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

Seventy-Ninth Session
March 17, 2017

The Committee on Commerce and Labor was called to order by Chair Irene Bustamante Adams at 12:48 p.m. on Friday, March 17, 2017, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 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/79th2017.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Irene Bustamante Adams, Chair
Assemblywoman Maggie Carlton, Vice Chair
Assemblyman Paul Anderson
Assemblyman Nelson Araujo
Assemblyman Chris Brooks
Assemblyman Skip Daly
Assemblyman Jason Frierson
Assemblyman Ira Hansen
Assemblywoman Sandra Jauregui
Assemblyman Al Kramer
Assemblyman Jim Marchant
Assemblywoman Dina Neal
Assemblyman James Ohrenschall
Assemblywoman Jill Tolles

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Kelly Richard, Committee Policy Analyst
Wil Keane, Committee Counsel
Pamela Carter, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry
Rajat Jain, Chief, Property and Casualty Section, Division of Insurance, Department of Business and Industry
Glenn Shippey, Actuarial Analyst II, Division of Insurance, Department of Business and Industry
Amy L. Parks, Chief Attorney, Division of Insurance, Department of Business and Industry
Catherine M. O'Mara, Executive Director, Nevada State Medical Association
Kathleen A. Conaboy, representing Nevada Orthopaedic Society
Jeanette K. Belz, representing Property Casualty Insurance Association

Chair Bustamante Adams:
[The roll was called.] We are going to commence the meeting on Commerce and Labor.

We are going to begin with Assembly Joint Resolution 10. I am going to ask our policy analyst to read the summary, and I will refer it to the Senate Subcommittee on Energy.

Assembly Joint Resolution 10: Expresses opposition to the development of a repository for spent nuclear fuel and high-level radioactive waste at Yucca Mountain in the State of Nevada. (BDR R-1012)

Kelly Richard, Committee Policy Analyst:
Assembly Joint Resolution 10 expresses opposition to the development of a repository for spent nuclear fuel and high-level radioactive waste at Yucca Mountain in the State of Nevada.

Chair Bustamante Adams:
I am referring A.J.R. 10 to the Senate Subcommittee on Energy. Are there any objections? [There were none.] It is so referred.

We have several bills today, so we are going to do work session first. We will then open up the hearing on Assembly Bill 83. That is the huge insurance bill that we heard a couple of weeks ago. We have answers from the Division of Insurance, so we will have them come back and go over those answers. We will not take action on A.B. 83; we are going to hear the answers and see if we have addressed all of the issues.

For work session, we are going to do Assembly Bill 150, Assembly Bill 195, Assembly Bill 242, and Assembly Bill 247. I am going to hold Assembly Bill 129, Assembly Bill 179, and Assembly Bill 211 to work through those.

Assembly Bill 129: Revises provisions relating to the practice of optometry and the issuance of a prescription for an ophthalmic lens. (BDR 54-744)

[Assembly Bill 129 was not considered.]

Assembly Bill 179: Revises provisions governing massage therapy. (BDR 54-766)

[Assembly Bill 179 was not considered.]

Assembly Bill 211: Revises provisions governing compensation and wages. (BDR 53-764)

[Assembly Bill 211 was not considered.]

Assembly Bill 150: Revises provisions governing private professional guardians. (BDR 13-808)

Kelly Richard, Committee Policy Analyst:
Assembly Bill 150 was heard in this Committee on March 13, 2017, and the sponsor is Assemblyman Sprinkle (Exhibit C). The bill makes changes to the regulation of private professional guardians. It creates private professional guardian entities, each of which must employ a private professional guardian certified by the Center for Guardianship Certification. The measure also requires certain persons working for private professional guardian entities to submit fingerprints to the Division of Financial Institutions every five years. The bill removes a prohibition against a court allowing a private professional guardian to proceed using summary administration. In effect, this revision allows a court to authorize a private professional guardian to administer estates under $10,000 without maintaining certain records.

During the hearing on this bill, Assemblyman Sprinkle discussed the amendment that is before you today, which modifies section 16 to allow private professional guardian companies to maintain a separate guardianship account for each ward unless otherwise ordered by a court.

Chair Bustamante Adams:
I will entertain a motion to amend and do pass.

> ASSEMBLYMAN OHRENSCHALL MOVED TO AMEND AND DO PASS ASSEMBLY BILL 150.
>
> ASSEMBLYMAN DALY SECONDED THE MOTION.

Is there any discussion?

Assemblyman Paul Anderson:
I spoke with the sponsor and would like to see if we can get a clarification on the record. I know that it was discussed during the hearing—in a familial relationship, how do I ensure that I can take care of my parents without having to go through a licensing or having them become my wards? Where is the line drawn to where I then have to go into a professional setting?

Wil Keane, Committee Counsel:
Section 1 of the bill revises the definition of private professional guardian for the purposes of *Nevada Revised Statutes* (NRS) Chapter 159, which also applies for the purposes of the professional licensing in NRS Chapter 628B. If the guardian is related to the ward by blood or marriage, the guardian can have as many wards as the court will appoint. According to section 1 of the bill, which amends NRS 159.024, a guardian may have as many wards that are related by blood or marriage as the court may appoint. There is no limit, and the person would not be a private professional guardian. If you are appointed as a guardian by the court to someone who is not related to you by blood or marriage, then you can be appointed to one or two wards and still not be a private professional guardian. If you are appointed by a court to be a guardian and you are a guardian to three or more people you are not related to by blood or marriage, then you would be a private professional guardian.

Chair Bustamante Adams:
Are there any other questions? [There were none.] We will vote to amend and do pass, as moved.

> THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to Assemblyman Ohrenschall.

Next in our work session is Assembly Bill 195.

Assembly Bill 195: Revises provisions governing cosmetology. (BDR 54-119)

Kelly Richard, Committee Policy Analyst:
Assembly Bill 195 revises provisions governing cosmetology (Exhibit D). It was sponsored by the Chair and heard in Committee on March 3, 2017. The bill allows the Governor to remove a member of the State Board of Cosmetology under certain circumstances. It combines the position of Board secretary and treasurer into one position, revises provisions governing deposits and use of fees received by the Board, eliminates the Board's revolving fund used for cash advances, removes an obsolete provision related to the examination of applicants as a purpose of a Board meeting, and allows the Board to receive certain criminal history reports. The bill also allows the Board, upon request, to provide examinations for licensure and registration in languages other than English, and allows the Board to issue duplicate licenses or certificates.

Relating to licensees, A.B. 195 revises certain continuing education requirements, the documentation required by certain applicants and the expiration of certain licenses. It reduces from 3,600 to 3,200 the number of hours needed to apply for a license as a cosmetologist, and requires students to receive a minimum of 10 percent of the total hours of instruction for a particular profession prior to commencing work on the public. The bill includes prostitution or solicitation of prostitution as a ground for disciplinary action by the Board, and eliminates a restriction against cosmetological establishments advertising or otherwise representing to the public that they are primarily engaged in cutting men's hair. The only amendment I have was a request by Assemblyman Kramer to be added as a cosponsor.

Chair Bustamante Adams:
I will entertain a motion to amend and do pass.

> ASSEMBLYMAN KRAMER MOVED TO AMEND AND DO PASS ASSEMBLY BILL 195.
>
> ASSEMBLYMAN DALY SECONDED THE MOTION.

Is there any discussion? [There was none.]

> THE MOTION PASSED UNANIMOUSLY.

I will take the floor statement.

The next bill is Assembly Bill 242.

