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

Seventy-Eighth Session
February 6, 2015

The Committee on Commerce and Labor was called to order by Chairman Randy Kirner at 1:30 p.m. on Friday, February 6, 2015, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/78th2015. In addition, copies of the audio or video of the meeting may be purchased, for personal use only, through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblyman Randy Kirner, Chairman
Assemblywoman Victoria Seaman, Vice Chair
Assemblyman Paul Anderson
Assemblywoman Irene Bustamante Adams
Assemblywoman Maggie Carlton
Assemblywoman Olivia Diaz
Assemblyman John Ellison
Assemblywoman Michele Fiore
Assemblywoman Marilyn K. Kirkpatrick
Assemblywoman Dina Neal
Assemblyman Erven T. Nelson
Assemblyman James Ohrenschall
Assemblyman P.K. O'Neill
Assemblyman Stephen Silberkraus

COMMITTEE MEMBERS ABSENT:

Assemblyman Ira Hansen (excused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Kelly Richard, Committee Policy Analyst
Matt Mundy, Committee Counsel
Leslie Danihel, Committee Manager
Earlene Miller, Committee Secretary
Jennifer Russell, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Bruce Gilbert, Executive Director, Silver State Health Insurance Exchange
Michael J. Willden, Chief of Staff, Office of the Governor
James Wadhams, representing Anthem Insurance Companies, Inc., Nevada Association of Health Underwriters, Nevada Association of Insurance and Financial Advisors, and Nevada Independent Insurance Agents
Dwight Mazzone, President, Mazzone & Associates, Las Vegas, Nevada
Stacy Woodbury, Executive Director, Nevada State Medical Association
Keith Lee, representing Nevada Association of Health Plans
Laurie Squartsoff, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Patty Thompson, Chief, Fiscal Integrity, Division of Health Care Financing and Policy, Department of Health and Human Services
Jesse Wadhams, representing Express Scripts
Liz MacMenamin, representing Retail Association of Nevada

Chairman Kirner:
[Roll was called and housekeeping items were reviewed.] I will open the hearing on Assembly Bill 86, sponsored by the Silver State Health Insurance Exchange.

Assembly Bill 86: Revises provisions governing the Silver State Health Insurance Exchange. (BDR 57-390)

Bruce Gilbert, Executive Director, Silver State Health Insurance Exchange:
I appreciate the opportunity to testify in support of this bill. By way of introduction, I became Executive Director of the Exchange in August of 2014. My background is in law and insurance administration. I was a trial attorney for about a dozen years, and I have been in the insurance industry for

more than 20 years. My previous experience includes heading a managing general agency for a Fortune 100 insurance carrier, acting as a high-level executive for companies administering employers' self-insured health plans, and serving as the Benefits Administrator for the state of Ohio, with responsibility for over 60,000 employees and $500 million in annualized health care spending. I have served governors of both parties, and in those roles my sole interest has been leveraging my knowledge and experience to bring operational excellence to state agencies. I have had frank and friendly discussions with those who philosophically support the Affordable Care Act and those who philosophically oppose it. In both cases, my stance has been the same. Debates as to whether the Affordable Care Act is good law are best held in Washington, D.C. My promise, at the time of my hiring, was that I would identify and remedy the core operational problems which plagued the Exchange in 2014, and that I would do my best to find ways to fix what had been broken, and ultimately create a functional marketplace for our state. I believe my staff and I have begun to make good on that promise.

The Silver State Health Insurance Exchange was established in statue in Nevada and began life as a state-based marketplace managing both operations and enrollment technology. In the course of dealing with operational problems and attempting to resolve a critical issue, specifically the failure of the application and enrollment technology created by Xerox, the Board of Directors of the Silver State Health Insurance Exchange made a practical and fiscally prudent decision in May of 2014 to end its dependence on the Xerox system and adopt the federal application and enrollment platform.

With this decision, the Silver State Health Insurance Exchange became a unique hybrid—a state-managed marketplace utilizing federal technology. The Board's actions that day had far-reaching and unforeseen consequences. Nevada had neither a purely state-based exchange nor a federally facilitated marketplace, but something new and different.

Along with Oregon and New Mexico, Nevada became one of three states identified as a supported state-based marketplace (SSBM). More states are considering following this path. We have been contacted by several states and asked to discuss our transition to the SSBM model. A bill is being introduced in the Vermont Legislature to replicate and offer the Nevada model as a cost effective and affordable replacement for their single-payer system.

