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

Seventy-Ninth Session
April 10, 2017

The Committee on Health and Human Services was called to order by Chairman Michael C. Sprinkle at 1:25 p.m. on Monday, April 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:

Assemblywoman Maggie Carlton, Assembly District No. 14
Assemblywoman Dina Neal, Assembly District No. 7

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Committee Policy Analyst
Mike Morton, Committee Counsel
Terry Horgan, Committee Secretary
Melissa Loomis, Committee Assistant

OTHERS PRESENT:

Michelle Thomas, Private Citizen, Las Vegas, Nevada
Kathy Silver, Co-Chair, Health Services Coalition
Matt Morrison, Executive Director, Healthcare Operations, Corporate Benefits, MGM Resorts International
Sunshine Moore, Regional Director, State Affairs, America's Health Insurance Plans
Rusty McAllister, Executive Secretary-Treasurer, Nevada State AFL-CIO
Ryan Beaman, President, Clark County Firefighters Union, Local 1908
Danny L. Thompson, representing Professional Fire Fighters of Nevada; and International Union of Operating Engineers Local 3
Thomas Morley, representing Laborers International Union Local #872/AFL-CIO
Russell Rowe, representing Boyd Gaming Corporation
Stacie Sasso, Executive Director, Health Services Coalition
Randy Soltero, representing International Alliance of Theatrical Stage Employees
Fran Almaraz, representing Teamsters Local No. 14; Teamsters Local No. 631; and Teamsters Local No. 986
James Sullivan, representing Culinary Workers Union, Local 226
Regan J. Comis, representing Nevada Association of Health Plans
Bobbette Bond, Director of Public Policy, Culinary Health Fund
Rachel Gumpert, representing American Federation of State, County & Municipal Employees International
James L. Wadhams, representing Nevada Hospital Association
Kathleen A. Conaboy, representing Nevada Orthopedic Society
Bret W. Frey, Legislative Liaison, Nevada Chapter, American College of Emergency Physicians
Karen Massey, Legislative Liaison, Medical Group Management Association
Dean Polce, President, Nevada State Society of Anesthesiologists
Donna Juell, Medical Practice Administrator, Premier Surgical Specialists, Reno, Nevada
George A. Ross, representing Sunrise Hospital and Medical Center, LLC
Chris Bosse, Vice President, Government Relations, Renown Health
Jerry Matsumura, Past President, Nevada State Society of Anesthesiologists
Catherine M. O'Mara, Executive Director, Nevada State Medical Association
Dena Schmidt, Deputy Director, Programs, Department of Health and Human Services
Celestena A. Glover, Chief Financial Officer, Public Employees' Benefits Program

Devin Brooks, Chief Executive Officer, Brooks Behavioral Health Center, Las Vegas, Nevada
Steven Brotman, Chief Executive Officer, Jeneven Consulting, LLC, Las Vegas, Nevada
Roxann McCoy, President, Las Vegas National Association for the Advancement of Colored People Branch 1111
Dan Musgrove, representing Amerigroup Nevada
Michael Hillerby, representing Hometown Health
Marta Jensen, Acting Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Glenn Shippey, Actuarial Analyst II, Life and Health Section, Division of Insurance, Department of Business and Industry
Lurline Wells, Private Citizen, Las Vegas, Nevada
Regina Strayer, Private Citizen, Las Vegas, Nevada
Delicha Hardeman, Private Citizen, Las Vegas, Nevada
Shane Piccinini, Government Relations, Food Bank of Northern Nevada
Jessica Preston, Intern, Food Bank of Northern Nevada
Deborah Braun, Chairman of the Board, Food Bank of Northern Nevada
Kerry Walsh, Outreach Manager, Supplemental Nutrition Assistance Program, Food Bank of Northern Nevada
Naomi Lewis, Deputy Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services
Emma Swarzman, representing Progressive Leadership Alliance of Nevada
Stacey Wittek, Community and Workforce Developer, Bridges to a Thriving Nevada
Jared Busker, Policy Analyst, Children's Advocacy Alliance
Leonardo Benavides, Extern, Legal Aid Center of Southern Nevada; and Washoe Legal Services
Steven E. Kane, Private Citizen, Reno, Nevada
Cecilia Colling, Legislative Chair, Nevada Women's Lobby

Chairman Sprinkle:
[Roll was taken. Committee rules and protocol were explained.] We will go ahead and begin our work session. Ms. Lyons will start us off.

Marsheilah Lyons, Committee Policy Analyst:
As a staff member of the Legislative Counsel Bureau (LCB), I may not advocate for or oppose any legislation that comes before this body. I have been asked to walk the Committee through the work session document that is before you. It is also uploaded on the Nevada Electronic Legislative Information System (NELIS).

Assembly Bill 156: Authorizes public and private schools to obtain and use an albuterol inhaler in certain circumstances. (BDR 40-581)

[Marsheilah Lyons read a description of the bill from the work session document (Exhibit C).] Assembly Bill 156 authorizes public and private schools to obtain and use

albuterol inhalers in certain circumstances. Assemblyman Yeager proposed several amendments to this measure which are attached for the Committee's consideration.

Chairman Sprinkle:
Are there any comments or questions on this bill? [There were none.] Not seeing any, I will take a motion to amend and do pass.

> ASSEMBLYMAN OSCARSON MOVED TO AMEND AND DO PASS ASSEMBLY BILL 156.
>
> ASSEMBLYMAN EDWARDS SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYMAN THOMPSON WAS ABSENT FOR THE VOTE.)

Assemblyman Carrillo will take the floor statement.

Marsheilah Lyons, Committee Policy Analyst:

Assembly Bill 346: Enacts requirements relating to certain providers of child care. (BDR 38-283)

[Marsheilah Lyons read a description of the bill from the work session document (Exhibit D).] Assembly Bill 346 enacts requirements relating to certain providers of child care. Assemblywoman Joiner proposed an amendment to this measure which is attached. This is the proposal that was presented in Committee.

Chairman Sprinkle:
Are there any comments or questions on this bill?

Assemblywoman Titus:
I will unfortunately have to vote no on this bill. I think it proposes undue hardships on very small child care establishments, especially in rural areas. I also spoke with one of the bill's advocates who said that, of the 109 complaints in the state over the small establishments, they were all complaints that the group had more children than they should have and not that there had been any injury or harm to the children. I believe there are plenty of laws already in place and, again, this is an undue burden, so I will have to vote no.

Chairman Sprinkle:
Are there any other comments? [There were none.] Seeing none, I will take a motion to amend and do pass.

ASSEMBLYMAN CARRILLO MOVED TO AMEND AND DO PASS ASSEMBLY BILL 346.

ASSEMBLYMAN McCURDY SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYMEN EDWARDS, HAMBRICK, OSCARSON, AND TITUS VOTED NO.)

Chairman Sprinkle:
Assemblywoman Joiner, you will take the floor statement.

Marsheilah Lyons, Committee Policy Analyst:

Assembly Bill 347: Establishes certain requirements relating to surgical technologists. (BDR 40-721)

[Marsheilah Lyons read an explanation of the bill from the work session document (Exhibit E).] Assembly Bill 347 establishes certain requirements relating to surgical technologists. There are no amendments included in the work session document for this measure.

Chairman Sprinkle:
Is there any discussion on Assembly Bill 347? [There was none.] Seeing none, I will take a motion for do pass.

ASSEMBLYMAN CARRILLO MADE A MOTION TO DO PASS ASSEMBLY BILL 347.

ASSEMBLYMAN THOMPSON SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

Marsheilah Lyons, Committee Policy Analyst:

Assembly Joint Resolution 9: Urges Congress not to repeal the Patient Protection and Affordable Care Act or its most important provisions. (BDR R-1084)

[Marsheilah Lyons read a description of the joint resolution from the work session document (Exhibit F).] Assembly Joint Resolution 9 urges Congress not to repeal the Patient Protection and Affordable Care Act or its most important provisions. No amendments are included in the work session document for this measure.

Chairman Sprinkle:
Is there any discussion on A.J.R. 9?

Assemblyman Edwards:
I am going to have to vote no on this. I do not think it is helpful to have the state try to do what the federal government is going to undo. I think it will put us in a bad position with our health care. I also think it closes off a whole lot of options.

Chairman Sprinkle:
Is there any other discussion on this bill? [There was none.] Seeing none, I will take a motion of do pass.

> ASSEMBLYMAN McCURDY MADE A MOTION TO DO PASS ASSEMBLY JOINT RESOLUTION 9.
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> ASSEMBLYWOMAN BENITEZ-THOMPSON SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYMEN EDWARDS, HAMBRICK, OSCARSON, AND TITUS VOTED NO.)

Assemblywoman Joiner, you can have that floor statement too. That should do it for our work session today. Thank you, Committee members, for being here and working through it. At this point, I will open up the hearing on Assembly Bill 382.

Assembly Bill 382: Establishes provisions governing payment for the provision of emergency services and care to patients. (BDR 40-570)

Assemblywoman Maggie Carlton, Assembly District No. 14:
I am here today to propose Assembly Bill 382. It is a work in progress, and I do not have a mock-up for the bill because there are going to be a number of amendments proposed. Rather than our having multiple documents, I will compile them and make sure the Committee gets them as we work through this.

The purpose behind this bill is to protect patients who, through no fault of their own, walk through an emergency room (ER) door and, whatever happens after that, end up with a bill they did not realize they were going to get. I call this the family emergency medical act. This is all about protecting the patients. This is not pointing a finger at the hospitals; this is not pointing a finger at doctors; we are not pointing a finger at anyone. We are here to take patients out of this equation so they are not caught in the middle when, through no fault of their own, they end up with one of these bills and have to figure out what to do next.

The components of this bill try to address all those issues. I want to thank the hospital association and the representative of the doctors for coming to meet with me. As soon as this hearing is over, I plan to ask everyone to join me and sit down and talk about what we can agree on and what we can do to help these patients. We will move forward and bring you back some type of resolution.

Sections 2 through 16 are all the different definitions. At section 16, you will notice there is language stating "to stabilize." There have been a number of conversations about those two words to make sure that we get the correct definition. That is still one of the topics of discussion—when does "stabilize" actually occur.

Sections 17, 18, and 19 are pretty much the same, but addressing the different instances that might happen to these patients. I will walk us through section 17, and then those same descriptions will also apply to sections 18 and 19. Section 17 specifies that "an out-of-network hospital with 100 or more beds that is not operated by a federal, state, or local governmental agency, or an out-of-network independent center for emergency medical care that is operated by a person who also operates such a hospital shall accept as payment in full . . . ." So this is for the out-of-network hospital or out-of-network independent center.

Section 17, subsection 1, paragraph (a), specifies a patient who "Was transported to the out-of-network hospital or out-of-network center for emergency medical care . . . ." One issue that arose, and was something I missed, involved language about the patient only being transported in a particular fashion. This bill is meant to address people who also come through the door. How many of us have scooped up a kid who has cut an arm, fallen off roller blades, or been injured at a soccer game? You scoop them up, walk them through the ER door, and you are there. We do not want to eliminate those folks. A lot of folks who come through ER doors do not come through medical transport, so one of the first amendments I will be asking the Committee's consideration on is to make sure we add those folks who end up walking through the door. If we go with the premise "whoever comes through the door," I think we will be safe.

