MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Ninth Session
March 10, 2017

The Committee on Health and Human Services was called to order by Chairman Michael C. Sprinkle at 12:25 p.m. on Friday, March 10, 2017, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/79th2017.

COMMITTEE MEMBERS PRESENT:

Assemblyman Michael C. Sprinkle, Chairman
Assemblywoman Amber Joiner, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblyman Richard Carrillo
Assemblyman Chris Edwards
Assemblyman John Hambrick
Assemblyman William McCurdy II
Assemblywoman Brittney Miller
Assemblyman James Oscarson
Assemblyman Tyrone Thompson
Assemblywoman Robin L. Titus
Assemblyman Steve Yeager

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Joseph (Joe) P. Hardy, M.D., Senate District No. 12

STAFF MEMBERS PRESENT:

Susan E. Scholley, Committee Policy Analyst
Mike Morton, Committee Counsel
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Valerie Wiener, Chair, Task Force on Alzheimer's Disease
Nick Vassiliadis, representing Cleveland Clinic Lou Ruvo Center for Brain Health
Naomi Lewis, Deputy Administrator, Program and Field Operations, Division of Welfare and Supportive Services, Department of Health and Human Services
Glenn Shippey, Insurance Actuarial Analyst 2, Life and Health Section, Division of Insurance, Department of Business and Industry
Janise Wiggins, Governor's Consumer Health Advocate, Office for Consumer Health Assistance, Department of Health and Human Services
Kris Kingery, D.V.M., Private Citizen, Reno, Nevada

Chairman Sprinkle:
[Roll was called. Committee rules and protocol were explained.] I will open up first with public comment. Is there anyone in southern or northern Nevada who wishes to make a public comment? [There was no response.] I will open up the hearing on Senate Bill 92.

Senate Bill 92: Revises provisions relating to the Task Force on Alzheimer's Disease. (BDR S-270)

Senator Joseph (Joe) P. Hardy, M.D., Senate District No. 12:
The bill removes the sunset on the Task Force for Alzheimer's Disease. I will give the secretary a copy of testimony in support of the bill from John Yacenda, President of the Nevada Silver Haired Legislative Forum (Exhibit C).

Valerie Wiener, Chair, Task Force on Alzheimer's Disease:
[Valeria Wiener spoke from prepared text (Exhibit D). It is a privilege to present a brief history of our work, our accomplishments, and most importantly the service the Task Force on Alzheimer's Disease (TFAD) has provided to Nevadans. I am seeking your support for Senate Bill 92, which would remove the statutory sunset and allow us to continue our work. The sunset was included in the bill when the language was being drafted. At that time, we determined the need to prove our worth, to have time enough to do meritorious work to serve the people of Nevada. At that time, I felt it should run for four years. Now we are at the end of that four-year period, which is why we are before you today to explain why we believe there is merit to continuing the work without a sunset.

There are about 50 forms of dementia. Alzheimer's disease is one form, and comprises about 70 percent of the dementia diagnoses. One in 9 people, or about 11 percent over the age of 65, have Alzheimer's disease. This translates into 39,000 people in our state, which is an increase of 39 percent in the past decade. We expect 64,000 people to have this disease by 2025 because nationally, Nevada has the third-highest population growth rate at 64 percent. That demonstrates the need for the work we do.

In 2011, Assemblywoman Debbie Smith introduced Assembly Concurrent Resolution 10 of the 76th Legislative Session. That resolution called for the creation of a task force to design, draft, and put together a state plan to address Alzheimer's disease. The task force was created during the interim. They met five times, and I was privileged to be the chair. By the October 2012 meeting, we had 117 recommendations to consider for the state plan. Subgroups had been meeting with medical experts, the population affected by it, and others who are concerned about Alzheimer's disease; and they addressed the quality of care, the quantity of care, public awareness, and access to services.

We selected 20 recommendations from that pool and included them in what became the January 2013 Nevada State Plan to Address Alzheimer's Disease. During the past two legislative sessions, both the A.C.R. 10 of the 76th Session task force and the Task Force on Alzheimer's Disease have spearheaded several vital measures to address recommendations in the state plan. During the 2013 Legislative Session, three bills proposed in the 2011 legislation moved forward, with one being to establish the TFAD before you today. The bill required a ten-member TFAD housed in the Department of Health and Human Services (DHHS), to address Alzheimer's disease, to review it, to evaluate it, and to update the state plan. In addition, we are required to provide an annual report to the Governor and meet quarterly (Exhibit E). We went above and beyond that, and we have from the beginning because TFAD members know how important these issues are to the people of our state. We meet six times every year, not four times. The law requires that the state plan be updated as needed, and we update it every two years (Exhibit F). In the 2013 Session, Senate Bill 86 of the 77th Session provided respite services for families of younger-onset Alzheimer's disease patients, and that bill passed.

In the 2015 Session, out of 20 recommendations in that year's plan, 6 were addressed legislatively. Assembly Bill 9 of the 78th Session dealt with guardianships—particularly those assets of people who are afflicted with Alzheimer's disease or another form of dementia. That bill did not pass; however, it was instrumental in igniting conversations about those needs. Senate Bill 177 of the 78th Session addressed caregivers of persons who are discharged from hospitals or moved to other facilities. This was a major effort of AARP and incorporated key concerns in the state plan. It became law. Senate Concurrent Resolution 2 of the 78th Session, sponsored by Senator Joe Hardy, an active member of the TFAD, urged and encouraged specific training for medical care providers and first responders regarding the care of persons with Alzheimer's and other forms of dementia. Senate Bill 196 of the 78th Session dovetailed into that, allowing health licensing boards to provide substitutions for some course requirements and allow training in Alzheimer's education.

