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

Seventy-Third Session
April 11, 2005

The Committee on Health and Human Services was called to order at 1:04 p.m., on Monday, April 11, 2005. Chairwoman Sheila Leslie presided in Room 3138 of the Legislative Building, Carson City, Nevada, and, via simultaneous videoconference, in Room 4401 of the Grant Sawyer State Office Building, Las Vegas, 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
Mrs. Ellen Koivisto
Mr. Garn Mabey
Ms. Bonnie Parnell
Ms. Peggy Pierce
Ms. Valerie Weber

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblywoman Chris Giunchigliani, Assembly District No. 9, Clark County

STAFF MEMBERS PRESENT:

Barbara Dimmitt, Committee Analyst
Linda Ronnow, Committee Attaché

OTHERS PRESENT:

Kathleen Van Wagenen, Administrator, Nevada Cancer Research Foundation, Las Vegas, Nevada
Jim Wadhams, Legislative Advocate, representing Nevada Hospital Association
Bill Welch, President and CEO, Nevada Hospital Association, Reno, Nevada
Robin Keith, President, Nevada Rural Hospital Partners, Reno, Nevada
Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Human Resources, State of Nevada
Jon Sasser, Attorney at Law, Washoe Legal Services, Reno, Nevada
Valerie Rosalin, Director, Consumer Health Assistance, Bureau for Hospital Patients, Office of the Governor, State of Nevada
Mike Sloan, Senior Vice President, Mandalay Resort Group, Las Vegas, Nevada
Patricia Allen, President, Health Strategies, Inc., Las Vegas, Nevada
Chris Campbell, Executive Director of Corporate Benefits, MGM Mirage, Las Vegas, Nevada
Scott MacKenzie, Executive Director, State of Nevada Employees Association, American Federation of State, County, and Municipal Employees Local 4041, Carson City, Nevada
Sally Tyler, Health Policy Analyst, Public Policy Department, American Federation of State, County and Municipal Employees, Washington, D.C.
Barbara Hunt, District Health Officer, District Health Department, Washoe County, Nevada
Douglas Busselman, Executive Vice President, Nevada Farm Bureau, Reno, Nevada
Trudy Larson, Assistant Chancellor, University and Community College System of Nevada
John Lilley, President, University of Nevada, Reno
David Thawley, Dean, College of Agriculture, Biotechnology, and Natural Resources, University of Nevada, Reno; and Director, Nevada Agriculture Experiment Station
John Pappageorge, Legislative Advocate, representing Republic Services, Inc.
Ed Allison, Legislative Advocate, representing Waste Management, Inc.
Kaitlin Backlund, Political Director, Nevada Conservation League, Reno, Nevada
Joe Johnson, Legislative Advocate, representing the Toiyabe Chapter of the Sierra Club
Nancy Howard, Assistant Executive Director, Nevada League of Cities and Municipalities, Carson City, Nevada

Leo Drozdoff, Administrator, Division of Environmental Protection, Department of Conservation and Natural Resources, State of Nevada

Chairwoman Leslie:
[Meeting called to order. Roll called.] I will open the hearing on A.J.R. 14.

Assembly Joint Resolution 14: Urges Nevada Congressional Delegation to introduce and to support federal legislation mandating reporting of results of all clinical trials and collection and analysis of data by appropriate federal agencies. (BDR R-1011)

Kathleen Van Wagenen, Administrator, Nevada Cancer Research Foundation, Las Vegas, Nevada:
We are in favor of A.J.R. 14. Dr. [John] Ellerton, our principal investigator, apologizes for not being able to testify in person.

Our foundation is a community clinical oncology program that is one of a network of community programs funded directly by the National Cancer Institute in order to bring clinical treatment and prevention trials to the citizens of our community. The foundation includes most of the cancer treatment professionals in the state. For twenty-two years, the National Cancer Institute has sponsored clinical trials available to the citizens of Nevada. It is essential that the results of all research trials, whether publicly or privately funded, and whether negative or positive, be made available to the medical community and the public. Information about treatment failure can be as important as information about treatment success.

Currently, much—but not all—of the results of the trials are presented at meetings and other medical venues. Nonetheless, a comprehensive and consistent policy to publish results is needed; however, this policy must be federal. Most of the research in the area of cancer is funded by the federal government or the national pharmaceutical firms, and the research is conducted at institutions throughout the country and often internationally. Individual state regulation would be impractical as a public policy and would make the research more difficult to conduct.

The National Institute of Health and the federal government are currently moving to ensure all results are published. They are an easier task for federally funded research, and they can be mandated as part of the research plan. For the pharmaceutical industry, voluntary publishing may not be sufficient to ensure that all the tests become public. A comprehensive federal policy mandating that such research disclosure is essential.

[Kathleen Van Wagenen, continued.] The Nevada Cancer Research Foundation, in its role as a research organization, supports results disclosure and A.J.R. 14.

Chairwoman Leslie:
This needs to be done at a federal level because that is where most of the studies are based. Is that the reason?

Kathleen Van Wagenen:
That is correct.

Chairwoman Leslie:
This resolution would simply express the Legislature's intent that Congress do something about it. Do you feel it's worth getting it on the record that we would like to have all those results reported back?

Kathleen Van Wagenen:
Yes.

Assemblywoman Parnell:
I think this is a great piece of legislation, even if it is just a resolution urging Congress. There are so many things that the public probably feels unsure about taking, because we don't know about the clinical trials.