Section 17, subsection 1, paragraph (b), provides for a patient who "Has a policy of insurance or other contractual agreement with a third party. . . ." A number of people asked me why it was written that way. Certain health funds, including the state's Public Employees Benefit Program (PEBP), are not insurance policies per se. Those are insurance products that are provided to the participant. That way, we address all folks who have some type of insurance product and are participants in an insurance plan.

Section 17, subsection 2, addresses emergency care and what actually happens. This involves paragraphs (a) and (b), which is a two-prong test. If someone ends up with one of these bills, there are two different ways they can be addressed. The first way is described in paragraph (a): "The average amount negotiated by a third party with in-network hospitals in the State for the same or similar emergency services and care . . ."—and here is a really important part—". . . excluding any deductible, copayment or coinsurance . . . ." The participant still has to pay their fair share. The participant is still going to pay their copayment or whatever is required of them. That is still part of their deal for walking in the door, so they still have to do that.

The second way, described in paragraph (b), is: "One hundred twenty-five percent of the average amount paid by Medicare . . . excluding any deductible, copayment, or coinsurance paid by the patient." So, one of these bills arrives at a patient's home. That patient did not

realize he or she was out of network. There is a way for that person's representative, as a participant of an insurance product, to be able to sit down with a hospital and say that these are the two ways we could possibly negotiate how to deal with that bill. That is the two-prong test, which is something that has not been in other bills before. There have been a number of discussions about the 125-percent-of-Medicare portion of the bill. I am still getting data on that. It is not written in stone, so it is something that is open to negotiation at the moment.

Moving on, the Commissioner of Insurance will adopt regulations that interpret the provisions of this subsection to make sure we are consistent with the law. The independent center or out-of-network hospital is not required to accept this if they do not want to. There is a mediation component built into this bill if those two things do not work, but I really believe 60 to 70 percent of the cases that walk through that ER door could be addressed this way.

Here is where there is another proposed amendment from the Office for Consumer Health Assistance. It addresses how they would go about doing this, the definition of "mediate," and where they believe it would fit into the *Nevada Revised Statutes* (NRS). I have also been told there will not be a need for a fiscal note. They believe they can do this out of reserves, contracting with someone who is experienced in this type of work. They can do a time and work study on it to see if we will need a position in the future. If we need a position in the future, we can discuss that during the Interim Finance Committee meetings.

One of the next issues that arose involved timing of the payments. A question was brought up whether it should be within 60 days after the receipt of the bill. A conversation suggested the timing allow 60 days after receipt of the actual medical documents, so the patient would have all the documents needed to address the problem.

Section 17, subsection 4, addresses the situation where the provider believes ". . . the amounts prescribed . . . are insufficient to compensate the out-of-network . . ." entity, and providing an opportunity to negotiate and move forward from there.

When you look at sections 18 and 19, the things we have just discussed would be applied to an out-of-network physician, and/or an out-of-network hospital with an out-of-network physician, and/or an in-network hospital with an out-of-network physician. We are trying to address all the different variations that could happen to this patient who has gone through that ER door.

Section 20 deals with the insurance company or insurance provider's responsibilities—what they need to provide in order for this process to move forward. There are responsibilities on all sides. It also makes sure that these contracts continue. In previous proposed legislation before this body, there were a lot of fee settings and studies. We are not trying to do that. We are trying to give known numbers and have a real conversation about what the bill should actually look like. Under section 20, subsection 3, there is a responsibility to make sure that our patients are informed so that they do not go to an out-of-network hospital and do not

receive service from an out-of-network physician or out-of-network independent center if it is not a real emergency. In all my years as a shop steward, one of the biggest responsibilities I had was educating my coworkers about how their health insurance actually worked. Section 20, subsection 3 is to make sure that we reach out and inform folks about what their emergency services really are and what the contractual agreements are.

Moving through the rest of the bill, we are going to ask that regulations be established for the filing and processing of complaints concerning rate of payments prescribed in sections 17, 18, and 19, and subsequent mediation to determine whether the rates paid were sufficient given the circumstance. If a determination is made that a rate is not sufficient, an acceptable rate must be paid to the hospital, independent center, or physician that filed the complaint. So there is some oversight here.

Reports need to be filed. Here we have a component where the participants, the insureds, will actually be saying that they are going to make sure there is network adequacy for the people in our network. This is not a way to say we are not going to contract with anybody, we just want to move on. Contracts in this particular case, in this insurance world, are very valuable. Negotiated contracts for large groups are very valuable. We do not want to get involved in contracts. If one large insurer in the state wants to negotiate one rate for those services, that is up to them. That is between two private parties; the state should not be getting involved in that. If our state insurance contracts with someone to provide the PEBP benefits, we do not want to get in the middle of that. That is what they are supposed to do. We do not want to be in the middle of contracts. What we want to protect is the patient who gets caught in the middle by getting one of these bills when they end up going through the wrong hospital door, or getting service from a doctor who is out of network.

There are documents uploaded in the Nevada Electronic Legislative Information System (NELIS). One is an abbreviated packet provided by America's Health Insurance Plans (AHIP) (Exhibit G). There is a 60-page document that backs this up. I did not want to overwhelm you and send all 60 pages, but if any Committee members are interested, I would be happy to make sure it is available. There are also several letters from a number of different patients that I have received (Exhibit H). Next, I have people in Las Vegas who are going to speak.

[(Exhibit I) was also submitted by Assemblywoman Carlton but not discussed.]

Michelle Thomas, Private Citizen, Las Vegas, Nevada:
I am here to speak in support of A.B. 382. The birth of my child was supposed to be a joyous time for my family, but it was terrifying. Due to the risk of hemorrhaging at 32 weeks, I was forced to have an emergency C-section and hysterectomy. Upon delivery, my baby required oxygen that tore through her fragile lungs, puncturing both lungs. That required several emergency procedures and an even longer stay in the neonatal intensive care unit (NICU) than I originally anticipated. My daughter Evelyn had to stay in the NICU for 26 days. I later learned that the NICU was out of network. This was frustrating, because I did not have control over which NICU I could take her to. In fact, I tried to move her, but was told

that she would not survive if we moved her. The doctors at the hospital jokingly called her their "million dollar baby." My husband and I did not understand why. The surprise bills that came later were even more horrifying than the labor and delivery process and shed light on that nickname. The NICU charges alone were $5,000 shy of being $1 million. The $995,000 price tag did not include the doctors' costs, the anesthesiologist, the hospital stay, or the battery of tests we both needed. I had private insurance through my husband's employer through the majority of my pregnancy; unfortunately, my husband had lost his job during week 26 of my pregnancy. I had insurance through [Consolidated Omnibus Budget Reconciliation Act] COBRA, but was uninsured for a small portion of my hospital stay.

The surprise medical bills I received affected my family and me in profound ways. While my baby and I were healing, I simultaneously had to deal with what felt like never-ending surprise bills. We were not in a place financially to pay all of them. At one point, we were going back and forth with the hospital billing department, and a representative suggested that we get a second mortgage to cover the costs. We lost what was supposed to be our forever home. The stress was staggering; there were daily arguments concerning money and bills. My husband and I almost ended up divorced. There was constant harassment via phone calls concerning billing and collections. We even sought an attorney to discuss bankruptcy. I am thankful Evelyn, who is here in this room, is happy and healthy, beautiful and brilliant today. My family experienced tremendous emotional, physical, and monetary stress through these unfortunate sets of circumstances, many of which stemmed from these surprise medical bills. I urge you to support A.B. 382, so families do not have to experience what we did. You can help prevent other patients from receiving such surprise medical bills.

Kathy Silver, Co-Chair, Health Services Coalition:
The Health Services Coalition is composed of 21 member groups. We cover about 350,000 members in southern Nevada. I also am the president of the Culinary Health Fund in southern Nevada, which covers about 130,000 lives. During my involvement with the Coalition, I have participated in two cycles of hospital negotiations here in southern Nevada. Over that time frame, the requests from the hospitals have been far greater than the hospital Consumer Price Index for services would have indicated they should be. When we negotiate with the hospitals, we are often put in a very lopsided situation. Either we negotiate from the point of view that we are going to be at a deficit because patients are going to show up at an ER or trauma center whether we are contracted with that hospital or not. We have no control over that, and the patient has no control over that. Or, we negotiate assuming the patient could wind up in a hospital that is contracted but see a physician who is not contracted. It requires a delicate balance—trying to find the right way to negotiate, keep hospitals in network, keep doctors in network, and not put our patients at risk for extreme medical losses as you just heard from the patient testifying earlier.

I think you have copies of these documents in NELIS. [The documents were not in NELIS.] I will try to explain what the documents show. The first document is an example of hospital billed charges. Every year, hospitals are required to submit a Medicare cost report. That cost report is designed to indicate to Medicare what the actual cost of care is for the hospital versus what that hospital charges. The examples I used came from one hospital in southern

Nevada. Case Number 1 was a 49-year-old female with lumbar displacement who had emergency spine fusion surgery. The hospital billed $598,692. Medicare cost-to-charge ratio at this hospital is 11.8 percent. That means, of the $598,692, 11.8 percent represented the hospital's real cost. This is not a perfect system, and I will be the first to tell you that hospitals under Medicare make money and lose money, but the idea is to find an average that is fair both up and down. In this case, our health fund, the Culinary Health Fund, would have allowed $78,322. Medicare would have allowed $49,398; Medicare at 125 percent would have allowed $61,747. The billed charges over the Culinary Health Fund rate were marked up 764 percent. Over the Medicare rate, they were marked up 1,213 percent.

In Case Number 2, a 61-year-old female with Parkinson's disease had brain surgery to place a deep brain stimulator electrode and generator. The hospital billed $324,747. On a cost-to-charge ratio of 11.8 percent, the fund allowed $56,535; Medicare allowed $32,996, and at 125 percent of Medicare, it would be $41,240. Again, the billed charges over Medicare were 984 percent, and over the Culinary Health Fund they were 574 percent.

Case Number 3 involved a 64-year-old male with an abdominal aneurism who had emergency heart surgery. The hospital billed $355,947. Again, the cost-to-charge ratio was 11.8 percent. The Culinary Health Fund allowed $65,873, and Medicare would have allowed $47,464. At 125 percent of Medicare the amount would have been $59,330. Mark-ups again were in excess of 500 percent to 700 percent.

This is not meant to vilify the hospitals. This is designed to represent what is a fair way to negotiate with hospitals on this out-of-network situation. As you can see, the fund is already paying more than the suggested amount placed in the bill—125 percent of Medicare. We are not trying to reduce what we pay. We are trying to protect the patient in case we are not able to negotiate rates with this hospital, so that we do not have to pay more than anything tied to billed charges would be in these cases.

Now I will discuss physician bills in a contracted hospital—these are non-contracted physicians in contracted hospitals. The first example involves a 66-year-old female in a traumatic motor vehicle accident who had emergency spine surgery performed by a non-contracted surgeon. The surgeon billed the patient $32,954. The Culinary Health Fund would have allowed $4,877 for that surgeon. Medicare would have allowed $3,664; Medicare at 125 percent would have allowed $4,280. Again, the billed charges have an unbelievable markup of just under 900 percent. My point is that billed charges have no correlation between billed charges and costs, or between billed charges and what insurance normally pays.

The next case is a 46-year-old female who went to the ER complaining of back pain and weakness in lower limbs. A non-contracted surgeon admitted the patient and performed thoracic spine surgery. The surgeon billed $46,209. The Culinary Health Fund would have allowed $3,426; Medicare would have allowed $2,207; Medicare at 125 percent would have allowed $2,759. Markup over billed over Medicare was 2,100 percent. Markup over the health fund was 1,348 percent.

