MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Third Session
April 9, 2005

The Committee on Health and Human Services was called to order at 10:11 a.m., on Saturday, April 9, 2005. Chairwoman Sheila Leslie presided in Room 4401 of the Grant Sawyer State Office Building, Las Vegas, Nevada, and, via simultaneous videoconference, in Room 3137 of the Legislative Building, Carson City, Nevada. Exhibit A is the Agenda. All exhibits are available and on file at the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Ms. Sheila Leslie, Chairwoman
Ms. Kathy McClain, Vice Chairwoman
Mrs. Sharron Angle
Ms. Susan Gerhardt
Mr. Joe Hardy
Mr. William Horne
Mr. Garn Mabey
Ms. Bonnie Parnell
Ms. Peggy Pierce
Ms. Valerie Weber

COMMITTEE MEMBERS ABSENT:

Mrs. Ellen Koivisto (excused)

GUEST LEGISLATORS PRESENT:

Assemblyman Richard Perkins, Assembly District No. 23, Clark County

STAFF MEMBERS PRESENT:

Barbara Dimmitt, Committee Analyst
Julie Morrison, Committee Manager
Joe Bushek, Committee Attaché

OTHERS PRESENT:

Andy Brignone, Legislative Advocate, representing Health Services Coalition, Las Vegas, Nevada
Cynthia Kaiser-Murphy, Senior Vice President of Human Resources, MGM Mirage, Las Vegas, Nevada
David F. Kallas, Executive Director, Las Vegas Police Protective Association (LVPPA) Metro, Inc, Las Vegas, Nevada:
Pam Coombes, Private Citizen, Las Vegas, Nevada
Frank "Ric" Coombes, Private Citizen, Las Vegas, Nevada
Jim Wadhams, Legislative Advocate, representing Nevada Hospital Association
Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Human Resources, State of Nevada
Vernon Manke, Management Analyst, Division of Health Care Financing and Policy, Department of Human Resources, State of Nevada
Robin Keith, President, Nevada Rural Hospital Partners, Reno, Nevada

Chairwoman Leslie:
[Meeting called to order and roll called.] We have most of our Committee here. During the first week of the session, we said that we would come to Las Vegas if you wanted us to, and I got word that you wanted us to. Here we are today. It is gratifying to come here and see the room filled with people. We know that health care is important to you. It's important to us. We are very happy to be here in Las Vegas today.

As you recall, during the hearing on February 10, the Committee received quite a bit of information about the crisis here in Las Vegas with the Health Services Coalition and the contract. At that time, we realized that perhaps we didn't have the information in our State data collecting system to be able to respond adequately to that. You told us, and we agreed, that every three years we can't keep going into a crisis situation where people like you are at risk of losing your health care and losing access to the hospital providers that you need. We asked for research and data to be prepared, and we're going to go through that this morning. Our staff has done an excellent job of collecting that information. That will be presented today.

I want to thank everybody—the Hospital Association, our staff, and our Medicaid staff. Charles Duarte is up there in Carson City; he did a great job of cooperating with our research staff in providing information. It is hard during a legislative session—on top of everything else that we're doing—to put together

a major resource document that you will see presented today, and we do appreciate everyone's cooperation with that effort.

[Chairwoman Leslie, continued.] Today—after we hear the answers from the questions that we raised that first week in February—we're going to be hearing two bills. Assembly Bill 322 will be presented by the Speaker of the Assembly, Assemblyman Richard Perkins. Then, I'll be walking us through A.B. 342, which I requested the first week of the session to be drafted in direct response to the concerns that you raised to us that first week. You know a lot of people say negative things about government, but I can assure you that this Committee of the Assembly has been listening to your concerns. I think you'll see that today with the bills that we're going to present, so that you can see that we understand that this is an issue of concern of yours. It's an issue of concern to us. I think we have two excellent bills here that will make a real difference in terms of your health care. Today, the things that we're going to cover are hospital profits, community reinvestment, hospital charges, hospital reporting and public information, health care planning, and community needs assessment.

At this point, we'll turn to our staff. The Committee members should have something entitled "Background Information on Hospitals in Nevada: Cost Containment, Charity Care, and Community Reinvestment" (Exhibit B). At this point, I'd like Barbara Dimmitt to walk the Committee through it.

Barbara Dimmitt, Committee Policy Analyst, Legislative Counsel Bureau:
This is a summary of research that was done by the Research Division, the Department of Human Resources staff, and the Hospital Association staff, under the direction of Bill Welch. In the tabbed sections, you will find all the original memoranda that came out of those separate documents. This summary document goes through and tries to integrate and weave them together so that they can stay on topic and try to answer the questions.

During the February 10 meeting, Chairwoman Leslie asked seven questions, and we tried to come back with answers. Go to page 2 (Exhibit B); that's the first question. It deals with the history of the health care cost-containment programs that were established in Nevada in 1987. Under Tab A, you'll find a memorandum that's exclusively devoted to summarizing that history. Obviously, there's much more to it than that. Basically, you will see in your summary document the major provisions of the 1987 cost-containment legislation, which included some reductions of billed charges and price freezes for a period of time. This was a time when data collection procedures were established to require hospitals to report data to the Division of Health and the Department of Health Care Financing and Policy. It also required hospitals to treat and share

the cost of treating the medically indigent. It also established the Legislative Committee on Health Care, which has been monitoring various health care issues, including cost-containment, ever since.

[Barbara Dimmitt, continued.] On page 2, you'll see the impact of the cost-containment program. That is a brief summary of what you'll find regarding how the cost-containment program worked. During the time that it was established, hospitals did reduce their billed charges, and the greatest reductions in the billed charges came in the first year. Hospitals were also allowed to apply various credits and carryovers, and to adjust their revenues based upon the Consumer Price Index (CPI), the medical component.

While the bill did not slow the overall health care cost increase, that was attributed, in part, to the fact that not just the billed charges or inpatient charges, but the other components of health care—including outpatient, pharmacy, and provider services—rose more than billed charges, and therefore, the net overall impact wasn't as dramatic as perhaps some had wished. It slowed the increase, which would mean that it would, perhaps, have increased more without cost-containment. The expiration of cost-containment occurred in 1999, and there were some other amendments to the program after that. You can get more information on that in the tabbed sections.

Question number two, on page 4 of your summary, was: “What has happened with hospital costs since the expiration of those cost-containment provisions?” The Department of Human Resources Division of Health Care Financing and Policy provided the data for this section, as well as the Nevada Hospital Association. The amount that patients overall—including third-party payers—paid to hospitals per inpatient adjusted inpatient day rose from $1,494 in 1999, when the program expired, to $1,873 in 2004. That was an increase of 25.4 percent. Billed charges increased by approximately 63.8 percent with the Department of Human Resources figures. I believe the Hospital Association has a similar, but slightly different, percentage. All of this raw data is in the tabbed sections in the back.

Hospital net revenues also increased about 28 percent for all hospitals after that expiration, and the medical component of the CPI increased by 24 percent. To really understand these figures, it takes a lot of looking at what exactly the figures are measuring and what the assumptions are in terms of developing the figures. This was a finding of the overall research. It is extremely difficult to compare costs and different kinds of financial data for hospitals, because each type of statistic is very specific and is trying to measure and understand a specific thing. It's kind of hard to throw numbers around and think you understand it.

[Barbara Dimmitt, continued.] On page 5, there are some definitions in the Department of Human Resources memorandum. I'll call your attention to it, because that's like a little glossary and may be helpful when you're reviewing this. Then, they provided a number of charts from the data that they do collect.

The third question is: "How have billed charges changed in Nevada, and how does this compare with other states?" Neither the Hospital Association, nor we, were able to find a direct multistate comparison of billed charges that was uniform enough and comprehensive enough to be able to say a whole lot about it. However, we did find some other information regarding this. What we did find is in your memorandum.

As far as a state-by-state comparison of hospital charges, we didn't find the billed charges information, but we did find other kinds of indexes. As you will see on page 6, Nevada hospitals tended to rank near the top of the list of the studies that we did find. Because this was a fairly common thing—third, fourth, fifth, and sixth-highest—the conclusion is that it is probably an accurate reflection of where we are.

Question number four on page 7: "What data currently are collected in the state regarding hospital charges, costs, and profits?" You will see here the different statutes described that require various reporting to the Division of Health Care Finance and Policy; that includes operating budgets, audited financial statements, balance sheets, discharge data, and a lot of information. The audits are not required of every single hospital. Some of the corporate hospitals have overall audits and are not required to do individual submissions and so forth.

However, the Nevada Hospital Association memorandum stated that audited annual statements are reported by most hospitals. It would appear that this has the potential of causing another issue with uniformity of data—if you're not getting the same kind of thing from every hospital—but we did not go into detail about that. How are profits reported by hospitals in the state, and where do these profits go? What we received from the Hospital Association was that there appeared not to be any standard reporting in the hospital industry to show exactly how each facility uses its profits, and the Hospital Association provided a number of charts to attempt to show some information regarding profits, profit margins, et cetera.

Community reinvestment and charity care: What are the current requirements for community reinvestment and charity care? We discovered pretty quickly that there is no statutory community reinvestment program that's analogous to the one on the federal government level that deals with banks and thrift institutions.

Therefore, there's no mandatory planning process or anything that hospitals have to go by. This is a private industry. They make whatever investments in their community they choose to make. The Nevada Hospital Association did provide some information on how hospitals in Nevada are doing that and what kind of activities they have.

[Barbara Dimmitt, continued.] Other things that we did find are statutory requirements that hospitals have to reduce charges by at least 30 percent for certain uninsured patients, if they make arrangements to pay their bill within 30 days—in other words, not to pay it within 30 days, but to make the arrangement to pay in that time period. Also, hospitals in Nevada must provide emergency services and care and must admit a patient if necessary, regardless of financial ability. There is a requirement that hospitals provide free care for approximately 0.6 percent of their net revenue for the preceding year. That's our disproportionate share statute also. Then, nonprofit hospitals can qualify for tax-exempt status with the IRS [U.S. Internal Revenue Service], if they provide certain kinds of community benefits.

Question seven: "What is the process by which new services and facilities are added to the market, and how has this influenced cost?" The memorandum in your tab (of Exhibit B) will give you considerable detail on the certificate of need process in Nevada. I tried to excerpt from that very briefly. We did have a certificate of need process. In fact, we had it before the federal government required it. Certificate of need is where if a hospital or medical facility wants to build a new facility or wing or get a new major piece of equipment, they have to get advanced permission to do that. Currently in Nevada, this applies only in the rural areas now. Washoe County and Clark County were exempted from this process.

