MINUTES OF THE
SENATE COMMITTEE ON COMMERCE, LABOR AND ENERGY

Seventy-ninth Session
April 3, 2017

The Senate Committee on Commerce, Labor and Energy was called to order by Chair Kelvin Atkinson at 8:09 a.m. on Monday, April 3, 2017, in Room 2135 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412E of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Kelvin Atkinson, Chair
Senator Pat Spearman, Vice Chair
Senator Nicole J. Cannizzaro
Senator Yvanna D. Cancela
Senator Joseph P. Hardy
Senator James A. Settelmeyer
Senator Heidi S. Gansert

GUEST LEGISLATORS PRESENT:

Senator Patricia Farley, Senatorial District No. 8

STAFF MEMBERS PRESENT:

Marji Paslov Thomas, Policy Analyst
Bryan Fernley, Counsel
Christine Miner, Committee Secretary

OTHERS PRESENT:

Catherine O'Mara, Executive Director, Nevada State Medical Association
Christine O'Donnell, Executive Director, Customer Experience, FAIR Health, Inc.
Bret Frey, M.D., American College of Emergency Physicians
Karen Massey, Medical Group Management Association
Dean Polce, D.O.
Kathleen Conaboy, Nevada Orthopaedic Society

Keith Lee, Nevada Association of Health Plans; Board of Medical Examiners
Chelsea Capurro, Health Services Coalition
Austin Osborne, Administrative Officer, Storey County
Ryan Beaman, Clark County Firefighters Union Local 1908
Rusty McAllister, Nevada State AFL-CIO
Mendy Elliott, Nevada Osteopathic Medical Association
Damon Haycock, Executive Officer, Public Employees' Benefits Program
Weldon Havins, M.D., J.D., President, Nevada State Medical Association
Jason Wasdon, President's Employee Benefits Advisory Committee, University of Nevada, Las Vegas
Bill Bradley, Nevada Justice Association
Krystin Herr Larkin, Immune Deficiency Foundation; ACT for Nevada
Lynn Albizo, Director of Public Policy, Immune Deficiency Foundation
Melanie Daniel
John Sande IV, Express Scripts Holding Company
Glenn Shippey, Division of Insurance, Department of Business and Industry
David Marlon, CEO, Solutions Recovery, Inc.
Jesse Wadhams, Anthem Health Insurance Company of Nevada

CHAIR ATKINSON:
We will open the hearing on Senate Bill (S.B.) 289.

SENATE BILL 289: Requires certain policies of health insurance to cover services provided by an out-of-network physician. (BDR 57-675)

SENATOR JOSEPH P. HARDY (Senatorial District No. 12):
There is an out-of-network problem for a person going to a facility for an emergency or to a random facility for a health procedure and the health care provider sends the bill to the patient, who had thought he or she was covered by his or her insurance. Senator Bill 289 is an attempt for insurance companies, medical facilities and physicians to come together to resolve the problem for patients. There is a proposed amendment (Exhibit C) identifying FAIR Health, Inc. as the database company.

CATHERINE O'MARA (Executive Director, Nevada State Medical Association):
The Nevada State Medical Association with S.B. 289 seeks to present a new and innovative way to deal with the out-of-network problem. Its goals are to protect patients, ensure there is continued access to health care services when they are needed most and provide reasonable and fair payment for health care

services provided in good faith. It wants to encourage continued good faith negotiations and contracting by providing a market-based solution. It is our goal to provide predictability to insurers and businesses with self-funded plans about expected costs of out-of-network services through a database that insurers are already using. The database is FAIR Health, Inc. We will show how it operates and how insurers in Nevada are using it.

Senate Bill 289 provides for patients, who find themselves in out-of-network situations, to not receive balance billing from physicians. The bill requires the physicians to accept the lesser of their bill charge or an amount equal to the eightieth percentile of charges for the same services in a geographic zip code. The payer will collect its portion of co-pay, coinsurance and deductible from the insured.

At the request of the Commissioner of Insurance, the proposed amendment, Exhibit C, identifies FAIR Health, Inc., or its successor organization, as the database. The intent is to enlist an independent nonprofit organization that is not affiliated, financially supported or otherwise supported by an insurer to maintain the database.

There are other databases collecting bill charges. FAIR Health is the only database of charges that meets the requirements of being non-conflicted and nonprofit. The amendment clarifies the bill will apply in circumstances where the patient goes to an in-network facility and receives unexpected out-of-network services. The amendment clarifies the patients will be responsible for their in-network portion, and the payer will pay the remainder of the eightieth percentile or the bill charge, whichever is less.

Up until 2009, insurance companies nationwide were routinely using the eightieth percentile from other databases of bill charges. One of those databases was Ingenix, Inc. There was a lawsuit filed in New York by its Attorney General which accused the insurance companies of manipulating the data and shortchanging the patients of hundreds of millions of dollars. Out of the lawsuit came a settlement, raising $100 million for the purpose of setting up a nonprofit, non-conflicted database to contain the data. FAIR Health, is this database.

CHRISTINE O'DONNELL (Executive Director, Customer Experience, FAIR Health, Inc.):
I will introduce you to FAIR Health and some of the resources we have to support the bill with my presentation (Exhibit D) and written information (Exhibit E). FAIR Health is an independent nonprofit organization. We are committed to providing actionable data for use by all stakeholders in the health care community. We do not lobby or take positions on policies. We are here to share experience and information.

Our mission is to bring clarity to health care costs and health insurance information. We were formed out of a settlement agreement where Ingenix, Inc., now Optum, Inc., was formerly distributing these data benchmarks being used by the industry. It was determined there was a conflict of interest because Ingenix was wholly owned by United Healthcare Services, Inc. FAIR Health was established to take over the database and extend its utility to all stakeholders in the health care community.

Organizations are using FAIR Health data for various reasons. Payers are using its data for developing in- and out-of-network fee schedules, for negotiating with providers and designing networks. It is being used to develop consumer cost transparency tools, educational information and for policy and research. A common use for FAIR Health data has been adopted as a standard to help with dispute resolution.

In 2016, FAIR Health was certified by Centers for Medicare and Medicaid Services (CMS) as a qualified entity. We are one of only four organizations across the Country entitled to receive Parts A, B and D Medicare data for all 50 states. Our private health care claims repository is the largest in the Nation. We have 23 billion claim records for medical and dental services performed in the U.S. These are contributed to us by 60 payers and administrators who collectively process claims on behalf of 150 million lives covered by private insurance. Our data is contributed by these payers in exchange for discounts on data products they license from us. All of these payers are using our data. We divide the Country into 493 regions, so the information reflects the local markets where the information is being used.

