List of
Patient Protection Commission (PPC)
Bill Draft Request (BDR) Proposals for 2023 Session – Ongoing Discussion

Updated 7.18.22

Subject 1: Improve Health Care Access

PPC Goal: Researching possible changes to state or local policy in this State that may improve the quality, accessibility or affordability of health care in this State – Increasing access to health care for uninsured populations in this State, including, without limitation, retirees and children. - NRS 439.916.1(i)(7).

Subject 1, Topic 1 (*Leanne McAllister, Yarleny Roa-Dugan, Tyler Winkler*)**:**

Explore 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 an expert 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.

Among the options considered by the vendor shall include a limited, state-funded Medicaid benefit for this population, similar to California's recent effort to cover 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.

The PPC must procure a vendor to complete the analysis at no greater than $200,000.

Subject 1, Topic 2 (*Yarleny Roa-Dugan, Tyler Winkler*)**:**

Permit access to the Silver State Health Insurance Exchange (Nevada's private insurance marketplace) regardless of immigration status.

Subject 1, Topic 3 (*Tyler Winkler, Lilnetra Grady*)**:**

Expand coverage to residents regardless of immigration status: Submit a 1332 waiver request; Develop new state funding mechanisms permitting Medicaid coverage.

Subject 1, Topic 1-3 Documentation and Analysis:

Updated information as of 6/21/22:

Regarding national statistics per a recent affinity group announcement through State Health and Value Strategies, immigrants (including "lawfully present" and undocumented individuals) make up 23 percent of uninsured people nationally, and those who have coverage experience high rates of churn. Regarding Nevada's uninsured population, please see the underlying Guinn report, available here.

Medicaid Coverage & Waivers

Sections 1115 and 1915(b) of Title XIX of the Social Security Act provide an avenue for states to seek federal waivers of Medicaid requirements. However, these waivers do not allow states to waive the prohibition on federal Medicaid funds being used by states to cover ineligible immigrants (e.g., undocumented residents and lawful immigrants who have not met the 5-year residency rule for coverage). See Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) and sections 1115 and 1915(b) of the Social Security Act.

Federal law does provide for an exception to this general prohibition with respect to emergency services. States can use federal Medicaid dollars to help pay for treatment of emergency medical conditions if the individual meets all other Medicaid eligibility rules in the state (e.g., income and state residency) but does not have an eligible immigration status or proper documentation. States may also choose to take up an option to cover pregnant women during pregnancy regardless of their immigration status. Nevada recently took up this option during the last legislative session.

Several states have been exploring options for addressing the gap in coverage for this immigrant population with non-federal funds. For example, California recently established a new slimmed down package of basic health care services, which includes preventative, primary care, behavioral health, and emergency care, under its Medi-Cal program (Medicaid), for young adults (19-25) regardless of immigration status. According to state officials, the state is braiding federal Medicaid funds for emergency services with state dollars to cover this new benefit. To ensure federal compliance, the state must ensure no federal funds are used to cover the other non-emergency portions of this new benefit. Early estimates for this new benefit for young adults had a state price tag of $98 million, with the offset of the federal Medicaid share of emergency services making up only $24 million of this total.

Nevada could consider a similar approach and establish a non-federally funded Medicaid benefit for this population for young adults. Unless other private or local resources are included, this benefit would need to be fully state funded. The fiscal impact of a new state-funded benefit is unknown at this time.

Exchange Plans & 1332 Waivers

With respect to the exchange, certain individuals are ineligible to shop for qualified health plans and cannot receive federal advanced premium tax credits (APTCs) due to their immigration status. It is largely unknown and debatable, at this time, whether the federal government would approve a 1332 waiver of the Affordable Care Act to waive the federal restrictions on eligibility that are based on immigration status. (See 45 CFR 155.305.) However, Washington recently submitted a 1332 Waiver to the federal government for approval of such a waiver and expects an answer to this request by September of this year.

If approved, the 1332 waiver will provide access to federally *non-subsidized* health and dental coverage (i.e., qualified health plans) that are available through Washington's state exchange to all Washington residents, *regardless of immigration status*, starting in plan year 2024. The key phrase here is non-subsidized. If approved, undocumented immigrants could apply for qualified health plan coverage on the Washington Exchange, but advanced premium tax credits would not be applied to reduce the cost of this coverage.

The Centers for Medicare and Medicaid Services (CMS) also recently approved a 1332 waiver from Colorado, which includes, among other items, permission for the state to use new federal pass-through funds from the establishment of standardized health plans to support state-based subsidies to improve the affordability of health insurance in the state. Those eligible for the state-based subsidies include those who are eligible for federal APTCs through the exchanges as well as Coloradans without proper immigration documentation.

PPC Goal: Reviewing the effect of any changes to Medicaid, including, without limitation, the expansion of Medicaid pursuant to the Patient Protection and Affordable Care Act, Public Law 111-148, on the cost and availability of health care and health insurance in this

Subject 1, Topic 4 *(Tyler Winkler):*

Address the housing crisis through Medicaid waivers, targeted legislation, infrastructure funding, and adoption of affordable housing policies. Establish rent controls. Recommend State pass legislation granting authorization to municipalities to address unaffordable, unsustainable rent increases. Develop permanent supportive housing plans. Pursue Medicaid state plan and waiver authorities (e.g., 1905(a), 1915(i), 1915(c), or Section 1115) to add certain non-clinical services to the Medicaid benefit package including case management, housing supports, employment supports, and peer support services.

- **To address housing insecurity among beneficiaries in the Medicaid managed care program, the Division of Health Care Financing and Policy (DHCFP) shall seek the necessary federal approval to permit Medicaid managed care capitation funds to be used by managed care plans used to pay for housing-related services as in lieu of other services covered by the State plan as described in 42 CRF 438.3(e)(2).**

Subject 1, Topic 4 Documentation and Analysis:

Proposed language is in an effort to help increase housing supports and services covered by managed care organizations (MCOs) for their members, and help increase interest among MCOs to offer/cover these services.

Side note: Currently, managed care plans in Nevada must use their own profits to fund such services. This proposed language would permit MCOs to choose to use Medicaid funds to offer these services as a covered benefit to members; this would likely increase the consistency, range and availability of these services to beneficiaries. If approved by CMS, MCOs have the choice to offer these housing supports and services in addition to Medicaid benefit set to their members while using Medicaid capitation dollars to fund them. This would be at no additional cost to the state if DHCFP determines they are "cost effective" and CMS approves them as such through a contract amendment. The "value-added" services that plans offer today related to housing are paid for with MCO profits. This could help increase the availability (and range) of these services across all MCOs and therefore members. California recently had a long list of housing-related services approved as 'in lieu of' services (ILOS) for their Medicaid managed care population. See: Community Supports Policy Guide (ca.gov)

Following the 81st Legislative Session (2021), Senate Bill (SB) 309 established the Medicaid Reinvestment Advisory Committee (MRAC). Per the Nevada Revised Statutes (NRS) 422.175, 422.185, 422.195, and 422.205 the Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP) is responsible for establishing, developing, and implementing a Medicaid managed care program(s) to provide health care services and access to care for Medicaid recipients. The purpose of the MRAC is to make recommendations, advisory in nature, based on reports reviewed to the Division and Medicaid managed care organizations concerning the reinvestment of funds by those Medicaid managed care organizations in the communities they serve.

As mentioned in the public comment provided by Nevada Association of Health Plans (NvAHP) on 6/15/22, the Healthy Living Expansion (HLE) Program is one example of an MCO reinvestment program. The HLE is a public/private partnership including Clark County Department of Social Services, Anthem, Health Plan of NV, SilverSummit, Molina, HELP of Southern Nevada, and the Southern NV Homelessness Continuum of Care.

The County provides funding from a US Dept. of Housing and Urban Development (HUD) Continuum of Care grant for Permanent Supportive Housing that supports the program's leasing costs. Anthem, Health Plan of NV, SilverSummit, and Molina provide match funding to the County for case management and supportive services and additionally provide medical case management for their respective members served in the program. HELP of Southern Nevada (Community Based Organization) provides housing-focused intensive case management and supportive services. Health Plans via Homeless Management Information System and the Coordinated Entry System provide the referrals.

HLE is a Permanent Supportive Housing project serving the most vulnerable, chronically homeless clients in the community queue who are not suitable for shelter due to their medical fragility. The program provides a safety net, including subsidized housing, intensive housing-focused case management, medical case management, and supportive services to assist households in becoming self-sufficient.

