December 27, 2022

The Honorable Steve Sisolak
Office of the Governor
101 North Carson Street
Carson City, NV 89701

RE: Patient Protection Commission January 1 Report

Dear Governor Sisolak:

In accordance with NRS 439.918, the Patient Protection Commission (PPC) is respectfully submitting its twice-yearly report to update regarding the meetings and activities of this Commission over the last six months. If further information is required, please contact me at your convenience. Thank you for your work and leadership in our State.

Respectfully,

Malinda Southard, DC, CPM
Executive Director of the Patient Protection Commission
m.southard@dhhs.nv.gov
(775) 750-4089

Cc: Richard Whitley, Director of the Nevada Department of Health and Human Services

Enclosures:
1. PPC January 1 Report
2. Summary Minutes for PPC Meetings Jun. – Nov. 2022

Patient Protection Commission January 1 Report

Background

Nevada Revised Statutes (NRS) 439.902-918 govern the Patient Protection Commission (PPC) to systematically review issues related to the health care needs of residents of Nevada and the quality, accessibility, and affordability of health care. During the 2021 Legislative Session, NRS 439.908 was amended and moved the PPC to the Department of Health and Human Services (DHHS). Additionally, Section 24 of Assembly Bill 348 designated the Commission as the sole state agency responsible for administering Nevada's participation in the Peterson-Milbank Program for Sustainable Health Care Costs.

Meetings and Activities

Since the last report, the Commission held six public meetings. The summary minutes surrounding each meeting are attached for your reference. Highlights of PPC meeting discussion and action items over this timeframe included:

- Discussion, debate, and vote on three PPC bill draft requests for the 2023 Legislative Session
- Health care cost growth mitigation strategies
    1. Provider price caps and provider price growth caps
    2. Prescription drug affordability strategies
    3. Health insurance rate review
    4. All-payer value-based payments
- Nevada's Consumer Health Experience State Survey (CHESS)
- Cost growth benchmark accountability mechanisms
- Lessons learned from other state's health care cost growth benchmark programs (Oregon and Massachusetts)
- Examples to measure primary health care spend in the state
- Implications of inflation for assessing cost growth benchmark performance
- Health Equity Plan
- Comparison of Nevada health care costs with other states

During its August 17, 2022, meeting the PPC voted to move the Stakeholder Advisory Subcommittee to solely an email distribution model soliciting feedback on the Peterson-Milbank Program for Sustainable Health Care Costs. Per NRS 439.912.2(a), each subcommittee expires 6 months after it is created but may be continued with approval of the Commission. This subcommittee is next scheduled for a continuation vote at the February 2023 meeting.

Current Commission Priorities

Bill Draft Requests

The Commission has provided recommendations for legislation in the 2023 Legislative Session working toward improving the quality, accessibility, and affordability of health care in our State. The three bill draft requests submitted in accordance with NRS 218D.213 to the Legislative Counsel Bureau have been printed publicly as Assembly Bills (AB):

- AB6: Health Care Cost Growth Benchmark
- AB7: Electronic Health Records
- AB11: Corporate Practice of Medicine

Peterson-Milbank Program for Sustainable Health Care Costs

Following the designation as the sole state agency responsible for administering Nevada's participation in the Peterson-Milbank Program for Sustainable Health Care Costs, the Commission has been working diligently toward actions to support the Executive Order for Nevada's Health Care Cost Growth Benchmark. Such actions include:

- Discussion and overview of cost growth mitigation strategies; a menu of strategies and actions that can be taken by the state, payers, purchasers, and/or providers to reduce health care cost growth and help all entities meet the cost growth benchmark.
- Deliberating the implications of inflation for assessing cost growth benchmark performance. Achieved consensus to protect the Nevada health care cost growth benchmark value and a firm commitment to acknowledging the impact of inflation and labor shortages when interpreting results of assessing cost growth benchmark performance.
- Received approved funding request to the Peterson-Milbank Program for Sustainable Health Care Costs to support additional Phase 2 health care cost driver analysis reports with Nevada Medicaid and the Public Employees' Benefits Program (PEBP) data.

Through Nevada's participation in this program, Bailit Health is providing technical assistance and support to the Commission and Stakeholder Advisory Subcommittee to engage cross-sector stakeholders in designing, adopting, and implementing policies to measure health care costs. The Peterson-Milbank Program for Sustainable Health Care Costs has currently only authorized Bailit Health to provide technical assistance to Nevada through calendar year 2022; however, a sustainability plan has been developed to continue this important work if Bailit Health technical assistance is, or is not, renewed. This sustainability plan includes a proposal in the Agency Requested Budget and a request for American Rescue Plan Act (ARPA) Fiscal Recovery Funds (FRF) to support technical assistance currently being offered by Bailit Health; followed by engaging and obtaining support of the Governor's Office and the Governor's Finance Office to advance these requests, and meeting with key legislators and staff to share program accomplishments and explain the importance of the program.

Description of Identified Issues

NRS 439.918.2.(a) requires this report to include, without limitation, a description of any issues identified as negatively impacting the quality, accessibility or affordability of health care in this State and any recommendations for legislation, regulations or other changes to policy or budgets to address those issues. Since the last report, the Commission has identified issues related to prescription drug affordability, health insurance coverage, and staff support for the health care cost growth benchmark; each noted below with recommendations.

Prescription Drug Affordability

Identified Issue

As noted by the Commission, a prescription drug affordability review board gives states the ability to limit how much its residents pay for certain high-cost drugs. A drug affordability review board would bring the parties together, increase transparency, and set an upper payment limit/cost sharing arrangement. In several states, there has been significant interest in legislation to further regulate drug prices, and the prescription drug affordability review board offers an opportunity for a coordinated strategy.

Further, Nevada has already taken steps to address prescription drug affordability and a prescription drug affordability review board (PDAB) is a natural step to ensure patients receive affordable healthcare. Nevada, pursuant to NRS 439B.630, requires the Department of Health and Human Services (DHHS) to compile a list of prescription drugs

essential for treating diabetes (Essential Diabetic Drugs or EDDs), a list of those Essential Diabetic Drugs that had a significant price increase as well as other medications that had a significant price increase and cost more than $40 per course of therapy in Nevada.
All manufacturers that produce medication included in Nevada's Essential Diabetes Drug List are required to submit to DHHS a report with data outlining drug production costs, profits, financial aid, and other drug-specific information and pricing data (NRS 439B.635). For drugs that experienced a recent significant price increase, manufacturers are required to submit a report that provides a justification for these price increases (NRS 439B.640).

Pharmacy Benefit Managers (PBMs) are required to submit reports regarding rebates negotiated with manufacturers for drugs on both the Diabetic Essential Drug List and the Over $40 Drug List (NRS 439B.645). DHHS is also required to maintain a registry of pharmaceutical sales representatives that market prescription drugs in Nevada (NRS 439B.660). These representatives are required to annually submit a list of health care providers and other individuals to whom they provided drug samples and/or individual compensation events exceeding $10 or total compensation exceeding $100 during the previous calendar year. Along with the work the PPC has done in establishing the cost growth benchmark and all payer claims database (APCD), these measures establish a firm footing to meaningfully address rising costs associated with healthcare through the establishment of a PDAB.

Recommendation
During its August 17, 2022, meeting, the Commission voted to provide a letter of support to Nevada Legislators regarding creation of a prescription drug affordability board (PDAB) and to set "allowable rates" for certain high-cost drugs identified by the PDAB.

Health Care Coverage Analysis

Identified Issue
During its August 17, 2022, meeting, the Commission voted to support exploring opportunities to provide basic health care coverage to infants, children and young adults up to age 26 who are ineligible for full Medicaid coverage under federal law due to their current residency or immigration status. This includes hiring a vendor to develop recommendations to the PPC on options to achieve this goal with non-federal, available revenue sources, including braiding local government, private grant, philanthropic, and/or state resources to support this effort. Further, among the options considered by the vendor shall include a limited, state-funded Medicaid benefit for this population, that leverages limited federal Medicaid funds available to this population for emergency services as part of this benefit. The vendor shall also be asked to conduct a return-on-investment study of at least two options selected by the PPC to inform future proposals and budget requests as they relate to addressing the growth in health care costs related to the health status of this population.

This issue and recommendation are supported by research by the Guinn Center for Policy Priorities on the number of individuals ineligible for full Medicaid coverage based on residency or immigration status in Nevada. The Guinn Center for Policy Priorities discovered that this population is estimated to be 30 percent of the state's uninsured population. When considering more recent statistics about the number of individuals without health insurance in Nevada, this population likely consists of about 90,000 residents. Without tangible policy solutions to this problem, Nevada will continue to face the downstream effects of leaving this sizeable population without access to affordable health care services.

Further, as noted by FamiliesUSA in a 2021 report titled: *The Catastrophic Cost of Uninsurance: COVID-19 Cases and Deaths Closely Tied to America's Health Coverage Gaps*; each 10% increase in the proportion of a county's residents who lacked health insurance was associated with a 70% increase in COVID-19 cases and a 48% increase in COVID-19 deaths. In other words, people living in communities with very high rates of uninsurance were much more likely to contract the virus and to die than were people living in communities with relatively few uninsured. Moreover, health insurance gaps had a particularly powerful impact on COVID-19 illnesses and deaths in certain states – including Nevada:

- In 11 states (Nevada being in the top 9), illnesses linked to health insurance gaps comprised at least 50% of the state's total COVID-19 **illnesses** from 11/22/20 through 8/31/21; and
- In 10 states (Nevada being in the top 10), health insurance gaps were linked to at least 40% of the state's total COVID-19 **deaths** from the same time period.

Recommendation

In addition to a letter of support to Nevada Legislators on this topic, the Commission has recommended a $200,000 line item in the Department of Health and Human Services (DHHS) Budget Account (BA) 3055 agency budget for the new biennium (beginning July 1, 2023) to secure funding for a vendor to best perform this fiscal and policy analysis and modeling necessary for informing Nevada policymakers about valuable and feasible solutions for meeting the health care needs of this uninsured population.

Staff Support for the Health Care Cost Growth Benchmark

Identified Issue

The Patient Protection Commission was designated through Assembly Bill 348 in 2021 to be the sole state agency responsible for implementation of the Peterson-Milbank Program for Sustainable Health Care Costs. The Peterson-Milbank Program recommends that each state should identify a core team which includes a full-time senior director to lead and prioritize the work and a group of individuals to support program operations. Further, the team should be responsible for the strategic guidance of the state's cost growth benchmark program; project management; convening and managing meetings; engaging stakeholders; managing contractors; communicating with legislators; and general program messaging to the public. This core program team will need to obtain feedback and necessary approvals from state agencies or others to report information and findings from analyses publicly.

Recommendation

Given these recommendations from Peterson-Milbank and workload considerations for a current Full-Time Equivalent (FTE) staff total of three in the Department of Health and Human Services (DHHS) Budget Account (BA) 3055 (for the Patient Protection Commission); the program has developed and proposed a sustainability program in the Agency Requested Budget. This budgetary request is in alignment with the Commission's proposed legislation to the 2023 Nevada State Legislature: Assembly Bill 6.

Collaboration

NRS 439.918.1, paragraphs (a) and (b) additionally requires the Commission attempting to identify and facilitate collaboration between existing state governmental entities that study or address issues related to the quality, accessibility, and affordability of health care in this State, including, without limitation, the regional behavioral health policy boards created by NRS 433.429; and attempting to coordinate with such entities to reduce any duplication of efforts among and between those entities and the Commission.

State Governmental Entities

The Commission's executive director was appointed in April 2022 and has been busy getting to know the state agencies involved in furthering the charge of the Commission and has since presented to, and/or met with the following:

- Joint Interim Standing Committee on Commerce and Labor; PPC introduction and health care cost growth benchmark.
- Nevada Department of Corrections; health care cost growth benchmark aggregate data request.
- Commissioner's Advisory Committee on Health Care and Insurance; PPC introduction and health care cost growth benchmark.
- Introductory meeting with the Nevada Office on Minority and Health Equity.
- DHHS Pharmacy Policy Advisor; pharmacy price strategy options.

- Regional Behavioral Health Policy Boards; PPC introduction and health care cost growth benchmark.
- Division of Health Care Financing and Policy; PPC and health care cost growth benchmark.
- Division of Insurance; PPC and health care cost growth benchmark data requests.
- Nevada Governor's Office of Science, Innovation and Technology (OSIT); Graduate Medical Education program.
- Nevada Public Employees' Benefits Program (PEBP); PPC and health care cost growth benchmark.
- DHHS, Tribal Liaisons, and DHHS Tribal Consult; PPC introduction and health care cost growth benchmark.
- Division of Public and Behavioral Health; PPC proposed BDR topics.

The Commission is willing to collaborate with any state governmental entity that studies or addresses issues related to the quality, accessibility, and affordability of health care in this State; and looks forward to continuing this practice through open communication with the Commission and offering direct collaboration from the executive director.

Reduce Duplication of Efforts

The Commission is committed to attempting to coordinate with any state governmental entity to reduce any duplication of efforts among and between those entities and the Commission. A direct opportunity to reduce such duplication has not yet presented itself, however the Commission will remain vigilant on this matter.

Next Steps

The Commission is next scheduled to meet in January 2023. Expecting to receive a debrief on the Phase 2 health care cost driver analyses from both Nevada Medicaid; and as a proxy for the commercial market – the Public Employees' Benefits Program (PEBP), with a focus on pharmaceutical and hospital spending. These analyses will help paint the picture on part of what is driving up health care costs in the state. Additionally in the first half of 2023, the Commission intends to explore in much greater detail four health care cost growth mitigation strategies, learning more about their applicability and potential effectiveness in Nevada. Expected outcome of both activities is leading to well-informed future health policy recommendations from the Commission.

Enclosure:

1. Summary Minutes for PPC Meetings Jul. – Nov. 2022

SUMMARY MINUTES

June 15, 2022

Pursuant to NRS 241.020(3)(a) as amended by Assembly Bill 253 of the 81st Legislative Session, this meeting will be convened using a remote technology system and there will be no physical location for this meeting. The meeting can be listened to via telephone or viewed live over the Internet.

Agenda Item I - Call to Order, Welcome and Roll Call

Chairman Khan called the regular meeting to order at 9:00 a.m. Those in attendance and constituting a quorum were:

Commission Members Present

Bobbette Bond
Sara Ralston
Lilnetra Grady
Flo Kahn
Dr. Ikram Khan
Leann McAllister
Yarleny Roa-Dugan
Sandie Ruybalid
Dr. Beth Slamowitz
Dr. Tiffany Tyler-Garner
Mason Van Houweling

Commission Members Absent

Leann McAllister, excused
Tyler Winkler, excused

Advisory Commission Members Present

Georgina Castaneda, representing Silver State Health Insurance Exchange
Laura Rich, Executive Officer, Public Employees Benefits Program (PEBP)
Barbara Richardson, Insurance Commissioner Nevada Division of Insurance (DOI)
Richard Whitley, Director Nevada Department of Health and Human Services (DHHS)

Commission Staff Present

Malinda Southard, Executive Director
Suzanne Sliwa, Deputy Attorney General

Agenda Item II - Approval of May 18, 2022, Minutes

Ikram Khan, Chairman

The Commission was presented with an email draft of the summary minutes of the May 18, 2022, meeting.

MOTION was made to approve minutes of the May 18, 2022, meeting as presented, by Commissioner Van Houweling. Seconded by Commissioner Tyler-Garner. Carried without dissent.

Agenda Item III - Public Comment

Helen Foley, Foley Public Affairs, Representing Nevada Association of Health Plans
Her industry is concerned with the lack of representation on the PPC. She recommended the PPC consider a Bill Draft to add an individual representing the insurance industry and provided examples of where the industry perspective could be beneficial. This included during PPC Bill Draft Request deliberations, not limited to fiscal impact and premium tax implications, affordable housing initiatives and Employee Retirement Income Security Act (ERISA) preemption to name a few. She added only 17 percent of the fully insured product in Nevada is regulated by the Division of Insurance. The Nevada Association of Health Plans wants to be a good partner to the PPC. Dr. Khan noted that the makeup of the commission is not determined by the PPC, but by the Legislature and Governor's Office.

Patrick Kelly, CEO, Nevada Hospital Association
Highlighted the issue of severe nursing and physician shortages in Nevada. Nevada is near the bottom nationally with regard to number of licensed nurses and physicians per 100,000 population. Recommends PPC proceed cautiously with any measures that can possibly reduce physicians in Nevada. Quality healthcare and improved access requires having enough providers to deliver the care.

Agenda Item IV - Review and Discussion of Possible Bill Draft Request Topics

Malinda Southard, Executive Director

BDR Topic 1-6 were presented for discussion during the 5-18-22 meeting. Today the discussion is opening to discussion topics 7-16. Executive Director Southard wants to ensure all commissioners have adequate time to discuss and understand each topic in order to make fully informed decisions or recommendations.