Other states are intrigued by the requirement that the Silver State Health Insurance Exchange be self-supporting. Every state-based marketplace in the nation is presently struggling with the concept of financial sustainability. There is no shortage of possible solutions. While Nevada assesses and collects a fee

from participating health insurers for each individual securing coverage through the Exchange, most other states have initiated market-wide assessments, collecting a fee on each individual policy sold on or off their exchange. A third group has combined the two approaches in varying degrees, and a fourth relies on general funds.

Unlike some of our fellow exchanges, we embrace the concept of fiscal self-sufficiency. The Board and every member of my staff recognizes and understands that to ensure the Exchange's solvency and success, we must serve our customers well while being good stewards of every dollar received and every dollar spent.

It is also important to recognize that while Nevada's Exchange does use the federal application and enrollment platform, all other aspects of our operations are state-based. The management and certification of insurance plans that are offered on the federal platform to our consumers occurs here in the state of Nevada. Other activities essential to the successful operation of an exchange—carrier onboarding, marketing, consumer education and outreach, and technical assistance—are entirely controlled and managed locally. Ours is a state-centric exchange, managed by and for the benefit of Nevadans, rather than one of thirty-four overseen by a federal agency 3,500 miles away.

Our Exchange is also significantly less expensive than the federally facilitated marketplace. Nevada's consumers would be paying over $800,000 more this year for the exact same health plans if our state Exchange did not exist.

The transition to a supported state-based marketplace was challenging, but in five months we were able to onboard all of our carriers onto the federal platform, develop compelling marketing and outreach initiatives, and create a foundation for success. Since that transition, our technology has been robust and reliable. Our carrier partners receive timely and accurate enrollment files, while our broker and agent communities have been able to help more Nevadans purchase health coverage than ever before. Our navigator agencies and entities have also assisted and enrolled thousands of consumers in health plans at our brick-and-mortar enrollment stores, as well as at events throughout the state.

As of today, over 50,000 Nevadans, many of whom are able to afford insurance coverage only because of the premium subsidies available through the Exchange, have chosen plans during this year's open enrollment. This number may seem small at first glance, but it is worth remembering that we are not talking about an abstract arithmetical value, but about people: mothers and fathers, adults and children, aunts and uncles and cousins, thousands and

thousands of people across the state who have come to understand how important it is to be covered for the medical expenses attendant to sickness and injury, and have sought our help to get the coverage they need.

Even with our recent successes, it is conceivable that the Exchange's metamorphosis is not over. Our enabling statute did not and could not have identified our agency as a supported state-based marketplace; the term did not yet exist and our current operational model had not yet been conceived. Assembly Bill 86 recognizes the possibility that there may be more change in our future, even as it resolves a statutory redundancy. An exchange established by state statute is, by definition, a state-based exchange.

We also believe section 2 of the bill, expanding the Silver State Health Insurance Exchange Board and allowing insurance industry representation, is a thoughtful and measured approach to assuring that stakeholders and industry experts be included in our policy-making process. Greater industry-specific knowledge on any Board is always a welcome addition. A closer working relationship with our insurers going forward cannot help but be to our advantage.

Finally, section 3 of the bill allows the members of the Exchange Board to receive the same standard compensation for service as the members of other boards in Nevada. The monies for this have been built into the Exchange's budget and can be accommodated without issue.

In sum, the Exchange supports A.B. 86. It permits the flexibility to adapt to changing circumstances and allows for greater stakeholder involvement in our governance. It represents forward thinking and will help the Exchange continue to assist Nevadans seeking to purchase affordable, quality health insurance.

Chairman Kirner:
We have some questions from Committee members.

Assemblyman Ohrenschall:
My question has to do with section 2, subsection 6 on page 3—the deleted language about a voting member not being affiliated with a health insurer. Last session I served on the Commerce and Labor Committee and I remember a very spirited debate over this language. The reason we put it in there was to try to ensure independence of every Board member and that there would not be any kind of influence by one of the companies that is affected. What is the purpose in removing that language?

Bruce Gilbert:
The purpose can most easily be explained by looking at what happened in 2014 when, it might be argued, there was not enough industry-specific knowledge on the board at the time they were moving forward. To some degree, the issues that were experienced in 2014 during open enrollment and thereafter could be attributed to a lack of industry knowledge. I do not think the intent is to affect in any way the independence of the Board. I think the idea is rather to ensure that there is sufficient industry knowledge and experience represented on the Board to assist in our decision-making.

Assemblyman Ohrenschall:
Do you know of exchanges in other jurisdictions that are allowing this kind of relationship for board members?

Bruce Gilbert:
Every exchange is to some degree unique, but there are a number of exchanges that do have representatives from the insurance industry, either sitting in an advisory board capacity or actually sitting on the boards. For example, Kentucky, which had a good outcome with its initial open enrollment, permits insurance representatives to sit on their board. They work hard to develop a close relationship with their issuers. It may be that, to some degree, the success they were able to enjoy was a result of having that association.