Using a Housing First model, the HLE program provides immediate placement into housing and a connection to medical step-down care without preconditions. Members are placed into scattered-site rental units across the community. Funding for leasing the rental units is provided through the HUD Continuum of Care Grant provided to the County. The provision of intensive case management and supportive services by Help of Southern NV is funded through the Health Plans. Housing locations are determined by the client and case managers with consideration given to proximity and access to medical and behavioral health providers, other services, and rent reasonableness.

PPC Goal: Researching possible changes to state or local policy in this State that may improve the quality, accessibility or affordability of health care in this State – Regulatory measures designed to increase the accessibility and the quality of health care, regardless of geographic location or ability to pay [NRS 439.916.1(i)(3)].

Subject 1, Topic 5 *(Beth Slamowitz):*

Classify Naloxone as an over-the-counter (OTC) drug to increase access through harm reduction programs. 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.

Subject 1, Topic 5 Documentation and Analysis:

With regard to the Substance Use Response Working Group (SURG) within the Attorney General's Office, the SURG is involved with addressing the topic of naloxone access and distribution. **Senator Fabian Donate** who chairs the prevention subcommittee, reported during the 6/7/22 SURG meeting that "A lot of programs nationwide are geared toward primary prevention, but not as much is being done in secondary prevention, so that is an avenue for innovative work. Tertiary prevention includes harm reduction and naloxone distribution."

Also during the 6/7/22 SURG meeting, Dr. Cantrell with Mercer (the company contracted to conduct the state needs assessment and develop the state plan, as required under SB390) reported as part of the prevention gaps that "Harm reduction and social determinants of health are important for

saving lives. When people are still using, we still want to give them enough chances at life to get into recovery in the future, and provide supports like housing, transportation, food and safety that a lot of us take for granted, but greatly affect health care and health outcomes. It's really hard to recover if you don't have these basic needs met. Innovative programs for needle exchange, vending machines, and naloxone distribution and education are especially needed in rural areas, with greater availability."

Additionally the Advisory Committee for a Resilient Nevada (ACRN, created under SB 390) met 6/22/22, discussing naloxone availability and distribution as a topic on which they plan to make recommendations to DHHS Director Whitley.

Community-based naloxone distribution is a rigorously evaluated, evidence-based intervention. Harm Reduction programs are our first line of defense to preventing overdose deaths. They are adept at reaching marginalized communities that mainstream medicine and public health cannot. They have distributed naloxone that laypeople have used to reverse hundreds of thousands of overdoses. Unfortunately, their ability to quickly and effectively get naloxone to the people who are most likely to reverse overdoses continues to be hampered by legal and regulatory barriers. These barriers slow down, and sometimes prevent entirely, purchases of naloxone.

Currently, under chapter 453C of the NRS, harm reduction programs, pursuant to a standing order from a properly authorized prescriber, can **store** and **dispense** Naloxone, but they are not able to purchase Naloxone directly. Across the United States (US), there is no standard way of acquiring naloxone. Different people and organizations do so in different ways. Access to naloxone often relies on a piecemeal assemblage of regulations, funding programs and advocates.

The state purchases its naloxone supply through Cardinal Health. They are contracted with Emergent BioSolutions for Narcan. The State Opioid Response purchases the 4mg Narcan Nasal Spray. The current cost is $68 per 2-dose unit. Needle Exchange programs are supplied with funding to purchase injectable naloxone. Injectable naloxone is substantially (3-4x) cheaper. Currently, the purchase of naloxone by the state is grant funded and there is no direct cost to the state. $1.2 million was set aside out of the State Opioid Response (SOR) budget for the purchase of naloxone over the period of September 30, 2021-September 29, 2022. The distribution of naloxone to community-based organizations interested in becoming distribution sites, is a collaborative effort by the State of Nevada STR grant and the Southern Nevada Health District (SNHD) First Responders-Comprehensive Addiction and Recovery Act (FR-CARA) Grant.

An identified roadblock for community providers and harm reduction programs is often not knowing what is available. There have also been struggles during periods when the state is waiting for new shipments of naloxone to arrive, which causes delays in getting naloxone to community partners. While there is no statewide standing order in place, the Medical Director of the Southern Nevada Health District has issued an order valid in that District. Each program or community partner is responsible for the completion of their own standing order. Nevada has done a lot to increase naloxone access, passing laws, and executing orders to greatly simplify prescribing and distribution, and essentially enabling naloxone to be sold and/or distributed without a prescription. However, significant barriers to purchasing of naloxone by community-based programs still exist.

As the US faces an unprecedented surge in opioid overdoses, harm reduction groups are seeing shortages in naloxone, a usually affordable and easy-to-use medication that reverses overdoses and has been credited with saving many lives. But it's not because of a lack of supply; there's actually plenty of

naloxone out there. Instead, the dangerous shortage of naloxone is all about soaring prices. Community groups working to prevent overdose deaths are now paying up to 30 times more for the life-saving medication – at a time when more Americans than ever are dying from overdoses. For naloxone, cost, availability, and lives saved are intimately linked.

Barriers to Naloxone Access

Cost

Naloxone is an inexpensive medication that's been around since the 1970s. Other life-saving medications such as insulin and EpiPens are also sold at prohibitively high costs. Naloxone was approved by the Food and Drug Administration for overdose reversal in 1971. The original patent expired long ago, but new delivery systems—like the auto-injector and the nasal spray—have allowed for new patents, of which there are currently seven, with the auto-injector and nasal spray not due to expire until 2035. In effect, companies are now charging for the delivery system, not the drug itself. The injectable form of naloxone is the cheapest, because it is not covered by patent.

Harm reduction groups able to purchase directly, used to buy naloxone from Pfizer to create kits that cost about $2.50 each. Now they have to pay $37 for a different generic medication or $75 for Narcan – a 15- to 30-fold increase. They simply haven't been able to afford enough kits to save everyone's lives. Emergent BioSolutions, the company that produces Narcan, has not raised the price since the medication was launched in 2016, but discounts are not offered to harm-reduction organizations.

Availability

Because there are no gaps in supply – only in price – the US Food and Drug Administration hasn't declared a naloxone shortage. Naloxone availability is extremely variable; it has been found to be inadequately stocked in areas with high overdose rates, minority neighborhoods, and areas with a low average household income. One reason for this lack of availability may be the result of a phenomenon known as "medication deserts," a term that describes areas where geographic access to pharmacies is severely limited and the stock at these locations may be insufficient to meet patients' needs. In poorer districts, where people who are unlikely to own cars live, pharmacies have a greater chance of not having medications stocked in comparison to those in more affluent areas.

Research also shows that people who use drugs often do not feel comfortable purchasing naloxone in pharmacies (Antoniou et al., 2021). Family and societal stigma also cause a lack of demand at the pharmacy counter and leads pharmacies not to carry naloxone or be open to the availability of state purchased supplies.

Manufacturers become reluctant gatekeepers, often causing administrative burdens and roadblocks for harm reduction programs to obtain naloxone.

1. **Large pharmaceutical manufacturer**
    a. For Harm Reduction programs, Pfizer requires U.S. Drug Enforcement Administration (DEA) registration of the prescribing physician even though naloxone is not a controlled substance. In their ordering system, one prescribing physician cannot provide their DEA authorization to multiple Harm Reduction programs, thus rendering statewide standing orders useless for naloxone procurement.
2. **Small pharmaceutical manufacturer**

a. Some small manufacturers, require physicians working with Harm Reduction programs to sign affidavits clarifying that their naloxone prescription explicitly authorizes "purchase," and not solely "distribution." Corporate compliance officers require this burdensome paperwork to document the transaction out of fear of U.S. Food and Drug Administration (FDA) enforcement. This applies even to states with standing orders, some of which explicitly forbid purchasing.