The effectiveness of certificate of need as a cost-controlling strategy was hard to decide upon. There were studies that indicated it didn't make a difference. After the certificate of need statute expired, some of the costs actually went down. There are other studies that found this not to be true. One study, on page 12, found a correlation between the certificate of need and the availability of indigent care, redirecting funds from investments and capital to subsidization of care. That was one possible effect. This study also determined that certificate of need may be useful in promoting regionalization of services with an improvement in patient outcomes. That study is available if anyone would like to see it; they can certainly request it.

Chairwoman Leslie:
I think what strikes me, as you were going through the document, is on page 2. When I see a statement like this in a LCB [Legislative Counsel Bureau] report, it

confirms what I think many of us believed on page 2, where she talks about how difficult it is to get information and the different holes in our statutes, that we're really not collecting the information that we need and how hard it is to compare one state to another. Nevertheless, the statement is made that, according to most sources of data identified by the research in this report, Nevada's hospitals are among the most expensive in the nation.

[Chairwoman Leslie, continued.] There it is in black and white. What I think all of us have experienced, we have a problem in this state. I think what Governor [Richard] Bryan tried to do with these cost-containment provisions in the 1990s was address that issue, and later on, in Section 2, when you look at the hospital cost trends starting on page 4, you can see that cost-containment seemed to work. Hospital prices did drop down. Then, over the years, different parts of the cost-containment legislation eroded. As it eroded, we saw that hospital costs went back up.

I think the bills we have today will have some provisions that have been revised. At this point, we'll have the Speaker present his bill, then I'll present mine. After that, we'll open it up for public testimony. The Speaker will be speaking to A.B. 322, and mine is A.B. 342.

Assembly Bill 322: Requires hospitals to adopt and carry out plans to benefit community. (BDR 40-1074)

Assemblyman Richard Perkins, Assembly District No. 23, Clark County:
I think it is clear that there's a significant interest in these bills. Health care, particularly hospital care—that care that is generally not discretionary and is often crisis-driven—creates grave concerns for our citizens, as is evidenced by the interest shown here.

It is as important to a family as security, shelter, and food. It is a life-or-death matter. Assembly Bill 322 represents my desire to make sure that we look out for Nevada first. If I might point to the original bill draft and just read the summary, it states, "Requires hospitals to adopt and carry out plans to benefit the community. An act relating to health care; requiring each hospital to adopt and carry out a plan for providing benefits to the community it serves; and providing other matters properly relating thereto."

We are all acutely aware of what a lightning rod issue health care benefits are these days. Health insurance has become more and more difficult to secure for many of Nevada's working families. For those of us who are lucky enough to be

covered, we often see major cost increases and are constantly in danger of seeing coverage diminish or disappear. We saw this clearly in February, when we had 300,000 southern Nevadans—mainly public servants and workers who keep the casino industry going—on the brink of having their hospital coverage interrupted or cut off.

[Assemblyman Perkins, continued.] Hospital costs are a major driver in escalating health care costs. Thirty-one percent of total health care spending goes to hospital care. I'm not trying to unfairly penalize the hospital industry here. Private businesses deserve profits, but we have seen a major profitability in this sector, even as costs have continued to increase for consumers.

Nevada has a very unique hospital market. In Clark County, over 83 percent of the beds are controlled by out-of-state corporations. As a point of comparison, in Washoe County, at least 60 percent of the beds are locally controlled. Nationally—particularly in large urban areas, comparable to Las Vegas—well over half of the beds are locally controlled. We are glad these companies have chosen Nevada to do business, as we're always at the bottom of the list in terms of health care access. So, we need all the help we can get. However, we also know that for many hospital companies, Nevada is a real profit center. Companies have strategically chosen Nevada because of Nevada's hospital business climate, and the need for services as our population grows.

We are lucky to have the few local and public institutions that we do have, especially in the rural counties. We are fortunate to have local health care providers. Assembly Bill 322 is an attempt to make sure that since we have this unique market dominated by out-of-state corporations, that we just ensure a level of local connection. We have heard back from the industry and some preliminary documents that the Chair requested regarding what hospitals currently classify as their community reinvestment.

The model that I used in crafting A.B. 322 attempts to define what can be counted for reinvestment and links turning in a documented reinvestment policy to the renewal of the hospital's operating license. In reviewing the information that was submitted back to this Committee, and after reading the Chair's A.B. 342—the hospital transparency act—I have realized that much of the reporting portion of my bill would work well within that bill. Assembly Bill 342 will be amended to become—assuming the Chair is in agreement—the Hospital Community Reinvestment and Transparency Act. While the reporting requirements are a very important element, I still want there to be a level of measurable accountability within the industry in Nevada.

[Assemblyman Perkins, continued.] Assembly Bill 322, as amended, would require hospitals to quantify the dollar value of their reinvestment in the community. I have been told from many sides that the hospitals already provide community benefits, but that it is difficult to get the word out about them. I applaud these efforts and firmly believe that hospitals should be recognized for their good work. This bill will provide a venue for hospitals to publicly share the reinvestment and charity work they do in their communities.

For those hospitals that are not benefiting their surrounding communities, there is an enforcement mechanism. To ensure that hospitals are investing in their communities, the Division of Health Care Financing and Policy will verify that the hospital's charity care and expenditures constitute at least 4 percent of its net operating revenue. If the Division finds that any major hospital does not meet that requirement, the Division will determine an appropriate fine.

Assembly Bill 322, as amended, also gives the Attorney General the power to investigate whether a major hospital is in compliance. We all want what is best for Nevada. We want the health and safety of Nevadans to come before the profitability of large out-of-state corporations. However, we also need hospital companies to continue to operate in Nevada and provide our residents with services. It is a delicate balance we are seeking, and I'm grateful for this Committee's willingness to take a hard look at this issue.

Chairwoman Leslie:
You said 4 percent would be the appropriate amount that a hospital should reinvest in the community. How did you come to that particular number?

Assemblyman Perkins:
In looking at the entire health care environment and looking at the percentage increases in Nevada—and those increases being at such a high level—it was my belief that we could then, in some fashion, by this reinvestment, lower the impact on Nevadans by a certain percentage. Taking the 4 percent off of the growth and the cost of health care, in essence, reduces the percentage increase to Nevadans.

As well, I'm a firm believer in the free market that our country is based upon. I think that hospitals should operate in as free a market as possible. Their ability to make profits should exist. This 4 percent threshold would not be too burdensome on the hospitals and, at the same time, requires them to be more connected to the local community.

Chairwoman Leslie:
I know in rural Nevada, they are struggling to keep some of their hospitals open. Do you have any information that shows whether this would be a burden to rural Nevada or how this would work in the rural areas?

Assemblyman Perkins:
I'm not nearly as concerned about reinvestment in rural Nevada. If it were the purview of this Committee and stood legal muster, I think rural Nevada could actually be carved out and we could do this in the two larger counties. It's been my experience—traveling throughout the state over the past few years—that rural hospitals have an extraordinary connection to their community. In those smaller communities, everybody knows everybody. The hospital administrator, doctors, and the health care professionals in those hospitals are known by everybody. With that kind of relationship, there is continual effort to have a connection, to reinvest, and to keep prices down. It's my experience that rural Nevadans wouldn't necessarily need this tool.

Chairwoman Leslie:
Once we have this in place, it will be interesting to see, because it might be just the opposite. It might be because those hospitals tend to be more locally owned and operated. We might find that the rural Nevada hospitals are actually investing more than the urban ones.

Can you tell us that statistic again? I want to make sure I didn't miss it; that was the one comparing Las Vegas to Reno in terms of the beds that are controlled by out-of-state corporations. I want to make sure we have that.

Assemblyman Perkins:
The statistics that I have are that 83 percent of the beds in Clark County are controlled by out-of-state corporations—both for-profit and not-for-profit. I didn't want to blur the line there. I believe in Washoe County, about 60 percent of the beds are locally controlled. That would mean only 40 percent of their beds are controlled out-of-state. The typical urban metropolitan area is about a 50/50 ratio.

Chairwoman Leslie:
The 50/50 ratio is what is normal in other states?

Assemblyman Perkins:
That's correct.

Chairwoman Leslie:
Did you look at rural Nevada?

Assemblyman Perkins:
I did not have an opportunity to look at rural Nevada.

Chairwoman Leslie:
I think we have our rural people here today; maybe they could tell us.

Assemblyman Horne:
In that area, you spoke about possible fines that may be given. Was there any discussion on the level of fines that there may be? Particularly with those statistics—you said with 80 percent controlled by out-of-state corporations—I kind of envision this absentee landlord that only sees what profits are coming out of there, and if it's not a big enough fine to catch their attention, it will just be the cost of doing business.

Assemblyman Perkins:
We have a very talented Division of Health Care Financing and Policy that regulates this industry in many fashions. The bill itself wouldn't create the specific fine. It would be created through regulation, as I envision it. I have total confidence in that Division to understand what level of fine would actually be a motivator or an influence on those types of business decisions.

Assemblywoman Angle:
I don't see throughout this mockup (Exhibit C) a definition of major hospitals. Could you give me a definition of what a major hospital is? I, like the Chairwoman, am a little bit concerned about rural Nevada. Even though that's the only hospital in the area, many of them are really on the edge of providing health care anyway.

Chairwoman Leslie:
If you look on page 4 of your binder of that excellent research document (Exhibit B), our staff put that in there. At the bottom in the footnote, it says "In Nevada, a major hospital is defined as a hospital with 200 or more licensed or approved beds." When Robin Keith comes up to testify, we can have her confirm that. My understanding is that all of the hospitals in rural Nevada are fewer than 200 beds. I think that answers your question, doesn't it?

Assemblywoman Angle:
That does. I wonder if we should put that definition in statute, or that's just in regulation.

Chairwoman Leslie:
Actually, in my bill, which is coming up next, you'll see it there.

Assemblyman Perkins:
If it pleases the Committee, it probably is helpful for our record for me just to run through the mockup (Exhibit C). I have a summary (Exhibit D) as well that I think describes it. Assembly Bill 322, as amended, would deal with the topic that Mrs. Angle just brought up. A major hospital is currently, as we define it, a hospital with more than 200 beds. I believe that your bill addresses that as well. Those hospitals will file a copy of their community benefit and charity care policies with the State Department of Human Resources. If the hospital is part of a larger national system, it shall file both its national policy, as well as a detailed and specific Nevada policy. It would file a copy of its policy for adherence to *Nevada Revised Statutes* (NRS) 439B.260— "Reduction of billed charges for certain patients and service; resolution of disputes"—with the Department of Human Resources.

