MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Eighty-second Session
March 13, 2023

The Senate Committee on Commerce and Labor was called to order by Chair Pat Spearman at 8:33 a.m. on Monday, March 13, 2023, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412E of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Pat Spearman, Chair
Senator Roberta Lange, Vice Chair
Senator Melanie Scheible
Senator Skip Daly
Senator Julie Pazina
Senator Scott Hammond
Senator Carrie A. Buck
Senator Jeff Stone

GUEST LEGISLATORS PRESENT:

Senator Heidi Seevers Gansert, Senatorial District No. 15
Assemblywoman Sandra Jauregui, Assembly District No. 41

STAFF MEMBERS PRESENT:

Cesar Melgarejo, Policy Analyst
Lynn Hendricks, Committee Secretary

OTHERS PRESENT:

Herb Santos, Jr., Nevada Justice Association
Misty Grimmer, Employers Insurance Company of Nevada
Victoria Carreon, Administrator, Division of Industrial Relations, Nevada Department of Business and Industry
Michael Hillerby, Nevada Optometric Association

Jonathan Mather, Doctor of Optometry, Nevada Optometric Association
Andrew Boren, Doctor of Optometry, Nevada Optometric Association
Spencer Quinton, Doctor of Optometry; President, Nevada Optometric Association
Al Rojas
Dylan Keith, Vegas Chamber
Caren Jenkins, Executive Director, Nevada State Board of Optometry
Michael Alonso, National Association of Vision Care Plans
Chelsea Capurro, Health Services Coalition
Carlos Hernandez, Nevada State AFL-CIO

CHAIR SPEARMAN:
I will open the hearing on Assembly Bill (A.B.) 165.

ASSEMBLY BILL 165: Revises provisions governing payments for a permanent partial disability. (BDR 53-777)

ASSEMBLYWOMAN SANDRA JAUREGUI (Assembly District No. 41):
Assembly Bill 165 is a clean-up bill that brings together two groups who normally are not at the table together: insurance companies and trial lawyers. Earlier this year, the Division of Industrial Relations (DIR), Nevada Department of Business and Industry, issued a memo stating that the legislative change in A.B. No. 458 of the 79th Session removed its statutory authority to grant lump-sum payment awards to injured workers in Nevada whose injuries resulted in less than 30 percent whole person disability. For this reason, the DIR was going to stop processing these claims. This bill will allow those injured workers to receive one lump-sum payment for their award.

HERB SANTOS, JR. (Nevada Justice Association):
I would like to thank Assemblywoman Jauregui for sponsoring A.B. 165 to fix an error that occurred in 2017. It was due to a drafting error in a last-minute amendment to the bill regarding an increase in the percentage amount that could be elected by an injured worker for their permanent partial disability (PPD) benefit. Unfortunately, no one caught the error at the time.

Since then, insurers have offered the PPD benefit in a lump sum for all PPDs under 30 percent. Most injured workers in Nevada have elected to receive the lump sum, and they have been processed pursuant to the forms authored by the DIR. In fact, the ability of an injured worker to receive a lump sum goes back to

1983. The only thing that has changed over the years is the percentage that could be elected.

In December 2022, a new election form was created to address changes made in the 2021 Session, and the error was realized. The DIR quickly withdrew the forms for an election of any lump sum from 1 percent to 29 percent and began work on an emergency regulation. The emergency regulation was processed and signed by the previous administration. However, that emergency regulation self-terminates on April 4, 2023. The current administration provided the DIR with an exception to the current regulation freeze, and a temporary regulation is in the works.

We are here today to permanently fix the error. This bill will reinstate the status quo for PPD lump-sum benefits that has been in place since 1983 in Nevada and allow lump sums for PPD awards from 1 percent to 29 percent. This bill is good for injured workers, insurers and employers.

