SUMMARY MINUTES

December 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

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

Commission Members Absent

Tyler Winkler – excused
Flo Kahn – excused

Advisory Commission Members Present

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

Advisory Commission Members Absent

Laura Rich, Executive Officer, Public Employees Benefits Program (PEBP) – excused

Commission Staff Present

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

Agenda Item II – Approval of the November 16, 2022, Minutes
Dr. Ikram Khan, Chairman

The Commission was presented with an email draft of the summary minutes of the November 16, 2022, meeting.

MOTION was made to approve minutes of the November 16, 2022, meeting as presented, by Commissioner McAllister. Seconded by Vice Chair Ruybalid. Carried without dissent.

Agenda Item III - Public Comment:
Patrick Kelly, CEO, Nevada Hospital Association

Mr. Kelly addressed issues raised in the PPC Meeting Slides beginning on slide 10. He noted that first, slide 12 makes the point that health care costs in Nevada have slightly increased faster than the incomes of Nevadans. Nevada health care providers purchase goods and services on a regional national basis. We pay the same price for drugs and medical supplies that is paid in the higher income states, such as Connecticut and Massachusetts. We compete regionally and nationally for nurses. Health care providers have no control over many costs. We wish our costs were based on the incomes of Nevadans, but they are not. Forbes reports that Nevada had the third lowest increase in overall health care expenditures per person over a recent five-year period. That is very positive; we are performing well nationally. Second, slide 13 raises the issue of high deductibles. Deductibles in combination with co-payments represent the out-of-pocket cost of health care. High out-of-pocket costs can cause people to forego care and not be able to pay their deductibles and co-pays. It often leads to medical debt. Frequently, hospitals and other health care providers receive no payment from patients with high deductible plans. Spending time evaluating the role of deductibles and co-payments is needed when a high percentage of people indicate they avoid receiving care because of out-of-pocket costs. Third, we must examine why many Nevadans failed to take advantage of the Medicaid and low-cost insurance programs available to them. It is estimated that 83 percent of uninsured Nevadans are eligible to participate in either Medicaid or the Silver State Health Insurance Exchange and they do not participate in either. Focusing efforts on enrolling these individuals would help reduce the number of people deferring care because of cost and affordability. As we enter the new year, we should address the worst statistic of all in Nevada, access to health care. We are ranked 50th in the country. More money must be spent to expand access to health care and federally designated health professional shortage areas. Access will not improve if reducing health care spending is the state's primary focus. A balance must be reached.

Agenda Item IV – Informational Item: Update on Investigation Concerning an 11/18/22 News Story Showing a Valley Hospital Medical Center Patient Who was Allegedly Assisted by Security Out of the Emergency Department and Across the Street and then Left on the Sidewalk Adjacent to University Medical Center
Paul Shubert, Bureau Chief, Department of Health and Human Services, Division of Public and Behavioral Health, Bureau of Health Care Quality and Compliance

Mr. Shubert introduced himself and explained that the Bureau of Health Care Quality and Compliance (HCQC) is the State Survey Agency responsible for periodically surveying and investigating complaints of medical facilities in Nevada for compliance with federal and state requirements. He commented that both the federal and state complaints regarding Valley Hospital are still under investigation, so he could not speak to any of their findings at this time. He remarked that he can describe the situation, their processes and provide explanation of some statutory and regulatory terms. Since Valley Hospital is deemed by an accrediting organization to be in compliance with federal regulations, HCQC began its investigation by reporting the allegations to the Centers for Medicare and Medicaid Services (CMS), in order to obtain authorization to conduct a federal investigation, which was authorized. The ongoing investigations are reviewing facility practices for possible violations of the Emergency Medical Treatment and Active Labor Act (EMTALA) and State and Federal Hospital Discharge Regulations and Conditions of Participation. In response to use in the media and others using the term "patient dumping", this is a slang phrase, as the term is not defined in statutes or regulations. The term "patient dumping" is also commonly associated with EMTALA requirements, however, in order for an EMTALA violation to occur,

several criteria must be met. One of those criteria is that "the patient must be suffering from an emergency medical condition upon arrival or during assessment at the hospital".

