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

Eightieth Session
March 15, 2019

The Committee on Commerce and Labor was called to order by Chair Ellen B. Spiegel at 1:35 p.m. on Friday, March 15, 2019, in Room 4100 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/80th2019.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Ellen B. Spiegel, Chair
Assemblyman Jason Frierson, Vice Chair
Assemblyman Skip Daly
Assemblyman Chris Edwards
Assemblywoman Melissa Hardy
Assemblywoman Sandra Jauregui
Assemblyman Al Kramer
Assemblywoman Susie Martinez
Assemblyman William McCurdy II
Assemblywoman Jill Tolles
Assemblyman Steve Yeager

COMMITTEE MEMBERS ABSENT:

Assemblywoman Maggie Carlton (excused)
Assemblywoman Dina Neal (excused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Karen Easton, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Heidi Englund, Private Citizen, Reno, Nevada
Kent Ervin, representing Nevada Faculty Alliance
Tom Clark, representing Nevada Association of Health Plans
Tray Abney, representing America's Health Insurance Plans
Chelsea Capurro, representing Health Services Coalition
Mike Ramirez, Director of Government Affairs, Las Vegas Police Protective Association Metro, Inc.
Thomas D. Dunn, District Vice President, Professional Fire Fighters of Nevada
Les Lee Shell, Chief Administrative Officer, Office of the County Manager, Clark County
Elizabeth VanDeusen, Executive Director, Nevada Chapter, National Hemophilia Foundation
Joseph González, Private Citizen, Las Vegas, Nevada
Bobbette Bond, Senior Director of Health Policy, Unite Here Health
Maya Holmes, representing Culinary Health Fund
Elizabeth MacMenamin, Vice President of Government Affairs, Retail Association of Nevada
Damon Haycock, Executive Officer, Board of the Public Employees' Benefits Program
Steven Parker, Immediate Past President, Nevada State Medical Association
Catherine M. O'Mara, Executive Director, Nevada State Medical Association
Robert Talley, Executive Director, Nevada Dental Association
John DiGrazia, Private Citizen, Reno, Nevada
Jesse A. Wadhams, representing Nevada Hospital Association
Helen Foley, representing Delta Dental Insurance Company

Chair Spiegel:
[Roll was called. Committee rules were explained.]

[Assemblyman Frierson assumed the Chair.]

Vice Chair Frierson:
I will now open the hearing on Assembly Bill 185.

Assembly Bill 185: Revises provisions relating to insurance coverage of prescription drugs. (BDR 57-277)

Assemblywoman Ellen B. Spiegel, Assembly District No. 20:
Assembly Bill 185 requires an insurance company to credit an insured's deductible with the amount paid by the insured for a covered prescription drug for which the insured paid a cash price instead of using their coverage. There has been a lot of confusion about this bill. I am going to walk you through an example which enables patients to manage their costs (Exhibit C). The example on page 3 uses levothyroxine, a very common drug for people

with an underactive thyroid. I reviewed an Explanation of Benefits (EOB) and went to the goodrx.com website and searched levothyroxine 50 micrograms, quantity 90. On the EOB I looked at, it referred to the base price of the drug as $35.99; the cost to the patient was $15; which left the cost to the insurance company of $20.99. Had the patient decided to fill their prescription at Walmart, they would have paid a cash price of $10, and the insurance company would have paid $0. This would have saved the insurance company $21 and the patient $5. If the same patient belonged to the Smith's membership, the patient would have paid $12, and the insurance company would have paid $0, with a cost savings to the patient of $3 and a savings to the insurance company of $21. If the same patient wanted to look at different drugstores to fill their prescription, they would have seen the other available alternatives. Someone who is cost sensitive is not going to fill a prescription at one of the higher pharmacies when it is cheaper through their insurance. This example shows the patient is saving money, the insurance company is saving money. Assembly Bill 185 is simply asking the insurance company to give the patient credit for the money they have spent and the savings they accrued for the insurance company. That credit comes in the form of being counted towards their deductible.

The various sections of A.B. 185 include which types of insurance plans are covered [page 4, (Exhibit C)]. If you look at the fiscal notes, there is confusion about the bill. People do not understand the revision to the bill is not for things that are not covered; it will actually save the insurance providers money. In section 10, I want to change the word "must" to "may" for the county entities, which would remove the fiscal note. When they realize it will save them money and is better for their insured, they will then be able to take advantage of it.

To clarify the legislative intent, it only counts toward what the insured pays out of pocket. If they use a manufacturer's coupon, the value of the coupon does not count; it is only what they are actually paying. If the plan has a separate prescription drug deductible, it must count toward that deductible. If the plan does not have a separate prescription drug deductible, it must count toward the plan deductible and their out-of-pocket maximum.

Currently, pharmacies do not have the technical capability of sending this to the insurance companies. If you are getting a prescription and not going through insurance, there is no relationship; they cannot transmit it electronically. If they have the capability to do it, they may do it. I know it does not exist today, but that does not mean it will not exist in the future. I would like it specified in the bill so there is no hurdle down the road when technology evolves. This would mean that people who are insured can submit their claims manually. This is not asking for the insurance companies to send them monies for the claims, it is to give them credit for what they are paying out of pocket. It does not apply to medications that are not covered by the plan.

Vice Chair Frierson:
You mentioned an amendment to address the fiscal notes which would change "shall" to "may." Is that everywhere in the bill?