MISTY GRIMMER (Employers Insurance Company of Nevada):
I do not need to repeat anything Mr. Santos said about the history of the challenge. He is right when he says insurers are supportive of this bill. It is a process we have all been using for a while. If you look back through the statutes, it has been State policy for decades. We appreciate the efforts of the DIR to put in the temporary regulation. We appreciate too the Committee's efforts to move this time-sensitive bill.

VICTORIA CARREON (Administrator, Division of Industrial Relations, Nevada Department of Business and Industry):
I echo the testimony heard earlier. When we discovered this error, we worked to address it on a temporary basis while we were waiting for legislation. The emergency regulation expires on April 4, 2023, and A.B. 165 would be a permanent solution. Should this bill be passed before April 4, we will withdraw the temporary regulation. I have written testimony (Exhibit C) with further background on the situation.

SENATOR LANGE MOVED TO DO PASS A.B. 165.

SENATOR DALY SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

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CHAIR SPEARMAN:
I will open the hearing on Senate Bill (S.B.) 134.

SENATE BILL 134: Revises provisions relating to vision insurance. (BDR 57-642)

SENATOR HEIDI SEEVERS GANSERT (Senatorial District No. 15):
Senate Bill 134 seeks to address the issue of insurers conditioning contracts with vision care providers based on the use and prescription of certain ophthalmic devices and materials.

One of the main issues with this practice is that it creates a conflict of interest for the insurer. When an insurer has a financial interest in a particular ophthalmic device or material, it may incentivize providers to use those products even if another product may be more appropriate or cost effective for the patient. This could result in patients receiving suboptimal care and incurring higher costs. In addition, providers may feel pressured to prioritize the financial interests of the insurer over the best interests of the patient.

I want to go through the sections of the bill. Currently, *Nevada Revised Statutes* (NRS) 686A.135 prohibits an insurer from entering a contract with a provider of vision care that conditions the provider's rate of reimbursement for vision care in prescribing ophthalmic devices or materials in which the insurer has an ownership or other pecuniary interest. Further, the insurer is prohibited from increasing the rate of reimbursement if the provider of vision care prescribes such ophthalmic devices or materials.

Senate Bill 134 expands on those prohibitions. Specifically, section 1 adds that an insurer is prohibited from entering into a contract with a provider of vision care that authorizes the insurer to set or limit the amount the provider of vision care may charge for vision care that is not reimbursed under the contract. For example, if an insurer covers a first pair of glasses, they cannot require that a second pair be discounted at 50 percent if the insurer is not going to cover it. If that is not under covered services, they would not be able to say, "You can only charge this much," or "You must provide a discount." In addition, the

insurer is prohibited from requiring the provider to use a specific laboratory as a manufacturer of ophthalmic devices or materials provided to covered persons.

Section 2 states that the prohibitions in section 1 are not applicable to any current contracts between an insurer and a provider of vision care, unless and until those contracts are renewed after October 1, 2023.

MICHAEL HILLERBY (Nevada Optometric Association):
By way of background, vision and dental plans are not health insurance. They are sold alongside health insurance, but they operate differently. The insurer is essentially paying for a specific set of benefits provided with vision plans. That includes some portion of the cost of the exam and some portion of the cost for frames and lenses. Vision plans are important in that they make sure people get the services and products they need, but they cannot exist without some level of regulation.

As Senator Seevers Gansert mentioned, the existing law contains some modest protections we put in place in 2017. Nevada does not regulate vision plans within its own chapter the way we do dental plans. Nevada has regulated dental plans since 1983 in NRS 695D. The language proposed in S.B. 134 is in NRS 686A, which regulates trade practices and frauds within the insurance statutes.

Senator Seevers Gansert explained the two things we want to prohibit from these plans. One is setting prices for things they do not cover. That is as simple as it sounds. If the insurer wants to provide some level of reimbursement to the patient and the provider, it must negotiate what those prices are. If it is not going to do that, it should not be in the business of setting prices for services and products.