It must demonstrate that the hospital's charity care expenditures, as reported to the Division of Health Care Financing and Policy, constitute at least 4 percent of its total operating revenue. If the Division of Health Care Financing and Policy finds that a major hospital does not meet the requirements as stated above, a fine shall be levied equal to the amount they were required to provide and the amount the major hospital actually provided. Perhaps that speaks directly to Mr. Horne's question.

The Attorney General may authorize an investigation to determine whether a major hospital is in compliance with this article. I think the mockup is very well put together, and a lot of the bill is stricken. Then, the two bills are kind of melded together.

It's not known by our citizens the logistical boundaries of bringing this to Las Vegas, and we're six days before a major deadline in Carson City. This is no small undertaking, but I think it's certainly important to the folks that are sitting behind me.

Chairwoman Leslie:
I'd like to proceed in explaining to you my bill. I have to clean up my summary, but I can also clean it up and have it for you by Monday. I have my notes. I don't have a nice clean copy like the Speaker does, but I will also provide it to the Committee.

Assembly Bill 342: Makes various changes concerning reporting of sentinel events by certain medical facilities, audits of hospitals and reporting of financial information by hospitals. (BDR 40-1163)

Assemblywoman Sheila Leslie, Assembly District No. 27, Washoe County:
This is the mockup (Exhibit E) of A.B. 342. The first thing I've added, as the Speaker referenced, is the reporting requirement that was in his original A.B. 322, it seemed to fit better in this document. The new title is the Nevada Hospital Reinvestment and Transparency Act. I also stole some of the preamble from the Speaker's bill that I liked. I'll read this into the record so people listening on the Internet can also hear it. It says, "Whereas the Legislature finds that access to health care services is a vital concern to the people of this state, the Legislature further finds that hospitals play an important role in providing essential health care services in the communities they serve. In addition, hospitals have become a dominant force affecting the provision of health care. The Legislature therefore also finds that hospitals play an important role in providing essential health care services in the communities they serve." I'd like to add that. In Section 1, you'll see mention of the sentinel events registry data.

The sentinel events registry has been put into place and is slowly starting to gather the data. What we were not able to get from the Legislature was sufficient funds to send the data to an outside health quality assurance company to analyze it and tell us what the data means. Are there places where we need to improve in Nevada to decrease hospital errors? All that Section 1 does is it allows the State to accept donated private or public funds to allow for this analysis to be done.

It also allows for the reports to be open to public inspection. It does say that the information will be aggregated so as not to reveal the identity of a specific person. No one's personal information will be revealed. I'm suggesting we take out "medical facility" also. It's important for people to be able to see where the errors are happening from a consumer perspective.

In Section 2, I'm going to suggest to the Committee that we consider changing the definition that is currently in state law of a major hospital having 200 beds. I'm going to suggest we lower that to 100 beds. I've been told that one of the hospitals here in the Las Vegas area has 199 beds, and one has 198 beds. I think we're seeing that some hospitals are trying to get under that 200-bed threshold so they don't have to comply with the audit requirements. I've been told—and we can see what our rural hospital folks say—that none of the rural hospitals actually go over 100 beds. This should not capture rural Nevada. I think we need to start looking at a major hospital being 100 beds or more. That's all that you find in Section 2.

[Assemblywoman Leslie, continued.] In Section 3, you'll see that we've made some changes in the audit requirement. Again, instead of having to have an audit for hospitals that are 200 beds or more, you would have to have an audit if you have 100 beds or more. This should help our State staff be able to analyze the data and make better comparisons across hospitals.

Section 4 has a number of changes. This is what I would call the data collection section. We discovered in doing the research that the hospitals are now submitting some reports to the State that the State isn't using, primarily the operating budget report. Why are we having the hospitals submit reams and reams of material that is not really useful to us in determining hospital costs? Hopefully, this will make the hospitals happy. I'm going to suggest that we delete the requirement, and that they submit their capital improvement budgets instead.

You'll see, in subsection 1(c), I'm adding in a requirement that they submit their capital improvement budget. I think that's how we can tell better where the hospitals are going. In Reno, I drove down recently to my health provider's hospital—Saint Mary's—and I could not believe the buildings going up there. There are huge buildings right by the freeway, and I have no idea what they're going to be using those buildings for. In Las Vegas, I understand that every time you turn around there are more buildings and more hospitals. I think it would be more useful for us to have the capital improvement budget so that we can understand what services the health care industry is planning to provide and where they're going.

I do want to point out to the Committee that I did make a mistake in the middle of the page. In one of the red underlines—it's actually in Section 4, subsection 1(c), line 13, where I say the "operating budget shall be filed within 30 days"—that should be the "capital improvements budget." Everywhere it says "operating budget" it should be "capital improvements." Please cross that out. When we take this bill up in work session next week, we'll have a corrected copy for you to see.

Subsection 2(a) requires a new report from the hospitals explaining the profit distribution among hospitals within the system. We heard from our research staff how that information is currently not available to us. In subsection 2(b), we add a requirement for hospitals to file their home office allocation policy with the State. We've heard before in our hearings that out-of-state corporations who operate hospitals in our state have obligations and assessments; the Las Vegas hospitals, for example, need to report back and send money back to their home office in order to pay for things like IT [information technology], human resource management, and that type of thing.

We just need to find it. All of the data collection section is designed to allow sunshine into the system. Let's see it so we know. How much is going back to the home office, and what is that money being used for? We know they have obligations; we just want to better understand them.

[Assemblywoman Leslie, continued.] In Section 4, subsection 2(c), there's an additional requirement. This came from the Speaker of the filing of their community benefits plan. There's no doubt in my mind that hospitals do reinvest in their communities at a certain level. We just don't know how much. If we have them file the same sort of plan, then we'll have a better idea of what's going on.

Section 5 is the new reporting section. As we heard from Ms. Dimmitt earlier, the Legislative Committee on Health Care was originally set up to work on hospital cost-containment language. That's when it was established. That's what it's for. I think that over the years, as the cost-containment provisions have been eroded, the health committee has lost that focus. In Section 5, I'm trying to bring a focus back by having some specific things for the Legislative Committee on Health Care to review. We changed the report date to October 1. This will allow the Committee almost the entire interim to review the information. The new reporting requirements to the Legislative Committee on Health Care are:

- Subsection 2(a) has an analysis of the profitability of hospitals.
- Subsection 2(b) is a summary of the most recent audit reports results.
- Subsection 2(c) also has an analysis of how profits are allocated among hospitals in the system.
- Subsection 2(d) has an analysis of the new capital expenditure budgets. This is so that the budgets' effect on health care access and affordability can be examined.
- Subsection 2(e) adds an analysis of the home policies.
- Subsection 2(f) adds an analysis of the community reinvestment policies.
- Subsection 2(g) adds a review and analysis of the standardization across reporting, so the interim committee can recommend report formatting if necessary.

We need to keep going on this, and as things change over the years, we need to understand it and then adjust our reporting mechanisms as necessary.

In subsection 3, we direct the Committee to do a comprehensive community-needs assessment based on the data collected. I feel strongly that these are not onerous requirements that we're putting on hospitals. This is information that they already have. We get rid of information we're not using and that is not useful—the operating budget. Instead, we ask for some specific

information—in standardized ways—that will allow our State staff to analyze that information and report it back to the Legislative Committee on Health Care so they can fulfill their obligation to recommend back to the full Legislature any changes we need.

Assemblywoman Angle:
I'm concerned about the major hospitals being back down to 100 beds. I'm wondering if we could be provided with a list of hospitals that this would affect. How many hospitals would fall within that 100-or-above range? I would like to see how this is going to affect the budgets of hospitals—especially rural hospitals—that fall within that range.

Chairwoman Leslie:
We'll get that information for you.

Andy Brignone, Legislative Advocate, representing Health Services Coalition, Las Vegas, Nevada:
I'm here today to speak in favor of A.B. 342 and A.B. 322. The magnitude and importance of these bills, and the issues that we'll be discussing today, is reflected in the standing-room only assembly of working families behind me. For every one of them, there are thousands upon thousands of others who are vitally interested in this subject and are equally impacted by rising health care costs.

These bills require and promote transparency of financial information, including pricing in a consistent, coherent, and complete manner for Nevada consumers of hospital care and the public in general. I was particularly alert to Mrs. Dimmitt's remarks about the difficulty of assessing data and analyzing the data, especially from the experts that the State has to do so. If the experienced experts can't figure it out, then we have some serious gaps and holes that we need to fill in order for us to make progress in this vital area.

These bills also promote verification and accountability, and substantially contribute to good planning and effective utilization of what is essentially a very important public resource hospital care. For Speaker Perkins, it promotes accountability for community investment of this very important public asset. The Nevada Legislature has a long history of requiring transparency and disclosure of information important to the public and Nevada consumers. The Nevada statutes are filled with examples of required disclosure of pricing and financial information.

The Nevada statutes currently require disclosure and reporting for:

- check cashing

- credit reporting
- personal property leases
- mortgage lending
- mobile homes
- hospital charges
- discount buyer clubs
- phone solicitors
- motor carriers
- door-to-door sales
- travel agencies
- swimming pools
- tinted windows
- dance lessons

[Andy Brignone, continued.] When you have your car repaired, you have a right to receive itemized pricing before you agree to the service. If it's important enough to require advanced disclosure of pricing when you have your car body repaired, then it should be important enough to require hospitals to disclose pricing when you go to a hospital to have your human body repaired.

There's precedent in the medical area to require advanced disclosure of pricing information. Every pharmacist has to post—at the pharmacy—a notice that customers have a right to a price list of all drugs and professional services. The Nevada Legislature did that 25 years ago.

All we're asking you today is to do the same thing in the area of hospitals, a far more expensive and complicated area. There are two areas of aspects of reporting disclosure and transparency. The first is their importance to the Coalition, which facilitates the hospital care of one-third of the insured population in southern Nevada. It's important to remember that the Coalition not only includes tens of thousands of Nevada employees, but it also includes Nevada's largest and most prominent employers. It is also important to remember that private health care, including hospital care, is provided directly or indirectly primarily by Nevada's employers. Nevada's businesses, who provide the health care, provide the coverage, buy the insurance, and pay the bills, have a right to know what they're buying and what it costs. A fringe benefit for an employee is not a benefit at all unless you can see what it is and see what it costs.

As you know, the Coalition recently finished arduous, difficult, and bruising negotiations for our current hospital contracts. Our actual experiences in these negotiations support these bills and support required reporting disclosure and

transparency on a consistent, coherent, and complete basis. We began these negotiations many months before these contracts expired. We told the hospitals up front that the Coalition's negotiating platform was transparency. We told them that if, for example, they have a cost that has increased, tell us what it is, show it to us, let us verify it, and we would work with them to make sure that that cost is taken into account in the pricing of our new contracts. We want the hospitals to be successful. We want them to be profitable, but we don't want them to break the backs of Nevada's businesses and Nevada's employees.