Assemblywoman Kirkpatrick:
Why would we not take out the part that they could benefit from actual contracts? It is important to have industry knowledge on many of these boards, but this takes out the part that says that they could benefit. What you do not want is one hand washing the other. You do not want them having inside knowledge on how to go for contracts. I do not believe we have any folks in Nevada who would do that; however, we always want to ensure that it is at arm's length ethics wise.

Also, I am a little perplexed as to why we are going from seven to nine members and from meeting once a quarter to a year and paying the members. We understand that the Silver State Health Insurance Exchange did not produce the results we wanted, but from my perspective of having to appoint people, it was very hard to keep people on the Board. Yesterday we had someone resign because the person was moving on to other opportunities. What happens if we expand the Board and it is hard to keep that quorum? Also, you would be having fewer meetings. It is possible you meet this month, in February, and not meet for another year. You will run into problems with people who are not engaged and you will be replacing folks on a regular basis.

We see this all the time. If the point is to not have meetings and discussions, then this bill does that. I am trying to understand that approach.

Bruce Gilbert:
Dealing first with the issue regarding contracts, the Silver State Health Insurance Exchange does not have contracts with carriers per se. This deals specifically with health insurers. Insurers come to us to get qualified, for the opportunity to be on the Exchange. We went from four to five insurers this year. In the course of our deliberations, certainly with respect to the Open Meeting Law, nothing takes place that any member of the public would not already know. The potential for anybody to benefit from that information is rather remote. I do not think that anybody could put themselves in a position to take advantage of knowledge which is provided to the Board.

This is a genuine effort to make certain that we do not walk down the same path that we did in 2014. There was a lot of technical knowledge and there were a lot of well-meaning people at that time. What was lacking was industry knowledge. That is, "If I do this, what can I expect to happen over here?" The decision to collect and remit premiums is a perfect example. It may have been that with industry guidance and knowledgeable individuals able to have greater input in the decision-making process, the Exchange would not have elected to do that. That would have resolved a number of problems that we experienced.

With respect to the movement from seven to nine members, it is an indication that we want to have more people involved, not fewer, and to have greater input from our stakeholders as opposed to dealing with the Board as it is currently made up. I do not think the intent is simply to add members, but to make certain that all of our constituent groups have the opportunity to be represented on the Board.

As for the prior history of the Board and its stability, my understanding is that the Board has been fairly stable. While you are correct that a Board member recently tendered a resignation, I do not anticipate a lot of turnover on the Board.

As far as the fewer number of meetings, I believe the "once a year" instead of "quarterly" is a minimum. My Board meets monthly. My expectation is that we will continue to meet monthly. I think this was intended to set a floor of one meeting as opposed to four. It is probably a recognition that we are finally clawing our way back and having a good experience this year. Perhaps less formal action in the future will be necessary. The Board met weekly for a period in 2014. I do not think there is an indication that we would meet only

once a year. I fully anticipate that we will continue to meet monthly as we move forward.

Assemblywoman Carlton:
On the language that we have been talking about, there were very hard-fought, passionate battles over that language. On a number of the boards that I sit on within the state, I have to sign disclosure documents. In a couple of instances I had to be replaced because there would have been a conflict. There was a reason for that. We thought it was a valid reason at the time. We have the Commission on Ethics in this state for a reason, and the last thing we want to do with something this important is to have a conflict and end up in front of our Ethics Commission. I would want someone to reach out and at least have a conversation with them.

My question is this: The Governor is getting a couple more folks on the Board, and the Legislature is not. How do we fix that part?

Bruce Gilbert:
The only way to fix that would be to add additional members to the Board beyond the nine.

Assemblywoman Carlton:
And take away from the Governor's portion.

Bruce Gilbert:
That is certainly within the realm of the Legislature and the Governor to agree upon.

Assemblywoman Bustamante Adams:
You said that you would like to invite some additional stakeholders that you believe are missing from the Board. What categories or industries do you think are not being represented?

Bruce Gilbert:
There are two that come to mind immediately. The first is the insurance industry—people who are in the same world that I inhabit. By serving as executive director of another board, I have found that academia also can be helpful. For example, someone who is an expert in health care policy and financing might be helpful to us.

Assemblyman O'Neill:
Who are the seven constituent groups? You are saying now that you do not have anybody who knows anything about insurance. Do you need an insurance person there now?

Bruce Gilbert:
I would not say that the members do not know anything about insurance. Certainly, the trials and travails that they went through over the last year have taught my current Board a great deal about insurance. What I am saying is that greater industry knowledge is currently lacking on the board. I believe it would be helpful to have industry representation.