Mr. Shubert provided explanations so that everyone gains an understanding that EMTALA is about emergencies and not necessarily associated with patients suffering from chronic conditions or conditions that do not seriously jeopardize the health or cause impairment or dysfunction of an organ or body part. HCQC has not received an EMTALA complaint from University Medical Center (UMC), the hospital that subsequently admitted the patient being discussed. He noted that the federal regulations and guidance indicate that a hospital must report within 72 hours to the State Survey Agency or CMS, any time it has reason to believe it may have received an individual who has an unstable emergency medical condition from another hospital. If a recipient hospital fails to report such a situation, the recipient hospital may be subject to termination of its provider agreement. Regardless, HCQC is investigating for possible EMTALA violations. Beyond EMTALA, there are federal and state hospital requirements associated with discharge planning. The federal requirements are found under the Condition Level requirement of "Discharge Planning" in the Code of Federal Regulations and the state requirements are found at Nevada Administrative Code 449.332. Once the investigations are complete, and pursuant to any citations the facility has had an opportunity to provide a plan of correction; the results of the investigations are made available to interested parties and the public through the website under the Division of Public and Behavioral Health. If citations of regulatory non-compliance are made, then depending on the level of the citation, or the severity and scope of the citation, HCQC and CMS may take additional actions to ensure the facility resumes compliance and to encourage the facility to maintain ongoing compliance with requirements.

A commissioner commented based on what Mr. Shubert said about UMC's response to this issue, she would like for Commissioner Van Houweling to provide information about UMC's experience with this patient during the next meeting. She further commented she is glad Mr. Shubert is helping the Commission understand EMTALA however, further, this type of incident should never occur. She requested for DHHS to provide suggestions for a zero-tolerance environment in Nevada.

Another commissioner asked how long the investigation might take and when Mr. Shubert would be able to report back to the Commission with additional information. Mr. Shubert answered most likely the federal and state results should be available in approximately two weeks.

Another commissioner asked, given that there is no state policy against actions such as this, what would be a repercussion from this investigation. Mr. Shubert answered DHHS would encourage the facility to comply with regulations and not allow this to happen again, there are state sanctions available and monetary penalties can apply. Again, it will depend on the scope and severity of the issues identified. There are also federal citations. However, most facilities bring themselves back into compliance and are reinspected to ensure they are complying before they are ever terminated.

Marla McDade Williams, Deputy Director, Representing Nevada Department of Health and Human Services (DHHS) clarified DHHS investigates these types of complaints under both state authority and federal authority and has a very active complaint system. They take anonymous complaints, complaints that are very direct, and the staff do a great job of assessing the issues and ensuring they apply within the authority they have under the statutes, regulations, and federal law. Every Legislative Session brings a new host of issues for DHHS to consider and as a Legislature moves forward and declares policy and law, state staff adapt and make changes as necessary.
A commissioner asked if Mr. Shubert has a ballpark figure about how many similar type, potential EMTALA violations, are investigated by the state in a given year. Mr. Shubert answered regarding EMTALA, in general, they have less than ten in a year. Regarding discharge planning, which may also include transfers or even admission requirements, they receive approximately 50-100 each year.

Agenda Item V – Recommendation to Support an Amendment to Assembly Bill 7
Commissioner Bobbette Bond

Commissioner Bond began her recommendation by stating that Assembly Bill 7 (AB 7) was drafted incorrectly by including a section of Nevada Revised Statutes (NRS) that is not the correct location for the bill language. While recognized, and an attempt made to change the language prior to the Legislative Counsel Bureau's (LCB's) deadline, the revision did not make it to the final Bill Draft prior to printing. This bill is about health information and patient records. She then introduced the opportunities the Commission now has with the bill. If the Commission supports and considers working on a new amendment to the bill to correct the flaws that it does not talk about interoperability nor about patient access in great detail. The other option is to try to accept amendments once the Bill has a hearing. Commissioner Bond opined that an amendment is the cleanest at this point.

Commissioner Bond proposed that if the Commission approves, they will work with Executive Director Southard on an amendment with LCB to capture the full intent of the PPC's proposal to make records interoperable and provide greater patient access to their medical records in whatever form they want, across the state.