The second is the insurer cannot require the use of a specific laboratory. The issue is that the industry has a lot of vertical integration, which is when one company controls or owns two or more stages of production in an industry. To give you a sense of the scope of that, there are approximately 200 million Americans with vision plan coverage of some sort. Of these, two-thirds are covered by one of two companies, and those companies are highly vertically integrated. They own the manufacturers of lenses and frames and many of the major retailers, and in some cases, they even own the labs and

the doctors' practices. Nevada banned the price setting of noncovered services in the dental statutes in 2013 in NRS 695D.227.

The most important issue with this vertical integration is that it opens the door for prices to go up for consumers. This assumes that doctors of optometry and ophthalmology have some interest in potentially gouging a consumer or that there is not enough competition. The Avalon Health Economics group has done a study of ten states showing that prices do not rise when you get rid of the noncovered services mandate. In fact, in 75 percent of cases, prices stayed the same or actually went down.

It is important that our doctors work with their local communities and their patients in an effort to find things that work for them. There is so much competition in this field, with online businesses like Warby Parker and major brick-and-mortar retailers like LensCrafters, Costco, Walmart and Target Optical. It makes no sense, and it is ultimately not possible, for your local doctors to raise prices to the point where they are taking advantage of the patient. Under federal law, the optometrist is required to hand you your prescription. You can then go anywhere to get your glasses, and an increasingly large number of patients do. There is a lot of advertising and resources behind those major companies, and it is in the best interest of our members and the patients they serve to find the best kinds of pricing.

JONATHAN MATHER (Doctor of Optometry, Nevada Optometric Association):
I am an optometrist who has been living and working in Carson City since I graduated ten years ago. Last week, we saw a patient named Christie in our office. She came in for her yearly checkup, and we found two problems. One is blurry vision, which is fairly common, but the other one is diplopia, also known as double vision. As you can imagine, that can cause quite a headache. Luckily, by adjusting her prescription, we were able to solve both issues so she could see both single-vision and clearly.

Unfortunately, after we saw the patient and got the prescription dialed in, we ran into problems when we went to pick out new frames and lenses. The patient's insurance company, like many others, owns the laboratory that creates the lenses that go into the frames. The alert in our system said that they would be unable to fill her prescription. We called the laboratory to see what the problem was with getting the prism she needed to keep her from seeing double. The lab said they could not do it in the type of progressive lens that helps her to

read and see far away at the same time. This meant she would have to move to a lower quality progressive lens. As you know if you wear progressive lenses, you have to move your head a little bit from side to side once you start reading. The lower quality and older technology lens means a lot more head movements and a lot more visits to your chiropractor.

The other issue we ran into was with the antireflective coating on the lenses. It provides a scratch warranty and higher quality optics, especially with nighttime driving and driving in the rain and snow. However, with the lower quality material and lower quality plastic used by the lab, they would not be able to give her the same antiglare coating she has had in the past. Her lenses would scratch easier and have more distortion, and they might even cause some double vision and worse optics. None of these were things we wanted for the patient.

In the past, this patient was able to get exactly what she needed and had no problems. This year, she came in for her yearly checkup and wanted new glasses so she could see sharper, and we did everything we could to help her. But the contract we had with her insurance said we had to use their laboratory, which meant we had to use their products and their prices, and to give the patient the copays they stipulated. None of those things were good for the patient.

We are left with two possibilities. Either we give the patient what is covered, have her pay her copay and come back in two weeks with all the problems we knew she were going to have, or we give the patient what she needs so she can see clearly and write off a huge amount of product at a loss.

This points out one of the issues we run into over and over. When we are forced to use the laboratories the insurers require, we give our patients lower quality products and lower quality services. As you know, doctors are here to take care of people. I got into this practice because I care for my patients and what they need, and all the years of schooling and practice I have had show me how to give them what they need. But some anticompetitive marketing and anticompetitive insurance practices have kept me from doing that properly.