Assembly Bill 242: Revises provisions relating to certain loans secured by a lien on real property. (BDR 54-857)

Kelly Richard, Committee Policy Analyst:
Assembly Bill 242 was sponsored by Speaker Frierson and was heard in this Committee on March 8, 2017 (Exhibit E). The bill excludes a borrower or guarantor of certain mortgage loans from being considered as part of the beneficial interest in the outstanding principal balance or the ownership interest in real property for the purpose of allowing the holders of 51 percent or more to act in the interest of all holders.

Chair Bustamante Adams:
I will entertain a motion to do pass.

> ASSEMBLYWOMAN CARLTON MOVED TO DO PASS ASSEMBLY BILL 242.
>
> ASSEMBLYWOMAN JAUREGUI SECONDED THE MOTION.

Is there any discussion? [There was none.]

> THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to Assemblywoman Jauregui.

The next bill is Assembly Bill 247.

Assembly Bill 247: Provides for the early termination of certain rental agreements by victims of harassment, sexual assault or stalking. (BDR 10-655)

Kelly Richard, Committee Policy Analyst:
Assembly Bill 247 was heard in this Committee on March 13, 2017 and is sponsored by Assemblyman Yeager (Exhibit F). The bill provides for the early termination of a rental agreement if a tenant, cotenant, or household member is a victim of harassment, sexual assault, or stalking. The measure further prohibits a landlord from taking certain retaliatory actions against a victim who terminates a rental agreement for this reason. It also makes changes to the qualifications of third parties who may sign an affidavit stating a tenant, cotenant, or household member is a victim of domestic violence.

Assemblyman Yeager submitted the attached amendment (Exhibit F), and this was discussed during the Committee hearing on the bill. The amendment retains certain language in the original statute related to the qualifications of those third parties. The other amendment I have is that Assemblywoman Tolles has requested to be a cosponsor of the bill.

Chair Bustamante Adams:
I will entertain a motion to amend and do pass.

> ASSEMBLYMAN OHRENSCHALL MOVED TO AMEND AND DO PASS ASSEMBLY BILL 247.

ASSEMBLYWOMAN TOLLES SECONDED THE MOTION.

Is there any discussion?

Assemblyman Hansen:
I will gladly support this bill. I opposed it two sessions ago, and the concern at that time was it would be abused so people could get out of their leases. However, the testimony indicated they are averaging only one per week in Nevada or 52 per year out of thousands and thousands of rental and lease agreements. The bill has in fact done exactly what the proponents said, and those of us in opposition back then were apparently in error. I am happy to see this expanded, and hopefully it will help people in these horrible circumstances to deal with it more efficiently. Congratulations to Assemblyman Yeager, and I just want to say I will be supporting A.B. 247.

Chair Bustamante Adams:
Is there any other discussion? [There was none.]

THE MOTION PASSED UNANIMOUSLY.

I will assign the floor statement to Assemblywoman Tolles.

That completes our work session. I am going to open the hearing on Assembly Bill 83. The goal of hearing this bill is there were a lot of unanswered questions that needed to be clarified. I will also ask those of you who want to put comments on the record regarding A.B. 83 to come forward after their testimony is completed.

Assembly Bill 83: Makes various changes relating to insurance. (BDR 57-159)

Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry:
I am here to ensure that we clarify all of the questions you had posed earlier on Assembly Bill 83. We provided a lengthy document (Exhibit G) that gives a series of answers and I hope you have had a chance to look through it. We have experts here, and as their technical knowledge is needed, we can bring them forward to introduce themselves. I will step through the questions that were posed in the initial hearing. One of the things that came out of the original testimony, and a lot of your questions were questions from the industry, was that we ended up talking about more clarification language. We have a couple of technical amendments we will be proposing at the end that have been done in agreement with the industry.

The first question is from section 33 and relates to credit scoring. The concern was whether credit scoring was an issue at all and what was the benefit of bringing forth this particular amendment. The real issue for this amendment has to do with the fact that the carriers are being forced to do the credit scoring every three years, and that is often not beneficial to the consumers. What we are trying to do is put control in the consumers' hands when they want

to make that credit score arrangement instead of making a forced credit score alignment which may harm them in some way.

Chair Bustamante Adams:
Section 33 was one of the issues for several people. Are there any questions on section 33?

Assemblywoman Jauregui:
Can you show us where in section 33 that language is located?

Rajat Jain, Chief, Property and Casualty Section, Division of Insurance, Department of Business and Industry:
Section 33 effectively eliminates some of the language that existed.

Assemblywoman Jauregui:
I specifically want to know where in section 33 we are eliminating that three-year requirement.

Rajat Jain:
It is on page 25, line 36.

Barbara Richardson:
The next section is section 36. This question came from Vice Chair Carlton, and it relates to "prior approval" versus "file and use." I want to make a clarification for the record: the state of Nevada is a "prior approval" state except for large group insurance and commercial insurance. That was the issue and question that came forward. It is our understanding that was not clear on the record.

Assemblywoman Carlton:
Currently it is prior approval for these chapters listed in the bill. Will it stay prior approval or will it go to file and use?

Barbara Richardson:
No, it will stay prior approval. The file and use is only for the large group and commercial markets. We do have large group health carriers.

Assemblywoman Carlton:
What is changing in this chapter, because I understood you to say that you were going to "file and use" for health care?

Glenn Shippey, Actuarial Analyst II, Division of Insurance, Department of Business and Industry:
The proposed change in this chapter is to create parallel sections of the law for health insurance policies, particularly individual health insurance policies and small employer health insurance policies whose rates are subject to prior approval. It would propose to eliminate the right of the carrier to request a reconsideration following the act of disapproval

of a proposed rate increase. It would still preserve the right of the carrier to request a hearing regarding a Commissioner disapproval of a rate increase. Currently the law has reconsideration rights which we are unable to accommodate in the area of health insurance plans with the timing we have to work with under present state and federal requirements. The reconsideration of rights is what is being removed from current law, specific to individual and small employer health insurance rate requests.

Assemblywoman Carlton:
I am still trying to figure out what is the problem you are trying to fix and how does this affect my constituents? I am just trying to figure out what problem we are trying to fix, and it is no secret I do not like file and use. I think it abuses people. I learned what a zero percent increase was in 1999. I want to ensure that people who are purchasing health care are not put in a position of their rates not being preapproved. I do not want to see happen to health care what has happened to car insurance. It is not good for Nevada.

Glenn Shippey:
We are proposing consumer protection. If the Commissioner disapproves a rate increase request for an individual health insurance carrier, currently the law allows and gives the carrier the right to request reconsideration. The existing statute is still going to apply outside of health insurance, so mostly to property and casualty lines. You can see that on page 32 of the bill. Section 44, subsection 3, states, "Upon receipt of a written notice of disapproval from the Commissioner . . . the insurer may request that the Commissioner reconsider the proposed increase or decrease." It is the reconsideration that is being removed for individual and small group health insurance rate increase requests in section 36. Section 36 repeats the NRS 686B.110 statute but removes the reconsideration right, following the disapproval of a rate increase by the Commissioner.

Assemblywoman Carlton:
My understanding is, under the file and use scheme, if the Commissioner does not disapprove a rate increase, it becomes automatically effective. And, it has to be disapproved within a certain amount of time. Is that still true?

Glenn Shippey:
Yes, that is not changing. This is how it currently exists and will continue.

Assemblywoman Carlton:
That is the problem I have had with how this scheme works. There is no actual approval mechanism; it is a default approval. If it does not get disapproved, it is automatically assumed approved. Is this correct?

