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

Seventy-Ninth Session
March 29, 2017

The Committee on Health and Human Services was called to order by Chairman Michael C. Sprinkle at 1:03 p.m. on Wednesday, March 29, 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:

Assemblywoman Ellen B. Spiegel, Assembly District No. 20

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Committee Policy Analyst
Mike Morton, Committee Counsel
Terry Horgan, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Richard Perkins, representing Nevada State Medical Association
Regan J. Comis, representing Nevada Association of Health Plans
Chelsea Capurro, representing Health Services Coalition
Chris Ferrari, representing Nevada Dental Association
Jack Warwick, Intern to Assemblywoman Olivia Diaz, Assembly District No. 11
Denise Tanata, Executive Director, Children's Advocacy Alliance
Kim Amato, Founder and Board President, Baby's Bounty, Las Vegas, Nevada
Elisa Cafferata, Director of Government Relations, Nevada Advocates for Planned Parenthood Affiliates, Inc.
Tess Opferman, representing Nevada Women's Lobby
Shane Piccinini, Government Relations, Food Bank of Northern Nevada; and representing Three Square
Katie Roe Ryan, Director, Communications and Public Policy, Dignity Health-St. Rose Dominican
Christopher B. Carothers, Private Citizen, Las Vegas, Nevada

Chairman Sprinkle:
[Roll was taken. Committee rules and protocol were explained.] I am going to open up for public comment. We will be having a second public comment at the end. [There was no one.] Not seeing anybody, let us open up the hearing on Assembly Bill 157.

Assembly Bill 157: Requires a provider of health care or health facility to provide a patient with certain information relating to insurance coverage. (BDR 40-697)

Assemblywoman Ellen B. Spiegel, Assembly District No. 20:
I am here today to talk to you about surprise medical billing (Exhibit C). For those of you who are not familiar with it, and for those of you who need a little refresher, a surprise medical bill is an unexpected bill someone receives for medical services that comes from a patient using an out-of-network medical provider [page 2, (Exhibit C)]. It could reflect differences in patient cost-sharing between an in-network and an out-of-network provider. For instance, you could have a 20 percent copay for in network and a 40 percent copay for out of network, or you could have different deductibles. It could include balance billing by an out-of-network provider who comes back to the patient for the balance owed. It could also reflect the amount of coverage that is provided by the insurance company. If you are very, very sick, you might run out of coverage—you may exceed your coverage limits—in which case your insurance will only pay up to the limit, and now you owe the balance. One issue we discovered as we worked on this bill is that most patients erroneously believe that preauthorization means the coverage has been verified and approved. Patients will get a bill and say that they do not understand why they are being billed when the procedure was preauthorized. The insurance company said it was okay. As it turns out, preauthorization just means that it is something that is medically necessary and eligible for coverage. I found a great PBS video on the Internet, and I have provided the address at the bottom of page 2.

When these bills come in, typically patients say that it is a really big surprise [page 3, (Exhibit C)]. According to the Kaiser Family Foundation, nearly 70 percent of patients with unaffordable out-of-network medical bills did not know that the health care provider was not in their plan's network at the time they received care. They might have looked it up in their directory; they might have spoken to someone; they might have even asked the provider if he or she was in network. The provider might have said yes, but had been working with out-of-date information. There are times when even the doctors themselves do not know whether they are in network. It is not that they are lying to you, it is that there are other things at play that could have them not be in network but not know it. Among insured, non-elderly adults struggling with medical bill problems, charges from out-of-network providers were a contributing factor about a third of the time. According to *Forbes Magazine*, about 25 percent of Millennials and Gen Xers owed bill collectors for unpaid doctor and hospital charges. This is even for people with insurance. Adults between the ages of 18 and 50 have the highest percentage of medical debt of any generational group. When you look at medical debt, it is a big problem. This slide [page 4, (Exhibit C)] shows all sources of consumer debt. Health care is the number one driver of consumer debt. It is bigger than student loans, it is bigger than credit cards, and it is also the number one reason for bankruptcy.

So, you would say that this is a big problem, but it must be something that is fixable; it must be something that is pretty easy [page 5, (Exhibit C)]. Wrong. This issue is something the Legislature has been handling since at least my first session, which was in 2009. Nobody has been able to resolve the problem [page 6, (Exhibit C)]. Part of what happens is the different stakeholders involved all say that it is "their" fault, and they point to someone else. That makes it very, very difficult because of the intricacies of the situation. Over the past number of years, I have had the privilege of serving on the National Conference of State Legislatures' (NCSL) standing Health and Human Services Committee. Last summer when I was at the annual meeting, I was in a session that talked about surprise billing. Something that occurred to me is that we might be taking an approach that tries to bite off too much. Rather than looking at solving the big problem—which is there—maybe we can compartmentalize it, isolate one element, and try a controlled approach to dealing with the problem.

What this bill does is stop surprise billing in nonemergency situations when preauthorization is required. I will explain that reasoning to you. When it is not an emergency, you are not dealing with things that have to happen right now. When preauthorization is required, we know by definition that the provider and the payer, or the insurance company, have to be talking to each other. There is time involved, and we can get things straightened out. What this bill does is require providers and payers to notify patients of their network status with enough time for issues to be resolved or for the patient to cancel the appointment without a penalty. It introduces a concept of verification of coverage. As everyone thinks their preauthorization means that they have coverage, now the insurance company will come back and tell them what they are covered for. That way, the patient knows in advance. It will prohibit balance billing in certain circumstances, and it will formalize a dispute resolution mechanism between the providers and the payers. A really big question everyone asks is, if we hold the patient harmless for the balance billing, then who pays the tab? Does the provider get stiffed, or does the insurance company pay more than it thinks it should be paying?