Assemblyman O'Neill:
Would you please tell me what industries are represented on the Board so we can see why you would need additional groups?

Bruce Gilbert:
My Board is composed of consultants, attorneys, and physicians for the most part.

Assemblyman O'Neill:
Consultants?

Bruce Gilbert:
They are consultants in a variety of industries. They fall under the consulting umbrella.

Assemblyman O'Neill:
So on the Board now, you have consultants, physicians, and attorneys who represent your various industries, but you need more. Now you need people involved in insurance. What industries would the other people represent? You are adding two.

Bruce Gilbert:
I have some very talented and hard-working Board members. Over the course of the last year, they have worked hours and hours dealing with the problems and issues they had to fight through in plan year 2014. They are rugged veterans at this point. They have a moderate amount of insurance-related knowledge. I say that from an insurance background of over 20 years. It is very easy to make policy. It is not always easy to make policy and understand the consequences that flow from that policy. I think that some of the decisions that were made contributed to the detriment of the Exchange. Those decisions resulted in the issues and problems that we experienced and were the direct

result of not having individuals on the Board who could take part in those discussions and understand the consequences of some of the decisions.

I am not at all suggesting that my current Board is not a competent, capable, and good board. What I am saying is, the Board's knowledge of the insurance industry is not as great as it would be if we had someone from the industry sitting on it. That is important because we have been able to move from being a start-up to being an operating entity. As a consequence, what we really are today is an insurance operational and administrative entity.

Chairman Kirner:
In section 1 of the bill you struck "state-based," indicating that you no longer consider yourself as "state-based" and I know you reclassified that as a supportive state-based marketplace. My question has to do with the recent court discussions about whether state-run exchanges or federally run exchanges would be able to get subsidies. How does that affect our state and this particular bill that you are putting forward?

Bruce Gilbert:
You are referring to *King v. Burwell*, 759 F.3d 358 (4th Cir. 2014), *cert. granted,* 135 S. Ct. 475 (U.S. Nov. 7, 2014) which is pending before the U.S. Supreme Court. The argument raised is whether the federal government can create something, an exchange, which is "established by the state." That is the operative language that we are talking about. If you look at section 1311 of the Affordable Care Act, it says that, in order for subsidies to exist, you have to have an exchange which has been "established by the state." It does not say "state-based" anywhere. *Nevada Revised Statutes* 695I.200, the first language in there says, "The Silver State Health Insurance Exchange is hereby established." Calling ourselves a "state-based" exchange is not necessarily the barometer by which we would be judged. Because we have a statute that established us, we are considered a state-based exchange, and would be for the purposes of *King v. Burwell*.

Assemblywoman Kirkpatrick:
I want to go back to Mr. O'Neill's question. If you look at section 2, this was controversial. We put a lot of work into what we wanted specifically for Board members and how we wanted the Board to react. Maybe we need to change the makeup of the Board. You cannot just add people for the sake of having people. Section 2, subsection 3, paragraph (a) says, "Expertise in the individual or small employer health insurance market," and if there is a consultant on there, he is probably not in the right place. It says we wanted someone from the insurance industry to be on the Board who could help us navigate through the system. Paragraph (b) states somebody with "Expertise in health care

administration, health care financing or health information technology." Are you saying that we are getting partial people? Paragraph (c) says, "Expertise in the administration of health care delivery systems." Paragraph (e) is pretty clear: "Experience in consumer outreach and education for those who would benefit from the services provided by the Exchange." That was the person who recently resigned.

I have to agree with Mr. Kirner. When you remove "state-based, it is bothersome because the state created this, and the state and the Legislature have the ability to audit it. If we do not have the right people on the Board, we might need to change the people first and then determine if we need them.

Mr. Willden, you were part of this in the beginning. I go back to section 4, subsection 1, paragraph (a), that the Board shall meet at least once a year. If you are not meeting weekly or monthly, could there be a recruitment problem? If you want us to give members $80 a day, it is a money problem for us because I want to know how to put those dollars aside for you. In this small bill there are a lot of issues and significant changes to what I believe the legislative intent was when we started.

Michael J. Willden, Chief of Staff, Office of the Governor:
I am here to give a different perspective. The Office of the Governor is interested in this legislation. In regard to section 1, which is eliminating the language "state-based," Mr. Gilbert pointed out that there are now three types of exchanges. We started out as a pure state-based exchange where we did everything, and at the other end of the scale is the fully federal market. We are now running something in between. We believe that the state, this body, and the Governor should have total flexibility because this is morphing all the time. We do not want to get into a situation depending on lawsuits and federal language and matters like that. We want to make sure we have flexibility. We certainly intend to not go to the federal marketplace. We believe we are in the right space now, and that is where we intend to be.

