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

Seventy-Eighth Session
April 13, 2015

The Committee on Commerce and Labor was called to order by Chairman Randy Kirner at 2:34 p.m. on Monday, April 13, 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
Assemblyman Ira Hansen
Assemblywoman Marilyn K. Kirkpatrick
Assemblywoman Dina Neal
Assemblyman Erven T. Nelson
Assemblyman James Ohrenschall
Assemblyman P.K. O'Neill
Assemblyman Stephen H. Silberkraus

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Kelly Richard, Committee Policy Analyst
Matt Mundy, Committee Counsel
Leslie Danihel, Committee Manager
Connie Jo Smith, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Jennifer Stoll, Director, State Government Affairs, Allergan, Portland, Oregon
Steven M. Friedlander, M.D., representing Nevada Academy of Ophthalmology
Jeanette K. Belz, representing Nevada Academy of Ophthalmology
Adam Plain, representing Nevada Dental Association

Chairman Kirner:
[Roll was called, and a quorum was present.] I am going to take the bills out of order. We will hear Senate Bill 217 (1st Reprint).

Senate Bill 217 (1st Reprint): Revises provisions relating to policies of health insurance. (BDR 57-836)

Jennifer Stoll, Director, State Government Affairs, Allergan, Portland, Oregon:
I am the Director of State Government Affairs for Allergan. I am here to present Senate Bill 217 (1st Reprint), which is sponsored by Senator Ben Kieckhefer. This bill allows patients to get access to their prescription eye drops earlier than the typical 30-day supply that most health plans recommend. Health insurers treat eye drops just like they do pills. Eye drops offer a lot of different challenges because many people have difficulty administering them in their eyes. Today, we are lucky to have Dr. Steven Friedlander, who is an ophthalmologist practicing in Reno, to talk more about patient care and, specifically, why this is an issue.

Should patients not get access to an early refill of eye drops, they tend to run out earlier, and this can lead to serious eye health problems, up to and including permanent vision loss. Eye drops can be challenging to instill. It is easy to accidentally lose a few eye drops in the process of putting eye drops in every

day. Many of these patients are elderly and may not have a steady hand which can be arthritic. Others are visually impaired. Again, it can be very difficult to put in eye drops. Almost 20 percent of patients have a difficult time putting eye drops in their eyes.

According to the Glaucoma Research Foundation, it is normal for a bottle not to last as long as the pharmacy would recommend it to be. About 21 percent of patients are denied early refills to their prescription eye drops. It is a true problem.

One of the interesting things about this bill is that it deals with a category of drugs dominated by generics, so we are not talking about high cost or very expensive drugs. It is not a mandate because we are not asking them to pay for something they are already doing. This is within the standard formulary. We are just asking for early refills so that if a patient goes in to the pharmacy on day 21, he or she can get access to their prescription eye drops.

This is also not a new concept. It was introduced in many states and is law in about a dozen states. It follows the guidance that is also put out by CMS, which are the Centers for Medicare and Medicaid Services, for any Part D health plan. I am asking for your support of S.B. 217 (R1).

Assemblywoman Bustamante Adams:
Can you repeat the percentage you said were denied?

Jennifer Stoll:
Based on pharmacy audits of claims, about 21 percent are rejected because they are what is called "refilled too soon"—that is the edit that the pharmacist gets. In other words, the patient goes in on day 26 or 27, and the prescription is rejected.

Assemblywoman Bustamante Adams:
You talked about other states. Do you know which were the most recent states that passed such language?

Jennifer Stoll:
The bill is moving through the Washington Legislature as we speak. It is going to the floor out of the committee and will then be on its way to the governor. It is law in Oregon, Utah, and many states on the East Coast.

Assemblywoman Bustamante Adams:
So it is just similar language regarding the other states, or did they modify it in any way?

Jennifer Stoll:
Yes, it is almost identical language. It is model language used by the American Academy of Ophthalmology.