[Andy Brignone, continued.] The Coalition promised and we asked the hospitals to promise us transparency. Let me give you some examples of what their view of voluntary transparency was: first, one hospital—who we negotiated with—said, "We want double-digit price increases to cover our costs. We're losing money on you." We said, "Fine, prove it to us." They weren't willing to go there. They said, "Trust us; we're losing money on you."

We went back to the drawing board and we did a little bit of independent research, and we discovered that this particular institution's operating costs were higher than 98 percent of their peers in the country. In other words, this hospital's operating cost put it in the top 2 percent of the 5,000 hospitals in the country.

We presented this fact to the hospital and asked them to address it with us, because, after all, they said they were losing money on us. Part of losing money, of course, is our cost structure. We tried to engage them on it. They essentially blew us off, said, "It's none of your business," and that was it for months.

When they were finally pressed to address it, they said, "We have higher costs because we deliver higher quality." Not wanting to trust them again, we went back and independently attempted to investigate that assertion. We discovered in our review of independent data of quality measures that this hospital had a higher complication rate than its peers—complication rates, of course, being a measure of quality.

There's one example of the failure of voluntary transparency. Another hospital—a different hospital—also sought even higher double-digit increases in prices. They based it on their diminishing profits on our book of business, and in fact gave us information that their profits modestly were in the single digit range, very modest.

We investigated that as well. Actually, we had a bit of luck, because this hospital accidentally sent us some sensitive internal information, which revealed

that in fact their profit margin on their overall book of business was well into the double digits—and I mean beyond the teens—not modestly in the single digits.

[Andy Brignone, continued.] Then, we learned that this hospital had sent tens of millions of dollars back to its home office as a home office allocation. So, what ordinary people would consider a multi-million dollar profit, in the hospital accounting world, became a multi-million dollar expense. Again, so much for voluntary transparency. We've tried it and it doesn't work. Voluntary transparency is akin to asking the fox to keep an inventory of the hen house. The fox is only going to tell you what's in the fox's best interests. And you must assume that it won't include all the chickens.

How can Nevada businesses and employees accept and pay huge price increases without financial information to see how these price increases are determined? How can other groups evaluate the community investment of this very important public asset? If a hospital reports modest or declining profits, we need to know how much profit is being relabeled as a home office allocation expense, with tens of millions of dollars being sent out of state. The key to the profitability puzzle is transparency of financial information, including billed charges, on a consistent, coherent, and complete basis.

The second aspect of these bills that I would like to discuss with you is the public dimension, the public aspect. Health care, including hospital care, is different than just about any other type of service or commodity you buy. It's different than tinting your windows. It's different than dance lessons; you buy health care not because it's a convenience or a luxury, but because it's a necessity. You access health care when you need it, not when you just want it. And in many cases, especially for hospital emergency care, you don't even get a choice about where you get that care. Even if you're conscious when the ambulance picks you up, you could get diverted to another hospital because of the overcrowding in the emergency rooms and the lack of beds there.

A consequence of a lack of consistent, coherent, and complete disclosure in reporting and transparency is poor planning—if it exists at all—and poor results. We have several living, breathing examples right here in southern Nevada. First, we have a new trauma center. We needed a new trauma center. Unfortunately, that trauma center is located very close to the existing trauma center. So while our population is growing and stretching to the perimeters of Clark County—north, south, east, and west—a trauma center is placed right near the existing trauma center. There's not one on the north end. There's not one on the south end. This is just poor planning.

[Andy Brignone, continued.] Second, we have a burgeoning population in the northeast part of town. There's not one hospital in that area to service those needs—poor planning. However, we do have two hospitals, and another being built very close by, virtually shoulder to shoulder, in the south end of town—poor planning. And as we have read in the press—at least over the last year, and it's certainly been going on a lot longer than that—we have a total lack of mental health care planning to deal with the burgeoning mental health care problem in southern Nevada. Again, this is poor planning.

Reporting and disclosure of financial information that is consistent, coherent, and complete is the first step in good planning for health care in Nevada. So, the Health Services Coalition endorses and supports these bills, and we hope you will too.

Chairwoman Leslie:
Just to reiterate, you do represent 300,000 people in Clark County; is that correct?

Andy Brignone:
Yes.

Assemblyman Mabey:
I don't know if you can compare a car to a body. I know you used that analogy. I work in hospitals; I deliver thousands of babies, operate on thousands of people, and I appreciate there's a concern with costs in the hospital, but I just don't see how you can compare the two.

In my experiences with most managed care companies, they don't really go off a billed charge. You hear examples that an aspirin costs $50 or an aspirin costs $20. Most managed care companies pay a per diem rate with some adjustments to that. If a patient comes in, and they're there a day, then the hospital is going to get a set rate, whether they did three procedures on that patient, or whether they did a CAT [computed axial tomography] scan or an ultrasound, they're going to get paid that one package rate. Most people aren't affected by this itemized thing. I hear it all the time that this hospital charged $42 for something. Well, unless they were self-pay, then most of my experience is that they would accept the cash payment. I have patients when they needed to be delivered. I say, “Go to the hospital, talk to the hospital, and see what they'll do.” They got a great rate. They'd say that if you pay a thousand dollars, we'll take care of your whole prenatal care visit, delivery, or your postpartum care and you'll be able to go home. They were right up front with them. I didn't really see that there was a problem.

[Assemblyman Mabey, continued.] Then, what happens with the indigent patient? Are you going to ask them if they are going to pay up front? No. The hospitals take them. They provide all of their care, whether they are there a day, week, or a month. I know patients that are in the hospital for an extended period of time. The hospital can't divert those. It's a dumping rule.

Do they do this in other states? Do they have these types of laws like this bill here?

Andy Brignone:
The short answer to your question is that it is difficult to see what the pattern is in other states, because there's such a hopscotch of legislation and reporting requirements in other states. I think Ms. Dimmitt's remarks reflected that. Some do, and some don't. There's a lot of pending legislation, but there really isn't any uniformity or consistency.

Assemblyman Mabey:
Okay. As far as the trauma center, is it wrong for a hospital if they want to try and put a trauma center in a certain place or build a hospital in certain places? Do you feel that shouldn't happen?

Andy Brignone:
I'm not saying that trauma center was not in the best private interests of the institution that built it. I was addressing the public interest in where resources ought to be allocated in our community.

Assemblyman Horne:
In the area of listing costs, procedures, and so on, wouldn't that place hospitals at risk of detrimental losses? Let's say in 2004, a hospital does 100 appendectomies and 30 of those are indigent care, so they eat that. The next year they do 100 as well, but 45 are due to indigent care, they have to eat that. Let's say the increase of the 45, like we saw during the recession here—because people lost their jobs, they lost their health care—it was a greater burden on the hospitals. Now, if we have it in this system where you have to give a fixed list—this costs this much, this is going to be this much, and they're bound to that—it makes it that much more difficult for them to recoup those losses.

Andy Brignone:
I appreciate what you're saying. First of all, they already do that in what's called a “charge master.” They already list all the costs. There's nothing in these bills that would prevent them from adjusting or changing the charge

master. They do change them at least annually, sometimes more often than that. All we're asking is that it be disclosed.

[Andy Brignone, continued.] The other point I would make about billed charges is that the goal of most managed care organizations is to have fixed-pricing per diems. The goal of the hospitals is to have billed charges, or more accurately, a percentage of billed charges. That's why billed charges are important. In our current hospital contracts, we do have areas where the pricing is a percentage of billed charges. It's not all fixed pricing or per diems.

Assemblyman Horne:
It's your understanding that that list already exists.

Chairwoman Leslie:
The charge master exists. Interestingly enough, we'll have this bill on Monday. The charge master, as I understand it under cost-containment, used to be provided to the State. That provision became eroded over the years and is no longer provided. I had a conversation last week with the Office of the Consumer Health Assistance. They really want that back, because it makes it impossible to really look at somebody's bill and see if they were overcharged or not without that basic information. That is in the bill we'll have on Monday, not in this bill. I think the point that I got from your testimony is that right now, we have voluntary transparency. Assembly Bill 342 changes that to an obligatory transparency of information. That is already collected, but it's not shared in a consistent, open fashion. Some of this used to be shared under cost-containment.

Andy Brignone:
That's correct.

Assemblyman Horne:
In southern Nevada, some hospitals are providing this transparency voluntarily, and if so, are you satisfied with the level of transparency those hospitals that are playing nice?

Andy Brignone:
I'm not entirely sure we can characterize it as “playing nice.” Their view of transparency, as my testimony reflected, is quite different than our view of transparency. Transparency that comes from data that they amass themselves may be a transparency, but the data may not be reliable. We would like to see the very competent, qualified experts so that the State—the people who already exist in analyzing this data—can have enough complete data for them to do their job well.

Assemblyman Horne:
When you go and buy a new car, there's a whole lot of information that we'd like to know about the dealer and what they initially paid for that car. I'm sure a lot of dealerships would be crazy if we were to have full disclosure of that information. I know I'd be better off in my car purchases. They want to make a profit, they want to hold something back, and hopefully they can get a bigger chunk in the end. If we had full disclosure at the hospitals, would we be putting them in a bind as well?

Andy Brignone:
Let me clarify my point about car bodies and human bodies. My point was only that if it's important enough for the Nevada Legislature to require disclosure when you have your car be fixed, why isn't it enough for the Nevada Legislature to require disclosure when you have your body fixed? That was the point.

The second point that I would make about buying a new car, with a little different subject, you can get that information. You can get that information from *Consumer Reports*. In our arena, you can't get that information from any other source. We've tried and the State has tried. As Ms. Dimmitt indicated in her remarks, it's very difficult, if not impossible, to get complete, coherent, and consistent information.

Cynthia Kaiser-Murphy, Senior Vice President of Human Resources, MGM Mirage, Las Vegas, Nevada:
I've been with MGM Mirage for 13 years, and in the capacity of being responsible for human resources, I oversee a wide range of the programs and benefits for our 40,000 employees. Over 35,000 of them are in southern Nevada. They live and work here. We are one of the state's largest purchasers of health care. There is no MGM Mirage program that is more important to our employees or to our company than our health benefits program. Last year alone, we spent $76 million on health care for our Las Vegas employees and their families.

In addition to that, we provided almost $75 million into Taft-Hartley [Labor-Management Relations Act of 1947] employer contribution health and welfare funds on behalf of our employees. In total, we spent over $151 million in health care for our people. That is more than any other private employer in the state of Nevada. As you may be aware, our company is quite likely to grow, and that number will significantly grow as well.