During this legislative session, TFAD is working with several advocacy organizations and groups on measures. Speaking of the session, I would like to personally thank one of our Task Force members, Assemblyman James Oscarson, who has been a dedicated member of TFAD for nearly two years. Assemblyman Oscarson, we appreciate your insights, your perspectives, your leadership, and everything you have shared—especially from the perspective of the smaller counties. It is very important to us to be inclusionary as we address these needs. Though we submitted the 2017 plan just a few weeks ago, we are reviewing recommendations in the current state plan, and several are being addressed legislatively. We also review every retired recommendation at least once a year to determine if it is still on a path to serving Nevada. Each TFAD member is assigned a recommendation based on his or her expertise, know-how, and experience. In addition, we have presentations and discussions; we work with community organizations; we create and work with awareness campaigns; and we stay engaged.

The commitment we demonstrated in the state plan has new recommendations based on our work. One new recommendation involves driving and dementia, another is related to veterans and families, and a third is a new take on guardianships. There are also recommendations concerning caregiver support and outreach to physicians. With the funding that DHHS and the Aging and Disability Services Division (ADSD) provide the TFAD, we get to do the work, address the issues, and create an opportunity in a forum where these conversations can take place. I cannot recall a TFAD meeting when new information was not shared with everyone. Either a TFAD member or someone making a presentation would make a connection that could not have been made without our being together. The TFAD gathering is an opportunity for the members to learn from each other.

We create a blueprint. We support and create initiatives, and we work with DHHS and ADSD so that they can support the work we do. They work with us and we work with them to implement the best practices to serve the most people in our state, because this population is ever-expanding. We are here to be the voice for the voiceless; we are here to advocate for those who cannot do it for themselves—and this includes the families and caregivers who all too often dedicate their entire lives to helping people with Alzheimer's disease or other forms of dementia. We also speak for our dementia-friendly communities who are joining the Dementia Friendly America and Dementia Friendly Nevada movements to honor, include, support, and respect people who are affected by these health challenges. When we leave this building, we will continue to do our work because it is important to us. We want to serve the courageous Nevadans in their efforts to deal with these challenges, because they are our neighbors, our friends, and our families. Based on our history and our accomplishments and the pledged commitment of every TFAD member who comes with their intelligence and their hearts, we strongly urge you to support S.B. 92 which would remove the sunset on the Task Force on Alzheimer's Disease.

Chairman Sprinkle:
Thank you very much for all the work that has been done in the past, and quite possibly into the future. Are there any questions from the Committee? [There was no response.] With all the work that has been done, you are stating that there is still a lot of work that needs to be done and that there is value in continuing with this task force.

Valerie Wiener:
I just came from a TFAD meeting. At that meeting, we determined two, possibly three, new recommendations to evaluate and have presentations on going forward that had not been before us prior to today. These are very viable and important issues to deal with. It is a

living, breathing, fluctuating document that we continue to visit and revisit. We just received new information on a recommendation in our appendix that we will take another look at. There is work, and we are thrilled to have the opportunity to do it.

Chairman Sprinkle:
Outstanding. Are there any questions from the Committee?

Assemblyman Oscarson:
It would be remiss of me to not thank Senator Wiener for her dedicated leadership to this very important committee. She tirelessly works on behalf of and advocates for these folks. This is so important, and it is such a great opportunity for me to serve on the TFAD. In order for this to move forward, I fully support continuing this committee.

Chairman Sprinkle:
I concur. Does anyone wish to speak in support of S.B. 92?

Nick Vassiliadis, representing the Cleveland Clinic Lou Ruvo Center for Brain Health:
We are one of the premier brain health research facilities and clinical trial facilities in the country, and we are located right here in Las Vegas. We are an active participant on this task force. I cannot stress enough how important we believe this task force is. It allows the entire community to marshal all its resources and bring them together, so it is not just a private company, a private research and clinical trials facility doing all the work on Alzheimer's and other forms of dementia. It brings members of the community, caregivers, families, legislators, regulators, and DHHS together to focus on this very important issue that we view as an epidemic. The elderly population is only going to continue to grow. Proportionally, we see the numbers of those affected by dementia increase as the elderly population grows and as the average rate of life expectancy also grows.

We would like to thank the sponsor of this bill for bringing it forward and, like Assemblyman Oscarson, also thank Senator Wiener for how tenacious she is on this issue. She does not let up; she is relentless. Thank you for continuing this fight with us, and I urge your support for S.B. 92.

Chairman Sprinkle:
Does anyone else wish to come up in support of S.B. 92? [There was no response.] Is there anyone in opposition wishing to testify? [There was no response.] Is anyone neutral? [There was no response.] Are there any last comments from the bill's sponsor?

Senator Joe Hardy:
Thank you.

[(Exhibit G) and (Exhibit H) were presented but not discussed and are included as exhibits for the meeting.]