With regard to section 2, increasing the membership, I sat as an ex officio member on this Board when I was at the Department of Health and Human Services (DHHS). There are three ex officio members on the Board: the Insurance Commissioner, who provides valuable insurance conversation; a DHHS representative; and the Budget Director, who helps with finance. As for the seven Board members now, we have what I would call a poverty representative, E. Lavonne Lewis who is a human resources executive. Lynne Etkins is from Legal Aid, a consumer advocacy organization for insurance and other issues. Barbara Smith Campbell, who has been the chair and was selected for her knowledge of running complex organizations, is the Assembly

appointee. Dr. Judith Ford, on the Board for her health care expertise, is the Senate appointee. Dr. Florence Jameson provides a health care provider perspective. Marie Kerr, an attorney, brings the legal perspective, and Leslie Johnstone, previously with the state Public Employees' Benefits Program, comes from the benefits side, not the insurance side.

I was the one who testified when we put this legislation through a couple of years ago. We were absolutely insistent that the insurance industry not be on the Board to start with because we thought there were potential inherent conflicts. Over the last year we saw that we missed three things, which I think can be dealt with through conflict of interest statements and recusing oneself from votes. First, the carriers themselves had valuable input. We had to do that through off-line and subcommittee conversations, and it did not come out well in the public process. The second was the brokers. The brokers were the heavy lifters in getting people enrolled, and we missed a lot of that public discussion with the brokers. Third, having a health insurance information technology professional would have helped us with moving the data back and forth between those entities. That is why we believe an expanded Board would be helpful.

With regard to the $80 compensation, most boards that work this hard in state government get the standard $80 fee. There is not a request for general funds here. It is paid from the fees that are collected through the Silver State Health Insurance Exchange. They budgeted for it. They would get the standard $80 per day when they meet, as often as they meet.

Assemblywoman Kirkpatrick:
I want it on the record that the Legislature will be able to audit that. I can tell you that there are plenty of legislators who would like to audit the Silver State Health Insurance Exchange, and it should be clear that by taking "state-based" out, we still have some authority.

Mike Willden:
We would agree that it should be audited. We were before Assemblyman Kirner this morning in another committee, and Julia Teska of the Department of Administration asked for additional auditing resources. This is one of the areas where we believe we could have had, and needed, additional auditing resources.

Chairman Kirner:
At this time I am going to ask those who are in support of the bill to come to the table.

James Wadhams, representing Anthem Insurance Companies, Inc., Nevada Association of Health Underwriters, Nevada Association of Insurance and Financial Advisors, and Nevada Independent Insurance Agents:

I am here today representing a variety of clients. Their common denominator is that they are insurance-oriented. Most of them are involved and equally invested in the success of the Silver State Health Insurance Exchange.

Having heard the questions, the point I would like to make is that the function of the Exchange has been misunderstood historically. When we went through the open enrollment period, it became clear that the Exchange is not an insurance company. It is not even an insurance agency. It is an electronic Internet portal where commerce is conducted and where people can access that portal to find out if they should be directed to the state Medicaid program and enroll under that protocol, or if they should go into the Affordable Care Act provisions for the purchase of insurance. The participation of people with expertise in technology is an element that would be extremely helpful. It certainly was not the intent of the Board, or the Director—Mr. Hagar and then Mr. Gilbert—that the technology piece would impede the opportunity for your constituents to access that insurance and, in some cases, premium subsidies that make that insurance affordable.

We support this bill. Assemblywoman Kirkpatrick's question is well-intentioned, but I do not think it is necessary or appropriate to take anybody off that Board. The individuals on the Board are all very capable and competent people. Their expertise, however, does not lie in that technology platform, nor, as Mr. Willden and Mr. Gilbert said, does it lie in the insurance operational program. This is the answer to one of those questions regarding insurance company expertise, which had to be brought to bear after we missed opening this effectively on October 1, 2013. We had to bring in the insurance companies to say, "How do we make these interfaces work? How do we make the technology play back and forth so that files can be moved from one point to the other?" As many of you recall, there were people who thought they signed up but could not find their insurance company, and the insurance company said we have not heard anything. That is all the information that did not flow.

The purpose of this is not to disappoint anybody from the Board but to add the areas of expertise. Some of these areas were identified in the original bill, in section 2, subsection 3(a) on page 2: "Expertise in the individual or small employer health insurance market." There is a reason it does not say "large employer." Large employers are taking care of their employees. It is the small employers who have to go out and shop, as do the individuals. That expertise was lacking. Could it be appointed? Yes, but I think the intent is to add a couple of seats to have more of that variety of expertise.