A commissioner opined the Commission certainly does not want to lose having a bill and that an amendment is the proper procedure to pursue that. He believes it is doable if they can lobby it right and advocate for it. Commissioner Van Houweling motioned to continue with the bill amendment to AB 7 focusing on medical record interoperability, electronic health records, and patient access to their health records electronically. Commissioner Ralston seconded. Carried without dissent.

Executive Director Southard introduced Mr. Bryan Fernley from the LCB and gave him a brief overview about the discussion that the commissioners had regarding AB 7 and potentially drafting an amendment to correlate to the Commission's full intent of the Bill. Mr. Fernley was invited to the PPC meeting to provide perspective on the proposal to do an amendment and answer any questions of the Commission.

Mr. Fernley noted that AB 7 was pre-filed, as required by statute, on November 18th. That is how it became AB 7 and will be referred to the Assembly Committee on Health and Human Services for consideration. The language provided by the Executive Director for the proposed amendment was received by LCB for AB 7 and will be provided to the committee chair and committee staff so that it can be presented and discussed when the Bill is heard during session.

Mr. Fernley clarified that the LCB has not prepared an amendment. They plan to forward the document that was submitted to them on 11/18/22 by the Executive Director to the Chair and staff of the Assembly Committee on Health and Human Services. A commissioner opined that document submitted on 11/18/22 for AB 7 should not be the genesis of a new amendment until the Commission has a chance to see it and accept the language. Mr. Fernley agreed and advised that the LCB will use what was provided to them to prepare a mock-up of the amendment and send to the Commission for review, likely before Session starts. Commissioner Bond asked if the Commission will be able to correct the mock-up if needed and Mr. Fernley responded in the affirmative.

Agenda Item VI – Consider Appointing Not More Than 4 Individual Commissioners with Nevada Legislature Experience to Provide Individualized Support via Email to the PPC Executive Director Before and During the 2023 Legislative Session for the 3 PPC Bills

Dr. Ikram Khan, Chairman and Commissioner Bobbette Bond

Chairman Khan began noting this topic came about by pondering how to provide input and support for the Executive Director, via email, before and during Legislative Session. He sought input from the Attorney General's (AG) office. He then invited Commissioner Bond to start the discussion.

Commissioner Bond gave a short overview, stating a solution is needed regarding how the Commission might move through the Legislative Session in whole, and how to track what is going on with the three bills the PPC introduced. The Legislative Session starts in February and ends the first week of June. Through that time, each Bill goes through a complicated process and there is a lot of input that is. This proposal considers if the Commission could have done

something about what is now AB 7, had they been more engaged earlier on. Commissioner Bond's proposal is to put a group of commissioners into a position where they can respond to emails that come in and participate in ensuring that these bills move as smoothly as possible by providing expertise in the Legislative process.

A commissioner stated that for context, this is a new Commission and some of the Commission members are new. There are a couple of things it would be helpful for the DAG to weigh in on. The first is that the Legislature is not subjected to open meeting law. The Commission does not have the capacity to compel the Legislature to do anything; these are all recommendations, and the Commission must be mindful of their process. Any time representing the Commission during the 2021 Session was based on the intent of the legislation that the Commission passed and the action they took during one meeting, which presented some challenging dynamics. Therefore, this commissioner would like to hear what the DAG's thoughts are on open meeting law and the public body and who has the authority to speak on behalf of the PPC. The Commission should be aware, and the public should be aware, of who is given the authority to speak on behalf of the Commission.

Deputy Attorney General Susanne Sliwa responded regarding who may speak on behalf of the PPC during the Legislative session, if there were a particular commissioner who would like to speak on behalf of the PPC during the session on a particular bill or issue, it needs to be addressed in an open meeting and voted upon.

A commissioner replied asking if this subcommittee, if given the authority by the Commission, would have the ability to have a discussion with the Legislature and negotiate on behalf of the PPC to ensure that the intent of the bill lines up with the Commission's goals. Further, if this Commission were to vote on that actionable item today, with that scope, is that enough of an action item with this public body and the Legislature, for the Commission to then understand that the subcommittee could then do that on behalf of the Commission with the pretext that they would report back to the full body. She asked if that is something that the subcommittee would have the authority to do if it were given the direction via action today.

Deputy Attorney General Susanne Sliwa noted the Commission would not be able to do that today.