Topic #7 Expand Medicaid Benefits to All Children regardless of Immigration Status. On behalf of Commissioner Leann McAllister.

It was suggested that a 1332 waiver request be submitted, and Executive Director Southard read into the record a statement of why this may not be the appropriate tool for this proposed expansion. Other comments included this would be a major fiscal impact on the state, and it would be helpful to know what the specific impact might be before weighing the pros and cons. Another commissioner wanted to know approximately how many undocumented individuals in Nevada would be eligible under this proposal.

Commissioner Ralston wanted to clarify she wished to have an open discussion with the other commissioners before deciding on any topics to formally bring forward. She does not want to be duplicative and still intends to make a recommendation or support other commissioner's measures.

Topic #14 Ensure Pharmacy Rebates Are Passed on to Patients - This proposal would require pharmacy benefit managers and health plan insurers to pass along the rebates and discounts provided by drug manufacturers to patients at the pharmacy counter. Commissioner Flo Kahn.

Commissioner Kahn notes this would be a direct benefit for prescription drug costs to the consumer. Current discounts are provided to Pharmacy Benefit Managers (PBMs) to get placement on the formulary, but these rebates were always intended to go to the consumer. There could be a percentage of the rebates that are passed on and the patients would immediately see costs reduced for those products with rebates.

Some of the comments regarding this topic included but were not limited to, this topic does nothing to change the high price of drugs themselves and nothing to ensure that insurance companies do not pay higher prices, which leads to higher premiums. It is an artificial solution and superficial fix pushed by the industry. PhRMA lowering their prices is a much better solution. Commissioner Kahn pointed out there are perverse incentives built into the system. If the costs of the drugs are lower, the drug does not get placed on the formulary. Getting rid of rebates must happen at the federal level. This proposal will get cost savings to the consumer quicker. Commissioner Slamowitz mentioned the biggest problem is that there is no transparency in the commercial market. This proposal does not get to the core of the issue or address the price of drugs. It does not change the back end of the cost to health plans. It is not effective for the larger issue of costs. Commissioner Kahn added that West Virginia has just passed a similar law so we will have good data to show how a similar proposal might work and if it would benefit consumers. Another commissioner opined costs start at the manufacturing level and are astronomical. This needs to be examined from all levels.

#15 Reduce Pharmacy Costs for Patients with Chronic Conditions - Eliminates the pharmacy deductible for patients who have a chronic condition. Commissioner Flo Kahn.

If the pharmacy deductible is eliminated, patients would have coverage on day one. Initially costs go up because utilization goes up. Some comments included but were not limited to this is proposed in the absence of pharmaceutical manufacturers coming to the table to reduce costs, which deductibles are in place to do. It still makes more sense to reduce the cost of drug. Another agrees and adds even if the deductibles are eliminated, the cost of drugs have not changed, and the manufacturers will still find a way to pass it on the consumer with higher premiums. Is better to simply lower price of the drugs. PEBP Executive Officer Rich pointed out that for high deductible health plans, there are IRS requirements that you cannot necessarily carve out deductibles. Commissioner Kahn added IRS indicated that for certain chronic conditions, you cannot have a pharmaceutical deductible because they do acknowledge those patients have a need for that medication and thus have eliminated the requirement for a deductible.

#16 Increase Access to Naloxone - Classify Naloxone as an over-the-counter (OTC) drug to increase access through harm reduction programs. Commissioner Beth Slamowitz.

This would allow community-based programs to obtain Naloxone from any board-licensed wholesaler, which in turn, would increase Naloxone access in vulnerable and underserved communities and help to combat the opioid and overdose crisis in Nevada. Nevada has passed laws to simplify access and distribution, but there is still more that can be done. Access to Naloxone has not reached a saturation point across the nation and there continues to be an opioid epidemic. There are legal and regulatory barriers. Nevada does not have a statewide standing order in place, and availability is variable. Because we cannot address supply chain and federal restrictions, the state can increase access through where and how we purchase to get Naloxone to harm reduction providers. One commissioner asked if this has been part of the discussion of the Attorney General's (AG's) Substance Use Response Working Group. Commissioner Slamowitz has not tracked those discussions and would be interested to know that as well.

#9 Create Prescription Drug and Health Plan Review Boards. On behalf of Commissioner Tyler Winkler.

Presented by Executive Director Southard in Commissioner Winkler's absence, this measure would give the state the ability to bring parties together and establish an upper payment limit arrangement. This directly addresses accessibility and affordability. Prescription drugs are one of the main drivers of cost growth. These boards could function as part of or in conjunction with the PPC so would be minimal costs to the state or absorbed by state agencies. One commissioner shared what she has seen in other states about the proposed affordability boards: They are very labor intensive and also require an adequate avenue of data to in order to support the costs to implement, therefore she disagrees in terms of the fiscal impact. Additionally, she believes there will need to be fiscal support due to the labor intensiveness of the proposed boards. Prescription Drug Affordability Boards have been brought up in the past in Nevada and have failed for these stated reasons, so this is a concern for her. Another commissioner commented she recognizes these boards cannot be operated without resources. She also feels compelled by the information that will be coming out of the benchmarking program. Added, in other states similar proposed boards also failed because of lawsuits filed by the pharmaceutical industry and believes we should also acknowledge that. The self-insured market uses the big commercial plans, Aetna, United, etc., so their numbers were not included in that 17% mentioned by Ms. Foley in public comment. She wants to ensure the PPC does not only see things through that lens and that the PPC understands that.

#8 Expand Access to the Private Insurance Marketplace (Silver State Health Exchange) regardless of immigration status. On behalf of Commissioner Tyler Winkler.

Presented by Executive Director Southard in Commissioner Winkler's absence, this measure would permit access to Nevada's private insurance marketplace regardless of immigration status. Some of these comments were also mentioned during discussion of Slide #5: Medicaid expansion. One commissioner noted they would like to request additional follow-up context for what this proposal looks like and the legal parameters; why not all, regardless of immigration status, may access this now.

#10 Address Health Care Market Consolidation to address the rising costs created by health care market consolidation by prohibiting hospitals and possibly some other facilities, such as freestanding ERs, from hiring physicians and revise the exemptions now in law to ensure only community hospitals and academic institutions are exempted. Commissioner Bobbette Bond.

Commissioner Bond notes there is supposed to be a requirement that physicians cannot be hired directly by hospitals. Nevada has this law in place, and it has gotten muddled. She would like this BDR to clarify existing law as this confusion is increasing in the face of now severe physician shortages. If a physician is hired directly by a hospital, other hospitals do not have access to that physician. This limits access to care especially for some specialties where there may be only one or two specialists in a particular area or in the entire state. One commissioner believes this could be a double-edged sword and needs to be carefully reviewed to ensure that there are no unintended consequences. Another commented she is interested in this topic and further discussion to help rein in price for patients. She also mentioned that an early presentation to the PPC from Dr. Jaime King addressed what other states were doing and that it might be helpful to recirculate this to the current PPC members for reference. Another commented that he is also aware of the existing law and the possible need to revisit the Attorney General's (AG's) opinion with this administration. Need to investigate if this proposal and the interpretation of law creates issues in the community for unique services when there are only a handful of providers for millions of individuals. When a provider comes "off the market", this limits access and puts a strain on the market overall. Need to review the existing laws to ensure they are being complied with appropriately. Need to encourage new providers to come to our state and compete in a free market. Another noted that for physicians who move to rural areas, this has been an issue forever and a huge challenge for access. Commissioner Bond explained the intent of this BDR is not to impact where the physician chooses to practice. More so, it is proposing clarification that a hospital cannot require the

physician to only practice at that hospital and is therefore tied by contract to only that facility. Additionally, public hospitals that are required to take care of everybody need all resources available. She appreciates all the comments, but current law is inconsistent in how it's applied, and clarification is needed through legislation.

#11 Require Transparency of Health Care Cost Data. Commissioner Yarleny Roa-Dugan.

The public needs more transparency regarding what hospitals and insurance companies charge. California has a look-up tool for certain procedures so the patient can compare health care procedures in an "apples-to-apples" comparison. Suggestion is to do this for not just certain procedures but for all health care expenses. She would like to introduce a measure to require DHHS, or the appropriate government body to create a freely accessible database of the cost to patients for a comprehensive list of medical procedures/treatments in situations where patients are paying out-of-pocket. As well as when using the different medical insurances available in the state and at various medical facilities in Nevada. The database should facilitate patients price shopping and making apples-to-apples comparisons, similar to the Procedure Price Lookup tool required by Congress in the 21st Century Cures Act. One commissioner pointed out that it is a complex and complicated scenario to come up with the cost of a procedure, as there are multiple variables. Also, there are different rates because insurers negotiate contracts with separate entities. It is difficult to come up with a comprehensive list price, especially if a complication arises. Another commissioner opined that a hospital provides more services than a freestanding Emergency Room (ER). The PPC should work on this proposal by utilizing the All-Payer Claims Database (APCD), benchmarks, and Federal work. This commissioner would like to hear from DHHS on what is already available and can be provided. Commissioner Roa-Dugan explained this tool could at minimum, give patients a starting price on procedures as an option instead of waiting until they must go to the ER. Price transparency mandated for all health plans. DHHS Director Whitley mentioned they have infrastructure out of the 2021 legislative session from the work on balance billing between health plans and the Office of Consumer Health. DHHS has a synergy there and can go into more detail on what the costs would be to add to transparency, and they do have a capacity already existing.

#12 Prohibit Certain Provider Billing Practices. Commissioner Bobbette Bond.

This is a request received from the health services coalition, representing 25 different health plans. Would like to propose ways to reduce the price of care when not providing care so as to not reduce services. Some costs are being charged that have nothing to do with patient care. For example, if a physician practices in a medical office, they can charge for care; if that same physician moves to a hospital campus to provide care, they can add a facility fee to that charge which is an increase in costs, but not an additional service. A second example is charging patients to fill out forms even though no services are provided. A third example is trauma fees for patients when they do not need trauma services. Need to stop the practice of billing patients when no care is provided. One commissioner feels this is of interest, especially for level 1 trauma centers. If a facility is not a designated trauma center, there should not be charged trauma center fees. A lot is involved in the presentation of a true trauma patient. The activation process is a significant undertaking. Need to carefully look at this before we get into charges for trauma.

#13 Review Insurance Benefit Design and Cost-Sharing. Unclaimed.

No comments or discussion.

Commissioner Ralston requested a process to group the BDRs by subject and have a review by an attorney for the single subject rule.

Discussion of this agenda item was completed for this meeting.

Agenda Item V – Overview of Nevada Health Care Quality Performance Data and Discussion of Potential PPC Recommendations
Michael Bailit, President, Bailit Health

Mr. Bailit began with a presentation on reviewing the health insurer and hospital performance data in NV. To evaluate the current state of health care quality in Nevada, Bailit Health carried out the following exercises: an assessment of Nevada's commercial and Medicaid performance on a targeted sample of national health insurer quality measures developed by the National Committee of Quality Assurance (NCQA); and comparing that performance to national benchmarks using NCQA's Quality Compass database. (Not publicly assessable, but they paid a fee to access.) Bailit Health's second analysis was an assessment of the overall Medicare Star Ratings and patient survey ratings for the largest hospitals in Las Vegas, Carson City, and Reno, using Medicare's Care Compare tool which is publicly accessible.

Points of interest included, absolute rates for quality measures declined nationally due to COVID and commercial rates are often, though not always, higher than Medicaid rates. A commissioner questioned why data was not submitted for certain payers? Mr. Bailit responded he did not know why they were not reported but suggested to take a step back and look overall at whether there is room for improvement. Mr. Bailit clarified this data was a relative comparison of how Nevada compares to other states. One commissioner stated for clarification that the Medicare patient survey is about perceptions of care and wanted to know what the overall rating included. Mr. Bailit asked Commissioner Van Houweling to explain. Commissioner Van Houweling pointed out the survey includes quality measures around hospital acquired conditions, outcomes, safety, mortality, etc. The Hospital Care Assurance Program (HCAP) scores are for patient safety and offers a comparison between like-sized hospitals across the country. This data being presented is for 2020. A commissioner commented to also keep in mind that larger hospitals have more difficulty keeping tabs on the benchmarks than smaller hospitals and patient satisfaction is subjective. Commissioner Van Houweling reminded the group that in 2020 Nevada hospitals were hit hard but added that is not an excuse, and still need to do better to improve ratings overall. A commissioner asked if Nevada's ratings were higher prior to the pandemic. Commissioner Van Houweling responded the HCAP rating is a cumbersome survey, and while not making excuses, Nevada was still well below the national average. We need to do better. A commissioner asked if Commissioner Van Houweling could bring back to the PPC strategies to improve these scores. She also wondered if there is a way to compare hospital systems to sister hospitals in other states with national systems feeling this could be helpful information for the PPC. Mr. Bailit responded they could do that, and Commissioner Van Houweling responded he will put this request on the Nevada Hospital Association's (NHA's) agenda and is glad there is visibility on this.

Use of Quality Benchmarks in Other States - One commissioner asked why certain measures were selected and others discontinued. Mr. Bailit responded the states looked at things such as where improvement was needed and could be achieved. They also developed principles and criteria for selection.

Discussion was had regarding pursuing quality improvement strategies in Nevada. A commissioner asked if this should be in conjunction with the PPC Bill Draft Requests. Mr. Bailit answered quality improvement is possible without legislation. Another commissioner asked if there were quality improvement initiatives in other states that involve hospitals which could be brought back to the PPC. Mr. Bailit answered that work also exists. Another commissioner was supportive of pursuing quality benchmark strategies in response to specific challenges we are seeing in Nevada. Nevada Division of Insurance Commissioner Richardson noted for the commissioners to also take into consideration that some entities cannot meet quality benchmarks. One PPC member wondered if Commissioner Van Houweling could take the PPC strategies presented to the NHA to ask if they might be supportive, instead of strategies simply being imposed on them. Commissioner Van Houweling let the PPC know the NHA annual meeting was coming up soon and he will raise it there. A

commissioner mentioned the PPC should focus on quality and finds it helpful when Mr. Bailit presents on what is happening elsewhere. Mr. Bailit reminded the commissioners they will have to consider how to pick priorities and criteria to identify because the opportunities are vast.

Agenda Item VI - Public Comment

No Public Comment

Agenda Item VII - Wrap up and Adjournment
Dr. Ikram Khan, Chairman

Meeting was adjourned at 11:25 a.m.

Respectfully submitted,

Lezlie Mayville
Office of the Patient Protection Commission

APPROVED BY:

Dr. Ikram Khan, Chair

Date: August 1, 2022

Meeting Materials

AGENDA ITEM	PRESENTER	DESCRIPTION
IV.	Malinda Southard, Executive Director, PPC	BDR Compilation of PPC Polling
V.	Michael Bailit, President, Bailit Health	Bill Draft Requests Review and Quality of Nevada Health Care

SUMMARY MINUTES

July 20, 2022

Pursuant to NRS 241.020(3)(a) as amended by Assembly Bill 253 of the 81st Legislative Session, this meeting will be convened using a remote technology system and there will be no physical location for this meeting. The meeting can be listened to via telephone or viewed live over the Internet.

Agenda Item I - Call to Order, Welcome and Roll Call

Chairman Khan called the regular meeting to order at 9:00 a.m. Those in attendance and constituting a quorum were:

Commission Members Present
Bobbette Bond
Sara Cholhagian Ralston
Dr. Ikram Khan
Leann McAllister
Yarleny Roa-Dugan
Sandie Ruybalid
Dr. Tiffany Tyler-Garner
Mason Van Houweling
Tyler Winkler

Commission Members Absent
Lilnetra Grady, excused

Advisory Commission Members Present
Ryan High, Executive Director, Silver State Health Insurance Exchange
Laura Rich, Executive Officer, Public Employees Benefits Program (PEBP)
Richard Whitley, Director Nevada Department of Health and Human Services (DHHS)

Advisory Commission Members Absent
Barbara Richardson, Insurance Commissioner Nevada Division of Insurance (DOI), excused

Commission Staff Present
Malinda Southard, Executive Director
Suzanne Sliwa, Deputy Attorney General

Agenda Item II – Approval of June 15, 2022, Minutes

Ikram Khan, Chairman

The Commission was presented with an email draft of the summary minutes of the June 15, 2022, meeting.

The Chair asked if there were any additions or subtractions to the minutes. None were suggested and approval of the minutes were carried without dissent by those present.