The final case was a 39-year-old female who had emergency gall bladder surgery performed by a non-contracted surgeon. The surgeon billed the patient $6,600. The health fund allowable for the contracted surgeon was $1,265. Medicare allowed $687; Medicare at 125 percent allowed $858. The markup was 960 percent over Medicare and 521 percent over the fund.

I realize these are pretty egregious examples when it comes to the physician charges. We showed them specifically because they are egregious examples. I hope it shows the Committee that this is what the patients face. The patients do not have the ability to negotiate with the doctors or with the hospitals to the same degree that we do. When they get a bill like this, they are completely out of luck. They are going to have to pay whatever the doctor says he or she is owed in billed charges.

Matt Morrison, Executive Director, Healthcare Operations, Corporate Benefits, MGM Resorts International:
I am here on behalf of MGM Resorts to testify in support of A.B. 382 and to echo many of the comments Ms. Silver made today. We welcome the opportunity to work with the Committee in order to find a solution that is fair and equitable to both payers and providers, and one that protects the physical, financial, and emotional well-being of patients who are often caught up in what sometimes could be considered predatory billing practices.

Assemblywoman Carlton:
Is Sunshine Moore on the phone? [Ms. Moore answered, "Yes."] Sunshine is with AHIP, and provided the document you received (Exhibit G). She is going to go over some general facts and will be available to answer questions.

Sunshine Moore, Regional Director, State Affairs, America's Health Insurance Plans:
I am speaking in support of A.B 382. America's Health Insurance Plans (AHIP) is the national association whose members provide major medical and supplemental health care benefits and services to more than 200 million Americans through employer coverage and public programs like Medicare and Medicaid, and to individuals and families both on and off the exchanges. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

We want to thank the author of the bill for putting this legislation before you today. Prohibiting surprise out-of-network bills is an essential consumer protection that will reduce Nevadans' exposure to high and unexpected out-of-pocket costs. Under current law, out-of-network providers can balance-bill enrollees for the difference between what the insurer pays and the bill charged amount, leaving patients vulnerable, as you have heard, to hundreds of thousands of dollars in unexpected medical bills. This can be particularly troubling for patients who already had health insurance and are recovering from a medical emergency.

By last count, about 27 states are working through this issue or implementing previous legislation, so we thank the author for her efforts to bring this important consumer protection

to Nevada. We support the bill's market-based reimbursement methodology. It will protect consumers from excessive bills or egregious charges while maintaining the stability of health plan networks.

Health plans develop provider networks to offer consumers and employers access to affordable, high-quality care, while shielding consumers from large medical bills. Without negotiated provider networks, consumers and employers would be subject to whatever prices providers choose to charge, with no frame of reference for what constitutes high-quality, high-value facilities and providers, compared to high-cost, low-value providers.

In a health care environment where that is lacking, consumers rely on their health plans to negotiate on their behalf and protect them from the risk of unexpected out-of-pocket costs. When providers contract with carriers, patients benefit. We agree with the author that a benchmark payment should be set to ensure reasonable, predictable, and timely resolution of claims. The bill's methodology for out-of-network facilities and providers to accept the health plan's average contracted rate or 125 percent of the Medicare fee schedule as fee payment in full appropriately reflects actual rates paid by health plans and other payers in the market for the same goods and services.

This type of market-based reimbursement methodology will limit consumers' exposure to higher cost-sharing. It maintains the incentive for participating providers to remain in health plan networks while continuing to encourage new providers to join networks and enter into mutually beneficial contracts with health plans. It protects the right of providers to not contract with health plans if they so choose, but still receive reasonable reimbursement for emergency services.

Finally, we think A.B. 382 would protect the vital role hospitals play in their efforts to hire and contract with providers who will participate in the same health plan networks as the hospital. It still takes a very similar approach to what is already in the Affordable Care Act (ACA) as far as payment methodology between the plan and the provider, but the ACA does not explicitly ban the practice of balance billing for the difference. The bill makes it clear that the enrollee is only responsible for their applicable cost-sharing, and is an important step to protect not just the insurance payer but also the consumer. America's Health Insurance Plans supports this bill.

Rusty McAllister, Executive Secretary-Treasurer, Nevada State AFL-CIO:
I was asked to speak partially because of my history in the emergency medical services (EMS) field, working for 33 years in Clark County as an EMS provider. Also, I have worked on this issue for 14-plus years. The EMS system in southern Nevada, as in the rest of the state, is controlled by an EMS protocol. Protocols are developed by health districts and the state. In many cases, they define where and how certain patients are treated with regard to where they go. Patients who are conscious, have the ability to answer questions, and have the ability to make a decision, get to choose which hospital they want to go to if they are in the back of an ambulance. They choose where to go unless their condition is too critical or they fall into certain categories. In those circumstances, they do not get a choice.

The examples I can give are listed in the Clark County EMS protocols. The most critical one is trauma. Many patients are not capable or in a position to make any decisions. Those patients are transported based on their condition and geographical location. In southern Nevada, if you are in a trauma situation, draw a line down the middle of the valley using I-15 as the boundary. Everyone west of I-15 goes to University Medical Center (UMC); everyone east of I-15 goes to Sunrise Hospital, unless you are in the south end of the valley. In that case, you go to St. Rose Dominican.

All burns go to UMC Trauma Center first, and then on to the UMC Burn Care Center. Many of the physicians who work in the burn care unit are not contracted. They do not have to be. They have a steady supply of patients because that is the only place to take them. Pediatric patients, anyone less than 18 years of age, are taken to one of four hospitals designated as pediatric centers. Strokes have to go to an approved stroke center, but fortunately, most of the hospitals in southern Nevada are stroke centers. Sexual assault patients—anyone less than 13-years-old has to go to Sunrise Hospital. Thirteen- to eighteen-year-olds can go to Sunrise or UMC. If they are over 18, they have to go to UMC. These are all protocols that the EMS providers must follow. If they go outside of protocol or unless they have a very good reason to do so, they are liable if something goes bad.

The last example involves an internal disaster. If a facility says it is on an internal disaster, it has too many patients and is not taking any more. They may be the closest facility or the contracted facility, but if they are not accepting patients, you have to go somewhere else. At that time, you may take that patient to a hospital that is not contracted. Again, the patient cannot make that choice.

The last thought I am going to leave with you is that you may hear from the opposition that the patient is alive. Well, it does not do much good to be alive and then have to file for bankruptcy after you get your bills.

Ryan Beaman, President, Clark County Firefighters Union, Local 1908:
I want to make a couple of other points. In my other job I am a firefighter. We work the streets and deal with these destination protocols. If someone is in cardiac arrest, that person is going to go to the closest facility. If someone is meeting the signs and symptoms of a stroke, we have a destination protocol for that. If someone is outside a 50-mile radius, we are going to use the closest facility. We cover some of the remote areas throughout Clark County, so we deal with air ambulances or fixed-wing ambulances, and those could be out of network. Those are all by-protocol destinations that the fire department has to deal with.

Chairman Sprinkle:
I will open up for questions.

Assemblywoman Miller:
How are Medicare and Medicaid patients currently handled?

Assemblywoman Carlton:
It is my understanding that billed charges cannot be applied to Medicare or Medicaid, but that is something I would like confirmed. Those rates are set, and there are no extra charges, so this would not happen to those folks.

Assemblywoman Titus:
I have to make a comment. Having served many a night in the emergency room, I really take exception to two of your folks who testified from Las Vegas using terms like "predatory billing" and "egregious billing." Section 17, subsection 3(d), talks about out-of-network hospitals and out-of-network independent centers for emergency medical care and states that they have to be billed within 60 days, but it does not specifically say how long before the insurance company has to settle. It says they have to be billed within 60 days, but I do not see anywhere in the bill where it has to be settled within a certain amount of time so the providers can be made whole.

Assemblywoman Carlton:
Assemblywoman Titus, in all the years I have been in this building when you have people come forward and testify, I never tell them what to say. I let them speak their hearts and how they feel. I believe as long as they are truthful and eloquent, I would never criticize a witness for a term that witness used. I feel that is what this process is all about.

As far as the time limits go, in the bill is a component where we are going to set up a mediation process. The amendment I talked about was 60 days to receive the medical documents. This is all still part of that general discussion. Those will be dealt with and set by regulation. We all want this to be resolved as soon as possible. We all understand what it is like to make sure bills are processed on time and to give people the adequate payment they are due. It would all be part of that mediation and arbitration process.

Assemblywoman Titus:
If they are mandated to accept whatever the insurance company says they are going to accept or maybe 125 percent of Medicare—which, I might point out, does not necessarily cover any of the charges or even come close—does this protect the insurance companies that say they really do not have to negotiate a reasonable contract with anybody now because providers are forced to take the insurance company's patients? How does this really improve access to care? The way the bill is written—because insurance companies can now say you did not negotiate a contract with us, so this is what we are going to pay you—where is the incentive for insurance companies to negotiate in good faith with the facilities and pay a reasonable rate? If the hospitals or ER doctors say that they cannot afford to stay open at that rate, the insurance company can tell them to either agree to this now, or, when you see our patients, we do not have to pay you anything other than what we decide.

Assemblywoman Carlton:
I believe your question is addressed in section 20—the review of network adequacy and making sure that folks do have contracts. This was a discussion point. This is not about getting in the middle of contracts. This is not about inspiring people to not have contracts,

this is to address those patients who are put in the middle on the other side. People want to negotiate. It would be a better deal for everybody—the hospital, the patient, the participant's payer—to have a good contract that protects a large group of people. We do not want to ever get in the way of that, and I have not heard anyone say that they want to discontinue that. We want those contracts to continue. I believe section 20 addresses the issues you have concerns with. Keep in mind, this only applies to hospitals with over 100 beds.

Chairman Sprinkle:
Are there any other questions from the Committee? How did you decide on 100 beds?

Assemblywoman Carlton:
It is a definition that looked reasonable and took some of the smallest hospitals out. We used the other language, because that would eliminate the government hospitals.

Chairman Sprinkle:
I will open it up for any testimony in support of A.B. 382. Please do not be redundant in your comments. "Ditto", "me too" or "other" is perfectly acceptable.

Danny L. Thompson, representing Professional Fire Fighters of Nevada; and International Union of Operating Engineers Local 3:
Me too.

Thomas Morley, representing Laborers International Union Local #872/AFL-CIO:
Me too.

Russell Rowe, representing Boyd Gaming Corporation:
I am here on behalf of Boyd Gaming Corporation and its employees and insured lives. We support this legislation and hope it can be worked out. It is an important bill to employers.

Stacie Sasso, Executive Director, Health Services Coalition:
I am also Executive Director of the Laborers Health Fund. We are in support of A.B. 382 and protection for the patients who find themselves in situations with no choice other than to seek care at an out-of-network facility in an emergency situation. We think this is the only way to protect the patient from facing medical bankruptcy, and we appreciate your support.

Randy Soltero, representing International Alliance of Theatrical Stage Employees:
Me too.

Fran Almaraz, representing Teamsters Local No. 14; Teamsters Local No. 631; and Teamsters Local No. 986:
I am here representing more than 50,000 Teamsters in the state of Nevada, many who have had problems with this type of billing. Me too.