3. **Distributors**
    a. Distributors do not have a model for situations of state-OTC versus federal-Rx. For example, a convoluted fix was necessitated by the fact that the prescription product division (McKesson Pharma) is a separate commercial entity from the medical supplies division (McKesson MedSurg), and syringe service programs are ineligible for McKesson Pharma accounts because they are not pharmacies. Therefore, naloxone has to be transferred between these divisions, creating delays and additional supply chain vulnerabilities.
4. **Charitable Donations**
    a. In order to receive a charitable donation of no-cost naloxone, programs must meet compliance requirements dictated by prescription-only status. To receive free naloxone through Direct Relief (Pfizer's donation of 1 million doses), programs must: "comply with State Board of Pharmacy regulations in storing and dispensing medications; and have a Medical Director or Pharmacist with a valid state license." Recently, the Buyers Club received a separate commitment of a 50,000-dose donation for member programs, and only three programs were able to produce the required paperwork to receive an emergency donation.

Buyers Club

Styled after early Acquired immunodeficiency syndrome (AIDS) antiretroviral purchasing groups, the Buyers Club is a collective of more than a hundred organizations comprising the backbone of community-based naloxone distribution in the United States. The primary purpose of the Buyers Club is to facilitate the purchase of naloxone. The Buyers Club negotiates with manufacturers. The programs place orders with the Buyers Club, which are then sent to the manufacturer. The manufacturer then ships directly to the program and the program pays the manufacturer directly.

The Buyers Club is an unfunded, volunteer effort and does not impose any fees. In addition to placing orders, the majority of staff time is spent on assisting programs in filling out the substantial paperwork required by the manufacturer, because naloxone is designated by the FDA to be prescription only. During COVID, retail pharmacy sales of naloxone declined 26% (JAMA Health Forum – Health Policy, Health Care Reform, Health Affairs | JAMA Health Forum | JAMA Network), while demand from Buyers Club programs increased 29%.

Financial Support for Naloxone

- Half of Buyers Club programs report having to do fundraising to purchase naloxone. GoFundMe pages, t-shirt sales, and donations to overdose memorial funds are common.
- A quarter of programs (25.3%) report regularly rationing naloxone due to inadequate financial support from state and federal government.
- Half of programs do not receive any financial support to pay for staff time to distribute naloxone.

The 2021 model legislation (Model Expanded Access to Emergency Opioid Antagonists Act (legislativeanalysis.org)) out of the White House for increasing access to opioid antagonists, included a section on funding. This included federal funds, grant programs, additional sources such as gifts and endowments, as well as state funding for services provided as part of increasing access and obtaining emergency opioid antagonists. This included

access within state and local educational institutions, and state and local correctional settings as applicable. It is necessary to find a way to provide a supply of affordable naloxone for harm reduction programs.

Many of the supply chain issues, may be solved if the FDA finds a way to change naloxone's prescription status. Until then, the state must look for a way to decrease the cost and increase the purchase points to help increase the supply and distribution to areas of need. Creation of an opioid antagonist access advisory committee under the authority of DHHS might be a good first step. To maximize impacts, high-value naloxone access laws should explicitly counter existing healthcare system inequities, address stigmatization of opioid use and naloxone, maintain reasonable prices for purchasing naloxone, and target settings beyond community pharmacies to distribute naloxone.

Subject 1, Topic 6 *(Mason Van Houweling, Leann McAllister):*

Insert clear, effective, and sustainable telemedicine language in the Nevada Revised Statutes (NRS): Codify current COVID-19 related telemedicine provisions, i.e., interstate licensure exceptions. Ensure that there is sufficient access to technology and connectivity to support telemedicine in Nevada. Address parity of payment. Address licensure and adequacy of network issues.

Subject 1, Topic 6 Documentation and Analysis:

- Per SB5 passed during the 2021 Session, payment parity for telehealth services, as applies to services other than mental health services, will expire by limitation 1 year after the Governor terminates the emergency described in the Declaration of Emergency for COVID-19, whichever is earlier.
- Therefore, **payment parity for telehealth services, as applies to services other than mental health services, will expire on May 19, 2023.**
  - Due to the end of the COVID-19 state of emergency in Nevada on May 19, 2022.
- **Payment parity for telehealth services, as applies to mental health services, will expire by limitation on June 30, 2022**.
- Possible challenges with permanent telehealth payment parity that arose during 2021 Session included fears of overuse of telehealth, or providers not adequately utilizing in-person treatment services, etc.
- Opportunity exists for the PPC to request these telehealth payment parity services to become permanent during the 2023 Session.
- Please also see this link to an article regarding telehealth legislation, and model practices: https://www.manatt.com/insights/newsletters/health-highlights/telehealth-model-legislation-a-comparison-of-ama

Background:
The COVID-19 pandemic has been a catalyst for the widespread adoption of telehealth by patients and payors and it has been demonstrated that healthcare services can be safely, effectively, and efficiently delivered to populations in need through technology enabled platforms. Telemedicine is critical to achieving the "Quadruple Aim in Healthcare," whose goals are:

1. Improve the patient experience (including quality and satisfaction)
2. Improve the health of populations
3. Reduce the per capita cost of healthcare
4. Improve provider satisfaction (professional wellness).

Historically, lack of payment was a major determining factor hindering the progress of the field, which has now been temporarily addressed via national and state waivers in the public health emergency. Although this form of healthcare delivery is not meant to replace in person care, these advances in policy must be protected so that the increased access to care provided to vulnerable groups is not suddenly rescinded.

The Research Division of the Legislative Counsel Bureau reported the state of telehealth in Nevada and the US - describing the challenges and opportunities the legislature has to enshrine a Health Equity framework to telehealth expansion in the Silver State.

Legislation addressing the following is needed to ensure continued progress:

- Codify current COVID-19 related telemedicine provisions, i.e., interstate licensure exceptions to address provider shortages and adequacy of network issues; allow providers out of State to provide services where there is a known critical shortage.
- Ensure that there is sufficient access to technology and connectivity to support telemedicine in Nevada with a focus on the rural communities along with addressing broadband network gaps within the major metropolitan areas of Nevada
- Address parity of payment to ensure access is not diminished due to reimbursement along with additional possible payment incentives for mental and behavioral provider services. Consideration for payment parity for those specialties where there are identified existing provider shortages.
- Include the 3 main forms of telemedicine in payment: synchronous (live video), asynchronous (recordings, photos for delayed assessments), audio, and remote patient monitoring.

Summary:
Expansion and access to telehealth as a service delivery model increases capacity, reduces healthcare costs overall, and improves access for healthcare consumers by saving travel time, gas, and lost wages along with addressing health equity to address geographic disparities. Impact on the State, healthcare providers in person services, and overall market impact may require further review. Increasing providers, technology allowances, and platforms for patient access will improve access to healthcare overall to patients.

Per the American Academy of Pediatrics (AAP) 2021 Policy Statement, Telehealth: Improving Access to and Quality of Pediatric Health Care:

- The growth and development of telehealth, or the provision of health services remotely, reflects the evolution of health care delivery systems to adapt to new technology and the needs of the population. The exponential growth in the adoption and use of telehealth services during health care disruptions, such as the coronavirus disease 2019 (COVID-19) pandemic, highlights the need to clarify the goals and best practices for using telehealth in child health. This policy statement addresses **how telehealth and telehealth policy can increase patient access to primary care and subspecialty pediatric expertise, support care coordinated within the medical home, and enhance communication and**

collaboration among clinicians and other stakeholders, resulting in cost-efficient, equitable, high-quality care.

Additionally, the AAP released a Technical Report in March, 2022: Telehealth: Opportunities to Improve Access, Quality, and Cost in Pediatric Care. This report describes the present state of telehealth and its current and potential applications. Telehealth has the potential to transform the way care is delivered to pediatric patients, expanding access to pediatric care across geographic distances, leveraging the pediatric workforce for care delivery, and improving disparities in access to care.

- Regulatory policy regarding clinic and hospital privileging, interstate licensing, and **payment parity** has historically lagged behind changes in patient demand, technology, and business strategies. Before the COVID-19 pandemic, adoption by Medicaid varied widely among the states, whereas Medicare paid for interprofessional telehealth consultations, store-and-forward imaging studies (radiographs, photos), and the review of biometric patient data provided by remote monitoring systems, with some stipulations. However, most state Medicaid programs do not provide for payment to an out-of-state physician who is not registered with the program in the state where the patient is covered, creating another barrier to care. Providing care to an established patient who is located, even temporarily, in a different state than that where the physician is licensed is also problematic in some instances and also raises concerns for some about malpractice coverage across state lines. Both the Medicaid and licensure issues are especially problematic for providers and health systems located close to state borders because their service areas may routinely encompass patients from several states and obtaining Medicaid participatory status and multiple state licenses is time-consuming and costly. Temporary accommodations have been put in place to address such issues during the COVID-19 pandemic and could be expanded, extended, and made permanent going forward. To ease multistate licensure for physicians, the AAP supports the independent Interstate Medical Licensure Compact, launched in 2017 (available in 29 states at the time of this publication), which has enabled the provision of telehealth services across some state lines, but significant barriers still remain from variable cross-state licensure requirements.