Other questions were related to the issue of having anyone involved with an insurance company being on the Board, as in the deleted portion in section 2, subsection 6 on page 3. If read carefully, it precludes most of us who have contracts with insurance companies for our health insurance coverage from being on that Board. That clearly was not the intention. This language is just over-broad. In a discussion I had in front of this body two years ago, it was suggested we could find retired insurance people to come in and bring that expertise, and they would not have a conflict because they are not active. Theoretically, that is probably true. What has happened, though, is that when people get to the point of being retired, they want to be retired. That recruiting effort was a steep hill to climb. While I appreciate the concerns, I think those can be addressed. On behalf of those associations, we want to support that bill.

There is one other piece, and I think it might be a drafting error. It is in section 3, subsection 1: "as fixed by the Executive Director." I do not think that was the intent, but it could be read to say that the Board hires the Executive Director, who in turn sets the salary of up to $80 for members of the Board. I do not think that was the intention; if that was a drafting error, I wanted to point that out.

Chairman Kirner:
We will have our legal staff take a look at that. Are there any questions?

Assemblyman Ellison:
You give a better insight, but Mr. Gilbert said that the Board meets once a month, and in section 4 it says at least once a year. How many boards meet once a year? This would be in statute. Eventually, that Board could be inactive most of every year.

Jim Wadhams:
I planned to testify in support of the bill. That point is well taken. Perhaps there is some adjustment to that. The notion behind taking out that language is to allow the Board flexibility to meet as often as it needs to. If the Legislature is more comfortable with having a minimum number of meetings, the people I represent would have no problem with that, but that is the policy of the Legislature to set.

Chairman Kirner:
There is an individual wishing to speak in southern Nevada.

Dwight Mazzone, President, Mazzone & Associates, Las Vegas, Nevada:
I am a licensed health and life insurance broker in Nevada as well as many other states. I have served as a stakeholder and was appointed by the Governor to serve on the task force for the Exchange. I have been to most, if not all, Board meetings. I would reiterate that the lack of knowledge from the insurance industry on the Board did hurt the Board and the prior Executive Director.

I am speaking in favor of A.B. 86, but I have a couple of friendly amendments.

Chairman Kirner:
Have you reviewed those friendly amendments with the sponsor?

Dwight Mazzone:
No, I was told to put my thoughts down, and these are my thoughts on section 2 of the bill.

Chairman Kirner:
The sponsor has not reviewed the amendments. You can talk about it in opposition and propose your amendments. Are there any others in support? [There were none.] With that I will move to the opposition, and you may proceed.

Dwight Mazzone:
In section 2, I would respectfully request that somebody with an insurance background be allowed to be on the Board. It was evident last session that this was not to be allowed because of thoughts that there might be a conflict of interest. I have served on this Board since its inception, and I cannot figure out where there might be a conflict of interest or where I might do better because I served on any of these Boards.

Under section 3, my only question would be "What is the fiscal impact to the Silver State Health Insurance Exchange budget?" If it comes out of the operating monies of the Exchange, then it has no impact on the state.

In section 4, I am opposed to changing the meeting to once a year. I would like to keep it at least once per quarter or more if possible. The reason is that I believe it would be a disservice to the citizens of Nevada to not allow them to have the opportunity to voice their concerns. I have been to a number of meetings where the citizens have been able to voice their concerns about issues going on within the Exchange, particularly regarding the enrollment in 2013 for the 2014 plan year.

Chairman Kirner:
Are there other individuals who oppose the bill?

Stacy Woodbury, Executive Director, Nevada State Medical Association:
The last couple of sessions, our Association has stated for the record that we believe it would be a conflict for the insurers to have a seat on the Board. I would like to put that on the record again.

Chairman Kirner:
Are there any questions? [There were none.] With that I will proceed to those who are neutral. Is there anybody who is neutral on the bill?

Keith Lee, representing Nevada Association of Health Plans:
The Nevada Association of Health Plans does support the bill as submitted, but I am appearing as neutral because I have discussed an amendment in concept with Mr. Gilbert and Mr. Willden. My suggestion is that, for the categories in section 2, subsection 3, paragraphs (a) through (e), it might be better if we limited each category to two members or something like that. That way we would ensure that there would not be an overbalance of one of these sectors versus another sector not being represented. I suggest that as a matter of discussion with this Committee. I will continue discussions with Mr. Gilbert and Mr. Willden. We support the bill, and we particularly support the provision on page 3, in section 2, deleting the prohibition against a representative from the health insurance industry serving.

