Amendment No. 673

Senate Amendment to Senate Bill No. 394	(BDR 38-950)
Proposed by: Senate Committee on Health and Human Services	
Amendment Box: Replaces Amendment Nos. 285 and 595.	
Amends: Summary: Yes Title: Yes Preamble: No Joint Sponsorship: No Digest: Yes	

Adoption of this amendment will REMOVE the unfunded mandate from S.B. 394.

ASSEMBLY ACTION		Initial and Date	SENATE ACTION		Initial and Date
Adopted ☐	Lost ☐		Adopted ☐	Lost ☐	
Concurred In ☐	Not ☐		Concurred In ☐	Not ☐	
Receded ☐	Not ☐		Receded ☐	Not ☐	

EXPLANATION: Matter in (1) ***blue bold italics*** is new language in the original bill; (2) variations of **green bold underlining** is language proposed to be added in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill proposed to be retained in this amendment.

EWR/RBL Date: 5/16/2017

S.B. No. 394—Revises provisions relating to Medicaid managed care and required coverage provided by health insurers. (BDR 38-950)

SENATE BILL NO. 394–SENATORS SPEARMAN, SEGERBLOM, DENIS, MANENDO, PARKS; CANCELA, CANNIZZARO, FORD AND WOODHOUSE

MARCH 20, 2017

JOINT SPONSORS: ASSEMBLYMEN NEAL; ARAUJO, DIAZ AND THOMPSON

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions relating to ~~[Medicaid managed care and required coverage provided by health insurers. (BDR 38-950)]~~ **health insurance. (BDR 57-950)**

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
Effect on the State: Yes.

~~[CONTAINS UNFUNDED MANDATE (§§ 5, 6) (Not Requested by Affected Local Government)]~~

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EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets ~~[omitted material]~~ is material to be omitted.

AN ACT relating to health ~~[care; requiring the Director of the Department of Health and Human Services to make coverage through the Medicaid managed care program available for purchase on the Silver State Health Insurance Exchange by persons who are not otherwise eligible for Medicaid under certain conditions; requiring the Director to seek any necessary waivers from the Federal Government to provide such coverage and to provide certain incentives to persons who purchase such coverage; requiring insurers to offer health insurance coverage regardless of the health status of a person; requiring insurers to provide coverage for certain essential health benefits without an annual, lifetime or other maximum limit on coverage; requiring insurers to allow the covered adult child of an insured to remain covered by the health insurance of the insured until 26 years of age;]~~ **insurance; requiring health maintenance organizations to provide certain data relating to health insurance claims to group purchasers of health insurance upon request; requiring the Legislative Committee on Health Care to study certain issues relating to health care during the 2017-2018 interim;** and providing other matters properly relating thereto.

Legislative Counsel's Digest:

~~The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) provides a refundable federal income tax credit and cost sharing reductions to certain eligible persons who earn not more than 400 percent of the federally designated poverty level in order to offset the cost of certain health care plan premiums. (26 U.S.C. § 36B, 42 U.S.C. § 18071, 45 C.F.R. § 155.305) The Act further requires that such credits and cost sharing reductions only be made available to purchase health insurance which is offered on a state health insurance exchange, which includes, without limitation, the Silver State Health Insurance Exchange established by this State in 2011. (26 U.S.C. § 36B, 42 U.S.C. § 18071; NRS 695I.200) Existing federal law authorizes the Secretary of the United States Department of Health and Human Services to waive certain Medicaid requirements or provisions of the Act to promote state health care innovation. (42 U.S.C. §§ 1315, 18052)~~

~~Existing federal law states that the purpose of the Medicaid program is to promote access to health insurance for certain low income persons. (42 U.S.C. § 1396) Existing law authorizes this State to enroll Medicaid recipients in a managed care program provided by a health maintenance organization pursuant to a contract with the Nevada Department of Health and Human Services. (42 U.S.C. § 1396u-2; NRS 422.273) Existing federal law also authorizes a state to receive its Federal Medical Assistance Percentage (FMAP) allotment of money from the Federal Government to reimburse providers of health care for medical services which are provided as part of a managed care program. (42 U.S.C. §§ 1396d, 1396u-2) Existing law requires this State to develop a State Plan for Medicaid which includes, without limitation, a list of the medical services provided to Medicaid recipients. (42 U.S.C. § 1396a; NRS 422.063) Existing law also prohibits a state from using FMAP or other federal Medicaid money to reimburse a provider of health care for medical services which are provided to a person who earns more than 138 percent of the federally designated poverty level or for administrative expenses which are unrelated to the administration of Medicaid. (42 U.S.C. §§ 1396a, 1396b(a)(7); 42 C.F.R. 433.15(b))~~