A significant portion of the $151 million is spent on hospitals. Of the $76,000 that we spent for our company-sponsored plan, we spent over $14.5 million last year to pay hospital bills. We are, therefore, deeply concerned about the cost

and quality issues related to both A.B. 342 and A.B. 322, which are being discussed this morning. In addition to my capacity with MGM Mirage and the Health Services Coalition, I also serve as a management trustee for the Health and Welfare Fund, which is supported by the contribution from employers for nearly 50,000 culinary members in Las Vegas. The culinary fund paid over $41.5 million to local hospitals for inpatient care and an additional $17.7 million for outpatient care last year.

[Cynthia Kaiser-Murphy, continued.] Those amounts do not include the doctors, our medicine, and other costs. With those numbers that are already staggering, we are experiencing double-digit increases for hospitals in the renewals and what they were asking for.

The health care costs for our company—and literally all the other companies—are increasing faster than any other expense in order to do business, and certainly, all of us are experiencing that crisis. That is why we're sitting here today. As your other speakers have made very clear, the task of negotiating hospital rates is challenging and very difficult. Quite frankly, we find a small number of people that really understand it and take the time to understand it, because it is so complex. For people running businesses, to take the time to learn and understand about all the intricacies of hospital contracting is certainly a large challenge.

The purchasing of health care services in general is not subject to the free market rules, where prices are set by arm's-length bargaining between a willing buyer and a willing seller. The role of the hospital in our local economy here in southern Nevada, is much more like that of a public utility or another quasi-monopolistic provider. Many times, as we've known with the growth in this community, demand has exceeded supply and our hospitals have been full or nearly full.

Large employers, such as MGM Mirage, are forced to contract with the local multiple hospitals. Both from a geographic and from a demand perspective, the need is quite great. We have limited choices about who we buy from. We are forced to pay the pricing that we're able to negotiate with these entities, and we really are in a need-to-buy situation. The recent crisis with the negotiations—where we were at risk of losing some of the hospitals—really represents a crisis and a risk for our families.

We recognize that hospitals, particularly for-profit hospitals—and of course we have many more for-profit hospitals here than we do not-for-profit—are clearly in the business to make money. We also know that hospitals, like other businesses, experience cost increases. One of the principal difficulties in trying

to negotiate these reasonable rate increases with the local hospitals has been the lack of reliable information, in formats we can actually get a hold of and use it. We don't know about the true costs, profits, and quality outcomes without a laborious exercise of going through, pulling reports, and trying to compare unlike data for those businesses. These problems are not unique to my company or to our industry. Countless other large and small businesses here in southern Nevada face these challenges, just in different scales and perhaps with different resources. We're fortunate to be a large enough company to have some resources dedicated to working on the problem.

[Cynthia Kaiser-Murphy, continued.]Every employer in this community is challenged with maintaining affordable health care. This year, as in the past, MGM Mirage heavily supported and remained an active part of the Coalition of Employers—as previously mentioned, over 300,000 members, including the family members. In our opinion, the ability to achieve a fair result in the negotiations really—on a go-forward basis, in the future—depends on our access to reliable financial information, as well as quality information.

For example, when we talked about the true costs incurred by hospitals, we determine a hospital's operating efficiency as compared to their peers. Are they asking patients to subsidize wasteful practices or inefficiency? What are the charges imposed by parent corporations? This was a huge topic in our last negotiations, based on what others in the state are reporting and the real profits reported to the State of Nevada. It's been a significant challenge to figure that out. Those are just a couple of examples of the type of information that's been discussed by other speakers as well.

We strongly believe that the hospitals are certainly entitled to a fair and reasonable profit. But we are in a situation where we have a lack of free market forces to ensure a fair result. We believe that it is essential the State require as much information as possible to be made available to the public, and to allow meaningful and productive negotiations.

There was a discussion earlier about other states, and when we were in the negotiations, we were actually looking at other states from time to time to try to do comparisons. Obviously, California has greater disclosure. We also know that Wisconsin has launched an excellent website that might be of some interest to the research staff. On the Wisconsin website, they allow hospital comparisons on cost, type of service, how much uncompensated care is provided, and what care is commonly provided at each facility. The basic information is available for consumers and businesses to use.

[Cynthia Kaiser-Murphy, continued.]Many of today's comments have focused on the cost issue. Certainly, the cost and quality issues are now interwoven. A major focus for our Health Services Coalition has been not only on affordable care, but on access to quality. That's the bottom line. You don't want to pay a lower price per service for something that's not a quality outcome. Numerous studies verified that getting good care when you need it is the most cost-efficient way to receive health care.

Then, like in the previously mentioned discussions, it's been very difficult to also get quality information on comparisons among hospitals in Nevada. The new state sentinel events registry—which I understand is collecting data on a variety of health care facilities, including the hospitals—is certainly a start. But, it only involves reporting hospital problems, and it only allows reporting to be aggregated, we learn virtually nothing about the individual hospital performance when we're in our contracting process.

Nonetheless, it's a great starting point. We would expect, at the very least, the ability to compare hospitals to each other when we're making important decisions about contracting for the services of our people. The bills before you today require the sentinel events data become accessible by hospitals to allow for these comparisons.

In summary, we applaud your efforts. At MGM Mirage, we will certainly work with all interested parties to find solutions to the many challenges with health care, and we appreciate the opportunity to be before you today.

Chairwoman Leslie:
It's important to have your perspective as well. You probably understand a whole lot more about profits than most of us. Do you think that we've achieved the right balance in this bill—speaking from a business perspective—of the requirements for the hospitals, in terms of reporting their profits and the other new information that we're requesting? I understand you've testified that there's a need for it. Do you think it's fair?

Cynthia Kaiser-Murphy:
We believe it is.

Assemblyman Mabey:
My understanding with MGM is that you'll have through the culinary; some of your workers use the culinary, but you have another half. For example, you wouldn't be under the culinary insurance, but probably through a managed care company; is that true?

Cynthia Kaiser-Murphy:
We're self-insured and we have an employer-sponsored plan. I participate in that plan.

Assemblyman Mabey:
That would go through, for example, Nevada Care or Sierra Health and Life?

Cynthia Kaiser-Murphy:
We actually contract and put the pieces of our plan together, because we're a large enough employer to do that. We don't buy through a managed care company. We will rent networks. Our networks are separate from the hospital contract, and we've chosen to work actively in the Coalition for that purpose.

Assemblyman Mabey:
Okay. I know that some companies have to work through a managed care company, and I am wondering if they ought to be in this loop too. We're asking the hospitals to show their profits and how much they make, but my experience is that my premiums have gone up, as a provider of care, over the past years. I know, as a physician, my payments have been pretty much the same over the past year. There have been very small increases over the years. I see that the managed care companies continue to do quite well. I just wonder if, when you or a person contracts with a managed care company, who then works with the hospital, they're making what looks like a good living. Perhaps we should look at that part of the equation, too.

Cynthia Kaiser-Murphy:
Although the specific example you're suggesting does not apply in our particular situation—largely because we are a big employer—I would think that the managed care companies would have a great interest in this as well. This is because they are also burdened with going out to negotiate with the hospital companies. One of the reasons why providers aren't able to have increases that perhaps are deserved is because so much money is going into the hospital system every year. It has been outrageous, and I can certainly understand your concerns about provider reimbursements.

David F. Kallas, Executive Director, Las Vegas Police Protective Association (LVPPA) Metro, Inc, Las Vegas, Nevada:
Having spent the last couple of months up in Carson City on issues relative to our organization, this is probably the second-most important issue from our perspective. Certainly, there are issues, but I think this issue is as important as any issue that the Legislature is going to deal with this session. It doesn't only impact the 320,000 people that participate in the Health Services Coalition—as

our organization does, and as most of the people that are sitting behind me do—but it impacts every single person in one way or another in the state of Nevada.

[David Kallas, continued.] Sometime or another, somebody is going to need some form of health care, whether it's through an individual provider, such as a doctor or to a hospital. It's going to impact them. We need to find a solution. I know over the last several years, sitting in as trustee in our organization, there isn't a time that has gone by when one of our consultants hasn't said to us that when we're looking forward as to what our costs are going to be, we can expect a 10, 12, or 15 percent increase in all of our costs. Our first question is: How are we going to pay for it? Are we going to increase the cost of contributions that our own employees who participate make? Are we going to have to reevaluate our plan and make modifications to benefits?

These are benefits that these people should be entitled to receive. I'm not just talking about the public safety people—not just police and fire—but I'm talking about the people that have built this community; our concrete workers, masons, carpenters, electricians, plumbers, pipefitters, culinary workers, food servers, bartenders, teachers, public safety officials, police officers, and firefighters. We can't continue to go down the same road we've been going down the last few years. Every time this hospital service issue comes up—every three years—it becomes problematic for everybody, not just the 320,000 of us that participate in that Coalition, but for every single person that resides in this state—man, woman, and child. We need to collectively find a solution. Nobody is begrudging, and nobody would ever begrudge, any business from making a profit, but what we have to say is: there has to be some accountability, there has to be some reasonableness to what they make, and eventually, we have to say that enough is enough.

Certainly, we've talked about it before, and statistics could be made to look like anything you want it to look like. It just depends on who is giving you the statistics. Certainly, they want to do it so they can profit, a position they're looking at. I happened to read a comment in the *Las Vegas Sun*, and trust me, I'm not one person. I'm not a person that believes everything they read. I certainly have been misquoted on many occasions and probably will continue to be. There was a statement made that was attributed to one of the representatives of the hospital, Mr. [Bill] Welch [President, Nevada Hospital Association], talking about the fact that in Nevada, because of the amount of people that are on Medicare and the amount of uninsured, that they've only made 1.8 to 2.2 percent profit in this state, where the national average is 3.3 percent.

[David Kallas, continued.] Recently, as I think was touched upon by Mr. Brignone, one of our local hospitals lobbied and received permission to build a new trauma center. I don't think any of us can sit here and think that the people that made the decision to want to put that trauma center in—the decision to want to go ahead and request that it be put in—didn't sit down and think, "How much money are we going to make if we put that trauma center on Maryland Parkway?" Not necessarily what type of services we can provide—and I'm not saying that wasn't a subject of conversation during those discussions—but certainly, if it wasn't going to be profitable, they never would have even considered it.

We're asking for people to do more than just consider how much money you're going to make. Consider what happens to us when you continue year after year to raise your costs. I don't think anybody sitting at this table or behind me has had their salaries increase 10, 12, or 15 percent year after year over the last 5, 10, 15, or 20 years. We've all talked about what the issue is, but nobody has really come up and said what the solution is going to be. As I sit here today, we certainly are in support of A.B. 322, A.B. 342, and the intent that both bills provide regarding hospitals, care, and giving back to our community. The Legislature has grappled with part of the solution for the last several months, in the form of the issue that came up with the property taxes.