In the last year, I moved into private practice from retail, and since then I have seen this going on more and more. The more I learn about the business, the

more heartbroken I am that I have to tell patients they cannot get what they need.

ANDREW BOREN (Doctor of Optometry, Nevada Optometric Association):
My practice has been in Reno for 24 years now. One issue is that the great majority of our patients are covered by vision plans, but not all of them. When we are mandated to give a large discount on materials that are covered, it forces us to price other materials higher. It also means a higher price for patients who are not covered, patients who pay cash. However, we have to price everything the same; we cannot give a different price for people who are covered and people who are not. That makes the costs higher for people who are not covered.

These companies are big enough that we cannot bargain with them. Their vertical integration is such that they own the labs and frame companies they want us to use, and now they own optometry practices that are direct competitors to us.

MR. HILLERBY:
Many of you have sat through a lot of insurance and mandated benefit hearings over the years, so you know that one of the key pieces within the health insurance world is you exchange volume for lower pricing. The argument is that you get better pricing when the company owns or contracts with a specific lab because of the volume of business they get, in this case from eye doctors, optometrists and ophthalmologists.

That is theoretically possible if you have an arm's length transaction. When the company that owns the plan also owns the manufacturing and the lab, there is no transparency at all. We do not know that lower pricing happens, and in fact we have some evidence that it does not. Based on that Avalon Health Economics study referenced earlier, we saw longer wait times and lower quality practices. Wait times dropped from 15 days to 7 days when they had a choice of labs. When they went to an independent lab, 58 percent reported higher or significantly higher quality. On an average lab order of $231 for lenses, the price increase was $9 at an independent lab. That ought to be an option that is available to doctors and their patients.

These are modest protections that we think make sense. There is plenty of data to back this up. We do not see price increases or gouging of customers; we do not see a lack of affordability and availability of the plans.

SPENCER QUINTON (Doctor of Optometry; President, Nevada Optometric Association):
I am an optometrist in Henderson in southern Nevada and have been practicing for nearly 24 years. I am here in support of S.B. 134.

We consider this the Nevada eyewear and eye care consumer protection bill. It will curb the anti-patient, anti-doctor mandates the vision care plans have been using for years to increase their profits in this vertically integrated business model. As has been discussed, it is at the cost of higher overall prices and reduced access for our patients.

I would like to speak more to the lab choice portion of the bill and how this affects us in real life. I see patients on a daily basis who need glasses for everything they do, patients like bus drivers, students, construction workers and office professionals. Almost everything we do requires good vision. When an individual who requires vision correction loses or breaks their glasses, or simply has a change in their vision that requires a new pair of glasses, these plans nearly always require that the materials are purchased from a lab owned by the vision plan. This often means longer wait times and inferior quality, and some patients will be without their glasses for a time. If they are just replacing their lenses, we may have to send them off for a week or two at a time. If they come back incorrect, they are gone for another week or two.

We have no alternative other than having the patient pay out of pocket, a luxury many people cannot afford. These are people who have paid for these benefits, and they should be able to use them. I feel for the people I see on a regular basis who cannot afford to pay out of pocket for glasses, so they simply go without and suffer with blurry vision. You do not want these people driving, sitting in a classroom or working in a factory.

This bill allows patients to use their benefits at the lab of their choice. They will be able to see more clearly and get their glasses faster and without increased out-of-pocket expenses. I urge your support of S.B. 134.

MR. HILLERBY:
I want to reiterate that vision plans are important. They are good for patients and for doctors. They exist for a reason. The changes in S.B. 134 are modest. The noncovered services language exists in 22 states and the lab choice language in 15 states. Currently, those plans are able to market themselves effectively and competitively, which we think is important.

SENATOR SCHEIBLE:
How is it even possible for insurance companies to require something beyond the services they cover? In the example Senator Seevers Gansert gave, they cover the first pair of glasses and then require the optometrist to offer the second pair of glasses at a 50 percent discount. Is that because the terms of the contract say if you do not agree to this, we will not partner with you as a covered provider?