Assemblywoman Spiegel:
No. Change the word "must" to "may," in section 10, line 19.

Assemblyman Daly:
Is the amount shown on your example of $35.99 the already discounted price?

Assemblywoman Spiegel:
This particular EOB said retail price.

Assemblyman Daly:
So that was without whatever the preferred provider discount might have been?

Assemblywoman Spiegel:
That is correct.

Assemblywoman Tolles:
Do you have any estimates across the state? Have other states implemented this?

Assemblywoman Spiegel:
I do not have any estimates across the state. Even if someone is saving $5 a month and they only have one prescription, that still can make a difference—particularly when we look at how many of our families are still qualifying for free and reduced price lunches. The difference of one prescription can make a difference if somebody has other conditions that require more expensive prescriptions.

In answer to your second question, there are other states that have done similar things—they have actually gone further. They have typically included the value of the manufacturer's coupon in the amount credited back—it is called the co-pay accumulator. This can be helpful because it allows consumers and patients to pay down their deductibles faster. It often drives the costs up to the insurance companies. The insured will pay their deductible faster, and the insurance company will have more financial exposure in a quicker time period. That could possibly drive up the cost of premiums. I am trying to come up with a methodology that will provide some relief to consumers and patients, without unduly burdening the insurance companies, to create a win-win situation.

Vice Chair Frierson:
You mentioned other states had done this but had gone further. Do you know which states?

Assemblywoman Spiegel:
Most notably Colorado. I think a few other states have also put this forth; I will check on that. I have been working with stakeholders on this for months, which is the reason for the conceptual amendments. I know there is still some work to be done, but we are moving forward in the spirit of still working on it.

Vice Chair Frierson:
Is there anyone to testify in support of A.B. 185?

Heidi Englund, Private Citizen, Reno, Nevada:
I am an activist for multiple sclerosis (MS), and I am representing the National Multiple Sclerosis Society (Exhibit D). I am also a retired State of Nevada employee, medically retired due to multiple sclerosis. My reasons for supporting A.B. 185 are simple. The main disease-modifying treatment I am on is an infusion of Tysabri, which costs about $23,000 per month. My other prescription drugs include the generic form of Ampyra, which costs about $1,000 per month; and the generic form of Cymbalta, which costs about $200 per month. I need to have insurance coverage regardless of my MS diagnosis; secondly, I cannot afford to pay higher deductibles, premiums, and co-pays. It is necessary that any out-of-pocket costs be credited back to me, understanding the high cost of these drugs. Anyone who requires medication, whether the cost is low or high, needs the protection of this bill.

Kent Ervin, representing Nevada Faculty Alliance:
We are in favor of this bill in concept. It is a win-win if the participant can pay a lower price, and it is also a lower price for the insurance plan. Our members are participants in the Public Employees' Benefits Program (PEBP). The Legislature has empowered the PEBP board to make hard decisions about the balances of costs, so we appreciate the conceptual amendment to allow them to do their job. We are neutral on the specific mechanisms of the bill as far as how it would work for the out-of-network pharmacies; there would be some administrative issues there.

Vice Chair Frierson:
Is there anyone with testimony in opposition?

Tom Clark, representing Nevada Association of Health Plans:
The bill sponsor has been working with us for quite some time on the structure and framework of this particular piece of legislation. We rise in opposition simply because we oppose the framework that was put in the original bill. We oppose the legislation itself; however, when looking at the intent and the clarification presented today, a lot of what we asked for in compromise is here. The structure is here; it is the nuts and bolts of how it will be implemented that we have concerns with. We need to educate the insured so they understand that if they submit a claim with receipts for the cash they have paid, it will only be applied to the deductible—they are not going to receive a cash reimbursement. Many times when we submit receipts to our insurance company, we expect that the insurance company is going to then reimburse us for the costs that we have submitted. We need to work out those types of details in this particular piece of legislation. It is friendly opposition and we look forward to continuing to work with the bill sponsor.

Tray Abney, representing America's Health Insurance Plans:
We have the same concerns that Mr. Clark has. We will continue to work with the Chair to get this bill figured out.

Chelsea Capurro, representing Health Services Coalition:
The Health Services Coalition is a group of self-funded, nonprofit health plans which are mostly union and employer self-funded. We still have some concerns, one of which is coupons. Assemblywoman Spiegel mentioned a little bit about allowing the coupons—those are usually the co-pay accumulators when you actually use your insurance. This is not using your insurance. Most of the time a coupon is used because a pharmaceutical company is trying to build brand loyalty. A lot of the time a generic option is available. In order to encourage people to use a brand-name drug, they will issue coupons. Hopefully, by working with the sponsor, we can get to some kind of agreement.

Mike Ramirez, Director of Government Affairs, Las Vegas Police Protective Association Metro, Inc.:
We are part of the Health Services Coalition. We would like to thank the Chair for having meetings with us and having that open door. Right now we are in opposition with the same concerns as stated, but hopefully we can come to some resolution.

Thomas D. Dunn, District Vice President, Professional Fire Fighters of Nevada:
I echo the same concerns as the previous speakers. There are a couple of other issues we have and would like to get on the record. By trying to associate the co-pay with either the prescription deductible or health insurance deductible, someone has to process that. There will be additional costs on our self-funded plans because we will have to hire somebody to manually process this, as well as get the right dollars to the right bank. It also may cause confusion for our members as to whether or not their plan is covered. We do not want our members confused when they go to the pharmacy and try to figure out whether the co-pay will count or not. Another issue we have is that some of the formularies change quarterly. Based on brand recognition, a lot of our members use generic drugs as a form of cost containment. There is a concern if and when this would even apply to their plans.