Assemblywoman Neal:
Section 7, subsection 2, states, "The provisions of this section do not affect any deductibles, copayments or coinsurance established by the health care plan." The person is going in before his or her prescription renewal, and it is a new prescription, correct? Technically, if a patient is between prescriptions and has a chance to go in and get a new prescription before that due date, does that not count as two? If it is a refill, does a refill count against the person's deductible?

Jennifer Stoll:
I can find that out for you. I think it would be plan specific, however. Again, we have Dr. Friedlander here. He can talk about specific, real-world patient experience, and I would defer to him for more information.

Assemblywoman Neal:
Yes, I would like a real-world example of what section 7, subsection 2, means in terms of copayments and coinsurance established by your plan.

Chairman Kirner:
My experience with this is that if a person gets an early refill, based on your insurance plan, the same copay is required. Dr. Friedlander, do you want to add comments with regard to the real-world issue?

Steven M. Friedlander, M.D., representing Nevada Academy of Ophthalmology:
I am an ophthalmologist practicing in Reno and Carson City. I am past president of the Nevada Academy of Ophthalmology and a member of the American Academy of Ophthalmology (AAO). I serve on the state affairs committee for the AAO, and I can support the statements that were made that these bills are going through various states throughout the entire country. These are patient advocacy bills. To speak to real-world examples, if patients who have glaucoma—which is a chronic condition much like hypertension—do not take the glaucoma medicine as prescribed daily, then they have an increased chance of blindness.

To try to address the question, we are talking about a chronic course of treatment. Patients are on these drops often for long periods of time, if not their entire lives, based on having something like open-angle glaucoma. I can see situations where patients would end up with 13 monthly refills in one year instead of 12 refills. That may directly address how many copays they have to

make or their deductibles. Certainly that is going to be based on his or her particular plan. The goal is to allow the patients to get the medicine to treat their conditions so they do not go blind.

Assemblywoman Neal:
How do you prove what the bill calls "inadvertent wastage"? Let us say that I am a glaucoma patient. To whom do I prove the inadvertent wastage, my doctor or the pharmacist?

Steven Friedlander:
I am not sure we are talking about proving it. The fact is that many patients have difficulty putting drops in their eyes. If you have ever put them in, you know that sometimes the drops hit your cheek. Sometimes you think you have a drop in, and you are not sure, and you put a second drop in. The drops are not measured. If you need a month's supply of blood pressure pills, the patient is given 30 pills. A bottle of eye drops is more variable as to how much you are getting and how much you are dispensing. If you have to put in an extra drop, or if one of the drops hits your cheek, or you squeeze the bottle too soon, then you are going to be missing some medication. The goal is to make sure the patient has his or her medication so they do not go blind.

Assemblyman Ohrenschall:
I can relate to your example with the hypertension medicine. I have been in that situation where I can just get the 30-day supply. I was going out of town and wanted to make sure I did not run out. I was having trouble finding my pharmacy. I had to pay out of pocket for that. Would this prevent that situation? I had to buy an extra month's supply just so I would have it. Would this bill prevent that kind of situation for folks with the eye drops?

Jennifer Stoll:
Yes, that is the absolute intent of this bill. It would allow you to go in and get your next month's supply for the copay or the coinsurance that you would typically be charged for the month's supply.

Jeanette K. Belz, representing Nevada Academy of Ophthalmology:
To Assemblywoman Neal's question, if you look at section 13 of the bill, the issue is subsection 2, paragraph (b), which states that the provisions of subsection 1 do not authorize any refills in excess of the number of refills indicated on the prescription by the prescribing practitioner. The idea is that you are probably not getting 13 for 12 because you have a prescription for 12 monthly refills. But you might be getting your 12 in the necessary amount of time, perhaps 10 or 11 months, so that you can get it when you need it because you inadvertently waste it.

"Inadvertent wastage" is defined in section 13, subsection 3, paragraph (a), as the loss due to difficulty applying the eye drops. If you look under section 13, subsection 1, it refers to "the request of a patient having difficulty with inadvertent wastage of a topical ophthalmic product, and pursuant to a valid prescription which bears specific authorization to refill." So that has to be indicated by the physician. You are right. You may not actually be wasting the drops. It is possible, but the idea is that for folks who are, they will receive the coverage when they need the drops, as opposed to going without for several days at the end of a prescription. As Ms. Stoll mentioned, this is consistent with what Medicare does as well.