The commissioner responded asking if it could be done in the future, if properly agendized. Deputy Attorney General Susanne Sliwa (DAG, Ms. Sliwa) answered that it could be. In reference to meeting and negotiating with the Legislature, the best way to do that, if there is a subcommittee, and the subcommittee wishes to do those things, then one member of the subcommittee could be designated by that subcommittee as the lead on that activity. The subcommittee would then need to present the recommendation to the full PPC. That would need to be agendized as an action item and the PPC would need vote on whether to accept that recommendation and authorize the designee of the subcommittee.

Ms. Sliwa continued she had discussed with Executive Director Southard and with Julie Slabaugh, Chief Deputy Attorney General, that what was being agendized and discussed at today's meeting was not a subcommittee, but simply no more than four commissioners providing support to the Executive Director. Further, that this group of commissioners was not going to be meeting and would not necessarily be a subcommittee. The discussions she had previously indicated that the individual commissioners who are providing support to the Executive Director do not necessarily need to be a subcommittee. The designation of those commissioners would need to take place in an open meeting, such as this one, and we do have that agendized. If there is no intent of forming a subcommittee, then the individual commissioners would not communicate with one another, but would only respond to and communicate with the Executive Director.

Chairman Khan asked Commissioner Bond if that fulfills the original intent of this communication. Commissioner Bond opined she does not think that is everything the Commission needs, but would like to appoint four people to support the Legislative process with the Executive Director. She also thinks the Commission needs to discuss who leads inside the Legislative building, in the future. For today, she would like the four-commissioner group to be able to provide email responses when the Executive Director asks.

A commissioner asked, in the context of ensuring that the Commission is compliant with open meeting law, is to make sure the public is informed and part of the process, and able to provide input – as long as the public is aware that this group exists and is meant to advise the Executive Director through navigating the Legislative process, why would there be any constraints with having those group members talk to each other. Further that it may not necessarily a subcommittee that is then subjected to open meeting law, but an advisory group created for advising the Executive Director during the Session on the Commission's Bill Drafts. Then subsequently authorizing the Executive Director to negotiate the Bills on behalf of the Legislature potentially. The group created needs to be able to talk to each other rapidly during the Legislative process because we never know when a Bill is going to be heard.

A commissioner commented the Commission needs a way to engage in the Legislative process because it is not realistic to do it once a month in a meeting.

Chairman Khan asked the DAG if the language that a commissioner mentioned earlier in forming a committee creates a problem in open meeting law. Ms. Sliwa answered if there is conferring among the commissioners, particularly commissioners who are designated by the PPC to address and explore a particular issue, that must be noticed, agendized, and follow open meeting law. Whether it is called a subcommittee, a workgroup, or an advisory group, the designation does not matter. What matters is that the commissioners are conferring and discussing PPC business. She stated that she understands the time constraint issue and that things can happen fast during the Legislative Session, but that is the way open meeting law is written. The PPC is a public body and will need to follow the open meeting law.

Chairman Khan questioned is if these designated commissioners can communicate with the Executive Director back and forth as individuals, not as a group, and whether that is appropriate. Ms. Sliwa answered that description would not be a subcommittee or workgroup. That would simply be the designated commissioners communicating with the Executive Director. That would not necessitate all the open meeting law requirements. What triggers the open meeting law requirements is when the commissioners communicate with each other.

The only way that the open meeting law would not apply to this process is if the individual commissioners, that had been designated by the PPC to provide support to the Executive Director, communicated with the Executive Director, and only the Executive Director, individually.

A commissioner expressed her frustration with this process and asked if the PPC can formally request today that the Executive Director provide all communications about the PPC BDRs to the Commission or a subset of the Commission. Ms. Sliwa responded in the affirmative.

Chairman Khan clarified that the designated commissioners, as individuals, can communicate back to the Executive Director, what they think needs to happen. Ms. Sliwa agreed and reiterated that it must be done individually.

MOTION was made to designate three or four commissioners willing to volunteer some of their time to support the Legislative process with the three PPC BDRs and the Executive Director by Commissioner Bond. Seconded by Commissioner Roa-Dugan.

A commissioner expressed her concern about the Executive Director sending out information to any subset of commissioners because she would want to see it too whether she is part of the designees or not.