James Sullivan, representing Culinary Workers Union, Local 226:
We support this bill because surprise bills can bankrupt working families, which is wrong. Limiting how much hospitals can charge in these situations will protect workers and all Nevadans from price gouging, and we believe A.B. 382 does just that. We support this bill.

Regan J. Comis, representing Nevada Association of Health Plans:
Me too.

Bobbette Bond, Director of Public Policy, Culinary Health Fund:
We support A.B. 382. I do want to put one clarification on the record related to Assemblywoman Titus' question about what would be the incentive to keep contracting. We have been working on this issue for a long time, and I think our goal this session is for all sides to come together and reach some sort of solution. It has to be one that does not incentivize us to not contract and does not incentivize doctors to not contract. It has to be something more than we would pay in a contract status, but less than those really high billed charges we are paying now. I think that is the goal on both sides.

Rachel Gumpert, representing American Federation of State, County & Municipal Employees International:
I am here on behalf of state workers in Nevada. We support this legislation and appreciate your taking the time to consider it. It is something that is crucial to consumer protection in Nevada, and thank you to the sponsor.

Chairman Sprinkle:
Is there anyone else here in northern or southern Nevada in support of A.B. 382? [There was no one.] I will open up for testimony in opposition to A.B. 382.

James L. Wadhams, representing Nevada Hospital Association:
I want to commend the bill's sponsor, who has been willing to meet with us and bring us into this discussion. Her sense of resolving this issue, bringing it to a resolution, and taking the patients out of the equation, is critical. You have heard examples of the bill-charge system and references to that. That is driven by the United States government and Medicare's requirements for hospitals to do this. The notion that is important in Assemblywoman Carlton's desire with this bill is to address the situation where the payments are fair. I agree with the speaker before me, Bobbette Bond, who said we have to find a way to find fairness so there is an incentive to contract.

I participated in discussions last week, and I think there is a significant opportunity to make this bill work and bring this to a successful conclusion. Although we appear in opposition, it is not in opposition to the sponsor's desire to work on this issue and find a system that is fair and that will resolve this issue.

Kathleen A. Conaboy, representing Nevada Orthopedic Society:
I, too, would like to thank the sponsor for putting this issue on the table. It really does need to be resolved. In fact, the physician community had come forward with a market-based

solution in the Senate. That is a solution that has not been tried in these many years we have been working on this problem.

Mr. Chair, you invited the Governor's Office for Consumer Health Assistance (GovCHA) to brief your Committee on March 10 on the topic of what kinds of problems come to that office for resolution. The director talked to you about appeals and prescription drugs, termination of benefits, and billing disputes. What she said about billing disputes was that there were 842 unresolved billing disputes in fiscal year 2016 that came to her office. That is an infinitesimally small percentage of the number of claims that are processed on behalf of Nevada patients on an annual basis. That indicates to me that a lot of these challenges get worked out between the physicians and the patients and the insurance companies, and, perhaps, with the hospitals. I know a lot of negotiating happens so that things do not get to the Office for Consumer Health Assistance.

I have issues about some sections of the bill. In section 18, subsection 1, paragraph (b), the language says that the bill applies when the patient has insurance that provides coverage and care by more than one in-network physician who essentially is the same type of provider as the doctor sending the bill. There was a two-year regulatory process looking at adequacy of networks in this state after last session. "More than one in-network physician" anywhere else in the state could be two people, and is a very low standard for the definition of an adequate provider network. As we go forward with the sponsor and talk about resolutions to questions, that is one thing we would like to keep on the table.

The second issue involves section 18, subsection 2, where it states that the out-of-network physician would accept payment in full at a rate that does not exceed the greater of the two options the sponsor described to you earlier in her testimony. The language does not say, "would accept the greater of", it says that the payment in full "does not exceed the greater of . . . ." It sets a ceiling and that, too, is problematic from our perspective. What are those amounts? What do those options mean? One option suggests "The average amount negotiated by the third party," who is questioning the bill throughout the state in one geographic region for similar services. It is not all third parties, not a market-based solution, but one party's average negotiated rate. It is unclear to those of us in the physician community who has this information other than the carriers themselves and the self-funded plans. Who would review the data, which would essentially be self-reported, for transparency and accuracy?

The second option suggests 125 percent of the average amount paid by Medicare in the geographic region which, again, is statewide. We have discussed this many times in the past. There are a number of problems inherent in using Medicare as a benchmark. First, as part of the federal system of paying for health care, Medicare rates are determined by a committee at the federal level. A specific amount is appropriated by Congress to cover Medicare claims and, based on utilization, the rates are set so reimbursements naturally do not exceed the appropriated amount. This is referred to as a resource-based system. Medicare primarily covers services for persons over the age of 65, which means that not all services are even accommodated in a Medicare rate formula.

Lastly, there is a laundry list of modifications that have been made to Medicare reimbursement over the last decade based on what is happening at the federal level. The federal government is moving away from fee-for-service reimbursement and replacing it with accountable care organizations, bundled payment models, risk-sharing contracts, and all kinds of initiatives to reward quality over volume. The point is, this movement away from fee-for-service is really not bad; however, Medicare reimbursement is a moving target and has been for many, many years. Why would a physician or another provider agree to accept a percentage of an unpredictable amount? Why would a member of any profession, any union, or any employee—public or private—accept as their salary an amount subject to change at any time, based not on their performance, but on outside national factors over which they have absolutely no control? No one would, so why would we expect this of the physicians and hospitals in our state? Actually, this is why most physicians seek dependable, fair, contracted rates with insurers and self-funded plans. Under these contracts, physicians provide access to quality care, patients get the care they need, and strong contracts assure financial predictability for both carriers and providers.

In section 19, subsection 4, at line 25, on page 9, the discussion about resolving disputes begins. If the physician feels that the reimbursement is not sufficient, they may enter into negotiations with the third party. Again, this would be a question we would like to continue discussing with the sponsor because, as currently drafted, the bill has no details about methodology, benchmarks, or any other parameters to assure an objective outcome.

Then, if the negotiations are unsuccessful, section 19, subsection 4 says that the physician may file a complaint with the GovCHA and that the office would determine an acceptable rate. Again, the sponsor has already mentioned that this is still subject to conversation, and we appreciate that because, again, there is no methodology described in the bill or objective benchmarks to assure unbiased and consistent processes.

I mentioned that we talked with the Nevada State Medical Association, the orthopedic surgeons, and other specialty advocates in the room about a market-based option. We would still like to keep that option on the table as we talk again with the sponsor about the details of the bill.

Bret W. Frey, Legislative Liaison, Nevada Chapter, American College of Emergency Physicians:

[Bret Frey spoke from prepared text (Exhibit J).] I have served as an emergency room physician in the state for 14 years now and, as Legislative Liaison for the American College of Emergency Physicians, I represent well over 200 emergency physicians statewide, many of whom are in the room today. The safety net of emergency care in Nevada, mainly due to historic difficulty in recruitment of both emergency physicians and on-call specialists, is quite fragile. These physicians are the safety net that so many patients rely upon in their greatest hour of need. Emergency physicians see patients and deliver expert care and are blind to the insurance status at the time this care is rendered. This is mandated by federal law and it is our moral duty. We are proud of our mission and are vigilant 24 hours a day, 7 days a week, 365 days a year.

I have been dealing with this issue, internally in our college and nationally, trying to come up with patient-centered solutions for more than a decade. Specifically in Nevada, I have not seen any example of an egregious emergency physician bill come before this Committee or any other in all those ten years. When a patient has a life-threatening condition, it is often a seconds-to-minutes emergency. Often, I need to reach out to an on-call specialist who can provide expertise to address this issue in real time. A great example of this is a vascular emergency known as a ruptured aorta—the main artery of the body—that can kill a patient very quickly if a diagnosis is not made and treatment is not rendered immediately. For many decades in the state, vascular call has been very difficult to maintain, especially in the north, and also at UMC. This is due to provider shortages and market conditions that were very unfavorable. Therefore, these patients would often be transported out of state at a great cost to patients, their families, the system, and insurers alike. We really want to avoid the unintended consequences that this legislation may very well lead to.

In closing, I would like to say that we have many access-to-care issues to worry about without creating more problems for the patients we have a moral duty to protect and serve. I ask the Committee to allow this issue to be addressed in a collegial manner with input from all stakeholders.

Chairman Sprinkle:
Thank you very much. We appreciate your comments. I know there will be a lot of work done on this afterwards, and we certainly appreciate your participation.

Karen Massey, Legislative Liaison, Medical Group Management Association:
I would like to thank Ms. Conaboy for providing a good description of why Medicare serves as a difficult benchmark for those of us in the provider community. Medicare and its relation to market rates varies significantly by specialty, so a percentile that might be acceptable in one specialty is very difficult in others. The concerns about the marketplace and the incentives that are in place with the bill as presented today have been mentioned before, and I would just like to echo them. A grave concern for our particular group is the fact that we might incentivize people not to contract.

I will make a couple of comments about the second item, the average amount negotiated by a party, to serve as further discussion with the parties after this hearing. It has to do with creating incentives in the marketplace to contract. If an insurer has one contract at a low rate, that insurer will be disincentivized to add additional contracts at a market rate because it will raise their average in the marketplace. So there are some unintended dynamics that could be in place that bear more conversation.

Talking about the average of insurance contracts, I am concerned about the weighting. If someone had a contract that covered 10 lives and another contract that covered 100,000 lives, would those two contracts be averaged? So there are lots of questions around that issue: what would be sufficient for an average; how would we know that it is an accurate measurement; is there an independent database; what would be the method to be assured that it was an accurate number?

I really appreciate Ms. Bonds' comments on this issue, and her acknowledgement that to create the market incentive, we really need that number to be above the average market rate. If we do not, we will not create an incentive for an insurer to want to be in-network, which is really the best way to serve the patients.

The third option set forth in the bill as written today is mediation. That is a concept that bears more explanation. There are lots of questions around the brevity with which it is written that bear more conversation. Arbitration is never without administrative costs. That is the part of the health care sector I live in. Would each concerning bill be subject to arbitration? Renown Regional Medical Center does 100,000 ER visits a year. For those circumstances, would it be a particular kind of bill and then it would be set for a period of time? Would it be a common dataset that we would submit? Would it be an in-person arbitration? There are lots of questions that go along with that, but it may be a promising line for more discussion.

Also, regarding arbitration, you have heard from a lot of folks today who represent plans that are [Employee Retirement Income Security Act of 1974] ERISA-based or self-funded. For those plans that are not subject to state law and regulation, would the ERISA plans that chose to participate in arbitration for the benefit of their patients be subject to all these provisions? Would that be an avenue whereby all of us could engage to take the patient out of the middle? Again, there are a lot of questions around that topic.

In closing, you have heard some patient examples, so I would like to give one provider example. Our ER group in the north is out-of-network with one insurer. The reason we are out of network with that one insurer is because they have offered us market rates that are about half the average. As a result, we have been unable to accept that contract. When those patients come to our hospital they are frustrated, and I am frustrated when I take their phone calls. We try to discount their bills, but we cannot compel the insurance company to consider them in-network; we cannot compel the insurance company to add that to their deductible for in-network. That is a frustrating situation for us. Under this bill, the insurance company that has chosen not to contract at market rates would enjoy a better rate than would the good partners we have in the marketplace—which is virtually everyone else. When those insurance companies go out to sell their product to an employer, they are going to be outbid. Our good partners are going to be outbid in the marketplace because this bad actor is going to have a lower cost structure. If we can do anything to address those dynamics, we will be happy to be part of more conversation.