Glenn Shippey:
We have not had a single case of a carrier deeming a rate increase approved because of our failure to act within the required amount of time that these statutes create.

Assemblywoman Carlton:
I understand that, and we do not make laws based on the people who are sitting in the office right now, because no matter who is there in the future, once it is in statute it is there. It is not just who we have now. Most of our regulators are really good, and I enjoy working with them, but I have to think about the future and what could end up happening with future rates. I am a firm believer in prior approval to ensure my constituents are protected and not being taken advantage of in a market which is more sophisticated than the average person actually understands. I think it is the regulators' job to do the approval process. That is the concern I have. It is nothing against what you are trying to do; it is just what is going to happen 20 years from now when we have this provision and someone could use it the wrong way. I appreciate your explaining it.

Chair Bustamante Adams:
Are there any other questions on section 36? [There were none.] We will look at sections 34 and 35.

Barbara Richardson:
In sections 34, 35, 37, and 39 there was some confusion because there ended up being separate sections in between them so when we ended up talking about the large deductible plan and workers' compensation, it was easy to make that transition. It is specifically only these sections, and the issue relates to making collateralization requirements on policy holders. As regulators, it is our concern to ensure the insurance companies are healthy and solvent, but the problem is the underlying employers are asking for such high deductibles that when they go down, they bring the insurance company with them. We are trying to make that collateralization requirement on the employers before they get into that kind of trouble.

Chair Bustamante Adams:
Are there any questions on these sections? [There were none.] We will look at section 67.

Barbara Richardson:
Questions that have come up in Sections 67 through 70 relate to survivorship clauses in contracts. We provided an exhibit as part of your Nevada Electronic Legislative Information System (NELIS) uploads [pages 15-17, (Exhibit G)] with your attachment that talks about the different type of survivorship clauses in different types of contracts and in bankruptcy. The idea is to protect the consumer beyond the term of the original bankruptcy issue. For example if you have a year-long insurance policy, we want to ensure you are still covered for that entire year even if the company or the carrier goes bankrupt. There are a lot of controls in place to ensure the consumer does not feel the harm in these particular situations. That is what the survivorship clauses are supposed to be doing.

Chair Bustamante Adams:
Are there any questions? I hope we answered your question, Assemblywoman Neal, because I know you had a question on section 70. Does anyone else have questions on this? We are not voting on this today; the purpose is to take each section step by step.

Assemblyman Kramer:
I have never thought of myself as lacking cognitive ability when it comes to reading a paragraph and determining what it says, but you are challenging me. As I look at section 70, I am having a tough time. "Each contract entered into for the purposes of a network plan between a participating provider of health care and the health carrier . . . ." What is the difference between a participating provider of health care and a health carrier?

Amy L. Parks, Chief Attorney, Division of Insurance, Department of Business and Industry:
The contracts we are talking about are contracts between a participating provider and a health insurance company. Another term for a participating provider is an "in-network provider." It is a doctor or a network of doctors or hospitals.

Assemblyman Kramer:
So this keeps the doctor from collecting or attempting to collect from the patient any money owed to the doctor, even if you have not paid your deductible?

Amy Parks:
Not exactly. This says that in certain cases, the doctor or the network of doctors cannot collect from the patient any more than their copays or deductibles. They are not allowed to collect from the patient anything that the insurance company would be responsible for paying pursuant to the policy.

Assemblyman Kramer:
It seems there are three ways a patient can pay: the copay, the deductible, and in some cases, a plan has a limit where they will not pay any more above that amount. You might be liable for amounts above that limit, but they cannot bill you for anything in between that the insurance company should have paid. If there is a negotiated rate for that, the patient is not liable for anything between the negotiated rate and their normal and customary. Is that correct?

Amy Parks:
Yes, that is correct.

Chair Bustamante Adams:
Are there any other questions on this section? [There were none.] We are going to look at sections 109, 113, and 134.

Barbara Richardson:
Sections 109, 113, and 134 relate to coinsurance and the change we would like to put in place, specifically for preferred provider organizations (PPOs). It has to do with out-of-network versus in-network payments. The concern from our perspective is that with the rules around small and large group health insurance plans, the options are getting more and more restrictive. We are trying to open some opportunities for potentially less expensive plans on the market if they fit the needs of those employers. For example, if an employer has

all of its employees living in one particular area right next to the hospital, the question is, is it reasonable for them to pay for services that might be way beyond what their employees would ever use? It would still take care of their emergency issues, but specifically it was just to open this potential product. Currently with the restrictions, that is not available. We do have Glenn Shippey if you have specific questions about how the plans may work.

Chair Bustamante Adams:
What mechanisms do we have in place if abuse begins in that new offering?

Glenn Shippey:
When carriers introduce features to policies and plans that are a bit unusual, we focus on transparency so that the purchaser—in this case the employees and dependents that may be covered under that employer-selected plan—would better understand how that plan works. We do force more prominently displayed portions of language on the actual documents that both the small employer and the employees and dependents would receive. We would ensure the carrier did its own outreach, and our website would include additional information to distinguish those types of plans from plans that consumers are typically accustomed to. Anytime there is a variation, it is a little bit different. We have had those types of experiences recently for 2017. We have done that on our website, and the carriers have done a good job explaining the different features of 2017 plans to those affected consumers.

Chair Bustamante Adams:
My other question is if this were allowed to happen and there was excessive abuse of the consumer, how do you remedy that? We have to then make a policy decision to revert back and not allow this type of coinsurance requirement. Is that correct? Is that how it would work?

Glenn Shippey:
I want to repeat something that is important and that the Commissioner in her response stated: We are talking about only the employer market—so small employers and large employers—and in these markets there is not one period in the year where the employer can purchase a policy. They can purchase a policy any day of the year. They could have an anniversary date any day of the year, which is different from the individual market. If there were issues with a particular plan, I think the employer would understand that. Usually the employer will hear first before our office hears, and the employer would have the freedom to choose something else if it no longer works for the employee's independence on that plan. The plan might work for some other employers. That additional choice on the marketplace at a lower price point may be something that some employers are looking for, as the Commissioner pointed out.

Assemblywoman Neal:
When I was reading your description of the third category of insurance that could be offered to employers, the first part states it does not provide coverage for non-emergency services out of network. I would like an example of that type of situation. The way you were explaining this section under the current statutes, out-of-network coinsurance is limited to

50 percent, and a plan could not have less than 40 percent of the coinsurance out-of-network providers. So if you were offering an exclusive provider organization (EPO), what would be the category of coverage they would have, because even if they have an 80-20 split, they do not really have a lot of medical expenses that are going to be covered. This is how I read it. There is a very limited menu of services they are going to cover, and the first thing that came to mind was when businesses are forced to offer an insurance plan to someone who is now making above a minimum wage and they have to provide something. I need a clearer example of what that looks like and how that works.

Glenn Shippey:
I think it is important to point out that this EPO type of plan currently exists today under a health maintenance organization (HMO) model. A pure HMO that does not have more than one tier only allows that member to seek care through those network providers. It is a comprehensive set of health insurance benefits, so the package of benefits offered is not narrowed; it is only the freedom to go outside the network that is eliminated. It is legal for HMOs, and this would allow preferred provider organizations (PPOs) to sell something like an HMO but they can do it as a PPO company. That is what an EPO is. An EPO is an HMO single-tier plan offered by a PPO carrier so that effectively, your out-of-network coinsurance responsibility is 100 percent There is no benefit out of the network. You still have that comprehensive set of benefits covered by the EPO policy. That does not narrow. You no longer can just go out of network to any provider, which is how PPOs work now. These EPO plans are common in other states, but currently they are not allowed in Nevada in our group markets.