In Nevada, we have 50 payer organizations contributing data to us for services performed in Nevada. In 2015, we had the most complete claims information. We had 12 million claims processed in Nevada. Since 2002, we have

approximately 188 million claims. We are adding two billion new claims across the Country each year. We divide Nevada into two areas, Reno and surrounding areas and Las Vegas and the surrounding areas. Medicare has a single-fee schedule for the entire State.

Once we receive the data, it is put through stringent auditing and validation processes, removing both high and low outliers that might distort the distribution of data. We combine the data into different products that are useful for different stakeholders in a community. We offer a free Website and free mobile applications for consumers to estimate costs of health care services and learn about health insurance reimbursement. We organize our data for the commercial market by type of claim and offer charge benchmarks and allowed benchmarks, two separate product lines.

Many academic and policy researchers are using our data for cost and utilization trending and other types of studies. States are using our data. New York and Connecticut have adopted FAIR Health data for their consumer protection transparency laws. It is widely used for workers' compensation fee schedules. New Jersey uses the database for auto-liability reimbursement claims. Many states use it for special health care-related programs such as reimbursement for emergency services and programs related to the neurologically impaired and pediatrics. We have been consulted by many states in the Country, and we make presentations and develop webinars to introduce and share our experiences.

We do not provide a single data point. We provide a range of values for every medical service and geographic area. We provide a range of percentiles from the fifth to the ninety-fifth, or more detailed. We array values from lowest to highest and assign them to percentiles. If we have 100 instances of a value for a charge or allowed amount, we array them from lowest to highest to assign them to percentiles. The fiftieth percentile is 50 percent of the data in our database for that service in that area. The eightieth percentile represents the benchmark for charges at the point that 80 percent of standardized data are equal to or less than the benchmark value, and 20 percent are higher. If there is not enough data to develop a benchmark, we derive data using data for related procedure codes and then apply a relative value methodology to come up with a value.

FAIR Health provides benchmarks based on allowed and charged data. For charges, it is based on the full non-discounted amount that providers charge on claim forms, and then we have a second product line for allowed data, which is the amount allowed for reimbursement by the payers based on their reimbursement policies. For in-network providers, it is based on the in-network negotiated rate. For out-of-network, it is based on what the insurance company is willing to pay based on their out-of-network reimbursement policies. FAIR Health does not set usual, customary and reasonable charges (UCR), the insurance companies do this. They may license for health data for this purpose. They may pick a percentile and determine that is their UCR and define it in their contract language. They may use our data in a formula to determine their UCR or not at all. Some plans are using multiples of Medicare.

FAIR Health not only reflects the data of the local markets, it also reflects the private insurance market. It is reflecting what is actually happening and reflects the experiences of the privately insured. Medicare rates are set in committees where they determine relative values and conversion factors. They adjust it for costs around the Country, and they do not cover all procedures. They cover procedures for the elderly, disabled and end-stage renal disease patients. Their rates are set with policy to drive certain behaviors and reward those behaviors. They are subject to meeting national budget constrictions. In contrast, FAIR Health is a mirror of the market, reflecting what is actually going on with payers and the privately insured.

FAIR Health is a unique organization, self-funding, self-sustaining and completely independent. We are dedicated to making the data available to all parties in the health care community. All operations are performed by expert in-house staff, and we have a customer support team to help those using our data.

MS. O'MARA:
One of our objectives in S.B. 289 is to provide predictability to insurers and businesses with self-funded plans of expected costs of out-of-network through a database. FAIR Health has data from 50 insurance companies in Nevada representing 80 percent of the private market. Many insurance companies such as United Healthcare Services, Cigna and Aetna are using FAIR Health for various purposes. Some of the purposes are to resolve out-of-network issues. United Healthcare will often pay out-of-network charges based on the terms of the health care plan, and in many cases, provide for either the out-of-network

provider's actual charge bill to the member or the reasonable and customary amount or base payment on what other health care professionals in a geographic area charge for services.

The bill encourages continued good faith negotiations and contracting by providing a market-based solution. For many years, options such as percentages of Medicare have been considered, which is comparing apples to oranges. It is a federal budget-based system which does not reflect our market. The federal system is reliant on money in the budget divided by the number of patients the budget is serving. Medicare does not have medical codes for every service. Anesthesia is not covered under CMS because billing is different. Medicare policymakers are gearing the funds towards primary care. Medicare dollars are focused on primary care rather than on specialist and emergency room care. It focuses on in-network providers rather than out-of-network services.

Senate Bill 289 seeks to provide reasonable and fair payment for health care services provided in good faith. We want emergency patients to be treated when on-call doctors have to provide the services. These doctors do not know what the insurance status is of a patient. The bill encourages on-call providers to continue providing services regardless of the patient's insurance status. The bill objective is to encourage this type of behavior.

The eightieth percentile is a number the industry is using as a standard. It is an industry standard New York and Connecticut have decided upon to set the benchmark for usual and customary rates. We are presenting this benchmark in S.B. 289. It ensures continued access to health care services when most needed. Providers have many reasons to be in-network. The primary reason is it is best for patients, being sure patients are covered. They have the incentive to care for patients at the outset, and it will drive them into contracting. For emergency services, there are federal laws requiring treatment regardless of the patient's ability to pay or insurance status.

On-call physicians, who are not the emergency room physicians, serve a small percentage of the patient population. Out-of-network issues are the exception, not the rule. The bill ensures this continuity.

Protecting patients is the most important aspect of S.B. 289. It allows families to focus on getting care for loved ones in an emergency, without worrying

whether surgery by an on-call physician is out-of-network. The intention is to find a solution for all Nevadans.

SENATOR CANCELA:
How big is the percentage of out-of-network charges?

MS. O'MARA:
I will provide that data to you. It is not as common as one might think. Patients often think they are out-of-network when they are in-network but have a high deductible plan or high co-pay. Health care is more expensive and insurance premiums are increasing. Insurance companies offer various types of plans to address this. Often, lack of the information on what a patient's insurance plan covers contributes to patient confusion.

BRET FREY, M.D. (American College of Emergency Physicians):
I will summarize my written testimony (Exhibit F). I have been practicing as a Nevada emergency physician for 14 years. I am involved with patient-centered solutions on out-of-network issues. Emergency physicians are 100 percent federally mandated. We see all patients at all hours of the day or night for every possible health problem. Any solution that is not a market-based solution is going to have an onerous impact for the safety-care network. The on-call physician list is a tenuous list. There are many specialties chosen to be on-call because the market is fairly stable. Specialty on-call health care providers, such as vascular or orthopedic, are necessary specialty coverages. We want to offer broad services for patients, including specialty care, to keep them from being transferred out of the State for this care.

KAREN MASSEY (Medical Group Management Association):
The Medical Group Management Association is the professional association for group managers. We support S.B. 289. The surprise coverage issue has national recognition. Patients are often surprised they have large deductibles not related to their coverage issues. The advent of FAIR Health as a solution was not available in previous Sessions addressing this issue. We were restricted to insurance companies' choices of UCR rates, the providers' choices of charges or arbitrary benchmarks such as Medicare and Medicaid. FAIR Health offers part of the solution to market-based fees helping to sustain the competitive market and the viability to attract providers and retain them in our communities.