Executive Director Southard called out all those in favor of the motion, including Commissioner Bond, Commissioner Van Houweling, Commissioner Ralston, Commissioner Grady, Commissioner Roa-Dugan, Commissioner Tyler-Garner, Vice Chair Ruybalid, and Chair Khan. Chairman Khan stated the motion carried. He then asked for volunteers to individually communicate with the Executive Director via email about the Legislative process and three BDRs. Commissioner Bond, Commissioner Ralston, and Commissioner Van Houweling volunteered.

Agenda Item VII – Recommendations and Possible Approval from Commission for the final January 1 PPC Report to the Governor and Legislature (as required by NRS 439.918.2)
Malinda Southard, Executive Director

Executive Director Southard introduced the January 1 PPC Report as required by NRS 439.918.2. To meet this requirement, and in due diligence to public process, Executive Director Southard drafted the January 1 Report, included in the meeting materials, and requested the commissioners all review and provide feedback on the statutorily required report. She noted no opposition on anything contained in the report and has only a few minor edits that were requested. She stated understanding this might be a new process of sharing this report publicly, both with the Commission and during the meeting today, and solicited approval from the Commission to submit the report as required pending discussion and comment.

Vice Chair Ruybalid noted that she has reviewed the report and commented it looks great. She appreciates the Executive Director's hard work on this. A commissioner asked about the recommendation for staff and how that might turn into staff because the recommendation is for two people to work on the Peterson Milbank project.

Executive Director Southard responded that she requested two staff to assist with the Peterson Milbank project and the continuation of the Health Care Cost Growth Benchmark because it is such a comprehensive project. With the movement of the Commission's bill (AB 6) through Legislative Session to the hopeful approval, we would need the additional support in developing annual meetings, the annual public reporting, and communication with stakeholders throughout the year on the process itself.

Executive Director Southard also clarified the requests in this report are solely recommendations. She had put the two additional staff in as a recommendation in requesting for the DHHS Patient Protection Commission budget. It is a small budget, with a small number of staff. Right now, the DHHS PPC staffing consists of the Executive Director and the Policy Analyst, in addition to a currently vacant Administrative Assistant position. The Executive Director noted with the addition of two more staff to support the work of the Health Care Cost Growth Benchmark, it is still under the minimum amount of staff that other states in the nation are using for this same project. This request is in a state agency budget request, rather than a request that is tied directly to the bill (AB 6). Therefore, it is a separate and aligned request.

A commissioner further opined this report is great and that it is meant for recommendations. She continued it is important that the State administration receive recommendations, and that there is a due process to implement any of the recommendations, referring to the previous question about adding staff. She stated that Executive Director Southard is in a situation where, if she does not ask, she may not get it; and it does take a lot of work to navigate all the responsibilities of the Commission. Her recommendation is that Executive Director Southard did not ask for enough staff. No opposition was noted during the meeting to the Executive Director submitting the PPC January 1 report as statutorily required.

Agenda Item VIII – Recommendations and Possible Approval from the Commission for the final 2022 Inaugural Patient Health Records Plan (as required by NRS 439.918.1.(c))
Malinda Southard, Executive Director

Executive Director Southard introduced the Inaugural Patient Health Records Plan as required by NRS 439.918.1.(c). To meet these requirements, the DHHS PPC team has developed a first draft baseline of the PPC Patient Health Records Plan, found in today's meeting materials. It is ideal for the Commission to approve a baseline iteration of the statutorily required plan, prior to the year's end, with the understanding that this plan will be reviewed and updated annually by the Commission, with a more formal and prolonged solicitation for public comment on this plan well in advance of each annual plan renewal date in December. In the Commission's due diligence, and transparency to the public, this plan was not only solicited previously for feedback from the Commission, but also solicited for public feedback in advance of today's meeting. Executive Director Southard noted that she has not received any formal opposition on the drafted plan to date. She also apologized to the Commission and the public that there was a very short window requested for review and

comment and took responsibility for not appropriately scheduling a more adequate public comment period for this plan well in advance. However, public comment will be accepted throughout the year for consideration for inclusion in the 2023 plan update. She then opened this item for discussion.