Assemblywoman Neal:
Why have they not been offered in Nevada? Clearly we are open to competition. The HMO had the ability to do it, and now the PPO will have the ability to do an in-network specific option. What can we see as the effect of that? Are we gaining more access for consumers to get a plan no matter who is offering it? What does the end customer look like who can be serviced from this language?

Glenn Shippey:
This is really about giving those small businesses in Nevada lower price-point options that would be at price points similar to what those single tier HMO plans are at. These types of plans would be available from the many PPO carriers that we have in the group markets, not just from the HMO carriers in those markets. It is more lower-priced options for the small businesses that struggle with the cost of providing health care to their employees.

Assemblywoman Carlton:
When did this particular provision become effective in statute? Do we know how long it has been there?

Glenn Shippey:
In the early 1990s there were some problems with EPOs in California that concerned the Division, and subsequently prompted the Division to take a position to not allow EPOs in the market. There was some harm done in California several decades ago. That was the origin. With the changes that have occurred over the last 30 years in health care, we are an outlier now by not allowing these lower-priced options to employers in Nevada. We are one of the few states that do not offer them.

Assemblywoman Carlton:
Can you provide any history to us on that? I remember part of it, but that is going way back. I knew there was something, and there was an issue. I think it was cost-shifting to the employee because the employer bought the plan; the employee thought they had more coverage than they actually had. When they used the coverage, it did not cover everything and they ended up with a bill. I think that was one of the issues in California, but I am not sure. Are there any cases you can provide to help jog my memory? The last thing I want to do is have an employer buy a product, offer it to his employee, and the employee ends up getting stuck with part of the bill because he thinks he can use it a certain way when he really cannot. This is a very limited plan, in my understanding.

Glenn Shippey:
I would be happy to research and get back to you quickly. I do not think it will take too long. I will point out again, for the record, that it is a limited plan only in terms of access to out-of-network doctors. It is not limited in terms of benefits that are covered under the plan. There is still a comprehensive set of benefits covered.

Assemblywoman Carlton:
Is specialty care covered?

Glenn Shippey:
Yes, fully.

Assemblywoman Carlton:
If there is no specialist in network that you need to see, there is no guarantee. I can speak from personal experience: We have an HMO, and there are times that there is no specialist in network, but they do refer us to someone out of network and there is an agreement on how we pay for that. You cannot have everyone in your network. If there is no specialist available and you have to go out of network, the consumer would pay the full price.

Glenn Shippey:
It works just like HMOs; the EPO would be considered a single-case contract expansion of that network. There are certain specialties that are not available even out of network in Nevada where those individuals do have to seek care outside of Nevada, and our carriers have to provide that medically necessary care to those members. They would do that with an EPO as well, just like they are currently doing with HMO-type plans.

Assemblywoman Carlton:
There is an issue in Nevada about emergency care and ending up in an emergency room that is out of network. How would the EPO look at that? Currently there are issues where you are on a soccer field in the northwest corner of Las Vegas, your child breaks a leg, you go to the nearest hospital and it is not in network, and you get stuck with the entire bill. Depending on who you have as your health care provider, there are ways to negotiate that. How would that be handled under an EPO? Would that be totally out of network and the consumer totally responsible?

Glenn Shippey:
All emergency room care would be paid as if it were in network for an EPO, just like other plans that exist today. It does not matter what hospital you go to; it is going to be paid as if it was an in-network hospital, and that would apply to an EPO as well. The difference between going to an in-network hospital and an out-of-network hospital for an emergency is you would get a balance bill. The difference between what the carrier pays the out-of-network hospital for that emergency and what the bill is from that out-of-network hospital to the consumer would be the responsibility of the consumer. That is currently the situation with the plans that exist today under both state and federal law. Exclusive provider organizations would be handled in the same manner.

Assemblywoman Carlton:
I am assuming that since this is a lower cost option, the contracted rate with that hospital would be at a lower amount, and the consumer would end up with a substantial surprise bill.

Chair Bustamante Adams:
This is exactly the purpose of our time here today. These are complicated issues, and we are taking it at a slower pace. We will look at Section 159.

Barbara Richardson:
The concerns in section 159 relate to ensuring the carriers provide the Division of Insurance with documentation about quality of care. Our intent with this section relates to ensuring carriers use a similar type of timeline. Managed care organizations (MCOs) were turning in their documentation at a different time than other health organizations. We are trying to get everyone on a similar schedule. We are looking for the same underlying data, we just do not want them to have to do duplicative work. We want to ensure we can get the information in a timely manner.

Chair Bustamante Adams:
Are there any questions on section 159?

Assemblyman Ohrenschall:
My question relates to the strikeout language on page 104, specifically lines 21 through 23. "A statement of any financial interest it has in any other business which is related to health care that is greater than 5 percent of that business or $5,000, whichever is less. . . ."

Does that appear somewhere else in the bill that I may have missed, or is it not considered important as a policy choice? Why are we striking out that language?

Glenn Shippey:
The intent of striking the hardcoded language is to give us flexibility in designing the type of information we would like reported to us on an annual basis. We tend to not want to be a hardcoded, boxed-in type of reporting, but it is still certainly an area we are interested in monitoring and collecting information regarding.

Assemblyman Ohrenschall:
If this bill passes, is the strikeout language at NRS 695G.130 something you propose to adopt into regulation to try to find out what other financial interests the company might have?

Glenn Shippey:
It is. We do that through regulatory guidance by designing the reporting form and the information we require with this type of report and the many other reports we require from carriers. We control the template used to collect the information that is reported so it is reported in a standardized manner. It is something we would work in; it would not be by regulation, but more of a requirement within the reporting template that we develop.

Barbara Richardson:
We have a corporate and finance section on our report for information specifically under these types of guidelines. The real issue for us is ensuring we are not asking for the information in two places. We do not like to force the carriers to provide something we can get. We get information under the current guidelines, and Mr. Shippey is correct in saying if we get the information this way and we find we need more information, that is when we develop further regulations to get more detailed information.

Assemblyman Ohrenschall:
This strikeout is duplicative. You will get this information anyway whether a company owns a surgery center or something else.

Barbara Richardson:
Yes, we do. We just do not happen to get it through the same framework that we get other reports. We get it through our corporate finance area.

Assemblywoman Neal:
What do you do once you receive the report and you find out that the quality or access to health care is not up to par, since the whole purpose of the report is to track those measures?

Glenn Shippey:
I would like to point out that this shifted over recently to the Commissioner from the State Board of Health. We are currently developing how we are going to build and approach this information. This came over along with the authority over the adequacy of networks for individual and small groups. We have a network adequacy council that was formed to

look at that. We are in the process of building out the internal processes of how we are going to choose to evaluate the data we collect pursuant to this statute and other areas. I do not have an answer for you with a lot of specificity because we are still in the process of building the quality reporting and how we evaluate and respond to the specific measures we collect.

Assemblywoman Neal:
In the process of your transition, who is now monitoring and evaluating quality of care?

Glenn Shippey:
There are outside accrediting entities that specialize in this; the National Commission for Quality Assurance (NCQA) is one of them. All of our health carriers have to be accredited, and they collect and monitor quality on an ongoing basis with our carriers. Without accreditation, HMOs, for example, would not be able to sell; any carrier on the exchange has to be accredited as well. We are trying to better understand those reviews performed by the accrediting entities to see what we can use to supplement and make it more local and look at the type of data that both NCQA and our agency would be collecting.