The out-of-network emergency services of the Medical Group Management Association are very low. It varies by specialties. It is uncommon for us to have out-of-network patients. We strive to be in-network with every insurer. Providers are motivated to be in-network. FAIR Health is a mechanism to address issues of those patients finding themselves out-of-network. There is only one insurer we are not in contract with because their rates are well below the market. I encourage the Committee to look at this as a solution to maintain a competitive marketplace and encourage parties to contract.

DEAN POLCE, D.O.:
I am an anesthesiologist practicing in Las Vegas and President of the Nevada State Society of Anesthesiologists. I support S.B. 289. I have submitted written testimony (Exhibit G). There are many situations in health care which are out of our control in emergency services. Anesthesiologists follow the physician's recommendation when a patient needs surgery services. The rates provided by Medicare and Medicaid are recognized by the federal government, the Congressional Budget Office and the U.S. Government Accountability Office. Those rates are not standard for specialty services like the services I provide. Medicare charges are 70 percent below our commercial rates. Physicians in-network earn a decent wage. Benchmarking with Medicare provides a substantially lower billing amount. It is a disgrace for physicians to knowingly charge patients for out-of-network services. There are possibly 300 incidents per year. The majority of anesthetics are delivered in-network. FAIR Health represents a market-based, unbiased, non-conflicted resource for payments.

KATHLEEN CONABOY (Nevada Orthopaedic Society):
The difference between the solutions offered in S.B. 289 and solutions we have considered in past legislations, is FAIR Health as a market-based solution. Changes in the marketplace have impacted physicians for the past ten years. In 2006, CMS initiated the Physician Quality Reporting System which rewards providers financially for reporting health care quality data to CMS. The reporting was first voluntary, then became mandatory. The Medicare Improvements for Patients and Providers Act of 2008 was issued by CMS. In 2009, the Health Information Technology for Economics and Clinical Health Act was enacted offering financial incentives to health care professionals for using electronic health records. In 2010, the Affordable Care Act (ACA) was enacted creating new ways for accountable care organizations, Medicare and Medicaid, to deal with care and payments in the marketplace. The Patient-Centered Outcomes Research Institute was established by the 2010 Patient Protection and

Affordable Care Act to look at clinical effectiveness. It created a Medicare value-based purchasing program. The Medicare Access and CHIP Reauthorization Act of 2015 created a value modifiers program and a more meaningful use for electronic health records.

The list of federal laws and what is happening on that level shows dependence on Medicare as a benchmark is subject to many changes and modifications. Implementation of federal programs are designed to push people toward bundled payments. It is not a dependable system right now. We are interested in a market-based solution that is geographically specific. One of our members is a large group of 20 orthopedic surgeons in Las Vegas. The group has an insurance office in its practice, and because of the complicated insurance situation, employs 30 people to process insurance claims. The group is in-network with everyone, but it is a complicated business.

KEITH LEE (Nevada Association of Health Plans):
I am representing the Nevada Association of Health Plans on S.B. 289. They oppose the bill. We have not thoroughly reviewed the amendment, Exhibit C. We will work with the stakeholders and hope to work out solutions to our objections. We consider S.B. 289 a consumer and employer unfriendly bill. It could drive up premiums, co-pays and restrict the marketplace. In all health care insurance mandates, the Nevada Association of Health Plans reviews the costs and creates analyses for deciding whether to remain in the marketplace. If an insurer withdraws from the marketplace, it further restricts competition. There are three ways we are dealing with out-of-network scenarios. First is traditional surprise billing, where an out-of-network provider is involved in a procedure resulting in the surprise billing to the consumer. The second is the traditional emergency room for services. The third scenario, a remote possibility, a patient intentionally goes to an out-of-network entity. These scenarios can create problems for all parties involved in the health care industry. The intention of health care plans is first to the consumer to ensure the patient receives good and credible care and then to ensure the provider is adequately compensated.

We are being asked in the bill to apply a percentage to billed charges as developed by FAIR Health. This is not market-based. Market-based is set in two ways: the government and Medicaid, and by arms-length negotiations between the provider and the payer. Health care plans rely on data accumulated by FAIR Health as a tool, not as a basis for setting the charges. The tool is simply a starting point to begin negotiations. Most of the members of the Nevada

Association of Health Plans negotiate by contract on behalf of their patients on out-of-network charges, but some refuse to do so. The better plan is to negotiate the out-of-network charges on behalf of the patient. The health plans are better suited to enter into negotiations with providers or patients.

One of our concerns with S.B. 289 is the reference to a particular service in a geographic area. FAIR Health has data on Reno and Las Vegas. What about the rural areas? Rendering health care in the rural areas is a challenge in Nevada. A better definition of a geographic area is needed. There is no data available for the rural areas to apply a percentile.

The amendment, Exhibit C, indicates "as calculated by FAIR Health, or its successor organization, provided that the successor organization is an independent nonprofit organization that is not affiliated, financially supported or otherwise supported by an insurer." We need that same affiliation protection from providers. A quick review of the FAIR Health Website shows the directors are in some way affiliated with providers. We hope to arrive at some solution that is palatable all stakeholders.

CHELSEA CAPURRO (Health Services Coalition):
While the Health Services Coalition appreciates the efforts of S.B. 289 to bring a solution to the issues and acknowledge there is a problem, we have concerns with the formula and of writing one specific vendor into statute. The eightieth percentile for services means 80 percent of providers are charging less, and this is how pricing will be set. The goal is to take care of patients and encourage contracting. This bill discourages contracting.

AUSTIN OSBORNE (Administrative Officer, Storey County):
Storey County opposes S.B. 289. Our insurance broker, LP Insurance Services, Inc., did an analysis of four large employers and reviewed the paid actuaries for its company. Their findings show our premiums will increase up to 8.5 percent. Storey County is a large employer with a full-time equivalent of 130. This translates in over a $100,000 increase for our employee insurance. The results may be similar for other large employers. We work hard with our internal team, our insurance brokers, insurance companies and our employees. We are proud to provide very lucrative benefits to our employees. The County is responsible to its taxpayers. Changing our current dynamic could force a reduction in benefits for our insurance program, and a smaller number of providers will offer health insurance. We ask the provisions of the bill be revisited, and appreciate

the attempts of the bill to bring about resolutions to some of our health care issues.