I would like to walk you through the bill, and I have a couple of conceptual amendments that are built into this as well [page 7, (Exhibit C)]. In section 1, we will be requiring patients to be given notice of whether the provider is in network or out of network at least 48 hours in advance of the service or care. We are going to come up with a process that is going to be detailed in regulations. We are going to add the concept of verification of coverage that I just explained. In section 1, subsection 2, we are going to modify the time frames. If treatment is scheduled more than one week in advance, then the patient must be given a week's notice. If it is less than a week in advance, the patient should be given at least 48-hours' notice.

In section 1, subsection 3, we will establish an independent dispute resolution process. Then we are going to add a section 1, subsection 4, paragraph (e) and a statement that "third party" does not include a Medicaid managed care organization or the state's fee-for-service program. That is because right now, you cannot balance bill in Medicaid, so there is not the same issue when dealing with Medicaid. We are just clarifying in the law what is already in practice.

In section 2, we are going to change the effective date. It will be January 1, 2018, for the purpose of adopting regulations and for everything that will be outlined in section 1. Then, January 1, 2019, will be the effective date for all other purposes. The reason for that is because the insurance companies have to get regulatory approval for their policies and plans. If we are adopting regulations by January 1, 2018, they need to have time to translate those regulations into what it means for their plans and get approval for them.

I will walk you through how we can make this work [page 9, (Exhibit C)]. In step 1, it is just as it happens today. The patient goes to the doctor and gives the insurance card to the provider at check-in. The provider contacts the insurance company to verify the information. If you have something that will require prior authorization, that request will be initiated. This is for something complex; not a routine visit, something just a step above. The payer, or the insurance company, is going to assign a confirmation number to that transaction. This is something that is important. We are building an audit trail of the decision-making process and of the information that is provided to the patient. The insurance company is going to come up with its prior authorization decision: it will either be yes or no, as they do today. The only difference at this point is that they are going to assign a confirmation number.

In step 2 [page 10, (Exhibit C)], the payer, the insurance company, is going to notify the patient and the provider of the prior authorization decision, which is what they are doing today; but now, they are also going to be verifying the coverage and what the copay will be. If there is coinsurance, they will specify what that is. They could even give the maximum out-of-pocket amount the consumer should expect to pay. The difference here is that the insurance company will be held to that information. It will be in writing; there will be a confirmation number, and the patient will have that confirmation number. The provider will get the information as well as the patient; but then the provider will also be providing that information back to the patient. That way, if the provider thinks that he or she is in network, and the insurance company says that the provider is not in network, or vice versa, the patient will have time to do something about that conflicting information.

Step 3 is the same as steps 1 and 2, but deals with multiple providers [page 11, (Exhibit C)]. Let us say you are going to have surgery. You will have to deal with a hospital, you will have at least one surgeon, you will have an anesthesiologist, and you might have a radiologist. You will have a host of providers. Step 3 repeats the process found in steps 1 and 2.

In step 4, the patient will have all this information and confirm back to the provider [page 12, (Exhibit C)]. The provider's office will say yes or no and, again, if there is an issue, it can be dealt with in advance. If there is going to be a very large bill because a provider is out of network, the patient will have the ability to say he or she needs to stay in network because of affordability, or the patient can request a payment plan in advance. The patient might also ask what else could be done, such as a less expensive treatment. Part of this is having the time to address an issue before it becomes a problem. The patient will bring the confirmation number to the appointment, and the provider will ask the patient for the documentation. It will all be verified. It will all circle around, and everyone's ducks will be in a row.

In speaking with Chairman Sprinkle, something that became apparent was that we needed to make this simple for the consumer—simple for the patient to understand. It gave me the idea to have a patient worksheet. This is a model of it [page 13, (Exhibit C)]. It is not comprehensive, but something a patient could use to protect their rights and remedies under the law. I will run through how it works. On the first line is the provider's name and area of specialty—in this case it is a hospital. The rest of the information recorded comes from paperwork received from the various providers. Is it in network? Yes or no. What is my copay? What is my out-of-pocket maximum? Also written down is the confirmation number and date from the provider and the confirmation number and date from the insurance company. Again, there is an audit trail. The patient would fill this out for each provider. If there are multiple pages, there could be a subtotal at the bottom of one page and then the total on the last page. The patient will have the ability to add up the numbers and know what he or she will be paying, out of pocket. They can clip all their supporting documentation to it, so they will know, under this law, that is what they will be paying. They would not be getting a surprise bill. That does not mean that the provider cannot charge whatever the provider would charge. It does not mean that the insurance company cannot pay whatever it would pay, but it just means that the patient is no longer walking in and signing an authorization that says, You can bill me whatever, and I understand that not everything may be covered by my insurance and you can bill me for the remainder. The patient is going to know.

I want to speak for a minute about the prohibition on balance billing [page 14, (Exhibit C)]. One problem I have heard multiple times is that somebody will go in for a procedure and think that everything was set up and that everyone was in network. The individual had worked really hard, made sure that it would be done the right way and that they would be controlling their costs. At the last minute, a provider swap happens, and the new provider is out of network. The patient did everything that needed to be done and was still slapped with a really big and unexpected bill. Under this bill, if the patient does everything he or she is supposed to do, that patient will not be balance billed. He or she has all their documentation with the confirmation numbers where it is confirmed that this is going to be in network with the dates and names of the people with whom they have spoken. If the process is not followed by the provider or the payer; if the insurance company does not send the documentation; if the provider does not send the documentation; if the patient does not have all the information needed in advance, that patient will no longer be held accountable. The patient worked in good faith to get what was needed. If that happens, then the patient cannot be balance billed by the provider or the payer. Then what will happen is that the provider and the payer are going to decide who will be stuck with the balance. If they cannot reach an agreement on their own, we are going to add an independent dispute resolution method they can use to figure out who gets paid what and who pays what, but it will not be the patient.