Agenda Item III – Public Comment

Patrick Kelly, CEO, Nevada Hospital Association

Mr. Kelly addressed the severe physician shortage in Nevada. Nevada already has issues with retention and recruitment of physicians. The state is ranked at the bottom in many national statistics for active physicians, primary care physicians, and general surgeons. Nevada is below the national average in 34 of 39 physician specialty areas, which restricts access to care. The Nevada Hospital Association is very concerned with a proposed Bill Draft Request (BDR) the PPC is considering which would impact existing physician shortages. New doctors have opportunities to practice most everywhere in the United States, need a stable and predictable income, and quality of life. Nevada needs to be able to recruit them and to provide options that meet their needs such as joining established medical practices, or hospitals. The logistics of physicians practicing at multiple hospitals eats away at valuable time that could be spent with patients. Other points to consider in this proposed BDR would be what happens to current doctors employed by hospitals? Would their contracts be terminated, and would that drive them to leave the state? These are questions the PPC should carefully contemplate. The physician shortage in our state is real and the PPC should not do anything to make it worse. Please allow doctors to choose how they wish to practice in our state.

Agenda Item IV – Reappointment of Stakeholder Advisory Subcommittee of the Peterson-Milbank Program for Sustainable Health Care Costs and Suggested Members

Malinda Southard, Executive Director

Chair Khan asked if everyone received the list of possible members and polled all members present. The list of suggested members was approved by Chair Khan, Commissioners McAllister, Van Houweling, Tyler-Garner, and Ruybalid. Commissioner Winkler asked if those on the list were willing to serve and Executive Director Southard responded that she has verified with all but two of those listed. Commissioner Winkler was satisfied and approved the list of names. Commissioner Ralston wanted to be sure that former actively participating members had the opportunity to continue, and Executive Director Southard confirmed they did. Commissioner Ralston had no objection to the list. Commissioners Bond and Roa-Dugan did not opine, and Commissioner Grady was absent, excused. A final decision will be made at the August meeting.

Agenda Item V – Review and Discussion of Possible Bill Draft Request Subjects and Topics

Malinda Southard, Executive Director

Executive Director Southard reviewed the format for this agenda item and added information provided in the Overview BDR Document and Detailed BDR Document. She gave the commissioners who provided clarified or additional information the opportunity to present their topic revisions. State Subject Matter Experts (SMEs)

present at this meeting were Dr. Antonina Capurro, State Medicaid Non-Clinical Services and Dr. Beth Slamowitz, in charge of State Pharmacy Strategies, along with PPC Ex-Officio Members, Ryan High, Laura Rich, and Richard Whitley, all of whom are SMEs for their agencies.

Subject 3, Topic 1 Additional Information or Revisions

Commissioner Van Houweling began by stating how much he appreciates the way this process has been organized and presented. He reiterated that this BDR goal is to encourage exchange of health information between systems. Chair Khan inquired if anyone was opposed or felt this topic should be eliminated. Chair Khan asked what work had been done to avoid Health Insurance Portability and Accountability Act (HIPAA) conflicts. Commissioner Van Houweling said patients already have electronic limited access to their records. This bill would give patients more direct access to transition from provider to provider. Another commissioner noted the purpose of this topic is attempting to connect Electronic Health Records (EHR) to EHR, so the patient has access to all clinical and diagnostic records; while continuing to follow all Centers for Medicare and Medicaid Services (CMS) and Federal regulations. Another Commissioner shared these are Federally mandated requirements and they do have standardized ways to protect health information. All HIPAA protections would still be in place. This is about improved patient access to the records. The other BDR topic that had clarifying changes will be skipped over until Commissioner Bond arrives to present her changes.

Executive Director Southard shared the overall BDR topics poll results, indicating how many responses each BDR received. Two BDRs had 5 responses; three BDRs had 4 responses; one BDR had 3 responses; and the rest had 0-2 responses. Mr. Bailit clarified there were a top five in BDR topics. One commissioner asked if among the top 5 topics, is there any natural alignment that could allow for combining. The PPC began discussing the top BDR topics receiving 5 and 4 responses via the poll.

Subject 2, Topic 1- Codify the Nevada Health Care Cost Growth Benchmark Program as set forth in EO 2021-29 and include a requirement to measure and report on primary care spending (5 responses):

One commissioner feels this BDR specifically "report on primary care spending", has some similarities with his BDR suggestion that would establish prescription drug and health plan affordability review boards because they are all related to affordability. Another commissioner agreed. There were no other comments.

Subject 3, Topic 1- Mandating that all providers of health care and custodians of healthcare records implement an interoperable electronic health care records system. Expand immunity for provider compliance with providing and receiving electronic medical records. Revision of Nevada Revised Statutes (NRS) 439.584 with relation to Health Information Exchange (HIE) and other areas identified, with PPC supported funding options (5 responses):

One commissioner questioned since there was a federal mandate to support this policy if this was already being implemented or under consideration of any other committees or legislators. Another answered that they do not know yet. The Chair noted the Federal Mandate is still in limbo. Deadlines have come and gone so we do not know yet who will enforce/implement the requirements. A commissioner added the need to ensure that the recommendation is compliant with current state and federal laws. Another wishes to see the specific revisions to the NRS and ensure DHHS has an opportunity to weigh in since Legislators will ask questions about logistics and funding. Also, she recommended if this moves forward there must be clear and concise language and correct intent on patient access. The Chair noted legal and other experts will address those questions and it can be added to the August meeting based on the intent of the commissioners. Another commissioner reported currently with Nevada's WebIZ system if a provider is not a Vaccines for Children (VFC) provider, they are not mandated to input the inoculation information into WebIZ. She inquired because there is a lot of missing information in the electronic health record (HER) systems we have now, will this proposed BDR topic additionally mandate providers to input all information into WebIZ?

The Chair thinks this is a good point. SMEs will have to investigate this and the fiscal impact, to be discussed at the next meeting.

Subject 1, Topic 1- Explore opportunities to provide basic health coverage to infants, children, and young adults up to age 26 who are ineligible for full Medicaid coverage under federal law due to their current residency or immigration status (4 responses):

One of the commissioners asked the SMEs about implementation and how it might work logistically. How to validate when looking at income, estimates on whether/how it would impact the state budget, etc. Ten percent of the state's population is uninsured even though Nevada is an expansion state, how mush would this add to the Medicaid program? The Chair added it was much more complex than what we see in the brief language. Do not want to become a medical tourism location. Directory Whitley pointed out that Nevada is one of the first states to integrate eligibility. We already have mixed eligibility for families. This helps the state have a building block and can also help with entering lines for social services and other residents are not aware they may be eligible for. A commissioner asked Director Whitley what is foreseen happening on the emergency Medicaid side. Director Whitley responded he does not see any changes to the emergency Medicaid program, and it would in no way restrict access. If anything, that program could be a touch point for other services people may be eligible for. Another asked the Director about the impact of taking care of very sick patients and the physician not being reimbursed, but the hospital is. Director Whitley explained DHHS is currently fully maximizing CMS rules related to emergency Medicaid so any additional coverages would have to be paid from the state general fund. A commissioner asked if this proposal would expand coverage beyond the acute care episode and could mitigate the need for higher cost care if care given in the right setting. Director Whitley deferred to Dr. Capurro whether certain aspects are reimbursable. Chair Khan asked for a fiscal impact analysis at the next meeting. He feels health care is just as important as education and we must find ways to provide these resources in our state. Dr. Capurro added it would be a Medicaid benefit not federally funded, meaning it would require 100% state funding. There are a lot of questions, and some answers are needed first to create a fiscal impact summary. Chair Khan again reiterated a minimal analysis would be important to have if the PPC decides to move this topic forward. Dr. Capurro said she would take this request back to her team, but they may have to make some assumptions. A commissioner reminded the group that this proposal is to explore the opportunities for coverage for those ineligible for full Medicaid with a study. To have the state take time now for a fiscal analysis is not material to this proposal. The Chair is asking for a first phase of exploration seeking some groundwork on this topic.

Subject 2, Topic 3- Address the rising costs created by health care market consolidation by prohibiting hospitals and possibly some other facilities, such as freestanding ERs, from hiring physicians. Revise the exemptions now in law to ensure only community hospitals and academic institutions are exempted (4 responses):

Commissioner Bond noted this request is to prohibit the corporate practice of medicine in Nevada. The corporate practice of medicine doctrine was established in Nevada and there have been at least 2-3 efforts to end that prohibition. This proposal is an attempt to clarify the statute to ensure interests are aligned around one law. Corporate practice of medicine is already prohibited, but this prohibition needs further clarification. Hospitals and facilities can hire physicians which is different than providing hospital privileges. If hospitals actually hire doctors, then they are taken out of the community to work at one hospital which can create access issues. If a physician works for a corporation, the interest of their patients may not be aligned. This BDR is an attempt to ensure doctors are available to all facilities and not continue the consolidation that restricts access to physicians. She mentioned the American Medical Association (AMA) has raised this as a concern for a long time. She also added that since she was late, she did not hear the NHA's public comment at the beginning of the meeting cautioning against this and will later review and listen to their stated concerns. Chair Khan asked what happens with managed care organizations (MCOs) that hire physicians, would they be affected? Commissioner Bond added that primary care doctors usually work for one facility, which is different than

hospital specialists. A commissioner asked her if a ban on non-compete clauses may have the same impact. Commissioner Bond was not certain if that meets the same goals but could look into it. A commissioner added as Mr. Kelly had shared, Nevada has a shortage of health care providers. This proposal would need to address income guarantees and how it would impact the health care provider shortage. We also need to follow the current laws. Commissioner Bond has some assignments to follow-up to help clarify the topic. She feels this is a simple BDR but a complicated issue.

Subject 2, Topic 6- Create a Prescription Drug Affordability Board. Expand on NRS 439B.630 and set "allowable rates" for certain high-cost drugs identified by the Board; Create a Health Plan Review Board, with similar function as above but for commercial health insurance plans (4 responses):

Commissioner Winkler noted this measure is straightforward and has some similarities with the benchmark codification and feels it could be combined under the topic of affordability review. Chair Khan is strongly in support of some pharmaceutical oversight. It will need teeth, though, not just to create more boards. Another commissioner noted there is good data on the books about prescription drug costs, but we do not have the tools to address them. Another commissioner agreed with the other commissioners and wants to see how this topic could be combined with the benchmark topic. Mr. Bailit added other states have prescription drug affordability review boards so we can get information on the financial/operational implications from other states. One question is how the health plan review board relates to the Division of Insurance (DOI) regulatory activities. Commissioner Winkler answered current DOI rate review does not apply to the fully insured large group plans. Nevada does have prior approval, but no affordability standards. This could be an expansion of the DOI work. Mr. Bailit clarified that in Rhode Island (RI), this work operates within the Office of the Health Insurance Commissioner, not as a separate board. Another asked if there were ways to get this work done without a BDR? Director Whitley mentioned the PPC could commission DHHS to do a cross-program analysis. Mr. Bailit opined he wasn't sure the prescription drug affordability review board could be done without legislative authorization. The commissioner clarified she was inquiring if this work could be done without a whole separate board such as through the PPC or DHHS, as she is more concerned about the work than the board itself. She suggests getting some legal assistance with this. SME Dr. Slamowitz added the drug affordability board would need access to drug pricing files, such as through Medispan, which are paid subscriptions. Other states that have these boards have fiscal notes attached. She also noted that a review board does not impact list prices, but it can help manage costs to insurers/patients if payment limits are established.

The BDR discussion ended with a proposal by Executive Director Southard to set aside the BDR topics with 0-2 responses, as well as the one BDR with 3 responses.

Executive Director Southard reminded everyone the next meeting was August 17 and asked the group if they wanted to entertain the option of adding another meeting to fully vet these topics. Chair Khan feels they can use the maximum time allotted to the August 17th meeting for BDR decisions as there are no other pressing agenda items needing priority. He wants to allow enough time prior to the next meeting for legal and technical review. One commissioner reported she was ready to vote and did not need an additional meeting. Another wondered if there are parts of the 5 BDRs that the PPC can do on their own without legislation since they have broad powers. Another wondered if any of these measures can be combined and/or undertaken by another DHHS agency. Chair Khan feels they first need feedback from the appropriate departments, (Legal and DHHS) then final, deliberate language can be shared with the commissioners prior to and at the next meeting. BDR draft deadline to the Legislative Counsel Bureau is September 1, 2022.

Agenda Item VI – More Detailed Discussion regarding Cost Growth Mitigation Strategies and Potential PPC Recommendations

Michael Bailit, President, Bailit Health

Mr. Bailit gave a "deep dive" presentation on two cost growth mitigation strategies to address provider prices; provider price caps and provider price growth caps. The presentation is based on two implementation guides that Bailit Health is developing for states with support from the Commonwealth Fund.

Provider prices have been a key contributor to health care cost growth, as demonstrated by national and state data. A provider price growth cap is a regulatory limit on the percentage by which insurer payments to providers can grow annually. A provider price cap is a regulatory limit on the absolute level of provider prices.

Both strategies are limited to fully insured plans and can be enforced through insurance regulation and/or purchasing authority. The strategies may also be combined. Understanding where prices are growing the fastest is a precursor to this work, such as the type of services. Mr. Bailit presented design considerations for implementing each strategy. In summary, these types of caps are highly effective in slowing cost growth but will likely be faced by intensive provider opposition because it will reduce the ability of providers to grow their commercial revenue. Mr. Bailit asked the commissioners if Nevada should consider pursuing either or both strategies, rational for recommendations and if they require any additional information as they consider this policy option.

Mr. Bailit urges the importance of having a stakeholder group to suggest recommendations. Chair Khan suggested giving the PPC time to digest this information and come back with questions. A commissioner would like the opportunity for more time to discuss the stakeholder group noted in Mr. Bailit's presentation and opportunities to expand the membership. The Chair does not want any subcommittee to become too large to be manageable. Another commissioner asked what the charge of the stakeholder advisory subcommittee is, and the Chair is answered to give input to the PPC. Another commissioner clarified that this subcommittee advises the PPC specifically to the health care cost growth benchmark work.

Agenda Item VII – Public Comment

No public comment

Agenda Item VIII – Wrap up and Adjournment

Meeting was adjourned at 11:20 a.m.

Respectfully submitted,

Malinda Southard

Malinda Southard
Office of the Patient Protection Commission

APPROVED BY:

_____ Dr.
Ikram Khan, Chair

Date: _____9/1/2022_____

Meeting Materials

AGENDA ITEM	PRESENTER	DESCRIPTION
V.	Malinda Southard, Executive Director, PPC	List of PPC BDR Proposals for 2023 Session-Summary
V.	Malinda Southard, Executive Director, PPC	List of PPC BDR Proposals for 2023 Session-Summary-Ongoing Discussion
VI.	Michael Bailit, President, Bailit Health	Cost Growth Mitigation Strategies-Provider Price Caps and Provider Price Growth Caps

SUMMARY MINUTES

08/17/2022

Pursuant to NRS 241.020(3)(a) as amended by Assembly Bill 253 of the 81st Legislative Session, this meeting will be convened using a remote technology system and there will be no physical location for this meeting. The meeting can be listened to via telephone or viewed live over the Internet.

Agenda Item I - Call to Order, Welcome and Roll Call

Chairman Khan called the regular meeting to order at 9:02 a.m. Those in attendance and constituting a quorum were:

Commission Members Present
Bobbette Bond
Sara Cholhagian Ralston
Lilnetra Grady
Dr. Ikram Khan
Leann McAllister
Yarleny Roa-Dugan
Sandie Ruybalid
Dr. Tiffany Tyler-Garner
Mason Van Houweling
Tyler Winkler

Commission Members Absent
All members present

Advisory Commission Members Present
Ryan High, Executive Director, Silver State Health Insurance Exchange
Barbara Richardson, Insurance Commissioner, Nevada Division of Insurance (DOI)
Marla McDade Williams, Deputy Director, Nevada Department of Health and Human Services (DHHS)

Advisory Commission Members Absent
Laura Rich, Executive Officer, Public Employees Benefits Program (PEBP), excused

Commission Staff Present
Malinda Southard, Executive Director
Suzanne Sliwa, Deputy Attorney General (DAG)
Kiley Danner, Policy Analyst

Agenda Item II – Approval of July 20, 2022, Minutes

Ikram Khan, Chairman

The Commission was presented with an email draft of the summary minutes of the July 20, 2022, meeting.

MOTION was made to approve minutes of the July 20, 2022, meeting as presented, by Commissioner Winkler. Seconded by Commissioner Van Houweling. Carried without dissent.