RYAN BEAMAN (Clark County Firefighters Union Local 1908):
Clark County Firefighters oppose S.B. 289. We have contracts with our Preferred Provider Organization giving us an avenue if there is some type of balance bill with the contract provider. The eightieth percentile provision is an issue for us. We question what happens when the doctor is paid by the insurer and a patient still gets a bill from the doctor. This is still an unanswered question. The bill eliminates our ability to negotiate the out-of-network claims. We do that to secure our plan. We have retirees who live in other states, and this bill only provides a solution for Nevada out-of-network situations. We could have two different claims pricing under the eightieth percentile. The bill indicates we would have to provide services not allowed by our plan. We will work with the sponsor of the bill to address our concerns.

RUSTY MCALLISTER (Nevada State AFL-CIO):
The Nevada State AFL-CIO opposes S.B. 289. There is an out-of-network issue. We oppose the bill for many of the reasons stated by others in opposition. We have been trying to address the issue for over ten years. Bills were presented in previous Sessions that would have paid 125 to 200 percent of Medicare for out-of-network and emergency services. None of the bills were agreeable to hospitals and physicians. How much more is 80 percent of a database for an area compared to 125 to 200 percent of Medicare?

Our health insurance fund has had difficulty negotiating with hospital networks and many physicians are within these networks. When we terminate a hospital network, it includes all the physicians within that network. Our members are not allowed to use the facilities because they are out-of-network facilities. If our members go to any of these facilities, or are taken there in an emergency, S.B. 289 will ensure the physician gets paid 80 percent of a database, even though our members are not covered at that facility. We as insurers would have to pay 80 percent back to the physician with this law.

MENDY ELLIOTT (Nevada Osteopathic Medical Association):
The Nevada Osteopathic Medical Association is neutral on S.B. 289 with some concerns. We will be working with the sponsor to review our concerns.

DAMON HAYCOCK (Executive Officer, Public Employees' Benefits Program):
The Board of the Public Employees' Benefits Program (PEBP) is neutral on S.B. 289 with some concerns. The eightieth percentile of fair market rate is concerning. We have a 60 percent discount for our in-network services. The utilization is 96.4 percent. Almost everyone in our program is using in-network services. The third-party administrator contracted with PEBP has done an analysis of the FAIR Health usual and customary discounts at the eightieth percentile benchmark. It is about 23.5 percent discount off billed charges. That is a 60 percent discount versus a 23.5 percent discount.

What is fair compensation? Ninety-six percent of our members use in-network providers who get compensated at the 60 percent discount I am constantly trying to negotiate with providers for out-of-network services who have threatened to drop our membership if we do not pay a certain rate. There are concerns about guaranteeing a certain amount of funding because we do not necessarily know if they are going to stay with our networks or will be incentivized to participate in our networks. The provisions of S.B. 289 may potentially tie the hands of PEBP. We will work with the sponsor. We do not like balance billing. Setting a certain standard and rate may incentivize providers to leave our network. We have attached a fiscal note at different intervals as to what will occur if certain physicians were to leave our network. It is sizeable, in the millions of dollars. This equals rate increases and higher costs. This prospective should be looked at to see if the 80 percentile is truly fair.

SENATOR GANSERT:
Does the 60 percent in-network discount vary between specialties?

MR. HAYCOCK:
The discounts vary. Sixty percent is an average. Some services have no discounts. It varies widely depending on what our networks can contract to help drive down costs.

SENATOR GANSERT:
When providers offer a minimal discount, is it because there are fewer people in that practice? Or is it because of the specialty?

MR. HAYCOCK:
It varies by provider. I will relay an anecdotal story. There is an individual on our plan with a rare disease. There is only one provider in the State who can treat

this person. The provider is out-of-network. We have successfully negotiated with the provider. To pay the provider 80 percent of the FAIR Health UCR, we would be liable for hundreds of thousands of dollars.

SENATOR GANSERT:
Is that someone with a chronic disease versus someone who went for emergency services?

MR. HAYCOCK:
Yes. The patient has a chronic disease. We continue to negotiate with urgent care or emergency room care who are out of our networks and have some high costs compared to something 60 miles down the road. The bill would guarantee those prices. If the patient does not get balance billed, then what happens when we are paying more for services we do not have to? How does that get assimilated to the membership? It increases rates.

SENATOR GANSERT:
I disclose that my husband is an emergency physician and I used to work in health care management and understand the business of medicine. My observations indicate there is a spectrum of negotiated rates depending on how many specialists are in a field. In the emergency room, it is difficult because people need to be taken care of right away. We need to maintain providers for access to care. Since the Affordable Care Act was enacted, the volume has increased extensively and most people have Medicaid or insurance.

SENATOR HARDY:
Please be reminded the percentile explained in the FAIR Health presentation, Exhibit D, is not a percentage. It shows the eightieth percentile is $108 in the data presented. The difference between percentile and percent is critical to be aware of. I want to ensure in the amendment a doctor who participates in out-of-network, agrees to accept the eightieth percentile of data. Some of the objections in testimony, including fiscal notes, were created prior to the amendment, Exhibit C. Data can be created for rural areas. Data from FAIR Health is non-conflicted. Will the doctors in the room stand if they like this bill? As you can see, there are many doctors standing. Predatory practice disappears with this bill. It is designed to protect the patient, and to avoid surprise billing. The amendment covers the issue of a patient using an out-of-network provider intentionally. Senate Bill 289 proposes a solution to out-of-network issues.

CHAIR ATKINSON:
I will close the hearing on S.B. 289 and open the hearing on S.B. 346.

SENATE BILL 346: Clarifies provisions governing the prescribing, dispensing and administering of drugs. (BDR 54-676)

SENATOR JOSEPH P. HARDY (Senatorial District No. 12):
Senate Bill 346 governs the practice of prescribing, dispensing and administrating drugs. An article from *The Journal of the American Medical Association* dated March 21, 2017, titled "Metformin for Prediabetes," states:

> Recent guidelines recommend considering use of metformin in patients with prediabetes (fasting plasma glucose 100-125mg/dL, ...), especially in those who are <60 years old, have a BMI >35 kg/m², or have a history of gestational diabetes. Metformin has not been approved for such use by the FDA.

Metformin has been approved for type 2 diabetes. The challenge is determining what medicines can be utilized for other uses and still be in accordance with the guidelines of the Board of Medical Examiners. Other medicines, approved by the U.S. Food and Drug Administration (FDA), have physiologic properties which can be used in other medical treatments.

There is a doctor at Loma Linda University Medical Center who runs a pulmonary clinic. She was trying to get her patients to quit smoking and was largely unsuccessful. She noticed there was a subgroup who quit smoking, and she was challenged as to why they quit. This group was on a medicine called Wellbutrin for depression. She began a study and discovered using Wellbutrin had up to a 50 percent chance of helping someone quit smoking. The pharmaceutical company discovered Wellbutrin was being used for smoking, so created an FDA-approved drug, Zyban, for smoking cessation. This is a common process in developing a use for a medicine which has been indicated and approved by the FDA for another use.