Assemblywoman Neal:
If a person is traveling out of town and ends up overusing the drops, what would he or she tell the doctor? Is that inadvertent waste if you left the eye drops in your hotel room? What if a contact lens is not put in your eye just right and you cannot take care of it. How do you go to your doctor and say, I inadvertently wasted my medicine; please give me my next prescription.

Jeannette Belz:
All I can tell you is that it does happen in real life. There are those folks who really do make a mistake with their prescriptions, as my mom did. When she happens to mention on the 25th day of her 30-day prescription that the pharmacy did not refill her eye drops, I panic because she has glaucoma. Now she does not have drops for several days. I called her ophthalmologist and got a small sample for her to tide her over through that period. I do not think you can prevent someone from purposely wasting the drops, if that is what he or she wanted to do, but that is not the intent of this bill. The intent of S.B. 217 (R1) is to get the medication to the people who inadvertently waste it so they will get their drops, the same number of eye drops, the same 12-month supply, but perhaps in less time so that they do not go without. I do not know how you can legislate that away from them.

Chairman Kirner:
Are there those who are in support of this bill? Seeing no one, is anyone opposed? Seeing no one opposed, is anyone neutral? [There was no one.] Would those presenting the bill like to make closing comments? Assemblywoman Carlton has a question.

Assemblywoman Carlton:
Apparently there is no room for error in these prescription bottles. They are cut so precisely, and the bottles are not very big. The exact dosage is in that bottle, so there is no room for error.

Jennifer Stoll:
The U.S. Food and Drug Administration heavily regulates the bottle sizes.

Chairman Kirner:
Seeing no other questions, do the presenters have any closing statements? [They did not.]

I will close the hearing on S.B. 217 (R1) and turn the Chair over to my Vice Chair to hear Senate Bill 159. [Assemblywoman Seaman assumed the Chair.]

Senate Bill 159: Revises provisions relating to insurance. (BDR 57-829)

Adam Plain, representing Nevada Dental Association:
I am here in support of Senate Bill 159 on behalf of the Nevada Dental Association. The aim of S.B. 159 is to make the lives of Nevadans easier by ensuring that the final determinations on their dental insurance claims are only reviewed by trained professionals. Let us acknowledge a reality: consumers, doctors, and insurers do not always agree on the necessity of a course of treatment. Because of this, we have legal and contractual protections that permit multiple levels of review before a claim is ultimately accepted or denied. Current law requires the use of binding arbitration to resolve disputes relating to independent medical evaluations. In instances where the insurance company requests the independent medical evaluation, the insurer is required to use a person who is certified to practice or is formally educated in that field. Yet this consumer protection currently only exists for medical and chiropractic care. There is no similar requirement for dental care. That is not to say that some insurers do not offer this protection voluntarily by contract, yet not all insurers do, and nothing prevents an insurer from ceasing to voluntarily offer it as a business decision.

Senate Bill 159 adds the words "dentist" and "dental" to existing consumer protection statutes to guarantee that Nevadans have access to an informed, professional opinion on the final determination of his or her dental claims.

Assemblyman Ellison:
You said only professionals can read the final determinations when trying to determine what the plans are. Could you explain?

Adam Plain:
If you look at the bill in section 1, subsection 3, it talks about the process for an independent medical examination or evaluation. If you go to the doctor for a procedure, and your physician says that you need to undergo a particular

course of treatment, the insurance company might say that the procedure is not medically necessary. The insurance company can require you, as the patient, to see a doctor of the company's choosing who will perform a physical evaluation of you to determine whether, for instance, the knee replacement is necessary.

The current statute says when the insurance company sends you to the physician of its choosing, the person the company sends you to has to be a certified physician, or someone trained in that field of medicine. The bill, as presented, would also make it so that if they require that same procedure for a dental concern, you are sent to see a dentist or someone trained in a dental field for that physical evaluation of your mouth and the surrounding organs.