Subject 1, Topic 7 *(Mason Van Houweling):*

Require that health carriers in the state of Nevada have sufficient availability of and access to mental and behavioral health professionals in urban and rural areas throughout Nevada. Identify and address mental health-focused physician, nursing and other licensed mental and behavioral health professional shortages: support professional development, facilitate improvements to the licensure attainment processes, Identify and address behavioral health-focused physician, nursing, and other licensed mental and behavioral health professional shortages within health carrier networks to improve access for patients in need. Expand the types of health carriers for whom these requirements will apply.

Subject 1, Topic 7 Documentation and Analysis:

Background:

- Support the development of **mental health physician and nursing workforce** and require that more health carriers in the state of Nevada have sufficient availability of and access to such professionals in urban and rural areas throughout Nevada.

Southern Nevada has a low physician to population ratio compared to other counties in Nevada and in the US. Clark County has a primary care

physician to population ratio of 1:1,244 while the national benchmark for this ratio is 1:631 (County Health Rankings, 2012). Clark County has 77 licensed Medical Doctors (MDs) and Doctors of Osteopathy (Dos) per 100,000 population compared to 114 in Carson City and 91 in Washoe County. (Nevada Journal of Public Health (2014) Pharr, Et al. 38.

Mental health is an essential part of a person's overall health. Positive mental health allows people to cope with the daily stresses of life, work productively, and make meaningful contributions to their communities. Similar to the Substance Abuse section, Nevada received F grades for categories that involve youth, including the prevalence of mental illness among youth and the proportion of youth experiencing a severe depressive episode. Nevada also has a high suicide rate compared to other states, but it has decreased since the last Nevada Medical Center (NMC) Healthcare Report Card resulting in a D grade. Nevada faces a severe shortage of mental healthcare providers, earning a D grade for the mental health provider rate. In all population groups, a large percentage of those with a mental illness do not receive treatment. This may be directly connected to the shortage of mental healthcare providers in the state, the lack of insurance coverage, and the remaining stigmas surrounding mental health. Although Nevada has recorded better than average grades for some mental health measures, the state still lags in areas involving access to treatment and provider availability. Nevada earned a C grade for mental health. Nevada ranks 50th in the nation for psychiatrists and 47th for psychologists. Nevada has 8.5 psychiatrists per capita compared to the national average of 16.1 (Nevada Hospital Association). The number of counselors is also limited at 1.7 per 100,000.

- Identify and address mental health-focused physician, nursing and other licensed mental and behavioral health professional shortages and support professional development and facilitate improvements to the licensure attainment processes.
  - Licensure reciprocity and review of licensure barriers/process
  - Expand Midlevel and other professionals' scope of practice
  - Improve reimbursement (current laws do not require reimbursement by commercial insurers to some providers including licensed clinical social workers)

- Identify and address mental and behavioral health-focused physician, nursing, and other licensed mental and behavioral health professional shortages within health carrier networks, to improve access for patients in need.

- Expand the types of health carriers for whom these requirements will apply.

Providing a mechanism to support and improve mental and behavioral health services and access to care provides a cost avoidance, reduction in use of acute hospital services, along with savings within the community related to communicable diseases and long-term physical illness, criminal activity. Nevada hospitals are providing care to this vulnerable population in emergency room settings even though mental/behavioral health care services are not part of their service lines. Removing barriers to provide care to this population is critical to improving the crisis that exists to include: Licensure reciprocity, expansion of scope of midlevels providers and review of health carrier network allowances. Additionally, consideration to include workforce shortages and patient access issues as part of the scope included in NRS 433C Regional Behavioral Health Authority.

The PPC Executive Director spoke with the Regional Behavioral Health Policy Boards in May 2022. Dr. Sara Hunt from University of Nevada, Las Vegas (UNLV) found a great example workforce pipeline program from Nebraska that has also worked in Illinois and is currently being launched by Kentucky (double-click on Adobe PDF icon further below to access the full presentation). The Regional Behavioral Health Policy Boards are expected to propose the legislative components of this type of model.

The Regional Behavioral Health Policy Boards (RBHPB) attempted to cement the Emergency Directive 011 into law as the "norm" during the 2021 Session (SB 44), but ran into some challenges. Here is the current status in Nevada:

- Board of Psych Examiners (Psychologists): are a part of an interstate compact, allowing reciprocity among all participants. This is the gold standard.
- Board of Social Work: would like to enter into interstate compact. The proposed bill from Rural Regional Behavioral Health Policy Board last session (SB 44) added the LMSW licensure type so they would be able to do so.
- Board of MFTs/CPCs: believe they would like to enter into interstate compact, but there is very little standardization of title/scope of practice/educational requirements for CPCs (and somewhat for MFTs), so it's more difficult.
- Board of Alcohol, Drug, and Problem Gambling Counselors: Also, not a lot of consistency across the nation. This licensing board tends to have much higher requirements for licensure in Nevada than other states and holds that as a show of quality.
- The Rural Regional Behavioral Health Policy Board will be sending letters to each of the abovementioned licensing boards to solicit feedback on what changes have/not been made by them in the wake of SB 44, and what else they would like to see in this arena.
- SB 209 requires the Legislative Committee on Health Care to conduct an interim study concerning the response by this State to SARS-CoV-2 and to make recommendations for legislation concerning the response by this State to future public health crises. This study includes reviewing components of Emergency Directive 011 for viable proposals during the 2023 Session.

- Dr. Sara Hunt, Assistant Dean of Behavioral Health Sciences, Director, UNLV Mental and Behavioral Health Training Coalition recently presented to the Rural Regional Behavioral Health Policy Board on 6/22/22 regarding mental health workforce and education.

Subject 2: Increase Transparency and Address Patient Affordability

PPC Goal: Examine the cost of health care and primary factors impacting those costs. - NRS439.916(c).

Subject 2, Topic 1 (*Sandra Ruybalid, Bobbette Bond, Lilnetra Grady*)**:**

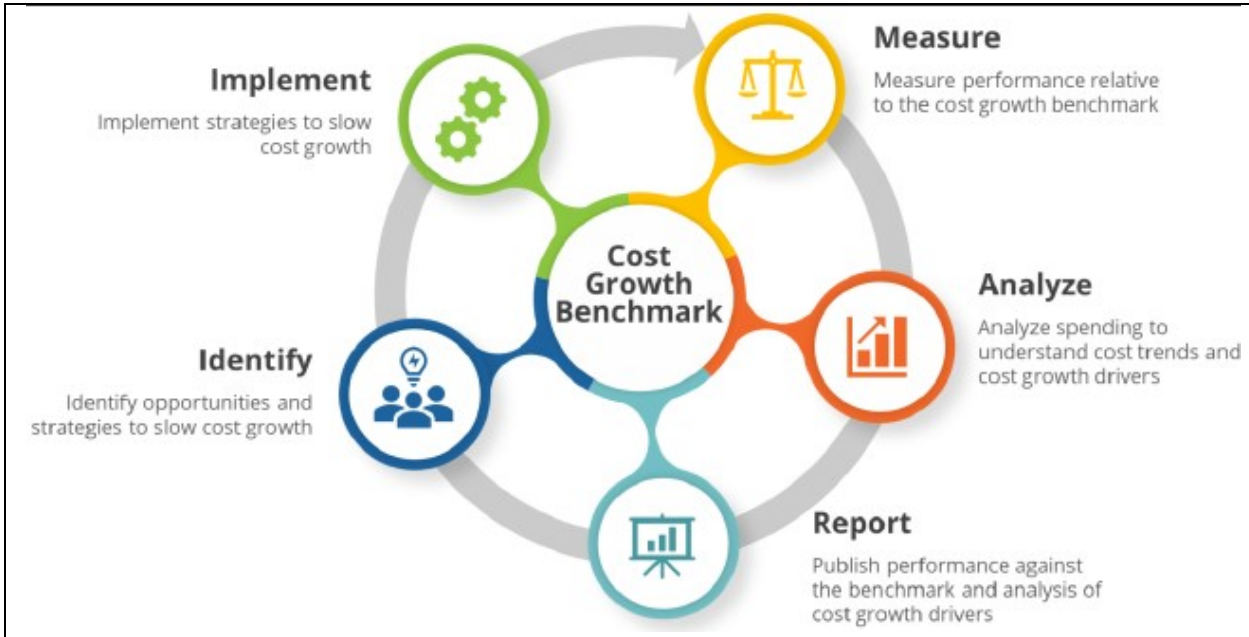
Codify the Nevada Health Care Cost Growth Benchmark Program as set forth in Executive Order 2021-29, and include a requirement to measure and report on primary care spending.