MR. HILLERBY:
The short answer is yes. It is a mandatory provision of the contract. When they own companies controlling two-thirds of the market, the independent doctor of optometry does not have much negotiating power.

SENATOR SCHEIBLE:
The alternative would be to continue to operate your freestanding or independent practice and not accept vision insurance. Am I understanding that correctly?

DR. BOREN:
That is true. For me, the conflict is bigger than just losing patients. I am a part of the community, and I am seeing the kids of people I used to see. It means not being able to see and serve those people. Not being able to accept patients is a bigger deal than not having their business. We want to be able to serve the people in our community.

CHAIR SPEARMAN:
This sounds like something we heard about some years ago. A couple of big box pharmaceutical companies had this kind of vertical integration. The insurance companies owned a particular pharmacy and required that people go there. There was no choice. Is this the same kind of situation?

MR. HILLERBY:
Yes, it very much is. There are companies that control every piece of the market in the optometric and eye health world. For example, EssilorLuxottica owns EyeMed, which is the largest health plan insurer. They are also the largest manufacturer of frames and lenses in the world. They own their own labs and may be the largest retailer in the world, or one of the largest. They own LensCrafters, Target Optical and other retailers around the world. They earned $26 billion in total revenue last year. That is who Dr. Boren, Dr. Mather and Dr. Quentin must negotiate with.

That sort of anticompetitive behavior is exactly what we are seeing that is ultimately bad for patients. What these plans provide is important, and this bill is asking for some modest regulation of those plans to be sure that patients are protected.

DR. MATHER:
Your example is right on the nose. The reason we are seeing this now is that EssilorLuxottica bought the insurance company in 2015. As they have vertically integrated these last five to seven years, they have realized they can line their pockets twice by charging patients for premiums and charging patients again every time they buy glasses. This is the problem, and it is getting worse. Unless there is some kind of protection in place, it is going to continue until we have no options other than giving patients nothing.

SENATOR SCHEIBLE:
Mr. Hillerby, you mentioned that part of the argument against this bill is that prices would go up. If I follow that line of reasoning, it means the only way prices can go down is if the ones who control pricing say, "No, we are not going to raise prices."

MR. HILLERBY:
Yes. That is where the marketing and vertical integration of these companies make this so interesting to figure out. The local ophthalmologist or optometrist has some control over the price they ultimately charge you for a second pair of glasses that is not covered by the insurance. However, it is not in their best interest to gouge patients. There is a lot of competition out there, and if their prices are too high, they will lose patients.

But vertically integrated companies can set all the prices all the way through the process, and there is no transparency. They own the plans, the labs and the manufacturers and can set those prices, and we cannot see what they are doing. Yes, both sides have the ability to set their own prices, but the profit margins are quite slim for the small optometrist office, particularly against those large retailers. Doctors can set prices, but so much of what they buy is controlled by those same companies. It makes it much more complicated.

In the end, the people who control two-thirds of the market are the ones to say whether prices will go up or not.

SENATOR STONE:
I see a lot of parallels in the pharmacy industry. We have three pharmacy benefit managers that control most of the prescription traffic, and they send all their business to mail-order pharmacies. What you see is the erasure of independent pharmacies. I like going to an independent pharmacy; I was the owner of many of them. I like going to an independent optometrist because I get personalized service.

It sounds like you are dealing with some monopoly interests that are governing what you can do in a contract. It is disturbing that they tell you what you can provide in the way of noncovered insurance coverage. You should be able to sell glasses according to the market. To say that this is going to increase cost for a savvy business person is not real. The independent practitioner can provide personalized service in a way that the larger businesses cannot. Are there other ways in which the independent practitioner is unique?

I hope there is nothing in your contracts with these providers that do not allow you to bravely speak out the way you are speaking out now. I hope there is no retaliatory effort to quiet you down by saying, "We control a lot of your traffic, and we are just going to cancel your contract because you are speaking poorly about us."