We had our residents in an uproar since last year, with the 20 to 28 percent potential increase in the property taxes. This Body took that issue on, and after much time, debate, and conversation, they came up with a solution. As I sit here today, I think you've already laid the foundation as to what the solution to this potential hospital issue could be and what our health services solution could be too. It's no different than the property tax issue. We need to allow people to make money. We need to be able to provide services, but we need to know when to say that enough is enough and let these other groups know in the hospital and health service provider field that we need to put some sort of containment in, just as we did with our property taxes. I would ask this Body to evaluate that and potentially come up with that as part of the solution.

Chairwoman Leslie:
I think you made some excellent points, one being that this is a statewide problem. Being from Reno, I appreciate that. It's not just happening in Las Vegas; it's a major issue with contract negotiations all over the state. God forbid you're an uninsured person and have to pay the billed charges. It's a real problem.

When we have the hospital people up here, I want to ask them about the other issue you laid out very well, I think, which is whether profits really are as low as

they appear to be when you mesh all the data together, and you can't really tell, because you don't know how much UMC [University Medical Center] is involved in all that. If the profits are really that low, how can they justify the huge capital expenses that we're seeing in Las Vegas and in Reno? Those buildings I saw when I went downtown—usually you get a return on your investment for capital expenses. If the profits are this low, how can they be doing that? We'll ask them about that relationship when they come up in a few minutes.

Assemblywoman Pierce:
If the profits were so low, what would be the point in making those capital improvements? Why do you invest in a community where you're making such small profits? That's the other part of the puzzle that doesn't make sense.

Pam Coombes, Private Citizen, Las Vegas, Nevada:
Little did I know when I made a 911 call in August of 1999 that it would basically destroy our lives. My husband had a heart attack, and I called an ambulance. They stabilized him on the floor of our house at that time, and then they transported him to the hospital. I did not accompany him in the ambulance. I drove my car. When I went into the hospital, my first thing was the welfare of my husband. I wanted to know if he was alive and where he was. They shoved a lot of paperwork in front of me. I didn't take the time to read it, of course, and that signed paperwork has basically destroyed our lives.

We were not insured. Several years later, what money we did have in our bank account—both savings and checking—were taken without our knowledge. Our house payment and everything, of course, bounced. We didn't have a dime to our name. We borrowed money. We lived on a couple of credit cards until I could get money out of a 401(k) that I had, only to find out that the hospital behind it had taken our money.

Frank "Ric" Coombes, Private Citizen, Las Vegas, Nevada:
We were told by a certain person at this hospital that they wanted $1,000 per month. We could not pay $1,000 per month. My wife sent him $100 per month. I was unemployed. I had a heart attack. We did not have insurance. She sent three payments in, and she had the third payment sent back, with a note from this person that they would not accept $100 per month, and that they want $1,000 per month or they will send it over to collections, which they did. They put a lien on my house. They completely cleaned out our bank account and took everything. I've had five heart attacks, I have three stints in, and I'm an over-the-road truck driver. I had one stint put in while in Louisiana, one in Illinois, and one in Wyoming. All of these hospitals worked with us. I'm a working man, and they took what they could. Why couldn't this hospital work

with us and take what we could afford to pay, instead of putting a lien on our house and taking our money out of our bank?

Pam Coombes:
That's a brief summary (Exhibit F) of our situation with the one hospital that he was transferred to; the first hospital could not meet his needs. He was transferred by ambulance, 36 hours later, to another hospital who did meet with us and who did take the payments that we could make. They have never harassed us and have never made a phone call to us. For that, I thank the system. But somewhere down the line something has to be done for those who can't be insured. He had a prior heart attack, so he was not insurable. I was insured. Our son that was living with us at the time had insurance. But he was not able to get insurance because of his prior heart history. We were at the mercy of the physicians and the hospitals at that time. We didn't have very good treatment on that situation.

Chairwoman Leslie:
We appreciate you coming down. I know it's very difficult to tell such a private story in public like this, with the cameras flashing. I thank you for that. It's important for the Committee to keep people like you in mind, as we move forward with these important public policy decisions, because they affect real people like you.

I can tell you on Monday, we're taking up a bill on debt collection policies. We will keep your testimony in mind as we move through that. The uninsured problem, when you have an illness like that—a serious heart attack—and then you become uninsurable is such a huge problem. It's such a huge hole in our health care system nationally. I don't have a good answer for you on how we deal with that. I do recognize that problem. You end up being one of those uninsured people—through no fault of your own, except you happened to have a heart attack—and that's completely unfair. I'm very sorry that our system isn't set up better for you.

Assemblywoman Pierce:
I just wanted to thank you for coming down and telling us your story. It's frightening for all of us to contemplate not being able to get health care and having what happened to you happen to us. I think that it once again illustrates that so many of the decisions Americans are making these days just have to do with health care—for example, where you work, and should you stay at a job you don't want because you have health care and you can't go to another job. As the Chairwoman said, this is a huge national problem. I hope we're making some progress on it.

Jim Wadhams, Legislative Advocate, representing Nevada Hospital Association:
Technically, I have to appear in opposition. The opposition is based upon the two bills as introduced and printed. I note they're very high bill draft numbers, so I suspect that these were in their original drafting—the part of that rush trying to beat the deadlines—and so I respect that. I also notice that the mockups make substantial changes, which I think corroborates my suspicion that maybe they were drafted very quickly. We are opposed to a variety of specifics in the bill, and I won't waste this Committee's time talking about that, because you're going to go into work session on these.

Chairwoman Leslie:
I think that if you have specific concerns, we would like to hear them today so that when we do go into work session—it's my intent with work session next week not to be taking a lot more testimony; we have a lot of bills to get through—so we would appreciate you laying them out quickly. I realize this is probably the first time you've seen these today. If you want to get back to us with your suggestions in writing on Monday, that's fine. But please, for the record, do mention where your concerns are.

Jim Wadhams:
Let me start with at least the top-line concerns. First of all, I think a lot of this information is available. I think it may be correct that it is time to rearrange how it is collected so that it is brought together. I think there has been a misperception as a result of the Enron scandal, and Congress adopted the Sarbanes-Oxley [Act of 2002] law, which is a tremendous burden on publicly traded corporations—all of our publicly traded corporations, from the biggest gaming establishments to the smallest publicly traded hospitals. There is credibility in data; the question is that we have to have the resources to bring it into a place where it may be accessible. We are committed to working with this Committee and any counterpart committee of the other House to do that. We really commend the attention to this. We heard several comments, particularly your comment on the sentinel event registry, which both you and I were there at 3:00 a.m.—although you were doing work and I was just supervising the others. That really raises a point I want to make very clearly here on the record: we have to address the public funding needs for a wide range of projects, including the sentinel event registry, as well as other areas.

The unmet needs in this community have to be addressed and the legislative will has to be exercised to do so. Planning where facilities go should be done on a statewide basis, obviously must incorporate the counties who have the zoning control over what can be placed where, so that the public planning process, which is identified by Mr. Brignone and the Chairwoman, is a critical component of this exercise. I'm sorry the audience left, but I suspect that virtually all of

them were fully insured, which I think is a tremendous expression of interest in the cost-shifting potential that goes on with the original drafting of some of these bills. We must be very careful that we are at least making a conscious public policy decision about the shifting of public care to private payers—whether they're collectively bargained or otherwise—that cost shifting that the committees have dealt with needs to be fully vetted by this Committee and your counterpart.

[Jim Wadhams, continued.] There were issues, and I would like to go through the mockups. I had seen things, and I think it was haste of drafting. It required sharing of data between private corporations, a clear violation of the antitrust law. I would also suggest that counsel for the LCB [Legislative Counsel Bureau] might find delegation of the types and amounts of fines to be perhaps an unconstitutional delegation of legislative authority to the executive branch.

Chairwoman Leslie:
Are you going to begin with A.B. 322?

Jim Wadhams:
I'm at a disadvantage since I have seen the mockup for the first time.

Chairwoman Leslie:
We will accept written comment on Monday, if you could provide that. If you want to do it in that way, we can take your testimony that way. I just want you to understand that the work session is not going to be the place for you to come back and give us oral testimony. We will be happy to take your written comments on Monday and have them in our work session document. If you want to do that and provide any other additional comments on the record here today, I think that would work.

Jim Wadhams:
One additional comment that I think was overlooked in the staff compilation is NRS 439B.430, being another very critical component that was originally adopted in the hospital review conducted in 1987, which makes it an absolute violation of law for any misallocation of hospital expenses. That's been on the books. I think it has been fairly successful. I would suggest that it's a healthy exercise to look at the public obligation of all privileged licensees, and that's an expression that appears in the preamble to both of these bills. We'll have written comments.

Again, I think that the amount of data that is available is—as you amply pointed out—probably redundant. Some should be discarded, but I think if we can reassemble that in a way that is helpful, in this regard, we will all benefit.

Chairwoman Leslie:
What about this idea of dropping the operating budget requirement that hospitals have to submit, and substituting instead the capital improvement budgets? Do you have a comment on that?

Jim Wadhams:
It's probably worthwhile doing that. I'm not sure I understand fully the reason for eliminating that existing requirement. However, I think it's probably worth doing. I think the Committee will find the capital improvements dramatically satisfying, but I'm afraid you'll find it very unsatisfying the public commitment to funding the public facilities. We need to bring that to bear as well. The growth in hospital beds—and we're still fiftieth in the nation per capita—has been almost exclusively out of the private sector. We need to find the public will for public funding.

Chairwoman Leslie:
Another issue that came up in our discussion today was this chart that shows hospital profits compared to capital improvements and community investment. It shows that profits have—on page 10, in tab D (Exhibit B)—not gone up dramatically, but yet, the capital improvement investment has gone up dramatically, and the connection between that. That just seems like a contradiction to me, that the hospitals would be investing so much in their capital improvements when their profits are so low.

Jim Wadhams:
There are two answers to that, and they're a bit more complex than I'm capable of explaining, but profits are an income analysis, and investments are balance sheet signals. But I think it's a fair comparison to look at the two. They are separately accounted for and done in completely different methods. I think that's part of the issue here. We need to correlate, not just whether a hospital made $7 million and turned around and invested $87 million; therefore, a net gain to the state of Nevada of $80 million in capital. That's a simple arithmetic calculation. I don't think that's what the Committee is after. I don't think it should be after that. We can't do those simplistic analyses. We have to look at how we meet the health care needs.

