion with Jerry Reeves, M.D., who is involved with

HealthInsights and Greenspun. Their initial data in the state of Nevada has been encouraging as well.

One of the issues that came up when looking at PCMH in Nevada was whether or not we had adequate primary care physician coverage to implement such a system. In response to that we can look at Utah which ranks lower than Nevada in the number of primary care physicians to general population. Even with the lower ranking they have much higher general health care outcomes and health care determinants than Nevada.

I am comfortable discussing the quality and the health outcome benefits of a PCMH. I am less comfortable discussing the financial statewide benefits. I will offer that the way Utah has achieved better health care outcomes with less physicians per capita is by leveraging their mid-level providers and medical assistants. It was mentioned that it took 10 years to grow a physician. It takes 5 to 6 years to grow a nurse practitioner, 4 years to grow an RN, 2 years to grow a licensed vocational nurse, and 6 months to 1 year to grow a medical assistant. This is with all working at their highest capacity. There is an opportunity for creating jobs which could attract physicians to practice in Nevada. Residencies are training physicians to work in PCMH and there are none available in Nevada.

Larry Matheis (Executive Director, Nevada State Medical Association):
The Nevada State Medical Association supports S.C.R. 4. It is more than a resolution as there are incentives for both the DOI and DHHS to help move these experiments along. We are at a stage that in order to achieve the reform of the coverage system, the delivery system and the payment system for health care, we are going to have to try a lot of different variations of integrating groups. We also need teams to assess and deliver care. The PCMH is one of those. We know it will vary depending on the type of population. It may be one variation of a model that will be most appropriate for the Medicaid population. A different model may be appropriate for a population with a lot of young working families. The principles will turn out to be consistent. The structure will come up similar. In developing standards for a model over the coming years, we will be able to look at the experiments and see which ones have the most hope. This is true with all the issues under the big rubric of health care reform.

In a period where there is increasing demand and decreasing workforce, we are reviewing how to put the pieces together to have an affordable system that is delivering quality care. This means we have to rethink almost every aspect of it. Most of the experiments will not work; we know that from our own experiences. Out of the experiments that do not work come the ideas of what can work. You have to start down the road. It has to be a joint venture where the state agencies that are involved in implementing health care reform bring experience to the table. The provider community, the physician community and the nurse community need to bring their expertise to the table. Commercial plans, insurers and those working in the quality field need to bring what they have to the table. This resolution provides the opportunity to have that table.

Nancy E. Hook, MHSA (Executive Director, Great Basin Primary Care Association):
The Great Basin Primary Care Association is a nonprofit membership organization. Our members include the FQHC, the Native American Tribal clinics and other safety net providers. Our members provide comprehensive primary care services to patients regardless of insurance status or their ability to pay by using a sliding fee scale or a discounted fee schedule. The FQHCs have always been patient centered. The required patient majority on boards of directors is one of our most unique characteristics. These majority boards ensure participation by patients in the design of programs and services.

The FQHCs in Nevada and across the Country are undergoing the transformation in practice required for recognition by the NCQA. It is not easy to change the process by which care is provided in consultation and collaboration with the patient and family. We support the development and implementation of a system of care delivery that is patient centered, and in which payment appropriately recognizes the added value provided to patients who have a medical home.

Elisa P. Cafferata (Nevada Advocates for Planned Parenthood Affiliates):
We also support PCMH and S.C.R. 4 medical homes. We know for about 40 percent of women who receive reproductive health care, that is the only doctor they will see for several years of their lives. It is a model with which we are familiar, and we support it. It helps women get the care they need.

David A. Johnson, M.D., (Nevada Academy of Family Physicians):
I am a family physician in Nevada. In Nevada we run a sick care system. We do not value preventative medicine well. The system we live in does not allow us the ability to do that. The PCMH is a model that has been developed and proven time and time again in almost every state in the union, except for Nevada, to be an effective model to put the patient at the center of the health care system. It allows us to use all resources available to care for a patient. The doctor is not the only one making the decisions and is not the only one responsible for the patient's care.

There is so much that happens in medicine after the doctor walks out of the room and all of it is left to the patient to navigate alone. The result is patients just fall down. They are barred from the care they need because they cannot navigate the payment issues or the system well.

The PCMH is a team approach that allows us to have a doctor-led team of professionals. There are mental health, pharmacy, physical therapy and patient advocates, somebody to help them navigate the system, professionals working as a team. This is done in so many places in the world. Nevada is really behind.

We have been working toward the PCMH in Nevada for a long time. It is a hard process to start. It takes a lot of moving parts and government support. An environment has to be created in which private insurers will come in and help pay. It changes the entire way that medicine is paid for. The system changes from sick care to health care. Doctors and their teams become reimbursed based on the quality of care delivered not the quantity of the care delivered. Right now doctors are paid for the time sitting in a room with a patient. When patients are with us, we get paid. If we take care of them outside, we do not get paid. The system discourages physicians from providing quality longitudinal care.

We use the example of the diabetic person. The diabetic patient has difficult problems. It takes a lot of people to teach lifestyle modifications needed for success at managing the disease process. Dr. Paul Grundy, one of the founders of the PCMH movement, shared with me a quote that really hit it on the head. He said, "It is unethical for us to sell an episode of care to a diabetic." Diabetic persons do not need an episode of care: they need a longitudinal team who will help them over the course of years. Right now they get an episode of care. They come to the doctor, we "monkey" with their insulin, we talk a little bit,

give them a little bit of advice and tell them to go to diabetes education. They may or may not go, and that is the end of it. The result is that we spend tons of money on reactive care. Now we have to do amputations and dialysis. They are going blind. All of these things could have been prevented.

We need the State to recognize the PCMH. We need this to form a group that can bring us into the twenty-first century as far as medical care delivery is concerned. The State's recognition will help us invite our third-party payers and physicians to cooperate in this process. It will be better medicine overall. It will be better for patients and there will be less "burnout" with physicians. There is no down side. All of the demonstration products have shown that a huge amount of money is saved by making primary care of the patient center. It keeps them out of the hospital and makes their disease processes better.

Chair Jones:
We will close the hearing on S.C.R. 4.

Marsheilah Lyons:
There will be a work session on March 5, 2013, on S.B. 99 and S.B. 100. If you have additional amendments to present, you will need to get those to me by Monday morning at the latest.

SENATE BILL 99: Provides for the protection of children in the child welfare system from identity theft. (BDR 38-65)

SENATE BILL 100: Revises provisions relating to certain providers of emergency medical services. (BDR 40-501)

Chair Jones:
There being no further business before this Committee, the meeting is adjourned at 5:20 p.m.

RESPECTFULLY SUBMITTED:

_____
Joyce Hinton,
Committee Secretary

APPROVED BY:

_____
Senator Justin C. Jones, Chair

DATE: _____

EXHIBITS				
Bill	**Exhibit**		**Witness / Agency**	**Description**
	A	1		Agenda
	B	9		Attendance Roster
	C	15	Bobbette Bond	Nevada Health CO-OP Simply Better
	D	28	Jon M. Hager	Silver State Health Insurance Exchange
S.C.R. 4	E	1	Senator Joseph P. Hardy	Primary Care for the 21st Century.
S.C.R. 4	F	3	Senator Joseph P. Hardy	The Patient-Centered Medical Home