Agenda Item III - Public Comment:

Patrick Kelly, CEO, Nevada Hospital Association

Mr. Kelly addressed access to healthcare and how it is complicated and fragmented. The healthcare delivery system is based on reimbursement rules, skinny networks, and ad hoc regulations, which is why it is difficult to fix. The PPC was charged with quality, accessibility, and cost. In the past, the PPC has focused on cost containment. Today, Mr. Kelly asked the commission to focus on access because without it, cost and quality are irrelevant. Without access, there is no care. With contained growth, there are inadvertent consequences such as decreased access. Nevadans already have poor access to care as 63.7% of the state's population resides in a federally designated primary care health professional shortage area. It is not just rural areas that are experiencing this shortage. The northern and southern urban areas experience higher percentages of this shortage. Once the state increases access to primary care, the need for access to more medical specialists and specialized facilities will increase because more illnesses will be diagnosed. We must assure that adequate levels of primary care and secondary care are available. Cost containment also produces unintended consequences including growing health inequities among Nevadans, poor management of diseases, and unnecessary disability and premature death. Before acting on anything Mr. Kelly asks the PPC to please examine the potential impact the proposal will have on health care access to all citizens now and in the future.

Agenda Item IV – Re-appointment of Stakeholder Advisory Subcommittee of the Peterson-Milbank Program for Sustainable Health Care Costs and Suggested Members

Malinda Southard, Executive Director

Chair Khan confirmed that all members of the PPC have received a copy of the list of new subcommittee members and proposed acting on this agenda item unless any objections were noted. Commissioner Bond stated she continues to have reservations about the intent of the subcommittee and proposed waiting to act on this agenda item until the BDRs have been submitted. Commissioner Winkler agreed. Commissioner McAllister opined that she is in support of approving the subcommittee now. Commissioner Ralston motioned that the subcommittee meetings be paused and instead moved to a stakeholder email distribution list. Commissioner Winkler seconded. Commissioner Ralston modified the motion to include the expired list of subcommittee member plus the new proposed list of subcommittee members on the newly proposed email distribution model. Commissioner Winkler seconded the amended motion. Chair Khan clarified that the subcommittee may make public comment at the PPC meetings or give their feedback in writing to Executive Director Southard and proposed a vote on the amended motion. Executive Director Southard called for a vote. All commissioners present raised their hands in agreement with the exception of Commissioner McAllister. The motion carried.

Agenda Item V – Review and Discussion of Possible Bill Draft Request Topics

Malinda Southard, Executive Director

Subject 2, Topic 1 - Codify the Nevada Health Care Cost Growth Benchmark Program as set forth in EO 2021-29 and include a requirement to measure and report on primary care spending

Executive Director Southard began by giving an overview of state agency responses to the proposed topic. Commissioner Bond questioned about logistics in what support the PPC will get from the Legislative Counsel Bureau (LCB) and requested a step in the BDR process in which the PPC can discuss the final BDRs with the LCB. Chair Khan clarified the PPC will approve basic language today, and if possible, the PPC will vote on language after LCB input, before the BDR is finalized. No other comments from the commissioners. Chair Khan motioned to approve Subject 2, Topic 1 as one of the BDR topics to be submitted. All commissioners present were in favor. The motion carried.

Subject 3, Topic 1- Mandating that all providers of health care and custodians of healthcare records implement an interoperable electronic health care records system. Expand immunity for provider compliance with providing and receiving electronic medical records. Revision of Nevada Revised Statutes (NRS) 439.584 with relation to Health Information Exchange (HIE) and other areas identified, with PPC supported funding options

Executive Director Southard again opened by discussing state agency responses received in relation to this proposed topic. Commissioner Winkler commented that the PPC discussed using a different term other than, "mandating", in the BDR language. Vice Chair Ruybalid asked if this would reduce the BDR to updating the existing NRS. Commissioner Van Houweling clarified that the current system is fragmented and allows for voluntary participation in electronic health record systems and suggested that the PPC mandate and require a central repository. He also reminded the commission that there is a provision in this proposed topic to permit five-year compliance. Commissioner Bond supports mandating that providers give their patients electronic access to their medical records. However, she thought there should be more than one process for patients to access their medical records and that NRS 439.584 may need altered. Chair Khan agreed, noting a significant fiscal impact and the need for added language to clarify this concern. Vice Chair Ruybalid asked for clarification about the central repository concept. Commissioner Van Houweling commented about the 21st Century Cures Act, Health Insurance Portability and Accountability Act (HIPAA), and the Health Information Technology for Economic and Clinical Health (HITECH) Act. In addition, he stated that Nevada has a health information exchange, just not a robust one. Currently, not all of Nevada health care providers submit data to this health information exchange. Commissioner Ralston clarified that patients already have access to their medical records and that this BDR would ensure electronic access. Executive Director Southard summarized the language for this BDR based on the PPCs recommendations. Commissioner Ralston made a motion for Subject 3, Topic 1 to be one of the BDRs the commission submits to the 2023 Legislature. Commissioner McAllister seconded. All commissioners present were in favor. Motion carried.

Subject 1, Topic 1 - Explore opportunities to provide basic health coverage to infants, children, and young adults up to age 26 who are ineligible for full Medicaid coverage under federal law due to their current residency or immigration status

Executive Director Southard discussed responses to questions posed to state agencies regarding this topic. The DAG questioned if the PPC has the funds designated to hire an expert and noted that unless the PPC amends a statute allowing the PPC to hire a vendor, the PPC could hire a vendor without a BDR. Executive Director Southard clarified that while the PPC does have the statutory authority to hire a vendor, it does not currently have funding in its budget to do so. Commissioner Tyler-Garner asked if there are other ways to ensure access to health care for this population besides a BDR. Another commissioner commented a letter may be written by the Executive Director to the Legislature in support of this topic, or the PPC may ask for American Rescue Plan funding. Chair Khan agreed with the PPC members to pause until the two remaining BDR topics were discussed to take a vote.

Subject 2, Topic 3 - Address the rising costs created by health care market consolidation by prohibiting hospitals and possibly some other facilities, such as freestanding ERs, from hiring physicians. Revise the exemptions now in law to ensure only community hospitals and academic institutions are exempted

Executive Director Southard first provided introductory comments in reviewing responses to questions posed to state agencies regarding this topic, then invited Commissioner Bond to present any additional information on this topic. Commissioner Bond stated that some entities are already allowed to hire physicians under NRS 695B. She clarified this BDR seeks to prevent hospitals from hiring physicians with the exception of public hospitals and academic institutions. Nevada is low on staff, especially physicians, and allowing one entity to employ physicians can create issues such as specialty physicians being tied up and not available for everyone and creating access issues. Commissioner Van Houweling agreed, stating there must be a balance. Patients need to have access to specialists. Chair Khan discussed how every hospital system in Southern and Northwestern Nevada is involved in academics. Commissioner Ralston supports this BDR because of how it will benefit patients. Commissioner Winkler stated that the intent is to guarantee that health care providers are not stuck at a specific facility so that patients have access to them when needed.

Subject 2, Topic 6 – Create a Prescription Drug Affordability Board. Expand on NRS 439.630 and set "allowable rates" for certain high-cost drugs identified by the Board.

Executive Director Southard again provided introductory comments in reviewing responses to questions posed to state agencies regarding this topic. Executive Director Southard then invited Commissioner Winkler to present any additional information on this topic. Commissioner Winkler wished to ensure that by controlling costs, those savings are passed on to consumers. Chair Khan fully supported this BDR. Commissioner Bond supported this topic and wanted to explore all the ways the topic could stay alive. Commissioner Tyler-Garner supported Commissioner Bond's recommendation. Vice Chair Ruybalid discussed the lack of authority in regard to the conversation surrounding creating a subcommittee to perform the work this topic is proposing and how the PPC does not have the authority to "set allowable rates." Chair Khan stated there would be a budgetary impact and that the PPC needs some input about what that impact would be.

Executive Director Southard began by reviewing the options the PPC had with the three remaining topics. One topic had the option to be voted on as the remaining BDR while the other two topics could be drafted as letters to the Legislature. Vice Chair Ruybalid motioned for Subject 1, Topic 1 to be put as an item for special consideration in the PPC's budget to fund the study and remove it from the BDR list. Commissioner Bond seconded. Eight Commissioners voted to remove Subject 1, Topic 1 as a BDR option and instead put this topic as an item for special consideration in the PPC's budget. The motion carried.

Executive Director Southard reviewed the verbiage for Subject 2, Topic 3. Chair Khan asked to proceed with voting for this topic as a BDR. Three out of ten commissioners raised their hands to vote for this topic as the third BDR that the PPC submits to the legislature. The motion failed.

Executive Director Southard reviewed the verbiage for Subject 2, Topic 6 and called for a vote. Three out of ten commissioners raised their hand in support of this topic as the third BDR. The motion failed.

The Commissioners discussed voting for a second time around on these topics because many were not aware whether they were voting to <u>exclude</u> the topics as a BDR or vote for the topics <u>to be the third BDR</u> that is submitted to the Legislature. Additionally, only six Commissioners voted, out of the ten present.

Commissioner Ralston motioned for Subject 2, Topic 3 to be the third BDR submitted to the legislature and the other two topics move forward with alternative support options. Commissioner Bond seconded. Chair Khan did not agree, stating that by voting that way, they are precluding Subject 2, Topic 6. Therefore, he proposed to vote on each BDR separately.

Executive Director Southard called for a vote on Subject 2, Topic 3. Five Commissioners raised their hand in favor of Subject 2, Topic 3 to be the third BDR submitted to the legislature.

Executive Director Southard called for a vote on Subject 2, Topic 6. Six Commissioners raised their hand in favor of Subject 2, Topic 6 to be the third BDR submitted to the legislature.

The Commissioners then discussed how some had voted for both topics, and that it was still unclear what they were voting for. Chair Khan called for a third and final vote.

Commissioner McAllister motioned to vote by roll call of the commissioners present. Commissioner Bond seconded.

Sara Cholhagian Ralston – voted for Subject 2, Topic 3
Sandie Ruybalid – voted for Subject 2, Topic 3
Tyler Winkler – voted for Subject 2, Topic 6
Dr. Tiffany Tyler-Garner – voted for Subject 2, Topic 3
Bobbette Bond – voted for Subject 2, Topic 3
Mason Van Houweling – **no longer present**, excused
Lilnetra Grady – voted for Subject 2, Topic 3
Yarleny Roa-Dugan – voted for Subject 2, Topic 3
Leann McAllister – voted for Subject 2, Topic 6
Dr. Ikram Khan – voted for Subject 2, Topic 6

Subject 2, Topic 3 – 6 votes
Subject 2, Topic 6 – 3 votes

Subject 2, Topic 3 carries.
Chair Khan suggested that Subject 2, Topic 6 be voted on for an alternative approach. Vice Chair Ruybalid motioned to put forward a letter from the PPC in support of Subject 2, Topic 6 to the Legislature. Commissioner Tyler-Garner seconded. Chair Khan called for a vote. Commissioner Bond asked to amend the motion to use any alternative method to move this topic forward, not limited to a letter from the PPC. Vice Chair Ruybalid seconded, and the vote ensued. Seven out of nine commissioners voted to move this topic forward by any alternative method. Motion carried.

Agenda Item VI – Public Comment

No public comment

Agenda Item VII – Wrap up and Adjournment

Dr. Ikram Khan, Chairman

Meeting was adjourned at 11:45 a.m.

Respectfully submitted,

Kiley Danner
Office of the Patient Protection Commission

APPROVED BY:

_____

Dr. Ikram Khan, Chair

Date: October 11, 2022

Meeting Materials

AGENDA ITEM	PRESENTER	DESCRIPTION
IV.	Malinda Southard, Executive Director, PPC	Suggested Members PPC Stakeholder Subcommittee
V.	Malinda Southard, Executive Director, PPC	Overview PPC 5 BDR (7.22.22)
V.	Malinda Southard, Executive Director, PPC	Detailed 5 PPC BDR (7.29.22)

SUMMARY MINUTES

September 21, 2022

Pursuant to NRS 241.020(3)(a) as amended by Assembly Bill 253 of the 81st Legislative Session, this meeting will be convened using a remote technology system and there will be no physical location for this meeting. The meeting can be listened to via telephone or viewed live over the Internet.

Agenda Item I - Call to Order, Welcome and Roll Call

Chairman Khan called the regular meeting to order at 9:00 a.m. Those in attendance and constituting a quorum were:

Commission Members Present

Lilnetra Grady
Dr. Ikram Khan
Leann McAllister
Sandie Ruybalid
Dr. Tiffany Tyler-Garner
Mason Van Houweling
Tyler Winkler
Mark Decerbo
Flo Khan

Commission Members Absent

Yarleny Roa-Dugan, excused
Bobbette Bond, excused
Sara Cholhagian Ralston, excused

Advisory Commission Members Present

Ryan High, Executive Director, Silver State Health Insurance Exchange
Laura Rich, Executive Officer, Public Employees Benefits Program (PEBP)
Barbara Richardson, Insurance Commissioner, Nevada Division of Insurance (DOI)
Richard Whitley, Director, Nevada Department of Health and Human Services (DHHS)

Commission Staff Present

Malinda Southard, Executive Director
Suzanne Sliwa, Deputy Attorney General
Kiley Danner, Policy Analyst

Agenda Item II – Welcome New and Returning Commissioners

Dr. Ikram Khan, Chairman

Chair Khan welcomed the newest Commissioner, Dr. Mark Decerbo. Commissioner Decerbo gave a brief overview of his background.

Agenda Item III – Approval of August 17, 2022, Minutes

Dr. Ikram Khan, Chairman

The Commission was presented with an email draft of the summary minutes of the August 17, 2022, meeting.

MOTION was made to approve minutes of the August 17, 2022, meeting as presented, by Commissioner Van Houweling. Seconded by Commissioner McAllister. Carried without dissent.

Agenda Item IV - Public Comment:

Patrick Kelly, CEO, Nevada Hospital Association

Mr. Kelly addressed Agenda Item VII and Agenda Item VIII. Regarding Agenda Item VII, Mr. Kelly said the Commission will discuss accountability mechanisms in three states and that it is important to put that conversation into context. Nevada is likely, very different from those states and the differences must be factored into the analysis. For example, Massachusetts has a robust health care delivery system and Nevada has access problems. Massachusetts ranks among the top five states in the country for the number of physicians per capita while Nevada ranks among the bottom five states in the country. Massachusetts has 33 percent more active nursing (RN) licenses per capita than Nevada. Access to care in Nevada is poor: 67.3 percent of the state's population live in a primary medical care health professional shortage area, 71.2 percent of the state's population live in a dental health shortage area, and 94.7 percent of the state's population live in a mental health professional shortage area. Nevada has unique needs that are unlike Massachusetts. Regarding Agenda Item VIII, Mr. Kelly said that caps may sound great, but in some areas of health care, Nevada needs to spend more to improve access. Cheap isn't any good if you can't access services. The Commission needs to take a hard look at Nevadans needs and develop a rational plan to meet those needs. The PPC must also assure a reasonable rate of return for health care providers. If not, capital expenditures will decrease, facilities will deteriorate, equipment will not be replaced and upgraded, and services will dwindle. In ten years, Nevada could have a dilapidated health care delivery system because of inadequate reinvestment. The cost to catch up will be astounding. The United States Supreme Court has stated on several occasions that a regulatory framework cannot be so unjust as to be "confiscatory". If the rates established by the state do not afford sufficient compensation, they may violate the Fifth and Fourteenth Amendments to the Constitution. Mr. Kelly asked the Commission to please be prudent in their actions because the health of millions of Nevadans depends on it.

Agenda Item V – Review, Discussion and Decision of PPC Letter of Support for Subject 1, Topic 1 and Subject 2, Topic 6

Malinda Southard, Executive Director

Subject 1, Topic 1 – Nevada Health Coverage Study for the Uninsured Immigrant Population
Subject 2, Topic 6 – Prescription Drug Affordability Review Board (PDAB)

Executive Director Southard discussed that Subject 1, Topic 1 has been picked up and included in a related American Rescue Plan Act (ARPA) request within the Division of Health Care Financing and Policy (DHCFP) to be put forward for approval by the Interim Finance Committee (IFC) during their October 20th, 2022, meeting.

Executive Director Southard discussed that the Subject 2, Topic 6 letter of recommendation is to be put forth

as an item for a Legislator or Legislative Committee, etc. to bring forward for the 2023 Session. One commissioner opined she supports sending the letter to all the members of the IFC ahead of the October meeting, as proposed.