Subject 2, Topic 1 Documentation and Analysis:

Health care affordability is a pressing problem for Nevadans. Health care spending growth has been exceeding wage growth, meaning health care spending every year takes a larger chunk out of household income. According to the 2022 Commonwealth Fund State Scorecard, Nevada ranked 46th in the U.S. in 2020 for employee total potential out-of-pocket medical costs as a share of state median income. The state also ranked 39th for the percentage of residents with medical debt (19%).

Executive Order 2021-29 established the Nevada Health Care Cost Growth Benchmark. As noted in the press release on 12/29/21, the executive order sets a benchmark for how much the cost of health care services should grow in a year. It also charges health care payors, namely insurance companies, and healthcare providers to work together to meet these goals. The State is taking a phased in-approach to allow for more collaboration between stakeholders. The Health Care Cost Growth Benchmark is the first step toward making health care more affordable and transparent.

As visually portrayed in the graphic that follows below, the Cost Growth Benchmark strategy has multiple components. The first two involve measurement of spending, including assessment of performance against the benchmark and deep analysis of claims data to understand what is causing spending to grow. The next component is public reporting and discussion of findings. This transparency is intended to promote understanding and accountability. The last two components involve identification of the leading cost and cost growth drivers, and adoption of strategies to mitigate future cost growth.



The State has made major strides toward implementing the Health Care Cost Growth Benchmark strategy.

First, with guidance from Bailit Health, the Department of Health and Human Services Office of Analytics (OOA) and the Public Employees' Benefits Program (PEBP) have each completed and released a five-year cost driver analysis report for Nevada Medicaid and PEBP. This report includes a drill down of the 10 (out of 11) standard Phase 1 analyses as recommended by the Peterson-Milbank Program. OOA and PEBP are currently working on the Phase 2 reports which will include a drill down into service category spend focusing primarily on price and utilization for professional and primary care, in-patient hospital, out-patient hospital, emergency department utilization, and pharmacy. The information was presented to the PPC in April 2022.

Second, on May 16, 2022, Bailit Health hosted a baseline data request informational webinar for all Nevada insurers to provide an overview, data specification manual, and technical assistance with the baseline data request and analyses. Payers were requested to report data in August 2022 for commercial, Medicaid, and Medicare. OOA staff will analyze the submissions and report findings to the PPC and the public in the first quarter of 2023.

Third, the PPC has received a presentation on cost growth mitigation strategies being pursued in other cost growth benchmark states. Considering that information and the April cost growth driver analyses using Medicaid and PEBP data, the PPC will consider cost growth mitigation strategies for recommendation later in 2022.

It is now necessary to commit to a long-term effort to address health care affordability for Nevadans by making the Nevada Health Care Cost Growth Benchmark program permanent. While the passage of AB348 during the 2021 Session designated the PPC as the "sole state agency responsible for

administering and coordinating matters relating to the participation of this State in the Peterson-Milbank Program for Sustainable Health Care Costs", legislation would ensure long-term engagement by the PPC and the Department of Health and Human Services in the Health Care Cost Growth Benchmark program. In so doing, Nevada would join California, Connecticut, Delaware, Massachusetts, Oregon and Washington as states with cost growth benchmark programs in statute.

To augment the Health Care Cost Growth Benchmark, Nevada should strengthen its primary care infrastructure. Nevada current ranks very poorly among states for some key measures of primary care, including 47th for diabetic adults without a hemoglobin A1c test and 50th for children without a medical home (2022 Commonwealth Fund State Scorecard). While there are many possible steps to improve primary care within the state, one is to ensure that there is adequate investment in primary care. To date, six states have set primary care investment targets (CO, CT, DE, OR, RI and WA), while others are measuring or have committed to measure primary care spending relative to total medical spend. Nevada should take a first step to address a pressing problem with profound consequences for the health of Nevadans by measuring and reporting on primary care spending relative to a primary care investment target that would be applied to commercial fully insured spending and Medicaid managed care spending.

Subject 2, Topic 2 *(Flo Kahn):*

Eliminate the pharmacy deductible for patients who have a chronic condition.

Subject 2, Topic 2 Documentation and Analysis:

Diabetes Patient Advocacy Coalition: They lay out their top policy issues here, including first dollar coverage for diabetes, caps on costs for people with diabetes, and rebate reform: https://www.diabetespac.org/advocacy.

Additionally, a California CalPERS Co-pay study was performed on patient cost-sharing and hospitalization offsets in the elderly.

Further, a Journal of the American Medical Association (JAMA) Research Letter Health Policy published on September 24, 2021: *Access to High-Cost Medications After a Cap on Monthly Out-of-Pocket Spending in California* notes, "High prescription drug costs are a substantial problem for many patients who cannot afford their medications, even with health insurance. Capping monthly out-of-pocket (OOP) costs for high-cost drugs may increase the affordability of these medications. In January 2016, Covered California implemented a monthly cap on OOP costs for high-cost drugs to increase patient access. We evaluated the association of this cap with high-cost drug use and OOP spending."

Lastly, in the Discussion section:
"The findings of this cross-sectional study suggest that Covered California's drug cap policy was associated with modest changes in high-cost drug use and adherence and with making expenses more consistent throughout the year. Although these results were found for Silver, Gold, and Platinum plans, they were not found for Bronze plans. Fewer enrollees reached the annual maximum OOP spending after implementation of the policy.

This study has limitations. This was a descriptive study; more detailed statistical analyses will be needed to establish causation. The proxy costs used to identify cap-eligible drugs are estimates and may not reflect actual spending. Similar to proxy costs, plan sponsors varied in the extent they reported cost-sharing amounts, although not over time. Thus, our results likely represent an undercount of the number of patients reaching the annual maximum OOP spending.

Caps on prescription drug OOP spending are relatively new. Most states that have enacted caps have focused on chemotherapy medications,[1] which have slightly lowered OOP costs for patients.[2] Other states have implemented or are considering similar policies for other drugs,[3,4] such as insulin.[5,6] Our findings suggest that cost-sharing caps for high-cost drugs may be associated with increased adherence and increased consistency of OOP spending for patients."

Please see full JAMA article, with additional charts, graphics and references here:
https://jamanetwork.com/journals/jamanetworkopen/articlepdf/2784481/taylor_2021_ld_210196_1631885863.05873.pdf

PPC Goal: Researching possible changes to state or local policy in this State that may improve the quality, accessibility or affordability of health care in this State – Increasing transparency concerning the cost or provision of health care [NRS 439.916.1(i)(2)].

Subject 2, Topic 3 *(Bobbette Bond):*

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.

Subject 2, Topic 3 Documentation and Analysis:

Prohibition on the Corporate Practice of Medicine

- The corporate practice of medicine doctrine has been long established in the state of Nevada through various Attorney General Opinions. Most recently, it was addressed in Attorney General Opinion No. 2010-03 in March 5, 2010 ("AG Opinion")
- Exceptions to the corporate practice of medicine prohibition can be found in state law (e.g., NRS 450.180(2), NRS 630.365). However, express language on the underlying prohibition that these exceptions are meant to address, along with the enforcement and penalties for the same, are not currently delineated in Nevada Revised Statute.
- In the AG Opinion, then Attorney General Cortez Masto, provided an opinion to the Administrator of Nevada's Department of Health and Human Services stating, in relevant part, "(I)t has been longstanding practice in Nevada that physicians only work as contractors for private hospitals, and not as employees. To depart from this practice would mark a significant change that would be tantamount to a change in state public policy. ***Ideally such change should occur through the legislative process in order to ensure full deliberation of the affected policies and interests of the public, physicians and hospitals***." (***emphasis*** added)
- The American Medicine Association has raised a number of public policy concerns with the corporate practice of medicine, such as (1) allowing corporations to practice medicine or employ physicians will result in the commercialization of the practice of medicine, (2) a corporation's obligation to its shareholders may not align with a physician's obligation to his patients, and (3) employment of a physician by a corporation may interfere with the physician's independent medical judgment. (see **AMA Advocacy Resource Center**, *Issue Brief: Corporate practice of medicine* at Issue brief: Corporate practice of medicine (ama-assn.org), 2015).
- Exceptions to the corporate practice of medicine have been addressed by the Nevada legislature over the years with these concerns in mind (e.g., research, public non-profits, academics). However, the underlying prohibition has not been addressed by the legislature and as such no clear mechanism for enforcement of corporations exists. However, licensed professionals can be disciplined under the authority of their respective boards.