Dean Polce, President, Nevada State Society of Anesthesiologists:
I want to speak out in opposition to this bill. I represent the largest anesthesiologist group in the state as well as the largest single-specialty group in the state. The major opposition to this bill is simply that Medicare is not an appropriate benchmark, and specifically for anesthesiologists. The U. S. Government Accountability Office has looked at payments from commercial payers relative to Medicare for all specialties, and the discount for an

anesthesiologist is about 70 percent. In the example used before, what would happen in an emergency situation where the rest of us would have to incur a 50 to 60 percent reduction in pay? I would say emergency services would be greatly reduced.

I do appreciate the comments that people are willing to work on this topic, as it is very complex; medical specialties are very different, and billing is very complicated. One hundred twenty-five percent of Medicare reimbursement may work for hospitals, but it does not work for providers. I think there is a better way of doing it. The concern is that, over the years, a benchmark to Medicare has always been utilized, so why would the advocates for the bill want to change now?

As a specific example, there was an individual advocating for the bill earlier in this hearing who talked about her daughter being born emergent. My son was born emergently. There were two anesthesiologists and two obstetricians who saved his life. The difference is that he had to be borne by a surrogate, and the surrogate is treated differently by the payers than if my wife had been able to carry the baby. We paid that entire bill ourselves, so I am very sympathetic to this topic, but I can tell you right now that my son would not be here if we had contracts that were so egregiously low based on a few bad actors.

The difference, and this is where it gets very complicated, between an elective C-section and an emergency C-section for an anesthesia provider is one modifier. We put an "e" next to the unit-based value we derive. That is why this is so complicated. Why would a payer pay 125 percent of Medicare for emergency service when for elective service they are paying 300 or 400 percent? It gets very complicated and, for the record, our group is the largest. We have been here the longest, and there has never been an out-of-network bill submitted on behalf of any patient. We do all the pediatrics, all the obstetrics, we do the majority of cardiac in the south, and we support anything that protects patients. Unfortunately, this bill, with Medicare as a benchmark, we do not support.

Donna Juell, Medical Practice Administrator, Premiere Surgical Specialists, Reno, Nevada:

We are a small surgical group here in the north. We have general surgeons, trauma surgeons, and one vascular surgeon. Almost everything I was going to say has already been said, except for one point I would like to underline. We are trying to recruit more vascular surgeons for the north, as we are at a crisis stage here. They are more difficult to recruit. There are a very small number of them available nationally, and it is very hard to recruit vascular surgeons to this area given this bill. As the anesthesiologist from the south said, 125 percent of Medicare undercuts so many of my current contracts that I fear those contracts would drop down to that rate. Why would they negotiate with me? If we are going to have a rate, we have to be careful where it is set, and insurance companies should not gain from this. Patients are unable to choose who their doctors are in an emergency situation.

The other side of that is that my doctors are unable to choose who they care for in an emergency situation. They are trauma doctors; they are vascular surgeons. They arrive and have no idea what insurance the patient has or does not have. They just take care of these

people. For the insurance companies to be pushing this so they pay less than they are able to contract for is not going to work. We are not going to be able to stay in practice. Private practices have a lot of pressure on them right now with the federal regulations and compliances and everything else we have to deal with. This would just be one more thing that would put us under.

George A. Ross, representing Sunrise Hospital and Medical Center, LLC:
I want to thank the sponsor of this bill for being so willing to negotiate. We recognize, as she does, that this is a serious problem in the state, and we are very thankful that she has an open mind about negotiations and has included us.

I also want to recognize the comment that the representative of the Culinary Health Fund made—that she realizes we have to find a number that is a happy medium, but one that is high enough that it incentivizes plans to continue to negotiate contracts with us. I will not repeat everything else that has been said on that subject, because we agree with it, on the opposite side.

I have some points to make that have not been made before. Those of you who have heard me testify on these kinds of bills will recognize them somewhat. Representing Sunrise Hospital, I represent the largest hospital in the state. It is also the largest Medicaid provider in the state. That puts it in a unique situation. The state has implicitly decided that much of the cost of Medicaid patients is going to be paid for by the contracts with all the other plans and providers. A little over half of the cost of Medicaid patients is paid for through the Medicaid plan. In Sunrise Hospital's case, that is 42 percent of the inpatients. It is also 55 percent of the ER. Add to that, 6 percent uninsured inpatients, and depending upon the month, 10 to 12 percent uninsured ER, none of which we are getting paid even remotely close to cost. When we are criticized for pushing hard on contracts, for trying to make those costs back, that is the reason. It is important, as you figure out what the numbers should be, that you take into account that you need to keep the existing hospitals that have a lot of Medicaid patients healthy. You need to maintain your access to high quality. That has to be your number one consideration.

Switching to Medicare for a moment, I have heard it said in other negotiations and meetings that various parts of the industry have accepted reimbursement at 125 percent of Medicare in other states. But there is a big difference between other states and Nevada in one key component, which is why I spent so much time talking about Medicaid. My client, Hospital Corporation of America, is in about 20 other states. The average percentage of costs that those 20 other states reimburse the hospital is 89 percent. So there is a big difference between getting 89 percent of cost, which is roughly Medicare rates, for 42 percent of your patients and 55 percent of your ER as compared to 53 percent of the costs.

I am trying to say that when we negotiate this and figure out how this bill should come out, it is going to be very important to find a way to make sure that those hospitals that are heavy Medicaid providers are protected and can still continue to operate with the high quality of care that they have.

Chris Bosse, Vice President, Government Relations, Renown Health:
I certainly appreciate the sponsor of the bill's willingness to work with stakeholders on this important issue. We, too, want to ensure that we protect patients from financial hardship when they seek emergency care. I think we all would agree that having a contractual relationship is the best solution because the payers and providers have a prearranged agreement, and the patient understands what their share of costs will be when they seek emergency care. But today, we are talking about folks who are in an out-of-network or non-contracted circumstance. I think it is important that the stakeholder group, especially, and this group, eventually, hear what the recommendations are. There are multiple aspects of this.

Karen Massey earlier touched on the topic of adequacy of network. I have an example in the north. Renown Regional is a non-contracted provider. There is a major payer in the north that has contracted with another local hospital. That other hospital does not provide the level of emergency care and unique services for both children and adults, or trauma services. Unfortunately for that payer's members, they are frequently or occasionally transferred from that other facility to Renown Regional to meet their needs. Over a nine-month period, there were more than 190 accounts. The total charges related to those services were about $3.3 million. The amount collected was less than $1.2 million. We have met locally, regionally, and nationally with that payer, trying to enter into some stopgap-coverage so that we could protect the patients—obviously accepting significantly less than billed charges. We just want to make sure that the patients are okay. We have held the patients' accounts and not billed them so we could have time to have these conversations. At every level of this conversation we have been told that we should bill the patient, that the payer determined their exclusive relationship, which was a business decision, was more valuable than entering into a stopgap contract.

While I know that just adds an additional layer of complexity, we want to be at the table and we want to be part of the solution, but we think adequacy of network is going to be critical and that we all have a responsibility to make sure that the care for patients is provided in a financially and clinically safe way.

The last point I would like to make is, as people consider the final solutions, it will be absolutely important that everybody leaves the table a little dissatisfied—both the payers and the providers. The payers are paying more than they think they should and the providers are collecting a little less than they think they should—so we all can enter into a contracted relationship, which, we all would agree, is the safest place for the patient.

Jerry Matsumura, Past President, Nevada State Society of Anesthesiologists:
[Jerry Matsumura provided a packet containing additional written testimony in opposition to A.B. 382 and other material (Exhibit K).] It was mentioned that this was a very infrequent occurrence. In the packet I submitted to you, you will find a document that has a picture of California on it [page 3, (Exhibit K)]. That was a study done by the California Legislature in 2015 and 2016 looking at the actual incidence and prevalence of out-of-network occurrences. It came out to 0.63 percent for inpatients and 0.20 percent for outpatients. The average

enrollee on an inpatient out-of-network bill would be $550 and for an outpatient it would have been $200. This is very much in line with numbers from the Nevada Governor's Office for Consumer Health Assistance (GovCHA), which are also included in the written testimony that was submitted. Data from 2012 showed an occurrence of 226 reported cases of billing disputes under the hospital subsection. Only 1 out of every 7 of those cases was actually considered an out-of-network issue, so we are talking about something that happens 1 in 5,000 times. That means 4,999 times we are getting it right. In 2006, I started on the Division of Insurance's Health and Life Advisory Committee and was part of Alice Molasky-Arman's balance billing workshops, so I have been working on this for a long time.

As doctors, we have been told that we need to do this and we need to do that. As an organization represented by the ER physicians and Dr. Dean Polce, the doctors have done their part of the work. We were asked to try to consolidate our groups so that there would be fewer groups and individual anesthesiologists that insurance companies had to contract with. In the south, there is now Anesthesiology Consultants, Inc. (ACI), which has 100 members; in the north, we have 62 members of Associated Anesthesiologists. That means there are a lot fewer groups these insurance companies have to contract with, making it easier for them.

The other thing we were asked to do was try to partner with facilities so that, if a patient went to a certain hospital or outpatient surgery center, that patient could be assured the in-house physicians, anesthesiologists in our case, were contracted. We have done that. We have partnered with two hospitals and two surgery centers to provide exclusive services there so that those hospitals and surgery centers can be very comfortable knowing that they have anesthesiologists on the panels these hospitals are contracted with. We had our own bill, [Senate Bill 289], which is also an out-of-network bill based on the FAIR Health Model. We hope to have the opportunity to present it to this Committee when it gets through the Senate.

Catherine M. O'Mara, Executive Director, Nevada State Medical Association:
I appeal to each of you as policymakers today. You have been presented with a kernel of a problem and a solution for just that kernel of the problem. In the physician community, we are very concerned that the solution that has been presented for that small problem is going to have vast unintended consequences. Will this solution protect that small percentage—less than 1 percent of bills in Nevada—from receiving a surprise bill? Yes, it likely will do that. However, will it create a number of other issues that you will all have to deal with as policymakers? You all have constituents in your districts who need emergency services. Some of you have hospitals in your districts. I would like you to think about what the unintended consequences of this bill may be.

The sponsor of the bill has been very gracious in meeting with us and offering to work with us after this hearing, and we accepted that offer and look forward to working with her. As written now, the bill does not meet the three goals that the sponsor has indicated were her goals. I will take those in reverse order.

Does this bill prevent the state from getting in between the contracting parties? No. This bill actually creates an artificial incentive for payers to not contract as much as they would without these parameters in place.

Does this bill provide a solution that includes known numbers? No, it does not. It provides two separate options. One option is 125 percent of Medicare, and those numbers will be unknown in future years, because there are many changes happening at the federal level relating to Medicare. We already know that there are specialties that do not fall under Medicare codes today, so we do not have transparency or known numbers when it comes to Medicare percentages. The second option is the average contracted rate as determined by the third party. I submit to you that we do not know what those numbers are either. Those numbers are exclusively in the possession of the insurers, the providers have no idea what those numbers are. Interestingly, even in the exhibit submitted by AHIP [(Exhibit G)], the national group of insurance plans which has a lot of data, what you do not see in that data is the average contracted rate. If we would like to deal with known numbers, let us deal with numbers that are transparent so we will all be on the same page as to what it is we are looking at.