A commissioner opined that she appreciates Executive Director Southard getting this far, but believes we are mixing up interoperability and patient records with all the other work being done such as prior authorization and what the Nevada Medical Association's requirements are for record retention. She opined that the plan needs another level of review and to separate some of it out that is not related to interoperability and patient access.

Vice Chair Ruybalid added that the patient access and interoperability rule contain things that are in this report, that is the connection at the Federal level. It is not just about interoperability, but also information sharing. There are a lot of extra requirements within the Federal Regulation that Executive Director Southard has included here. Executive Director Southard clarified that the burnt orange text in the document is proposed language from CMS in their December proposed rule update.

A commissioner opined that the burnt orange text should be taken out until it is passed because she thinks it is confusing and that the CMS proposed rule update may change. Another commissioner asked if the burnt orange text could be submitted as reference material. Vice Chair Ruybalid recommended that the burnt orange text be instead included as a simple link to the proposed rule, and if someone wants to do a deeper dive into that material, they can.

Moving on to Section IV – Recommendations, Executive Director Southard noted she received comment from the Nevada State Medical Association that while this section is related in statute to paragraph D, the recommendations to the DHHS Director and the Legislature should be contained in a separate document, rather than in the Patient Health Records Plan. Additionally, she received comment from the Nevada Association of Health Plans (NvAHP), along similar lines, that the two topics, Health Care Cost Growth Benchmark and patient access to records and interoperability, do not naturally dovetail. Therefore, NvAHP is recommending the plan to focus on patient data access and protection.

A commissioner asked when the plan must be submitted. Executive Director Southard answered that there is no deadline in statute, but this was a new requirement that was brought about in the 2021 Legislative Session through AB 348, and thought it would be helpful if the Commission could get our inaugural version approved prior to year's end.

A commissioner opined she would like until the next meeting to review this document and provide more substantive content since there is no deadline and it is the first draft. Chair Khan agreed with the suggestion and no opposition was noted.

Agenda Item IX – Discussion of Nevada's Health Care Costs in Context Relative to Other States
Michael Bailit, President, Bailit Health

Executive Director Southard introduced this topic from the commissioners' request to have Mr. Bailit present data and hold a discussion regarding Nevada's health care costs in context relative to other states nationally.

Mr. Bailit stated that for context, the Commission has heard in public comment from Mr. Kelly the last couple of meetings, that health care spending in Nevada is low. The purpose of this brief presentation is to verify and contextualize this information and to demonstrate that despite comparatively lower per capita health care spending, health care affordability is a serious concern for Nevadans, based on multiple data points. Again, the Commission has heard it reported in public comment that health care spending in Nevada is lower, but it is important to contextualize it in income, and income in Nevada is also lower. When we adjust for median income, the state's per capita health care spending moves from third lowest to tenth lowest. For health care spending, we are using data from the Office of the Actuary at CMS.

Mr. Bailit also reviewed change in spending in the commercial market because that is where affordability is the greatest

concern. He looked at the data over the last 20 years and found that health care spending per enrollee per year has grown annually at 4.4 percent while median household income in the state grew 1.7 percent. That is more than twice the rate of income growth, which means that more and more take-home income each year is going to pay for health care bills. It is not going to pay for education, housing, or other social goods. When we look at affordability in terms of what workers are paying, workers pay for health care in two ways. They pay for contributions to premiums as payroll deductions and they also pay through cost sharing at point of service. So, we looked at two different trends using data from the Commonwealth Fund. The first is worker contributions, which grew in Nevada between 2015 and 2020, at more than double the national rate for both single and family coverage. We saw the same thing in terms of deductibles. Deductibles grow when employers are trying to manage premium growth. Employers will typically expand product offerings to have larger deductibles and consumers, or workers, who are trying to manage their payroll contributions, will often pick plans with larger deductibles to keep the contributions manageable. We can see, in both ways, Nevada workers have been spending a lot more, and spending a lot more relative to workers, in other states. Growth in health care spending, defined in terms of premium contributions and deductibles, is taking up more and more take-home pay.

A commissioner asked to clarify that this analysis does not show, but infers, that when employers increase their deductibles and coinsurance, in order to make premiums more affordable, they are not doing so to have their trend go down. They do not then have lower insurance rates that they are covering. Insurance rates are going to continue to go up.