Chairman Sprinkle:
With that, I will close the hearing on S.B. 92, and open up the work session. The first bill on our work session is Assembly Bill 85.

Assembly Bill 85: Requires instruction in cardiopulmonary resuscitation and the use of an automated external defibrillator in certain schools. (BDR 34-569)

Susan E. Scholley, Committee Policy Analyst:
[Susan Scholley read an explanation of the bill from prepared text (Exhibit I).] Assembly Bill 85 was sponsored by the Assembly Committee on Health and Human Services and is related to instruction in cardiopulmonary resuscitation and automated external defibrillators in certain schools. The bill was heard in this Committee on March 1. It requires that instruction in resuscitation techniques and the use of defibrillators be provided as part of a course of study in health, taught to pupils in middle schools, junior highs, high schools, and private secondary schools. This bill simply removes the existing qualifier in the statutes that instruction is conditioned upon the availability of money. There were no amendments proposed at the hearing.

Chairman Sprinkle:
Are there any questions or comments on A.B. 85 from the Committee?

> ASSEMBLYMAN CARRILLO MOVED TO DO PASS ASSEMBLY BILL 85.
>
> ASSEMBLYMAN McCURDY SECONDED THE MOTION.

Is there any discussion on the motion?

Assemblywoman Titus:
I had significant concerns about the unintended consequence and potential cost to rural areas that might not be able to support these programs; however, I have been reassured by the sponsor of the bill and many other interested parties that the school systems should be able to cover this as a mandate. I will be supporting the measure.

Chairman Sprinkle:
Are there any other comments on the motion?

Assemblyman Oscarson:
I, too, was compelled by the stories told here in the Committee, as well as by the opportunities young people have to learn this and perhaps be able to utilize it to save a life. I know the bill's sponsors have been all over this building, working hard to make sure that this is a viable component and option for the schools. I had a long discussion with Assemblywoman Titus and appreciate her support. I look forward to supporting the bill as well.

Assemblyman Carrillo:
As someone who was once put in that position, I fully support this bill.

Chairman Sprinkle:
Are there any other comments from the Committee? [There were none.]

THE MOTION PASSED UNANIMOUSLY.

Assemblyman Carrillo will take the floor statement. We will move on to Assembly Bill 111.

Assembly Bill 111: Authorizes the Division of Welfare and Supportive Services of the Department of Health and Human Services to use money in the Fund for Energy Assistance and Conservation to assist certain low-income households in paying for Internet service. (BDR 58-641)

Susan E. Scholley, Committee Policy Analyst:
[Susan Scholley read an explanation of the bill from prepared text (Exhibit J).] Assembly Bill 111, sponsored by Assemblyman Thompson, authorizes the Division of Welfare and Supportive Services in the Department of Health and Human Services to use money in the Fund for Energy Assistance and Conservation to assist low-income households in paying for Internet service. This bill was heard in the Committee on February 22. There was an amendment proposed at the hearing by the sponsor of the bill, Assemblyman Thompson, to include parameters for use in determining how much assistance could be provided for Internet service. There was a conceptual amendment presented at the hearing, and attached now to the work session is a mock-up which essentially incorporates that conceptual amendment into a more formal mock-up. In addition, the sponsor has asked the following legislators be added as sponsors on the bill: Assembly members Araujo, Carrillo, Daly, Fumo, Miller, and Neal, and Senators Cancela and Segerblom.

Chairman Sprinkle:
Are there any questions or comments on A.B. 111?

Assemblyman Oscarson:
I recognize the need for Internet in all homes. My kids and grandkids get their grades and their parents get updates from the schools on the computer. I am concerned if we do this that there will be broadband in homes that do not have computers to utilize those services; however, it is a concern as well that the access would not be there. I wish the amendment had gone further and explained the costs associated with broadband that we were told was available in some areas for low-income households. I will vote yes with the hope that there can be additional language added; but I will reserve my right to change my vote on the floor.

Assemblyman Thompson:
What additional language would you like in the amendment? The purpose of the amendment was stated during the hearing, and it has not been changed since.

Assemblyman Oscarson:
I want to make sure we know that there are lower rates available in some areas for those services. My concern is taking money out of this pot that is designated for another service. I understand the need for it, because I have witnessed it in my home, but we need to make sure. We need something to the effect of where these low-income programs are available, that the lower rates are available. They were saying the rates could be $5 and $10 per month. I want us to be aware of those lower rates and see that they are being utilized before anything else. I think you concur with my sentiment, but it was not conveyed.

Assemblyman Edwards:
I was hesitant about the bill until I spoke with the sponsor, and I appreciate his input. I will be voting yes.

Assemblywoman Titus:
I am conceptually against using a designated pot of money and moving it to another, unintended use. I have big concerns about that. I will be supporting it to come out of Committee, but I may be changing my vote on the floor. I am concerned that a family will not be in a position to choose whether it is going to have heat or an Internet connection. One pot of money intended for power and heat is now also going to be used for the Internet. If they do not have heat, I am concerned. I have been reassured, which is why I am going to support it now.

Assemblyman Hambrick:
I will be supporting the measure, but I wish to reserve my right to change my vote on the floor.

Assemblywoman Benitez-Thompson:
Does the amendment change the fiscal note on this bill? Committee members are concerned about a fixed pot of money.