Speaking of transparency and that AHIP exhibit, I would point out to you pages 2 and 3 where they talk about the modality they used to determine those numbers. They actually referenced FAIR Health, which is the database we, as a physician community, have been proffering to you this session as an independent, non-conflicted database. What the AHIP presentation does not do that FAIR Health does when they set their benchmarks, is they do not get rid of the outliers, they are skewing the numbers higher than what they would be if we used the dataset that was set by FAIR Health.

Discussing the first goal, we appreciate the goals the sponsor is trying to meet here. We agree with those goals. The number one goal is really to protect patients. While this bill may protect that small group of patients in those unique instances of out-of-network billing, this bill will actually hurt patients, your constituents, in the long run. You have to accept the reality of the access-to-care problem that we have in Nevada. This bill will affect emergency room physicians and also those on-call physicians who are called in to help with an emergency delivery. In the spring, John Packham, Ph.D., provided a report to the interim Legislative Committee on Health Care in which he stated that among physicians in surgical specialties, Nevada was ranked 51st in the nation. For physicians in general surgery, we are ranked 51st in the nation; physicians in orthopedic surgery are 51st in the nation. In pathology, we are ranked 50th; and neurological surgery is 50th.

I would like to point out that if this bill has the impact on the physician community we think it will, it will drive physicians out of Nevada. If your constituents go to the ER for treatment and they need specialty care, they will be forced out of Nevada to obtain that specialty care. There is nothing in this bill that will protect your constituents from the costs associated with that out-of-state care.

Chairman Sprinkle:
At this point I am going to open it up for testimony neutral to A.B. 382.

Dena Schmidt, Deputy Director, Programs, Department of Health and Human Services:
I wanted to confirm for the record the comments made earlier by Assemblywoman Carlton regarding the fiscal impact. We are unable to determine exactly what this caseload would look like, and it is a new service to us, so we have identified the ability to use some fees in contract until we can determine an appropriate caseload.

Celestena A. Glover, Chief Financial Officer, Public Employees' Benefits Program:
We, too, are testifying as neutral. The Public Employees' Benefits Program does everything it can to ensure that its participants get the best care at the best prices. We believe this bill does assist us with ensuring that they are not balance billed if they have to see an out-of-network provider.

Chairman Sprinkle:
Is anyone else here neutral? [There was no response.] Assemblywoman Carlton, would you like to come back up for some closing comments?

Assemblywoman Carlton:
Thank you, Mr. Chairman, and you have given us way too much time. Much more than I ever expected. I was not going to bring up the FAIR Health bill in the Senate because I did not feel it was part of this. I have had conversations with the proponents of that payment formula for non-contracted doctors and a vendor called FAIR Care. I do not believe this particular formula is a solution. Also, the proposal of FAIR Care places one particular vendor in statute, which is something I am not familiar with and not comfortable with at all. That proposal is based on usual and customary charges. This is the same as billed charges. They are not regulated. They are completely set by the provider, they are without limits, and they are several times higher than possible contracted rates. These are the exact issues that I am trying to resolve. They are the problem, not the solution. If either of those were acceptable, the 80th percentile of payment would make reimbursement rates so high in statute that health plans would be unable to contract. Going forward, it would do exactly the opposite of what we are trying to do here with physicians. The doctors would just take that rate in statute, and contracts would go out the window.

Finally, that bill mandates that the health plans provide an out-of-network benefit. Let us think about that. An out-of-network benefit would effectively eliminate several types of health care coverage that Nevadans have choices for today.

If this truly is a small problem, then it should not be a large issue to work on. I look forward to working with all the folks who came to the table. I thank the folks who came to me before the hearing; I look forward to talking to the folks who did not come to me before the hearing and having discussions on this. We are going to work on this very hard and try to get this Committee something back very quickly so it can be processed in the appropriate time frame.

Chairman Sprinkle:
I appreciate the work you and those who have spoken with you are putting into this issue. We know what a large issue it is. I would strongly suggest that any others who are supportive or in opposition to this reach out to you so we can have something to look at.

Assemblywoman Carlton:
I am in my office until 8 or 9 o'clock tonight. I hope all those folks come by my conference room and we can sit down and talk and start the discussions very soon. I plan on dedicating an inordinate amount of time on this tomorrow.

Chairman Sprinkle:
With that, we will close the hearing on A.B. 382.

[(Exhibit L), (Exhibit M), (Exhibit N), and (Exhibit O) were submitted but not discussed and are included as exhibits for the meeting.]

Now, we will open the hearing on Assembly Bill 355.

Assembly Bill 355: Revises provisions relating to the adequacy of health care services offered by a network plan. (BDR 57-1118)

Assemblywoman Dina Neal, Assembly District No. 7:
I am here to introduce Assembly Bill 355. This bill came about because of a constituent in my district who owns a behavioral health company. Ultimately, what he is seeking is a level playing field. They are trying to make sure there is access to the network to become an essential community provider (ECP). Federal law allows those to exist, but the timeline is a very long one. This bill creates a different pathway at the state level for them to become a registered ECP.

Devin Brooks, Chief Executive Officer, Brooks Behavioral Health Center, Las Vegas, Nevada:
On behalf of myself, as a health care provider, and also representing various community health coalitions, I would like to introduce A.B. 355. This bill would give recognition to essential community providers, ECPs. Essential community providers are something that came about from looking at federal guidelines in regard to Centers for Medicare and Medicaid Services (CMS) funding and working with underserved populations. What we dealt with as health care providers are some challenges in regard to the network plans when it comes to managed care for Medicaid recipients here in Nevada. A lot of managed care organizations (MCOs) have found it challenging to credential health care providers in underserved communities.

We thought it would be beneficial as a state not only to have the federal ECPs, but to incorporate them at the state level as well. From the federal standpoint, being recognized as an ECP comes with benefits, so those network plans that are managed care organizations for

the Medicaid recipient population have access and contracts in good faith. They do not have any fees associated with working with recipients in those network plans. We thought this would be something beneficial for the state.

We have contracts with these managed care organizations. They are not allowing different health care providers to participate in those underserved areas, so as a result, recipients in those areas do not get access to health care services.

What we are hoping to have is a process similar to the federal one in regards to it being recognized at the state level. The same benefits they would receive from the federal standpoint would be there from the state. From the state standpoint, the process in which they go about being recognized as ECPs can be done in a timely manner. For example, for those who want to become an ECP from a federal standpoint, you are looking at petitioning in 2017 and not necessarily being recognized until 2019 or 2020. As a state, we can make sure the time it takes to be recognized as an ECP is improved.

Steve Brotman, Chief Executive Officer, Jeneven Consulting, LLC, Las Vegas, Nevada:
We are here to introduce a state recognition plan to recognize essential community providers [page 2, (Exhibit P)]. The Affordable Care Act (ACA) mandates that, in order to be within the marketplace, the state has to have some sort of delineation of what an essential community provider is and recognize ECPs in order to be adequate within the network. We want to extend that into the Medicaid space. Some of the legislation we will discuss extends commercially, and some extends into the Medicaid space. From the Medicaid space, we want ECPs to be vetted as distinct behavioral and mental health care facilities serving underserved communities. We want the state to vet certain essential community providers in order to ensure that we are providing adequate services to underserved communities.

Essential community providers are designed to increase access and quality of services to underserved communities. Additionally, ECP distribution and concentrations will be managed by not only the Division of Insurance (DOI) but also by the Division of Health Care Financing and Policy in the Department of Health and Human Services. This is to provide accountability measures for the insurance carriers to be in compliance as part of network adequacy provisions. We really want to have an opportunity to enforce the insurance companies to contract with groups that are in underserved communities and deliver services to increase access and quality of care.

It will not just be the DOI that will be responsible. In addition, the Division of Health Care Financing and Policy will also be responsible for the adequate distribution of services, considering ECPs encompass interdisciplinary and integrative health care providers. Essentially what we mean there is that we want these agencies to ensure that these ECP concentrations are located in geographical areas of need.

I believe there are some positive economic impacts to Nevada I would like to emphasize [page 3, (Exhibit P)]. Nevada receives federal funds as a part of being enrolled in the marketplace. A significant amount of those funds are intended to reach underserved and

vulnerable populations. Managed care organizations are a subset of the groups that are managing these funds that are supposed to be allocated to underserved and vulnerable populations. We believe they have not been allocating those funds appropriately to recipients typically inhabiting geographically underserved areas. The MCOs have been unable to adequately ensure access to critical psychiatric services specifically to high-risk underserved communities. We feel that establishing ECPs may encourage and entice psychiatric services, which are desperately needed, to migrate into these underserved communities. As a result, funds which should be utilized to treat and assist in prevention of escalated disease are not being allocated to needy recipients, and may be absorbed by insurance carriers as part of their contracted agreement with the state.

We do not want people to not receive adequate services and then have the insurance companies keep the money because they get a capitated rate. Every dollar they do not spend on individuals they get to keep, and that money gets circulated outside the Nevada economy. The more funding we have for the Nevada health care system, we can actually infuse more into the Nevada health care economy. So, we believe that A.B. 355 will increase funding to the Nevada health care economy and limit recycling unspent funds to the corporate headquarters of insurance companies which we do not believe are registered and located in the state of Nevada.

Here is a snapshot of data [page 4, (Exhibit P). These are snapshots of historically underserved communities in the Las Vegas area by ZIP codes. This shows the percentage of Medicaid recipients in those communities. In those communities, there is a particularly high presence of ER visits related to mental and behavioral health issues, which is interesting. However, the most interesting thing is that not one of these ZIP codes has a psychiatrist in it. When we go to an affluent community such as Summerlin, which is a very wealthy suburb of Las Vegas, we would expect there would be a low number of Medicaid recipients in that community. We see about a 4- to 4.5- percent drop in cases of mental health needs related to ER visits. In these districts, there is a provider-recipient ratio of anywhere from 2,500:1 to 5,600:1 versus 27,000:0, 17,000:0, 19,000:0, and 35,000:0. We do not have a system that encourages psychiatric services to be provided in underserved communities. We believe that by establishing ECPs, we can give some protection to providers to entice things such as psychiatric services.

This data was acquired from the Division of Health Care Financing and Policy. It is off their website [page 5, (Exhibit P)]. We looked at hospital utilization rates and what sort of insurances were being billed for those services, and we saw inordinate amounts of density of Medicaid in those districts we indicated had high Medicaid populations. Then we looked at the total utilization based on different physiologies that were addressed, such as mental health services.

In summary, we want to create distinction of the ECPs [page 7, (Exhibit P)]. We want the state to recognize those in a timely manner, and we want to increase access and quality of care to notoriously at-risk populations. We believe there is a set number of 30 percent, which is actually mandated by the federal government already, by hardwiring it into the bill.

If there are any changes at the federal level, it will protect Nevada citizens. We also want to empower the DOI, as well as the Division of Health Care Financing and Policy, to govern network plans more stringently to ensure proper network adequacy and promote increased funding to reach into that health care economy and not be retained as much by the insurance carriers.

Chairman Sprinkle:
Was anyone going to walk us through the bill?

Steven Brotman:
Section 3 of the amendment (Exhibit Q) defines an "essential community provider". That is language straight from the federal government. We are not really expanding on that so much, although I would like to emphasize there are some components to this bill that are still works in progress.