Mr. Bailit agreed and noted both the purchasers, who are buying the coverage, and the workers, who are paying a portion of the coverage, are picking up the results of health care spending that is growing at twice the rate of people's wages.

Mr. Bailit continued that all these high deductibles and cost sharing result in elevated medical debt. In The Commission heard from Mr. Kelly earlier about the problems of hospitals and other providers collecting coinsurance. We are sort of in a vicious cycle where employers and workers try to manage fast growing expenses by changing benefit design that leads to workers having to pay higher deductibles and higher coinsurance, which they cannot afford. That results in more bad debt, but all the bad debt is brought on by the fact that health care costs are high and growing at a fast rate. A fifth of state residents with credit bureau records had medical debt in collection and that ranked Nevada 39th out of 51 for residents experiencing medical debt. So, again, per capita health care spending might be lower relative to other states, but the affordability perspective does not look very good.

Mr. Bailit contextualized the next couple of slides before moving on, stating that ultimately, the perspective that we might care most about is the consumer's perspective and the extent to which health care costs are impacting how they access services. High health care costs and fast-growing health care costs result in poor access. The higher that costs are, the worse access is. In reviewing data from the Kaiser Family Foundation, Mr. Bailit noted that Nevada ranks sixth in the country for the percentage of adults who reported not seeing a doctor in the past year because of cost, and tenth in the country for the percentage of children whose families had trouble paying for their child's medical bills. This is one measure. The next slide has additional measures and is from data that has been previously shared by the Executive Director. This was a survey conducted in summer 2022 in Nevada, and 59 percent of survey respondents reported delaying or going without health care, within the last year, explicitly due to cost. As shown in the slide, this was further broken down into how respondents specifically delayed or went without health care. Mr. Bailit opined that when 60 percent of survey respondents are not accessing needed care, that is an access barrier.

In summary, health care spending in Nevada is lower than in most other states, but it has been growing faster than income, including through premiums and deductibles. There are a high percentage of residents with a credit bureau record who are in collections, right now, for medical debt. Lastly, access to care is impeded by high health care costs. Mr. Bailit then closed by opining that clearly there is a need to focus on both cost and access. It is not one or the other because there is a causal relationship between the two.

A commissioner opined that what is missing, is that there is a lot of money being made by our hospital systems and insurance companies in Nevada. We do not see the profit side of any of this data with all the work that we are doing on

the Benchmark and in looking at what it means to be a patient with high costs. We are not seeing how those costs relate to price. There is a gap in the data about how much health care costs versus what is being charged. She questioned what kind of profits are being made by these hospital systems and the insurance industry that provides this coverage and wondered how we can see that data. She opined that it tells a piece of the story that the Commission has not previously worked on and should be put on a future agenda.

Agenda Item X – Determine Meeting Schedule and Activity Priorities of the Commission in 2023
Malinda Southard, Executive Director

Executive Director Southard reminded everyone that during the November 2022 meeting, the Commission gained consensus to meet in person, one to two times per year, with the Zoom option also offered for those in-person meetings, and otherwise meet nearly completely virtually. Executive Director Southard posed two questions, first, for the January 2023 meeting, is the Commission open to holding this meeting in person at the Grant Sawyer building in Las Vegas, with the Zoom option, and second, would they like for that meeting to be either on the third Wednesday or third Thursday.

A commissioner opined that she understands why some people want to meet in person, and she agrees that it should happen once or twice a year, but she requested that it not be during the flu season. She suggested that it be in spring or summer because many of the commissioners work in health care and would potentially be bringing viruses with them to the meeting.

Chairman Khan noted that there was only one commissioner who previously noted challenges with the meeting being on the third Thursday of each month. Therefore, the third Thursday has the majority. Regarding the question about holding hybrid meetings, he opined it is a good option because those who cannot travel can still connect via Zoom.

Another commissioner opined she agrees with the earlier statement of concern about everyone's health. Chairman Khan then directed Executive Director Southard to plan to have an in-person meeting in the spring.