Assemblyman Thompson:
If it is all right with you, a representative from the Department of Health and Human Services is in the audience and said she would explain the process.

Chairman Sprinkle:
Yes, that is fine.

Naomi Lewis, Deputy Administrator, Program and Field Operations, Division of Welfare and Supportive Services, Department of Health and Human Services:
The original fiscal note on this bill was submitted with many assumptions. After meeting with Assemblyman Thompson and discussing the bill, there is a change to the assumptions. There is a cost for this particular proposal. We believe there is about $592,000 in costs that would be associated with the benefits that would be given out. There is also about a $350,000 cost for the system changes that would be required. In our discussions, we were going to use the existing pool of money to cover those costs, and therefore, there would be no additional moneys into the program. We will be adjusting the fiscal note in the Nevada Electronic Legislative Information System (NELIS) to reflect that.

Chairman Sprinkle:
Thank you. Are there any other comments on this bill? [There was no response.] Then I will accept a motion to amend and do pass.

> ASSEMBLYMAN EDWARDS MOVED TO AMEND AND DO PASS ASSEMBLY BILL 111.

> ASSEMBLYMAN McCURDY SECONDED THE MOTION.

Is there any other discussion on this motion?

Assemblyman Thompson:
I want us to move forward with a vote, but there are some inaccuracies as to what was stated on the record. It was my understanding in the hearing that there would be no fiscal note. What I just heard is a little bit different from what my intent was. It was my intent not to bother any of the dollars, and that there would be no fiscal note. It sounds as though the way it was just presented was a little different.

Chairman Sprinkle:
Are there any other comments on the motion? [There was no response.]

> THE MOTION PASSED UNANIMOUSLY.

Assemblyman Thompson, would you like the floor statement?

Assemblyman Thompson:
Yes, I would.

Chairman Sprinkle:
Let us move on to Assembly Bill 141.

Assembly Bill 141: Revises the organizational structure and purposes of the Office of Minority Health. (BDR 18-214)

Susan E. Scholley, Committee Policy Analyst:
[Susan Scholley read an explanation of the bill from prepared text (Exhibit K).] Assembly Bill 141, sponsored by Assemblyman Thompson and others, was heard in this Committee on February 27. This bill reorganizes the Office of Minority Health in the Office for Consumer Health Assistance in the Department of Health and Human Services (DHHS). It changes the name to the Office of Minority Health and Equity and makes it an office within the DHHS. It also clarifies that the Manager of the Office serves at the pleasure of the DHHS Director in the unclassified service of the State and will provide administrative support to the Advisory Committee on minority health. The bill also expands the definition of minority group to include persons with disabilities, persons who share the same sexual orientation, and transgender persons. This bill also provides authority to the office to make recommendations for policy changes and to engage in advocacy on behalf of minority groups. The bill also requires the Director of DHHS and the State Board of Health to appoint nine voting members to a restructured Advisory Committee on minority health with staggered two-year terms for those members. The terms of the current Advisory Committee members will expire on July 1, 2017. Finally, the Legislative Commission will appoint a legislator to serve as an ex officio, nonvoting member. There were no amendments proposed at the hearing.

Chairman Sprinkle:
Are there any comments or questions on A.B. 141? [There was no response.] Seeing none, I will accept a motion for do pass.

> ASSEMBLYMAN YEAGER MOVED TO DO PASS ASSEMBLY BILL 141.
>
> ASSEMBLYMAN CARRILLO SECONDED THE MOTION.

Chairman Sprinkle:
Is there any discussion on the motion? [There was no response.]

> THE MOTION PASSED UNANIMOUSLY.

Assemblyman Thompson, would you like this floor statement also?

Assemblyman Thompson:
Yes, thank you.

Chairman Sprinkle:
The last bill is Assembly Bill 214.

Assembly Bill 214: Establishes a program to increase participation by certain demographic groups in clinical trials. (BDR 40-707)

Susan E. Scholley, Committee Policy Analyst:
[Susan Scholley read an explanation of the bill from prepared text (Exhibit L).] Assembly Bill 214 involves increasing participation by certain demographic groups in clinical trials. It was sponsored by Assemblywoman Neal and heard in this Committee on March 3. This bill requires the Division of Public and Behavioral Health (DPBH) in the Department of Health and Human Services (DHHS) to establish a program to encourage participation in the clinical trials of drugs and medical devices by persons who are members of demographic groups that are underrepresented in such trials. It also requires each state or local governmental entity that conducts such trials to adopt a policy concerning the identification and recruitment of such persons to participate in those trials.

At the hearing the bill's sponsor, Assemblywoman Neal, submitted a proposed amendment which is shown in the attached mock-up. Summarizing the amendment, it directs DPBH to use strategies recognized by the United States Food and Drug Administration for identification and recruitment, removes the requirement for conducting conferences and training, and requires DPBH to include some additional information in postings on its website. It also requires DPBH, with assistance from the Office of Grant Procurement in the Department of Administration, to apply for grants and to submit a biennial report no later than May 1 of even-numbered years on the status of the program to encourage participation in clinical trials.

Chairman Sprinkle:
Are there any comments or questions from the Committee on A.B. 214? [There was no response.] Not seeing any, I will accept a motion for amend and do pass.