Les Lee Shell, Chief Administrative Officer, Office of the County Manager, Clark County:
We are also a member of the Health Services Coalition. We represent about 20,000 lives and our plan covers about ten entities. I will just say that we echo what the previous speakers have said.

Elizabeth VanDeusen, Executive Director, Nevada Chapter, National Hemophilia Foundation:
While A.B. 185 is a good start for addressing some of the out-of-pocket costs patients face, it does not address the issue of medication affordability barriers. It is my hope that with a few edits, the bill could be very effective at protecting patients' abilities to afford their medications.

Our concern is, the bill only references cash pay by the insured. People with specialty medication for bleeding disorders and other chronic diseases cannot afford to cash pay. A co-pay for a bleeding disorder patient could be anywhere from $500 to $5,000 monthly with insurance. Because there are no generics available, the cash pay price is even higher

than the co-pay. Most of our families meet their deductible and out-of-pocket maximum within the first few months of their plan, which could be $2,000 to $4,000 for a deductible and $6,000 to $12,000 for max out-of-pocket. Coming up with thousands of dollars in a month or two is not affordable with the average Nevadan's income. Our families frequently access a variety of different programs, such as manufacturer assistance, co-pay cards, and charitable programs. These programs pay the co-pay or coinsurance to the insurer, helping the families meet their deductible and max out-of-pocket so that they can rely on their insurance to cover their monthly medication.

Insurers are using a new practice called the accumulator adjuster to not count third-party payments toward deductibles and max out-of-pockets. Not only does this negate charitable resources available to patients, on the second or third month patients still have to come up with thousands of dollars to continue their medication. Fortunately, this practice is not yet widespread in Nevada, but it is allowed by most plans per the fine print in their contracts, and it could be implemented at any time. Other states, such as Virginia and Arizona, are proposing legislation to ban it. I was encouraged by the bill, but disappointed because as currently written it does not block this practice. I hope you will consider adding the language "payments made on behalf of the insured" and specifying maximum out-of-pocket costs to fully protect Nevadans' ability to afford their medication.

I would like to challenge the viewpoint that, while it may have some impact on insurers, the patient implication of having to come up with thousands of dollars within a month's time frame to afford their lifesaving medication is a greater burden.

Vice Chair Frierson:
Have you provided your proposed language to the bill sponsor?

Betsy VanDeusen:
Yes. We have submitted it from the National Hemophilia Foundation (Exhibit E) and also the Nevada Chronic Care Collaborative (Exhibit F).

Joseph González, Private Citizen, Las Vegas, Nevada:
I would like to share with you the reasons why I do not believe A.B. 185 is effective or helpful to families like mine. After hearing my story, I hope you will be open to making a few small changes to the bill.

Assembly Bill 185 specifies cash pay only. In order to effectively help my family access charitable programs to afford our medications, we ask that you include the language "payment on behalf of the insured."

I am a Nevada resident and currently dealing with metastatic cancer and severe epilepsy. I have a wife who has a bleeding disorder and an autoimmune disease. I have five children who have had a number of chronic diseases. Our family deductible is $4,000 and max out-of-pocket is $11,000 per year. Our insurance benefits kick in after our deductible has been met. Many of our family's medications are considered "specialty medication." For

some of our medications, there are no generics. For others, such as my seizure medication, my doctor has ordered me to take a name-brand medication. When I tried taking the generic, my seizures increased drastically. My body responds better to the name brand so that I can help care for our family. My co-pay for the generic is $20 per month; my co-pay for the name brand is $780 a month. I am fortunate that the manufacturer of my medications has a charitable program called the "co-pay card," which helps pay for any medication and leaves me with a $40 co-pay. The insurance plan we recently had did not apply the $740 paid monthly by the manufacturer to my deductible or max out-of-pocket balance. The insurer claimed that since it came from a third party, they do not have to apply it. This is called the accumulator adjuster. Next month my medication will again be $780. The charitable program will pay $740, and I will pay $40. Again, none of the funds paid by the co-pay card will apply toward the deducible or max out-of-pocket. By month three, my co-pay card is maxed out. I will not have met my deductible and I will not be able to afford my seizure medication, cancer medication, or medication for my wife and children.

My family can budget to meet our deductible and max out-of-pocket, but we rely on a combination of co-pay cards and manufacturer charitable programs to help us reach the $4,000 deductible and $11,000 max out-of-pocket. Just to be clear, the insurer is still getting the money, just not directly from our bank account. If we did not use these programs, we would have to come up with the $11,000 in the first two months of the plan. If you pass Assembly Bill 185 as written, it does not specify that all forms and sources of payment need to be recognized or credited toward the deductible and max out-of-pocket.

Vice Chair Frierson:
Is your position that you oppose the bill because it is not going far enough? It seems to me it would be an improvement for you. Are you saying the current problems with the system would not be addressed?

Betsy VanDeusen:
We are talking about $40 versus $4,000. While the $40 is a help, it does not negate the problem that they still have to come up with $4,000.

Vice Chair Frierson:
So this bill does not hurt it, it just does not make it significantly better?

Betsy VanDeusen:
It does not address the elephant in the room of patient affordability.

Bobbette Bond, Senior Director of Health Policy, Unite Here Health:
We do not actually have a problem with the intent of the bill; I think we have a problem with the unintended consequences of the bill. I would like to highlight what Chelsea Capurro said regarding the impact of the coupons. The testimony you just heard talked about the difference between a brand-name and a generic. Often we see a coupon is provided for a high-end brand-name drug which, once a generic is available, they are trying to keep the market from moving to a generic. We have a problem with that, because the generics are

affordable and they are medically identical in their treatment. I do not want to challenge the testimony of the patient who has a lot of other challenges going, and there may be exceptions in the way generics work. But generics are a big solution and they bring down drug prices about 85 percent once they hit the market. There are a lot of reasons they do not get to market quickly enough—we support making sure they get there as quickly as possible. We run into barriers when the pharmaceutical company pays the patients' cost to keep people on the brand name by giving them coupons instead of moving them to generics. Medicare does not allow coupons; the state of Massachusetts does not allow coupons when there is a generic available. We would ask that it be made clear there is attention to not requiring us to add drugs that we do not cover; not requiring us to use pharmacies that we do not cover; and not allowing a brand name to be a coupon product in this program when a generic is available that the insurance company covers.

Maya Holmes, representing Culinary Health Fund:
I would like to share the concerns raised by the Health Services Coalition and the other members of the Coalition, of which we are also a member. We are opposed because we believe the bill does not meaningfully address the high cost of prescription drugs. The elephant in the room is that drug manufacturers can, and do, charge whatever they can force the market to bear, especially if they have patent exclusivity and they have a patient base that is in a desperate situation. As a result of these dynamics, the costs of prescription drugs continue to escalate at unsustainable rates, hurting patients and their families. We really need transparency in drug pricing, access to more generics, and ways to truly measure what is a reasonable price.

Vice Chair Frierson:
Is there anyone else with testimony in opposition? [There was no one.] Is there anyone with testimony in the neutral position?

Elizabeth MacMenamin, Vice President of Government Affairs, Retail Association of Nevada:
I represent the Chain Drug Committee with the Retail Association of Nevada. I would like to thank Assemblywoman Spiegel for bringing together the industry stakeholders to discuss this concept. The Retail Association's Chain Drug members are dedicated to assisting patients to obtain prescription drugs at the most cost-effective method possible—one good example is the chart [page 3, (Exhibit C)]. This shows the results of prescription benefit managers being able to negotiate prices with Big Pharma, and the manufacturers that set the price for the drugs. As you see highlighted, Smith's and Walmart negotiations were able to bring down the cost of the drug for these patients that required levothyroxine.

We appreciate the permissiveness of the language allowing pharmacies to submit health insurance deductibles. However, there is no technology available for sharing this information. A pharmacy benefit and health insurance plan are two different entities; typically, the two do not meet. Normally, you would not have a deductible on your pharmacy plan—you would have a co-pay. I have not heard of too many plans that offer

that. I do appreciate the Assemblywoman's ability to leave it permissive so if this does happen in the future, we have the ability to transmit the cash payment.

Damon Haycock, Executive Officer, Board of the Public Employees' Benefits Program:
We could not determine what the total costs would be as the bill was written. We understand the intent of this bill and for the most part, we actually adhere to it as it is written. We have similar language in our pharmacy contracts with our pharmacy benefits manager. So if the usual and customary price, which is the cash price, is less than the negotiated discount price, the pharmacy is supposed to submit the cash price which goes against the deductibles in our plan. The one caveat is that we only offer pharmacy benefits as an in-network benefit. There is no mechanism for an out-of-network pharmacy because we have a shared deductible on our plan. On our high deductible health plan, there is one deductible for pharmacy benefits and one for medical benefits. When an individual satisfies the deductible on one side or the other, there is real-time data sharing. That will not occur. Even if there is a manual claim process, it takes time and effort. As you heard from other testimony today, a live body will have to process that information. That was our only concern about the bill. We could not determine what actual costs would be to build that out. We appreciate the conceptual amendment which would change the word "must" to "may". We should be good partners and try to lower the costs of drugs for everybody.

Vice Chair Frierson:
Is there anyone else to testify in the neutral position? [There was no one.] Assemblywoman Spiegel, would you please come up to provide any closing remarks.

Assemblywoman Spiegel:
I would like to clarify one issue. In response to Ms. Bond's comments, I did not include the value of coupons in this bill. I also only included medications that are on the formulary of the plan. I know there is still some work to be done. I look forward to continuing working with my stakeholders. *Nevada Revised Statutes* 687B.113 refers to the control of health care and contains provisions encouraging the use of certain services and facilities. It specifically states, "An insurer shall include provisions in a policy of health insurance encouraging the insured's use, if medically appropriate, of services and facilities that are the most efficient or that tend to control or reduce the cost of health care." The provisions of this bill, and the legislative intent, fulfill that. I am looking forward to working with my stakeholders to reach a consensus which will help patients control the cost of their health care, bring down prices, and do it in a way that works for everybody.

[Written testimony of Kenia Leon in support of Assembly Bill 185 was submitted for the record (Exhibit G).]

Vice Chair Frierson:
I will now close the hearing on A.B. 185 and open the hearing on Assembly Bill 225.

Assembly Bill 225: Revises provisions relating to health insurance. (BDR 57-937)

Assemblywoman Ellen B. Spiegel, Assembly District No. 20:
I have more stakeholders on Assembly Bill 225 than I have had on any other bill. I began meeting with stakeholders on this bill last summer. The changes and amendments reflect input I received during those meetings as well as recent meetings. I would like to take a moment to walk you through the bill. Sections 1 through 4 of this bill talk about what happens when patients go to, or are taken to, an out-of-network emergency room due to the sudden onset of a serious medical condition that requires immediate medical attention. In these instances, health insurance companies would be required to count any deductible, co-pay, or coinsurance that the patient pays related to the incident toward their annual out-of-pocket maximum. The criteria laid out in section 2 details what is known as the "prudent layperson standard"—the 2017-2018 Interim Committee on Health Care recommended that it be put into the *Nevada Revised Statutes* (NRS). As I continue to review the bill, I will be presenting some conceptual changes and amendments (Exhibit H). In section 2, subsection 2, I was asked to change "unborn child" to "fetus".

This bill would only apply if someone is out of town and they are taken to an emergency room and their coverage only covers them in town. There have been instances where people thought they were having a heart attack. They went to the emergency room and it turns out they were just having indigestion. The insurance companies would then do what is called post-claims underwriting—they come back and say, That really was not a heart attack; therefore, we are not covering it. This bill would fix that for patients.

The remainder of the bill relates to medical billing practices. During one of my many stakeholder meetings, most of the people in the room were shocked to learn that preauthorization does not actually mean that the procedure or service is preauthorized. To an insurance company, the term "preauthorization" actually means utilization review has occurred and the insurance company deems that the procedure or service is medically necessary. It does not mean that the procedure or service is covered by the patient's policy. It does not tell the medical provider whether the patient has coverage for the procedure. It also does not tell the medical provider if the patient's coverage is in effect. This results in people making financial decisions that are not based on fact. They receive the treatment, not knowing if they have coverage or have less coverage than they expected, and then get a bill they did not anticipate. They might have made a different decision had they known what the cost was going to be. This also frequently results in providers not getting paid for work they have performed in good faith.

The remainder of the bill, if passed, would prohibit health insurance companies from retroactively denying claims on the grounds of ineligibility if the company previously provided prior authorization for the service, and the health care provider verified that the patient has coverage, and that the procedure for which the patient obtained prior authorization is covered under the patient's policy of insurance.

In section 5, as it is structured right now, the bill has responsibilities that are there for the insurance company and the medical provider. I was asked to make sure that there were responsibilities in there for the patients as well. I think we need to clarify that claims may be denied for either consumer failure to pay premiums or if there is fraud. Those are also included in the Affordable Care Act (ACA) as patient responsibility. This amendment is taking those elements and putting them into statute. Another provision that we need to add is Medicaid ineligibility. So if someone gets preauthorization while they are on Medicaid, and by the time they schedule their procedure they are ineligible and they do not disclose that, and there is a lag between when the provider's office calls to find out, those could be excluded as well.

In section 6, we want to put in place a process of how this would actually work. We need to have a differentiation between prior authorization and verification of coverage. People think that when they get something preauthorized it means it is authorized. It does not. So we are adding in an extra piece for verification of coverage. When the medical providers call their office, we require the insurers to say the patient is actually covered, this procedure is covered, or they are not covered, and here is what it will cost them. It would require insurers and payers to grant "prior authorization" for one year. This is because, with a number of conditions such as cancer, people have ongoing treatments that could last over the course of the year, and it helps for continuity of care. We would require providers, in statute, to verify coverage and confirm whether the patient is in-network and the treatment that has been preauthorized is covered by the policy. The insurers need to issue an authorization number, such as the one cited in section 6, subsection 1, paragraph (c), and perhaps change that name to verification number so it is clearer in the statute and clearer for the process.

We have established that if there is prior authorization and a verification number, section 5 applies to the patient and that the provider must be paid in accordance with their contract with the insurer, and if the patient is in-network, there would be no balance billing other than the applicable co-pays. This means they would not get a surprise bill for thousands of dollars, unless that was what their co-pay was supposed to be and they knew that in advance.

We would include additional elements that would increase transparency and the issue of prior authorization for health care providers based on the Consensus Statement from the American Hospital Association, America's Health Insurance Plans, the American Medical Association, APhA, BlueCross BlueShield Association, and the Medical Group Management Association. They have put together a joint statement on this and there is some model legislation which we have already incorporated into this, so we have some good policy.

The last thing I would like this bill to address is the practice of insurance company clawbacks. That is when an insurance company changes their mind about paying a provider for a procedure or service, and they claw back the money they have already paid. Aside from the obvious, it often happens after too much time has elapsed for the provider to go back to the patient for payment. Because the provider has already done the work in good faith, they deserve to be treated fairly. I would add a section that prohibits payers or insurance

companies from obtaining clawback payments that are made to providers for services that were rendered more than one year in the past.

Vice Chair Frierson:
You mentioned a couple of extra changes. Were those changes also proposed during your stakeholder discussions?

Assemblywoman Spiegel:
The one extra addition was Medicaid ineligibility. I had a conversation with Medicaid and it was just an error that it was not originally in the bill. Everything else came up with various conversations with stakeholders, either in a large group or individual conversations.

Assemblyman Yeager:
I really like the amendments you are proposing in section 6—prior authorization versus verification of coverage. I think it is important to be precise when talking about the language of insurance policies; this is an area that is difficult enough for the average consumer to understand. You discussed adding a clawback section. Do you have some examples of why an insurance company might try to claw back a payment after more than a year?

Steven Parker, Immediate Past President, Nevada State Medical Association:
One might assume that these things get handled quickly. If you assume that, you are wrong. These claims can be reviewed months or years after they have been submitted, where something is found to be wrong or it does not fit quite right on the insurance company's side. At that point, they can go back to the physician and deny payment. It happens more frequently with oncologists. Sowjanya Reganti, who is an oncologist at one of the largest groups in Reno [Cancer Care Specialists], wanted to be here today, but she is at a conference currently. She mentioned that it is not infrequent that they will be in the middle of a series of chemotherapy treatments for a patient when they get a message from the insurance company that the course of therapy—which may have been prescribed for six to eight months and approved—all of a sudden is not approved in the third month. This is one of example of where somebody got it approved up front, yet weeks later it is not approved.

Assemblyman Yeager:
Are there substantive reasons why an insurance company would come back years later and try to take the money that was paid?

Steven Parker:
We were in a situation where that happened. An issue was found with coding and billing and the insurance company came back to us and said, We need money back, and we want to take it back all to the way to the time when it occurred. This had gone on over a six-year period. We were forced to refund money going back six years from when the error occurred. That did create a significant financial strain on our practice to have to reimburse money going back six years.

Assemblyman Yeager:
Do you have a contractual obligation with the insurance company to allow them to do this kind of review?

Catherine M. O'Mara, Executive Director, Nevada State Medical Association:
Sometimes, as a provision in contract, they can agree to a two-year lookback. Often the payers will not agree to any lookback restriction. That is why we have seen, in at least 24 other states, some statutory protection ranging from 12 to 18 months, or some other reasonable time period. We know Massachusetts is looking at a six-month review—it has not passed into law yet. That is why there is some statutory protection.

Assemblyman Daly:
Is there a section to define the terms you are talking about?

Assemblywoman Spiegel:
Yes, we plan to put some of those definitions into statute so there is clarity.

Assemblyman Daly:
People do not understand their own insurance. Professionals understand it, but then they talk above your head. In reference to section 5, what if somebody calls the insurance company, obtains preauthorization and coverage verification yet the procedure cannot be done for two months. The person then loses their coverage before the procedure. What happens then?

Assemblywoman Spiegel:
That is part of the amendment for section 5. The claims can be denied for either failure to pay premiums or fraud. Basically, if the person is no longer in the plan, it does not apply.

Assemblyman Daly:
I know under a lot of plans you have a year to file your claim. We have timely filing issues all the time and there are a lot of steps you have to go through. If you have one insured, if you have double coverage, you have to coordinate those benefits. You are waiting on some other person who may or may not care about your plan at all to respond back.

Assemblywoman Spiegel:
I appreciate what you are saying. One of the things we have been discussing is a time frame for the verification number. From my perspective, it needs to be a fairly short window—probably something like 72 hours. Something that is close enough that the medical provider can have a reasonable sense that if the person says it is their insurance, they will have that insurance for three days. That is one of the things we are still working on.

Assemblyman Daly:
Suppose a person gets preauthorization for a complex illness and while they are in the hospital another serious complication arises that needs to be taken care of right away. There are new steps that have to be followed for something that was not originally anticipated.

People get confused on what is and what is not covered. It gets to be very complicated very quickly. What would happen then?

Assemblywoman Spiegel:
I am not an expert on this, but I do know there are provisions in the NRS for continuity of care. There are also provisions in the ACA to cover what happens if somebody's insurance changes. The NRS covers a lot of those situations.

Vice Chair Frierson:
Is there anyone to testify in support of Assembly Bill 225?

Robert Talley, Executive Director, Nevada Dental Association:
Over the summer we surveyed our members on the top issues impacting their practices. Seventy-five percent of the dentists responding told us they had experienced challenges with denial of preauthorized claims. For example, the patient visits the dentist and it is determined they need a service beyond just a cleaning. The dental provider requests a preauthorization for the procedure so they can give the patient an estimate. The insurer issues the preauthorization. All parties—the insurer, the provider, and the patient—are now clear on what their obligations are and then the work is done. The problem occurs when the claim is submitted and payment is denied. The patient and the provider are only asking that when an insurer provides a preauthorization approval for the service, the payment is guaranteed.

In another instance, 81.5 percent of the dentists responding reported problems with insurers retroactively denying a claim that had already been paid. This can happen years after a service has been preauthorized and performed. The association believes that a fair timeline, for both the provider and the insurer, should be statutory. Health care providers are required to submit claims within 30 days of treatment. This provides predictability for the insurer.

We are asking, if an insurer authorizes and then pays for a treatment, the provider should be able to rely on that authorization and payment. We are not aware of any statutory time limit for insurers to take back or claw back those guaranteed payments. We have members who have been asked for repayment years after a claim has been filed. This is not fair to the patient or the provider.

John DiGrazia, Private Citizen, Reno, Nevada:
I have practiced dentistry for 20 years in Reno. I am here in support of Assembly Bill 225. I would like to provide you with information based on the challenges my patients are facing. Many of our clients' ability to access dental care is dependent on their insurance benefits. All too often, I am caught in the middle—where an insurance company will pay on a claim and later come back and ask for a refund because they made an error on their part. Sometimes these requests happen months, and up to a year, after the date of service and the patient is asked to pay more than they had anticipated. As you can imagine, this creates confusion for the patient, our office, and it creates a barrier for access.

In some instances, a patient may have moved, they have died, or we are no longer able to reach them. At that point, our only recourse is through a collection agency, which is not a desirable course of action. In one instance, out of frustration, I instructed my staff not to refund the insurance company until we had contacted the patient. In that case, the insurance carrier took the refund out of a separate patient's payment to offset their error.

This bill provides insurers with a one-year window to adjust their claim payment but we would prefer 90 days. That is three times the amount of time that we, as providers, are afforded to submit the claim to the insurance company.

Vice Chair Frierson:
Do you have any examples where the insurance company made a mistake and owed money back to you?

John DiGrazia:
I cannot think of a time that has happened. We audit ourselves once in a while and find a claim that we have not submitted that we should have. That is the only time some money was owed to us because we had not submitted the claim ourselves.

Steve Parker:
We had a situation where a glitch was found in the billing and it was brought to our attention by the insurer. They found that the glitch had existed for six years and they did ask us to go back and refund that money. When we recontracted with that same insurance company, we asked them to put in a time limit on how long they could back but they denied the request. Some insurance companies have been willing to do that—they are the exception, not the rule.

Jesse A. Wadhams, representing Nevada Hospital Association:
We think the provisions of this bill, especially some of the components about the prudent person standards for medically necessary treatment, hospitalization, and the emergency room, are very important. We stand in support of the bill.

Catherine O'Mara:
We support the conceptual amendment and want to highlight a couple of aspects of the bill. We do support the prudent layperson, and including that in the NRS—we think that is very important to protect our patients. I am sure many of you have heard us talk about the Emergency Medical Treatment & Labor Act which requires providers to administer care, regardless of the person's ability to pay in an emergency. Public policy is that we want patients to get care if they believe they need it in an emergency situation. We also support the prior authorization language. It is important to note that prior authorization does not mean confirmation of coverage; it is really a secondary look that insurers make at the medical necessity of either the course of treatment or the medication. It has become an increasing frustration for my physicians.

In 2018 the American Medical Association conducted a survey on prior authorizations. Ninety-one percent of the respondents reported that prior authorization did not result in a

delay of care for the patients. Seventy-five percent reported that patients actually will abandon what physicians believe is necessary medical treatment, either to delay it to a future time, or they will never get back to resolving it. Ninety-eight percent report there is no clinical benefit to performing the prior authorization. Almost 30 percent report that prior authorization actually leads to a serious adverse event. More than one in three physicians have staff that work exclusively on prior authorization. What we are trying to do on the prior authorization portion is, if you perform it at the beginning of a course of treatment or at the beginning of the year, it should be good for a significant period of time. Dr. Parker brought up the oncology example. I just want to clarify what happens. If you know your patient is going to need a round of chemotherapy that could last for four to six months, you should be able to get one prior authorization that would last for the entire course of treatment. This way the patient does not have to go through the anxiety every night, before they receive the chemotherapy, wondering whether or not the insurer is going to agree with the doctor that it is medically necessary.

The Nevada State Medical Association supports putting some kind of reasonable restriction on how far back you can go—you have heard six years. When we talked about this in our policy committee, I have heard everything from one year to seven years. Sometimes there might be an audit five years later and an eligibility issue has then arisen. At that point, it is really a hardship for our physicians, most of whom are in small businesses, to go back and readjust it. If they want to push back, the insurers will eventually figure out a way to get those dollars. We are just asking for some kind of reasonable timeline. If the mistake goes beyond that year, then they should be precluded from doing that.

Vice Chair Frierson:
Is there anyone else who wishes to offer testimony in support of A.B. 225? [There was no one.] Is there anyone who wishes to testify in opposition?

Tom Clark, representing Nevada Association of Health Plans:
I would like to clarify the friendly opposition; the bill sponsor is working with us diligently. We look forward to continuing to work with her on the amendments as they come forward on each particular section. If we do reach impasse, then I will not come up friendly; I will simply state that I am in opposition.

Chelsea Capurro, representing Health Services Coalition:
The ACA already mandates that all plans cover true emergencies out of network at in-network costs. This bill is trying to do something else, which is including any out-of-network payments and annual maximums patients must pay. This is not part of the ACA. We have an issue when we are adding additional mandates on what we already have to comply with on the ACA. We also have some issues on the prior authorization for one year. We appreciate that the failure to pay premiums or fraud section, which also is not including eligibility, can be an issue for a lot of our members. I would also like to point out on the clawback provisions—while we can get prompt billing, sometimes it takes longer for complex cases. Regarding the testimony on the six-year issue, I have no knowledge of that

case; however, the physician said it was an error on their side. So it is difficult when the physicians are making errors and we are having to pay for those errors.

Thomas D. Dunn, District Vice President, Professional Fire Fighters of Nevada:
We all want more access and more affordable health care for all of our members in the state. With our self-funded plans and our trusts, every dollar in our trust is precious. We do not make a profit; we are trying to provide the best possible product for all of our members. Any potential increase in cost to our plans would either lead to fewer services provided or an increase to both the employee and the employer. Our concern with this bill is the inability to get some cost containment back for the right reasons. A few years ago I had a preauthorization for one of my members. They received the treatment, but because of a glitch in our insurance system, I got a bill from the hospital for $38,000. It took another couple of months to get it fixed. Ultimately, at the end of the day, I did not have to pay anything. I actually got a reimbursement back from the hospital for some of the costs I had previously paid. One of the concerns we do have is the timelines for the ability of cost recovery or audit.