~~Section 2 of this bill requires the Director of the Nevada Department of Health and Human Services to seek any necessary waiver of certain provisions of federal law to allow a Medicaid managed care program to be offered for purchase through the Silver State Health Insurance Exchange to persons who are otherwise ineligible for Medicaid. Section 48 of this bill revises the definition of "qualified health plan" to include the Medicaid managed care program so that it may be offered for purchase in the same manner as other health plans through the Silver State Health Insurance Exchange. Additionally, section 2 of this bill requires the Director to seek a federal waiver to allow persons to use the federal income tax credit and cost sharing reductions authorized by the Act to purchase coverage through a Medicaid managed care program which is made available by the Silver State Health Insurance Exchange.~~

~~To the extent allowed by federal law or if any necessary waiver is granted by the Secretary of the United States Department of Health and Human Services pursuant to section 2, section 3 of this bill allows any person who is not otherwise eligible for Medicaid to purchase coverage through the Medicaid managed care program. Section 3 requires the Director of the Nevada Department of Health and Human Services to set the annual premium to be paid by a person who purchases such coverage. Section 3 further requires that the benefits offered in such a Medicaid managed care program be the same as those provided to other Medicaid recipients. Finally, section 3 prohibits the Nevada Department of Health and Human Services from using any federal money to offer such coverage through the Medicaid managed care program.~~

~~Existing Nevada law provides that an insurer may not deny, limit or exclude a benefit provided by a health care plan in certain limited circumstances, including, without limitation, when a person has contracted for a blanket policy of accident or health insurance or in certain cases relating to adoption. (NRS 689B.500, 689C.190, 695A.159, 695B.193, 695C.173, 695F.480) The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) prohibits an insurer from establishing eligibility rules for a health care plan based on certain health status factors, including, without limitation, preexisting conditions, claims history or genetic information, and also prohibits an insurer from charging a higher premium, deductible or copay based on these health status factors. (42 U.S.C. § 300gg-4) Sections 8, 15, 19, 24, 28, 34, 41 and 45 of this bill align Nevada law with federal law and require that all insurers offer health insurance coverage regardless of the health status of a person and prohibit an insurer~~

~~from denying, limiting or excluding a benefit or requiring an insured to pay a higher premium, deductible, coinsurance or copay based on the health status of the insured or the covered spouse or dependent of the insured.~~

~~The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) prohibits an insurer from imposing an annual or lifetime limit on the monetary value of certain essential health benefits which must be covered under a health care plan, including, without limitation, outpatient services, pregnancy, maternity, and newborn care and certain contraceptive drugs, devices and services. (42 U.S.C. § 300gg-11) The Act also authorizes the Secretary of the United States Department of Health and Human Services to specify the services which must be covered as part of an essential health benefit. (42 U.S.C. § 18022(b)(2)) Sections 9, 13, 25, 29, 35, 42 and 46 of this bill align Nevada law with federal law in this manner, and require the Nevada Department of Health and Human Services to issue regulations that determine the services which must be covered as an essential health benefit by an insurer, including, without limitation, the services currently required to be covered under the Act.~~

~~The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) requires all insurers to extend coverage for the covered adult child of an insured until such child reaches 26 years of age. (42 U.S.C. § 300gg-14) Sections 10, 14, 26, 30, 36, 43 and 47 of this bill align Nevada law with federal law in this manner.]~~

Section 1 of this bill requires a health maintenance organization which provides a health care plan to certain large employers or multiple employer trusts to provide to the employer or trust upon request, not more than once every 3 months, either: (1) all claims data relating to the enrollees of the health care plan; or (2) sufficient data for the employer or trust to calculate the cost of providing certain medical services through the health maintenance organization. Section 1 requires such data to: (1) be free of any personally identifiable information; (2) comply with all other federal and state laws concerning privacy; and (3) be easily accessible. Section 1 also requires a health maintenance organization, upon the request of certain large employers or multiple employer trusts, to prepare an annual report relating to the cost and percentage trends in such data.