> ASSEMBLYMAN McCURDY MOVED TO AMEND AND DO PASS ASSEMBLY BILL 214.
>
> ASSEMBLYMAN THOMPSON SECONDED THE MOTION.

Is there any discussion on the motion?

> THE MOTION PASSED UNANIMOUSLY.

Chairman Sprinkle:
I saw Assemblywoman Neal here. Would you like the floor statement on your bill? [Assemblywoman Neal nodded yes.] With that, I am going to close the work session and invite up our presenters on out-of-network billing.

Glenn Shippey, Insurance Actuarial Analyst 2, Life and Health Section, Division of Insurance, Department of Business and Industry:
I appreciate the opportunity to discuss a topic that has generated many consumer complaints over the years. At the table in southern Nevada is Janise Wiggins, the Governor's Consumer Health Advocate. Our office works closely with her office to assist consumers who are balance billed.

The Division of Insurance has no regulatory authority over providers. We also do not have regulatory authority over self-funded health plans. Those are the plans that large employers offer, such as the big unions in the state. We rely on and often hand off consumers to Janise and her staff who have the experience and knowledge to assist in negotiating down these balances for consumers experiencing this type of harm.

A recent survey by the Kaiser Family Foundation identified that about one in three households with unaffordable medical debt accumulated that debt as a result of balance billing. In about seven out of ten of those households, the individuals were unaware they were seeking care from providers that were not in-network at the time of care. We will start with what balance billing is [page 2, (Exhibit M)]. It is a bill to a consumer from a provider for the difference between what the provider gets paid by the health insurance company and what the provider initially bills the consumer for that service or for those services. These are out-of-network providers. Network providers have contracts with carriers that establish specific reimbursement rates, so there is no balance bill there. The out-of-network provider, for a service that is covered by the health plan, generally gets paid what would have been paid if that provider was in-network. That rate is commonly referred to as "usual, customary, and reasonable"—it basically pays the out-of-network provider the in-network rate for that service in that geographic area. Most of the time, that reimbursement rate is below the billed charges that come from that provider, and that creates the balance bill.

There is a specific type of balance billing that has gotten a lot more attention, and is something I will focus on in this presentation—"surprise" billing [(page 3, (Exhibit M).] This is balance billing that occurs completely by surprise, and that is where it gets its name. The consumer does everything he or she is required to do. The consumer follows all the instructions in the plan documents from the health insurance company. If a surgery was needed, they get prior authorization; it is scheduled at the in-network hospital. They go to the hospital but sometimes come out of the hospital with a balance bill. This surprise balance billing is most prevalent, however, with emergency care. The Affordable Care Act (ACA) does allow an individual to go to any hospital if it is an emergency, and it has to be treated as though it is in-network, but if there is not a contract with that hospital, that will generate a balance bill. Even if the individual goes to an in-network hospital, there are many providers at in-network facilities that are out-of-network for that particular health plan. They are involved in a treatment for the individual, and that generates balance bills.

The next two slides [pages 4 and 5, (Exhibit M)] are from a study done in Texas. This study looked at three very large health insurance companies in Texas; it looked at the hospitals that were in-network for those three carriers and determined whether the providers in those network hospitals for these different specialty areas were in-network or out-of-network for those health carriers. What you can see is for two of these three carriers, about half of the doctors who practiced in those emergency rooms (ERs) in the state of Texas in 2014 were out-of-network, so that was generating balance billing. These other specialty provider types also commonly have doctors who are out-of-network working in the in-network facility. In terms of dollars billed for out-of-network care at in-network hospitals in the state of Texas in 2014, you can see ERs generated the bulk of the balance billing dollars Texans covered under these three health plans faced.

Currently, there are no protections in either Nevada law or in federal law for consumers against balance or surprise billing. Network providers are prohibited from balance billing by the contracts they enter into with health insurance companies. This is something carriers require when a provider enters into a contract to be part of a network. Our carriers require them to not balance bill if it is a covered service under the plan. Several states around the country have enacted balance billing laws, but the National Association of Insurance Commissioners (NAIC)—a national body of state regulators that meets three times a year and conducts many conference calls during the year to hammer out these model laws—in November 2014 released its Network Adequacy Model Law. Nevada was one of the states in the working group that put this model law together. This Network Adequacy Model Law addresses surprise billing [page 6, (Exhibit M)].

The NAIC model approach [page 7, (Exhibit M)] focuses on transparency and consent. Health carriers and facilities are required to provide "conspicuous written disclosure" of network status. They have to warn that out-of-network physicians might balance bill. It also gives patients the right to request a full list of network participation for all providers based at the in-network hospital. In nonemergency situations, if consumers receive a balance bill of more than $500, they may opt for mediation. The consumer pays the in-network cost share and gives it to the carrier. The carrier then uses its mediation process with the provider or providers, which may result in a reduction or elimination of the balance bill to the consumer. In emergency situations, consumers have to pay only what they would pay for care received by an in-network provider. Bills of more than $500, the consumer sends to the carrier. The carrier uses mediation with the provider; the consumer does not have to take any additional steps, and is guaranteed protection from the bill.