Sections 5 and 6 are specifically geared toward the commercial side of the insurance. We have met with Division of Insurance representatives. They have assured us that because they are federally mandated to follow a majority of these processes as part of being enrolled in the marketplace, that we are not reinventing the wheel here. There are some components in section 6 that would be new and potentially change the landscape of commercial insurance, but we have been informed that it would likely only affect the largest of the contracts within the state.

Chairman Sprinkle:
Are you talking about the amendment and not the bill?

Steven Brotman:
Yes, I am talking about the amendment (Exhibit Q), which is the mock-up, Proposed Amendment 3466, dated April 8, 2017.

Sections 5 and 6 are specific to commercial insurance plans. The DOI is already compliant as part of being in the federal marketplace for most of these components. In section 6, there are some points that may affect some of the largest carriers in the state in terms of how they are going to have to restructure their distribution of providers to reach underserved communities.

In sections 9 through 11, we are specifically targeting language that is going to change some activity within the Medicaid responsibilities, and may have some fiscal impact at the Medicaid-department level—the Division of Health Care Financing and Policy. They do not have a system to credential ECPs, so we are asking them to invent a system to do that, and we provide language to guide them on part of that process. That is part of the work in progress where the Division of Health Care Financing and Policy would actually begin credentialing some of these ECPs to basically counteract insurance companies which are charging exorbitant fees to community providers—upwards of 30 to 40 percent reduction in CMS funds for services. We are trying to counteract that by ensuring that ECPs are not

penalized by MCOs, thus enticing potentially better services to those areas—high quality services. Perhaps we can entice psychiatrists to come to these underserved areas if they are not going to have to take a 40 percent pay cut to do so.

There are some components of this that we understand are probably overreaching, such as section 11, subsection 2, paragraph (a). We will be striking this. We understand it is unrealistic to rubber-stamp authorizations; however, we do want these ECPs to have the freedom to negotiate their own contracts with carriers to ensure that authorizations are fair and balanced. Otherwise, ECPs should not be penalized and paid at a lower rate. The ECPs are basically going to look a lot like federally qualified health centers (FQHCs). They have to have a compliance officer, and they have to have a board of directors to maintain compliancy and good work by the organization. That should be another protection for the state's funds. That is the meat of this bill; everything else is changing a word or definition here or there.

Chairman Sprinkle:
I will open this up to questions from the Committee.

Assemblyman Oscarson:
As a former chair of this Committee, I found it critically important to work with the Insurance Commissioner, especially when her name is mentioned seven times in this bill. Have you reached out to her at all?

Devin Brooks:
We have not had an opportunity to reach out to her yet. We definitely wanted to position ourselves to be able to have those conversations.

Assemblyman Oscarson:
We are up against a deadline. It would seem to me that working with her in the few days we have left to accomplish this large a task would be prudent. I will be surprised if that can happen in this short period of time. In the past when I worked with her, we spent 16 months working on issues that were critical and vital to the state of Nevada—one of them being network adequacy. She convened on her own, without legislative mandate to do so. She has a very strong working group that participates with these kinds of issues. My suggestion would be to work closely with her to ensure that you have a voice in that group.

Steven Brotman:
I completely agree with you how prudent it would be to discuss this with the DOI Commissioner. Luckily, it turns out that a majority of these provisions are already under their governance. We are not actually changing their bylaws as much as this bill originally made it seem; we are having more of an effect on the Division of Health Care Financing and Policy (DHCFP). We have been in contact with DHCFP a little bit as well as with the DOI, but not specifically with the Insurance Commissioner. They probably face changes, but DOI really does not face any changes.

Assemblyman Oscarson:
I will respectfully disagree with that, but we will move forward.

Chairman Sprinkle:
Are there any other questions from the Committee? [There were none.] Not seeing any, thank you for your presentation today. Is there anyone here in support of A.B. 355?

Roxann McCoy, President, Las Vegas National Association for the Advancement of Colored People Branch 1111:
I am here to support A.B. 355. Devin Brooks is a young businessman who is providing a service to the minority community that has gone underserved for a long time. I applaud him and his newness and for having the courage to come before you to present what these issues are. I would like for you to get outside your political box for a minute, and look at someone who is a businessman who is trying to make a difference in a community that is well underserved. I would like for the insurance providers to contract with community providers in geographical areas of need, which Mr. Brooks is trying to do. I would like for him to have local mental health care providers in our communities.

Chairman Sprinkle:
Is there anyone else in support of A.B. 355? [There was no response.] Is there anyone in opposition to A.B. 355?

Dan Musgrove, representing Amerigroup Nevada:
Amerigroup is one of the two managed care companies that are current providers for the state's Medicaid managed care program. This is a surprise to all of us, because A.B. 355, as written, did not include managed care. We have been watching for the amendment all day and I guess it just appeared so, candidly, I do not have a lot to address. We have been in contact with the sponsor through the interim and through this session and tried to talk to her about the bill, but did not have that opportunity, although we would love a chance to work with her. After a quick review of the amendment, I have a couple of comments to make on it, as well as on their presentation.

One of my clients is WestCare Nevada, which is located at Stewart and 13th Street, right in the heart of downtown Las Vegas, right in the center of what you would call an underserved area. I can tell you for a fact that two managed care companies contract through WestCare to provide behavioral health and substance abuse services. Last year, we billed Medicaid $3.5 million. Those are services that went directly to that community, so when they talk about dollars being spent on behavioral health, I think that is a mischaracterization.

In terms of the amendment in front of us, I appreciate the fact that they are willing to strike the section regarding preauthorization. Managed care companies need the ability to do preauthorization to make sure that we have clinical appropriateness to services that are being rendered to our patients and to our clients. We have very strict credentialing standards to ensure members get appropriate care. Anytime we look at lessening those standards we have issues, because our job is to safeguard the state's Medicaid dollars. There is a very fine line

between appropriate services, appropriate credentials, and appropriate providers. We want to make sure our credentials are high and that we ensure the folks who receive Medicaid benefits get the best and most appropriate services.

Candidly, DHCFP, the administrator for Medicaid, has very strict network adequacy standards in its contracts with us. In fact, the new managed care contracts that start July 1, 2017, go even further to make sure that we have strict guidelines and that there are a lot of fail-safes that ensure we are providing the best service to Medicaid recipients. In my very cursory review of the amendment, I would like us to have the opportunity to work with the sponsor on this bill. At this point, we are opposed.

Chairman Sprinkle:
Is there anyone else in opposition to A.B. 355?

Michael Hillerby, representing Hometown Health:
Like Mr. Musgrove, we just recently saw the amendment. We did have a chance, through the Association of Health Plans, to let the sponsor know we had some concerns with the original bill, but we will need some time to digest this amendment. Upon a quick review, there is some language eliminating prior authorization. That is an important part of keeping insurance premiums down, and there are some things we do to make sure care is provided correctly and in a cost-effective manner, so we have some concerns. We will look through this amendment and get some specific comments to the sponsor after we have done so.

Chairman Sprinkle:
Is there anyone else in opposition to A.B. 355? [There was no one.] Is there anyone neutral to A.B. 355?

Marta Jensen, Acting Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
The provisions of this bill would require Medicaid to register an essential community provider which provides behavioral and mental health services to vulnerable persons. This is currently not an activity we do within the Division, so we have been unable to determine what a fiscal note would be for this. I expect we would need some additional staff, but the parameters have not yet been established, so we are not really quite sure where this needs to go, but we are open to looking into that.

In addition, our contracts with the MCOs are risk-based and allow each plan to negotiate its rate with a provider. This bill mandates minimum rates for services by the ECPs, which would have an impact on our monthly capitation rates. When the expense goes up to the managed care, we do an actuarially sound review and determine their capitation rates, which is a per-member, per-month rate. Unfortunately, we do not have the fiscal impact on that either as we just saw the amendment and would need to do further research on that.

Glenn Shippey, Actuarial Analyst II, Life and Health Section, Division of Insurance, Department of Business and Industry:
I just want to point out that, on behalf of Commissioner Richardson, I have been meeting with the bill's sponsor over the last several days. The process that is being built around using these newly-recognized essential community providers for the evaluation of the adequacy of commercial-market networks is something that does work within the current process. The Division of Insurance does not see a material impact being proposed in this bill at the present time.

Chairman Sprinkle:
Is there anyone else neutral to this bill? [There was no one.] At this point, I will allow those people in southern Nevada who wish to come up in support of A.B. 355 to come up and briefly make their statements, and then we will be closing the hearing.

Lurline Wells, Private Citizen, Las Vegas, Nevada:
I am a clinician in Las Vegas, and I have been working in the community for approximately 11 years. I work with individuals who are underserved and often homeless. They have a lack of transportation and other issues they deal with on a regular daily basis. I support A.B. 355 because I think that the smaller organizations such as my own and Mr. Brooks' organization are not being allowed to provide the services that are needed for these clients. Many of the funds go to the larger organizations versus the smaller ones, and we are, in fact, in the trenches with these individuals. This bill would allow us to work within our own community with the individuals we are serving.

Regina Strayer, Private Citizen, Las Vegas, Nevada:
I am in support of A.B. 355. The reasons are very simple. I am an adult with attention deficit hyperactivity disorder and bipolarism, and I have a lot of mental issues I have to work through. Through programs and bills such as A.B. 355, I am able to get the help I need to be a productive member of society and relate in a professional manner instead of as a person with no ability to control myself. Without bills like A.B. 355, I can tell you from my own past, that is not possible for a lot of us. So, I support A.B. 355.

Delicha Hardeman, Private Citizen, Las Vegas, Nevada:
I support A.B. 355. I have been seeing a therapist through fee-for-service for myself, and my seven-year-old granddaughter has been seeing them through me. Because of not being able to have a bill like A.B. 355, my daughter has a lot of problems going through her health maintenance organization (HMO) because she does not have fee-for-service like me. She is not able to get the help she deserves to get because she does not have fee-for-service coverage. Instead of taking her to someone in her HMO whom I do not trust, I take her to someone who will be able to help her. It is a struggle for me with my anxiety and everything I go through because she is not able to get the help she needs, so I do support A.B. 355.

Chairman Sprinkle:
At this point I will ask the sponsor if she would like to make any closing comments.

Assemblywoman Neal:
The meeting in my office this morning was with the Division of Health Care Financing and Policy and with Mr. Shippey from the Division of Insurance. It was not with the Commissioner herself, but they met and had a conversation about the changes in the bill. When we met last Friday with the Division of Insurance, they suggested that the registration process go through the Division of Health Care Financing and Policy. I did not allow some folks to attend that meeting because it was the first time the Division of Insurance had sat down and talked to DHCFP. The two agencies had been having trouble getting a meeting, so I called them in on Friday and had Mr. Brooks come so they could discuss the bill. I was not going to allow folks in who were probably in opposition when we were just trying to explain the bill to those two agencies, and then allowing the two agencies to talk to each other. I wanted to clarify that.

Hopefully, folks are clear that Mr. Brooks and Mr. Brotman are not trying to lessen the credentialing standards. They are trying to walk through the doorway. Why should the big guys be the people you have to ask permission from? That is a problem. We need to figure out how a small business can maintain themselves in behavioral health, whether it is by this pathway or another. The current setup does not allow them to maintain their business model. That has been an issue for a while, and I think we need to address it. As you heard earlier, it has taken them five years to get credentialed, and that, in and of itself, is a problem.