Chairwoman Leslie:
We're not looking at the financial data. In the bigger picture, it just doesn't quite seem right that the hospitals are investing in building—like Saint Mary's is doing in Washoe County, and I hear it's the same down here, putting money in new buildings and new trauma centers—yet we hear that profits are so low. If they're really that low, why are the hospitals willing to invest that much? It would seem an investment like that would need a return.

Jim Wadhams:
I think this is a larger economic question typical of all businesses. If there's an opportunity for a return by investing in a business with which you're familiar, and you see that will bring gain over the course of time, you will do that. Sometimes, you will invest more than you gain in anticipation of the future revenue being greater. This happens in all industries in our state. They may sacrifice profit on the short-term for investment, currently, that will bring gain in the long-term. Again, we are fiftieth in the nation in terms of hospital beds per capita. The demand far outstrips the capacity. Why are they doing it? Because they expect soon that the capacity will be more responsive.

Chairwoman Leslie:
It sounds like your answer is that profit line that—looking at this chart—went down from 2003 to 2004, is going to go way up.

Jim Wadhams:
It could go way up. I think the point you're trying to draw out of me is if that profit line goes negative, you will see that capital investment sharply drop, and then the public funds will have to fully fund the increasing of the capacity. We have let the public sector, at the legislative level and at the county levels, fall behind in their commitment to the constituents they serve.

Chairwoman Leslie:
We don't want to get into a discussion about psychiatric private beds in Las Vegas, because we've had that discussion before.

Assemblywoman Weber:
I think this might be a question for staff. Hearing the public and the private beds that are available in Nevada, how many beds do we have from the public hospital side, and when was the last increase that we did have?

Chairwoman Leslie:
I believe we only have one public hospital in the state, and that is UMC. Is that right, Mr. Wadhams?

Jim Wadhams:
One true county hospital.

Chairwoman Leslie:
That's the only public hospital. Is that what you meant when you said more public dollars—more UMC-type hospitals? Is that what you were referring to?

Jim Wadhams:
Yes. Public funding of both facility construction and care. Your efforts to get more public funding for care is precisely what I'm talking about.

Chairwoman Leslie:
You're not really talking about hospitals, so much as the funding for the care?

Jim Wadhams:
You have to have both. It's easy to criticize the private sector, but the public obligation ought to be met as well. As many of us know, our attempts to increase public programs are not easy to accomplish. That's part of the issue.

Assemblywoman Weber:
I would actually like to see, of course, over time—the last ten years—how many beds we have for folks that do not go to the private care side. You see the building around our valley, or maybe you can while you're in town today, but what have we done in that arena, and maybe that warrants more discussion in itself.

Jim Wadhams:
We would defer, of course, to the statistical analysis of the Bureau of Licensure and Certification, the State agency that does track the beds.

Assemblyman Horne:
Mr. Wadhams, you mentioned NRS 439B.430. I didn't understand your reference to that statute, and what you were trying to convey to the Committee.

Jim Wadhams:
I will read an excerpt that encapsulates the reference I'm trying to make here. This has been on the books since 1987. "No hospital may engage in any transaction or agreement with its parent corporation, or with any subsidiary affiliated person which will result or has resulted in... deception as to the true operating results of the hospital; deception as to the true financial condition of the hospital; allocation to the hospital or proportion of expense combined facilities," et cetera.

I don't want to read this to you, Mr. Horne, but I do think that tends to suggest that we have laws. If we need to strengthen them we need to. We need not duplicate them. I think you have precious little time to engage in these policy debates, and duplicating laws is probably not productive.

Assemblyman Hardy:
I have to weigh in on this particular discussion. I served on the voluntary board of directors of the St. Rose Hospital and was the maker of the motion to build the Siena campus. That particular decision came about after much soul searching on the part of the directors of the board of St. Rose. St. Rose is a nonprofit organization. It really came down to the reality of the growth that the city was having, what we were going to do, what our responsibility for the health of the community was, and what we were going to do to protect the health of the community, recognizing that hospitals have to make a living. I would propose that sometimes hospitals have an investment in the community because they care, and the hospital is not a building. The hospital is a bunch of people who sit around and care about people.

The doctors whose incomes go down because they aren't making as much money as a result of the managed care organization don't quit being doctors. They are still doctors. Hospitals are nothing more than those kinds of people. You make a decision not to get more money as much as, perhaps, to keep your market share or to care for people, but it is not a "let's build another hospital so we can make more money" in its simplicity. There's more to it than that. You look at that particular graph, where it says "capital improvements and community investment." The community investment is that charity care bad debt. You have to be able to say how the hospital is going to survive, and if the hospital survives, it has to be able to have nurses and all of the professionals in it that you're going to be able to afford to pay. A lot goes into that. The reality is that the burdens we put on the hospitals are going to have to come from somewhere. That somewhere is going to make it more difficult for us to pay nurses enough money to work here and take care of us.

Chairwoman Leslie:
I just think it's interesting that the Coombes', who we heard from today, had their problem at that particular hospital. Maybe you can intercede and help with their billing problems, because it seems like maybe it's happening on the backs of people who can least afford it.

Assemblyman Mabey:
On the first page of A.B. 342, lines 11 through 14, regarding the reports received by the repository, my concern—and I don't know the way it works now—is that as a medical society, we really are trying to somehow work on, when we make a mistake, that those mistakes will be discovered. This is so we can try to rectify those and make sure they don't happen again. I wonder: if these types of things are public knowledge, will that make it less likely that we would be willing to disclose a mistake and try to fix the problem?

Chairwoman Leslie:
That's the kind of debate we'll have in the work session, for sure.

Jim Wadhams:
Two quick comments. I think the sanctity of this peer review has not debated in this session in the Assembly, but it was carefully considered in a counterpart committee in the Senate. I think that will be sustained. That's a bit of a separate issue. The sentinel event issue was one that Assemblywoman Leslie and a variety of us worked on very hard during A.B. 1 of the 18th Special Legislative Session, and I think it was a sentinel event for that particular legislator to have accomplished that. Unfortunately, the Legislature didn't express the will to fund that, and it should be funded out of General Fund dollars this session.

Chairwoman Leslie:
Were you there at the budget hearing when I brought it up? That would have been helpful.

Jim Wadhams:
If you would have someone tell me when that particular issue is going to come up again, as you're closing the budgets, I will absolutely be there and put that on the record.

Chairwoman Leslie:
That's interesting to have on the record, because one of the reasons I put in this bill that we would be able to accept private donations is that I've not been able to generate enough support at the Legislature to have it publicly funded, because I agree with you, and I think it's a responsibility of the Legislature to fund it.

Jim Wadhams:
Not only do I agree with you today, I did it early in the morning and I went to Senator Raggio and said that we're okay with funding this. There is no resistance in this corner.

Chairwoman Leslie:
We will do that when we close this budget.

Jim Wadhams:
We do, however, have a little bit of a concern. As most of you are aware, we have passed a privacy law called HIPAA [Health Insurance Portability and Accountability Act of 1996]. Personal health information is absolutely protected. We have to be very careful in these kinds of reporting mechanisms

that we don't leave the trail obvious. There are relatively few sentinel events in our community and our state. Breaking down those barriers—obviously, in a rural community not everybody is going to know about the sentinel event; they will know the person, and that is exactly what HIPAA was designed to protect against.

Chairwoman Leslie:
That's a good point.

Jim Wadhams:
We need to be very cautious in that regard.

Assemblyman Mabey:
Do you support the wording here, oppose it, or are you neutral?

Chairwoman Leslie:
The wording in A.B. 342, in Section 1.

Jim Wadhams:
I am concerned about identifying specific medical facilities for precisely the reason that I just raised, about the HIPAA personal health information risk. As we work through this, I'm pretty comfortable that you will probably not make that deletion for the reason I raised. However, we do support that this registry be funded and that data be collected.

I want to clarify something about the issue of psychiatric beds. Through the efforts of yourself and Senator Townsend, we began to impose participation by third-party payers into some level of mental health benefits. I think, without a doubt, the primary source of that revenue comes from State funding, and again, it is the will of the Legislature that has to be focused and concentrated on that. I think the separation between physical health and mental health has long been abandoned.

Chairwoman Leslie:
I've been trying for six years. I'm in my seventh year on that issue. Any help you can give me, I would tremendously appreciate.

Jim Wadhams:
We support those efforts in the regard that capital investment, whether public or private, tends to follow adequacy of reimbursement.

Assemblyman Hardy:
How many sentinel events do we have in our state in one year?

Chairwoman Leslie:
We just started collecting that data. It was obligatory starting January 31 and the report I saw, it wasn't very many.

Jim Wadhams:
I think the number was in the single digits, and the hospitals also voluntarily and retroactively reported. Again, this should be fully funded and it should be operational, and we support that effort.

Chairwoman Leslie:
The last report I saw, it was picking up. It had started very slowly in the retroactive, but as I recall in the first quarter of this year when it started—January 1—it was starting to get bigger, but we can get that.

Assemblyman Hardy:
I have precincts in my district that won't tell me how they voted, because there are too few in the precinct. This is so I would be able to tell who voted for me. They have more sentinel events than we have. So there's a correlation with what you can extrapolate to.

Chairwoman Leslie:
That is one of the reasons that I got shut down on the funding for this. People on our subcommittee felt that there hadn't been enough experience yet, because we don't have enough data. We've had three months of the required data, so we don't even know yet how many sentinel events we've really had. They thought it was premature to appropriate money to analyze something that we don't even know, as you pointed out how many. We'll look at that, and we'll get that number for our work session.

Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Human Resources, State of Nevada:
I oversee some of the cost-containment provisions that are being addressed by these two bills. With me today to help do that is Vern Manke. Mr. Manke is probably the foremost expert on information that we collect on hospital financial information, as well as utilization information, in the state. I think he can answer a host of questions that you may or may not have about this. We also received the mockups early in this hearing. We've had a chance to look at some of it. I'm going to try and address some of the sections of both A.B. 322 and A.B. 342 as we see them. We'd like the opportunity for further analysis and to provide that in writing to your staff.

I'm going to start with A.B. 322. We do support the intent of this bill to look at community reinvestment and agree that licensing in the state does convey some

obligation to provide services in the community to meet unmet needs. We agree with that overall intent. We also have some information. The change in A.B. 322, which is also going to be reflected in A.B. 342: changing the definition of hospitals to major hospitals, I believe, achieves some of the intent that you folks are looking for. It does exclude rural hospitals. I don't know if Carson-Tahoe Hospital continues to make that cut as a rural, but it includes them in this bill. I think with their growth, it is probably appropriate to include them in this bill.