Many states are looking at enacting all or some form of the network adequacy approach in their state laws. Of states that recently enacted laws, one is Florida [page 8, (Exhibit M)]. Florida's surprise billing law prohibits surprise billing in emergency situations and requires that the health carrier is solely liable for payments beyond the cost share to the member. The provider cannot balance bill that member; only the carriers are liable for that payment. It also requires increased transparency and notice to consumers about the possibility of being treated by an out-of-network provider, similar to the Network Adequacy Model Law. It requires hospitals to post on their websites the health plans with whom they are in-network, and puts consumers on notice that patients may be seen by out-of-network providers, so there is disclosure prior to going to that in-network hospital if the consumer exercises that right. It also creates a binding independent dispute resolution process in order for health carriers and medical providers to resolve payment issues.

Not that long ago, California also passed a surprise bill law [page 9, (Exhibit M)]. Some aspects of it are similar to Florida's. It adopts informed financial consent for private insurance. It also creates a binding independent dispute resolution process. What is different with the California law is that out-of-network providers can bill full amounts for out-of-network services at in-network facilities only if the patient consents in writing at least 24 hours in advance after receiving an estimate of the cost and notice that in-network options are available. Also, California's law establishes a reimbursement rate for noncontracted out-of-network providers. It is established at the greater of the average contracted rate, which is determined by a state agency through data collection and analysis—it is not determined by the carrier—or 125 percent of the Medicare payment for the same service in that geographic region.

Janise Wiggins, Governor's Consumer Health Advocate, Office for Consumer Health Assistance, Department of Health and Human Services:
Within our office, we also have the Bureau for Hospital Patients. I am going to review what the Office for Consumer Health Assistance is and what we do, and then I will talk about some of the out-of-network cases we see. The mission of the Office for Consumer Health Assistance (OCHA) [page 2, (Exhibit N)] is to allow all Nevadans access to the information they need regarding their health care concerns, to assist consumers and injured workers in understanding their rights and responsibilities under various health care plans and policies of industrial insurance, and to advocate on their behalf when necessary. There are several different programs within our office. We have a Consumer Health Assistance Program. We have a generalist ombudsman to assist consumers. We also have a Bureau for Hospital Patients ombudsman, an ombudsman who deals with Medicare and Medicaid issues, and a workers' compensation ombudsman. The Office for Consumer Health Assistance is also responsible for independent external appeals. After a consumer has an adverse determination or denial of a claim through their insurance, they usually can appeal that internally with the insurance carrier once or twice. After that, some claims may be eligible for an external review, and consumers come to our office to request that process. We do not have clinicians within our Office, so those types of cases are referred to specific entities that are licensed by the Division of Insurance to provide those types of clinical reviews.

The next slide [page 4, (Exhibit N)] goes over our intake process. Consumers can contact our office by phone, fax, email, or walk in to open up a case. Providers can open up cases with our office; social workers and community members can refer folks to our office. The form we require is our Request for Assistance form on our website. We can also provide it via fax, email, or in person. It includes a Health Insurance Portability and Accountability Act (HIPAA) consent form and also the Appointment of Governor's Consumer Health Advocate (GovCHA) as Authorized Representative consent form so we can negotiate bills and other claims issues on that consumer's behalf.

When cases come into our office, they are generally assigned the next day. We give our ombudsmen about seven to ten business days to make an initial response to a consumer. That does not mean that we are going to resolve their issue within that time frame, just that we will make our first contact and let the consumer know what additional information we might need, such as documentation. The type of documentation we usually request includes copies of the bills, explanation of benefits (EOBs), any medical records, determination letters from their health plan, and any other correspondence so we can see what the consumer sees. Usually we tell people it will take about 60 days, but it depends on the complexity of the case. Some cases can be resolved in 24 to 48 hours.

The most frequent types of cases we see at OCHA [page 5, (Exhibit N)] involve uninsured and underinsured patients and issues related to the Affordable Care Act (ACA). We call those our access-to-care types of cases. There are also appeals and grievances dealing with benefit denials. Those can either be prior to a service or after a service is received. Terminations of benefits include such issues as cancelation of a health plan policy or quality-of-care concerns. We also deal with hospital and ancillary medical billing disputes. Most of those revolve around affordability of the bill, accuracy of the bill, if the consumer was billed adequately or timely, and balance billing and out-of-network issues. We also receive a substantial number of prescription drug-related cases where people are having problems with access to a prescription drug, do not understand their benefit, there is a cost issue, or that prescription drug is not on their formulary.

Thanks to Glenn Shippey from the Division of Insurance who provided an excellent review of out-of-network claims; I do not need to work that hard on the next slide [page 6, (Exhibit N)]. A lot of what was covered in his presentation is very similar to what is on this slide. The only thing I would add is what our office frequently sees—a consumer goes to a participating hospital or ambulatory surgical center that is an in-network provider on their plan, but they are serviced by a nonparticipating physician. Quite often that happens in the ERs, but it can also happen during a scheduled situation where the consumer is unaware that someone who is going to be assisting in a surgical procedure could be considered out-of-network. Additionally, this type of situation occurs when consumers access emergency laboratory or radiology or are in a doctor's office. The consumer submits a specimen and the specimen is sent to an out-of-network lab unbeknownst to the patient. Additional out-of-network claims we frequently see in our office [page 7, (Exhibit N)] can be prompted when a consumer schedules and elects, knowingly or unknowingly, to receive medical services from a nonparticipating provider. Out-of-network issues can definitely be experienced unknowingly, but there are times when consumers knowingly elect to go out-of-network. Sometimes that is a decision they make based on information they receive from their provider or information that they just feel as a patient is better for their care, so they may choose to go out of the state or want to access a provider who is not on their plan. That is a choice the consumer has made.