If a person has diabetes with diabetic neuropathy, it is not unusual for a physician to use Amitriptyline, the generic name for Elavil, for relief of the burning sensation in the feet caused by peripheral neuritis. It is not approved by the FDA for this use.

Physicians disclose to patients when prescribing a drug originally designed for one treatment, it is being used as a treatment for a different condition. Senate Bill 346 allows medical personnel who prescribe medicines to be able to use off-label medicines.

WELDON HAVINS, M.D., J.D. (President, Nevada State Medical Association):
I am a physician and a practicing attorney. I am an ophthalmologist and teach health law at Touro University Nevada. I am the president of the Nevada State Medical Association. The Nevada State Medical Association supports S.B. 346. Current medical practice commonly uses off-label medications. These medications have been established as safe and effective for treating a particular disease. It is often discovered the medication is useful for another disease. Twenty to thirty percent of medications prescribed are off-label, meaning the use of pharmaceutical drugs for an unapproved indication. It is common practice.

Medications are prescribed for various reasons. One is cost. There is a drug used to treat wet macular degeneration, the most common cause of legal blindness in adults. The wet form involves new vessel growth in the back of the eye. It has been difficult to treat until a drug called Macugen was introduced. It is injected into the eye once a month for several months. The cost is $800 per injection. Another drug called Avastin, used for cancer treatment, has similar properties to Macugen. In an experimental trial, Avastin was found to be just as effective as Macugen. The cost for Avastin is $8. Cost savings for the patient is often considered when using off-label drugs.

The treatment for obesity is called phentermine. It is a controlled substance approved for 90 days. Phentermine combined with a drug called topiramate, originally used for seizures, is the most effective medication treatment for obesity. The combination product of phentermine and topiramate is called Qsymia. The cost of Qsymia is $200 per month. Phentermine costs $11 per month, and topiramate costs $10 per month. These lower cost drugs are being used in obesity clinics across the U.S. for the patients' benefit.

Sometimes a drug is used because it may be the only effective treatment for a condition. Minipress is a drug developed and approved for the treatment of high blood pressure. Minipress has been found to be very effective for bed wetting in children and adults. It is an invaluable product used off-label.

I am on the Division of Health Care Financing and Policy, Pharmacy and Therapeutics Committee. The Pharmacists on the Committee claim that up to 40 percent of patients do not fill their prescriptions because of costs of drugs. Costs are a factor for patients. Using off-label medications is effective as a treatment for conditions the medication was not originally developed for.

Some say S.B. 346 is not good because it provides immunity to health care providers. The word immunity does not appear in the bill. It does not reduce the ability of plaintiffs' attorneys to sue in civil court for patients injured by medications on- or off-label. The bill will prevent licensing boards from sanctioning physicians for using medications off-label as long as the medications have a rational scientific basis, have been used in trials and have been found effective for the disease. Off-label prescribing is a fact of life.

SENATOR SPEARMAN:
Would you repeat the information from pharmacists stating many people do not get their prescriptions filled?

DR. HAVINS:
I am one of the physicians on the Pharmacy and Therapeutics Committee. The pharmacists tell me up to 40 percent of patients do not fill prescriptions as prescribed. They refuse the medications because of costs. They often can only afford half of the prescription cost. This is often not clinically effective. With the costs of pharmaceuticals rising, this is not just a Nevada situation. Many physicians in the U.S. are using effective off-label pharmaceuticals, and costs are one of the reasons.

JASON WASDEN (President's Employee Benefits Advisory Committee, University of Nevada, Las Vegas):
I am a member of the University of Nevada, Las Vegas, Benefits Advisory Committee and Chairman of the Administrative faculty. We support S.B. 346.

MR. LEE (Board of Medical Examiners):
I am representing the Board of Medical Examiners and the Nevada Association of Health Plans on S.B. 346. When a physician prescribes an off-label drug, it is not considered out of the physician's scope of practice. The Board of Medical Examiners has submitted a conceptual amendment (Exhibit H) to delete in Section 1, "... is not subject to professional discipline ...". A physician who prescribes off-label drugs is not violating the applicable standard of care, but

may still be subject to discipline. The language needs to be deleted because section 1, subsections 1, 2 and 3 apply to whether the physician has provided the appropriate standard of care. This can only be decided in a legal hearing if a complaint is filed against a physician.

The Nevada Association of Health Plans has submitted a conceptual amendment (Exhibit I) to add a new section to the bill. Health plans' formularies are developed as part of their plans. The added language makes it clear that prescribing a drug pursuant to this law does not require health insurance plans to pay for or cover the costs of the drugs unless prescribed for the purposes approved by the FDA. It also allows plan immunity from liability for any injuries to the patients resulting from the use of off-label drugs.

CHAIR ATKINSON:
I have written testimony from Wendy Stolyarov of the Libertarian Party of Nevada (Exhibit J) supporting S.B. 346.

BILL BRADLEY (Nevada Justice Association):
The Nevada Justice Association opposes S.B. 346. We believe patient safety and protection are imperative. The language throughout the bill provides immunity to physicians for the unreasonable dangerous off-label prescription of drugs. Appropriate off-label prescriptions can be good. It can also be a bad thing. There are articles written about the hazardous consequences of off-label prescriptions. Conscientious physicians, who do their research and believe a drug is useful for a condition and provides the appropriate information to patients, should be given that opportunity. Some patients have not been given information about the risks and benefits of an off-label prescription, and horrendous physical complications have occurred. There is no accountability for the patient for improper off-label prescribing in S.B. 346. There are studies supporting and studies criticizing a drug for a particular use. This bill will eliminate the consideration of the studies that criticize a drug and would provide protections to a physician if the prescription is recklessly written. We oppose any bill impacting patients' rights to hold unreasonable physicians accountable or providing immunity to drug manufacturers encouraging off-label use of medications without proper testing and disclosure.

SENATOR HARDY:
In answer to some of the opposition, disclosure to the patient about prescribing an off-label medicine is important. The amendments need to be clarified. In

South Dakota in the Air Force, I knew a woman who had Raynaud's Phenomenon, which made her hands go blue, white and red. South Dakota is very cold. Knowing the physiology of Raynaud's, I gave her Minipress. It changed her life, and she did not worry about going outside in South Dakota again. The New England Journal of Medicine later released a report that Minipress will work for Raynaud's Phenomenon. This is how medicine works.

CHAIR ATKINSON:
We will close the hearing on S.B. 346 and open the hearing on S.B. 436.

SENATE BILL 436: Prohibits certain discriminatory designs for prescription drug benefits in health benefit plans. (BDR 57-996)

KRYSTIN HERR LARKIN (Immune Deficiency Foundation; ACT for Nevada):
The Immune Deficiency Foundation supports S.B. 436. Patients with chronic conditions are only afforded one type of health coverage for their specialty medications. Their drug formulary employs a caution requirement known as coinsurance. Coinsurance requires a percentage of the drug costs be paid out-of-pocket by the patient which is often 40 percent of the prescription costs. With specialty medications having this co-requirement, patients with chronic conditions are left paying high costs for their medications. Cost-sharing requirements are usually applied after the patient's deductible has been met, which leaves many patients charging to the maximum limits of their credit cards in the first few months of their plan coverage.