I would like to make several points. We are talking about three parties to what we are doing here with insurance. We have the patient, who is represented by a consumer of health care delivery services, and we have the provider, who is represented by the physicians on the Board. Now we are suggesting that the appointing authority can consider someone representing the health association. I fail to see, if someone from the health insurance company is appointed, how that is more of a conflict of interest than having a physician on it who is a provider and the recipient of what is being paid. I do not think there is a conflict of interest. Please keep in mind we are talking about one voice among seven. We are not talking about an overwhelming influence that would change the whole direction of the Board to the benefit of insurance carriers.

As I indicated, the Nevada Association of Health Plans supports this bill. We made the suggestion about limiting the numbers from each sector to be represented on the governing board.

Chairman Kirner:
Are there any questions? [There were none.] Seeing no further testimony from Las Vegas, I will close the hearing on A.B. 86 and open the hearing on Assembly Bill 87.

Assembly Bill 87: Revises certain provisions governing the duties of insurers with regard to Medicaid. (BDR 57-326)

Chairman Kirner:
I invite representatives from the Department of Health and Human Services to come to the table.

Laurie Squartsoff, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
With me is Patty Thompson, Chief of the Fiscal Integrity Unit of the Division of Health Care Financing and Policy. We are pleased to present an overview of Assembly Bill 87. The importance of this bill for the Division of Health Care Financing and Policy is that there is a proposed revision to *Nevada Revised Statutes* (NRS) 689A.430, regarding individual health insurance, and NRS 689B.300, regarding group and blanket health insurance, to more clearly define liable insurers for health benefits for the Medicaid program and replace outdated language. The revision would maximize the ability of the Division to ensure that Medicaid is the payer of last resort when a Medicaid beneficiary has other health care insurance.

This bill will more clearly define the entities that are considered third parties and health insurers by adding pharmacy benefit managers (PBMs) to the definition. This will assist the Division of Health Care Financing and Policy and its agents to recover payments from all other liable parties for health care costs. Section 1902(a)(25)(A) and (G) of the Social Security Act requires all other available third parties to meet their legal obligations to pay claims before the Medicaid program pays for the health care of an eligible individual. The Deficit Reduction Act (DRA) of 2005 made a number of changes to the Social Security Act, with the intent to strengthen state regulation. Specifically, section 6035(a) of the DRA clarified specific entities that are considered health insurers, and required health insurers to cooperate with third party liability (TPL) efforts.

The proposed amendment will more clearly define the requirements of health insurers to provide the state with eligibility and coverage information in order to (1) identify potentially liable third parties, (2) properly avoid payments for services covered under the state plan when another party is liable for payment, and (3) to recover payments from third parties.

The guidance from the Center for Medicare and Medicaid Services (CMS) issued in September 2014 further outlined state responsibilities to pass laws regarding the submission of health insurance information to Medicaid agencies, or their agents, to be proactive in maximizing third party liability recovery. These revisions will more fully align current NRS language with the intent of the Social Security Act, the Deficit Reduction Act, and clarifying guidance from CMS.

The overview of the proposed amendment to A.B. 87 (Exhibit C) is that, at present, some insurers interpret section 4 of both NRS 689A.430 and NRS 689B.300 of the current statute to mean that the Division should provide Medicaid recipient information to the insurer to perform the data match for the Division, or that the Division make individual requests for each Medicaid recipient, which is not practical or efficient due to the volume of recipients. By revising the language in these sections, and aligning the language with federal regulation, the Division will be able to maximize recovery and thus ensure that Medicaid is the payer of last resort.

Finally, there is clarification to both of those sections, specifying the Medicaid agency, or its agent, provides authority for contractors of the Division, such as managed care organizations, or third party liability vendors working on behalf of the Division, to perform the necessary recovery activities. This bill has no fiscal note attached.

Chairman Kirner:
Are there any questions?

Assemblywoman Kirkpatrick:
Why did you not do this through regulation? Typically when folks are trying to stay in line with the federal government, they come before the Legislative Commission to do things through regulation. Why did it not come through the Department of Health and Human Services? Why do we have to put this in statute? My concern is that the federal government is constantly changing, and I do not want to hamstring you if something changes in the next year based on what statute says.

Laurie Squartsoff:
It is my understanding that the reason this is coming to you as a statute change rather than through regulation is that, early in this process, we had conversations with the Department of Business and Industry, and we figured this would be the most appropriate location. If there is another place for us to have that conversation, we certainly would be happy to look at alternatives.

Assemblywoman Kirkpatrick:
I am saying that rather than count on the Legislature to constantly be updating, in my experience, the regulation is a little easier way for you to navigate and stay in lock step with the federal government.