Chair Khan asked the commissioners if there was any opposition to sending the letters of support. With respect to Subject 2, Topic 6, one commissioner stated she opposes the letter of support regarding Subject 2, Topic 6 because she has concerns about what the PDAB would do; and the letter fails to address how patients would be impacted by a PDAB. Further, the letter does not suggest that patients will benefit from the proposal. Additionally, the commissioner stated that the letter fails to address that drug pricing is not just one group. For example, the letter only addresses pharmaceutical drug manufacturers and does not look at the actions of the pharmacy benefit managers (PBMs), pharmacists, wholesalers, and insurers, who all have a role in drug pricing. Another commissioner opined he is opposed because we see a lot of consolidation in the end chain or independent pharmacy users and by not articulating what happens independent of meaningful PBM reform in the state, this will harm independent pharmacies and cause worse access and worse pricing for patients. The commissioner further stated that something like this is well-intentioned, but without meaningful PBM reform this could have very strong unintended consequences and harm patients, so he is opposed to the letter in its current form. Another commissioner asked to clarify that the Commission is just reviewing the letters of support because they have already agreed that they are supporting it. He stated that he is not opposed to including language that specifies the primary purpose is to increase affordability for patients. However, this is just a letter of support, not a policy document or proposal. Another Commissioner asked if this is an actionable item that needs to be voted on. Chair Khan stated there does not need to be a formal vote and that they are indirectly taking a vote by the majority wanting to proceed with wanting to send the letters. This discussion today was whether there were any changes or objections that needed to be added or subtracted because the Commission had already deliberated last meeting.

Agenda Item VI – Brief Overview and Roadmap of Nevada's Health Care Cost Growth Benchmark Program, and Highlights of Nevada Consumer Healthcare Experience State Survey (CHESS) Findings

Malinda Southard, Executive Director

Executive Director Southard presented an overview of the Health Care Cost Growth Benchmark in Nevada and what has been accomplished so far, what we are in the middle of completing, and where we anticipate heading with this project.

Executive Director Southard highlighted some key findings of the Nevada Consumer Healthcare Experience State Survey (CHESS), as led by Altarum. Altarum fielded the survey in Nevada from June 21st through July 8th, 2022 and has now analyzed and produced data briefs detailing the survey results. The data briefs will be uploaded to the news section of the PPC website once they are available to publish. The State asked for survey briefs on three important topics: health care affordability, prescription drug cost concerns, and hospital prices. Highlights from the Nevada CHESS Briefs include that a substantial portion of Nevada respondents worry about affording healthcare costs both now and in the future, and many (65%) reported experiencing financial hardship due to hospital costs. Most Nevada respondents believe the major reason for high healthcare costs is unfair prices charged by powerful industry stakeholders such as hospitals, pharmaceutical industry, and health insurers. When asked about the top three healthcare priorities the government should work on, Nevada residents most strongly supported addressing high healthcare costs including prescription drugs. Over half (59%) of all respondents reported delaying or going without healthcare during the prior 12 months due to cost. One commissioner asked, regarding setting limits on health care cost growth, if there were any questions around trade-offs that would have to be made in order to achieve that regarding pharmaceuticals. She wondered if the respondents were asked if they knew that by limiting prices, they would have more limited access to medicine. Executive Director Southard will verify that information. Other commissioners opined on the topic as well. One commissioner asked if the briefs will be

presented to the PPC. Michael Bailit stated that we can ask Altarum to present so that the Commissioners can ask questions. He noted that, in his opinion, the fact that 59% of all respondents reported delaying or going without healthcare during the prior 12 months due to cost, is the most compelling data point and urges the Commission to consider what action it can take. Another commissioner shared a link to the Congressional Budget Office estimate of the impact of pricing costs on the development of new drugs because it was found to be moderate; and is important for the other Commissioners to review that report.

Agenda Item VII – Cost Growth Benchmark Accountability Mechanisms in Three States, Findings from a Study of Massachusetts, and Potential Accountability Mechanisms for Nevada

Michael Bailit, President, Bailit Health

Chair Khan first noted that Nevada is different and what works in another state does not automatically work in Nevada. The dynamics are different, the population makes us different, and the systems are different. He continued to note that just because something is working in another state does not mean it will work here, and strongly cautioned against that interpretation.

Mr. Bailit presented what three other states have done to foster accountability for Cost Growth Benchmark performance, beginning with Massachusetts. The current approach in Nevada is to utilize public reporting at the state market insurer and large provider entity levels. Massachusetts was the first state to adopt a Cost Growth Benchmark and did so via 2012 legislation. That legislation also established a body called the Health Policy Commission (HPC), which was authorized to moderate compliance with the Benchmark and to establish accountability mechanisms. Mathematica recently performed a qualitative analysis regarding how the Massachusetts Benchmark and the HPC's accountability mechanisms had influenced motivations and actions by several players. The analysis was performed to help understand lessons and considerations for other states who are considering using accountability tools. The analyses have not been formally published yet but will be made available as soon as they are. Mr. Bailit further noted there are some states, and Massachusetts is one of them, where there is a huge disparity in spending that largely correlates with market power. The dominant health systems in the state have prices that are far above those that are not. The Cost Growth Benchmark has not addressed that issue.

Mr. Bailit then discussed three different accountability tools in the statutes of Massachusetts. The first is public hearings, where people are called to testify in front of the Commission. The second is to issue a formal report each year that includes the results of the Benchmark performance and extensive quantitative analysis of what is driving spending growth with policy recommendations. The third is Performance Improvement Plans (PIPs) which may be required if individual payer and provider entities have an annual rate of spending growth that is considered excessive. Mr. Bailit then reviewed the strengths and weaknesses of each mechanism.

One commissioner asked if there were suggestions for mitigating the waning effect of the benchmark. Regarding suggestions for mitigating the waning effect, yes, the HPC sought, just this year, additional authorization, and authority for taking action. They feel that after ten years, the tools that worked early on are not working as well anymore. Massachusetts commercial spending growth on a per capita basis, was running higher than the U.S. national average every year until they implemented the Benchmark, leading to under the U.S. national average every year since 2013. The data indicate that it has had impact. Additionally, the first Performance Improvement Plan requirement was applied this year to the largest health system in the state. Another commissioner asked, with respect to quality of care, has there been simultaneous surveying or work done to say how that has impacted health outcomes. Mr. Bailit stated that yes, the analyses he is aware of on quality and equity do not show any decline in quality.

Chair Khan opined quality may the first to decline because there are no established good, objective quality measures nationally. As you start controlling and regulating providers, access declines and Chair Khan feels

very strongly about any related effect in Nevada, which already has significant access problems. One commissioner clarified the reason she asked about quality is because it is really easy to look at these in silos. You can hold down the cost of providers, but if that means people will not then be able to access them, we have not solved the problem. That is why it must be looked at as a whole and not siloed. Chair Khan stated cost controls also affect the hospital services. Hospitals invest in new technology, which is very expensive, and they do not recover the cost for a few years. Another commissioner clarified that this is just a presentation of what Massachusetts has done and what stakeholders' perspectives are on those and at the end of the presentation they will have an opportunity to talk about the applicability of them.

Mr. Bailit continued with the presentation stating that the Performance Improvement Plan was part of the 2012 legislation. However, the HPC never applied a requirement for a PIP until this year (2022). Respondents who saw the PIP as a strength thought that the PIP, which is public, gave some insight into payer and provider spending performance. The PIP is supposed to be the plan of the organization to slow their health care spending growth so that it comes in below their Benchmark. The limitations included that with only one formal PIP requirement, despite many PIP referrals each year, the current PIP process may not be an effective accountability mechanism. In summary, the HPC achieved early success through effective use of its accountability tools and authority, persuading health care entities to hold spending growth below the Benchmark. However, the influence of the Benchmark on payers and providers has waned over time, as stakeholders realized the limits of the scope and authority of the HPC's accountability mechanisms. To address these limitations, most respondents recommend stronger enforcement going forward.

Mr. Bailit then presented on accountability mechanisms in the two other states. California recently passed cost growth benchmark legislation in 2022 which requires public reporting and annual public meetings. Additionally, there is progressive enforcement of compliance with cost growth benchmarks, beginning with technical assistance and increasing over time to include required testimony at public meetings, performance improvement plans, and assessment of escalating financial penalties. Additionally, Oregon passed cost growth target legislation in 2021 which requires public reporting and annual public hearings. Accountability mechanisms have not yet been applied but include the requirement of PIPs from any payer or provider organization that unreasonably exceeds the benchmark any year. Additionally, fines are assessed for late or incomplete submission of data and/or performance improvement plans. Further, organizations that exceed the Benchmark in any three of five years without justification are subject to a financial penalty that will vary based on the amount of the spending that exceeded the Benchmark. California and Oregon are the only two states that have financial penalties for exceeding the Benchmark. Next month the PPC will hear a presentation from Oregon on its Cost Growth Benchmark program. As a reminder, the Nevada Cost Growth Benchmark BDR includes public reporting and an annual informational public hearing on health care cost trends and the factors contributing to such costs and expenditures.

A commissioner noted that throughout the presentation he has reflected on the first couple of meetings in 2021 where the PPC identified what the charter was for the benchmark program in Nevada and where we are going. He recalls access and looking at some of the key reasons why Nevadans were leaving the state to access care across the spectrum in other states. Health care on the East Coast is much more robust because of the nature of graduate programs and as Mr. Kelly stated earlier, the number of physicians per capita is much different. Nevada has close to a million (902,000) people on Medicaid when you include adults and children. The Commission always needs to think about access and if what we are doing will improve access or limit the availability of access in the state. We certainly want to be innovative, but we also want people to invest in the health care systems in the state of Nevada.

Another commissioner opined she appreciates this discussion surrounding risk and access and having the benefit of not only hearing from the survey respondents but also from people engaged in this industry even as it relates to access. We see through the survey respondents that the Nevada health care system has reduced access because of cost. She encourages everyone to push through fears around crashing the system

and consider strategies that the Commission can pursue recognizing that it will be incremental. With anything, there are some costs and some gains that could be made, but with a firm commitment to moving the system forward in ways that allow more people to access the system, not solely looking at it from a provider standpoint, because we are the Patient Protection Commission, looking at it from the patient's perspective.

Agenda Item VIII – Deep Dive on Options for Health Care Cost Growth Mitigation Strategies: Revisit of Price Caps and Price Growth Caps; and Prescription Drug Affordability Strategies

Michael Bailit, President, Bailit Health and Alyssa Vangeli, Senior Consultant, Bailit Health

Executive Director Southard noted different strategies being discussed today should be looked at as a menu of options that the PPC may want to consider as different policy options moving forward and asked the Commission to have an open mind going into this discussion.

Mr. Bailit started the presentation noting he and his colleague Ms. Vangeli will be reviewing two different categories of price growth mitigation strategies that other states are either pursuing or considering. Other strategies will be introduced at the next meeting. The PPC may decide they like all of them or none of them, but the reason they are being presented is so the Commission can consider what actions to support to ensure the Cost Growth Benchmark is met and so that the 59 percent of Nevadans who are not accessing care or are delaying care because of cost goes down as a percentage. Mr. Bailit then reviewed provider price caps and provider price growth caps, which are two different strategies. The data shows that what is driving national health care spending, especially in the commercial market, is provider price increases. A Provider Price Growth Cap is a regulatory limit on the percent by which insurer payments to providers can grow annually. It is not setting or capping prices. It is capping how much insurers can increase payments annually. This can be applied to certain classes of providers where price growth has been problematic or more broadly. This is an insurance regulation strategy.

Mr. Bailit continued that in comparison, a Provider Price Cap is a regulatory limit on the absolute level of provider prices. This can be applied broadly across the commercial market, just for out-of-network payments, just within the Public Employees' Benefits Plan (PEBP), or just within a public option. It can be implemented through the state's purchasing authority and/or through insurance regulation. The reason to consider implementing the Provider Price Growth Cap and/or the Provider Price Caps is because provider prices are the primary factor driving health care spending growth. This also addresses market dysfunction where there is a high degree of price variation. Mr. Bailit then went on to discuss examples of other states implementing price growth caps and provider price caps. If these strategies are selected, it would be necessary to identify which services to target. It would also have to be determined whether to apply these strategies within a specific program or more broadly. The level of cap would need to be determined, whether to phase this in over time, and whether to include a transition period. Lastly, it would need to be determined how to implement this i.e., at the individual level or aggregate level. Mr. Bailit then asked the Commission to contemplate if either of these strategies should be considered in Nevada and if anyone requires additional information.

One commissioner asked Mr. Bailit to define the 59 percent of Nevadans not accessing care because many commissioners and the Department of Health and Human Services have reached out and qualified many Nevadans for the appropriate level of coverage. Mr. Bailit stated that the 59 percent was one of the findings from the CHESS survey. The commissioner additionally asked about the effect of the pandemic in driving a period of inflationary costs. Mr. Bailit responded we are just beginning to see data from 2020 and 2021 and the trends on hospital prices, especially commercial prices and pharmacy prices, have been the largest driver of commercial spending growth five years pre-pandemic. Another commissioner opined that she likes the state that set a price cap as a percentage of Medicare because the cap itself can grow as Congress changes

Medicare rates which makes our health care system much more of a public good. She would like to hear more about that state and how it is working and not working. Another commissioner asked for more in-depth information specifically about Rhode Island because they have a focus on improving primary care that includes a rate review process. Another commissioner asked about the relative prevalence of the number of physicians per capita in our state as well as GME penetration in terms of how many physicians are being trained and kept in the state. He also wondered how the physician credentialing process relates to the overall supply and how price caps may affect those choosing not to enter the market. Another commissioner would find it helpful to have information on unintended consequences or latent effects and any strategies employed to mitigate those consequences. Another commissioner commented that patient deductibles continue to rise and wondered if there is an avenue for the PPC to look at that. He asked how the PPC can shorten that gap so that patients do decide to seek medical care and not delay it or not get their medications and end up in the emergency department. He asked if the PPC has any authority or leverage. Mr. Bailit discussed that the reason why deductibles and coinsurance have gotten so high is because health care costs have gotten so high. Insurers go to employers and tell them they have to decide between increasing premiums or increasing deductibles as a response to health care costs being so high which then shifts it to patients. It all comes back to our efforts to try to at least reduce the rate of spending growth. Another commissioner opined that at a minimum we need to focus on reducing cost growth, but it must guarantee that it does pass down to patients. Chair Khan opined that he disagrees that insurers go to the providers and tell them that they must increase their premiums or their deductibles. As another commissioner mentioned, it is difficult for patients to pay their deductible, so he does not believe that any providers would tell insurers to increase the deductible knowing that they will not be able to collect it. Chair Khan stated that deductibles were a big debate, and he was part of the discussion during the Affordable Care Act. After it passed, insurers increased their deductibles and if the deductible was low, the premiums were extremely high. That is how the cost shift to the patients took place. Chair Khan stated that one must be careful on the factual history of deductibles and premiums. \

Mr. Bailit introduced his colleague Ms. Vangeli to present on prescription drug affordability strategies that states are considering. Ms. Vangeli noted that she will provide a menu of options that the PPC can pursue for containing cost growth and improving affordability for prescription drugs. There are a couple of reasons to focus on pharmaceutical spending including that pharmaceutical spending growth in Nevada is significant. According to the phase one cost driver analysis for Nevada Medicaid, pharmacy spending was among the top two categories of spending growth from 2016-2019 at 27 percent. For PEBP, pharmacy spending grew an average of 16 percent per year from 2017-2020. As noted earlier, there is currently a phase two process underway to collect data on pharmaceutical spending as well as other spending growth from commercial insurers. The Nevada CHESS survey reported that over half of respondents were concerned about prescription drug costs with nearly 1 in 3 respondents reporting hardship over the past 12 months. Additionally, respondents across party lines expressed a strong desire for policymakers to enact solutions. While modest progress has been made at the federal level, states can take further action to control pharmaceutical spending. The law that was passed and signed into law in August 2022 included some provisions to lower prescription drug for people with Medicare but did not include provisions that extend to the commercial market. Ms. Vangeli acknowledged that the issue of prescription drug spending is complex and there are several entities in the drug distribution and purchasing panels from the manufacturer to the wholesaler to the pharmacy to the patient and considering the role of PBMs adds another layer of complexity. There are different approaches that states can take to address the complexity and several complementary strategies that can be pursued to address underlying spending and improve affordability at the state level for medications. Nevada has already made some progress on prescription drug price transparency through legislation. DHHS is required to compile a list of prescription drugs essential for treating diabetes and a list of drugs that had a significant price increase and cost more than $40.00 per course of therapy. Additionally, all manufacturers of the Essential Diabetes Drug List must submit a report to DHHS with data outlining drug production costs, profits, financial aid, and other drug-specific information and pricing data. For drugs with a recent significant price increase, manufacturers must submit a report providing a justification for those price increases. Pharmacy Benefit Managers (PBMs) must submit reports regarding rebates negotiated with

manufacturers for drugs on the Essential Diabetes Drug List and the Over $40.00 Drug list. Lastly, DHHS is required to maintain a registry of pharmaceutical sales representatives that market prescription drugs in Nevada. There is also pending prescription drug legislation. The Nevada Joint Interim Standing Committee on Health and Human Services included two BDRs for the 2023 legislative session. The first proposed legislation requires DHHS to license and regulate pharmaceutical sales representatives who are operating within the state. The second proposed legislation licenses and regulates a PBM operating in Nevada. The reason why we cannot directly regulate the price that a pharmaceutical company can charge for medications is because pure price setting would violate federal law. There are federal preemption issues related to patent law and the Dormant Commerce Clause prohibits states from passing laws that discriminate against out-of-state commerce, unduly burden interstate commerce, or regulate commerce occurring outside the state. A commissioner commented that there are also laws that stop price gouging, and she wonders why those laws do not come into play with prescription drugs. Ms. Vangeli noted that Maryland did previously propose a price gouging law, but it was not upheld in the courts. She will find out the reason why that law was not upheld and bring that research back to the Commission. Ms. Vangeli continued with the presentation and proposed two approaches to lower prices without setting prices. The first is to regulate payments, not prices. The second is to tax excess prices or excess price increases. Next, Ms. Vangeli discussed four price control strategies that have been proposed in other states: Upper Payment Limits (UPLs), International Reference Pricing, Prohibition of Unsupported Price Increases, and Penalization of "Excess" Prices. Ms. Vangeli then asked if Nevada should consider pursuing prescription drug affordability strategies in addition to the Prescription Drug Affordability Board and if anyone requires additional information.