Section 2 of this bill requires the Legislative Committee on Health Care to study certain issues relating to: (1) making a program similar to the Medicaid managed care program which is currently available to certain low-income persons in this State available to persons who are not eligible for Medicaid; and (2) ensuring the same level of health insurance coverage which is currently available in this State pursuant to the Patient Protection and Affordable Care Act (Public Law 111-148, as amended) is maintained if the Affordable Care Act is repealed by Congress. Section 2 requires the Legislative Committee on Health Care to submit a report relating to these issues to the Director of the Legislative Counsel Bureau by not later than September 1, 2018.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Delete existing sections 1 through 52 of this bill and replace with the following new sections 1, 2 and 3:

Section 1. **Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:**

1. Except as otherwise provided in subsection 4, not more than once every 3 months, a health maintenance organization shall provide to a group purchaser that submits a written request:

(a) All claims data relating to the enrollees in a health care plan provided by the health maintenance organization pursuant to a contract with the group purchaser; or

(b) Sufficient data relating to the claims of enrollees in the health care plan to allow the group purchaser to calculate the cost-effectiveness of the benefits provided by the health maintenance organization. Such data must include, without limitation:

(1) Data necessary to calculate the actual cost of obtaining medical services through the health maintenance organization, organized by medical service and category of disease;

(2) Data relating to enrollees in the health care plan who receive care, including, without limitation, demographics of such enrollees, prescriptions, office visits with a provider of health care, inpatient services and outpatient services, as used by the health maintenance organization to make calculations which are required to comply with the risk adjustment, reinsurance and risk corridor requirements of 42 U.S.C. §§ 18061, 18062 and 18063; and

(3) Such data as used to establish an experience rating for the enrollees in the health care plan, including, without limitation, coding relating to diagnostics and procedures, the total cost charged to any person for each drug, device or service made available by the health care plan and all reimbursements made to a provider of health care for such drugs, devices or services.

2. If a group purchaser files a written request, the health maintenance organization must also provide an annual report relating to the quarterly data required to be made available to the group purchaser pursuant to subsection 1, which must include, without limitation, sufficient detail to demonstrate the annual changes in the cost and the percentage of increase or decrease, as applicable, for each category of information made available pursuant to subsection 1.

3. A health maintenance organization shall provide the data required by this section in an aggregated form which complies with federal and state law, including, without limitation, the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any applicable regulations.

4. Before providing any data pursuant to subsection 1, a health maintenance organization shall ensure that a professional statistician examines the data to confirm that such data cannot be used to identify and does not provide a reasonable basis upon which to identify a person whose information is included in the report. If the professional statistician is not able to make such a confirmation, the data must not be provided by the health maintenance organization to the group purchaser until such confirmation is obtained.

5. A health maintenance organization must provide the data required by subsection 1 in a format which is easily searchable electronically or on a secure Internet website.

6. A group purchaser must have policies and procedures in place which are compliant with federal law, including, without limitation, the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and the regulations adopted pursuant thereto, and the laws of this State to ensure the privacy and security of the data made available to a group purchaser pursuant to this section.

7. As used in this section, "group purchaser" means:

(a) An employer that employs at least 1,000 employees, at least 300 of whom are enrolled in a health care plan which is offered by a health maintenance organization; or

(b) A group of employers that cumulatively employ at least 500 employees and which has formed a trust for the purpose of funding health care benefits for at least 300 employees who are enrolled in a health care plan which is offered by a health maintenance organization.

Sec. 2. **1. The Legislative Committee on Health Care shall, during the 2017-2018 interim, study opportunities for:**

(a) The establishment of a program similar to the Medicaid managed care program authorized by NRS 422.273 to be made available through the Silver State Health Insurance Exchange established by NRS 695I.200 to a person who is otherwise ineligible for Medicaid;

(b) A person who is determined eligible for advance payments of the premium tax credit and cost-sharing reductions pursuant to 45 C.F.R. § 155.305 to use such credits and reductions to pay for coverage obtained through the program described in paragraph (a); and

(c) The Nevada Legislature to ensure the current level of health insurance coverage provided in this State pursuant to the Patient Protection and Affordable Care Act, Public Law 111-148, as it existed on the effective date of this act, is maintained if the Affordable Care Act is repealed by Congress.

2. The Legislative Committee on Health Care shall conduct the study required pursuant to subsection 1 in consultation with:

(a) The Department of Health and Human Services;

(b) The Division of Insurance of the Department of Business and Industry;

(c) The Silver State Health Insurance Exchange; and

(d) Any other entity identified by the Committee which has expertise in the topics listed in subsection 1.

3. The Legislative Committee on Health Care shall submit a report of the results of the study required pursuant to subsection 1 and any recommendations for legislation to the Director of the Legislative Counsel Bureau for transmittal to the Legislature not later than September 1, 2018.

Sec. 3. **This act becomes effective upon passage and approval.**