Chairman Sprinkle:
Thank you, we appreciate that. There were many people, even while you were not in the room here, expressing a desire to reach out to you and maybe work on this, either between now and deadline or in the interim. It sounds as though there is interest in trying to work on this issue. I think reaching out to them would be a good idea. With that, I am going to close the hearing on Assembly Bill 355 and open up the hearing on Assembly Bill 427.

Assembly Bill 427: Revises provisions governing eligibility of certain convicted persons for public assistance. (BDR 38-1054)

Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27:
I am here to give a quick introduction to Assembly Bill 427, then I will let the members from our local food bank present the bill. This concept originated during the course of a conversation about what was working well and what was not working well in government. An intern who works with the food bank realized they were having a problem with paperwork and obtaining a very specific type of certificate in order for people to access the Supplemental Nutrition Assistance Program (SNAP).

Shane Piccinini, Government Relations, Food Bank of Northern Nevada:
This bill is really short. In 1996, the United States Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act; we call it the welfare law. That law prohibited anyone convicted of a drug felony from receiving either federally-funded cash assistance through the Temporary Assistance to Needy Families (TANF) Program or through food stamps, known as SNAP. It is important to note that drug felonies were the only

criminal convictions that barred access to the SNAP or TANF programs. Under current Nevada law, when drug felons are looking to obtain SNAP benefits, they must provide documentation of a 30-day rehabilitation class enrollment or completion during the preceding 20 years.

Jessica Preston, Intern, Food Bank of Northern Nevada:
A reason this is very important is because when individuals with drug convictions are denied food stamps and cash benefits, establishing economic stability upon reentry becomes very difficult for them, which, in turn, makes their recovery incredibly complicated. By helping individuals lead a more stable life, public assistance and food stamps can help improve reentry outcomes and have a positive effect on public safety. The TANF program and food stamps are also important for people participating in residential treatment and other programs.

I would like to quickly share one story. During my first two weeks of doing observations, I was with our SNAP outreach team, when a young gentleman walked in. It was his first time applying for welfare assistance. He had checked yes on the drug felony box. By the time it was his turn to sit down and go over the application, it took our outreach specialists only about 30 seconds to say that they could not help him unless he had the certificate. This gentleman was not sure how he was going to be able to get the certificate and did not have the means to pay for a class in Nevada. So, we had to send him away with no benefits. Even though he came into a resource center looking for resources, he left with nothing.

Shane Piccinini:
What A.B. 427 accomplishes is that it removes the burden on the client to prove that he or she has been through the treatment program required by the *Nevada Revised Statutes* to access SNAP or TANF. This is one of the last barriers the state has to food security in Nevada, which is the approach we are taking with this bill.

Deborah Braun, Chairman of the Board, Food Bank of Northern Nevada:
I am here on behalf of our 14-member board in support of this bill. By removing the treatment program requirement, the Division of Welfare and Supportive Services will not have to require proof. They have current procedures in place in line with the new proposed section 1, subsection 2, paragraph (a).

Chairman Sprinkle:
Are there questions from the Committee?

Assemblyman Edwards:
If this goes through, what do you think will happen as far as the number of people who would be receiving benefits?

Shane Piccinini:
That is a good question and a really difficult one to pin down.

Kerry Walsh, Outreach Manager, Supplemental Nutrition Assistance Program, Food Bank of Northern Nevada:
Unfortunately, that question is very tough to answer. There are many clients who know they do not qualify for SNAP or TANF when they arrive. They know they need to do a drug treatment program before applying, so the number this will affect is hard to pin down. I am sure we will have a lot of people come through who will say that they have drug felonies but do need public assistance.

Chairman Sprinkle:
Are there any other questions from the Committee? [There were none.] I have one concerning section 1, subsection 2, paragraph (a) where it begins "Demonstrates . . . ." You said there is already something in place. Could you describe what that is?

Shane Piccinini:
I am a little hesitant to speak for the Division of Welfare, but the regulations currently say that the individuals will be verified as to not "currently possessing, using or distributing controlled substances" since their treatment began if they have no other arrest records or if they provide statements from their parole officers if they are currently serving probationary periods.

Chairman Sprinkle:
I appreciate that, but I do think this is extremely relevant to the bill, so I am wondering if there is anyone who wishes to come forward to speak directly to this. In essence, it says, "Demonstrates to the satisfaction of the Division . . . , " and we need to know what that is.

Naomi Lewis, Deputy Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services:
You are exactly correct. Currently, the agency looks at two things. One is that they are participating in or have successfully completed a treatment program. The second component is that they have not used, possessed, or distributed any drugs since their conviction.

Chairman Sprinkle:
How does the Division know if they have not used or possessed drugs since their conviction?

Naomi Lewis:
Currently, we work with the parole officer or the probation officer, and they confirm that there have been no further problems since the conviction. If there is no parole or probation officer, then it is based on whether the individual has not been recharged or had any additional offenses since the original conviction.

Chairman Sprinkle:
Are there any other questions from the Committee?

Assemblyman Hambrick:
Would part of making sure they are clean and straight include random testing?

Naomi Lewis:
It does not, unless their parole or probation officer is doing the testing, which it is assumed they do.

Chairman Sprinkle:
Thank you, and we will open this up to support for A.B. 427.

Emma Swarzman, representing Progressive Leadership Alliance of Nevada:
We are in full support of A.B. 427 because everyone deserves a second chance. As a social work student, this bill aligns with the values of our profession. Nevada as a state has to do a better job of providing assistance to its eligible members who are in desperate need of TANF and SNAP. When a person with a record has to demonstrate that he or she is not currently involved with controlled substances in order to qualify for these benefits, it gives them both incentive and hope to show the world, or at least Nevada, that the second chance they have received to do better for themselves and their families is truly appreciated. This is the time for such right action on their part, not for onerous retaliation by the state.

I can only imagine how difficult it can be for them to return to their communities after their experiences with law enforcement agencies. We should be supporting their life-changing decisions, not making it more difficult for them to start a healthy or positive lifestyle. Helping individuals eventually get their lives and families back together will help them be better members of our community, in turn creating a safer place for us all. I urge this Committee to please help our state get back on track and be a clear leader in these issues, and opt out of this limitation to help fellow Nevadans who want to do better for themselves and their families. It will make for a win-win situation.

Stacey Wittek, Community and Work Force Developer, Bridges to a Thriving Nevada:
We are in support of A.B. 427. My job is to work with individuals in or near poverty to identify their barriers to self-sufficiency and security, and address them by building resources. In my capacity in this work, I have not found an able-bodied group of individuals facing more barriers to self-sufficiency than ex-felons. The SNAP is a getting-by resource. It does not solve poverty. Motivated and persistent individuals can sometimes connect these resources with other resources to get ahead, and that is why I support A.B. 427.

Jared Busker, Policy Analyst, Children's Advocacy Alliance:
We are in support of this legislation, as we believe it will expand services to children and families.

Leonardo Benavides, Extern, Legal Aid Center of Southern Nevada; and Washoe Legal Services:
We want to say ditto as well. This would be great for many of the people we serve, and we appreciate the Assemblywoman for bringing this bill forward.

Steven E. Kane, Private Citizen, Reno, Nevada:
I would like to offer myself as a human resources (HR) expert. I have been qualified for that in court, and I have testified before Congress. When I was in industry, I had HR responsibility for 30,000 employees. I have discussed this matter with other HR folks, and we all feel about the same. If you have an individual who is spending much, or even part, of his or her time looking for the next meal, trying to figure out how they are going to eat that night, or how they are going to feed their kids, they are not going to be focusing on a job. Employers would just as soon not have those people working, because they would not be focusing 100 percent on their job. I support A.B. 427.

Cecilia Colling, Legislative Chair, Nevada Women's Lobby:
We feel this bill is in the best interests of women and children and the individuals who are suffering from alcohol or drug abuse.

Chairman Sprinkle:
Is there anyone else in support of A.B. 427? [There was no response.] Is there anyone in opposition to A.B. 427? [There was no response.] Is there anyone neutral to A.B. 427 who wishes to come forward? [There was no response.] Are there any closing comments? [Assemblywoman Benitez-Thompson indicated there were not.] Okay, we will close the hearing on A.B. 427.

[(Exhibit R) was submitted but not discussed and is included as an exhibit for the meeting.]

I will open it up for public comment. Does anyone wish to come forward under public comment? [There was no reply.] All right, we will close public comment. Thank you, Committee, very much. This meeting is adjourned [at 4:02 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 the Work Session document, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau, regarding Assembly Bill 156.

Exhibit D is the Work Session document, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau, regarding Assembly Bill 346.

Exhibit E is the Work Session document, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau, regarding Assembly Bill 347.

Exhibit F is the Work Session document, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau, regarding Assembly Joint Resolution 9.

Exhibit G is a link to the America's Health Insurance Plans, Center for Policy and Research website containing a document titled "Charges Billed by Out-of-Network Providers: Implications for Affordability (2015)," submitted by Assemblywoman Maggie Carlton, Assembly District No. 14, in support of Assembly Bill 382.

Exhibit H is a packet of letters provided by Assemblywoman Maggie Carlton, Assembly District No. 14, in support of Assembly Bill 382.

Exhibit I are charts including "Average Billed Charges Per Adjusted Inpatient Admission," "Top Inpatient Categories Billed in Nevada," and "Outpatient Categories Billed in Nevada," submitted by Assemblywoman Maggie Carlton, Assembly District No. 14, in support of Assembly Bill 382.

Exhibit J is a letter to Chairman Sprinkle and the Committee, dated April 10, 2017, presented by Bret W. Frey, Legislative Liaison, Nevada Chapter of the American College of Emergency Physicians, in opposition to Assembly Bill 382.

Exhibit K is a letter to Chairman Sprinkle and the Committee, dated April 10, 2017, plus supplemental information, presented by Jerry Matsumura, Past President, Nevada State Society of Anesthesiologists, in opposition to Assembly Bill 382.

Exhibit L is written testimony dated April 5, 2017, submitted by Aviva Gordon, Legislative Committee Chairwoman, and Amber Stidham, Director of Government Affairs, both representing the Henderson Chamber of Commerce, in opposition to Assembly Bill 382.

Exhibit M is a letter to Chairman Sprinkle and the Committee, dated April 7, 2017, from Keith R. Brill, M.D., Section and Legislative Chair, Nevada Section, American Congress of Obstetricians and Gynecologists, in opposition to Assembly Bill 382.

Exhibit N is written testimony titled "Examples of Medical Costs AB 382," submitted by Assemblywoman Maggie Carlton, Assembly District No. 14, in support of Assembly Bill 382.

Exhibit O is a chart titled "Emergency Room Billed Charge Examples," submitted by Assemblywoman Maggie Carlton, Assembly District No. 14, in support of Assembly Bill 382.

Exhibit P is a copy of a PowerPoint presentation titled "AB 355 Revising Provisions Related to the Adequacy of Network Plans," by Devin Brooks and Steven Brotman, presented by Steven Brotman, in support of Assembly Bill 355.

Exhibit Q is mock-up proposed Amendment 3466 to Assembly Bill 355, dated April 8, 2017, submitted by Assemblywoman Dina Neal, Assembly District No. 7, and presented by Devin Brooks and Steven Brotman, in support of Assembly Bill 355.

Exhibit R is a letter to the Committee dated March 7, 2017, submitted by Jim Hoffman, Legislative Committee, Nevada Attorneys for Criminal Justice, in support of Assembly Bill 427.