Assemblywoman Neal:
Can you give me the background on why the shift happened from the State Board of Health to the Division of Insurance?

Amy Parks:
It was our understanding the Division of Health was doing this to a certain degree. When they no longer had adequate funding or staffing, then-Commissioner Kipper volunteered the Division of Insurance to take over quality care monitoring and control along with the network adequacy project. This is why it is with us now. I do not know if any of you were involved in our huge project to develop the Network Adequacy Advisory Council with Assemblyman Oscarson. That is the approach we are going to take with this quality of care project as well.

Chair Bustamante Adams:
We will now look at section 162.

Barbara Richardson:
Section 162 relates to determining, at the federal level, the status of the Affordable Care Act (ACA) and the many changes that are going on around it. Last time, we discussed the Division having some rulemaking authority should there be significant changes. We want to let everyone know we are bringing forward an amendment to put a sunset, and it is attached as the last exhibit [pages 21-22, (Exhibit G)]. We are proposing a sunset; the idea is not to give us unlimited authority. We are not comfortable with that; we want to ensure it is for this limited, specific issue.

Chair Bustamante Adams:
We will pause here. I know, Assemblywoman Carlton, the sunset was one of your questions. Are there any other questions on section 162?

Assemblyman Daly:
I remember the hearing on this, and that was one of my concerns—the ACA—and you come back with a sunset. My concern here is with everything in flux at the national level and referring to the ACA, whether it is going to be that or some variation or something completely different. Is there any chance for temporary regulations which you can put into place without having the hearings which move more quickly, but then they end? That then gives you time to go through the full regulatory process. If something was urgent, there is an emergency provision for that as well. You would have to go to the Governor and say it is emergent. Those also end, but it gives you time to go through the full regulatory process. I do not know if those are options you feel comfortable with, but I know there is concern about not going through the existing regulatory process for such a huge unknown at the national level.

Barbara Richardson:
We completely agree. We are very nervous, and we are watching every day for the changes that may come forth. I think that is why we wanted to put this out there. The assumption is that we will never make a move without the Office of the Governor or hopefully, if there is a special session, with the legislators being part of the decision making. I think there are some technical issues which may come quickly that we might have to handle on our own. If those happen, it is really a matter of timing in most cases. It has never been in my comfort level to ignore the current law. Whether I like the law or not, I do not feel comfortable ignoring it. That would be the option I might have to take. That is what concerns me.

Assemblywoman Carlton:
I have great respect for our regulators in Nevada; I think they do a very good job. If this hits the fan, there is going to be a lot more going on than just this. I really think the policy part of it should come with us. I should not have to hope for a special session, but I do not want the 63 of us legislators to be excluded from the discussion. I have nothing against the Executive Branch of government, but we have three branches for a reason, and these types of policies and this impact will affect every one of our constituents. I understand having to move nimbly, quickly, in dealing with things, but I do not want it to be at such a rate that we legislators do not have an impact, because we are the ones who had to make all of the decisions on these things.

Even with the sunset, I would be concerned because whatever Washington, D.C., does is not just going to put a divot in our budget, it will put a crater in it. There will be a lot bigger issues, and we will have to get together and figure out how we are going to protect the citizens of Nevada. I would hate to see the 63 of us left out of that discussion, and I see this provision as being used to leave us out of that conversation, when I think we should be very

involved in it. I understand why. I am glad you are being proactive; I am just uncomfortable with not knowing what magnitude impact could end up hitting us.

Chair Bustamante Adams:
Are there any other questions on section 162?

Assemblywoman Tolles:
Is there some way to write in parameters of what might be minor adjustments to address your point versus major adjustments that would be better suited for a special session?

Barbara Richardson:
There would be ways to do that; however, it is a policy decision that still belongs with the legislative body. If that is something you would like us to look at, we could.

Chair Bustamante Adams:
Yes, if there are other options to consider. Are there any other questions on section 162? [There were none.] Are the single amendment pages not part of the March 2 letter? Are they amendments we want to review?

Barbara Richardson:
That is correct. There should be four of them. Amendments to sections 110 (Exhibit H) and section 114 (Exhibit I) are very similar—they clarify the product discontinuation notice. It ensures that people know which product is discontinued, and it is based on employers. Specifically, you will find the amendment on section 169 (Exhibit J) relates to an effective date relative to these particular discontinuation notices. Because of the change in timelines that the Affordable Care Act has provided this year for potential rate information and product discontinuances and altered plans, and the way they are trying to get that information in a much quicker, shorter timeline based on some of the tools that are in place, we are concerned with letting the consumers know so far ahead of the open enrollment period that they do not remember when issues are going on. The idea is to shorten it from 180 days to 90 days, which is closer to when people are making choices. We have found that in these cases consumers receive this information so far away from where the choice time period comes, they forget to go back in, or they do not take the time to reach back into the system. Section 169 alters that effective date for these particular sections of the bill because it just so happens that the 180-day notification hits June 24 of this year. The concern from the industry and from us is we do not want the consumers to receive a notice saying that a plan is going to be discontinued when it is just because the bill did not get signed before that particular time and deadline.

Chair Bustamante Adams:
Are there any questions on sections 110, 114, and the "effective upon passage and approval" date for the changes in section 169? [There were none.]

Barbara Richardson:
The last amendment (Exhibit K) we put forward relates to service contracts. You may remember that there was an industry member who had some concerns about the service contract provider we had in the bill. We met with that organization and a couple of other groups to ensure we were being mindful of their concerns. We did agree to a couple of changes. The changes in sections 123, 127, and 128 relate to our use of the term "director," which could be a very broad determination for a service contract provider, depending on how large they are. They were asking us to work on the language of the controlling person as the person we want to get information from. Ultimately, that is what we wanted. Our concern when we used the broader language was that we thought that captured everyone. As it turned out, it captured more than everyone, and that is not really what we were after. Through those discussions we were able to get that clarified and work with the industry. We are very comfortable with the limitations. It just happens to be spread among those particular three sections.

Chair Bustamante Adams:
Are there any questions on sections 123, 127, and 128 regarding service contracts? [There were none.] We are going to hear comments on A.B. 83; you may want to get some things on the record if your issues were addressed or in the testimony of our last meeting.

Ms. O'Mara, I know you want to get some things on the record, so if you will go specifically by section, it would help me keep track.

Catherine O'Mara, Executive Director, Nevada State Medical Association:
I appreciate the opportunity to return today to put some comments on the record. I also appreciate the time you have taken on this bill to try to help some of us who are having a tough time understanding certain provisions and the implications to our members.

Assembly Bill 83 has brought us into the Division of Insurance because it legislates some of the requirements that need to be in contracts that are currently freely negotiated. We are here trying to understand the provisions in A.B. 83 and how they affect our members.

In A.B. 83, we have concerns with the provisions in sections 67 through 109, noninclusive. We share some concerns about section 162 in allowing the Division to be able to work around the Administrative Procedure Act because we want to ensure we preserve our voice in this matter. I want to ensure there are open meetings and there is an opportunity for the provider to be heard.

The provisions we are going to discuss were taken from a national model code that were promulgated by insurance commissions at the national level There were some providers participating in that but, for the large part, the provider voice went unheard. Their opportunity to negotiate some of these provisions did not follow through. The National Association of Insurance Commissioners' (NAIC) model bill included many other provisions that are not in this bill. We just wanted to point that out. The NAIC also has some provisions on adequacy of network and health carrier selection standards. Those provisions

are not in this bill, so we are picking certain sections, but we do not have the full universe. I am bringing that to your attention; I am not saying that we want the full universe, but I just want you to know that we are picking certain sections and putting them in here so it is really important that we understand what they do, because sometimes model legislation and Nevada legislation do not exactly match.