Agreeing, Executive Director Southard then transitioned the discussion to Commission activity priorities for 2023. During the November meeting, the Commission agreed to focus on two pillars, health care affordability and health care accessibility. Health care affordability will continue to focus on the Peterson Milbank program for sustainable health care costs and the Nevada Health Care Cost Growth Benchmark. She then announced that Nevada support for the Peterson Milbank program has been authorized for another two years. However, the technical assistance we currently receive from Bailit Health will be reduced in this next phase. The Peterson Milbank program has asked us to draft how Nevada might like to prioritize the technical assistance requested from Bailit Health. Executive Director Southard asked the Commission if they have any ideas on how we could prioritize this technical assistance in 2023. Peterson Milbank has similarly identified that in this next phase, in addition to the technical assistance from Bailit Health, specific support for Nevada is likely to include analytic support to understand cost drivers, communication support for effective dissemination and stakeholder engagement, and convenings for cross-state exchange learning and peer networks. Executive Director Southard then asked if there are any initial thoughts or questions for the first pillar.

A commissioner opined that learning from other states is very valuable. She wondered how other states are discovering the data about profitability within their health care systems and moved for that to be a priority. Vice Chair Ruybalid asked if there would be any technical assistance with the BDR that is trying to codify the Benchmark work. Executive Director Southard answered in the affirmative.

Executive Director Southard noted that under the second pillar, health care accessibility, there was a great discussion in November surrounding the potential to survey medical and nursing residents statewide to determine what motivates them to either stay in or leave Nevada after completion. A survey along those lines is currently in the works in Southern Nevada and the Commission expressed great interest in developing that type of survey, statewide. In addition, if the Commission agrees, our state DHHS PPC team can perform an environmental scan of work that has already been done in

the state to improve health care accessibility, including workforce strategies. We then propose the idea of bringing the results of this environmental scan, along with a broad array of ideas, to the Commission in March for consideration under this pillar for how the Commission can help move the needle in a positive way for health care accessibility in our state.

Executive Director Southard clarified an environmental scan regarding health care accessibility includes determining what work has already been done in this state to effect health care accessibility in a positive way i.e., reports, commissions, committees, etc. that were developed in the past to address this issue. Then, come up with a menu of ideas, per se, for the Commission to discuss how they might address health care accessibility in this next year.

Executive Director Southard then gave a brief snapshot of what the Commission should expecting to address in the first few months of 2023. We have incorporated the four health care cost growth mitigation strategy exploration discussions into the first four meetings of the year, along with the Phase II Cost Driver Analyses for Medicaid and the Public Employees Benefits Program, and our first Baseline Benchmark Findings Report.

Agenda Item XI – Public Comment

Barry Cole, Nevada Psychiatric Association

Dr. Cole told the Commission that in the Nevada Psychiatric Association's February business meeting, that will take place in mid-February, they are having parallel essay contests for all medical students in the state of Nevada and all psychiatric residents in the state of Nevada. They are asking medical students to tell them what they foresee as need, to remain in Nevada, and after they have completed medical school, will they commit to doing residencies here. For the psychiatric residents who are graduating, they are asking them to identify what would help them commit to staying in Nevada. Currently, they are losing three out of four psychiatric residents at the end of their training, primarily to California and Utah, who can out-compete Nevada. Dr. Cole then suggested that he come back to the February PPC meeting and give the commissioners the ideas that the medical students and residents have. He noted that will be part of their planning for going to the Legislature, to ask for ways to make Nevada better for medical students and psychiatric residents.

Chairman Khan asked Dr. Cole to forward the information he receives, ahead of time, so it can be distributed to the commissioners to review in preparation to ask him educated and informed questions.

Agenda Item XII – Wrap up and Adjournment

Dr. Ikram Khan, Chairman

Meeting was adjourned at 11:19 a.m.

Respectfully submitted,

Kiley Danner
Office of the Patient Protection Commission

APPROVED BY:

_____
Dr. Ikram Khan, Chair

Date: _____

Meeting Materials

AGENDA ITEM	PRESENTER	DESCRIPTION
VII.	Malinda Southard, Executive Director, PPC	Draft PPC January 1 Report
VIII.	Malinda Southard, Executive Director, PPC	Draft Patient Health Records Plan
IX.	Michael Bailit, President, Bailit Health	Discussion of Nevada's Health Care Costs in Context Relative to Other States