One commissioner asked for more information regarding the International Reference Pricing option. Additionally, he asked what pharmaceutical legal challenges will be tried and how the Dormant Commerce Clause comes into play if we are looking at rate setting regulations or tying it to international reimbursements. Another commissioner commented that she is also excited to learn more about International Reference Pricing. Regarding the strategies that put penalties in place, she fears that those may be less effective because it may become the cost of doing business. Another commissioner commented that penalties for excess prices or unsupported price increases concerns him. He acknowledged that another commissioner brought up earlier that prescription drugs are not in a silo, but sometimes we treat them as if they are. He opined that he thinks that could be potentially problematic. While he understands that we are not discussing the Medicaid population in particular, he wanted to give some examples. Regarding Medicaid fee for service, we are prohibited by statute to cover anti-obesity medications. That is something we are looking into potentially adding in the future where we would have an increase in spend. We would be spending more on medications but at the offset of improved health outcomes such as helping individuals lose weight, improve their diabetes, and get their hypertension under control. These are downstream effects in a different silo. By just looking at prices, sometimes you miss out on the very important offsets. Another example from the Medicaid point of view is diabetes medication. We often spend more on our preferred drug list for our fee for service population on a medication that has better outcomes. Those patients do better because there is less risk of amputation or going blind. Cost offsets other than prescription drugs that accrue in a different silo. Another example is on the inpatient side. We often spend a lot of money on very expensive antibiotics that are more expensive than other options, but these get the patients out of the hospital faster and prevent bounce back and getting dinged by the government in terms of CMS callbacks. Therefore, he tends to worry about penalization for prices when we look at drugs in a silo. Additionally, he discussed a recent landmark Supreme Court case looking at PBM regulation and suggested that the Commission should look at supporting SB 392 that is going to be brought forth during the 2023 legislative session. He opined that the PPC can look at adding some things to that bill because there are some PBM practices in this state that are harming patient access such as increasing prescription drug prices. Another commissioner noted that given the role prescription costs are playing as a driver, we should consider affordability strategies. Additionally, in support of our efforts, it might be helpful to know if there are other comparators and any limitations to using Canada as a comparator. Another commissioner asked if we could discuss on a future agenda the lack of GME slots and the growth of medical professionals in the state. The State of Nevada has 407 CMS approved slots. That was set in 1996

and as the East coast moved to the West coast, a lot of those slots never moved over. So, that is something he thinks we should look at in terms of specialties and where we can grow together as a state. He would like to be able to extend an invitation to the Dean of both medical schools, UNR and UNLV, to give us their thoughts on health care and where we should grow. Lastly, he asked if there is an opportunity for us to get back to in-person meetings. Chair Khan endorsed his thoughts and asked Executive Director Southard to look into the agenda item regarding GME and the logistics of in-person meetings.

Agenda Item IX – Public Comment

No public comment

Agenda Item X – Wrap up and Adjournment

Dr. Ikram Khan, Chairman

Meeting was adjourned at 11:07 a.m.

Respectfully submitted,

Kiley Danner
Office of the Patient Protection Commission

APPROVED BY:

Dr. Ikram Khan, Chair

Date: November 7, 2022

Meeting Materials

AGENDA ITEM	PRESENTER	DESCRIPTION
V.	Malinda Southard, Executive Director, PPC	PPC Letter of Support for Subject 1, Topic 1 and Subject 2, Topic 6
VI.	Malinda Southard, Executive Director, PPC	Roadmap of Nevada's Health Care Cost Growth Benchmark Program, and Highlights of Nevada Consumer Healthcare Experience State Survey (CHESS) Findings
VII.	Michael Bailit, President, Bailit Health	Cost Growth Benchmark Accountability Mechanisms
VIII.	Michael Bailit, President, Bailit Health, and Alyssa Vangeli, Senior Consultant, Bailit Health	Health Care Cost Growth Mitigation Strategies

SUMMARY MINUTES

October 19, 2022

Pursuant to NRS 241.020(3)(a) as amended by Assembly Bill 253 of the 81st Legislative Session, this meeting will be convened using a remote technology system and there will be no physical location for this meeting. The meeting can be listened to via telephone or viewed live over the Internet.

Agenda Item I - Call to Order, Welcome and Roll Call

Chairman Khan called the regular meeting to order at 9:00 a.m. Those in attendance and constituting a quorum were:

Commission Members Present
Sara Cholhagian Ralston
Dr. Ikram Khan
Leann McAllister
Yarleny Roa-Dugan
Sandie Ruybalid
Dr. Tiffany Tyler-Garner
Mason Van Houweling
Tyler Winkler
Flo Khan

Commission Members Absent
Bobbette Bond – excused
Lilnetra Grady – excused
Dr. Mark Decerbo – excused

Advisory Commission Members Present
Ryan High, Executive Director, Silver State Health Insurance Exchange
Laura Rich, Executive Officer, Public Employees Benefits Program (PEBP)
Richard Whitley, Director, Nevada Department of Health and Human Services (DHHS)

Advisory Commission Members Absent
Barbara Richardson, Insurance Commissioner, Nevada Division of Insurance (DOI) – excused

Commission Staff Present
Malinda Southard, Executive Director
Suzanne Sliwa, Deputy Attorney General
Kiley Danner, Policy Analyst

Agenda Item II – Approval of September 21, 2022, Minutes

Dr. Ikram Khan, Chairman

The Commission was presented with an email draft of the summary minutes of the September 21, 2022, meeting.

MOTION was made to approve minutes of the September 21, 2022, meeting as presented, by Commissioner Van Houweling. Seconded by Commissioner Winkler. Carried without dissent.

Agenda Item III - Public Comment:

Patrick Kelly, CEO, Nevada Hospital Association

Mr. Kelly addressed inflationary pressures on health care providers and how it affects cost and access. The cost of labor, supplies, and drugs have increased rapidly. Each has risen more than twice the level of the Governor's cost growth benchmark of 3.19 percent. It is unreasonable to think that healthcare providers can contain costs under 3.19 percent when inflation is surging. It is important to remember that the cost growth benchmark was established when inflation was supposed to be "transitory". Today, everyone agrees that the inflation rate in America is not transitory. In his Executive Order establishing the benchmark, Governor Sisolak recognized that the economy might change. He wrote, *"Should the PPC find that there have been significant changes to the economy after the effective date of this Order, it may recommend to the Governor changes to the cost growth benchmarks"*. The PPC should recommend to the Governor that the targets be modified to reflect inflationary pressures. If the PPC proceeds to codify the provisions of the Governor's Executive Order, codification should include language that accounts for inflation. The Governor's Executive Order also stated that relevant partners should be engaged to develop strategies to help meet the targets that are data-based and practicable. That engagement should be made a condition of PPC action. We offer one strategy that is data-based and practical; increase the number of nurses in Nevada. Nevada's nursing shortage is severe. Earlier in the year, hospitals paid more than $250 an hour for certain nurse specialties. Some nurses were making more than doctors. While prices for traveling nurses have decreased, hourly rates are still exorbitant. The salaries of staff nurses have increased, too. The NHA conducted a survey of its member hospitals. We asked hospitals to provide the number of staff openings they had on July 1, 2022. The number of staff openings for Registered Nurses was 2,393, Licensed Practical Nurses was 188, and Certified Nursing Assistants was 616. We know other healthcare providers have significant openings too. For months, hospitals have averaged approximately 475 patients daily who are medically cleared for discharge by their doctors but cannot be discharged from the hospital. Post-acute providers have the beds, but they don't have the nurses to staff them. Keeping patients in hospitals unnecessarily drives up cost. But more importantly, it causes access problems. Patients cannot access the post-acute care services they need. We do not need a big, expensive study to identify one of the biggest cost growth drivers in Nevada. It is simple; the lack of nurses in this state is a huge cost growth driver and we encourage the PPC to address it swiftly.

Agenda Item IV – Presentation from Health Care Cost Growth Benchmark State: Oregon

Sarah Bartelmann, Cost Growth Program Target Manager at the Oregon Health Authority

Ms. Bartelmann presented Oregon's health care cost growth target accountability mechanisms in detail, how Oregon works with payers, some lessons learned from the data submission, and summarized the Oregon Cost Growth Target setting which uses phased in implementation. Oregon began considering how to address cost containment in 2017. A legislative task force was charged with considering a hospital rate-setting model and recommended a Cost Growth Target approach that led to the establishment of the Cost Growth Target program in 2019. Additionally, an Implementation Committee was launched, and in 2020-2021 developed recommendations to guide the program, established accountability mechanisms, and launched data submission guidelines. In 2022, the Implementation Committee engaged with provider organizations

and began state and market level public reporting. Early next year, in 2023, they will begin payer and provider level reporting and identify strategies to achieve the set target. Performance Improvement Plans (PIPs) will begin in 2024 and financial penalties will begin in 2027. The Implementation Committee set Oregon's cost growth target for ten years with the target set at 3.4 percent for 2021-2025 and 3.0 percent for 2026-2030. The Advisory Committee will revisit the target in 2025 and determine if 3.0 percent is still appropriate. One strategy that has already been launched to address cost growth is the adoption of Advanced Value-Based Payments (VBP) which set targets for Oregon's Medicaid Managed Care Organizations. That work spun off into a voluntary, collaborative partnership with payers and providers to accelerate VBP adoption across markets. Oregon has a broad charge in which the establishing legislation clearly intends for the Cost Growth Target to apply to all providers and payers both public and private. The Implementation Committee recommended the measurement should be inclusive of spending on behalf of Oregon residents who are insured by Medicare including Medicare Advantage, Medicaid including managed care and fee for service, and Commercial insurance including self-insured. Spending through the VA and the Department of Corrections are also included. This adds up to spending on behalf of more than 90 percent of Oregon residents. Due to the large number of plans in the state, the Implementation Committee recommended only collecting data and reporting on cost growth for payers that meet a minimum member population size.

A Commissioner asked when the data is collected from insurers and is on various aspects such as hospital claims or pharmaceutical claims, does Oregon reach out to those entities to talk through the data to better understand the numbers? Is that part of the validation process? Ms. Bartelmann answered that she has only been discussing their process with payers, but they have a separate, parallel, staggered process for the providers. Oregon has about 50 provider organizations that meet the threshold for inclusion. After validation of data with payers, they create a state level data file with data summaries for all provider organizations and then conduct validation processes and individual meetings with all the provider organizations. Another Commissioner asked who in the state is having the meetings and reviewing the data. Ms. Bartelmann answered that her team includes analysts, actuaries, and policy analysts who prepare the data and conduct the meetings. Another Commissioner asked when the data is presented, is it public or just to the Commissioners? Ms. Bartelmann answered that when data is presented for individual payer and provider meetings, they prepare a data summary that is confidential at that stage. The summary is given to them directly for review and discussion and broken out in more granularity than for public reporting.

Ms. Bartelmann continued with her presentation and discussed Oregon's accountability measures. Oregon decided on Performance Improvement Plans (PIPs) and financial penalties, which were codified in legislation. Oregon's approach to accountability includes transparency, performance improvement plans, and financial penalties. The Implementation Committee established early on an understanding that not all cost growth is bad. Ms. Bartelmann stressed the importance of ensuring that nothing in the Cost Growth Target is creating intended or unintentional dampening effect on those policies that they want to see happening across the state. Therefore, before any accountability measures are applied, Oregon will ensure statistical confidence and determine reasonableness. Oregon wants to ensure that this program is not being used to deny coverage or create additional access barriers. A few additional questions were asked by various commissioners and answered by Ms. Bartelmann.

Agenda Item V – Nevada's Health Care Cost Growth Benchmark: Data Update

Malinda Southard, Executive Director

Executive Director Southard provided an update on the status of Nevada's Health Care Cost Growth Benchmark work regarding data submissions. Nevada Health Insurers were requested to submit aggregate, de-identified data for Nevada's Baseline Benchmark analysis for applicable types of plans. Executive Director Southard then discussed the summary table of information provided by the Department of Health and Human Services (DHHS), Office of Analytics (OOA) on the status of data submissions from Nevada Health Insurers. All insurers except for Aetna, who requested an extension, have submitted data. Some insurers are currently

preparing resubmissions and our OOA team has been working with all health insurers to address any questions they have and to provide technical assistance related to the data request. Aetna requested an extension to submit data. Anthem successfully submitted complete data for all three markets in which it operates. Centene did not submit spending data for its self-insured commercial business, as requested. Notably, most health care coverage in Nevada is self-insured. Centene also did not provide aggregate partial claim spending. Partial claims are claims that are paid for self-insured employers who carve out a benefit, most often pharmacy. Cigna successfully submitted data for the one market in which it operates. Humana did not submit aggregate partial claims spending for its self-insured commercial business or Medicare Advantage spending data, as requested. Renown did not submit aggregate partial claim spending for its self-insured commercial business, as requested. Finally, UnitedHealthcare did not submit spending data for its self-insured commercial business nor aggregate partial claims spending, as requested. Executive Director Southard relayed Nevada remains hopeful that the requested data will be submitted in the future, as aligned with the goal to improve transparency and affordability in our health care system.

A Commissioner asked regarding those that have not submitted data yet, have you given them a new timeline or are they still within the timeline to submit? Executive Director Southard answered that some health insurers have requested an extension, and some have submitted all data they wish to at this time.

Agenda Item VI – Presentation of Options for Health Care Cost Growth Mitigation Strategies: Rate Review

Alyssa Vangeli, Senior Consultant, Bailit Health

Executive Director Southard introduced the last two topics on mitigation strategies that are associated with Nevada's benchmark project and encouraged the commission to consider what strategies might work best in our state.

Ms. Vangeli began the presentation with an overview of Health Insurance Rate Review. It is a mechanism that allows state regulators the opportunity to review and, in some cases, disapprove or modify proposed health insurance rate increases. Rate Review is a function of Nevada's Division of Insurance (DOI), and it is important to note that the Rate Review authority of DOI can only be exercised over the fully insured market, and not the self-insured market. Rate Review is an important strategy that can be used to push down premiums in state-regulated health insurance markets. The Affordable Care Act provides a floor for the rate review process. It requires health plans to file and publicly justify the reasonableness of the proposed rate increases in the individual and small group market over a certain threshold, which is currently 15 percent. One important reason to focus on Rate Review is to increase affordability for individuals and businesses. Almost two-thirds (65 percent) of respondents from a recent Nevada survey reported experiencing at least one health care burden in the past year; and 83 percent worried about affording health care in the future. Over half (59 percent) of all survey respondents reported delaying or going without health care in the prior 12 months due to cost. A recent national report showed Nevada among the top eight states for the highest average employee share of premium (9.4 percent) as percent of median state income in 2020. Nevada is also one of the top four states where workers were responsible for 37 percent or more of their family premium. It is important to keep in mind that the Rate Review process does not dictate how much of the insurance premium is paid by the employer and how much employees are responsible for. The current Rate Review authority and process in Nevada requires prior approval by the DOI for any individual or small group rate change.

A Commissioner stated that she has a concern about the term, "affordability". Her concern is that if you artificially cap a premium or a rate increase because of affordability concerns, then you are just cost shifting. Ms. Vangeli answered that one of the reasons to consider incorporating affordability in addition to the other factors is to take into account the other factors that are being considered as to why the premium or rates are increasing and those include underlying costs. Ms. Vangeli reiterated that Rate Review is just one strategy for affordability and that it can be complementary to other potential strategies. The Commissioner commented

that the DOI currently only has authority over a very small portion of the Nevada insurance market and that both large group and self-insured are the largest markets in Nevada. So, if you look at Rate Review in that context, then there would be a lot of cost shifting that could potentially occur. She further stated it is important to look at expanding the authority of the DOI to look at those larger markets.