Let us start with section 67. I know the Commissioner raised sections 67, 68, and 70 during her presentation. Unfortunately, we were not able to review the exhibits on NELIS until approximately five minutes before the hearing, so we have not had a chance to look at her comments in detail. I think section 67 requires that each contract between a network plan, a participating provider of health care, and the health carrier has to include this section. This means between the physician and the insurance plan.

Regarding Assemblyman Kramer's point, if you read the section 7 language, it says the "Provider of health care agrees that in no event, including but not limited to, nonpayment by the health carrier. . . ." The health carrier may not bill the patient what the insurance company owes. This seems logical; we do not want to bill the patient for things the insurance carrier should be paying. In practice, a physician will bill the patient because they have not gotten paid by the insurance plan. That will usually alert the patient to the fact that their insurance plan has not paid their doctor, and sometimes they will pay it and then submit it to their insurance plan, or sometimes they will call their insurance plan and ask why this was not paid. We want to ensure that this does not have an unintended consequence where we cannot readily communicate with the patients about the status of their insurance bill.

We actually would strike this section, but in the spirit of trying to work through and make a good policy, we would suggest instead a modification in cases where the insurance plan has gone insolvent. When that happens, the insurance plan goes into receivership and the provider continues to provide care to the patient, and the provider may not be able to bill the patient for those services while they are providing care. The provider may not know the insurance plan is insolvent. We would then request the Division to provide a way for the health care provider to receive notice of the insolvency within five working days of their notice of insolvency and to clarify what the provider's obligations are under this bill in whatever form it passes. The notice to the provider would say: this insurance plan is insolvent, and here is what you need to do to take care of the patient and to inform if there are any protections for the provider to preserve their ability to be paid at the end of the termination of the receivership.

Chair Bustamante Adams:
Is it now different than five days or does it just not exist?

Catherine O'Mara:
Five business days is something we came up with. We can talk about that notification. The notice itself does not exist, and I believe providing notice is something—and I do not want to speak for the Commissioner, but we have had a few meetings—she is willing to consider. It would be good to ensure the patient is provided notice that their insurance plan

has failed. Sometimes the patient is not going to know because it is their employer that has contracted for the insurance plan. We have to make sure that everyone understands what is going on.

We also wanted to request timely notification of any of the other reasons for nonpayment under section 67. We would like the phrase "timely notice" to be outlined in regulation. We would also request notice of the date on which the patient is no longer covered by the plan due to their nonpayment of the premiums. As long as the patient is paying premiums, that plan is guaranteed. Once they stop paying premiums, it is no longer guaranteed. The provider community would like to be notified when that occurs. I do not know who we ask to provide notice. Is it the receiver? Is it the Commissioner of Insurance? I am unsure, but we would just like to receive notice of that.

Assemblywoman Carlton:
I understand where you are coming from, but every time I walk through the doctor's office, the first thing they do is pick up the phone and hit the code to ensure my insurance is still valid. I am filling out the form while they are doing it. When you make the appointment, they check it, and when you walk through the door, they check it. I am unsure if this provider notice is necessary because you should be able to find out right then, especially if you are seeing a specialist. They will make that phone call to ensure your insurance is up to date. If a preauthorization was required somewhere along the way, there is a code number. I am unsure if this type of notice would really work better than the way it is being done now, with the provider double-checking with the insurance carrier to ensure the patient has insurance.

Catherine O'Mara:
In general, our medical practices are able to access and figure out what is going on with an insurance plan. When I spoke to practice managers recently in Reno, a few of them mentioned there are over a hundred different types of insurance companies, each with between four and eight plans. You are talking about a lot of different things to consider. In some cases, yes, they would be able to call and find out what is going on; however, not in every case. If there was a standardized process where they were notified upon the Commissioner of Insurance's receipt of notification that an event occurred, the physician can actually help the patient. If the patient does not know what is going on, then the patient does not know the status of their insurance plan. They are paying premiums, but they do not necessarily know. This is a standardized way for the provider community to receive notification of that. We feel we help operate as a safety net in trying to make sure people are insured, in network, and doing all of those things. Ninety percent of the time that works out fine, but we are not always able to do that. It does not change the treatment for the patient; the patient still gets treated. It is just a sunshine transparency requirement that we would like to see so that providers understand what is going on with the plan.

Assemblywoman Carlton:
Are we still on the insolvency discussion? It seems to me that confirming coverage is on the consumer and the provider more than it is on the Commissioner of Insurance. It is my responsibility to take my driver's license, my health care card, my referral, my preauthorization slip, all of those things. That is my responsibility, and the provider's responsibility is to check all of that before I walk through the door. I am not sure why having it go backwards when it has been going forward the entire time would provide more transparency. Right now we have this system of ensuring everyone is working toward ensuring the coverage is valid, from the consumer up the line, rather than from the Commissioner of Insurance down. If the Commissioner said the wrong thing and someone told me at the doctor's desk: You cannot come in because the Commissioner of Insurance said this, I would say, Excuse me? I want to ensure we are on the same page.

Catherine O'Mara:
This does not change the incentive to the provider to confirm insurance. The provider wants their patients to be insured and in network. They have a lot of incentives to do that. This does not change that, but the Commissioner of Insurance is notified when there is an insolvency. I am not sure how many times this occurs, but when we discussed it with her, it seemed the Division would be willing to provide notice that the insolvency had occurred.

Assemblywoman Carlton:
This is just about insolvency then.

Catherine O'Mara:
The first point is insolvency. The second point would be timely notification of any other reason for nonpayment under section 67. There are a lot of other examples in this section besides the insolvency of an insurance company, even though that is what they are getting at in this section, as I understand it.

Assemblywoman Carlton:
I guess I have to do a culture shift because it seems the way we have it now is consumer-driven, and I know what my responsibilities are. If there was an issue with the premium and I was told I could not be seen for some reason, I am just confused why we would go top down rather than bottom up.

Catherine O'Mara:
The care for the patient does not cease. What we would like to have is the Commissioner provide a way for the health care provider to receive notice of the insolvency within a certain time of the insolvency and a clarification of the provider's obligation. The Commissioner of Insurance receives the notice that the insolvency has occurred. They forward that to the provider and say, This is what is going on and, under the law, you are required to do continuity of care. However, the law ends up coming out. It is an opportunity to provide transparency and clarity, and I do think this is pro consumer because it will clear up some of those misconceptions. If the person calls and says they did not get an answer from the insurance company, they do not necessarily know that is because of insolvency. Maybe they

just did not get an answer. We want to ensure we are promoting treatment of patients and physicians understanding what is going on, and this seems like the most streamlined way to notify the provider.

Assemblywoman Carlton:
I think I need to separate the insolvency discussion from anything else. When you work it from the consumer side, in knowing what is going on, the last thing I need when I am trying to figure out how to get health care is to put the Commissioner of Insurance in the middle. She sets the rules and we are supposed to take it from there. If she sends out some type of notice that prohibits me from getting to where I need to go—I just do not see that level of regulation getting involved in my actual day-to-day health care. I am totally confused on this, so we will try to figure out how this works. I understand this issue of solvency, but on the other side, I am not sure I am there yet.