Reasons to ensure corporate practice of medicine does not allow hospitals to hire a physician to practice solely at a hospital facility or for one hospital system are:

i. Hospitals are extremely competitive, particularly in Nevada where very few statutes exist to compel hospitals to provide needed services or to restrict them from expanding into high profit services already available in the geographic area.
ii. Hospitals depend on having physicians that will use their skill and training to provide services at the hospital.
iii. If hospitals and free-standing Emergency Rooms (ERs) can become the sole employer for a physician, that physician is unable to provide

services to other hospitals in the community, which disenfranchises those hospitals, and reduces competition.

iv. Physicians being owned by hospitals also causes a conflict for the physician that can put the interests of the hospital ahead of the interests of the patient, such as keeping the patient longer than the patient needs to be at the hospital, refusing to refer a patient to a competing facility, and other types of behavior that serve the needs of the hospital. This has been raised by the American Medical Association (AMA). See attached document.

v. Physicians do not need to be employed by a hospital to have privileges there – they can work at all hospitals by having privileges at the hospital. All hospitals offer privileges to doctors to work at their facilities without hiring them. But if they do hire them, that physician can no longer work elsewhere.

vi. The Nevada Hospital Association has attempted in several legislative cycles to pass a law allowing hospitals to hire physicians. These efforts have failed. However, some hospitals are hiring physicians anyway. This is because NRS does not clearly state that Nevada does not allow physicians to be hired by hospitals – it instead states when a physician can be hired by a hospital- so the statutory assumption exists without the language. It is unclear when or how the prohibition became confused in statute.

vii. In addition to revising the statute to specifically state that physician employment by a hospital is prohibited, the current exceptions, that allow a physician to be hired, and are in statute, should be reviewed and clarified to ensure only academic institutions and public hospitals can directly employ physicians.

viii. Many states have corporate practice of medicine laws, and Nevada has had a practice and an understanding that physicians cannot be hired by hospitals, but it needs codification.

Added by Commissioner McAllister - The PPC may want to consider a state-wide ban on physician non-compete clauses. Many states, and D.C., have such bans in place aimed at increasing competition to lower costs for patients. This video from Nevada's own (he used to practice here) ZDoggMD is short and to the point on why "Non-Compete Clauses Hurt Both Doctors and Patients".

Subject 2, Topic 4 *(Yarleny Roa-Dugan):*

Require DHHS, or the appropriate government body, to create a freely accessible database of 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 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. Mandate medical facilities in Nevada to notify DHHS or the government body creating the procedures/treatment cost database of the pricing for procedures/treatment at their facilities.

Subject 2, Topic 4 Documentation and Analysis:

As passed during the 2019 Legislature, AB 469 (now NRS 439B.700 - NRS 439B.760) revises provisions governing billing for certain medically necessary emergency services. DHHS has current infrastructure in place with regard to surprise/balanced billing synergy, as noted within the Office for Consumer Health Assistance process where consumers can appeal out of network charges and use a database to determine the appropriate amount to settle on.

The 21st Century Cures Act or HR. 34 seeks to increase choice and access for patients and providers. To meet with U.S. House of Representatives (HR). 34 requirements, CMS created a procedure lookup tool for outpatient procedures done in both ambulatory surgical centers and hospital outpatient departments. The tool shows national average prices for patients using Medicare and no supplement policy.

The tool proposed would be very similar to the "Procedure Price Lookup Tool" ran by CMS. Where it would differ is that the proposed tool would include not only surgical procedures, but **all** types of procedures and treatments; as well associated out-of-pocket costs both with and without insurance. The proposed tool would allow Nevada patients to navigate to a single site to search for any health care procedure or treatment and compare costs.

Below are two links to the CMS procedure look-up tool listed as an example of how the proposed website interface might look:

- https://www.medicare.gov/procedure-price-lookup/
- https://www.medicare.gov/procedure-price-lookup/cost/78226/

Subject 2, Topic 5 *(Flo Kahn):*

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.

Subject 2, Topic 5 Documentation and Analysis:

Modeled after a bill introduced in California (AB 933 & 2942 – Daly/SB 1361 - Kamlager) and sponsored by the California Access Coalition, a network of local and state behavioral health organizations that advocate to eliminate barriers that keep Californians from accessing medication and behavioral health treatment.

Please note fact sheet on SB 1361.

In addition, attached is a study by the University of Southern California (USC) which analyzes the association between rebates and list prices: https://healthpolicy.usc.edu/research/the-association-between-drug-rebates-and-list-prices/

Also, included is the California Health Benefits Review Program (CHBRP) analysis on rebate pass through provision's impact to California premiums.

Oklahoma pharmacist op-ed on rebate reform: https://www.oklahoman.com/story/opinion/2022/03/27/viewpoint-middlemen-blame-rising-medicine-costs-oklahoma/7119824001/

Finally, West Virginia passed the first rebate pass through measure last year. It is being fully implemented as of July 1st.

Subject 2, Topic 6 *(Tyler Winkler):*

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.

Subject 2, <u>Topic 6</u> Documentation and Analysis:

A prescription drug/ health plan affordability review board gives states the ability to limit how much its residents pay for certain high-cost drugs and the affordability/efficacy of health plans available. Costs and plan coverage involve many complicated issues and affect numerous stakeholders, a drug affordability review board would bring the parties together, increase transparency, and set an upper payment limit/cost sharing arrangement.

This proposal Directly address accessibility, affordability, and quality of health care as well as leverages the Peterson-Millbank cost growth benchmark. Several analyses have shown prescription drugs to be one of the main drivers of cost growth. In several states, there has been significant interest in legislation to further regulate drug prices, and it offers an opportunity for a coordinated strategy.

Affordability review boards follow directly from the data we are collecting and analyzing as a cost mitigation strategy to ensure the Benchmark strategy is successful. If these boards would function similar to/or perhaps as a part of the PPC, the costs would likely be nominal or could be assumed by the appropriate state agencies.

Prescription Drug Affordability Boards (PDAB) – *report provided by Tyler Winkler (6/28/22)*

Nevada has already taken steps to address prescription drug affordability, and a PDAB is a natural step along with our cost growth benchmark to ensure patients receive their healthcare. Nevada, pursuant to NRS 439B.630, requires the Department of Health and Human Services (DHHS or the Department) 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 <u>other medication</u> 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 meaningful address rising costs through the establishment of a PDAB.

Insurance Rate Affordability and Standards Review[1]

Along the same lines, an expanded and improved insurance rate review process would also serve as an effective cost containment strategy. Hospital costs are a particularly significant driver of insurance premiums rates. As health care consolidation increases, costs rise, and insurers may be less likely to exert negotiating power to lower those costs. As Nevada works to focus and address health care costs, Rhode Island's affordability standards, offers an avenue for health care cost controls.

Rate review is a promising tool for cost containment. As evidence shows it can keep premiums low and can also to impact payer-provider negotiations. Placing responsibility for hospital cost containment alongside insurance rate review not only allows for coordinated reform across insurers, but also gives an insurance department, like OHIC, insight into where unintended consequences might occur or other costs might pop up as the state works to control other health care cost drivers.

The Affordable Care Act (ACA) created a floor for "unreasonable" insurance premium increases, as well as adding the Medical Loss Ratio (MLR) requirement, which limits the amount of premium dollars that insurers can spend on administration, marketing, and profits.
Nevada law requires prior approval by the Division of Insurance for any individual or small group rate change. Notably absent is review of fully insured large group plans. Nevada only has "prior approval" authority, which allows them to reject, approve, or reduce proposed premium rates, but does not set standards for affordability or access.