Ms. Vangeli continued, noting to engage stakeholders, the DOI can communicate with carriers via public meetings to enable open dialogue. If Nevada opts to pursue other affordability goals such as primary care spending investments or value-based payments, the rate review process could be used to obtain information on progress toward those goals. The final option to strengthen Rate Review is to improve monitoring for impact on access, quality, and equity which can protect against unintended negative consequences on access to care and member experience and examine disparities in access to affordable health care coverage. As an example, Rhode Island has a robust rate review process. The Office of Health Insurance Commissioner (OHIC) has authority to review large group policies, as well as individual and small group. OHIC also has the authority to require submission and allow for review of provider-payer contracts. OHIC has a broad charge to protect the public interest and improve the health care system, which applies to the rate review process. They have a highly transparent stakeholder engagement process with regular public meetings, opportunities for written and oral comment, and advisory committees. Lastly, their rate review process is tied to broader affordability goals of adoption of value-based payments, primary care spending, and provider price growth caps.

The commissioners had some questions and discussion. Mr. Bailit commented that in his experience with rate review, a fair amount of focus is looking at the profits or contributions to reserves of the insurers and trying to ensure that the rates that are developed are not in excess of what is required. He acknowledged that there could be an impact on provider contracting, but that a lot of the impact is focused on administrative and margin charges of the insurers. Another Commissioner noted it would be helpful to hear from the Nevada DOI. Additionally, regarding the marketplace, she wants to know what we are looking at in terms of their authority. Where would they like to see their authority grow and do they have the capacity to take that on from a resource standpoint? The Public Employee Benefits Program (PEBP) Executive Officer commented the Cost Growth Benchmark is something that is vital to the PPC as they consider policy recommendations and PEBP is glad to be a part of it, however some of the strategies presented today have the potential of being problematic in Nevada. PEBP is constantly dealing with balancing lower costs with having greater access because access issues in our state are very significant, especially in Northern Nevada, and even worse in rural Nevada. Nevada consistently ranks 48th and 49th in providers per capita regardless of primary care or specialty care. Rhode Island is in the top 5 and Oregon ranks in the top 20. She reiterated that we have a major access problem in Nevada and that is something the PPC should keep in mind as the suggestions and recommendations are being considered. Another Commissioner asked for clarification of the rate review process in Nevada.

Agenda Item VII – Presentation of Options for Health Care Cost Growth Mitigation Strategies: All Payer Value-Based Payments

Michael Bailit, President, Bailit Health

Mr. Bailit presented on the last of the cost growth mitigation strategies; multi-payer value-based payment. Value-based payment (VBP) is a strategy by which health care purchasers and payers use payment to hold provider organizations accountable for quality and cost of care. The term quality is used broadly to talk about processes and outcomes, as well as access, patient experience, and equity. Advanced VBP models transfer some risk to a provider organization and may or may not include prospective payment. VBP models are potentially a cost growth mitigation strategy because they can use a budgeting mechanism to apply to payment. Moving towards VBP models is most effective when multiple payers align around a common model. There are also non-cost growth benchmark states pursuing this model, such as Arkansas. Some examples of multi-payer VBP models include hospital global budgets, episode-based payment, specialty capitation (specialty prospective payment), global capitation, and total cost of care with shared savings.

A Commissioner asked, in terms of engaging in a multi-payer value-based payment model, can we do that through regulation, or do we have to get statutory authority? Mr. Bailit answered that we do not need statutory authority or regulation. These are truly voluntary efforts in Oregon and Rhode Island. Their key stakeholders, meaning their largest provider organizations and largest payers, have all realized the importance and wanted to collaborate. Therefore, we would need to have agreement and collaboration among Nevada's leading provider organizations and leading payers to pursue this model. Another Commissioner opined she would like additional information to consider such as administrative costs of running VBP programs and what happens to patients who are very ill, because providers are encouraged to no longer provide care because of capitation. Mr. Bailit answered that there are two types of costs: the costs associated with planning and the costs associated with implementation and operation. The costs are going to vary based on the model. In response to the question on high-risk, high-need patients, not all these models are capitation. Any payment model that is not fee for service and that is structured so that it is rewarding, reduces rates of spending growth. For all of those, there is some measure of risk that you are creating a financial incentive that could limit access to care for patients. Another Commissioner echoed the concern for chronically ill patients and asked to hear from the provider side and why they are interested in moving to a VBP model. Mr. Bailit answered that providers are supportive for a few reasons: some of these payment models afford providers significant flexibility where fee for service payment does not, some models such as Hospital Global Budget give some degree of revenue certainty, and in some states, there is recognition from provider organizations that patient affordability is a real problem. Additionally, Mr. Bailit gave some examples of mitigating strategies for high-risk patients. Lastly, Mr. Bailit suggested looking at the experience in Nevada such as what has worked and what has not and asking providers and payers about their experiences.

Agenda Item VIII – Presentation on Primary Care Spend Measurement Examples from Other States

Michael Bailit, President, Bailit Health

Executive Director Southard introduced this topic as one that a commissioner had asked to discuss in more detail because one of the Commission's bill draft requests (BDRs) for the 2023 Nevada Legislative Session, to codify the health care cost growth benchmark, does include measurement and reporting on primary care spend and it would be helpful to have examples from other states we might learn from.

Mr. Bailit began the presentation with some reasons why Nevada may want to measure and invest in primary care. Primary care is associated with improved population health and more equitable outcomes. Increased primary care investment translates to expanded care teams, more convenient, low-cost access to care, and strong connections to public health and social supports for people with social risk. Additionally, it reduces the need for emergency department visits and hospital stays and may have a moderating effect on total cost of care. Nevada ranks 48th in the country for primary care physicians per capita. An estimated 67.3 percent of the state's population reside in a federally designated primary care health professional shortage area. Nevada currently ranks poorly among states for some key measures of primary care. The cost growth benchmark BDR leverages the cost growth benchmark data collection processes to collect more detailed information on primary care-related spending. While there are many possible steps to improve primary care within the state, one is to ensure adequate investment in primary care, which first entails the measurement of current primary care spending.

A Commissioner commented that she would like the Commission to consider three things: what other states are doing to increase residency programs or primary care doctors in their states; if other states are doing tuition reimbursement or other things for medical students who commit to staying in primary care for a certain number of years or for a certain percentage of their practice; and third, the impact of quality of life in the state and attracting primary care physicians to our state (school systems that attract young physicians when they are deciding where to set up their practice early in their careers, value children, and economic opportunities

for their spouses). Another Commissioner asked to for future agenda items: if there are any inherent barriers to implementing some of the approaches that were discussed today, and which approach Nevada is best positioned to implement.

Agenda Item IX – Public Comment

Angie Wilson asked when reviewing Medicaid/MCO claims and costs, will you [the PPC] be considering the impact of claims and costs and provider types that are 100 percent FMAP? I ask because the reimbursement rate is set in the federal register and with new designations for tribes, we expect reimbursements to tribes to increase, resulting in higher "perceived" costs to the state although it is reimbursed at 100 percent.

Vice Chair Ruybalid explained to the Commission that FMAP is the federal Medicaid match that is set by the federal government. Mr. Bailit answered that for purposes of measuring benchmark performance, Nevada will look at spending for Medicaid and will not be accounting for the fact that these services will have a higher FMAP than other services, but the services and associated payments referenced will be a very small percentage of total Medicaid spending. Therefore, Mr. Bailit does not believe there will be a substantive impact on the benchmarking analysis due to the marginally higher federal match.

Agenda Item X – Wrap up and Adjournment

Dr. Ikram Khan, Chairman

Meeting was adjourned at 11:10 a.m.

Respectfully submitted,

Kiley Danner
Office of the Patient Protection Commission

APPROVED BY:

Dr. Ikram Khan, Chair

Date: 12/5/22

Meeting Materials

AGENDA ITEM	PRESENTER	DESCRIPTION
IV.	Sarah Bartelmann, Cost Growth Program Target Manager at the Oregon Health Authority	Presentation from Health Care Cost Growth Benchmark State: Oregon
V.	Malinda Southard, Executive Director, PPC	Nevada's Health Care Cost Growth Benchmark: Data Update
VI.	Alyssa Vangeli, Senior Consultant, Bailit Health	Presentation of Options for Health Care Cost Growth Mitigation Strategies: Rate Review
VII.	Michael Bailit, President, Bailit Health	Presentation of Options for Health Care Cost Growth Mitigation Strategies: All Payer Value-Based Payments
VIII.	Michael Bailit, President, Bailit Health	Presentation on Primary Care Spend Measurement Examples from Other States

SUMMARY MINUTES

November 16, 2022

Pursuant to NRS 241.020(3)(a) as amended by Assembly Bill 253 of the 81st Legislative Session, this meeting will be convened using a remote technology system and there will be no physical location for this meeting. The meeting can be listened to via telephone or viewed live over the Internet.

Agenda Item I - Call to Order, Welcome and Roll Call

Chairman Khan called the regular meeting to order at 9:00 a.m. Those in attendance and constituting a quorum were:

Commission Members Present

Bobbette Bond
Sara Cholhagian Ralston
Lilnetra Grady
Dr. Ikram Khan
Leann McAllister
Yarleny Roa-Dugan
Sandie Ruybalid
Dr. Tiffany Tyler-Garner
Mason Van Houweling
Tyler Winkler
Dr. Mark Decerbo

Commission Members Absent

Flo Khan – excused

Advisory Commission Members Present

Ryan High, Executive Director, Silver State Health Insurance Exchange
Laura Rich, Executive Officer, Public Employees Benefits Program (PEBP)
Barbara Richardson, Insurance Commissioner, Nevada Division of Insurance (DOI)
Richard Whitley, Director, Nevada Department of Health and Human Services (DHHS)

Commission Staff Present

Malinda Southard, Executive Director
Suzanne Sliwa, Deputy Attorney General
Kiley Danner, Policy Analyst

Agenda Item II – Approval of October 19, 2022, Minutes

Dr. Ikram Khan, Chairman

The Commission was presented with an email draft of the summary minutes of the October 19, 2022, meeting.

MOTION was made to approve minutes of the October 19, 2022, meeting as presented, by Commissioner Van Houweling. Seconded by Commissioner Winkler. Carried without dissent.

Agenda Item III - Public Comment:

Helen Foley, Nevada Association of Health Plans (NvAHP)

On behalf of the Nevada Association of Health Plans, Ms. Foley addressed some concerns to the PPC. Regarding the Draft Health Equity Plan, she discussed slide seven on guiding principles, which speaks about the PPC's work being informed by a diverse group of stakeholders and that the PPC will educate itself and actively collaborate with state agencies and organizations. The Nevada Association of Health Plans (NvAHP) has engaged with the PPC throughout its tenure, however, there is no representation by health plans on the PPC. Today, we ask how can we engage more meaningfully with this commission? We find that at almost every meeting, questions arise regarding insurance and there is no one to weigh in to provide needed information. An insurance executive was asked to be part of the Commission's stakeholder advisory group, but the expanded stakeholder group was rejected by the PPC. Regarding the cost growth mitigation strategies, NvAHP would like to reiterate concerns on impeding access to care with provider price caps/price growth caps – what mechanisms does the PPC envision having as guardrails in case this has unintended consequences? NvAHP is very concerned about including large groups in rate review. Large groups are rated based on their experience. However, the current proposal indicates that a community-type rating with a variable high-and-low amount is being proposed. Groups that would have gotten a lower premium because of their experience would now have to get a higher premium to offset a group that has higher medical costs. For example, a group that has 51 employees could end up subsidizing a group that has 2000 employees. Since large groups have more flexibility in designing their benefits than individual and small groups, this could also impact the plan design for large groups. We often have large groups wanting to provide more benefits, but there may be hesitancy based on the need to have rates approved. Better performing groups would have more incentive to self-insure and pull out of the fully insured market, which means that the cost for large groups would then go up. We also caution you to be very careful about inflation. The PPC cannot view these targets in a vacuum. Inflation will influence costs from the providers, in the hospital setting, and in premiums. The PPC is focused on reducing premiums by reducing administrative and provider costs. Everyone knows the rising cost of prescription drugs is one of the main drivers of premiums. We encourage the PPC to explore ways to reduce the cost of prescription drugs to have any meaningful impact of premiums. Thank you for your time. NvAHP looks forward to continued conversations regarding these important issues.

Patrick Kelly, CEO, Nevada Hospital Association

Mr. Kelly addressed the PPC Commissioners regarding questions that were raised at the last PPC meeting about markets and cost shifting. The Kaiser Family Foundation reports that Nevada's health care expenditures per capita are among the lowest in the country. In fact, Nevada has the third lowest health care expenditures per capita in the United States. All the other states participating in the Peterson Milbank Health Care Benchmark program are much higher. Nevada's health care expenditures per capita are $8,348.00. Massachusetts is $13,319.00. That is 55% more than Nevada. Delaware, Connecticut, New Jersey, and Rhode Island are all thousands of dollars higher than Nevada. An important question to ask and consider is, do states with higher health care expenditures per capita have better patient access? Nevada has the third lowest health care expenditures per capita in the nation and we have poor access. Some may say we have one of the

lowest health care expenditures per capita, but our insurance rates continue to increase. One of the reasons is cost shifting. Cost shifting occurs when some groups do not pay the full cost of care received and other groups make up the difference. In Nevada, cost shifting primarily occurs from government payers to non-government payers. This is important because Nevada hospitals treat a disproportionate number of Medicare and Medicaid patients. Medicaid and Medicare beneficiaries represent 37% of Nevada's insurance market, but they comprise 70% of the patients treated in our hospitals. This distinction is important because Medicaid and Medicare payments do not cover the cost of care. Additionally, approximately 5% of hospital patients are uninsured. Typically, they are unable to pay the full cost of their care. Approximately 75% of the care provided in Nevada's hospitals is subsidized by non-governmental payers. The remaining 25% of patients are charged their cost of care plus the shortfall. If we want to improve access to care and lower the increases to the 25% of commercially insured patients, cost shifting must be addressed. Government payors must cover at least the cost of care provided to their beneficiaries.

Nicole Chauvet

Ms. Chauvet questioned why organizations in Nevada are not following what Governor Newsom recently signed into legislation. In short, Governor Newsom is making an effort to modernize California's medical malpractice system. In doing so, they have raised the caps for wrongful death lawsuits to compensate for inflation. Also, the major concern is that patients do not have rights in this area. Many patients cannot obtain an attorney for medical malpractice because the caps are so low. This is wrong, especially when it comes to wrongful death. If you had a loved one who passed away, such as I have recently, you would understand the struggle that you go through when you feel as if you have no justice. I question how we got here. There is no way the community members of Nevada would vote for their rights to be taken away like this. I understand the concept of keeping our doctors in Nevada. However, there must be balance because the system is currently drastically skewed. What would it take to have a revote to create a system by the people and for the people in this area? Not by insurance companies or medical corporations.

Agenda Item IV – PPC Bill Draft Request Update

Malinda Southard, Executive Director

Executive Director Southard discussed that the drafted language for the three bill draft requests (BDRs) for the 2023 legislative session was received and reviewed by the commissioners for any obvious errors or omissions. She noted that one obvious error was noted regarding the electronic health records BDR in that the words, "ensure patients" were somehow omitted from the final version of the intent that was listed on the BDR form to the Legislative Counsel Bureau (LCB). Executive Director Southard has since been in contact with our Deputy Attorney General (DAG) and LCB bill drafter, requesting an appropriate revision of the language to match the full intent of the commission. That re-do language was received from LCB and immediately sent for review by the Commission on November 15th, 2022, with no additional feedback received from the commissioners. No other obvious errors or omissions were noted from the Commission and the three BDRs will be pre-filed today, per the LCB deadline. Upon printing, each pre-filed bill will be made public. With the PPC BDRs in the hands of the legislature, Executive Director Southard will be working with the legislature and transparently sharing the process along the way. Future meeting updates on the PPC bill progress will be for discussion purposes only. This is designed to help manage expectations and the realities of the Nevada legislative process and our responsibilities to follow open meeting laws in our state.

One Commissioner asked if she could have one more day to review the language and what would happen if the BDR was submitted to LCB a day later than the deadline. The DAG commented she would not recommend missing the deadline. The Commissioner requested to have until the end of the day to provide any feedback to Executive Director Southard on the Commission's BDRs. No opposition was stated to this request.

Agenda Item V – Discussion of Drafted PPC Health Equity Plan Requested for Feedback from the Commission for Posting on PPC Website

Kiley Danner, PPC Policy Analyst

Ms. Danner addressed the Commissioners and noted that each should have received a copy of the Draft Health Equity Plan. She discussed the recommendations and feedback that was received. Slide two was recommended to clarify the definition of health and health equity, and removal of slide three. Slide five was recommended to include a general summary of Nevada's health disparities. Lastly, slide eight included questions posed by a commissioner. Ms. Danner asked the Commissioners if they had any ideas for specific steps to ensure there are not any unintended consequences or inequities as a result of the Health Care Cost Growth Benchmark.