DR. BOREN:
The entire menu of materials from anywhere are available to me. At times, I have found myself on the phone with a doctor in Vermont who invented a certain process for making specialty contact lenses to fix eye diseases. I enjoy being able to provide things that are hard to find. Our practice has a lot of

severely developmentally disabled patients. They have a lot of special needs that cannot be filled off the normal menu.

SENATOR STONE:
Over the years, we have seen the scope of what optometrists can do significantly increase. For example, you can treat certain diseases that are not related to vision.

Some of these assembly line, big box optometry departments want you to come in, get the frames and lenses and go. They do not get into more of the specialty services. You might catch something like an imminent retinal detachment and make sure the person gets the appropriate treatment, where a big box store might not because they are just looking for vision issues. Is that correct?

DR. BOREN:
I do not want to malign anybody, but that is what my colleagues who work in those settings tell me.

MR. HILLERBY:
Nevada law, as in other states, makes sure those practices are independent. We want to make sure doctors are able to exercise independent judgment. I do not represent the Nevada State Board of Optometry, but were they here, they would tell you the same thing. You know who your employer is and where you are working, but our doctors pride themselves on following that law and being independent and committed to patient care.

SENATOR STONE:
Regarding specialized services you offer, there are some diseases that run in families, such as diabetes. A practitioner who saw you for a long period of time would know to look for something like that.

DR. MATHER:
That is true. Continuity of care is important in all kinds of health care. For example, three weeks ago, I saw a mother whom I first saw when she was 12 years old. She was bringing in her 6-year-old daughter and a 7-month-old infant. She has a visual acuity of -15, which means she is profoundly nearsighted. She brought her daughter in, and it turned out her daughter is also profoundly nearsighted. At this age, however, she can eventually get to 20/20 vision with therapy. I happened to be there when this little girl got her

first pair of glasses, and it was exciting to watch her be able to see at last. With that in mind, we made an appointment for the baby, and I will see that child within the next few weeks. If she has the same problem and we can catch it before her first birthday, her chances of having 20/20 vision ultimately will be much greater.

CHAIR SPEARMAN:
Mr. Hillerby, you mentioned that EssilorLuxottica had a profit of $26 billion last year, is that correct?

MR. HILLERBY:
That was the total revenue for the entire company.

CHAIR SPEARMAN:
Do you know the average salary for their employees?

MR. HILLERBY:
I do not.

AL ROJAS:
I live in Assembly District No. 12 and Senate District No. 21. I am 63 years old and suffered a retinal detachment. We are all going to be vulnerable to retinal detachments because as you age, your eye turns into water. It is because we are on cell phones all the time. We should be making it easier for a person without insurance to get glasses. I have never had insurance; I have always had to pay cash.

We should make it easier for young kids to have reading glasses so their eyes are not strained and do not develop improperly. This is a huge problem. I almost lost vision in my right eye because I woke up one day and my eye looked like a cherry 7-Up with everything ripped up inside. I have read stories of adults who are working on their computer one day, and the next day they wake up and cannot see. These are true things, and I think any of these optometrists will confirm what I am saying.

We have to increase competition, and we have to make it easier for people to buy glasses. Just about everyone is going to need glasses some day. I ruined my eyes when I was a kid by watching TV.

There is another issue I wanted to raise. I moved to Nevada from California six years ago. I think they should extend prescriptions so they last two years instead of one year.

DYLAN KEITH (Vegas Chamber):
We are in support of S.B. 134. We believe it will provide greater access to care and give more flexibility to providers as they are trying to do their jobs. We think it is a step in the right direction.

CAREN JENKINS (Executive Director, Nevada State Board of Optometry):
We are in the neutral regarding S.B. 134.