In 2015, *Health Affairs* reported that adjusted premiums in the individual market were lower in states that had "prior approval" authority along with MLR requirements from 2010 to 2013.[2] While more stringent rate review is shown to keep premiums lower, some states have expanded the scope of their rate review processes to tackle issues of accessibility and affordability. Specifically, since 2010, Rhode Island has been using its unique regulatory structure to better control rising hospital costs through insurance rate review.

Rate Review as a Cost Containment Strategy

In 2004, Rhode Island enacted a law that split the Office of the Health Insurance Commissioner (OHIC) from the rest of its insurance department in order to better understand and oversee the relationship between insurers and providers.[3] In Rhode Island, the health insurance commissioner has

[1] Summarized and adapted for relevant information from the National Academy for State Health Policy. (NASHP) https://www.nashp.org/insurance-rate-review-as-a-hospital-cost-containment-tool-rhode-islands-experience/

[2] *Health Affairs*: States With Stronger Health Insurance Rate Review Authority Experienced Lower Premiums In The Individual Market In 2010–13; Available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.1463

[3] http://webserver.rilin.state.ri.us/Statutes/title42/42-14.5/index.htm

oversight over the individual market, the small-group market, and fully insured large-group markets. The legislature also charged the OHIC with promoting greater accessibility, quality, and affordability in the health insurance market that ultimately led insurance regulators to oversee negotiated rates between insurers and hospitals.

The OHIC's work to oversee hospital costs largely relies on a "public interest" criterion in the state's insurance statutes, and affordability is a public interest. The 2004 statute also created the Health Insurance Advisory Council, which made a number of recommendations, including adopting their own Cost Growth Benchmark. In identifying cost drivers and subsequently developing cost containment strategies, as Nevada is currently doing, Rhode Island developed the affordability standards which emphasized the need for reduced insurance costs, and by extension, reduced hospital costs.

With the adoption of the affordability standards, the commissioner directed insurers to comply with four new criteria in order to have their premium rates approved:

1. Expanding and improving primary care infrastructure;
2. Spreading the adoption of the patient-centered medical home model;
3. Supporting CurrentCare, the state's health information exchange; and
4. Working toward comprehensive payment reform across the delivery system.

The fourth standard– comprehensive payment reform—was one of the most important cost containment tools. In order to set measurable goals to hold insurers accountable for this, the commission put six conditions into place that insurers had to adopt in their hospital contracts. The conditions included:

1. Paying for inpatient and outpatient services using "units of service" that encourage efficient resource use.
2. **Limiting the average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than Centers for Medicare & Medicaid Services' National Prospective Payment System Hospital Input Price Index ("IPPS") plus 1 percent for all contractual years.**
3. Giving hospitals an opportunity to increase total annual revenue based on meeting mutually agreed upon quality goals.
4. Including contract terms to meet agreed upon obligations for administrative simplification.
5. Including contract terms that promote and measure improved care coordination.
6. Including transparency for these six terms in contracts.

Impact

A 2019 *Health Affairs* review found that implementation of Rhode Island's affordability standards led to a net reduction in per enrollee spending by a mean of $55 from 2010 to 2016.[4] The study showed that outpatient and inpatient utilization did not significantly change but spending per encounter decreased in Rhode Island compared to a control group. Quarterly fee-for-service spending actually decreased by $76 per enrollee, but the requirement to increase non-fee-for-service primary care spending raised per enrollee spending by $21, netting out to a quarterly savings per enrollee of $55. In addition, patient cost sharing was lower in Rhode Island after the affordability standards were implemented compared to a control group.

[4] *Health Affairs;* Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers; available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05164

Quality metrics did not change with implementation of the standards. In fact, interviews conducted for a 2013 review of the standards found that the "at-least-50-percent" provision for hospital contracting caused a "culture shift" among hospitals by focusing their attention to meeting quality measures. The one challenge in understanding the impacts of Rhode Island's affordability standards is the relationship between hospital contracting and the primary care investments, making it somewhat difficult to know how a state might fare if it only enacted standards around payment reform without the primary care investment.

Since implementation in 2010, Rhode Island has updated its affordability standards over time to align with other goals. The most recent affordability standards, adopted in 2016, require insurers to spend at least 10.7 percent of their annual medical spend on primary care. States have begun to mirror Rhode Island's affordability standards in their insurance rate review process to advance health policy goals. In 2019, Colorado enacted HB 19-1233, which established a Primary Care Reform Payment Collaborative that, among other things, was tasked with creating an affordability standard to require additional investment by insurers in primary care.

Similarly, Delaware enacted SB 116 in 2019 to create an Office of Value-Based Health Care Delivery within its Department of Insurance. The office's goal is to reduce health care costs by providing high quality, cost-efficient health insurance products with stable, predictable, and affordable rates. With the implementation of Rhode Island's affordability standards, the state was able to successfully cap growth in hospital costs and thereby constrain premium growth.

Prescription Drug Affordability Boards (PDAB) – *report provided by Dr. Beth Slamowitz (6/24/22)*

The price of drugs continues to escalate – even during a global pandemic. A June 2020 Gallup survey found that 90% of Americans worry that drug companies will take advantage of the pandemic to raise drugs prices. One hundred companies raised prices on 636 drugs in the first days of 2021 with the median increase of 5% and those were only the early announcements. In 2020, prices were raised an average of 5.5% on 860 drugs. The public has reason to worry. List prices are the basis of what pharmacies pay and what patients pay.

Drugs prices consistently rise faster than inflation and rise higher than other consumer goods. As a result, drugs are increasingly unaffordable for the average consumer; escalating drug prices force insurers to increase premiums for all of us. Government programs are similarly challenged to manage ever rising drug costs in the context of budgets that must provide an array of services to large and diverse populations.

Affordability starts with the idea that at a certain cost, health plans can afford to provide ready access to needed treatments. When drug costs put stress on the healthcare financing system, patients and consumers suffer with high out of pocket costs and lack of access and insurance premiums rise.

The drug industry wants us to see each drug as a separate financing issue when in fact, our healthcare financing systems (health plans, government, patients and consumers) must pay for all drugs for all the people who need them.

A PDAB would not regulate manufacturer list prices. The PDAB would regulate in-state the charges and payments made for a particular drug among state-licensed healthcare entities – wholesalers, other distributors, pharmacies, hospitals, physicians, and insurers.

The overarching goal of any PDAB is to find an Upper Payment Limit (UPL) at which insurers, purchasers, and government programs can afford to provide the drug to everyone in the state who should get the drug. The point of an UPL is to *expand* sales and patient access. The purpose is not to reduce manufacturer revenue. The PDAB function is not punitive.

A PDAB will need to access publicly available pricing and cost information – some of which will come from subscription data services, called "drug pricing files". Medispan and FirstDataBank are two such services. Both services require paid subscriptions to access drug prices and price increases. The cost of the subscription is often determined by how the data is intended to be used. As of 2021, there were Prescription Drug Affordability Boards in Colorado, Maryland, and Oregon. Maine, New Hampshire, and New York also have boards.

Key issues to consider when designing and implementing a PDAB include:

1. Designing the scope
    a. Which drugs will be subject to review by the board?
    b. Which payers will have access to the prices?
    c. What information and data will the board consider when setting limits?
2. Determining the timeline
    a. Will there be a review process for board recommendations?
    b. Over what time period would any recommendations be implemented?

Drug Affordability Boards must be able to consider the following:

1. Availability and efficacy of therapeutic alternatives
2. Out of pocket costs and impact of availability and costs on health and financial wellbeing of patients
3. Decisions on whether to do an affordability review **and** whether to deem drug unaffordable must be done in public meeting, with opportunity for public comment.

Oregon – In 2021, Oregon passed SB 844, which created a PDAB. Senate Bill 844 (SB 844) enacted a PDAB charged with conducting an affordability review of identified drugs that meet a certain threshold and further establish an upper payment limit for these drugs. The threshold for such a review includes: 1) brand-name drugs or biologics with a launch wholesale acquisition cost (WAC) of $30,000 or more per year or a $3,000 WAC increase over 12 months, or2) generics with a WAC of at least $100 that increased by 200% or more over a year, or 3) other drugs that could create affordability challenges for the state. In addition, the PDAB will analyze the cost of administering and delivering the drug to patients to aid in determining an upper payment limit.