Assemblywoman Neal:
What you seem to be doing in section 67 is shifting a lot of responsibility to the Commissioner of Insurance. Why would it not be the provider's responsibility? They are this one government agency, and then you have all of the providers. Providers capture more than HMOs. You say you are representing the physicians. You want the Commissioner to give all of these notices to the physicians, and I am wondering where the physician's responsibility is because there should be a balance. You are saying you think it goes this far, and then you are shifting the burden and responsibility to them, and that seems excessive to me.

Catherine O'Mara:
The physician's responsibility is to continue to treat the patient. The mechanism the Commissioner is able to use is she has access to the providers on the insurance plan. It was explained to me that it would not be difficult for them to notify all of the providers upon receipt of insolvency. If there is an issue with the other sections, I am confused why the provider has the responsibility when the insurance company is not paying. Maybe it is not the Commissioner's job, but I do not know that it is the provider's job. I think maybe we just disagree on that. I do not think we are trying to shift the burden to the Commissioner of Insurance. We are just trying to find the most streamlined way, and if it is only for insolvencies we can accomplish that, then maybe that is the only way we can do it.

Assemblywoman Neal:
Let me clarify because I was not speaking on the insolvency. I was speaking on your number two reason, which was any other reason other than insolvency. I just want to clear that up, and we can leave that issue.

Chair Bustamante Adams:
Ms. O'Mara, how many more sections do you have?

Catherine O'Mara:
That was my first section, Madam Chair. I have approximately eight more, and I think I can make my record briefly.

Chair Bustamante Adams:
It is a work in progress, so we are not going to resolve all of the issues here. This is for you to put it on the record that there are some concerns we still need to work through.

Catherine O'Mara:
We appreciate the opportunity, and we do have a follow-up meeting with the Division. We will continue to do our best to understand the bill.

Section 70 appears to us to be duplicative of section 67. Our notes indicate section 70 is pertinent to bankruptcy or insolvency proceedings. I believe they stated that on the record today, but it is not clear from the language what is intended, so we would request some clarity there. Section 71 requires timely notice, and we would request a definition of "timely notice" through the regulatory process. Section 76 has been taken out, and I think the explanation was they discussed it with industry and believed they should take out this section. That was part of the amendment packet of the first hearing on this, and we would like clarification as to why that was taken out. This seems like a good provision for patients.

Chair Bustamante Adams:
What section was that?

Catherine O'Mara:
That was section 76. We are fine with section 77. In section 79, the responsibility of the provider—and this goes back to what Assemblywoman Carlton was saying about how we check when you come in and you show us your card—is to notify a patient. Let me back up; section 79 requires the health plan to notify the provider if they are supposed to collect copays and deductibles. The provider is then supposed to notify the covered person of their personal financial obligations for any health care services that are not covered. I am just pointing out that we are only able to do that to the extent that we have the information. Again, this highlights a very big issue with insurance and coverage in that we need to continue to work together to understand what the policy provisions are. We need to have good communication between the plan, the physician, and the patient.

Assemblywoman Carlton:
We now have consumer-driven health plans that have high deductibles in Nevada. The issue I have seen is that the providers do not submit the bill to the insurance company; therefore, even though I have receipts that show I have hit the high deductible, the insurance company does not know it because the provider has not contacted them, so I keep getting charged. I am right now almost $1,500 over the amount of the deductible right now, but I cannot prove it because the provider has not submitted their bills.

I think there is an issue going both ways. If you are in an HMO, it really does not matter when the provider submits the bills, but when you are making that upfront payment and hit that threshold mark, it does matter. For the Committee and for you to understand, that makes a big difference. I can walk in the health provider's door and show them my receipts, but because of what is being said when they do the authorizations when I call my insurer, they say the provider has not sent us a bill yet, and it has been 90 days. I think we have a problem going both ways on this issue, and it is impacting everyone. The provider should want to be paid. The last time it happened to me, I had to wait six months to be reimbursed. And compared to trying to get reimbursed from an insurance company, I would rather do an extra special session in the legislature. Since we have this section in front of us, I have a chance to tell you we are having problems both ways.

Catherine O'Mara:
Section 81 requires a health carrier to establish a mechanism by which a participating provider of health care can, in a timely manner at the time the health care services are to be provided, determine whether the person to whom health care services are to be provided is a covered person or within the grace period for payment of a premium. This is getting back at that ability for the provider to help the consumer understand whether they are covered and what their responsibilities are. We would request that "mechanism" be defined in regulations. We would request to the extent possible that the "mechanism" be as uniform as possible across carriers. We request this because of the hundreds of insurance carriers and the four to eight types of insurance plans under each of those. That is a request we have made, and we would also suggest adding at the end of this section that information provided to the provider regarding the grace periods is binding on the health carrier for the purposes of payment to the providers. That is in line with American Medical Association's (AMA) comments to the National Association of Insurance Commissioners' (NAIC) bill. Section 82 provides that the contract should establish a dispute resolution procedure. I am putting on the record we would prefer at some level an independent body be a dispute resolution body.

Assemblywoman Neal:
In section 82, you are saying that you want an independent person, but you did not say why.

Catherine O'Mara:
You have a couple of levels of appeals, and often they are the same person or department adjusting the claim. The appeal process can seem to be meaningless. I do not know if they are always meaningless, sometimes they are probably not, but because it is always departments within the insurance carrier, we would like an independent body that could evaluate these types of disputes. We understand this is a contract, so eventually it ends up in court if there is an ongoing dispute. If there was a less costly way to resolve some of these things, we would like that.

Assemblywoman Neal:
In section 81, regarding the word "mechanism," did you have a conversation with the Division of Insurance about what their interpretation of "mechanism" meant? Were you just not satisfied with their definition? When I read it I thought it was pretty clear. There was some assumption and common theme associated with that.

Catherine O'Mara:
We did discuss "mechanism" with them and request that it be part of the regulatory process. I do not know that they had a definition of "mechanism," but if they do, we would like to hear what it is. Again; keep in mind the volume of insurance plans we are talking about. Each contract is going to set up its own mechanism. To the extent we can have some uniformity so that—if any of you go into that same office and you all have your various types of insurance plans—there is some sort of uniform way to look it up. Some insurance plans want things faxed, some want information over the phone, some want information by email, some have a portal online; there are many different ways to do it. If there is a way we can streamline that a little bit, that would be helpful to providers and patients.

Section 83 is another situation where there is a requirement for timely notification. Section 83, subsection 3 states:

> While a contract described in subsection 1 is in force, the health carrier shall provide timely notice to the participating provider of health care of any changes to the provisions of the contract or the documents incorporated by reference in the contract that would result in a material change in the contract.

We are talking about a case in which the contract is going to change materially which means a significant or substantial change. We would request "timely notice" be defined. Actually what we request is that we strike "timely" and add at the end of that section "90 days prior to the implementation of the changes and allow a provider to reject those changes without terminating the existing contract." The effect of adding that language would allow us to strike section 4.

Chair Bustamante Adams:
Which section was that?

Catherine O'Mara:
This is section 83, subsection 3. If that is not a possibility, then we would request that "timely manner" be defined in regulation.

The last section is section 109. This is a section that—and the Chairwoman and I discussed this a little bit and I know that the Commissioner has discussed this as well and you also went over it in the original presentation as well—removes the cap on copayment so when you have a more expensive plan or you have a higher deductible and now you have no cap on copay, it will impact the consumer. It is just a decision you have to make. It is a policy decision you have to make. I understand what the intent is; we want insurance plans to succeed

in Nevada. We want businesses to be able to afford insurance plans, but you have to balance—and that is going to have consequences if those plans are out there. I think it is important for everyone to understand that, because that is going to impact other things.