Also, this bill has benefits [page 15, (Exhibit C)]: it has benefits to the patient; it has benefits to the providers; and it has benefits to the payers. For the patients, it will stop the practice of what I call writing blank checks to out-of-network providers. They will know their financial exposure before incurring the expense, not after. It gives them an opportunity to negotiate pricing or select another provider before the procedure. The providers are going to have fewer bad debts from patients, because the patients are not going to be surprised, and they will have a defined dispute resolution process. The payers get benefits too. They are going to wind up having fewer insureds using non-network providers. The insurance companies really want to keep people in network; that is cost effective for them. They, too, will have a defined dispute resolution process.

This has been a very challenging bill to work on. I have been with a working group that ranged from 30 to 35 people, and we have had several meetings. I recognize that it is not 100 percent there yet, but I am confident that this approach can give the patients—our constituents—the information they need so that they can make the right choices financially and so that they can address their medical issues.

Chairman Sprinkle:
Thank you for that detailed presentation. Much of what you just presented and the flow charts are not located in the bill. Is this what you will be bringing forward as an amendment, or is this a suggestion about how the process would work?

Assemblywoman Spiegel:
We are looking at amending the bill to say that the process will be defined by regulations and those regulations will be developed by January 1, 2018. This is a vision for how the process would work and what would be contained within the regulations, but it is not definitive.

Chairman Sprinkle:
It is not your intent to put those specifics in the legislation, because those deviate from the original bill.

Assemblywoman Spiegel:
It is the intent to have a process and structure in place so everyone will feel comfortable allowing the patient to have recourse. We will be getting rid of the finger-pointing and the "he said; she said." What is happening today, and has been happening for years, is that it always falls back on the patient. The patients could be doing everything they think they should be doing, but they are the ones who wind up with the liability, so there will be a process, and this is one possibility.

Assemblywoman Titus:
This really affects private insurers because the Centers for Medicare and Medicaid Services (CMS) already have pretty strict guidelines that providers such as myself have to follow concerning patient notification. When a patient comes to my office, I have them sign a form that says, "You may be billed for additional services." If I order a test that I am not sure will be covered by insurance based on the diagnosis, I have them sign a form that says, "This may not be covered." We do that at the moment. Say I want to order a vitamin B-12 level on a patient. Without a specific diagnosis, Medicare or Medicaid will not pay for it, so I have the patient sign that waiver. That way the patient is notified. I understand what you are saying, but it is due diligence that we have to inform the patient. We are already obligated to do that under CMS. At the same time, there are times when I do not know what the cost is going to be. I also have cash-paying patients who are people with high deductibles. However, there is a caveat. I tell them that they may get an additional bill if I have to do a urinalysis or if I have to do a urine culture. It is about communication. Where is this different than what we are already obligated to do?

Assemblywoman Spiegel:
It was clear that we were writing out Medicaid, and we can absolutely write out Medicare because they have their own guidelines. This bill is about notice to the patient, the consumer. I know that there are providers such as you who are not necessarily going to know what a lab is going to charge or what any other provider is going to charge. That is why this comes back to a very confined time: only a nonemergency situation when preauthorization is required. There is time then for the consumer or the doctor's office to arrange tests and tell the patient what it is going to cost before the patient incurs the expense. It is about notice; it is not about the charge itself.

Assemblywoman Titus:
Going back to that very question, in section 1, subsection 2, paragraph (a), it says "Not later than 48 hours before the provider or health facility is scheduled to provide the services and care." In paragraph (b) it says "In writing and by telephone." Do you really mean by telephone, because then you say "may be provided by electronic mail." Are you sure you want "and" there as opposed to "or"? How do you document that they got the notice?

Assemblywoman Spiegel:
"Or" is fine. The way it would be documented is by use of confirmation numbers. Patients would be given confirmation numbers just as though they were booking travel arrangements. There would be documentation on both sides.

Assemblywoman Titus:
What generates that confirmation number? Is it going to be a patient identification? I am worried about confidentiality and some of the Health Insurance Portability and Accountability Act (HIPAA) concerns. What would you accept as a confirmation number?

Assemblywoman Spiegel:
The payer would generate the confirmation number. It would be whatever identification that office wished to assign to that patient. In the case of an insurance company, it could be a claim number, possibly appended with the date. It is one of the things that would be outlined in the regulatory process. That is why I presented a vision; I did not present what the final process will be.

Assemblywoman Titus:
I appreciate what you are trying to do. I am a consumer also, and family members have received billings that surprised them, so I understand what you are trying to do. I am concerned about how we get there—understanding all the obstacles in the way.

As a provider, I have to get prior authorization. I do a lot of office surgery; I do a lot of skin biopsies, so I have to get a prior authorization to do that procedure on patients, and I do. There is a disconnect however. I will not know until I actually do the procedure how long it takes, how big it is, and—because I may have to go back in again—what the cost might be. So at times, I cannot come up with a number before the procedure—some procedures, possibly—but even with a colonoscopy, there might be a biopsy, which changes the cost. I am worried about setting a finite number to a procedure you have to prior authorize when you may not know what the end cost might be.