Maryland – The drug affordability board is run by an independent state agency. https://pdab.maryland.gov/

Colorado –In June 2021, Governor Jared Polis signed into law Senate Bill 21-175 establishing the Colorado PDAB. This bill requires the PDAB to identify drugs with 1) an initial wholesale acquisition cost (WAC) of $30,000 or more for a 12-month supply or for a course of treatment that is less than 12 months in duration; or 2) an increase in the WAC of $3,000 or more during the immediately preceding 12 months for a 12-month supply or for a course of treatment that is less than 12 months in duration. The PDAB is then charged with establishing an upper payment limit for any of these drugs deemed unaffordable for Colorado consumers, limited to taking action on more than 12 prescription drugs in a year. The drug affordability board is run out of the Dept of Insurance, and the Medicaid pharmacy Dept is only involved in a consulting capacity. https://doi.colorado.gov/insurance-products/health-insurance/prescription-drug-affordability-review-board. The bill called to increase state expenditures by about $800,000 and 5.0 full-time equivalent (FTE) in Fiscal Year (FY) 2021-22 and $500,000 and 4.0 FTE in subsequent years through the program's repeal date, which is assumed to fall in FY 2027-28. The following expenditures were included:

Cost Components	**FY 2021-22**	**FY 2022-23**
Department of Regulatory Agencies		
Personal Services	$200,297	$200,297
Operating Expenses	$4,050	$4,050
Capital Outlay Costs	$18,600	-
Consultant	$75,000	
All-Payer Health Claims Database Fees	$50,000	$34,000
Legal Services	$382,824	$191,412
Centrally Appropriated Costs1	$112,796	$85,720
FTE – Personal Services	3.0 FTE	3.0 FTE
FTE – Legal Services	2.0 FTE	1.0 FTE
Total	$843,567	$515,479
Total FTE	5.0 FTE	4.0 FTE

Virginia – Virginia proposed an amendment to its PDAB bill (SB 376), to include potential general fund provisions. This amendment provides $385,000 and five positions the first year and $770,000 and five positions the second year from the general fund to implement the provisions of Senate Bill 376. creating a Prescription Drug Affordability Board. The board chair shall hire an executive director, general counsel, and staff to support the board. The cost estimates are based on two states that recently created similar boards, Maryland and Colorado.

Maine – There is a Prescription Drug Affordability Board in Maine. The PDAB is focused on public payors except for the Medicaid program. The PDAB falls under their Department of Administration and Finance.

It was legislation from NASHP that helped Maine get their PDAB established – NASHP currently has an RFP out to help states with data NASHP Announces RFP to Support PDAB States — Due July 26, 2022 - The National Academy for State Health Policy

Prescription Drug Affordability Boards are not without merit but can be labor intensive and resource heavy. The state must ensure that there is access to appropriate data, adequate oversight and that there is adequate funding and FTEs to ensure proper and valuable execution.

PPC Goal: Researching possible changes to state or local policy in this State that may improve the quality, accessibility or affordability of health care in this State – The use of purchasing pools to decrease the cost of health care [NRS 439.916.1(i)(1)].

Subject 2, Topic 7 (*Lilnetra Grady*)**:**

Review and/or study of changes to insurance benefit design and impacts to patients. Specifically, reviewing changes to cost sharing requirements.

Subject 2, Topic 7 Documentation and Analysis:

Health insurance coverage has long been a difficult benefit for many small businesses to incorporate into their compensation packages. Premiums for even modest health packages constitute a significant outlay for small businesses and increases in premiums and deductibles attributable to employee illness forced many owners with the unpleasant choice of placing their business at financial risk or ending health insurance for their employees.

Health insurance pools, which are also sometimes called insurance purchasing alliances or health insurance purchasing co-ops, were originally created to address this problem. They provide group health policies exclusively to small businesses.

Small businesses that join one of these pools can typically count on the following benefits:

1. A community premium rate that is significantly lower than any individual rate it could demand, because the membership gains collective leverage that forces insurance carriers to modify premium and deductible demands
2. In many cases, premium increases are capped for the first several years of the policy
3. Centralized administration of the policy among all of companies covered under it, which results in savings in work hours and paperwork
4. Standard rates and benefits that do not fluctuate according to company size or work force health history
5. Selection of plans from multiple insurers (some plans allocate plan selection power exclusively with employers, while others allow workers to select from a menu of plans)

https://www.inc.com/encyclopedia/insurance-pooling.html

Subject 3: Improve Health Care Quality

PPC Goal: Reviewing proposed and enacted legislation, regulations and other changes to state and local policy related to health care in this State. - NRS 439.916.1(h).

Subject 3, Topic 1 *(Mason Van Houweling, Bobbette Bond, Tyler Winkler): *Revised BDR language as of 7/18/22* Will be presented to PPC on 7/20/22.*

1. *Mandating that all providers of health care and custodians of healthcare records implement an interoperable electronic health care records system*.
    i. NRS 629.051 states that healthcare records "may be retained, authenticated, and stored" in an electronic computer system. Mandating providers to maintain an electronic healthcare record to assist patients with access and sharing of their medical records.
    ii. Support/consider mandating providers maintaining an electronic healthcare record or other tools to assist patients. Ensure categories of clinical information to be reported, including, claims data, diagnostic data, (demographics, clinical care documents, lab results, or radiology reports).
    iii. Allow for a provision to permit a period of 5 years for compliance with mandate for rural providers or those lacking the resources.

2. *Expand immunity for provider compliance with providing and receiving electronic medical records:*
    i. To encourage participation and alleviate concerns of risks, expand immunity under NRS 439.593 to health care providers for acts related to submitting, accessing, utilizing, disclosing, or relying upon information within the health information exchange.

3. *Revision of NRS 439.584 with relation to HIE and other areas identified:* Ensure this recommendation is compliant with current State and Federal law. Maintain language that supports exchange of patient medical records electronically.

In addition, PPC supports exploring funding options:
    i. Provide funding for technical support and resources for providers to allow for integration of systems and ensure fully electronic record access and exchange of information.
    ii. Provide funding for patient education with relation to access.
    iii. PPC recommends maintaining current HIPAA rules expanded under the Emergency Waivers to allow for continued patient access to information.

Subject 3, Topic 1 Documentation and Analysis:

1. HEALTHCARE INTEROPERABILITY:

Background:

Care coordination has been identified as a top patient priority and requires the integrity of the medical record to have complete/accurate information available at the point of care; as well as ensuring patients are able to access their medical record and share that information with the medical provider of their choice. Patient education with relation to use and access along with provider support are key to creating interoperability.

Summary of Proposal.

The Patient Protection Commission has a duty to "[e]stablish, submit to the Director and annually update a plan to increase access by patients to their medical records and provide for the interoperability of medical records between providers of health care in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any other applicable federal law or regulations." NRS 439.918. This proposal is intended to facilitate patient access and interoperability via the following policy and legislative changes:

1. *Mandating that all providers of health care and custodians of healthcare records implement an interoperable electronic health care records system*.
    iv. NRS 629.051 states that healthcare records "may be retained, authenticated, and stored" in an electronic computer system. Mandating providers to maintain an electronic healthcare record to assist patients with access and sharing of their medical records.

    v. Support/consider mandating providers maintaining an electronic healthcare record or other tools to assist patients. Ensure categories of clinical information to be reported, including, claims data, diagnostic data, (demographics, clinical care documents, lab results, or radiology reports).

    vi. Allow for a provision to permit a period of 5 years for compliance with mandate for rural providers or those lacking the resources.

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ii. Provide funding for technical support and resources for providers to allow for integration of systems and ensure fully electronic record access and exchange of information.
iii. Provide funding for patient education with relation to access.
iv. PPC recommends maintaining current HIPAA rules expanded under the Emergency Waivers to allow for continued patient access to information.

B. Impacted Sections of the Nevada Revised Statutes (non-exclusive):

NRS CHAPTER 629 (NRS 629.051, NRS 629.061)
NRS CHAPTER 439 (NRS 439.581 to NRS 439.595)

Note: BDR topic proposed by Bobbette Bond to "**Prohibit providers from billing patients for fees that are not related to actual care, such as facility charges at a physician office and trauma activation fees for patients not admitted to the hospital" has been withdrawn per Commissioner Bond 6/28/22.**