Committee Action:
Do Pass ____________
Amend & Do Pass ____________
Other ____________

Senate Committee on Health and Human Services

This measure may be considered for action during today's work session.

SENATE BILL 394

Revises provisions relating to Medicaid managed care and required coverage provided by health insurers. (BDR 38-950)

Sponsored by:	**Senators Spearman, Segerblom, Denis, Manendo, and Parks and Assemblywoman Neal, et al.**
Date Heard:	**April 5, 2017**
Fiscal Impact:	**Effect on Local Government: May have Fiscal Impact.** **Effect on the State: Yes.**

Senate Bill 394 requires the director of the Department of Health and Human Services (DHHS) to seek any necessary waiver of certain provisions of federal law to allow a Medicaid managed care plan to be offered for purchase to individuals otherwise ineligible for Medicaid through the Silver State Health Insurance Exchange (SSHIX). The director of DHHS must also seek a waiver to allow individuals to use the federal income tax credit and cost-sharing reductions authorized by the Patient Protection and Affordable Care Act (PPACA) to purchase coverage through a Medicaid managed care plan available on the SSHIX.

To the extent authorized by federal law and pursuant to waivers granted, S.B. 394 allows any person who is not otherwise eligible for Medicaid to purchase coverage on the SSHIX through a Medicaid managed care plan. The director of DHHS sets the annual premium of such plans; benefits are the same as for other Medicaid recipients; and no federal funds may be used to provide such coverage.

In addition, S.B. 394 aligns Nevada law with federal law, by prohibiting health insurers from:

- Denying, limiting, or excluding a benefit or requiring an insured pay a higher premium, deductible, coinsurance, or copay based on the health status of the insured, his or her spouse, or dependent; and

- Imposing an annual lifetime limit on monetary value of certain essential health benefits, which must be covered.

The bill requires DHHS to issue regulations establishing the services that must be covered as essential health benefits, which must include the services currently considered as such by the PPACA.

Finally, health insurers in Nevada must extend coverage for an adult child of the insured up to 26 years of age.

Amendments: Two amendments were proposed to this measure.

1. Danny Thompson, representing Laborers' International Union Local 872/AFL-CIO, presented the attached amendment during the bill hearing. It requires a health maintenance organization to provide certain data to a group purchaser who files a written request.

2. Following the hearing, Senator Spearman requested an amendment to delete Sections 2, 3, and 48 of the bill, which: (1) require DHHS to seek necessary waivers to allow Medicaid managed care plans to be offered for purchase through the SSHIX to people otherwise ineligible for Medicaid; (2) make such coverage available on the SSHIX; and (3) revise the definition of "qualified health plan" to include a Medicaid managed care plan.

   Instead, Senator Spearman proposes requiring the Legislative Committee on Health Care to study the requirements proposed by Sections 2 of the bill, in collaboration with the Department of Health and Human Services; the Division of Insurance, Department of Business and Industry; SSHIX; and other stakeholders during the 2017–2018 Interim. In addition, the Legislative Committee on Health Care must evaluate strategies for the State to maintain the current level of health insurance coverage should the PPACA be repealed and make recommendations to the 2019 Legislature.

[INTRODUCTORY LANGUAGE THAT MAY BE ADDED TO SB 394]

SUMMARY—Revises provisions relating to the release of health maintenance organization claims data under certain conditions.

AN ACT relating to health care; requiring health maintenance organizations to provide certain claims data to certain employers and group purchasers.

Legislative Counsel's Digest:

Section 1 of this bill requires a health maintenance organization, including, without limitation, a health maintenance organization which offers a Medicaid managed care program, to provide certain group purchasers on request either: (1) all claims data relating to the enrollees of such coverage once every 3 months; or (2) sufficient data to calculate the cost of providing certain medical services through the health maintenance organization.

[BILL LANGUAGE TO ADD TO SB 394]

Sec. 1. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 3, if a group purchaser files a written request with a health maintenance organization, the health maintenance organization, not more frequently than once every 3 months, must provide to the group purchaser in a timely manner:

(a) All claims data relating to the enrollees of a health care plan provided by the organization pursuant to a contract with the group purchaser; or

(b) Sufficient data relating to the enrollees of the health care plan for the group purchaser to calculate the cost-effectiveness of benefits provided by the health maintenance organization, including, without limitation:

(1) Data required for the group purchaser to calculate the actual cost of obtaining medical services through the health maintenance organization by medical service and disease category;

(2) Such data relating to patients, including, without limitation, patient demographics, prescriptions, office visits with a provider of health care, inpatient services, outpatient services as used by the health maintenance organization to make calculations which are required to comply with the risk adjustment, reinsurance and risk corridor requirements of 42 U.S.C. §§ 18061, 18062 and 18063; and

(3) Such data as used to establish an experience rating for the group of enrollees, including, without limitation, coding relating to diagnostics and procedures, the total cost charged to any person for each drug, device or service made available by a health care plan and all reimbursements made to a provider of health care for such drugs, devices or services.

2. If a group purchaser files a written request with a health maintenance organization, it must also provide the quarterly data required by subsection 1 in an annual summary trend report, with sufficient detail to show annual changes in both dollars and percentage for each category of information provided and required by subsection 1.

3. A health maintenance organization must provide the data required by subsections 1 and 2 in an aggregated form which complies with federal and state law.

4. Before providing any data pursuant to subsections 1 or 2, a health maintenance organization shall ensure that a professional statistician examines the data to confirm that the

data cannot be used to identify and does not provide a reasonable basis upon which to identify a person whose information is included in the report. If the professional statistician is not able to make such a confirmation, the data must not be provided by the health maintenance organization to the group purchaser until such confirmation is obtained.

5. A health maintenance organization must provide the data required by subsections 1 and 2 in a format which is easily searchable electronically or on a secure Internet website.

6. A group purchaser must have policies and procedures in place which are compliant with federal law and the laws of this State to ensure the privacy and security of the data made available to the group purchaser pursuant to subsections 1 and 2.

7. As used in this section, "group purchaser" means:

(a) The Division of Health Care Financing and Policy of the Department of Health and Human Services relating to a Medicaid managed care program offered pursuant to NRS 422.273;

(b) An employer with not less than 1,000 covered lives total and not less than 300 covered lives who are enrolled in a health care plan which is offered by the health maintenance organization; or

(c) A multiemployer trust formed for the purpose of providing health benefits with at least 250 covered lives.

Sec. 2. NRS 695C.050 is hereby amended to read as follows:

695C.050 1. Except as otherwise provided in this chapter or in specific provisions of this title, the provisions of this title are not applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer

licensed and regulated pursuant to this title except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, must not be construed to violate any provision of law relating to solicitation or advertising by practitioners of a healing art.

3. Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and is exempt from the provisions of chapter 630 of NRS.

4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734, 695C.1735 to 695C.1755, inclusive, 695C.176 to 695C.200, inclusive, and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694, 695C.1695, 695C.1708, 695C.1731, 695C.17345 and 695C.1757 ***and section 1 of this act*** apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

Sec. 3. This act becomes effective on July 1, 2017.