One commissioner opined that one of the steps to ensure no unintended consequences is to continue stakeholder engagement, ensuring the Commission receives feedback from various groups. Another commissioner opined along with ensuring stakeholder feedback, the Commission should take efforts to solicit general public feedback, as well, to make the Commission more accessible and available to patients in Nevada.

Agenda Item VI – Nevada's Health Insurer Rate Review Process

Barbara Richardson, Insurance Commissioner, Nevada Division of Insurance (DOI)

Insurance Commissioner Richardson provided an overview of the Nevada Division of Insurance (DOI) Rate Review process for the fully insured health benefit plans and addressed some questions from the Commission during the October meeting. She began with an overview of the updated projections for health care sources in Nevada. The information was derived from multiple sources as there is not a definitive set of data that provides an annual look at the Nevada health insurance market. Once annually, the DOI compiles the latest data from the same set of reliable data sources to create a clear picture of the current state of the health insurance market. The DOI has statutory authority to review and approve health benefit rates for the individual and small group markets, which covers approximately 7% of the state's population. Large group commercial plans account for 12% of the population's health insurance coverage. The timing of individual and small group product and rate review filings is based upon the federal Affordable Care Act requirements; individual and small group filings are annually due to the DOI during the first week of June. To create uniform meaning in the information that carriers must include in each rate filing, a rate checklist is provided prior to rate filing season, including all information the federal government, the State, and the DOI require for individual and small group filings. Carriers must also include actuarial memorandum to provide specific information related to the filing such as support for the development of proposed rates, required actuarial certifications, premium development template, and Nevada data template. The DOI contracts with an outside actuarial firm to conduct an independent, detailed, actuarial rate review of every submitted rate request. Throughout the review process, the outside actuarial firm and DOI staff each independently reach out to the carriers to get clarification of different elements within the carrier's filing, to maintain the integrity of an independent review. The objections period may relate to incomplete information and submission support related to included or not included trends or factors used for development that promotes weights; or anomalies, outliers, or inconsistencies which lack proper explanation or support. At the completion of the outside actuarial firm and DOI rate review, additional information is considered when determining the final approved rates. Next, a final rate gets approved and posted on the DOI website for consumer input. Then, a final rate is approved and submitted to the carrier, the public, the Centers for Medicare and Medicaid Services (CMS), and the Silver State Health Insurance Exchange. Insurance Commissioner Richardson then discussed the Nevada Medical Loss Ratio Rebates. In response to the Commissioner's requests during the last PPC meeting, Insurance Commissioner Richardson replied in detail. CMS timelines do not always factor into federal decisions on other issues and sometimes can end up affecting rates. Nevada relies on competition between carriers to create

the downward pressure on network contracts with providers, facilities, hospitals, and pharmaceuticals. These situations can result in rate increases to ensure a carrier has adequate surplus and capital to pay its consumer claims and liabilities. Otherwise, the rates would be inadequate. In response to a question about the DOI's ability to take on additional rate oversight to include the large group market in Nevada, Insurance Commissioner Richardson thought it would be helpful to understand why Rhode Island may have done that.

Chair Khan asked if the population data submitted for small and large groups includes the Employee Retirement Income Security Act of 1974 (ERISA) membership. Insurance Commissioner Richardson answered, the small group level funded plans and the association health plans are under the U.S. Department of Labor, which is the ERISA data. That population is very small in Nevada. A commissioner asked about what impact the public option might have on rates in the state. Insurance Commissioner Richardson replied the concern is the possibility of having the second lowest silver plan be the determining factor and regardless of what that plan is, it will be used as a bellwether for other plans regarding how much the federal government will give back to Nevada, and how much the risk adjustments provide back to the consumers. Relatedly, another commissioner inquired if a legislative remedy is required for this concern. Insurance Commissioner Richardson replied, a legislative remedy would be necessary to change the public option. The commissioner then opined this is something the Commission may want to consider in the future. Another commissioner opined that the information contained in the Forbes article about the most and least expensive states for health care needs to be taken in context of the average household income for constituents in the United States, as Nevada is well below the average household income. Therefore, everyone must consider what the average patient can afford here in our state. Another commissioner opined that one of the things not considered here is the percentage of profits that are tied to providers can be broken up between the hospitals and the physician/provider communities; profits are invisible when looking at the data presented today.

Agenda Item VII – Prioritization of Cost Growth Mitigation Strategies

Michael Bailit, President, Bailit Health

In September and October, Bailit Health presented overviews of four cost growth mitigation strategies summarized in the meeting materials for today. All four strategies are informed by the phase one cost growth driver analysis using both Nevada Medicaid and the Public Employees' Benefits Program (PEBP) data, which show that prices are driving high spending growth. These four strategies all have the opportunity and intention of helping Nevada keep health care spending below the cost growth benchmark.

Mr. Bailit gave a summary of provider price caps and price growth caps. Mr. Bailit then discussed the feasibility of implementation and potential impact of each. Political feasibility is challenging because it is likely for strong opposition from whichever provider types might be targeted. Whether administered through purchasing authority or insurance regulation, it is not that complex. In terms of impact, it can be significant, but depends on where the caps are set and how broadly they are applied.

Ms. Vangeli gave a summary of prescription drug affordability strategies and then discussed the feasibility of implementation and potential impact. The feasibility varies significantly based on which of the strategies would be pursued, but a high-level overview was provided. Political feasibility would be challenging due to the likelihood of strong opposition from the pharmaceutical industry. In terms of financial feasibility, a prescription drug affordability board would have high implementation costs for the state, whereas international reference pricing and penalizing excess drug prices would have medium/low costs for the state.

Next, Ms. Vangeli provided a summary of health insurance rate review and then discussed the feasibility of implementation and potential impact. Politically, this could be challenging based on the level of opposition from the health insurance industry. Financial feasibility and administrative complexity are low to medium based on mechanisms pursued. The potential impact on slowing health care cost growth is medium to low based on mechanism such that adding affordability/public interest criteria may result in lower premium

increases; expansion to large group market may result in lower premium increases for large businesses and their employees; and additional transparency through public hearings could help put downward pressure on premium increases. However, it is challenging to quantify what these impacts would be.

Chair Khan inquired what percentage of health care costs are related directly to prescription drugs. Mr. Bailit answered it depends on the market; meaning we only have data for PEBP because without an all-payer claims database, we do not have access to that broader data in the state. A commissioner stated that even though ERISA plans, which the Culinary Health Fund is a part of, do not provide that data publicly, she would be willing to pull that data and provide it to the PPC Executive Director. She further offered to ask the Health Services Coalition if they are interested in providing their pharmacy data voluntarily for the purpose of evaluating prescription drug costs. Mr. Bailit shared that across other states, in the commercial market, the percentage of health care costs related to prescription drugs are approaching a quarter of total spending. Further, if we look at medical pharmacy, the infusion drugs sometimes referred to as part B, that percentage will increase, and that spending is growing much faster than retail pharmacy.

Mr. Bailit continued with an overview of multi-payer value-based payment (VBPs), and then discussed the feasibility of implementation and potential impact. In terms of political feasibility, the level of support or opposition from payers and providers depends on the scope of VBPs and the extent to which providers are expected to take on financial risk. Depending on how this is done, it may not be quite as effective at slowing cost growth as the other strategies. Lastly, the impact depends on the model being selected and the type of budgeting mechanism applied to payments. Both Oregon and Rhode Island are pursuing this approach, and both had their payers and providers agree on compacts and targets for implementing these models

A commissioner asked what potential impacts on health outcomes (health equity, affordability, and access) are for each of these strategies and any others that may be explored. Further, he is interested in exploring all four of the strategies presented. Another commissioner is interested in exploring two of the strategies further: regulation of prescription drug payments with the international reference pricing and provider price caps. Further, she is interested in exploring if other states are only doing caps for people who live within the state, not having an impact on health tourism. Another commissioner is interested in exploring all four of the options further and would like to continue the discussion from the Nevada perspective. Another commissioner is also interested in exploring all four strategies, but specifically would like to concentrate on ensuring that patients come first and that there is equity and access. One commissioner opined that he is relatively opposed to the prescription drug affordability strategy unless pharmacy benefit manager (PBM) reform regulation is added and is therefore more interested in a deeper dive on the other three strategies. Another commissioner opined that she does not think any of the strategies should be taken off the table and that she supports further exploration of each of the strategies. Chair Khan opined that he would also like to further explore all four strategies. He asked Executive Director Southard to add one strategy to the agenda at a time starting in January 2023. Another commissioner concurred.

Agenda Item VIII – Implications of Inflation for Assessing Cost Growth Benchmark Performance; Options Presented

Michael Bailit, President, Bailit Health

Executive Director Southard introduced this topic as a request from Chair Khan. There are five potential options for responding to the pressures of inflation for assessing cost growth benchmark performance. However, per the Chair's request, this introductory conversation will include just three options.

Mr. Bailit began with a definition of inflation to ensure a common understanding. The cost growth benchmark, which used potential gross state product (PGSP), a forecast of future state economic growth, uses an inflation measure termed personal consumption expenditures (PCE). PCE is defined as a measure of the prices that people living in the U.S. pay for goods and services. It is derived from a survey of businesses and what they

sell and is the Federal Reserve's preferred measure when setting monetary policy. For context, when the governor issued the Executive Order establishing the cost growth benchmark, the methodology for establishing the value was a weighted average of forecasted median wage growth and forecasted gross state product or potential gross state product. Inflation was embedded in the gross state product value and the value that was embedded in it was the long-term forecast for inflation, the federal government's target rate, of 2%. The cost growth benchmark values reflect a shift in weighting from heavily on GSP or PGSP because it is long-term forecast to weighting more on median wages. The Executive Order for the Nevada health care cost growth benchmark states the PPC may recommend changes to the benchmark or changes to the way benchmark performance is assessed, should they find there have been significant changes to the economy. The statistical relationship between inflation and health care spending shows that inflation and growth in real gross domestic product (GDP) are highly predictive of growth in health care spending. However, the effect of inflation on health care spending lags over two years due to the prospective nature by which prices are set for health care services. Commercial payer prices are often set in multi-year contracts and public payers set prices prospectively, but do not change them frequently. Inflation (PCE) has climbed dramatically since late 2021 and health care prices began to rise slightly in the summer of 2022. General inflation is forecast to significantly drop in 2023, largely in response to rising interest rates.

Option number 1 presented to the Commission for responding to inflation and workforce cost pressures is to make no adjustments and commit to acknowledging the impact of inflation and labor shortages when interpreting results. The strengths of this option include consistency with the original intent for the benchmark values to be established for long-term use; and it maintains some degree of accountability for affordability during a period when wages are not growing as fast as inflation. Option number 2 presented to the Commission is to create a specific allowance for exceeding the benchmark on a time-limited basis for those years with very high inflation. This would be an adjustment applied assuming that lagged impact. This option maintains benchmark values but creates a temporary adjustment to inform interpretation of performance, thereby acknowledging the impact of inflation and labor shortages. It also maintains accountability for affordability, albeit at temporarily increased levels. Option number 3 presented to the Commission redefines the benchmark values on a time-limited basis for those years with very high inflation. Strengths of this option include that it acknowledges the impact of inflation and labor shortages and maintains accountability for affordability, albeit at temporarily increased levels.

A commissioner asked Mr. Bailit to clarify that these options are just for the benchmark and reporting and clarifying that there are no penalties for exceeding the benchmark in the program's current form. Mr. Bailit agreed and stated the only accountability mechanism currently in place is public reporting of who met or did not meet the benchmark. The commissioner opined that for that reason, she is in favor of option number 1. Another commissioner agreed that because the benchmark is not associated with any penalties right now, she also favors option number 1. Mr. Bailit shared there is some value in the other approaches, as the application of the benchmarks in other states, in practical terms, is when payers and providers sit down to negotiate contracts. If the benchmark value is viewed as being more reflective of what is happening with inflation and costs for providers, then it is more likely that the insurer and provider will negotiate a rate around the benchmark value. Therefore, the concern with option number 1 is that it might mean that the benchmark has the potential to lose its value in being a restraint on spending. A commissioner asked if the benchmark already includes inflation. Mr. Bailit answered that is correct, in part, because it is a weighted average. For the gross domestic product (GDP) measure, it assumes that inflation is 2%. Another commissioner opined she would lean towards option number 2. Another commissioner opined that he is in favor of option number 3, recognizing that we are in some extraordinary times. Another commissioner opined that she wants to heavily advocate for option number 1 because in her opinion, options 2 and 3 have the potential to hurt consumers more than option number 1. Another commissioner opined he is also in favor of option number 1 along with several other commissioners.

Agenda Item IX – Prioritizing Goals, Objectives, Activities of the Commission in 2023

Malinda Southard, Executive Director

Executive Director Southard began with an overview of the priority charge of the commission thus far in improving health care affordability, the health care cost growth benchmark. This project's continuous cycle is a focus on health care affordability and is expertly aligned with the primary charge of the PPC itself to systematically review issues related to the health care needs of residents of Nevada, and the quality, accessibility, and affordability of health care. Executive Director Southard also noted that she queried the commissioners to submit other topics or issues within the statutory charge of the commission they would like considered as an added priority and focus in 2023, and has received input to improve health care accessibility, thus far. Along with Chair Khan, she would like to suggest for discussion today that the PPC consider accessibility and affordability as the two main pillars for the commission's work over the year ahead. She noted the Commission can always review a range of strategies to improve provider accessibility in 2023 to help bring forward educated and thoughtful recommendations to the Governor and the Legislature on both proposed pillars and provided an outline of the suggested goals.

One commissioner noted that the Commission has discussed the shortage of nurses and physicians in Nevada and that it occurred to her that instead of the PPC trying to figure out why they are not staying, the Commission can instead look to ask them directly in a statewide survey. She asked the other commissioners for their support for this idea and suggested coming up with strategies on how to meet their needs after the PPC receives the results of the survey. Another commissioner seconded the proposal and thinks it is a great idea. She hopes there would be a section on how those nurses and physicians feel about raising families in our state. Another commissioner opined that she would like the commission to consider some sort of actionable item that empowers the Executive Director, in her capacity, to use the resources available to her. Specifically, she noted that the budget is small, and would like to ensure the Executive Director has the resources to be successful. Chair Khan opined that we would need a third party to help develop the survey questions and that the survey could be easily conducted before graduation. Another commissioner opined the need to also ask why some providers are not coming to the state and wondered if the PPC can ask the state licensing agency what the average time is for physicians moving into Nevada to get their license. Another commissioner opined that she agrees the survey is a great idea and suggested paying the Schools of Public Health to find a graduate student that incorporates the survey into their core assignment. Included in the discussion, another commissioner opined that he would like to find out what else affects accessibility such as transportation or cultural biases because that ties into our commitment to health equity.

Executive Director Southard then discussed the meeting cadence for 2023. She has asked the commissioners for their recommendations and came up with three options: to meet 100 percent virtually; meet in-person two times a year and otherwise virtual; or meet in-person four times a year and otherwise virtual.

Chair Khan noted that Wednesdays are challenging for him and suggested Thursday meetings in 2023. Further discussion was noted and a final meeting cadence for 2023 was not yet decided.

Agenda Item X – Public Comment

Barbara Richardson, Insurance Commissioner, Nevada Division of Insurance (DOI) indicated that she received two questions via chat during the meeting. The first question was whether Rhode Island was the only state to oversee the large group market. Insurance Commissioner Richardson answered no and that she was researching Rhode Island to give everyone an understanding. The second question asked why the DOI does not seem to be interested in overseeing some of the large group market since they often complain about not overseeing ERISA. Insurance Commissioner Richardson answered the DOI is not complaining about not overseeing ERISA, that it is just a fact. She apologized for coming across as possibly complaining and noted

that regarding the question about overseeing the large group market, her presentation was simply to explain to the Commission what the issues were and that overseeing the large group market could not be easily integrated into the oversight in the small and individual markets. There is no interest or disinterest from DOI, it is a policy decision that gets made through the legislative process.

Agenda Item # – Wrap up and Adjournment
Dr. Ikram Khan, Chairman

Meeting was adjourned at 11:06 a.m.

Respectfully submitted,

Kiley Danner
Office of the Patient Protection Commission

APPROVED BY:

Dr. Ikram Khan, Chair

Date: 12/22/2022

Meeting Materials

AGENDA ITEM	PRESENTER	DESCRIPTION
V.	Kiley Danner, PPC Policy Analyst	Draft PPC Health Equity Plan
VII.	Michael Bailit, President, Bailit Health	Cost Growth Mitigation Strategies Summary
VIII.	Michael Bailit, President, Bailit Health	Inflation Option Analysis