Assemblyman Nelson:
What happens right now, in most cases, if they do not go to binding arbitration? Do they go to the review panels, or do they have to file a lawsuit?

Adam Plain:
The contracts require binding arbitration as part of what is called the internal review process. You go through this process where your claims are escalated to different levels, and that is done internally. Once a certain point is reached where you have exhausted all of your appeals through the internal review process, you can get access to the external review process, where it goes from an appeal to your insurance company to an appeal of a third party. In the state of Nevada, for example, they may use the Governor's Office for Consumer Health Assistance. If it is a plan through Medicare, say Medicare Advantage, it may go through the Centers for Medicare and Medicaid Services, but it is ultimately escalated to an outside source at that point.

Assemblyman Ohrenschall:
Do you envision this bill, if it passes, mostly being before the fact or after the fact? If someone is in excruciating pain and the dentist says I need to do a root canal or crown, most people are not going to say, "Let me wait and see if there is going to be a denial, or if I go to arbitration." The patient is going to want the pain alleviated and have it dealt with. Do you see this, if it passes, working after the fact in terms of who gets stuck with the bill, or do you think this will be before the procedure happens?

Adam Plain:
The answer depends on the type of claim being presented. To use a medical example, let us say you have requested a knee replacement, and the doctor has said you need to have your knee replaced. That would be something where the insurance company requires prior authorization before the procedure even occurs. If that prior authorization is denied, then you can escalate through the

appeals process before the procedure occurs. If it is something that is more of an emergent care, such as if you are in immediate pain, the doctor is more likely to perform the procedure because it is an immediate concern. Then you are going to be adjudicating whether the claim is paid or not. In those cases, an independent medical examination or evaluation is made more difficult because some treatment has already been administered, and you cannot see the person in the condition prior to the treatment having been administered to make that evaluation.

Assemblyman Paul Anderson:
I would like to clarify some of the problems we are running into. Are we saying that we have medical professionals who are diagnosing things or giving a prognosis on something that should be done by a dentist? Or are they denying their ability to see a dentist on those particular issues?

Adam Plain:
Under the current statutory construction, if a dental provider were to say, my patient requires this procedure and it needs prior authorization, it goes to the appeals process. The insurance company would be under no legal requirement to have a dentist actually examine that claim before it is denied. They would be able to use administrative staff or other personnel to do that review.

Assemblyman Paul Anderson:
Are we seeing that happen? Are you seeing items denied by administrative folks, or by doctors who might not have the expertise to give a proper prognosis on that?

Adam Plain:
Yes, that does occur.

Vice Chair Seaman:
Does the Committee have any further questions? Seeing none, is there anyone else who is in support of S.B. 159? [There was no one.] Is there anyone who is in opposition to S.B. 159? [There was no one.] Is anyone neutral on S.B. 159? [There was no one.] Would the presenter like to make a closing statement? First, Assemblyman Nelson has a question.

Assemblyman Nelson:
Mr. Plain, do you represent the Nevada Dental Association?

Adam Plain:
Yes, I do, Assemblyman Nelson.

Assemblyman Nelson:
You have received no opposition to this bill?

Adam Plain:
At the hearing on the Senate side, there was one interested party who was opposed to the bill. That was a misunderstanding about the intent of the bill and how the bill was structured. That was sorted out after hours, so to speak, and the bill was passed without an amendment.

Vice Chair Seaman:
We will close the hearing on S.B. 159. Is there anyone who has any public comment? Seeing no one, today's hearing is adjourned [at 3:02 p.m.].

RESPECTFULLY SUBMITTED:

_____
Connie Jo Smith
Committee Secretary

APPROVED BY:

_____
Assemblyman Randy Kirner, Chairman

DATE: _____

EXHIBITS

Committee Name: Assembly Committee on Commerce and Labor

Date: April 13, 2015 **Time of Meeting: 2:34 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster