MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Eightieth Session
April 3, 2019

The Senate Committee on Commerce and Labor was called to order by Chair Pat Spearman at 12:05 p.m. on Wednesday, April 3, 2019, in Room 2135 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 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 Pat Spearman, Chair
Senator Marilyn Dondero Loop, Vice Chair
Senator Nicole J. Cannizzaro
Senator Chris Brooks
Senator Joseph P. Hardy
Senator James A. Settelmeyer
Senator Heidi Seevers Gansert

GUEST LEGISLATORS PRESENT:

Senator Yvanna D. Cancela, Senatorial District No. 10
Senator Julia Ratti, Senatorial District No. 13

STAFF MEMBERS PRESENT:

Cesar Melgarejo, Committee Policy Analyst
Bryan Fernley, Committee Counsel
Lynn Hendricks, Committee Secretary

OTHERS PRESENT:

Barbara Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry
Barry Gold, AARP
Tom Clark, Nevada Association of Health Plans; Board of Medical Examiners
Michael Hillerby, Hometown Health

Jon Hager, Hometown Health
Andy MacKay, Nevada Franchised Auto Dealers Association
Jesse Wadhams, Las Vegas Metro Chamber of Commerce; Nevada Hospital Association
Mac Bybee, Associated Builders and Contractors of Nevada
Scott Muelrath, Henderson Chamber of Commerce
Joan Hall, Nevada Rural Hospital Partners
Chelsea Capurro, Health Services Coalition
Bobbette Bond, Culinary Health Fund
Rocky Finseth, Pharmaceutical Research and Manufacturers of America
Bill Head, Pharmaceutical Care Management Association
Todd Ingalsbee, Professional Firefighters of Nevada
Mike Ramirez, Las Vegas Police Protective Association; Law Enforcement Coalition
Jim Sullivan, Culinary Union
Damon Haycock, Public Employees' Benefits Program
Jay Parmer, Association for Accessible Medicines
Stacie Sasso, Executive Director, Health Services Coalition
Michael Brown, Director, Department of Business and Industry
Julie Kotchevar, Administrator, Division of Public and Behavioral Health, Department of Health and Human Services
Brooke Maylath, President, Transgender Allies Group
Bishop Bonnie Rudden, CEO, The Gathering Place
Lindsay Knox, Nevada Orthopaedic Society; Board of Osteopathic Medicine
Catherine O'Mara, Nevada State Medical Association
Maggie O'Flaherty, Ambulatory Surgery Center Association of Nevada
Tina Dortch, Program Manager, Nevada Office of Minority Health and Equity, Department of Health and Human Services
Marlene Lockard, Nevada Chiropractic Association
James Overland, Nevada Chiropractic Association
David Ravetti, Nevada Chiropractic Association
John Eddis
Rusty McAllister, Nevada State AFL-CIO

CHAIR SPEARMAN:
I will open the hearing on Senate Bill (S.B.) 481.

SENATE BILL 481: Revises provisions relating to health insurance. (BDR 57-788)

SENATOR JULIA RATTI (Senatorial District No. 13):
This is one of two bills you will be hearing today that came from the Legislative Committee on Health Care working with the Division of Insurance, Department of Business and Industry. The goal of these two bills is to make sure the insurance market has the mechanisms to keep it stable, that Nevadans have access to health insurance and that there are consumer protections to keep health care affordable and available to every Nevadan who needs it.

The first of these two bills, S.B. 481, focuses primarily on consumer protection. Much of what is in this bill, as with many things in health care and health insurance, is in response to the fluid federal environment, which changes on a daily basis. Our intent with this bill is to make sure that when Nevadans purchase health insurance, we have the consumer protections needed to make sure that insurance actually provides a benefit to them and they have the protections they deserve.

There have been numerous changes in Nevada's health insurance market in recent years. Some of those changes have been beneficial to Nevada's consumers, while others have had a negative impact. Last fall, the Legislative Committee on Health Care asked the Commissioner of Insurance to look at the State's health insurance market and develop some consumer protection initiatives for consideration by the Legislature. Senate Bill 481 provides consumer protection alternatives for the State's individual qualified health plans, short-term limited duration policies and association health plans (AHPs).

Sections 1 through 5 of S.B. 481 use language taken from Washington State statutes and are related to self-funded multiple employer welfare arrangements (MEWAs) or trusts. These provisions add restrictive language for self-funded AHPs in Nevada. As of April 1, 2019, the new federal AHP regulations allow self-funded AHPs to be sold in Nevada. Self-funded MEWAs have a long history of major solvency and fraud issues. This language places a minimum requirement on the number of employers and employees in a self-funded AHP and further limits them to arrangements that have been in existence and continuously operated for a period of ten years.

Our intent is to sweep in the self-insured self-funded groups. We are not concerned about other AHPs that do not fit that model. We are in conversations with several parties to ensure the language in this bill does not include any

groups we do not intend. We do not yet have amendment language, but we are working on it.

Sections 6 and 10 of S.B. 481 allow only one short-term limited duration health insurance policy with a maximum coverage limit of 185 days to be sold in any 365-day period. Short-term plans are intended to be a solution for someone who loses their health insurance for a short period of time. Typically, they do not cover many of the essential health and state-mandated benefits, and they exclude all pre-existing conditions. These provisions are intended to keep short-term policies truly for the short-term needs they are intended to cover and not let them become a habit. We do not want consumers buying one short-term plan after another and not getting the benefits provided by a plan compliant with the Affordable Care Act (ACA).

Sections 8 and 9 of the bill limit a carrier's ability to cancel a short-term policy once it has been issued. This would force insurers to underwrite a policy at the time of application, which would mean consumers would be aware of exclusions prior to purchasing the policy. The problem we are trying to solve is a situation in which a consumer purchases a plan and the insurer does not check for pre-existing conditions. Then when that consumer has a medical event, the insurer says, "That was a pre-existing condition, and we don't have to cover it." Forcing the underwriting process at the front end and disallowing cancellations means if consumers purchase a plan, they can be assured of coverage.

Sections 7 and 11 prohibit a health benefit plan from issuing a policy that is not a qualified health plan certified by the Silver State Health Insurance Exchange. Eight states currently have no off-exchange market, and this would help ensure consumers who are eligible for subsidized plans are offered that opportunity. This is intended to be targeted only at the individual market. This is not intended to apply to all group, large employer or small employer plans.

BARBARA RICHARDSON (Commissioner of Insurance, Division of Insurance, Department of Business and Industry):
I have written testimony (Exhibit C) with technical details on the provisions of S.B. 481.

A recent court case, *New York v. U.S. Department of Labor*, may affect the rule we are considering regarding the MEWAs. The U.S. Department of Justice has

not decided whether it will appeal the decision or have the U.S. Department of Labor (DOL) amend the rules. Until that decision is made, the best we can do is set up protections for the State.

In Nevada, we have been very successful in having our small employers bring those fully ensured small group plans to the ACA market and the individual market. However, as of April 1, the self-insured MEWAs and AHPs are being allowed to come into states. In the past, self-funded plans have had a lot of fraud and solvency issues, which is why they have been heavily regulated.

Our goal is to make sure our consumers are protected regardless of how the DOL case is resolved. Carriers are required to have certificates of authority with us, and we look at their solvency, but we do not have a chance to look at their products or policies. We want to be sure that if they are doing business in Nevada, they have been there for quite a while. We are not saying, "No, you can't come in," but rather, "You need to have a minimum of 20 employers and 75 employees." We want to know that proposed plan arrangements are in existence already and continuously for 10 years as of December 31, 2015, or are being sponsored by an AHP that has been in existence for 25 years. This will not stop them from moving forward; it just ensures that we are working with people who are well-versed in this industry.

Sections 6 through 10 allow a customer to only hold one short-term limited duration health insurance policy with a maximum coverage limit of 185 days in any 365-day period. Under the current federal rule, you can hold a renewable policy for three years, but it has none of the usual protections in it. We have a regulation already in place with a cap at 185 days. This provision moves that regulation into statute in case the Legislature wants to alter it. When the ACA was in place, the restriction was 90 days, and this moves it up to 185 days. Those who need a short-term plan should still be able to get one without turning a short-term plan into a long-term plan. The recent federal rule changes it to 365 days with 2 renewals, which effectively gives 3 years of coverage.

Sections 8 and 9 limit the insurance carrier's ability to cancel a short-term policy. As Senator Ratti noted, people are purchasing short-term plans, and then as soon as they go to the hospital, the carrier claims the condition was pre-existing and cancels the policy. This provision requires carriers to do some underwriting at the front end instead of misleading consumers who believe they have insurance and find out they do not.

Sections 7 and 11 require all individual health benefit plans to be certified by the Exchange. The off-exchange market has shrunk dramatically to the point that in 26 percent of the states, individual policies are being sold off-exchange. As of today, there are eight states that have no off-exchange market. One of the reasons we are promoting this bill is to allow those people who qualify for subsidies to be able to get them. We know there are some plans off the exchange that may be different than the ones you can find on the exchange. We will be looking for a way to help alleviate the pressure but still allow consumers to get the benefit of those subsidies. If they are qualified for them, they deserve to be able to use them.

Section 12 expands the powers of the Exchange related to the purchase and sale of qualified health plans. The issue on this one has to do with being able to purchase a plan if you are on the border of two counties. For example, if you are on the border of Storey County and you get all of your benefits in Reno, you can only buy the Storey County plan, which is much higher for the same benefits in Reno. There are some federal restrictions around this, and we are working with our federal partners to get around them, but this would at least open the door for those discussions.

SENATOR HARDY:
Section 7, subsection 2, paragraph (d) of the bill says, "A carrier shall not issue a health benefit plan that is not a qualified health plan pursuant to NRS [*Nevada Revised Statutes*] 695I.080." What are these qualifications?

MS. RICHARDSON:
They need to be qualified health plans in order to qualify for the subsidies for individuals.

SENATOR HARDY:
What does that mean?

MS. RICHARDSON:
They need to have all the ACA mandates and the essential mandates of the State.

BARRY GOLD (AARP):
We support S.B. 481.

TOM CLARK (Nevada Association of Health Plans):
We appear in opposition to S.B. 481. We have been working with the bill's sponsor, but we want to get on the record that we believe sections 7 and 11 are detrimental to the market. We are working to put together the data to support that premise and will continue to work with Senator Ratti on this bill.

MICHAEL HILLERBY (Hometown Health):
We are a member of the Nevada Association of Health Plans and are opposed to S.B. 481. We have concerns about sections 7 and 11 of the bill. We cover about 7,000 lives off-exchange throughout northern Nevada. These are people in our experience who are most likely not eligible for the subsidy. They have been looking in the individual market. Our consumers know about access to the Exchange and those subsidies, and they are concerned that if this limitation were to pass, we would not be in a position to cover those 7,000 lives. We do not offer on the Exchange for a host of reasons, and I can go into detail if the Committee desires.

JON HAGER (Hometown Health):
I am the former director of the Silver State Health Insurance Exchange. Hometown Health is opposed to this bill.

On the MEWA sections, we would strongly urge language that spells out the focus on self-funded plans. If that is specified, we are okay with those provisions.

In section 7, which eliminates our ability to offer products off-exchange, I want to clarify that all of our health plans offered in the individual small group market have all of the protections required. The only difference is that there is no subsidy for those that are off-exchange. If we are required to offer on the Exchange, we will have to pay an additional 2.5 percent to 3 percent fee to the Exchange, plus there is something called silver-loading or cost-sharing that adds another 5 percent to 12 percent. Our rates will thus increase between 7 percent and 15 percent if we are required to be on the Exchange. All of our members would have to go through the process of determining if they are eligible for subsidies. If they go through the Exchange, this bill would still allow us to sell off-exchange.

I also wanted to let you know that protections are available in the plans we sell in the individual small group market.

ANDY MACKAY (Nevada Franchised Auto Dealers Association):
We are neutral on S.B. 481. We are in the process of setting up an AHP, and we are concerned that this bill was going to put the brakes on it. However, since we have a captive layer, these provisions will not apply in our situation. At the same time, the Committee might want to consider that if you are in a fully insured AHP and you want to grow into a self-insured plan, this bill precludes that.

JESSE WADHAMS (Las Vegas Metro Chamber of Commerce):
We are neutral on this bill. We have an AHP that is fully insured. We understand that the bill is not intended to apply to the fully insured MEWAs but to self-funded plans. The language may need a little refinement to clarify that fully insured MEWAs already have a certificate of authority through the underlying insurer. That is more a technical difference than a philosophical one, however.

MAC BYBEE (Associated Builders and Contractors of Nevada):
We are neutral on S.B. 481. We offer a fully insured insurance program through our AHP and simply want to echo the concerns of Mr. Wadhams. We appreciate the sponsor's openness to refining the language.

SCOTT MUELRATH (Henderson Chamber of Commerce):
We represent over 1,800 small businesses; in fact, nearly 85 percent of our members are businesses with 50 employees or less. I appreciated the comments from Senator Ratti and Ms. Richardson that clarified the bill's intent. Our concern is that the language in this bill be clearly directed toward self-funded plans, specifically in section 3, subsections 1 and 2.

Our AHP has met with great success in Nevada, insuring about 400 businesses and nearly 10,000 lives. We are fully ACA-compliant, meeting all the required benefits, and we just want to be able to continue to do the good work we are doing. We want to thank Senators Ratti and Woodhouse for accepting our input on this bill.

SENATOR SETTELMEYER:
You mentioned problems with fraud and insolvency. Could you give us some examples of the problems you are running across and how this bill would potentially resolve that issue?

MS. RICHARDSON:
Before the ACA came into effect, we ran into a series of self-insured companies that were floating between the regulations of the DOL and the State insurance regulators under the MEWA description of being self-funded. There are quite a few still out there, including one that was taken down by the FBI in Michigan and one in California called the American Trade Alliance. That is what we are trying to steer clear of, those organizations that appear quickly and disappear quickly.

With regard to fully insured MEWAs under the AHP, we fully support them in Nevada. They have been great for our small employers. If they need clarifying language to make sure the bill only applies to self-funded plans, we are good with that.

With regard to the comment that the bill prevents a fully funded plan from becoming self-funded, we have a pathway built in for that. We just want you to have enough experience to build from fully funded into self funded, if that is where you are moving.

SENATOR SETTELMEYER:
I appreciate that, but do you have any examples in the State of Nevada of insolvency or fraud problems that this bill will address?

MS. RICHARDSON:
It will address the American Trade Alliance, which is in Nevada. We have been putting out press releases the last couple of months specifically on issues having to do with some unauthorized insurance, all of which is self-insured. We have gone after NexGen, the American Trade Alliance and others. I will get more specific information for you.

SENATOR RATTI:
There will not be any examples from relatively recent history because the ACA had these protections. Because those protections were rolled back at the federal level, we need to step forward on the self-funded AHPs.

I would point you to section 4 of the bill, which states in part: "The Commissioner may not issue a certificate of authority to a self-funded multiple employer welfare arrangement ... ." That was our attempt to specify the

intended target of the bill. We will sit down with counsel and make the language stronger to assure those with fully funded AHPs are not swept in.

SENATOR HARDY:
I am confused about section 4, subsection 7 of the bill where it talks about AHPs that have been in business for 10 years and 25 years. Who will be in business in ten years if we do not allow new companies to grow?

MS. RICHARDSON:
New companies can start if they operate under the protection of established companies. For example, the AHP of the Las Vegas Metro Chamber of Commerce could probably move into a self-funded program at some point. An AHP that was just started has additional insurance layers on top of their self-insured status. That gives them protection and allows them to move forward. They have a regulated insurance carrier tied in with them.

SENATOR HARDY:
You are saying that there is a caveat to section 7 that would say, "... unless they have a super-insurance that covers them." The existing language does not give me any indication of what you just said.

MS. RICHARDSON:
I appreciate that. As it happens, the captive market is not regulated the same way as the self-funded MEWA market. They are reviewed differently. This particular group is coming in through the captive section; they are not coming in as a standalone AHP.

SENATOR HARDY:
Can we not add something to the bill to state that this applies unless you are coming through with a different system?

MS. RICHARDSON:
Yes. We can work with anybody who has some language that might open that door. It is just a matter of getting the language worked out.

SENATOR RATTI:
If you are trying to come in by yourself without an insurance partner and completely self-funded, this is the only door open to you, and we are closing that door. If you are coming in with an insurer partner, you can come through

the captive market, and that door is open. This is about folks who do not have a partner that has already been certified and authorized in another chapter.

If we can sit down with counsel and figure out a way to link that language so it is clear in the statute, we are happy to do that. It is absolutely not the intent of this bill to sweep in folks who have a partner that has already been vetted and are not at risk for the fraud and abuse this bill is intended to stop.

The bottom line here is to protect consumers so they do not pay a premium for a product that either goes bankrupt or does not cover the benefits they thought they were going to get. At the end of the day, we need to make sure there are not insurance products in the market that do not provide the benefits they get paid for. That is the intent of this bill.

CHAIR SPEARMAN:
I will close the hearing on S.B. 481 and open the hearing on S.B. 482.

SENATE BILL 482: Revises provisions relating to health insurance. (BDR 57-531)

SENATOR RATTI:
Senate Bill 482 is a companion bill to S.B. 481. It focuses on a more complex topic, which is how to stabilize the health insurance market in Nevada. Again, this is an area where changes at the federal level create instability and put us in a position of trying to react. We all remember the trying times of the "bare counties," when 15 of our 17 counties had no insurers on the Exchange. I think everybody in this room wants to make sure that does not happen again so Nevada has the most stable health insurance market possible.

There is a lot of history and other information we could share about this topic; however, since we are under deadline right now, we will just present the actual bill. Keep in mind that a significant report on this topic has been published, and we would be happy to come back to the Committee at some point in the future to give you the full presentation on the results of the interim work that has been done.

One of the many issues addressed by the Legislative Committee on Health Care during the last Interim was ways to help stabilize Nevada's individual health insurance markets. Nevada has been similar to most states in experiencing both

significant rate increases in the State's individual health insurance markets along with a reduction in the number of Nevadans purchasing individual insurance. After the passage of the ACA in 2014, enrollment in the State's individual health benefit plans increased from 77,617 in 2013 to 116,131 in 2014. Individual market enrollment continued growing and reached its highest levels in 2016 with 143,257 total covered lives. Unfortunately, the number of covered lives in the individual market has reduced substantially since then, with approximately 114,000 covered lives at the beginning of plan year 2019. Senate Bill 482 was intended by the Legislative Committee on Health Care to look for some potential solutions to help stabilize the individual market.

Sections 1, 2 and 55 of S.B. 482 authorize the Commissioner of Insurance to enter into compacts with neighboring states to ensure essential insurance is available to Nevada residents, and to also allow health benefit plans sold in contiguous states to be sold in Nevada when essential insurance is not available or is insufficient in Nevada. This change will allow the State to look for different options to ensure bare counties are covered and will also give Nevada consumers additional options if Nevada carriers do not offer viable plans for those areas. This will have the most effect in the border communities, where we might be able to be more creative about getting more options.

Sections 3 through 44 of the bill are related to the creation of a State reinsurance program. This program was included to help legislators explore options and costs to help stabilize and lower individual health insurance premiums in Nevada. The Commissioner will go into more detail of the study's results. However, when we looked at the costs of the program and the number of people it favorably benefits, it does not appear that the reinsurance program is a viable option to pursue this Session. This information came out very recently. We are not at a comfort level where we want to jump into reinsurance, but we are also not at the point where we want to just walk away.

Sections 45 to 54, 58 and 59 authorize the Commissioner to apply for a State Innovation Waiver in accordance with section 1332 of the ACA. The ACA allows states to request innovation waivers, called "1332 waivers," to waive some of the requirements of the ACA, which may allow the State to develop innovative solutions for reducing premiums and stabilizing the Nevada health insurance market. The process to request a 1332 waiver must first be approved by the Legislature and the Governor. This authority would give the State additional flexibility and time to look for solutions in our health care markets. It

is important that we start the 1332 waiver process, otherwise we would be delaying any potential solution until the end of the next Legislative Session, and that is probably not appropriate. Again, this all comes back to the fluidity of the national state of affairs and how Nevada reacts to it.

Section 56 repeals the right to enroll in an individual health plan sold off the Exchange at any time during the year, subject to a 90-day waiting period. Nevada is the only state that allows policies to be sold outside of the open enrollment period.

Section 57 removes the tobacco and age band limits from NRS 687B.500. Upon further review of this language, in order to ensure we are always protecting the rates of our older constituents, we are proposing a conceptual amendment (Exhibit D) that removes sections 5 through 44, which is the reinsurance program, and section 57, which is the premium rates.

The Division of Insurance has been working with the Legislative Committee on Health Care to come up with different ideas for ways to stabilize the market. Because of the timing of the bill-writing process, all of those ideas went into the bill. We now have the data and information to determine which ideas should move forward at this time—which doors we should keep open and which doors we should close.

MS. RICHARDSON:
I have written testimony (Exhibit E) summarizing the effect of this bill and including technical data on the insurance market in Nevada. In addition, we prepared a 93-page report that describes the results of the Wakely Actuarial Study. That report has been provided to the Committee members but is not presented as an exhibit today.

As noted in Exhibit E, Nevada's individual market premiums appear to have reached relative stability. However, the news from the federal government is that there will continue to be changes and possible upheavals in the ACA market due to a series of proposed regulation changes and the potential effect of the outcome of two court cases, *Texas v. Azar* and *New York v. Department of Labor*. Those will affect the ACA and its outlay in the U.S.

With regard to section 55, under federal law, compacts between states are derived from rules developed by the National Association of Insurance

Commissioners. Specifically, we are looking to enter into compacts that will allow consumers on the state lines between Nevada and Utah, Arizona and California to enter into that market. The ACA requires that states still control their consumers and consumers' benefits, so our Nevada consumers would get Nevada benefits.

One of the reasons we brought this bill forward is because of the bare counties situation in 2018, when a large insurer pulled out of the market and made us scramble. The goal is to have something in our back pocket to keep that from happening again.

With regard to the 1332 waiver, we have already taken a few of the steps in this process. Legislative authority is required to take any further steps, and the final step is legislative approval of the plan. You will have plenty of time in the next interim to work on that piece.

With regard to section 56 of the bill, this specifically has to do with the required waiting period.

As noted, the proposed amendment in Exhibit D removes section 57 from S.B. 482. This section was originally included to give the State some flexibility in case the federal law is changed. However, we have to wait for the next change in the ACA before we can react to it.

Exhibit D also removes sections 3 though 44 of the bill, which cover the State reinsurance program. Exhibit E has a fair amount of detail about this program to help you understand those sections in the Wakely Actuarial Study.

SENATOR SEEVERS GANSERT:
You mentioned that the multi-state compacts would have Nevada benefits. You might have someone in Elko whose network is in Salt Lake City, Utah, but the parameters of what is covered and so forth are based on Nevada's statutes. Is that right?

MS. RICHARDSON:
Yes, that is how this will be worked out. No matter what else happens, Nevada is responsible for Nevada citizens. If the Nevada Legislature puts forth a mandated benefit, Nevada citizens would still be eligible to have that benefit regardless of where they pick up their services.

SENATOR SEEVERS GANSERT:
To be able to move forward, you have to get a 1332 waiver, is that right?

MS. RICHARDSON:
No. That particular provision falls under section 1333 of the ACA. The ACA has a series of requirements that fall under the rules from the National Association of Insurance Commissioners. The 1332 waiver has to do with getting money rather than getting into a compact.

SENATOR RATTI:
To move forward on the 1332 waiver, we need the authorization of the Legislature. We could not have used it as a solution to the bare counties situation in 2018 because that tool did not exist in the NRS. We are adding it in so if we in the future have a similar situation, we will be able to act.

SENATOR SEEVERS GANSERT:
Do you need authorization to move forward to create something like that?

SENATOR RATTI:
Yes, authorization from the State.

VICE CHAIR DONDERO LOOP:
On page 3 of Exhibit E, where you were talking about the Commissioner applying for the state innovation waiver, how long does it take to do that? Is it a long process? How does that work?

MS. RICHARDSON:
It is a long process, but not extremely long. It requires legislative authorization, and it requires an actuarial and economic study, which is what the Wakely Actuarial Study is. We have a couple more hoops we have to jump through, but they are minor. We could do it within a couple of months once you decide if there is something in particular you would like to have as an alternative.

VICE CHAIR DONDERO LOOP:
Are we at the end of that process, then?

MS. RICHARDSON:
We are not at the end until the Legislature makes a decision. We are holding data so we are ready should you make one.

SENATOR RATTI:
This would set up the situation so the Legislative Committee on Health Care could make the decision during the interim, if we decide there is a market stabilization tool in a 1332 waiver we need to pursue. I want to be fully transparent with this. We would have the authorization going forward to continue to apply for the 1332 waiver. We need the full Legislature's authorization, but some of those decisions could be made during the interim.

These two bills, S.B. 482 and S.B. 481, started in the 2015 Legislative Session, were carried by the Legislative Committee on Health Care during the Interim and are now being shepherded by the Senate Committee on Health and Human Services. They included bipartisan support and Chair Spearman's efforts in 2015 and now. We know that regardless of what is happening at the federal level, it is our collective obligation to make sure that we are taking care of the insurance market in Nevada.

This is a complex process; I wish there were simple answers we could bring to you. As the Chair of the Senate Committee on Health and Human Services this Session, I am more accustomed to talking about the details of mental health, substance abuse or other things, but this is the tool that helps us get access to all those services. It requires that we all pay attention to what we are doing to make sure we keep our market stabilized. I am appreciative of the bipartisan effort we have had on this throughout the entire process to make sure every Nevadan who needs coverage has it.

MR. GOLD:
We support S.B. 482. I have a written statement (Exhibit F).

JOAN HALL (Nevada Rural Hospital Partners):
We support this bill. Ten of our members were in those bare counties, so we are appreciative of this discussion. The hospitals in border communities would also benefit from this bill.

MR. CLARK:
We want to thank the Legislative Committee on Health Care, Senator Ratti and the Commissioner of Insurance for bringing forward this important piece of legislation. We also appreciate the removal of sections 3 through 44 of the bill because it will allow us to continue to work on those concepts. Section 45 is important because it allows the Commissioner to apply for that waiver, and that

is an important component of stabilizing the market. The same is true of section 56, which sets up a fixed open enrollment period for individual plans. For those reasons, we are very much in support of S.B. 482. We look forward to continuing to work with the sponsor of the bill and the Commissioner as we move ahead.

CHELSEA CAPURRO (Health Services Coalition):
We are opposed to the bill as written. We have just seen the proposed amendment in Exhibit D and will want to take a look at that. We had some concerns with the reinsurance program, which the amendment removes. We will continue to work with the sponsor on this bill.

BOBBETTE BOND (Culinary Health Fund):
We have been working on this issue in several states. I want to make sure the record is clear that we are supportive of a waiver, but we would like to be involved as stakeholders in the solution. More than $20 million in new money has to be found, and we are concerned about the source of that money. In other states, bills that were introduced on this subject have sometimes taxed nonprofit health plans like ours to pay for the reinsurance program. That would be a problem for us because we are not able to participate on the Exchange. We opposed the federal transitional reinsurance program that taxed our plans. We understand that there needs to be a solution in Nevada, but we want to make sure we are included in the discussion of where the money would come from. It does not appear from the layout of this bill that there would be an opportunity for that, and we want to make room for that.

VICE CHAIR DONDERO LOOP:
I will close the hearing on S.B. 482 and open the hearing on S.B. 369.

SENATE BILL 369: Revises provisions relating to increasing the cost of prescription drugs under a pharmacy benefits plan. (BDR 57-735)

SENATOR RATTI:
This is another bill that originated in the Legislative Committee on Health Care and is being carried forward by the Senate Committee on Health and Human Services. In the Legislative Committee on Health Care, we had presentations from pharmaceutical companies, pharmacy benefit managers (PBMs), payers, hospitals and health care providers. As we were going through all those conversations, I realized that every aspect of our health care system is required

to lock in their prices for a year. Physicians negotiate their prices with the hospitals and providers they work for and lock them in for at least a year and sometimes longer. Insurance companies have to put their plans together and file them with the Division of Insurance. There is a rate-setting process, and they lock in their prices for a year. The individual consumer who is purchasing insurance either as a member of a group plan through their employer or as an individual on the open market typically has to comply with an open enrollment period. There is a period of time when people can join a plan, and once they join their pricing and benefits are locked in for a year.

The only part of the health care system where pricing is not locked in for at least a year, particularly as it flows down to the consumer, is the pharmaceutical company/PBM portion. I asked the simple question, "Why not?" and never really got an answer. My response was to bring forth S.B. 369.

In the past few years, we have seen headline after headline and many high-profile articles about exponential increases in the prices charged by pharmaceutical companies. We have seen radical price jumps for drugs that have been on the market for quite some time. We have seen, for example, an HIV drug that jumped from $13.50 per dose to $750 per dose. A drug to treat drug-resistant tuberculosis went from $500 to $10,800. Those headlines weigh heavily on our constituents. You have all heard stories from constituents who have experienced an increase in drug prices they did not anticipate and cannot control, even though they thought they had locked in a plan for a year.

Senate Bill 369 seeks to address the rising costs of pharmaceuticals to the end consumer so an individual in a plan will not have drug prices raised during the plan year. I work with an advocate who has multiple sclerosis (MS). Every year during the open enrollment period, she shops her plan to make sure she is on the plan with the best price on that drug. When that drug price increases in the middle of a plan year, that is unfair to the end consumer. Everything else in the health care system is locked in for a year, so why would we not be able to lock in the price of pharmaceuticals?

This Committee is familiar with this topic, and I know you will hear more bills on the various layers within the drug pricing structure, from the manufacturer to the PBM to the payer. All of that is important. Again, the intent of this bill is to make sure that the consumer does not experience a price increase in the given plan year.

Section 1, subsection 1, paragraph (e) of S.B. 369 focuses on the PBM and states the PBM may not raise the price of a given pharmaceutical within the plan year. Section 2 of the bill says the pharmaceutical company cannot raise that price within the plan year. Neither of those parties are able to raise that price. That is basically what the bill does.

I believe we will need an amendment to make this bill work in practical terms to state that in addition, no drugs could be pulled from the formulary during the plan year. If we go back to the case of my friend with MS, she should be guaranteed that the drug she needs will stay in the formulary at least for the plan year and will not be moved to another tier. When we move drugs within tiers, that has the effect of raising the price.

As with all pharmaceutical bills, S.B. 369 will start an interesting conversation. There are a lot of people here today who will share their opinions about how it may or may not work in the real world. Again, every other player in the health care system locks in their prices for a year, which at the end of the day benefits the patient in terms of the stability of their experience. If we can do that with hospitals, doctors and insurance providers, we should be able to do that with pharmaceuticals as well.

SENATOR SEEVERS GANSERT:
The bill would not allow someone to change prices, delete medications from the plan or change the tier of medications, but they could add medications to the formulary. Is that right?

SENATOR RATTI:
Yes. They can lower prices, and they can add drugs. We will need an amendment to address the formulary piece.

VICE CHAIR DONDERO LOOP:
Does that affect generic versus brand name medications?

SENATOR RATTI:
The bill is silent on any specific pharmaceutical in the formulary, generic or not. If a generic drug came out within the plan year, it could be added to the formulary. Sometimes when we add a generic to a formulary, we want to take a brand name drug and put it up a tier to raise the price and drive people to the generic version of the drug. The bill as currently written would prohibit that. The

tier could be changed in the next plan year, but not in the current plan year. That would also give the consumer time to adjust and get ready to move to the generic next year.

SENATOR SEEVERS GANSERT:
I was thinking about the timeline when people sign up for plans. You said your friend with MS looks every year and decides which plan to use based on the formulary. Does she get a month or two months to make that decision? Does this bill give consumers time to prepare if they need to change plans, or would they have to wait for open enrollment?

SENATOR RATTI:
With the exception of the off-market individual plans we discussed in the last bill, which do not currently have an open enrollment period, this would happen during the open enrollment period for the consumer.

SENATOR HARDY:
There are a lot of things that can happen to raise the cost of the raw materials that go into medications. A hurricane, for example, can knock power out and destroy roads and other modes of transportation. This bill would preclude anybody from raising prices for any reason whatsoever in spite of the cause.

SENATOR RATTI:
The best way I can answer that is to say yes, it would preclude raising the price for any reason. However, in the conversations I have had with the industry, in most cases they are already locking in prices between, say, pharmaceutical companies and PBMs, or between PBMs and payers, for much longer periods than one year. This bill just makes sure the price does not change for the end user within a plan year because either the pharmaceutical company or the PBM has raised the price.

SENATOR HARDY:
If the drug is the same price but you cannot get it, it does not help you.

SENATOR RATTI:
In situations where there is a need to raise prices based on natural disasters, we could look at writing in extra language so there is an out for that.

I consider S.B. 369 to be a conversation in progress. The bill came out March 20, and I have been meeting with various folks and talking through the practical implications of how it would work. I do not know that I have been able to meet with everybody who has an interest, so I would anticipate an amendment and will be continuing the conversation after the hearing today.

MR. GOLD:
We support S.B. 369. I have a written statement (Exhibit G) for the record.

ROCKY FINSETH (Pharmaceutical Research and Manufacturers of America):
We appreciate Senator Ratti bringing this bill forward. We have had an opportunity to sit and discuss the intent and her goals and objectives of the bill. While we are opposed to the bill as written, we believe we can get to a spot that we can work with her on it.

MS. CAPURRO:
We support the idea of formulary stability, but we still need to look at how this would impact our plans. We need our PBMs to have some flexibility in order to find the best deals. We will be meeting with Senator Ratti tomorrow and will continue to work with her.

BILL HEAD (Pharmaceutical Care Management Association):
The Pharmaceutical Care Management Association is the PBM trade industry association. We are neutral on S.B. 369. We appreciate the discussion Senator Ratti has started. We have a concern about the formulary changes. We want to drive people to generics because they save the payer costs, and more importantly, they save the consumer costs. With the issue of changes to the formulary, our concern is that it will keep costs high and not drive consumers to lower cost alternatives. I would point out that last Session, you allowed formulary changes twice a year in the small group and individual markets. This would be at odds with that. That being said, we want to continue the dialogue and will work with Senator Ratti on this.

TODD INGALSBEE (Professional Firefighters of Nevada):
We support the idea of this bill. We want to make sure we can get our members the cheapest drugs we can. We have some questions, and I will meet with the bill's sponsor on those.

CHAIR SPEARMAN:
I will close the hearing on S.B. 369 and open the hearing on S.B. 276.

SENATE BILL 276: Revises provisions relating to prescription drugs. (BDR 57-599)

SENATOR YVANNA D. CANCELA (Senatorial District No. 10):
This bill adds to the conversation about the high cost of prescription drugs. Senate Bill 276 came out of a recent federal rule proposed by Alex Azar, Secretary of the U.S. Department of Health and Human Services, dealing with PBMs. I will talk a bit about PBMs generally and then walk you through the bill.

I would note that the federal rule is still in the open comment period of the rulemaking process. This is a radical idea; Secretary Azar said that this is one of the most ambitious proposals to change drug pricing in U.S. history. I want to make sure it is clear to the Committee that I recognize that, and I am open to continuing to work with folks to make sure we get good policy that does not have unintended consequences or make the whole drug pricing system into more of a mess than it already is.

In the past, health insurance companies negotiated with drug companies directly. As you may know, PBMs are third party administrators of prescription drug programs for end payers such as private insurers and Medicare Part B. They first appeared in the 1960s. In addition to negotiating with drug makers for discounts and rebates, they also work with insurers to decide which drugs to cover. They can contract with pharmacies to distribute medications and handle payments. With things like preferred formularies and exclusion lists, which you have heard about today, PBMs can also help determine which drugs consumers receive without incurring additional out-of-pocket costs.

The focus of S.B. 276 is on the discounts and rebates negotiated by PBMs. Those get discussed quite a bit because there is not a lot of transparency about what the rebates are or where they go. In the early years, PBMs made money from contracts with health plans. Over time, they began to keep portions of the rebates. There has been a lot of news lately about companies committing to passing those rebates on to consumers. The reality is that the easiest way to reduce the cost of prescription drugs for patients is for drug manufacturers to start reducing their prices. However, that will not happen without pressure.

This bill allows for rebates to be removed from the drug payment system and moves PBMs to reimburse through transparent administrative fees. It would not immediately reduce the prices drug manufacturers charge because we need to create a structure that does that. Often, drug manufacturers point to PBM rebates as the root cause of increased drug prices. If rebates are removed, it should follow that drug prices would then be reduced to the level the rebate now provides, and the market would shift.

This bill is an attempt to ensure that any payer, whether an individual or a group, is paying the lowest price possible for prescription medications. Ideally, taking rebates out of the system would change the way drugs are priced and ensure that patients are paying lower prices. That is the intent of the bill.

Section 1 of S.B. 276 prohibits a PBM from accepting a rebate or reduction in price from a prescription drug manufacturer in connection with the sale of the prescription drug unless the full value of the rebate or reduction is applied to the price paid by the person to whom the drug is dispensed.

Section 1 also prescribes the conditions under which a PBM can accept remuneration from a drug manufacturer. They can accept a rebate if the value of that rebate is in a contract between the PBM and the manufacturer, and the full value of the rebate is paid to the dispensing pharmacy and applied to the price paid by the covered person to whom the drug was dispensed. The customer would receive the rebate at point of sale.

In addition, the PBM must annually disclose, in writing to a contracted pharmacy benefits plan and to the Commissioner of Insurance, the services provided to each manufacturer in connection with an agreement between the PBM and the pharmacy benefits plans.

Sections 4, 21 and 23 prohibit an insurer, including a local government, the Public Employees' Benefits Program (PEBP) and the Medicaid program, from accepting a rebate or reduction in price from a manufacturer in the same circumstances outlined in section 1 and any other remuneration from a manufacturer.

I know this bill is perhaps ahead of its time, but it merits discussion to understand how entrenched rebates are in our government, our health systems

and our private sector drug pricing systems. I believe these changes will improve the lives of patients, which is why I brought S.B. 276 forward.

SENATOR SETTELMEYER:
I appreciate this bill coming forward. I remember having the discussion a couple of sessions ago and trying to make sure the rebates actually made it to the end user, the consumer. I would like to see this bill pass.

SENATOR CANCELA:
I should warn you that this bill is in the running this Session for the bill with the highest fiscal note. We are close to the $700 million mark.

MR. GOLD:
We support S.B. 276. I have written testimony (Exhibit H).

MR. FINSETH:
We stand in support of this bold legislation. I have written testimony (Exhibit I).

MR. HEAD:
We appreciate Senator Cancela's openness in discussions with us on this. It is a very popular issue these days, so we appreciate the open dialogue she has maintained.

We are in opposition to S.B. 276 because from the PBM perspective, rebates drive down the cost. They pit pharmaceutical companies against each other. That competition benefits the payer, and ultimately the payer decides what to do with the rebate. More and more, we are finding that PBMs are being requested to pass through 100 percent of the rebate. On average, they pass through more than 90 percent of rebates. But again, it is the determination of the payer to decide what to do with it.

As you may recall, California passed a pharmaceutical pricing reporting bill a couple of years ago, and the first report came out earlier this year. Both the California Department of Insurance and the California Department of Managed Health Care concluded that rebates actually caused a slight decrease on premium costs. Often, employers use rebates to lower copays and premiums. The conclusion was that rebates were a benefit to the payer and to the consumer. This past summer, the Office of Inspector General at the U.S. Department of Health and Human Services issued a report on Medicare Part D

and concluded that accounting for rebates had no impact on prescription drug price increases.

That is our perspective. Obviously, there are other viewpoints on this, and the federal rule is still in the comment period. That ends on Monday or Tuesday of next week and provides a lot of information from a lot of perspectives. For that reason, we would urge that this issue be covered in an interim study so we can delve into the details and learn more about it.

MIKE RAMIREZ (Las Vegas Police Protective Association; Law Enforcement Coalition):
We oppose the bill as written. We would be interested in an interim study.

MR. INGALSBEE:
We are opposed to the bill as written. We would definitely be supportive of an interim study and would like to work with Senator Cancela on that.

MS. CAPURRO:
We are in opposition and agree with many of the remarks in opposition. We have some concerns with the bill as written, but we like the concept behind it. We need more time to fully vet the issues and understand how this would impact our plans. I do not want to sound like a broken record, but we think a study during the interim would be a great idea.

JIM SULLIVAN (Culinary Union):
I would like to echo what the people before me just said. We fully support the intent of this bill, which is lower drug costs, but we do not know exactly how it would affect our plan at this point. We would support an interim study on this to get a better picture of what is going on with PBMs.

MS. BOND:
We appreciate Senator Cancela bringing this bill forward. We are totally on board for some way to refigure and reconstruct the system. In the last two years of working on this issue in detail, we have seen the need for more transparency.

One problem with this legislation now is that about 91 percent of rebates are coming to the health plans. If we lose those rebates, we need something else to take their place. We use those rebates to lower our cost share and co-premiums

and the premiums for our members. We need something to force the drug companies to respond to the loss of rebates by reducing their prices, as they have been saying they would.

We would support an interim study where all the stakeholders can come together.

DAMON HAYCOCK (Public Employees' Benefits Program):
The Public Employees' Benefits Program is one of the unintended consequences mentioned by Senator Cancela; we also contribute $40 million to $50 million to the bill's fiscal note. We collect 100 percent of the rebates from our PBM, who is annually audited by our independent claims auditor, and 100 percent of those rebates go back to the premiums of every member in our plan. We do not keep any cut for ourselves and do not make a profit as a government entity. That is to the tune of about $11 million a year. On March 28, our board approved our rates for the next year, and they included $11 million from rebates. This will become an immediate hole in our budget if the bill is passed as written on the effective date in section 25. This is a huge concern for us.

We are testifying in the neutral position on this bill. The PEBP board just wants you to know that it creates a problem for PEBP.

JAY PARMER (Association for Accessible Medicines):
The Association for Accessible Medicines is the generic and biological manufacturers' trade association. We are neutral on S.B. 276.

We would like to be part of the dialogue if this becomes an interim study. We had an opportunity to speak briefly with Senator Cancela yesterday. We feel that a healthy discussion about the role generics play in the cost of providing prescription drugs and the reduction in those costs is something that would be important for us to participate in. We would look forward to working with her on the interim study.

STACIE SASSO (Executive Director, Health Services Coalition):
The Coalition would like to see a sustained effort to restructure the prescription drug program levels and ensure prices go down for all purchasers, whether that be the plan or the individual. We would support a study that focuses on the part rebates play in pricing and how we can ensure drug companies will reduce their prices if rebates are revoked.

SENATOR CANCELA:
The testimony we heard today makes it abundantly clear that this bill is not ready to move forward in its current shape. I will likely be bringing an amendment to propose this as an interim study. It is worthy of study based both on the effect it has on our State's budget and the level of interest in figuring this out.

CHAIR SPEARMAN:
Would the interim study go to the Legislative Committee on Health Care? I am worried because at the end, studies get cut. Just something to consider.

SENATOR CANCELA:
I will.

CHAIR SPEARMAN:
I will close the hearing on S.B. 276 and open the work session on S.B. 201.

SENATE BILL 201: Revises provisions governing loans. (BDR 52-568)

CESAR MELGAREJO (Committee Policy Analyst):
I have a work session document (Exhibit J) that summarizes the bill and amendments submitted.

SENATOR SETTELMEYER:
One of the things we discussed during the hearing on this bill was the concept that the interest that can be charged by payday lenders are capped at a certain percentage. I asked whether the fees would be inside or outside of the rates lenders charge. If it is inside, that basically eliminates their profit margin and will put them out of business. If that is the goal, that is another discussion. Was there any resolution on that?

SENATOR CANCELA:
I want to make sure I understand your question. You are asking about the fee that would be charged per transaction, not some other fee. Is that right?

SENATOR SETTELMEYER:
Yes. The question comes down to whether the fee is counted within the percentage the lenders are allowed to charge, or it is a pass-through, meaning it

goes directly to the customer and is not counted as part of the lender's percentage.

SENATOR CANCELA:
My understanding is that different states have different models. The intention is to have the fee cover the cost of the transaction. The way some states have it, the cost is passed directly on to the consumer. It can be part of the overall loan package. But the fees are nominal in cost, so they should not affect the lender's profit margin.

SENATOR SEEVERS GANSERT:
I was surprised the bill did not require a two-thirds majority to pass. In section 8, subsection 5 of the bill, it states, "The Commissioner [of Financial Institutions] shall adopt regulations that ... establish the amount of the fee required." We are actually establishing a new fee.

SENATOR CANCELA:
That is a question more for Counsel.

SENATOR SEEVERS GANSERT:
I have another concern. I spoke to the Purchasing Division of the Department of Administration, and the way Purchasing works for the State is we have to go through a request for proposal (RFP) process and then establish who the contractor is going to be before we provide payment for services. The way this bill is written, the Commissioner establishes a new fee, and then that fee is supposed to pay the vendor directly. We do not normally establish contracts directly like that. You have to go through an RFP process, and then you pay for services once they are rendered. This bill skips a step.

BRYAN FERNLEY (Committee Counsel):
Regarding the two-thirds vote, the constitutional provision regarding a two-thirds vote, which is Article 4, section 18, subsection 2 of the *Constitution of the State of Nevada*, says in part, " ... an affirmative vote of not fewer than two-thirds of the members elected to each House is necessary to pass a bill or joint resolution which creates, generates, or increases any public revenue in any form ... " Under S.B. 201, the Commissioner establishes the fee, and that fee is never paid to the State. It is collected by the lender and paid to the vendor. The fee is therefore not increasing public revenue and does not require a two-thirds vote to pass. It is a revenue source for the vendor operating the database.

SENATOR SEEVERS GANSERT:
I am not sure I have ever seen a fee going directly to a vendor without an RFP process where services are paid by the State.

I have another question about the safe harbor provision. If this database is established, it seems a lender who checks the database should have safe harbor if the database says the loan is allowable. Why was the safe harbor provision removed?

SENATOR CANCELA:
The safe harbor language was taken out because the database would eliminate the need for that provision. I asked lenders to give me language to have a safe harbor provision that would not bypass the database safe harbor language, but I did not receive anything from them. My concern with the existing safe harbor language is that it could theoretically be used to bypass the database, and I am concerned about having that loophole in the bill.

SENATOR SEEVERS GANSERT:
Thank you. It seems like there could be a way to write in language stating that if the lender checks the database and the transaction looks good, the lender would have safe harbor if they made the loan.

CHAIR SPEARMAN:
It appears we have a number of questions that deal with the financial aspects of the bill. Would it be helpful to re-refer the bill to the Senate Committee on Finance and get all those questions answered?

SENATOR CANCELA:
The Senate Committee on Finance addresses budget issues. In my opinion, the fiscal questions on S.B. 201 should be left to the Fiscal Division of the Legislative Counsel Bureau to discuss with the Division of Financial Institutions (FID) directly. These questions are related to the technicalities of the bill and not how the bill would relate to the budget process. I would feel more comfortable having Fiscal and the FID's financial analyst discuss the fiscal questions directly.

MICHAEL BROWN (Director, Department of Business and Industry):
We will find the answers to these questions as soon as we can.

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

SENATOR CANNIZZARO SECONDED THE MOTION.

SENATOR SETTELMEYER:
Let me repeat that these entities are limited by the percentage they can charge on loans. If the fee is inside that calculation, it takes away from their profit margin, and if their profit margin is eliminated, it eliminates the industry. If that is the goal of the bill, that is another discussion. I have been having the argument for a while that I am tired of these payday loan bills. We need to make the decision that they are lawful or they are not. We need to put on the record that the percentage should be determined before we move the bill forward.

I appreciate the sponsor's comments about sections 12 and 13 of the bill regarding safe harbor. I believe there should be a safe harbor provision. If a customer makes a loan knowing full well they were fired earlier in the morning, it is not the fault of the lender that the customer lied about having a job. There is no way the database knows that this person lost their job earlier in the day. I have major concerns about that.

Going back to Senator Seevers Gansert's concerns, I believe the bill was deliberately structured to find a way around the two-thirds rule. The fee should have gone to the Department of Business and Industry, and the only reason it did not is to get around the two-thirds rule.

For these reasons, I will be voting no on S.B. 201.

SENATOR SEEVERS GANSERT:
I appreciate the Military Lending Act portion of the bill. This is extremely important, and I am supportive of that. However, I will vote no because of the two-thirds issue. It is a new fee, which is clearly stated in the bill.

SENATOR HARDY:
During the hearing on S.B. 201, I heard that this bill will not impose any new laws on the payday loan industry. What I am hearing now, however, is that there is newness to this that gives some disquiet to some of us. I will vote no, anticipating that there may be some resolution of this before we figure it all out.

THE MOTION PASSED. (SENATORS SEEVERS GANSERT, HARDY AND SETTELMEYER VOTED NO.)

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VICE CHAIR DONDERO LOOP:
I will open the hearing on S.B. 470.

SENATE BILL 470: Revises provisions relating to certain professions. (BDR 54-785)

SENATOR PAT SPEARMAN (Senatorial District No. 1):
I am pleased to present S.B. 470 for your consideration. We will be bringing a conceptual amendment to change "physicians" to "medical facilities" throughout the bill. The bill as written requires physicians to have training in cultural competency. I met yesterday with Catherine O'Mara of the Nevada State Medical Association. She detailed some concerns she had, and this is the compromise we came up with. The cultural competency piece is still in there, but it no longer singles out doctors for this training.

JULIE KOTCHEVAR (Administrator, Division of Public and Behavioral Health, Department of Health and Human Services):
One of our functions within the Division of Public and Behavioral Health (DPBH) is to cover health care quality and compliance. We also oversee regulating medical facilities.

This bill would expand the cultural competency training we currently provide to staff who work in hospitals and nursing homes so they can have better interactions and be more respectful of people who receive care. We have recently seen an uptick in complaints about the way people are treated when they go into hospitals and nursing homes. When we investigate these complaints, we often find they are caused by staff not knowing how to interact with people rather than a deliberate attempt to do harm. When you are in a hospital or nursing home, you are already in a vulnerable state, and the last thing you want is to be made to feel uncomfortable by staff interacting with you in a way that is not consistent with your cultural expectations.

Right now, we do cultural competency training as we can. This bill would require facilities to provide this training as part of meeting licensing standards.

SENATOR HARDY:
There are a lot of different kinds of medical facilities. Are you specifically talking about hospitals and nursing homes?

MS. KOTCHEVAR:
Our intent was for it to be medical facilities. There is more included in that definition than just hospitals and nursing homes, though they are the majority.

SENATOR SEEVERS GANSERT:
Would the State provide this training, or would you hire someone? How do you demonstrate that you received this training?

MS. KOTCHEVAR:
We use community outreach funding to contract with providers for training. Medical facilities can either use our trainers or provide evidence that they gave the training themselves. It would be either one or the other. We do not charge facilities for that training; we use our community outreach funding.

SENATOR SEEVERS GANSERT:
This type of training is important. I am sure the amendment will make the options clear.

SENATOR SETTELMEYER:
Is this additional continuing medical education (CME), or does it replace one of the existing required hours?

MS. KOTCHEVAR:
We have not figured out all the details yet. It is not our intent to overload staff with excessive training. At the same time, we want them to have training on this, including treatment of patients. We may have a conversation with facilities when we work out the wording to make sure it is not overly burdensome.

SENATOR SETTELMEYER:
I appreciate that. I want to make sure medical staff have enough time to worry about the classes that are actually necessary. My philosophy is that if I end up going to a hospital and I am unconscious, I do not care about anything except who is the best doctor to take care of me. I do not want this to take away from medical training time. I have had doctors in emergency rooms who did less than stellar work, and I would have preferred that they had spent more time learning

how to do their current job better, as they seemed to lack the ability to read x-rays.

SENATOR SPEARMAN:
Let me address that. I have been made aware of several instances where it was clear that staff attending patients did not understand cultural competency. In the U.S. right now, there are a lot of tensions between people of different ethnicities and affectual orientation. I do not want to see a culture that tolerates disrespecting people because of their gender, gender identity, ethnicity, marital status or anything else. You will hear some testimony as to why this is necessary. This will not overload staff.

If you are a person of color or are in some other identified marginalized group who has to go into a hospital, you have to care who the doctor is. It makes a difference.

SENATOR SETTELMEYER:
I appreciate that. From a rural perspective, I have not run across that in any way, shape or form. We are just lucky to find a doctor or a facility at all; we are happy to find anyone who is willing to help serve rural Nevada. But that is a different problem.

SENATOR SEEVERS GANSERT:
The bill speaks of one hour of training. The proposed amendment may need to talk more about what is being taught than the length of the class. Accreditation is not based on the number of hours but on the standards of care and so on. I would expect it to be more centered on the competencies that need to be known.

MS. KOTCHEVAR:
You are correct. We have been trying to shift away from hours of training and focus more on whether people have learned enough to have a competency in a particular area. We want them to have competency in infection control, appropriate treatment and being respectful to people. It may not bother you how you are treated during the short time you spend in an emergency room; however, as a cancer survivor, I guarantee you that it matters when you are in the hospital for longer than a day. You want people to respect you and your privacy and what you are going through while you are in the hospital.

SENATOR BROOKS:
Did you intend this to cover all the individuals who work in medical facilities?

MS. KOTCHEVAR:
It is intended to cover anyone who provides direct care, which could include nursing staff, doctors, people who deliver meals and people who clean the rooms. It is people who interact with patients and who need to be able to have a respectful interaction with them. It is more than just doctors; as much as we love them, they are not in the room with you all the time. It is all the people who provide direct care.

SENATOR HARDY:
This is something we all have to be aware of. There are plenty of materials on cultural competency out there that we can access. I am grateful we are including everybody in this process because that is important.

Counsel informs me that there are 16 entities that qualify as medical facilities, and some may or may not want to be included.

SENATOR SPEARMAN:
We came to this compromise at 8:45 this morning, and it was important to get it on the record. We will continue to refine the language.

BROOKE MAYLATH (President, Transgender Allies Group):
We are in support of S.B. 470.

At one point in my life, I presented to the world as a white man. I never thought twice about being able to go into any sort of medical facility and get the best treatment available at that facility, whether it was rural or urban. Today, when I walk into a medical facility as a transgender woman, I do not know whether I will even get treated. That is what this bill is about.

Nineteen percent of transgender people in this State have been refused health care treatment outright simply for being transgender. Twenty-eight percent have delayed or postponed necessary medical care because they are afraid of being denied services or treated poorly in a medical facility. When they do get treated, they often get treated poorly. Their preferred names and pronouns are not used, and they may even be called "it" and dehumanized in a manner that discourages healing rather than promoting it.

In a study in San Francisco several years ago, 13 out of 25 participants, all transgender women, described the failure of security guards, receptionists, nurses and physicians to use the correct pronoun or the patient's female name despite patients' requests. Other participants described humiliating incidents in which they were called by male names or pronouns in front of other patients. The emotional burden of these experiences is significant. One patient said:

> I spent so much of my life trying to deny that I had this feminine part. And then when I finally went through all this living hell to get to the point where I can say, "Okay, this is me. I am predominantly female, and that is how I am going to live my life, and that's how I want to present myself." And then you have someone call you "sir"—it's almost like someone stabbing you right in the middle of your chest. It hurts that bad.

There is a lot of negative feedback out there. We are called sluts and whores and junkies and drama queens. Cultural awareness training, such as we have provided in Reno for years, helps turn this around. Everyone needs to have this training if they are going to work in a medical facility.

I am grateful for this bill coming forward. Please hear the stories and know there are people who are treated like dirt when all they want is to be treated like humans.

BISHOP BONNIE RUDDEN (CEO, The Gathering Place):
The Gathering Place is a nonprofit organization serving vulnerable and marginalized citizens of Clark County. I am here today to share my support of S.B. 470 relating to cultural competency training. Part of my work in Nevada is as a contractual employee for the Department of Health and Human Services providing cultural competency training to medical facilities.

I am in full support of the bill language. With the growing health disparities among children, adolescents, seniors and the LGBTQ community, and the stigma that is attached to many of these populations, this training for medical facilities is critical. One hour of training is a small amount of time, yet the reward to patients is enormous.

I will share one brief story of a transgender sister who was critically injured during a shooting in February 2018 in Las Vegas. Although she identifies as

female and asked providers to address her in this manner, the local facility ignored these legally binding requests and only referred to her by her given male name. The atrocities continued with a lack of appropriate care due to her transgender status, such as throwing bandages at her when her leg was wounded, refusing to treat her wounds and many more examples of inappropriate treatment.

I could share multiple stories of vulnerable patients who have been mistreated and stripped of their civil rights here in Nevada medical facilities. Let me simply say that all providers are in need of equality, diversity and cultural competency training to understand patients' rights and ways in which to address their vulnerable needs.

Senate Bill 470 is a beginning step to address the diverse needs of Nevada's communities and clients. I urge you to support the passage of this bill.

LINDSAY KNOX (Nevada Orthopaedic Society; Board of Osteopathic Medicine):
We do not have any comments on the amendment because we have not seen it. We are opposed to the bill as written based on the time it would take away from patient care. We will work with Senator Spearman and hope we can come to resolution.

CATHERINE O'MARA (Nevada State Medical Association):
We are opposed to the original bill. I know Senator Spearman took to heart the concerns we shared with her last night about mandating CME on this topic. She has been working with DPBH to resolve the issue. We would like to keep talking about the amendment, and I am sure the facilities would also like to participate in that discussion.

We believe every patient deserves to be treated with respect, and we do not condone any disrespectful or harmful behavior. As early as before the year 2000, the American Association of Medical Colleges integrated cultural competency into the curriculum for all medical schools. A cultural competency curriculum should not just be an add-on to present medical education. It is meant to be integrated into everything physicians learn in medical school. You do not have "Cultural Competency 101" as a class; it is not a stand-alone class. It is integrated into all the other classes they learn on patient care.

I am troubled by the testimony we have heard. My heart goes out to the patients who were mistreated, and I hope there is some recourse for them. I hope there was a way for them to report that behavior, perhaps through the patient satisfaction surveys every physician and facility use so they could have their voices heard. I believe those are usually anonymous. We want to correct inappropriate behavior without mandating additional training across the board.

We look forward to continuing the discussion with the proponents of this bill in whatever form it takes.

TOM CLARK (Board of Medical Examiners):
We are neutral on S.B. 470. I was going to give you a detailed explanation of how our CME process works, but since there is going to be an amendment that removes that, I will not bore you with those details. I am happy to provide it if it is needed.

MAGGIE O'FLAHERTY (Ambulatory Surgery Center Association of Nevada):
We share similar concerns, but since we have not seen the amendment, we are currently neutral on this bill.

JESSE WADHAMS (Nevada Hospital Association):
We just learned of the amendment that would add medical facilities into this bill. We are neutral on the bill at this point and look forward to seeing the language and working with the proponents of the bill.

MS. HALL:
I echo what Mr. Wadhams just said.

TINA DORTCH (Program Manager, Nevada Office of Minority Health and Equity, Department of Health and Human Services):
The purpose of the Nevada Office of Minority Health and Equity (NOMHE) is to improve the quality of health care services for members of minority groups, increase access to health care services for members of minority groups and disseminate information and education to the public on matters concerning health care issues of members of minority groups. In addition to ethnic and racial groups, we recognize members of the LGBTQ community and persons who are differently abled in the definition of minority groups.

With Nevada trending towards a minority/majority demographic, having a culturally competent pool of physicians and medical facilities supports NOMHE's goal in reducing health-related disparities. Senate Bill 470's requirement that medical facilities have cultural competency training within each period of licensure aligns with NOMHE's mission. Having a culturally sensitive medical workforce serves to combat disparities experienced by minority populations.

It is worth noting that when we talk about disparities, utilizing the normal measures of frequency of occurrences does not apply. Any disparity that is experienced has to be addressed because it can have a deleterious effect and can become a systemic, ongoing problem.

An enlightened workforce is deemed impactful to addressing these determinants of health, and NOMHE stands ready to support any following training module.

SENATOR SPEARMAN:
I would like to give special thanks to Ms. O'Mara, who was the only person who took the time to meet with me to express her concerns about the way S.B. 470 was originally drafted.

In the 1950s, President Eisenhower issued an executive order that integrated the U.S. armed forces. In the 1970s, the military realized that an executive order was not enough to change the culture people had lived in, so they created the Race Relations School. In 1980, it was renamed the Equal Opportunity Management Institute. I was fortunate enough to be a student at the time.

I want to emphasize what it feels like when you are constantly marginalized, especially when it comes to medical services. At the age of 7, I took a bus ride to Nashville, Tennessee. When I got there, I was thirsty. I asked my mom if I could go in and get something to drink. I went in and saw a man spit in one of the water fountains, so I went to the other water fountain. Just before I put my head down to drink, my mother grabbed me by the back of my blouse and pulled me away. With clenched teeth, she said, "Are you trying to get killed?" I did not know what she was talking about. She later explained to me about Emmett Till and how he was brutally beaten, mutilated and murdered, and nobody seemed to care.

We have read of stories in the South, and even in the north, that when integration began, people were spit upon and constantly called out of their

names. Even today, in this very building, we have people identifying people who are undocumented as "illegal." Ain't nobody illegal. They may be undocumented, but they are not illegal.

I cannot express to you how profoundly saddened I am that I even have to explain this to you. It is real. The lady Bishop Rudden talked about had been shot in the leg, and she had been in a rehabilitation facility for about a month. She told staff that a custodian had gone through her purse and stolen money; no one did anything. Her mother had to take a leave of absence from her job and come to Nevada to change her bandages, because the people in the facility would not change her bandage. They always identified her by her dead name, and even the placard outside her door had her dead name.

If you were born into privilege because of your skin color or your gender, it might be difficult to understand why we need this training. But as someone who has lived it—as someone who has been called the N-word—as someone who had to run for my life in Petersburg, Virginia, in 1977—as someone who was kicked out of a Dairy Queen in the 1980s—I can assure you that this training is definitely necessary. As long as we have people anywhere, and especially in this building, calling folks who are undocumented "illegal," you bet your bottom dollar we need this training.

VICE CHAIR DONDERO LOOP:
I will close the hearing on S.B. 470.

CHAIR SPEARMAN:
I will open the hearing on S.B. 365.

SENATE BILL 365: Revises provisions relating to health insurance. (BDR 57-684)

SENATOR MARILYN DONDERO LOOP (Senatorial District No. 8):
This bill creates a contractual protected system to address the issue of third-party access to certain provider networks. A silent preferred provider organization (PPO) is a term used to describe when a noncontracted payer or plan administrator applies a contracted payer's fee schedule to services rendered by a provider without the provider's prior knowledge or consent. Silent PPOs have impacted providers' account balances since the early 1990s. Currently, the practice of leasing or brokering a contracted payer's fee schedule

extends beyond the PPOs to include other parties, such as third-party administrators, managed care or health maintenance organizations, self-insured plans and other health plans.

In order to address the issue of third-party access to provider networks, the National Conference of Insurance Legislators (NCOIL) drafted the Rental Network Contract Agreements Model Act. The Model Act was adopted by NCOIL's Health Long-Term Care and Health Retirement Issues Committee in 2008 and was readopted in 2017. Senate Bill 365 creates a similar act in Nevada.

Section 1 of the bill provides that it is an unfair method of competition to knowingly utilize a health care provider's contractual discount without a contractual relationship. Violations are subject, pursuant to NRS 686A.187, to payment of an administrative fine of not more than $5,000 for each violation and/or suspension or revocation of the license.

Sections 7 through 11 of S.B. 365 establish a contractual protected system for health carriers to enter contracts and information without a health care provider's services and discounts. Section 7 lists the plans and coverages that are not subject to these provisions.

Section 8 requires certain disclosures in a health carrier's provider network contracts and authorizes third parties to sign a contract to access a network contract. In addition, section 8 requires a health carrier to maintain a website with certain information about third parties that have access to the network contract.

Section 9 of the bill authorizes a third party to enter contracts with other third parties under the same terms and conditions as their contract.

Section 10 of the bill requires a third party to establish a website to identify other entities to which it has granted access to provider network contracts.

Section 11 of S.B. 365 requires that health carriers and third parties comply with the requirements for websites under sections 8 and 10 when submitting remittance advice and explanation of payments to providers of health care.

MARLENE LOCKARD (Nevada Chiropractic Association):
We have a summary (Exhibit K) of the problem the bill is trying to solve and how it solves it.

In the last two days, I have heard from a number of stakeholders who have various concerns about the bill. Discussions have begun, and we want to continue those discussions to come up with an amendment that will encompass as many of those concerns as possible.

Senate Bill 365 is not about surprise billing or out-of-network issues. This is a bill that will allow providers to know which network is paying them for services. It is important to note that silent PPOs have been banned at the federal level by the Federal Employee Health Benefit (FEHB) program.

JAMES OVERLAND (Nevada Chiropractic Association):
I am the immediate past president of the Nevada Chiropractic Association.

Thank you for hearing S.B. 365. This bill is about transparency. Generally, the bill will set requirements on certain health issue insurance plans that lease, sell, assign or rent networks of health care providers to other entities. Silent PPOs are arrangements under which an insurance company, a third-party administrator or a self-insured employer contracts with another company to gain access to discounts.

The problem arises when a silent PPO imposes a discount on a provider that the provider is unaware of and has never signed a direct contract for. Providers receive significant reimbursement reductions from payers where they may have obtained a patient through their own efforts. The provider in this case has not bargained for the discount. In effect, the provider is reimbursed at a discounted rate from a network without receiving the benefits of being in that network. This bill would not have been submitted if contracts specifically stated they may be leased, rented, assigned or sold for the purpose of discounting of services.

One federal court decision described it like this: "A silent PPO is a term of art for a kind of PPO abuse." Essentially, a silent PPO occurs when a payer receives a PPO discount to which it is not entitled. In a silent PPO, after the patient pays his or her share of the bill and the provider submits the outstanding balance to the payer for payment, the payer declares that the provider is a member of a

PPO. The payer then proceeds to pay the provider at the PPO discounted rate instead of the usual and customary rate.

As Senator Dondero Loop noted, NCOIL has adopted a model law for states considering regulating network rentals and banning silent PPOs. To our knowledge, Texas, Florida, California, Oklahoma, Louisiana, North Carolina, Ohio and Connecticut have enacted legislation defining and regulating silent PPOs. Silent PPOs have been completely banned in 11 states.

We ask this Legislative body to help the providers of health care in Nevada.

SENATOR HARDY:
What does this bill do?

DR. OVERLAND:
This bill allows health care providers to decide if they want to have their contracts assigned, leased, rented or sold. It lets providers decide if they want to offer discounts. The bill will also let them know if a discount fee will be applied when they sign a contract. Currently, it is only when providers receive a discounted payment that they learn their contracts were transferred in some way.

SENATOR HARDY:
They would not have any idea what that discounted rate would be.

DR. OVERLAND:
That is correct. It is not specified. Generally speaking, the discount is between 20 percent and 30 percent.

DAVID RAVETTI (Nevada Chiropractic Association):
I am a practicing chiropractor in northwest Reno. I am also the northern Nevada director for the Nevada Chiropractic Association.

This bill might be a little confusing unless you do a lot of medical billing. Early in my practice, I signed up for several PPO networks. I made the business decision to be included in the network into the insurance company's list of discounted providers that would benefit the patients by allowing them to pay a smaller copay and deductible. The insurance companies would benefit from paying me less, and I would benefit from seeing more patients. It was a win-win situation.

Where things went haywire with this method was when the insurance company rented my discount to other insurance companies. Just a few months ago, I received an explanation of benefits (EOB), and there was a big cut in my check. I called the insurance company and asked them where that discount had come from, because I was not contracted with them. They gave me the name of a third-party administrator. It was not easy to get hold of that person, but when I did I asked them where the discount had come from since I did not know them either. They said they got it from another third-party administrator whom I did know, having signed up with them some 30 years ago. They rented my discount to the other third-party administrator, who rented it to the insurance company.

Not only was this unfair and deceptive, it was also incredibly difficult to find out who had that contract. It was difficult to change the contract, and once I did get off the panel so the contract did not keep following me, it was hard to notify the insurance company that took the discount. My billing person spends hours doing this, and according to her, "There should be a law against this." I agree.

JOHN EDDIS:
I am a chiropractic physician in Carson City. I am in support of S.B. 365.

I went through the same steps Dr. Ravetti did to find out how I got on the panel that discounted my fees. I am small potatoes; I am a sole practitioner, not a hospital. Insurance companies are big businesses with their own law firms to protect them. I do not have that, and reading and understanding the contracts I have to sign is as difficult as reading these bills. Sometimes the language is not clear, and one word here or there can make a difference.

I have the option of choosing which contracts I want to be a part of to see if it fits my bottom line to keep me in practice. So far, it has; I have been in practice for 35 years, and it is not easy. I have a son now with a six-digit debt coming out of school, and I fear he will experience some of these reductions in fees he is being paid.

I get EOBs from insurance companies that discount my fees and then tell me they are part of my provider network when I never signed up with them. I found out just like Dr. Ravetti did and went through the same steps to figure out where this came from. The company that sold my information was sold to

somebody else, and they picked up a few more insurance companies. When I found that original contract, I had signed up with a local hospital and a local outpatient surgery center, not the auto insurance company that discounted my fees.

I appreciate, Senator Settelmeyer, that you pay attention to the bottom line. The bottom line is that the little people who are doing the work in the field would like your support to look at the legal aspects of this situation to stop these larger companies from taking advantage of us. If I bring a new doctor into my office, he is not automatically part of my contract with that insurance company; he has to sign his own contract with them. That is not the way they see it.

MS. O'MARA:
We are in support of S.B. 365. The issue of rental networks is something we need to pay attention to. This bill is getting at the silent PPOs and not all rental networks. I would like to point out the provisions we particularly like in this bill is the notification and transparency piece in sections 8 and 10.

What happens is a provider will contract with a big-name insurer, and that contract is between those two parties. That insurer will then sell that provider's contract to other entities the provider never heard of. When a patient presents an insurance card to the provider, it is from that big-name insurer, but the payer is actually a third entity. When the EOB comes, it will have the payer's information, but it does not always say which PPO or insurer the discount comes from.

We are asking for transparency and notice. It is an issue of fundamental fairness that providers have that information, especially because they are not technically parties to a contract here. Their services are being rented without their knowledge, and it is those silent cases we are trying to get at with this bill. I bring that up because it is important to note that not only have several states outlawed silent PPOs, the FEHB program has banned them as well.

The NCOIL Model Act is based on a compromise between the American Association of Preferred Provider Organizations and the American Medical Association. It is compromise legislation. It is not everything the doctors would want; we would obviously want to make sure the discounts are not being applied without our knowledge as well. But this is a great step in the right

direction that will help providers know who is renting their networks, who is accessing their care, who their patients are and more.

SENATOR HARDY:
If the doctor does not have a contract with someone, how does he or she break the contract?

MS. O'MARA:
The physician has to follow any of the payer policies as they may be updated, but the service has already been rendered. The patient showed up and had an insurance card from a big-name insurer that the provider had a contract with. The service was provided, and the patient's end of the process is done. The problem comes in when we go to bill, and we do not know who the payer is. In some cases, the payers have become insolvent, and it takes several months to discover this. If we ask the PPO, "What is going on with this? This patient is your insured," they say, "No, the patient is this payer's insured, and you have to deal with them." There is no phone number to call; they may be in receivership. We have to take all this time and work just to find out who is responsible for this insured. Often there is no resolution.

The other way it happens is a payer will come up with an EOB, and the provider says, "I have never even heard of this before. You're giving yourself a 25 percent discount; where are you taking that from? Is it Insurer A or Insurer B? Is it someone we even have a contract with?" Even if we do end up ultimately getting paid on a non-negotiated discounted rate, it can take several months and cause endless frustration for the physician's office staff and the patient, who might be receiving EOBs and not really know either.

DR. HARDY:
Will this bill outlaw that?

MS. O'MARA:
Yes.

MS. HALL:
Our members have the same issue Ms. O'Mara just described. When a plan rents an existing network, it is not transparent to the patient, the provider or whoever provides that care. The notification procedures described in sections 8 and 10 are very important. We hope you will support this bill.

MR. HILLERBY:
This is a new issue to us; we had not heard of silent PPOs. We already do some of the things laid out in section 8. We do lease plans; for example, we lease our PPO network to PEBP. During the bare counties situation, we worked with SilverSummit Healthplan to help bring them in by making our network available. We also do some of the key pieces in section 8, particularly subsection 1.

We make sure our providers know we may lease the contract. We make sure whoever leases the contract abides by all the current provisions of that contract, including payment rights. All of our claims are repriced through Hometown Health to be sure that payer knows what the allowable was, what payment is supposed to go to the provider. The situation Ms. Lockard and others described is new to us and very concerning, if there are people out there trying to take advantage of providers that way.

I will not spend time going through all the concerns with specific language. We will happily work with the sponsor to see if there is a way we can address the bad behavior going on but still allow the appropriate kinds of leasing of networks by Nevada-regulated insurers to large payers like PEBP and others so people have access to care.

MS. CAPURRO:
This is a very complex topic, and we need more time to fully understand how this impacts our members. We have some concerns that this could possibly lead to surprise bills. We will continue work with the sponsor.

MR. INGALSBEE:
My concern is for our members who might get treatment thinking it is covered by their insurance and then get stuck with the bill if it is not. If there is a cost difference the provider did not expect and our members are not aware of, who is responsible for the payment? That is the concern we have. We will work with the sponsor on this bill.

MS. BOND:
We use something called a "wrap network." I have had some conversations with Ms. Lockard about whether the wrap networks are part of this issue. We are not yet sure if this bill will impact us or not. We are in favor of the transparency discussed and making sure the doctors know what discounts are being used and what they signed. Contracts should be clear.

We have real concerns about patients getting stuck with bills they did not expect. The underlying problem here is that discounts are being requested because health care is very expensive without a discount under the noncontracted rates. We are all using different ways to find a solution to high physician charges.

We would like to understand more. We hope we can work something out. We understand the need for transparency. We do not want our members stuck.

CHAIR SPEARMAN:
Could you explain what a wrap network is?

MS. BOND:
Our network exists in Las Vegas because our members are in Las Vegas. If they are in Reno or California and get hurt and need to get care, there is another network that wraps around our PPO.

RUSTY MCALLISTER (Nevada State AFL-CIO):
We are also seeking more information along the lines of what Ms. Bond said and are neutral on S.B. 365 at this point.

We have a tremendous number of members who either live or work out of Nevada. Some live out of state and get their care in the city or town they live in. We use a wrap network through our normal PPO, but it is a wrap network that they have negotiated or worked out an agreement with. If they were to get surprised with a bill because a provider says, "I didn't know I was going to be on this network," that is not good for the patients either. That is not good for the people seeking care.

Another concern is that during certain times in the economy, some workers have to go to other states to find work. That means they may be seeking health care in Kentucky, Illinois or wherever there is work. If S.B. 365 interferes with the way wrap networks function, those workers will not be covered. We need to know more about whether this is going to affect our members.

SENATOR DONDERO LOOP:
I am pleased that the neutral comments were about patients. This is one of the issues: patients always pay. Doctors and patients are on the same side of this issue. I ask your support for the bill and will continue to work with the

stakeholders. Just know that this would create a contractual protected system to address the issue of third-party access to certain provider networks.

SENATOR HARDY:
If I understand this, S.B. 365 means the doctor will know his or her contract has been rented out and at what rate. Both doctor and patient will know they are now under somebody else and not their original contract. They will have an opportunity to not continue the contract they did not want to be in in the first place that they magically got included in.

SENATOR DONDERO LOOP:
I do not believe the patient would know. The patient gets a bill from the doctor and pays it. Perhaps Dr. Ravetti or Dr. Overland could explain the doctor's end of it.

SENATOR HARDY:
You said this was not a surprise billing issue or an out-of-network issue. But what you are describing is a virtual out-of-network issue.

DR. RAVETTI:
A lot of these abuses come from worker's compensation and medical pay for automobile accidents. Usually the patient has no copay at all. You cannot get less than no copay, so it is not too much affected there.

DR. OVERLAND:
When a patient comes in, they may have a copay or a deductible they have to satisfy first. We provide the service and send the billing for our services to the payer or the insurance company. We are the ones who get the surprise that it has been discounted. There is no way we pass on any of this to the patient. The patient has paid his or her copay or deductible, and this issue does not affect them one iota. They will not get a balance bill. The discount only applies to the provider. There is no surprise billing at all.

SENATOR HARDY:
I saw a patient who thought they were under contract. I did not sign the contract. What prevents the doctor from saying, "Somebody owes me money, and the person I know owes me money is the patient"? Is that not legal?

DR. OVERLAND:
With respect to some of the provisions that patients will come in, the doctors may or may not be a provider in the network. They may be out-of-network providers. When we are out of network providers, there is a different scale of reimbursement than if we are on the panel for providers. We have to abide by the different type of insurance company that the individual presents when they come in. In other words, the patient does not get extra billing at all. They will still get the treatment care.

Let me give you an example. In October 2015, I treated an individual who had been in an automobile accident. I got a reduced EOB. After many phone calls, I found that in 2005, I signed a contract with a company that agreed to send me a lot of patients if I gave them a discount. When I was informed of this, I told the company I did not want to offer that discount again, and they told me I could opt out, which I did. However, my opt-out was only for that one particular patient and that one incident. They would not tell me who the contract was with, so I could not find out who had sold my contract.

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CHAIR SPEARMAN:
I will close the hearing on S.B. 365. Is there any public comment? Hearing none, I will adjourn at 3:11 p.m.

RESPECTFULLY SUBMITTED:

Lynn Hendricks,
Committee Secretary

APPROVED BY:

Senator Pat Spearman, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	2		Agenda
	B	10		Attendance Roster
S.B. 481	C	3	Barbara Richardson / Division of Insurance	Written testimony
S.B. 482	D	1	Senator Julia Ratti	Conceptual amendment
S.B. 482	E	8	Barbara Richardson / Division of Insurance	Written testimony
S.B. 482	F	1	Barry Gold / AARP	Written testimony
S.B. 369	G	1	Barry Gold / AARP	Written testimony
S.B. 276	H	1	Barry Gold / AARP	Written testimony
S.B. 276	I	2	Rocky Finseth / Pharmaceutical Research and Manufacturers of America	Written testimony
S.B. 201	J	3	Cesar Melgarejo	Work session document
S.B. 365	K	1	Marlene Lockard / Nevada Chiropractic Association	Bill summary