Senate Bill 436 will require health plans and insurers to have at least 25 percent of their offerings within each level of coverage allow for a flat dollar co-payment structure be available before the patient's deductible has been reached. The bill will ensure the co-payment structure is reasonably graduated between the different formulary tiers. It will prohibit all prescription drugs within a given class be placed on the highest cost tier. The provisions would apply to the entire drug benefit.

Colorado and Montana have taken steps to ensure patients with chronic conditions who take high cost specialty medications are not discriminated for only having health care coverage choices in which coinsurance is imposed on their medications. By requiring just one-quarter of the plans within each coverage level have this pre-deductible co-pay structure, it is providing families the option to select a plan fitting their financial needs. Health plan insurers are

still able to offer a variety of cost-sharing structures within their other plan designs. I have written testimony from ACT for Nevada strongly supporting S.B. 436 (Exhibit K).

LYNN ALBIZO (Director of Public Policy, Immune Deficiency Foundation):
I am here to testify on behalf of the Immune Deficiency Foundation (IDF). I will read from my written testimony (Exhibit L). The Immune Deficiency Foundation supports S.B. 436. This bill offers a balanced approach and not a cap on co-pays. It provides options for patients. A patient choosing a plan with a higher premium will be able to predict what the co-pays will be.

SENATOR SPEARMAN:
Would this bill apply to senior citizens?

MS. ALBIZO:
Yes, it is not limited to patients with chronic conditions. It is providing patients choices in choosing their insurance plan. Most senior citizens are enrolled in Medicare. This bill focuses on private insurance. We are introducing it because of our concern for people with chronic conditions who require expensive medications. Many are still unable to afford their medications even with insurance.

SENATOR CANCELA:
Can you expand upon the pricing of drugs? It starts with the manufacturers, works its way through the pharmacy benefits managers (PBMs), the insurers and then the customers, who are the last entities on the chain of pricing. By starting at the insurance section of the chain, it does not get to the root of the problem. How do you propose dealing with high manufacturer costs as well as the interaction S.B. 436 proposes with PBMs by regulating them? It puts the scheme of how drug prices are set into collusion.

MS. ALBIZO:
There are many concerns about drug pricing, and there is conflict between the health insurance companies and the pharmacies. We are considering the issues from the patients' points of view. Senate Bill 436 will take effect for them right away. We are not taking a position on the top of the chain, the manufacturers. This bill could still apply if the costs are addressed. We are looking at what the costs are to the outcome of the patients by making an affordable option. It is reasonable because it gives them alternatives for choosing their health plans.

SENATOR CANCELA:
My concern is with the drug manufacturers continuing to drive up drug prices, and the negotiation chain continues to be dysfunctional for consumers. Regardless of consumer protections being put in place, the root of the problem is the cost of drugs, and this issue is not being addressed. I agree consumers need more choices and protections, I struggle with a solution that does not address the root of the problem.

MS. ALBIZO:
With IDF and other patient groups, there are fewer choices since generic medications are not available for their conditions. The available medications are life-saving, and we do not want to inhibit their availability. We are not taking sides on the issue of drugs' costs.

MELANIE DANIEL:
I will share my story about living with a severe, life-threatening condition and the challenges I face in affording the high co-pays for the medications I need. I have common variable immune deficiency (CVID) which is a primary immune deficiency. People with CVID are highly susceptible to infection from foreign invaders such as bacteria, or more rarely, viruses, and often develop recurrent infections, particularly in the lungs, sinuses, and ears. To fight infections, I take weekly infusions of immunoglobulin. I will need to take the treatment for life to maintain my health. I take 25 other medications, including antibodies 2 times per day. If I do not take these medications, I could become very ill. I was forced to skip some treatments because of the high costs of the medications, and I succumbed to pneumonia. I have had pneumonia 14 times. My medications and treatments cost $9,000 per month. There are no generic drug alternatives. I have health insurance through the State. I am disabled and no longer able to work. My husband and I have limited resources and do not have available funds to pay for my medical care.

Even with health insurance, my coinsurance for my immunoglobulin medication requires a 20 percent co-pay. I must meet my deductible at the beginning of the plan year, which begins July 1. Last year, my husband secured a new credit card to cover the costs of my medications. Passage of S.B. 436 would enable me to choose a plan with flat-fee co-pays. It also enables me to plan my expenses for the year rather than pay huge upfront costs for my medications. I will not be forced to skip some treatments which puts my health at risk. It is

important legislation for me and others like me who have life-threatening chronic conditions and cannot afford treatments.

MR. WASDEN:
The University of Nevada, Las Vegas, President's Employee Benefits Advisory Committee supports S.B. 436.

CHAIR ATKINSON:
I have written testimony in support of S.B. 436 from Thea Zajac, of the Leukemia & Lymphoma Society (Exhibit M) and James D. Lee, Neuropathy Action Foundation (Exhibit N).

MS. CAPURRO:
The Health Services Coalition represents 350,000 members. It is union and employer self-funded plans. We are funded not-for-profit plans. Mandates impact our ability to provide care to our members. It is concerning for the Health Services Coalition to be mandated to provide health coverage when there is no accountability to the pharmaceutical companies and drug pricing. We would like to see pharmaceutical pricing be addressed.

MR. BEAMAN:
The Clark County Firefighters have concerns with S.B. 436. To manage our plans, we look first to using low-cost drugs. The maximum amount a member can be out-of-pocket is $6,800, which includes treatment, prescriptions, co-payments and deductibles. Our concern is limiting our charges to our members. We will meet with the sponsor with our concerns for those members who have high-deductible plans.

MR. LEE:
The Nevada Association of Health Plans opposes S.B. 436. Thirty-five percent of insured citizens in Nevada are in plans managed by the Commissioner of Insurance. Many are under the Employee Retirement Income Security Act of 1974 or Taft-Hartley plans and would not be directly affected by this legislation. Premium mandates are paid by everyone, even those not directly affected. The effective date of the bill is January 1, 2018. The Nevada Association of Health Plans is in the process of developing health plans for 2018 which are required to be submitted to the Commissioner of Insurance in June. It is impossible and impractical for the effective date to apply to health plans.

JOHN SANDE IV (Express Scripts Holding Company):
Express Scripts Holding Company opposes S.B. 436. Our concerns have been covered in testimony opposing the bill, and we agree with those concerns.