Assemblywoman Spiegel:
I understand that there are a lot of complexities involved in this; and, Assemblywoman Titus, if this bill goes forward, I would welcome you to be part of the process in helping develop the regulations. I think that they need to be developed in a way that works for the providers, the payers, and, ultimately, the consumers. This is not meant to be something that is going to be crippling. It is meant to be something that is going to help the patients so that they do not open their mail one day and find a $14,000 bill that they were not expecting and that they cannot pay for.

Assemblyman Carrillo:
For clarity, if someone were to get prior authorization for something like a surgical procedure, the insurance company approves the prior authorization but it does not say exactly what is covered at what level. Does that prior authorization also include the facility at which the procedure is going to be provided?

Assemblywoman Spiegel:
It is my understanding that the prior authorization will look at the medical necessity of your having the procedure done and whether that procedure is eligible for coverage. The key word is "eligible" for coverage. It does not mean that you will have coverage, which is why this bill introduces a second concept called verification of coverage. Something that is always a challenge, and becoming more so, is that it has been drummed into patients that if they do not get prior authorization when they need it, they will not have coverage. But that made everyone think that prior authorization meant that if you got prior authorization that you had coverage. It does not meant that; it means that it is eligible. If you have exceeded your medical maximum, you are not going to have coverage even if you have a prior authorization. If your policy has lapsed, even if you have a prior authorization, you are not going to have coverage. There are always situations where, even if you have a prior authorization, you might not have coverage. This bill is also predicated on the consumer's policy not having lapsed and that the consumer had done what he or she was supposed to do and met their copays and all other components. This bill is supposed to provide an indication of what they would have to pay, worst-case scenario.

I spoke to someone this morning who told me about a $14,000 bill she got that was not expected. As she was telling this story, she said that if they had told her in advance that it was going to be $14,000 and she knew that her insurance was only going to cover a few hundred dollars, she would have suggested to her doctor that she do the first four treatments that were covered by the insurance, and then see how she was doing and whether she needed the rest. Or she could have negotiated something in advance or tried to work out a payment plan. She, however, was never afforded that opportunity; she was told she had prior authorization and then received a bill for $14,000.

Assemblyman Carrillo:
If a patient ultimately ends up being hospitalized instead of going home after a surgery, what happens in those circumstances? Are they currently being blindsided by a massive bill?

Assemblywoman Spiegel:
Yes, that could happen, but the scenario you are describing went from being a planned procedure to an emergency situation. The emergency component is not covered by this bill. Overall, one of the things that is unfortunate in trying to deal with surprise billing, balance billing, and all the ancillary issues is that it is so big and complex that nothing has been able to pass the Legislature. This bill is taking a very confined, controllable piece and trying to see what happens. Can we make this work? If we can have an approach and make it work here, then we can learn from that and decide how to expand and tackle some of the other pieces where there are more variables and it is less controlled. We have to walk before we can run.

Assemblyman Yeager:
I had a question about page 2, line 3 of the bill where writing and/or telephone notification is mentioned. If someone chose to notify by telephone, do you envision that the provider would actually have to speak to the person on the telephone? Would leaving a voicemail be adequate, or would that be decided through the regulations?

Assemblywoman Spiegel:
I believe it would be whatever form of notice was approved by the patient. Patients complete HIPAA forms when they start out with doctors and specify what types of contact are okay. If the patient says a voicemail can be left; they could leave a voicemail. It could be in writing. They could say no messages; I need to speak to someone live. Whatever the patient specifies.

Assemblyman Yeager:
You are proposing a conceptual amendment with the time frames. It makes sense to me that if the procedure was scheduled less than a week in advance and was not an emergency, there would be 48-hours' notice. On the other one, you contemplated one-week's notice. My partial concern there is that in the state of Nevada we have such a hard time getting folks in to see specialty providers. What if, within that week's notice, the patient decided not to go forward with that procedure. Would that be enough time for the provider to schedule someone else? Where did you come up with the one-week notice, and do you think it would create a scenario where we would have providers with cancelled appointments not able to fill their schedules?

Assemblywoman Spiegel:
That was part of why we went back to one week. The thought was that 48 hours was not giving enough time to our providers to allow them to reschedule. Part of this is looking at all the moving pieces. There is the payer component—the insurance company that has to give notice—the patient component, and the provider component. One week gives enough time so scheduling adjustments can be made. There cannot be so much time involved that nothing can get done.

Assemblywoman Joiner:
I want to commend you. I think this is a really manageable chunk of this complex issue. This is so clear to me in cases where it is elective surgery, for example. I had a constituent who got knee surgery over the holidays, and she could have picked any day she wanted for that surgery. She found out that one of the providers that day was out of network and got hit with a $20,000 bill. It is still happening, but it is inexcusable. She could have picked any other day, is what she said to me, and she would have had she known. I am really hopeful that we can come to some sort of resolution on this piece of it.

My question relates to the notification. My only concern is with section 1 and how the notification happens. I have heard that other states are having the patient sign that they understand what they have received. My concern is that an email could go to an inbox or go to spam, or the voicemail would not be received or on the wrong phone. I really want to make sure that patients also understand. Just getting a voicemail that says the doctor is not in network does not give the patient enough information to make a decision. I would hope the language would be tighter and have the patient acknowledge it had been received.

Assemblywoman Spiegel:
That was part of how the vision of the patient worksheet came about. If you look at the patient worksheet, there is room for the patient to record what has been received from both the provider and the insurance company. That way there is a check and balance and the patient knows to be looking for the information from two different sources. That is where the patient's understanding winds up getting facilitated. It will be right in front of them; they will be putting it together; it will be in black and white. If there is a piece that is missing, the patient will know to follow up and pursue that missing information. If there is a blank box on that worksheet, the patient will be vulnerable.