It gets back to a big issue—when an insurance plan is sold to an employer, the employees need to be educated on that at some point so they understand what their benefits do and do not do, especially if they get narrower or the caps are removed or there is a hugely high deductible, which we know is very common. We are just pointing this out and taking this opportunity to reemphasize this education by an insurance carrier. The people purchasing the plan need to understand what they are purchasing so they know how to best access the health care system.

Chair Bustamante Adams:
Which section was that?

Catherine O'Mara:
That was section 109, subsection 3.

I would like to take a moment to thank you again, Madam Chair, and all of the Committee members, for reviewing this process with us again and for letting us make a record.

Assemblywoman Neal:
It is more a question to you, Madam Chair. After she went through all of the sections, I need some clarification so I can walk away less confused. Are you bringing the Division of Insurance back to the table?

Chair Bustamante Adams:
Yes. Thank you for those comments. Ms. O'Mara and the Division are meeting on Tuesday to work through these issues. Some of the items will be taken into consideration, but some of it we may be able to address.

Kathleen A. Conaboy, representing Nevada Orthopaedic Society:
We have been collaborating with the Nevada State Medical Association for months on this legislation. I want to add a couple of things. I was with Ms. O'Mara when we met with the Commissioner and her staff. When we were there, we talked about what the NAIC had done at the national level collaborating with a number of entities as they were developing their model language. We went back and looked at the AMA's comments to the NAIC. Some of the sections are in this bill and those are the ones that Ms. O'Mara just reviewed. There are other sections in the NAIC model law that are not included in this particular omnibus bill. Some of them related to network etiquette, which has been a long-term issue and we spend a lot of time in the regulatory arena on that issue as well. I think it might behoove all of us to get to some of the issues of transparency, what is available to patients if there were some health carrier selection standards—and this is language from the NAIC model law—for selecting and tiering as applicable for providers. They would be developed

by the Commissioner, the carriers would be subject to them, and it would be for providers by specialty as well. That might help with the transparency aspects. This language requires certain things and disallows other things. We can put that in writing when Ms. O'Mara submits her written comments to you.

I wanted to ask you, Madam Chair, if I could take 60 seconds to share some information. I was at a meeting of the American Academy of Orthopaedic Surgeons yesterday in San Diego. Their incoming president was relating the confusion in the system, and I think Assemblywoman Carlton and others refer to this as the Affordable Care Act (ACA) modifications unfolding. This is what has been happening at the federal level to physicians since 2006. By 2006 the Physician Quality Reporting System (PQRS) was initiated by the Centers for Medicare and Medicaid Services (CMS) as voluntary, and two years later the Medicare Improvements for Patient and Providers Act (MIPPA) made PQRS permanent. In 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act offered financial incentives for meaningful use in the electronic health records. In 2010, the ACA did several things: it established accountable care organizations, some of which failed; it created The Patient-Centered Outcomes Research Institute (PCORI) to look at clinical effectiveness—and I think we were referencing that today when we talked about quality of care delivered; it developed the CMS Innovation Center to test different delivery systems to see what works; it created Medicare value-based purchasing; and it denied Medicaid payments for preventable hospital-acquired conditions like post-operative infections.

In 2015, the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) came into effect and repealed the Medicare sustainable growth rate. Payments are based on performance and quality so there was a lot of effort at the federal level to improve quality based on outcomes. In 2015 MACRA created the Merit Based Incentive Payment System (MIPS), which rolled up to PQRS, had a value-based modifier, and had further discussion about the meaningful use of the electronic health records. We also now have bundled payment initiatives and alternative payment methods. I am just adding to your discussion about how confusing a lot of this is to the carriers, providers, and certainly to the patients. We appreciate your deliberative nature today and the ability to participate in this conversation.

Jeanette K. Belz, representing Property Casualty Insurance Association:
We have submitted a letter regarding section 86 (Exhibit L). It is very explanatory; and if anyone has any questions, I will be happy to put them in touch with the gentleman who submitted it. We just want it on the record.

Chair Bustamante Adams:
Commissioner, if you could come back to the table. I know this is a work in progress and you have continued conversations with the doctors, so we will not go through each section, but do you have any closing comments?

Barbara Richardson:
Certainly, thank you. I want to reiterate that we are and will continue to be meeting with the providers. One of our concerns though is that we are very uncomfortable being put in the possible position of stepping in between two contracting parties who are supposed to be sophisticated parties. A lot of the discussion you heard from the providers puts us in that position, and we are really supposed to be trying to create a competitive market and keep that open. If that is not the will of the Legislature, we need to know that. Our mission statement specifically is driving toward an open competitive market. Some of the requests that are being made basically tie our hands, tie the industry's hands, tie the providers' hands, and do not make this a competitive market. The two parties would then be losing their contracting power with each other. We want to ensure everyone understands that is not always in the best interest of the consumer, and this is what we are going to be paying attention to.

Chair Bustamante Adams:
Thank you, I appreciate that comment. We will close the hearing on A.B. 83. This is a work in progress, it is a complicated bill because of its technicalities, so we will continue to have the conversations, but I wanted to bring up the answers we have so far because we have a tendency to forget if too much time passes.

Assemblywoman Carlton:
Is this the only Insurance Commissioner's bill, or do we have another one to look forward to? I see you shaking your head that it is not. Madam Chair, I would recommend a subcommittee on the next one.

Chair Bustamante Adams:
Is there any public comment in Las Vegas or here in Carson City? [There was none.] We will adjourn and have a great Friday. [Meeting adjourned at 2:35 p.m.]

RESPECTFULLY SUBMITTED:

_____
Pamela Carter
Committee Secretary

APPROVED BY:

_____
Assemblywoman Irene Bustamante Adams, Chair
DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a Work Session Document for Assembly Bill 150 dated March 17, 2017, presented by Kelly Richard, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit D is a Work Session Document for Assembly Bill 195 dated March 16, 2017, presented by Kelly Richard, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit E is a Work Session Document for Assembly Bill 242 dated March 16, 2017, presented by Kelly Richard, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit F is a Work Session Document for Assembly Bill 247 dated March 16, 2017, presented by Kelly Richard, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit G is a letter dated March 2, 2017, with five attached exhibits regarding Assembly Bill 83, to Assemblywoman Bustamante Adams, written and presented by Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry. The attached exhibits refer to the following:

1. Section 33 of Assembly Bill 83;
2. Sections 35 and 37-39 of Assembly Bill 83;
3. Section 69 of Assembly Bill 83;
4. Title 57: Administrative Hearings—NRS 679B.310; and
5. Proposed Amendment to Section 162 of Assembly Bill 83.

Exhibit H is a proposed amendment to section 110 of Assembly Bill 83, submitted by the Division of Insurance, and presented by Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry.

Exhibit I is a proposed amendment to section 114 of Assembly Bill 83 submitted by the Division of Insurance, and presented by Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry.

Exhibit J is a proposed amendment to section 169 of Assembly Bill 83, submitted by the Division of Insurance, and presented by Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry.

Exhibit K is a proposed amendment to sections 123, 127, and 128 of Assembly Bill 83, submitted by the Division of Insurance, and presented by Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry.

Exhibit L is a letter dated March 16, 2017, to Assembly Member Irene Bustamante Adams, Chair; and Assembly Member Maggie Carlton, Vice-Chair; and honorable committee members regarding Assembly Bill 83, written by Christian Rataj, National Association of Mutual Insurance Companies, and Mark Sektnan, Property Casualty Insurers Association of America, submitted by Jeanette K. Belz, representing Property Casualty Insurance Association.