MR. HAYCOCK:
The PEBP Board is scheduled to meet regarding S.B. 436. There are some administrative challenges to the bill. The effective date of January 1, 2018, is an issue. Our plan year is July 1 through June 30, the same as the State's fiscal year. The mid-year requirement would affect PEBPs benefit programs. We offer a single self-funded group insurance health plan including the health savings account and health reimbursement arrangement governed by the Internal Revenue Service (IRS). We do not have another co-pay plan we can implement quickly. The 25 percent policy to apply a co-payment structure before payment of a deductible requirement is not applicable to PEBP. The IRS will not allow us to offer a health savings account on a high-deductible health plan unless we have coinsurance, co-pays and out-of-pocket maximums. We cannot specifically carve out a benefit for pharmaceuticals that is different.

This bill would nullify our ability to offer the health savings account and may end our consumer-driven health plan. It is a great motivator to our participants. The amount of money saved since 2011 when we implemented our consumer-driven health plan is significant, and there are many participants on our plan today who like and are motivated to have the health savings account. The pre-tax dollars help pay for their health care.

We are concerned the bill will alter PEBP as an agency. We just approved contracts for our health maintenance organization (HMO) contracts for the next plan year. These all include plans that offer a co-insurance amount for specialty drugs. There could be significant administrative burdens.

GLENN SHIPPEY (Division of Insurance, Department of Business and Industry):
The plan benefit design mandated by S.B. 436 would not be compliant with the U.S. Department of the Treasury's rules for high deductible plans. High deductible plans do not pay on any claims before the deductible is met by the insured except for preventive care services. We have some health insurance carriers who only offer high deductible plans in some of our markets. Those carriers could not comply with this mandate.

MS. LARKIN:
From the patient's perspective, providing options not currently available is an important issue. The flat co-payment structure is an option because the lower tiers have coinsurance. We understand the concerns for costs of pharmaceuticals. The bill seeks to improve access to affordable and transparent coverage for medications. This is important for consumers when they are selecting the best health insurance for their needs. We will address the concerns with those in opposition and in the neutral position to the bill. It is our intention for a seamless rollout of the mandates in the bill. We will work on the effective date portion.

CHAIR ATKINSON:
We will close the hearing on S.B. 436 and open the hearing on S.B. 262.

SENATE BILL 262: Revises provisions concerning payments for treatment relating to mental illness or the abuse of alcohol or drugs. (BDR 57-455)

SENATOR PATRICIA FARLEY (Senatorial District No. 8):
Senate Bill 262 addresses inpatient mental health or drug addiction services. I will explain the bill from the perspective of families of patients admitted to mental health or drug and alcohol addiction treatment centers. When a person who is suffering from mental health or drug addiction agrees to treatment, the family has hours to find a treatment option, not days or weeks. Although families may work with their health insurance carriers, there may not be an available treatment center in their insurance plan at the time the family member agrees to treatment. Many times, the only options are out-of-network providers or out-of-state facilities. It is often a life or death situation.

The bill specifically focuses on the out-of-network provisions of a health insurance plan. If the out-of-network benefits are available, the patient typically signs an assignment of benefits form. An assignment of benefits is an agreement by which patients request that their health benefit payments be made directly to a designated medical provider. The signed agreement is usually honored by the insurance carrier.

Sometimes, the insurance company will pay the patient instead of the provider, 30 to 60 days later, thus giving a person in rehabilitation or mental health inpatient care a huge check, which is not a good thing. Often a check of that nature will be spent on the very thing for which the person is seeking treatment.

I have personal knowledge of this happening to a family member of mine who spent the money from a check meant for the provider on the Las Vegas Strip. That person returned to using drugs and had zero funds left. The provider was not paid for the services provided. It is a serious issue to give a person in need of treatment a large check. If the person is in drug treatment, there is a serious concern the person will overdose. The money allows a person to spend it on questionable behaviors.

Senate Bill 262 requires that every payment made pursuant to a health insurance policy for treatment related to mental health, alcohol or drug abuse be made directly to the provider of the treatment. A licensed clinical and alcohol and drug abuse counselor is also included in those providers that must be directly reimbursed for providing such treatment.

The measure expressly allows such a provider to refund to a person receiving treatment any amounts that the person paid to the provider. The bill extends these requirements to benefits provided through self-insurance by local government agencies, self-insurance by PEBP and employers who provide benefits through individual, group and blanket health insurance policies.

There is a Proposed Amendment 3356 (Exhibit O).

DAVID MARLON (CEO, Solutions Recovery, Inc.):
Solutions Recovery supports S.B. 262. We are one of the largest drug and alcohol treatment providers in Nevada. For decades, insurers and payers have been utilizing assignment of benefits agreements. It is standard practice in the insurance industry. It allows the insurer or payer to pay the provider directly. Some payers have not been complying with the assignment of benefits. They pay the benefit funds directly to the beneficiary. In the case of drug and alcohol treatment, this is particularly dangerous and deadly. Some families are terrified a check may be sent to the patient. Other families have lost loved ones who were new in recovery, received a check, spent the money on drugs or alcohol and overdosed. I know of a woman in recovery who received a check, spent the money on alcohol, then committed suicide out of remorse. There is no additional cost for insurers in S.B. 262. It is simply proposing insurance companies honor the assignment of benefits and to pay benefits to the provider, not a newly recovering person with addiction.

SENATOR SETTELMEYER:
In cases of urgency, sometimes the parents or a loved one pays a recovery center immediately regardless of available benefits. What happens when a person pays the center? How do we ensure the payer gets the funds returned if the facility is paid once insurance is settled?

MR. MARLON:
Drug and alcohol treatment centers are acutely aware of the dangers of newly recovering patients receiving refunds or payments. If a payment was made at our facility by a family member, and the patient did not stay, a refund is due. We attempt to return the funds to the family member or a fiduciary rather than a newly recovered patient. Senate Bill 262 applies to plan payments and assignment of benefits, not direct patient payments.

SENATOR FARLEY:
Whether it is insurance-based or out-of-network, the first question asked by the provider is about the assignment of benefits. The patient signs the assignment of benefits upon admittance to a facility. The provider then feels comfortable payment will be made. The bill addresses those times when for some reason, the insurers pay the patient instead of the provider even though an assignment of benefits form is signed. The insurers do not want to encourage out-of-network providers getting paid. We are not asking the insurance companies to create new policies or practices. The bill seeks the enforcement of the assignment of benefits, especially when it is detrimental to patients whose conditions are related to mental health or addiction.

SENATOR HARDY:
In S.B. 262, section 1, subsection 2 states a provider may refund to the person who received the treatment not more than any amount that the person who receives the treatment paid directly to the provider for the treatment. Does that mean payment is given to the person who made the payment? Perhaps the language could be tightened up so the family member who funded the treatment gets paid instead of the person who benefited from the funding by the family member.

MR. MARLON:
The bill was drafted to direct insurers to pay providers directly. If there is a case of overpayment, or a family member paid in advance, there is a mechanism

within this bill for the money to be refunded from the provider, not the insurer to the beneficiary.