Assemblyman Thompson:
I have a question about enforcement. Is section 1, subsection 3, the enforcement piece? I do not see who the enforcer is, and how strong would that enforcement team be to make certain this does not happen?

Assemblywoman Spiegel:
Part of what is happening today is that patients are getting sent to collection companies and then lawsuits are occurring over bills. I am looking to put a dispute resolution process in place. That is a component I want to see in the bill for enforcement. There also are civil remedies.

Assemblyman Thompson:
We also need to include that, before things are sent to collection agencies and being reported on your FICO Score, there needs to be a provision for people to resolve it first before it goes to those extremes.

Chairman Sprinkle:
Are there any other questions?

Assemblywoman Titus:
Is there anywhere in any of your revisions that makes the insurance companies pay once they settle on an amount? Okay, this is what you have to pay; everyone agrees; these are the numbers; this is what you might experience. There is nothing in here that forces insurance companies to then pay that amount.

Assemblywoman Spiegel:
If the patient has a piece of paper from the insurance company that says what the coverage will be and this is what the charges will be, the provider will also have a copy of that. The provider will have that, and it will be enforced. That is the representation from the insurance company, and it also gives some protection to the providers.

Chairman Sprinkle:
To follow up, I would go back to Assemblyman Thompson's question. That all sounds good, but I am not seeing anything that would enforce that in this bill. It is certainly something to think about. Are there any other questions from the Committee? [There were none.] Will anyone wishing to speak in support of A.B. 157 please come forward. [There was no one.] I do not see anyone here or in southern Nevada. Does anyone wish to come forward in opposition to A.B. 157?

Richard Perkins, representing Nevada State Medical Association:
We are in opposition to A.B. 157 as written. I want to commend Assemblywoman Spiegel for bringing the bill forward. She mentioned that she had dealt with balance billing in various forms since 2009, but I have been dealing with it since 1989. It is not a strange topic to this Legislature. I think her idea is a strong one and can be built upon. There are a handful of challenges in the concepts and in the bill, and we would love to participate with her to help correct them—for example, the timelines. Not every nonemergency situation is not urgent. If I were sitting on your side of the table, I would not want to hear from a lot of constituents about how they had something scheduled that could not happen because of a specific timeline that was involved. I understand why she has incorporated that concept in order to make time for the patients to be educated, but that could be a concern.

Providers want to be in network. They want to be in as many networks as they can, but it just does not always work out through the negotiations they have with particular payers. The concept of a worksheet is a good one. I am not sure how it would work, but we would love to work with Assemblywoman Spiegel on moving those concepts forward.

The other concern I have involves the example she used, which is a very real example. Someone goes in for a particular procedure, and there is a doctor swap. The doctor who actually ends up on the procedure is out of network. It happens a lot in our state, unfortunately, but the last thing we would want to have happen involves someone going for some sort of surgery. An anesthesiologist gets swapped out for another, and they find out they are out of network, and the provider says he or she will not participate. That would be bad for the patient as well. None of these issues can be corrected or overcome. We all recognize that we have a provider shortage in our state. I am assuming that as we grow our providers and our networks, some of these issues will be addressed. An unfortunate aspect of it has been asked by many Committee members and mentioned by Assemblywoman Spiegel as well. It is my belief that, while you cannot put all the regulations in statute, nor should you, there should at least be some sort of enforcement structure more vetted in regulation. Again, that is something we would be more than happy to work out with her.

The only other concern I would like to mention is the dispute resolution. It is a creative way to go about this, but we already know that we have a shortage of providers. If a provider is taking time off work to go into dispute resolution, that is time that cannot be spent with patients. Yes, there are some office staff who could probably participate in that, but I suspect any of those discussions are going to take time away from patients, and we are somewhat concerned about that. Those are the bulk of our concerns, but we are more than happy to work with Assemblywoman Spiegel on this somewhat creative approach to surprise billing.

Regan J. Comis, representing Nevada Association of Health Plans:
We, too, come up in opposition to the bill as written but appreciate the Assemblywoman including us in her workgroup and want to continue to work with her. We also have some concerns regarding the independent dispute resolution that we are working through in the working group—what that would look like and how it would work out. We are committed to working with her.

Chelsea Capurro, representing Health Services Coalition:
We are in opposition as the bill is written, but we appreciate and want to thank the sponsor for taking time to work on this with us through working groups and individually. We have the same kinds of issues as have been mentioned, but we want to get there and work with her on this. Another point concerns the independent dispute resolution. At times, that could end up costing more than what we are actually looking at in terms of the balance bill that would be sent. We want to make sure we are doing this the right way, and we are happy to keep working with the Assemblywoman on this.

Chairman Sprinkle:
Is there anyone else in opposition to A.B. 157? [There was no one.] Is anyone coming up in neutral to A.B. 157?

Chris Ferrari, representing Nevada Dental Association:
We are appearing in neutral on A.B. 157. When I saw Assemblywoman Spiegel's presentation, I was reviewing what she is looking to do. She is trying to accomplish something very significant, but, from a dental perspective, we pointed out to her that we have patients who are receiving surprise bills with the surprise being on the provider's side. They are not being compensated for covered services. The arbitration piece certainly needs some fleshing out, which Assemblywoman Spiegel indicated during the course of our meeting. We believe this is a very important piece of policy that she is pursuing, and we would like to commend her for her efforts and always being very pleasant to work with.