Chairman Kirner:
I have spent 35 years in benefit management, and my understanding of a pharmacy benefit manager is that they are not an insurer. Their role is to negotiate for lower-priced prescription drugs. How do you bridge the concept that they are an insurer? They do not offer insurance policies or anything of that nature. Would you mind addressing that?

Laurie Squartsoff:
In the group of frequently asked questions that we received from CMS, the answer on Question 2 is that third parties are subject to the DRA-amended provisions and include self-insured plans, pharmacy benefit managers, and other parties that, by statute, contract, or agreement, are legally responsible for the payment of a claim for a health item or service.

Chairman Kirner:
My understanding is that pharmacy benefit managers are not legally responsible for paying claims.

Laurie Squartsoff:
Yes, but the guidance for this is under the third party. They would provide us with the information for the people who receive services, and ensure that we have the complement of the information from both the PBM and the insurer that they work with.

Chairman Kirner:
So that imposes a whole new role upon the pharmacy benefit managers; is that what you are describing? In other words, do they have to do some additional reporting?

Laurie Squartsoff:
It requires a change in the role between the insurers and the PBM.

Chairman Kirner:
Are there any other questions?

Assemblywoman Seaman:
Has there been a problem collecting from third parties? Is this because of this language?

Patty Thompson, Chief, Fiscal Integrity, Division of Health Care Financing and Policy, Department of Health and Human Services:
Yes, our third party liability vendor has had some difficulty with certain PBMs. They have stated that the law does not require them to cooperate. That prevents us from recovering from those individuals or those carriers. I also wanted to add that CMS has told us that our state law must require the health insurer that contracts with the PBM to provide information to the PBM to then provide to us. We may need to clarify the language that we have put into the amendment, but that is the intent.

Assemblywoman Seaman:
What other alternatives are there if we do not bring this into compliance with federal regulations? What would happen?

Patty Thompson:
We would still be in the difficult position of getting the information from the insurers through the PBMs, and that would restrict our opportunities for maximizing our TPL recoveries.

Chairman Kirner:
I would like to invite those who are in support of the bill to step forward. [There was no one]. Those opposing the bill may come forward.

Jesse Wadhams, representing Express Scripts:
I represent Express Scripts, a pharmacy benefit manager. We are opposed to the bill as written, not necessarily to the concept of the bill. This particular provision in section 1, subsection 5 on page 3 defines as an "insurer" a pharmacy benefit manager. A pharmacy benefit manager is not an insurer. It does not write contracts of insurance. This dovetails on a couple of questions that have been noted here.

However, we do understand what the state is trying to do under the Deficit Reduction Act of 2005, which did clarify a number of third parties that need to report the data. There is no issue there; we can help make something work. In fact, as defined, this may actually be a little under-inclusive of the number of third parties the state is trying to target. We would say that there may be a better way to get to the intent of the Deficit Reduction Act of 2005.

[A letter from Cynthia Laubacher of Express Scripts was submitted in opposition to A.B. 87 (Exhibit D).]

Liz MacMenamin, representing Retail Association of Nevada:
I echo some of my colleague's concerns. In the past, the Retail Association of Nevada has had a great working relationship with the Department of Health and Human Services. We would like to continue that. We would be glad to work on this to try to meet the concerns that have come forward for some of our members. Some of the concerns that were voiced were about looking at the PBMs as people who pay claims. They do not pay claims. When I heard that language, it piqued my interest. I would like the opportunity to work with the Department. I have sent the information out to my members, and they would like the opportunity to address a few concerns they have.

Chairman Kirner:
Are there any questions? [There were none]. Are there any others opposed? [There were none.]

[Letters in opposition to A.B. 87 were submitted by April Alexander of the Pharmaceutical Care Management Association (Exhibit E) and Maral Farsi of CVS Health (Exhibit F).]

I will invite to the table anyone taking a neutral position. [There was no one.] I would like to ask those who are opposed to please work with the Department and see if you can square away some of the language. I will now close the hearing on A.B. 87.

If there is anyone with public comment, now is the time to come forward. [There was no one.]

This meeting is adjourned [at 2:39 p.m.].

RESPECTFULLY SUBMITTED:

_____
Jennifer Russell
Committee Secretary

APPROVED BY:

_____
Assemblyman Randy Kirner, Chairman

DATE: _____

EXHIBITS

Committee Name: Committee on Commerce and Labor

Date: February 6, 2015 **Time of Meeting: 1:30 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
A.B. 87	C	Laurie Squartsoff	Proposed Amendments
A.B. 87	D	Cynthia Laubacher	Letter in Opposition
A.B. 87	E	April Alexander	Letter in Opposition
A.B. 87	F	Maral Farsi	Letter in Opposition