DEPARTMENT OF HEALTH AND HUMAN SERVICES PATIENT PROTECTION COMMISSION

Helping people. It's who we are and what we do.

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

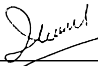
Dr. Ikram Khan, Chairman

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