Chairman Sprinkle:
Is there anyone else who would like to speak in neutral on this bill? [There was no response.] Assemblywoman Spiegel, did you want to come back up?

Assemblywoman Spiegel:
I want to thank you for your time and for your consideration of the bill. I have been working with my working group—some of whom you heard from today. I will continue working with my group and hope to come back to you with some resolution and, hopefully, a solution so that we can move forward with this important piece of legislation, but done in a confined way.

Chairman Sprinkle:
Thank you for bringing this bill forward. It sounds as though, conceptually, a lot of people are in support of what you are trying to accomplish, so I would strongly recommend you keep working with them.

With that, I will go ahead and close the hearing on A.B. 157 and open the hearing on Assembly Bill 340. I do not see Assemblywoman Diaz here. She stated that she was feeling ill, so it looks as though the two of you will be presenting her bill, which I am certainly okay with.

Assembly Bill 340: Requires the Department of Health and Human Services to take certain actions to improve access to diapers and diapering supplies for recipients of public assistance. (BDR 38-871)

Jack Warwick, Intern to Assemblywoman Olivia Diaz, Assembly District No. 11:
The Assemblywoman is, unfortunately, sick today. She wants to send her apologies for not being able to come before you herself, as this is an important issue to all of you and involves the well-being of your most vulnerable constituents—Nevada's children. After reading research from Kim Amato and being educated by Denise Tanata from the Children's Advocacy Alliance, Assemblywoman Diaz felt compelled to carry this bill. As a result of the research and numerous conversations she has had with them on the subject, she learned of the financial hardship and dire need that many of Nevada's families face in order to provide one of the basic necessities babies need—diapers.

Denise Tanata, Executive Director, Children's Advocacy Alliance:
[Denise Tanata spoke from prepared text (Exhibit D).] The cost of diapers places a huge burden on Nevada's most at-risk families. Infants, on average, use about 240 diapers per month—which costs a family approximately $78 per month—and that is if the family has the resources to purchase in bulk. For example, a two-parent family with an infant, making just over $2,200 a month, which is about 133 percent of the federal poverty level, would spend about 3.5 percent of their monthly income on diapers. For families receiving public assistance, this cost is compounded by the fact that diapers are labeled as luxury items, resulting in their not being covered by Temporary Assistance for Needy Families (TANF); food stamps; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); and other supplemental assistance programs.

A study by Yale University found that 30 percent of mothers reported that they were unable to afford to change their child's diapers as often as they would like. To stretch the use of diapers, they found that some parents are reusing diapers. This means taking the diaper off, getting rid of the excrement in the diaper, and reusing it. They are also leaving diapers on longer than they should be left on, which often can lead to health problems such as urinary tract infections, which can also result in chronic conditions for very young children.

Some people bring up the use of cloth diapers as a less expensive option. In today's world, that is not an option for many low-income families. Most child care centers will not accept cloth diapers for sanitary reasons. You have to have disposable diapers. Also, many who stay at home do not always have access to washers and dryers in their housing, and you cannot wash cloth diapers in a laundromat. So, there are many reasons why this is an issue for families, and particularly for low-income families. For families who can afford to purchase diapers, there is price inequality. Low-income families pay upwards of 2 to 3 times the price of diapers compared to middle- and high-income families. This is largely due to their inability to purchase diapers in bulk at big box stores or through the Internet due to a lack of transportation, cash flow, or credit. These families are also burdened by the sales tax they pay on diapers. In Nevada, the lowest sales tax rate is 6.85 percent. This results in paying more than $60 a year in taxes for diapers alone.

The bill before you does not ask for money at this point. We are asking for a study to be done to look at different options for the state to receive funding, to see what flexibility they have with the resources currently available, or to see different ways they can provide assistance to those families who are already on assistance programs. This would include looking at programs related to smoking cessation, prenatal care visits, or pediatric follow-up appointments with providers of health care. We are also asking that the committee established to put together this report would report the results of the research to the Director of the Department of Health and Human Services at least twice per year. It also would authorize the Director, if such opportunities exist, to take action in order to increase the availability of diapers as well as diapering supplies to those recipients of public assistance. As is happening now, the Director would work collaboratively with diaper banks in the state and with different nonprofit organizations to increase access. Also, and this is one of the biggest factors, the Director should work to make sure that information about resources that are available to these families is posted and provided to those families who are current recipients of public assistance. We have Kim Amato with Baby's Bounty in southern Nevada who will speak.

Kim Amato, Founder and Board President, Baby's Bounty, Las Vegas, Nevada:
[Kim Amato spoke from prepared text (Exhibit E).] I am the founder of Baby's Bounty, a nonprofit organization that provides diapers to low-income families as part of the National Diaper Bank Network. Diapers are an expensive necessity that help parents both maintain and monitor their children's health. Newborns should be changed as often as every hour, while older babies can be changed every three to four hours. Infants are sufficiently hydrated and ingesting adequate volumes of breast milk or formula when they produce six to eight wet diapers a day. When families are unable to afford enough clean diapers, babies and young children may wear dirty diapers longer than is recommended. Prolonged contact with urine and feces leads to infections, as was previously mentioned. Mothers are extremely distressed by diaper rash and may have feelings of embarrassment, guilt, or frustration. Women with "diaper need" also reported more difficulty with stress management, depression, and coping with trauma, which can negatively affect a child's health and development. Diaper need is

even more distressing to mothers than not having enough food for their families. Thirty-four percent of families surveyed by the National Diaper Bank Network had cut back on basics such as food, utilities, and child care to purchase diapers for their child.