[Charles Duarte, continued.] The hospitals that are currently engaged through the current statute in NRS 439B.400 include Desert Springs, Saint Mary's, Sunrise Hospital, Valley Hospital, and Washoe Medical Center. The change in definition of major hospital under NRS 439B.155, which is being proposed in A.B. 342, would add ten more hospitals to the list. It would include Carson-Tahoe, Mountain View, North Vista, Northern Nevada, St. Rose Dominican at Rose de Lima Campus, St. Rose Dominican at the Siena Campus, Southern Hills Hospital, Spring Valley, Summerlin, and, I think, Washoe South Meadows would be added to that list.

We believe it achieves the intent that you're looking for, to increase the number of hospitals that would be included in this. At the same time, it excludes the rural hospitals. Currently, there are eight public hospitals, including University Medical Center; seven others are public hospitals in rural communities. I just wanted to put that on the record. I don't have the bed counts for those, but there are eight public hospitals in the state of Nevada.

With respect to Section 2 in the mockup of A.B. 322: hopefully, I clarified what that change does, as well as the change that's being proposed in A.B. 342 for NRS 439B.155, in terms of the definition of major hospital.

With respect to A.B. 322 in mockup form, we do have a concern with the penalty section of that bill, from the standpoint of potential conflict with existing statute—in NRS 439B.320 through NRS 439B.340. We would like an opportunity to look at that. Specifically, there are some indigent care obligations already outlined in NRS 439B.330.

Vernon Manke, Management Analyst, Division of Health Care Financing and Policy, Department of Human Resources, State of Nevada:
The indigent care obligations lined out in those three citations he gave you—and that's the 0.6 percent of the net inpatient revenue that's calculated—that the hospitals with 100 beds or more in Clark and Washoe Counties have to provide indigent care for free, essentially, until they meet that obligation. That may conflict with what we're looking at here, since the community benefits are

providing charity care and whatnot. We'd have to look at that, or somebody should look at that.

Chairwoman Leslie:
We'd appreciate you looking at that and getting back to us early next week.

Charles Duarte:
I believe that the majority of the remaining sections of A.B. 322 were then moved into the mockup version of A.B. 342. I'm not going to comment on Section 1, the sentinel events section. Section 2 of the mockup—the new Section 2 of the mockup—I guess it achieves the goal we talked about with respect to defining a major hospital down to 100 beds and keeping with the rural hospitals out of that, with the exception of Carson-Tahoe.

With respect to Section 4 of the bill, I think there's been prior testimony that some of the reporting that is being requested here may cause redundancy with some of the information that we already get, with a couple of exceptions. One of the exceptions is the community reinvestment component, and then the other is home office expense. There may be ways of extracting home office expense costs from some of our Medicare cost reports. I'm not too clear on that methodology. We certainly would like to take a closer look at these sections and see if there's some way to hone this down a little bit. Currently, we are getting a lot of information. In fact, I have three reports here that we routinely publish each year. We actually publish these reports twice per year, including a summary of hospital utilization, hospital and nursing facility utilization, financial reports, and a host of other financial information. We want to make sure that we're not duplicating it.

Like I said, we're pretty clear that there's no duplication, in terms of the community reinvestment component or in the profit distribution component that's being required.

Chairwoman Leslie:
I would recommend your suggestions. We don't want to be redundant if you are getting some of this information; maybe we just need to have a new format with the title so it's clear where that it is and how we can analyze it. If you have suggestions after you have more time to think about it that would be great. You know our deadline.

Charles Duarte:
I understand the deadline; we'll try to get this done on Monday. In terms of Section 5, the only suggestion I have here is that rather than a report October 1 of each odd-numbered year, we actually produce a report that includes all the

financial information I've previously referenced each year, and that's filed to the Legislative Committee on Health Care and also to the Legislative Counsel Bureau each year. We would suggest, rather than creating a new report, that we just incorporate some of the requested information—the new information—into the existing report that we already publish each year. I think that would meet the intent of this bill and reduce any possible redundancy.

[Charles Duarte, continued.] I think we will provide you with written comment on both mockups, do some review of the changes being requested in A. B. 322 with respect to the 4 percent charity care obligation, and get back to you in writing on Monday.

I do have one other set of comments I'd like to make, only because I understand A.B. 353 will deal with a number of these issues on Monday. But because there was so much testimony around it involving these two bills, I would like to make a couple of comments. One is that a comparison of charges is not going to affect health care cost increases. Billed charge master is extremely complicated. It's primarily not a paper document. It is a huge electronic document that is not comparable hospital to hospital. Any effort to look at comparing billed charges between hospitals is probably going to be an exercise in futility. That's my fear. It would be costly and difficult to do.

The issues of price, cost, quality, and efficiency are not issues that can be addressed through billed charge, in my opinion. Very few services today are actually reimbursed via billed charge. A very small percentage of people are affected by billed charge. You had testimony earlier from a couple who were affected by billed charge. We've talked about this previously in S.B. 9. The issues around billed charge have a very limited impact; they primarily affect a small portion of services and outpatient hospital services. Most payers, whether they are private or public payers—including the federal government—really don't look at billed charge. They use diagnosis-related groups in the Medicare program, or they pay per diem.

I think the most useful information that can be looked at state to state and within the state, comparing hospital to hospital, is to look at a report that's already published called *Personal Health Choices*. This is published by the Health Division of the State of Nevada. It provides a comparison of all hospitals in the state of Nevada by diagnosis-related grouping. For example, I just opened up the book and I have a page for DRG 015. This is a set of procedures based on a particular diagnosis, and this particular diagnosis is transient ischemic attack or precerebral occlusion. It's a stroke. If you go down this list you can look at, by county, the average length of stay, patient discharges, and the average billed charges associated with each of those disease-related groupings.

[Charles Duarte, continued.] I think that this provides a phenomenal amount of data that we really haven't talked about, nor has the Health Division talked about publicly, and very few people probably look at it since they're not aware of it. This provides a host of information that's already published for the public to utilize in looking at costs, lengths of stay, and patient discharges in every hospital in the state of Nevada by disease-related grouping. This is a payment methodology used by Medicare and other major payers. I just wanted to point that out. On Monday, we'll talk more about this. I wanted to make sure folks knew, since the people in the audience may not be there on Monday. We collect a lot of information that I think is useful for purchasers, as well as for the public, in terms of what the cost of medical care really is in hospitals.

Chairwoman Leslie:
Thank you for your comments and your willingness to work with the Committee on this important issue as we move forward over the next year or so, figuring out how to get the right information so people can make good choices. It seems clear to me that you understand the intent of these bills. I appreciate that, and I'll look forward to your comments.

One thing that you said, I'm confused about. What is a public hospital and what isn't? You said there were eight. I always think of UMC as the big public hospital here in the south. Are the other seven private nonprofits and that's why you think of them? What makes you say those are public hospitals?

Charles Duarte:
These are county-owned and operated hospitals in rural communities.

Chairwoman Leslie:
Just so I understand.

Charles Duarte:
I can rattle them off, but not off the top of my head.

Chairwoman Leslie:
That was a major point. It's not so important to me to know which ones they are, as to understand what you meant by “public.” So, they are just like UMC, owned and operated by the rural counties themselves?

Charles Duarte:
Yes, Madam Chair.

Robin Keith, President, Nevada Rural Hospital Partners (NRHP), Reno, Nevada:
I'll start with the mockup on A.B. 322, which I just saw this morning for the first time. I haven't had time to digest it. It appears our concerns have been fully addressed, and I'd just like to state that I appreciate Speaker Perkins' recognition of the rural hospitals' contributions and their strong connections to their communities.

With regard to A.B. 342, this is another one where I'm seeing the mockup this morning. It's been difficult to absorb all of that and also to listen to the testimony at the same time. In any case, I will spend more time on the bill. It is my understanding that the main body of the bill does not apply to hospitals of less than 100 beds. I do need some time to actually look at Section 4 and verify that.

I do want to put NRHP on the record with concerns that were already expressed by Mr. Wadhams, with regard to the confidentiality of persons in facilities in the sentinel reporting process that was developed—after a great deal of work by lots of people—in the 2001-2003 interim. That process was implemented January 1, and there really hasn't been enough time to know how that process is going to work.

With regard to the change from 200 beds to 100 beds, that does bring Carson-Tahoe Hospital—who is a member of NRHP—into some statutory requirements that heretofore have not applied to them. I would like the opportunity to analyze that more fully. I'd like to just point out that Carson-Tahoe is a sole community provider in this community, Carson City.

Carson-Tahoe is spending about $120 to $140 million to replace its facility. It will be adding 20 beds. As it does that, it's replacing what's virtually an antique here in the community. I would point out that this is a very significant community benefit, and if it's the Committee's intent to pull Carson-Tahoe into the requirements throughout the statutes for major hospitals, we would take the position that we would oppose that and feel that that was unnecessary in view of their sole community provider status.

Finally, I would just state our appreciation for the recognition of the needs of small and rural hospitals and their relationship to their communities.

Chairwoman Leslie:
I understand that you need more time to look at the bills. I appreciate your comments. Carson is growing, and Ms. Parnell knows that more than anybody. Isn't Carson the one that wants to create their own local public health authority,

rather than have the state do that, because they are growing? I'm pretty sure Carson City is the one that is going forward with that.

Robin Keith:
The people in the audience are confirming that it's Carson City. It's not the hospital; it's Carson City.

Chairwoman Leslie:
I meant Carson City. I guess I see that as a reflection of acknowledgment on their behalf also that they are a growing community and they're not the same as some of the other rural communities that aren't necessarily growing. It wasn't my intent to go get Carson-Tahoe. We'll hear more testimony, maybe from Ms. Parnell, or you can check with your client and let us know. But it might be appropriate to include them.

Assemblywoman Parnell:
I would like to say that one of the reasons that Carson City is looking at the health district and the expansion of our hospital is because we've really become a regional care center. There is no competition. We are pulling people in from Douglas County, Storey County, and Lyon County, and we are now becoming the provider for many of our neighboring counties. I just wanted to clarify that.

Chairwoman Leslie:
I think that's an excellent point. Committee, my intention is to take these up Wednesday in our mammoth work session.

This meeting is adjourned [at 12:49 p.m.].

RESPECTFULLY SUBMITTED:

_____
Paul Partida
Transcribing Attaché

APPROVED BY:

_____
Assemblywoman Sheila Leslie, Chairwoman

DATE:_____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: April 9, 2005 **Time of Meeting: 10:11 a.m.**

Bill	Exhibit	Witness / Agency	Description
	A	********	Agenda
	B	Barbara Dimmitt / LCB	Background information
A.B. 322	C	Assemblyman Perkins	Mockup of A.B. 322
A.B. 322	D	Assemblyman Perkins	Summary of A.B. 322
A.B. 324	E	Chairwoman Leslie	Mockup of A.B. 324
	F	Ric and Pam Coombes / Private Citizens	Summary of hospital experience