On the next slides are examples of cases we have seen recently [pages 8 and 9, (Exhibit N)]. In the first case, we had a consumer who went to the ER and was taken to an out-of-network hospital. The insurer paid at the in-network rate; however, in doing so, the hospital balance billed the patient over $100,000. Our office submitted a request to the insurer asking for intervention, which is usually in the form of an appeal, and for them to take another look at the situation and see what was really in the consumer's control in selecting, going to, or being admitted to that out-of-network hospital. In this situation, we were able to get the insurer to reprocess the claim, resulting with the insured only being responsible for the $1,000 copay. That was a successful resolution for that consumer.

The next case involves a consumer who was admitted through the ER to an out-of-network hospital. The insurer paid the in-network benefit level, which left the consumer with a balance bill of $68,000. We submitted Level 1 and Level 2 appeals to the insurer; however, the insurer upheld both requests, meaning that they continued to deny the claim. The hospital agreed to reduce the bill by 30 percent, according to section 260 of Chapter 439B of *Nevada Revised Statutes* (NRS) related to the Bureau for Hospital Patients. In that case, the consumer still owes close to $47,000. It was still a positive situation with some reduction in the bill, but most people probably do not have $47,000 to pay that balance bill.

In another situation, a consumer was involved in a motor vehicle accident in rural Nevada and was transported by air ambulance to a hospital. This air ambulance provider was out-of-network on this consumer's plan. The air ambulance billed $54,000 to the insurer. The insurer paid the in-network benefit rate of $9,400, which is what their contracted providers receive as payment in full. However, because this air ambulance was not a contracted provider, they accepted the $9,400, but also balance billed the patient the $44,600. In this situation, our office contacted the insurer and asked for intervention via an appeal and an additional payment; however, the insurer upheld the claim as processed according to the member's plan. The air ambulance denied financial hardship discounts in this case due to the consumer's income and assets. Sometimes certain providers such as air ambulance companies may have hardship programs, but they have their own financial criteria, and in this situation, they determined that this consumer was over income or over assets for their program.

In the last situation, the consumer provided a specimen at a doctor's office. The provider sent the specimen to an out-of-network lab. The claim was denied by the insurer, which paid zero dollars. The laboratory billed the consumer the full amount of $1,250. In this situation, we were able to submit an appeal. It was upheld as processed per the plan; however, we contacted the lab, and the lab agreed to a 50-percent discount. The consumer paid the $625 in this situation just to prevent that bill from going on their credit report.

I would like to take a moment to make some remarks about the estimated number of cases you are seeing on this slide [page 10, (Exhibit N)]. At a different presentation that The Office for Consumer Health Assistance attended here with this Committee in 2015, it was a bit different than what you are currently seeing. When we last presented information before this Committee, it was not specifically about the topic of out-of-network or balance billing.

Since that time, we have initiated some strategies to better track out-of-network cases. When you are dealing with out-of-network-related cases, there are several elements to consider when tracking the data to understand the scope of the issue. First, you need to look at what the problem is, why the problem exists, who the provider is in the situation, at which facility treatment occurred, under which insurer, and where was the service provided—in state or out of state. Also, at the time the service was provided or prior to the time of the service being provided, were there attempts to seek a prior authorization? Currently, if we were to track that type of information, it would be very tedious and laborious. It might affect our efficiency in some capacity, so we are looking at ways we can better partner either with other entities or get a better technology system within our office to track this type of information to that specificity.

Chairman Sprinkle:
Thank you both very much for a concise but very informative presentation. You got to the heart of a general overview of this issue for the Committee. Are there any questions from the Committee?

Assemblyman Oscarson:
Are you seeing your workload increase with some of the higher deductible plans? I am sure people are calling in talking about having huge bills who were not aware that they had a $5,000, or $10,000 or $15,000 deductible. I know that is not part of balance billing, but is that creating consternation with some patients?

Glenn Shippey:
We do receive consumer inquiries regarding the increasing cost-share levels in plans. Many are aware that deductibles, particularly in the individual and small-group markets, have been increasing; that trend has also carried over into the large-group markets, so I would say yes to your question.

Janise Wiggins:
Yes, we are seeing the same things in our office. We are having consumers contact us who purchased a plan, either on or off the Silver State Health Exchange. They may or may not have been aware of what the deductibles were, or even understood what a deductible, a copay, or coinsurance is. Often, our office is doing a lot of education for consumers to help them prevent surprise billing, whether it is an out-of-network issue or it is a surprise bill, just because they do not understand how their insurance plan works and they do not understand claims and processing. We try to educate consumers to understand that their insurance card is not a credit card. You do not just go to a provider, slide the card, and everything is paid. Instead, on the back end, after receiving that service, there is a claims process. In insurance, you may be responsible for four different out-of-pocket expenses, and we try to explain that to them using a bucket analogy. The first bucket is the monthly premium you pay; the second bucket may be your copay when you actually see a doctor; the third bucket would be coinsurance; and the fourth bucket would be your deductible. We are finding that we have to do a lot of education with consumers.