While this bill mostly does not affect NRS 636, it does affect optometrists. The Nevada State Board of Optometry takes no position on the bill. However, Mr. Hillerby was correct when he said that we strengthened NRS 636 in 2019 to ensure optometrists were employed only by optometrists, so as to ensure the independent judgment of those healthcare professionals. If an optometrist were employed by a big box retailer who is in the business of selling glasses, the emphasis would become profits rather than patient care. That was unacceptable to the Legislature in 2019 and to optometrists generally.

The Board has noted a marked increase in the number of complaints regarding the quality of eyeglasses provided by optometrists, who in large part were part of this vision insurance program. The complaints ranged from "It takes way too long to get my glasses, and when I get them, the prescription is not accurate" to "My doctor is trying to rip me off." The patients who are complaining have no sense of why their order needs to be sent to labs that take two to three weeks to do the work. Nor do they have an awareness of the quality issues that sometimes come from those labs.

The optometrists themselves would prefer to use an independent lab with a faster turnaround and higher quality. The complaint with the insurance-owned lab is that they have to send the glasses back because the prescription is not accurate, and having them remade takes another two to three weeks. The patient might be without a correct prescription for up to six weeks.

MICHAEL ALONSO (National Association of Vision Care Plans):
We are in opposition to S.B. 134.

In the National Association of Vision Care Plans (NAVCP), eight of our member plans form a diverse market in Nevada and work with Nevada employers to provide vision care benefits to over 2.3 million people. Our member plans reflect different business models, offering different benefits to enrollees in different business policies to providers. In Nevada, 484 vision care providers participate in vision care plans, and on average they choose to contract with more than three of our member plans.

The NAVCP believes that S.B. 134 would increase patient costs by limiting the ability of vision care plans to negotiate prices of services and materials on behalf of the patients. Specifically, the bill would make it illegal for vision care plans to negotiate prices for services and materials that patients pay for out of pocket.

In some instances, markups on eyewear and other vision care materials can be as high as 400 percent over wholesale costs. Discounts negotiated by vision care plans help cut those markups, resulting in a direct cost savings to the patient.

In addition to providing plans at different price points and coverage levels, vision plans make sure the patient receives consistent treatment from all providers. It is important for vision plans to be able to negotiate and verify what discounts and pricing a patient will receive across the plan's network. This is particularly true for vision care practitioners who self-refer their patients to the products available through their own practice. This bill limits the ability of our plans to market different options to consumers in Nevada and pushes all consumers towards higher cost alternatives.

We are happy to work with the bill's sponsor and proponents to try to come up with better language. For now, we are opposed to S.B. 134 as written.

CHELSEA CAPURRO (Health Services Coalition):
The Health Services Coalition is a group of 25 union and employer self-funded health trusts. Some of our members include Boyd, Caesars, Clark County, the Culinary Union, the Teamsters and many others. There are around 280,000 members in the State.

We have concerns about S.B. 134 regarding surprise costs to patients. The provisions in this bill were part of A.B. No. 436 in the 81st Session, and we

objected then as well. That bill included five provisions; we agreed to three of them and worked out amendments. The provisions in S.B. 134 were the two provisions we objected to last Session.

Our concerns are based on our desire to protect our patients from unknown prices and escalating prices. Plans may negotiate with vision plans to ensure our members can affordably get glasses and other vision benefits for themselves and their family members without price gouging. Services offered in addition to these critical benefits are services patients may not need, but the optometrist wants to provide. Patients are not always able to determine what is and is not covered or what is and is not needed. Patients who do not go to a contracted provider will have these costs, but patients who go to a contracted network provider know what the copay will be and that they will not be charged unexpected prices. That is a key reason our plans support having a network.

Vision providers are not required to contract with a plan, and plans establish contracts with vision groups to ensure patients do not have unexpected or confusing bills. We want our contracted providers to help protect our patients, not price gouge them, which is why we try to negotiate discounts on noncovered services. We cannot support sending our patients to a contracted doctor who then charges unknown and unexpected prices for services not in the contract. This bill will prevent our vision plans from negotiating those discounts and protecting our members from high costs.