Approximately 2,500-plus diapers are needed every year at a cost of anywhere from $900 to $1,500 a year if parents do not have access to Internet-based diaper distributors. Due to economic restraints, low-income families have limited or no Internet access for purchasing; they cannot buy in bulk; they lack transportation to supermarkets, discount stores, and warehouses with lower diaper prices; and must rely on local convenience stores to purchase diapers by the diaper. The cloth diaper issue is that they cannot be taken to a laundromat, and many child care centers will not accept cloth diapers and require that infants wear disposables. Diaper need has many detrimental outcomes for families' and children's health, emotional well-being, and educational opportunities. Without sufficient diapers, parents must often keep their children home from day care and early childhood education, limiting early development and education opportunities that are particularly important to low-income children.

Without proper child care, parents cannot work to support their families and cannot attend schooling that will help them provide a firmer economic base for their family. A single mother, working full time at the minimum wage, spends 6 percent of her annual gross income on diapers. The creation of a committee to research opportunities to use federal money to increase the availability of diapers and their supplies to certain recipients of public assistance, especially as an incentive to complete certain programs, is one I urge you to consider when representing the community.

Chairman Sprinkle:
Thank you for your comments. If there is nothing else, I will open up to questions from the Committee.

Assemblyman Thompson:
Thank you for stepping in for Assemblywoman Diaz. This is a great bill, but I have some suggestions to make it even more comprehensive. In section 2, where you are talking about the federal government, you should also be looking at local resources and foundations. You should open it all the way up. Let that committee check every nook and cranny it can. Also, if we can consider it, maybe this should not just be for recipients of public assistance, because we have a lot of struggling families out there. Sometimes it is a prideful thing to feel as though you need to go into a public assistance office; but if they just need to get diapers, maybe there is a streamlined process where they can get diapers. Those are my two suggestions, but I love the bill and think it is something we need to do.

Assemblyman McCurdy:
I really like this idea, and I think it is long overdue. I was wondering if there would be an opportunity for you to take to Assemblywoman Diaz the idea of expanding this to cover our seniors. They may wear Depends or be in need and also may be on public assistance. I would like to see this expanded to cover them and allow more opportunities for them as well. It would make this an even stronger piece of legislation.

Assemblywoman Titus:
Looking at the bill, in section 2, you mention that the Director shall appoint a committee within the Department without really any definition of who the members of the committee would be or how often it would meet. You say what the committee is looking to do, but you do not mention the committee structure itself—who the people on the committee would be. In section 2, subsection 2, it says "The Committee must report the results of its research to the Director at least two times per year," but then it does not say that the Director ever reports back to us, or the body, to give us an update on where they are going with it and costs. Have you thought about that? I would echo my colleague Assemblyman McCurdy. There is a true need among our senior population for things such as Depends. Some of these health care needs are really not just related to infants. Those are my two questions: Are you looking at better committee structure, how they are reporting, and whether they are going to come back to us; and then the senior component.

Denise Tanata:
I have been writing all your suggestions down and will definitely take them back to the Assemblywoman for consideration. Yes, absolutely, on your first question: I would like to expand the committee. We can definitely look at doing that; I know that is done in other pieces of legislation. I will also have some discussions with the Department about who should be on there and if we need to be more explicit—as well as the structure and the timing of the committee. I am also going back to the Assemblywoman for consideration, but the idea of bringing that report back to the Legislature so you can see what we have come up with and what potential projects or implementation plans we have is a good recommendation as well.

Assemblywoman Titus:
On the same line as Assemblyman Thompson's question about looking at grants, I do not see any mention in the bill about going to the actual producers of the product and looking at any programs they might already have in existence for low-income families. Do they do donations? What do the companies such as Johnson & Johnson, who make these things, offer the consumers? I do not see that is part of your direction. Have you already reached out to the producers?

Denise Tanata:
There has been a large national effort looking at this issue around diapers. There have been a lot of conversations with some of the national organizations and with some of the large manufacturers as well. There are some efforts on the private side, and people are going through some Internet resources. I am aware of at least one program where they would allow

some of the nonprofit organizations to buy in bulk at cost if there is an agreement that they would sell them at cost. There are things additional to government programs we could definitely include, as Assemblyman Thompson referenced, such as some of the nonprofit organizations and the foundations, but we could also look at the manufacturers as well. I think it is an excellent idea to include those in the work of the committee.

Assemblyman Edwards:
What do you see a government committee being able to do better than your own organization can on this issue, and why do you think that the people who would need such a thing would actually know about the committee? Would not your organization be better situated to expedite this? You could be working on this for the next three months before this committee would ever be approved, get started, and set up. It seems to me that you are in a better position to provide what you are seeking.

Denise Tanata:
We would be more than happy to be a part of this as well as Ms. Amato's group. This was put together in collaboration with the Department, particularly around the federal government opportunities that are available. All those opportunities go through the Department of Health and Human Services, so they have a lot of the authority and control about what those funds can be used for, even having access to identifying where we can access the populations that are already receiving public assistance, which would probably be the populations most in need of these types of resources. I might be agreeing with you that it needs to be both a public and a private effort, but I do see the need for having the state agency as part of that collaborative effort.

Assemblyman Edwards:
Could you explain a little bit more about what value government at the state level brings to this overall effort?

Denise Tanata:
I will get back to you with some of that information. It was the Department of Health and Human Services that made the recommendation to Assemblywoman Diaz to establish this committee through their office.

Assemblyman Edwards:
I want to make sure they are not punting the ball to you, although you may be better qualified and situated to achieve the mission.