Mike Ramirez, Director of Government Affairs, Las Vegas Police Protective Association Metro, Inc.:
Likewise, same sentiments as everyone else.

Les Lee Shell, Chief Administrative Officer, Office of the County Manager, Clark County:
Obviously, as we have had discussions today, health plans are complicated. Anything we can do to help those plans be less complicated and open access to our members is a good thing. Just to reiterate a couple of concerns that were already put on the record, this clawback concept is new to the bill—I do not think the intent is for those preauthorized to not be eligible because you now become ineligible for coverage. The members still get the service. We obviously should have the ability to claw back for services that they are not eligible for. We do have an over/under payment—we do go back and compensate physicians and facilities for things that we have not properly paid. Some of the complex cases take a while to get a clean claim. Those generally do not happen in 30 days. So there is a long time lag for us to get all of the information that we need to pay those claims.

Helen Foley, representing Delta Dental Insurance Company:
We share many of the concerns that you have heard today. We just want to make sure that if there is a prior authorization, there is a time period in which they should be able to receive the service—so we can make sure they still are covered by the plan. I think the amendment does address this, but there are a few other things we would like to continue working on.

Maya Holmes, representing Culinary Health Fund:
We share the concerns that have been laid out by the Coalition and the members on this issue. We are in a position where we are very concerned about this bill and its impact on driving up health care costs. This will ultimately increase costs to employers, premiums,

deductibles, and out-of-pocket costs, and could lead to cuts in benefits. We want to ensure that it would not have those consequences.

Damon Haycock, Executive Officer, Board of the Public Employees' Benefits Program:
We are testifying in the neutral position. We have spoken with Assemblywoman Spiegel and in the initial outlay of this bill we did not see too many concerns. However, there are some things that we think should be at the forefront of everyone's mind as they talk about these conceptual amendments. You have heard about the one-year prior authorization—we see a good concept in doing so, but as long as it is for eligible members. We would also suggest adding deductibles, coinsurance, and the other accumulators, so everything is picked up.

Assemblyman Yeager asked about when there are clawbacks years later. I can give you two examples: (1) We have a process at Public Employees' Benefits Program—if we find a provider has gross negligence or malpractice, we are not required to pay those claims. As many of you know, those malpractice suits can take years; and (2) We had a provider audit that was performed by our preferred provider organization network, and they found that a provider had been overbilling the entire network and all of their groups for about three years. To find a way to satisfy some of the costs, there were settlements. One thing that is very important is how long providers have to submit their claims. The Public Employees' Benefits Program has a regulation that allows providers to submit them up to one year after service occurs. As this conceptual amendment is written, there would be no clawbacks after one year. If it took almost a year to get the initial claim, and it turns out the payment was in the first 30, 60, or 90 days, this would prevent our program from being able to recoup those funds. We hope there would be some leniency in the amount of time.

Vice Chair Frierson:
I will invite Assemblywoman Spiegel to present any closing remarks.

Assemblywoman Spiegel:
I just want to say that these issues are very complex. In finding good policy, we need to be thinking about our patients. We need to be thinking about their access to care and their ability to get quality care on a timely basis, and in a way where they know what kinds of expenses they are going to be incurring.

I just want to leave you with a story. One of my constituents came to me last fall. His doctor had recommended that he get some testing and he said, "I am not sure if my insurance covers that." The doctor's office got a preauthorization but said they could not verify the coverage—so he said, "Okay, do not do it." So a month or two goes by and the doctor says, "I really think you need to get this testing done." The patient said "I need you to go back to the insurance company to see what my exposure is going to be because if it is going to be really expensive, I do not want to do it." The doctor's office said, "We have the preauthorization. We verified you have coverage, and it will be covered—so do the test." The patient went ahead and had the testing done. As it turned out, it cost the patient $360 and the patient had no idea of the cost until after the test was done. He said that if you had told him it was going to be $360, he would not have done this. I sent him to the Office for

Consumer Health Assistance to get help from the state, because it just is not fair that if a patient goes in and tries to do everything right in the system, he still winds up having problems. This bill will help address those types of concerns. I know there is still a lot of work to do.

Vice Chair Frierson:
We will now close the hearing on Assembly Bill 225. Is there any public comment? [There was none.]

The meeting is adjourned [at 3:11 p.m.].

RESPECTFULLY SUBMITTED:

_____
Karen Easton
Committee Secretary

APPROVED BY:

_____
Assemblywoman Ellen B. Spiegel, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a PowerPoint presentation titled "AB185," dated March 15, 2019, presented by Assemblywoman Ellen B. Spiegel, Assembly District No. 20.

Exhibit D is written testimony presented by Heidi Englund, Private Citizen, Reno, Nevada, dated March 14, 2019, in support of Assembly Bill 185.

Exhibit E is letter dated March 14, 2019, from Nevada Chapter, National Hemophilia Foundation, in support of Assembly Bill 185.

Exhibit F is a letter dated March 13, 2019, from Nevada Chronic Care Collaborative, in support of Assembly Bill 185.

Exhibit G is written testimony by Kenia Leon in support of Assembly Bill 185.

Exhibit H is conceptual amendments to Assembly Bill 225 presented by Assemblywoman Ellen B. Spiegel, Assembly District No. 20.