SENATOR HARDY:
I understand that mechanism, but the refund has to go somewhere. Suppose an addict goes into treatment and does not stay, and the only funds expended were a prepayment amount. Does that prepayment go to the patient or the person who originally funded it?

MR. MARLON:
Transactions are typically made by credit card, and the refunds are applied directly to the credit card. In some cases, the patient pays and refunds are due to the patient.

SENATOR HARDY:
I agree.

SENATOR GANSERT:
The issue is making sure whoever paid the money is refunded the money.

SENATOR FARLEY:
I agree. We can add language clarifying a refund should go to the payer who advances said funds.

SENATOR SPEARMAN:
Section 3 of the bill states a clinical alcohol and drug abuse counselor who is licensed pursuant to chapter 641C of *Nevada Revised Statutes* must be directly reimbursed for providing such treatment. Is it possible to put some type of a true-up mechanism in the bill so if it is a parent or someone else who pays and the patient does not stay in treatment, there be a certain time limit given for the refund?

SENATOR FARLEY:
I will reach out to the provider community and ask what the standard policy is and see if we can add some time limit language.

CHAIR ATKINSON:
I have written testimony in favor of S.B. 262 from Steven Cohen (Exhibit P).

JESSE WADHAMS (Anthem Health Insurance Company of Nevada):
Anthem is opposed to S.B. 262. The bill muddies up current law, which is a fairly clear and working system. A number of laws cover and promote the use of assignment of benefits under a policy of insurance. The assignment of benefits functions as the bill proposes. The health insurer directly pays the provider. Nevada law promotes the assignment of benefits. A health insurer who ignores an assignment and pays the individual incorrectly owes the payment to the provider immediately upon notification of the error. Occasions when payment is made to the individual are rare. We think the issue arises when an out-of-state insurer pays under a contract made to an out-of-state individual. If a Californian with a California insurance policy uses the benefit in Nevada, that contract is governed by California law.

MR. LEE:
The Nevada Association of Health Plans opposes S.B. 262. I echo the comments of Mr. Wadhams. Refunding to the person who receives the treatment, in section 1, subsection 2 appears to be discretionary, and it should be a mandatory payment. The bulk of the problem is with the out-of-state insurance companies, especially with respect to drug and alcohol addiction issues. Often these individuals want to be away from their homes for treatment. We need to create a safe harbor in the bill so if an insurance company pays directly to the provider without an assignment of benefits, such a situation constitutes payment in full under our obligation to the insured and does not give the insured a cause of action against the insurance company for making the direct payment to the provider.

SENATOR HARDY:
Section 1, subsection 2 states the provider may refund. It sounds like the provider has the option not to pay the money back at all.

MR. LEE:
That is the way I read it, subject to legal counsel advising otherwise.

SENATOR HARDY:
So, are you for refunding money that was not due?

MR. LEE:
As I read this, it is the provider who receives the money. If there is any money due back to the patient, it should say “shall refund” rather than “may refund.”

SENATOR SETTELMEYER:
Are you indicating the problem is out-of-state providers sending a check to Nevada to a patient in a rehabilitation facility?

MR. WADHAMS:
We think this is a rare situation in which the assignment of benefits may not be effective because, under Nevada law, the insurer may be liable for a double payment. We think it could be out-of-state patients with out-of-state insurance seeking treatment in Nevada that may be the issue.

MR. LEE:
Nevada law is binding on assignment of benefits and creates an obligation that is enforceable. We do not know what other states' insurance laws are on assignment of benefits or if their laws are enforceable in Nevada.

SENATOR FARLEY:
This bill refers to insurance plans and patients covered and governed by Nevada laws. Under those laws, the bill proposes to enforce insurers who engage in the assignment of benefits agreements be forced to pay the provider per the agreement and not the patient. The insurance carriers are against this because it is a tool to make doctors and providers contract with them. They do not like to pay out-of-network or non-contracted doctors. This bill applies specifically to not paying a person who can create danger to themselves.

CHAIR ATKINSON:
We will close S.B. 262 and open the work session on S.B. 201.

SENATE BILL 201: Enacts provisions relating to conversion therapies. (BDR 54-301)

MARJI PASLOV THOMAS (Policy Analyst):
I will read the summary of the bill and the amendments from the work session document (Exhibit Q).

SENATOR HARDY:
The amendment clarifies many things. One of the challenges I still have is the ecclesiastical leader who believes in chastity before marriage and fidelity afterwards. When a professional counselor counsels someone but is acting in his or her ecclesiastical role, I do not see where he or she is protected. The bill

limits a person's own agency to ask for help for a sexual addiction or something that could be construed as a behavior.

CHAIR ATKINSON:
I will entertain a motion on S.B. 201.

SENATOR SPEARMAN MOVED TO AMEND AND DO PASS AS AMENDED S.B. 201.

SENATOR CANCELA SECONDED THE MOTION.

THE MOTION PASSED. (SENATOR HARDY VOTED NO.)

* * * * *

CHAIR ATKINSON:
I will close the work session on S.B. 201.

Remainder of page intentionally left blank; signature page to follow.

CHAIR ATKINSON:
Hearing no further business, I will adjourn the meeting at 10:30 a.m.

RESPECTFULLY SUBMITTED:

Christine Miner,
Committee Secretary

APPROVED BY:

Senator Kelvin Atkinson, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	1		Agenda
	B	7		Attendance Roster
S.B. 289	C	4	Senator Joseph P. Hardy	Proposed Amendment
S.B. 289	D	18	Christine O'Donnell / FAIR Health, Inc.	Presentation
S.B. 289	E	4	Christine O'Donnell / FAIR Health, Inc.	Written Information
S.B. 289	F	2	Bret Frey / American College of Emergency Physicians	Written Testimony
S.B. 289	G	2	Dean Polce	Written Testimony
S.B. 346	H	1	Keith Lee / Board of Medical Examiners	Conceptual Amendment
S.B. 346	I	1	Keith Lee / Nevada Association of Health Plans	Conceptual Amendment
S.B. 346	J	1	Wendy Stolyarov / Libertarian Party of Nevada,	Written Testimony
S.B. 436	K	2	Krystin Herr Larkin / Immune Deficiency Foundation	ACT for Nevada Written Testimony
S.B. 436	L	2	Lynn Albizo / Immune Deficiency Foundation	Written Testimony
S.B. 436	M	2	Thea Zajac / Leukemia & Lymphoma Society	Written Testimony
S.B. 436	N	1	James D. Lee / Neuropathy Action Foundation	Written Testimony
S.B. 262	O	6	Senator Patricia Farley	Proposed Amendment 3356
S.B. 262	P	1	Steven Cohen	Written Testimony
S.B. 201	Q	4	Marji Paslov Thomas	Work Session Document