Denise Tanata:
Working collaboratively together will be most effective in being able to get this done.

Chairman Sprinkle:
I do not see any other questions from the Committee, but I have one about section 2, subsection 3, "If the Director determines any such opportunities exist, the Director shall take all necessary action to increase the availability. . . ." If we are looking at federal dollars that are meant for very specific things, and this committee determines that those dollars may be utilized for this project, is the language in the bill saying that other services may be at the detriment of providing these diapers and supplies?

Denise Tanata:
Chairman Sprinkle, that is an excellent question. If it is all right with you, I would like to take that back to the Department to get clarification, which we can follow up with you on.

Chairman Sprinkle:
Yes, and I appreciate that. I speak for myself when I say that I appreciate and am supportive of what this bill is trying to accomplish, but if some of the unintended consequences are that some of the other services that the state provides with these same dollars could be in jeopardy, then that is certainly going to cause me some concern.

Denise Tanata:
Absolutely. Thank you.

Chairman Sprinkle:
Is there anything else from the Committee? [There was no reply.] Not seeing any, I welcome anyone else who wishes to speak in support of A.B. 340.

Elisa Cafferata, Director of Government Relations, Nevada Advocates for Planned Parenthood Affiliates, Inc.:
We certainly are supportive of the health care needs of families in our community. We actually run a program called the Teen Success Program which helps teen moms. We mentor them and provide them with budgeting tips, how to cook on a budget, and how to find services and health care for their children. We know this is certainly a challenge, for young moms especially, and so we support this bill.

Tess Opferman, representing Nevada Women's Lobby:
We are in support of this bill. We know that diapers are a necessity for families and mothers, and we do not want this to be a place where mothers feel they need to cut costs, because it is not a place they can cut costs. Trying to limit diaper use is detrimental to the child and the family, so we are in support of this bill, and we urge you to support it as well.

Shane Piccinini, Government Relations, Food Bank of Northern Nevada; and representing Three Square:
The food banks in Nevada are happy to receive these donations; however, we never receive enough in terms of what is given to our warehouse for diapers and diapering supplies. Our clients are constantly asking us for assistance in trying to get these things. It is our thinking that this is a great step forward in trying to help the low-income families we serve resolve one more financial burden they are trying to address as they get themselves out of their situations.

Chairman Sprinkle:
Is there anyone else wishing to speak in support of this bill?

Katie Roe Ryan, Director, Communications and Public Policy, Dignity Health-St. Rose Dominican:
On behalf of our three hospitals and women's care centers of excellence, each of which has a WIC clinic and deals with these struggling families on a daily basis, we are also very much in support of this legislation.

Chairman Sprinkle:
With that, I will call for anyone in opposition to A.B. 340 who wishes to come up and testify. [There was no one.] Not seeing anyone, how about neutral? [There was no one.] Do you have any closing remarks?

Denise Tanata:
In closing, I want to thank Jack Warwick for stepping up for Assemblywoman Diaz, who is not feeling well. I have taken note of the suggestions brought forward by the Committee members. I greatly appreciate those, and there were a lot of really good suggestions on how we can make improvements to this bill. We will be presenting these to the Assemblywoman and look forward to working with the Committee to get this moved forward.

[(Exhibit F) and (Exhibit G) were submitted but not discussed, and are included as exhibits for the meeting.]

Chairman Sprinkle:
I will go ahead and close the hearing on A.B. 340 and open up again for public comment.

Christopher B. Carothers, Private Citizen, Las Vegas, Nevada:
I am an insurance agent and want to make public comment about A.B. 157. I am in full support of it. One of the things over the last five or six years I have done is come here to Carson City to talk about some of the issues I have had with the clients we serve with health insurance needs. The problem of surprise bills occurs over and over again. It is very important to be able to address this issue, and I really implore you to find some sort of resolution and make this bill come forward in some form. We have patients, our clients, who go into the hospital; for example, they preplanned having a child. They make sure the

doctors are in network, the hospital is in network; and then they get a rogue bill out of left field for about $4,000, and they do not have the means to pay it. Insurance today has two separate out-of-pocket buckets: one for in-network services; one for out-of-network services. Consumers need to know whether they are going to be in network or out of network, so I am in full support of this, and anyone in our industry is in full support as well.

Chairman Sprinkle:
Thank you for your comments. Is there anyone else here for public comment? [There was no response.] Seeing none, I will close public comment. If there is nothing more from the Committee, thank you all, and we are adjourned [at 2:25 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 PowerPoint presentation regarding Assembly Bill 157 titled "AB157: Addresses Surprise Medical Billing In Pre-Authorized Treatment," dated March 29, 2017, submitted by Assemblywoman Ellen B. Spiegel, Assembly District No. 20.

Exhibit D is a 2017 Safety Policy Brief titled "Diaper Assistance for Families," submitted by Denise Tanata, Executive Director, Children's Advocacy Alliance, in support of Assembly Bill 340.

Exhibit E is written testimony presented by Kim Amato, Founder and Board President, Baby's Bounty, Las Vegas, Nevada, in support of Assembly Bill 340.

Exhibit F is a letter to Chairman Sprinkle and the Assembly Committee on Health and Human Services dated March 28, 2017, submitted by Alison M. Weir, Chief of Policy, Research and Analysis, National Diaper Bank Network, New Haven, Connecticut, in support of Assembly Bill 340.

Exhibit G is written testimony submitted by Pam Russell, Executive Director, Women and Children's Center of the Sierra, Reno, Nevada, in support of Assembly Bill 340.