Lastly, a critical way we ensure vision cost savings for our members is using contracted labs. Those savings are passed to our members through lower premiums and out-of-pocket costs. There may be other ways to address the concerns raised in this bill, and we are happy to work with the Committee and the sponsor.

CARLOS HERNANDEZ (Nevada State AFL-CIO):
We are in opposition to S.B. 134, and we echo all the comments made by Ms. Capurro.

CHAIR SPEARMAN:
Usually in plans related to insurance, the Employee Retirement Income Security Act of 1974 (ERISA) is usually not considered part of that. Does this bill include ERISA plans?

MR. HILLERBY:
It does not. One of the things we learned last Session is that because the plans are so big, they do not operate differently whether they are in an ERISA plan or a traditional State-regulated plan. Because they are so big, they offer the same plan to employer groups, union groups and others. What we hear from members is that you do not negotiate with them; you are given a contract, and you either sign it or you do not. These discounts are not individually negotiated with practices. They are simply part of taking that contract.

We also learned that those plans do not operate differently whether they are in the ERISA market or the state market. They offer the same vision network and the same kinds of benefits and pricing regardless.

CHAIR SPEARMAN:
If this bill were to pass, would it be any different than it is now for all disciplines?

MR. HILLERBY:
That is a question best asked of the plans. It would not be appropriate for me to answer that.

SENATOR SEEVERS GANSERT:
I am the mother of four, and we have been going to the same optometrist forever. It is really helpful to have someone that you can count on. As was mentioned, this is a highly competitive market, and private practitioners have to contract with these large insurers because they dominate the market. I do not think this is going to affect them negatively.

SENATOR DALY:
I have a comment on the ERISA question. The plans under ERISA are regulated by the federal government and are under federal law. In fact, ERISA is exempt from any provision in State law that mandates certain coverages. If an ERISA plan enters into an agreement that is in violation of this provision and somebody says, "Hey, you can't do that, Mr. ERISA plan," the federal government preempts that. We cannot dictate plan design or coverage to an ERISA plan.

Mr. Hillerby is correct when he says that most often, we are not trying to be outside the normal processes in the industry, and there are things covered by

ERISA plans that are mandated by the State. But we do try to make sure our members, the people we are representing, have that coverage.

I see this as a competition issue. Throughout State and federal law and over the history of time, whenever somebody dominates the marketplace in such a fashion that they control what everybody else does, whenever they do things not because they are just or fair but just because they can, the government will eventually come in and regulate that monopoly. If I remember my economics correctly, if you do not have any competition, you will set prices where supply meets demand. You will not set the price so high that nobody buys it because they cannot afford it, and you will not set the prices lower. You will set the price where supply crosses demand to maximize your profit. This is what these companies are attempting to do.

Without some State regulation, without these protections, if the status quo remains the next time contracts are handed out, they will say, "We aren't going to contract with you; instead, we're going to cut you out of the market. We hope you survive, but if you don't, that was our plan in the first place."

Another thing I remember from my economics class is that competition is a good thing. Competition will adjust those prices down. Any arguments I have heard on the other side about prices going up is speculation, and it goes against the economic standards that everybody recognizes. Competition helps, and people will price at the place where supply meets demand. If they are not checked to maximize the profit, that is what will happen. That is what is happening now and why we are trying to adjust it.

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CHAIR SPEARMAN:
I will close the hearing on S.B. 134. Is there any public comment? Hearing none, we are adjourned at 9:39 a.m.

RESPECTFULLY SUBMITTED:

Lynn Hendricks,
Committee Secretary

APPROVED BY:

Senator Pat Spearman, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Introduced on Minute Report Page No.**	**Witness / Entity**	**Description**
	A	1		Agenda
	B	1		Attendance Roster
A.B. 165	C	3	Victoria Carreon / Division of Industrial Relations	Neutral Testimony