Assemblyman Oscarson:
For the record, Nevadans are fortunate having the two of you representing them in these instances. A number of my constituents have utilized your services, and we are fortunate to have you representing and advocating for them.

Assemblywoman Titus:
Thank you both for your presentation. It is a very difficult and challenging subject. Although I am a provider, I also have health insurance, and frequently I do not know what my copays are or if I am going to get another bill. It is really important to try to address some of these issues from a consumer's standpoint. I have huge concerns about this, and I see it all the time. As a provider, if I see a patient for an illness and I take a culture, I warn them that they may get another bill and that I do not know what that bill is going to be. Patients need to be informed so there are no surprises, but also, I am concerned about the insurance companies being accountable and giving information to their clients. There is a big disconnect. There are the insurance companies and the providers and then there are the patients, but they are not all communicating. Hopefully, this body can resolve some of this because these are issues that are not going to go away. This presentation can give us a start on what the issue is, because it is huge and really important and I would love to hear some other solutions. We all know there are problems, but we have to find some solutions.

Chairman Sprinkle:
Are there other comments or questions from the Committee? [There was no response.] This was quickly put together; so once again, I really appreciate your presenting on this issue. I am sure there will be a whole lot more discussion on this issue. At this point, I would like to open for a second round of public comment.

Kris Kingery, D.V.M., Private Citizen, Reno, Nevada:
I am a single mother of a five-year-old, a full-time veterinarian, and a 20-year caregiver for my mother with Lewy body dementia. I am here in support of the Task Force for Alzheimer's Disease, S.B. 92. I have had the pleasure of working with them and being in on many of their meetings over the last two years. I started out doubting this was going to go anywhere, thinking, "Wow, they are making a lot of really important changes," and not only for dementia sufferers, people in institutions, and through the social services, et cetera, but they are also listening to people like me—a family caregiver whose only job is to take care of my family. On television Saturday morning March 4, 2017, Dr. Jon LaPook mentioned that one in every three families will be dealing with this in 10 to 13 years, and that by 2050, potentially $1 trillion will be spent trying to cover families and help with this disease. It is more important to come up with other alternatives and other ways to help people like me, because we are in the trenches. If we can make small changes now and continue with services to help families, potentially we will not go down that road. It may change this bulge they are predicting. I am really hoping people support the task force and all the changes that are being made now. Nevada is one of the leaders in this country in looking at this problem and addressing it. We are not just talking about it; we are actually taking steps and making changes. I am really hoping folks support this bill.

Chairman Sprinkle:
Thank you for your comments. We appreciate it. Is there anyone else under public comment wishing to come forward? [There was no response.] I will close public comment, and this meeting is adjourned [at 1:42 p.m.].

RESPECTFULLY SUBMITTED:

____
Terry Horgan
Committee Secretary

APPROVED BY:

____
Assemblyman Michael C. Sprinkle, Chairman

DATE: ______________________________________

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a letter dated March 10, 2017, to the Committee from John A. Yacenda, President, Nevada Silver Haired Legislative Forum, supplied by Senator Joseph (Joe) P. Hardy, M.D., Senate District No. 12.

Exhibit D is written testimony dated March 10, 2017, in support of Senate Bill 92 presented by Valerie Wiener, Chair, Task Force on Alzheimer's Disease.

Exhibit E is a copy of a report dated January 2017, entitled ”Task Force on Alzheimer's Disease Annual Report," supplied by the Department of Health and Human Services.

Exhibit F is a copy of a report dated January 2017, entitled "The Nevada State Plan to Address Alzheimer's Disease," supplied by the Department of Health and Human Services.

Exhibit G is a copy of a letter to the Committee dated March 1, 2017, submitted by Wendy Simons, Private Citizen, Reno, Nevada, in support of Senate Bill 92.

Exhibit H is a copy of a letter to the Committee dated March 10, 2017, submitted by Barry Gold, Director of Government Relations, AARP Nevada, in support of Senate Bill 92.

Exhibit I is an explanation of Assembly Bill 85, part of a work session document dated March 10, 2017, presented by Susan E. Scholley, Committee Policy Analyst.

Exhibit J is an explanation of Assembly Bill 111, part of a work session document dated March 10, 2017, presented by Susan E. Scholley, Committee Policy Analyst.

Exhibit K is an explanation of Assembly Bill 141, part of a work session document dated March 10, 2017, presented by Susan E. Scholley, Committee Policy Analyst.

Exhibit L is an explanation of Assembly Bill 214, part of a work session document dated March 10, 2017, presented by Susan E. Scholley, Committee Policy Analyst.

Exhibit M is a copy of a PowerPoint presentation entitled, "Out-of-Network Billing," prepared by the Division of Insurance, Department of Business and Industry, State of Nevada, presented by Glenn Shippey, Insurance Actuarial Analyst 2, Life and Health Section, Division of Insurance, Department of Business and Industry.

Exhibit N is a copy of a PowerPoint presentation dated March 10, 2017, titled "Balance Billing Presentation," prepared by the Office for Consumer Health Assistance, Bureau for Hospital Patients, presented by Janise Wiggins, Governor's Consumer Health Advocate.