Chairwoman Leslie:
We value the work that you and Dr. Ellerton are doing in Las Vegas.

> ASSEMBLYWOMAN KOIVISTO MOVED TO DO PASS ASSEMBLY JOINT RESOLUTION 14.
>
> ASSEMBLYMAN HORNE SECONDED THE MOTION.
>
> THE MOTION CARRIED. (Assemblyman Hardy was not present for the vote.)

Chairwoman Leslie:
I will close the hearing on A.J.R. 14 and open the hearing on A.B. 353

Assembly Bill 353: Makes various changes concerning hospital charges. (BDR 40-1164)

Chairwoman Leslie:
We are passing out a new mockup on A.B. 353 (Exhibit B). We are going to follow this hearing with a companion bill that Mrs. Koivisto has, which is A.B. 296. We heard some testimony of the concept of bill charges, especially from the Coombes family. They testified how their lives changed due to the financial devastation of their hospital bills. They were able to transfer to UMC [University Medical Center of Southern Nevada] and were able to get their bill settled. They are still having problems with aggressive bill collectors from the first hospital that they went to. I think this is a problem that Nevada families are facing.

I asked the Legislative Counsel Bureau to do research on health care costs of bankruptcy. There was a study published in *Health Affairs* in February 2005, which said that 55 percent of bankruptcies have a medical cause to them. I wanted to cite a couple of things that came out of that study on health care expenses and family finances. About 20 million American families, or about 1 in 7 families, have reported problems paying their medical bills in 2003, and 63 percent of these families reported difficulty paying for other basic necessities like rent, mortgage payments, transportation, or food as a result of their medical debt. People in families with medical bill problems are four times more likely to delay health care because of the cost concerns and five times more likely to have unmet medical needs because of costs, compared to people in families without bill problems. This is a nationwide issue.

In terms of A.B. 353, I wanted to originally call this bill the "Stop Predatory Debt Collection Act," but decided not to put that title on it. If you will look at your mockup, Section 1 establishes some new reporting requirements with regard to hospital charges, debt collection, and discounting rate adjustment policies. Subsection 1 requires that hospitals file their charge masters annually with the State. This was something that the State used to collect under cost containment; however, we stopped collecting it in 1999. There is currently no way for consumers, the State, or insurers to verify the pricing of hospital services. To my understanding, it is very difficult to compare the charge master between hospitals. In this bill we are asking that the State be authorized to collect that information so that consumers can begin to understand where the starting point is for their charges. This is intended to apply only to major hospitals and not rural hospitals.

Subsection 2 requires that hospitals file a copy of any rate adjustment or discount policy they have for uninsured patients, if they have such a policy, and a copy of any policy they may have on collecting unpaid debts from patients, including whether or not they use collection agencies. After the hospitals have filed their policies, they are only required to refile them if the policies change, and we know that some hospitals have charitable policies when it comes to collecting debt. We

would like to see those in writing and have them available for consumers and our own health consumer office.

[Chairwoman Leslie, continued.] Subsection 3 requires that the State do an annual review of both rate adjustment policies and debt collection policies. This Committee and the Interim Health Committee need to be able to understand what is happening in our state, so that we do not have repeat stories like the Coombes family.

Subsection 4 defines the charge master. Subsection 5 specifies that the file charge masters will be publicly available. The intent is to have it available on the Internet in [Microsoft] Excel format.

Section 2 changes the rate adjustments that hospitals are required to offer to certain patients without insurance. Bill charges have gone up 67 percent since 1999, when the cost containment provisions sunsetted. The current rate adjustment to be given to people with no insurance, is set at 30 percent today, and was set before 1999. It has not changed, despite the fact that bill charges have continued to increase.

The information that was provided by the Division of Health Care Financing and Policy on Saturday I found disturbing. The bill charges have risen, and the rate adjustment for insured purchasers have changed as bill charges have changed. The uninsured group has remained the same, and these people get charged the most and are expected to pay the most, because they only get that 30 percent rate adjustment. The people who have the least amount of money get the least amount of discount on the bill charges.

Mr. [Charles] Duarte's staff advised us that the rate adjustment that is now mandated in NRS [*Nevada Revised Statutes*] 439B.260 should be raised from 30 percent to 50 percent for inpatient hospital services, and from 0 percent to 30 percent for outpatient services. This will be the discount rate adjustment that an uninsured person receives, which will be more in line with the discount or rate adjustment that the insured person receives. I also think it might help the medical debt problems that we heard about on Saturday.

If the hospital is going to make an arrangement with an uninsured person to pay a bill, they should make it on a bill that is reasonable and reflects what someone with insurance would have paid. This whole section is about leveling the playing field so that the uninsured person is not penalized the most.

Subsections 4 and 5 of Section 2 deal with another aspect of the problem the uninsured face. I have heard from consumer groups that, even though we have had NRS 439B.260 in statute for some time, people who should be eligible for the

uninsured rate adjustment many times do not hear about it, and so their bill goes directly to collections. To get the rate adjustment you have to make arrangements within 30 days, and you have to set up a payment plan within 30 days of leaving the hospital. You can take longer to pay, but you must have that plan in place within the 30 days. If you don't know about the policy, how are you going to file a plan?

[Chairwoman Leslie, continued.] In Subsection 4, I am requiring that major hospitals post in English and in Spanish the directions for how to get the uninsured rate adjustment or discount. Other states have done this with success. We see often the uninsured are also the people who are least likely to be able to navigate the medical system. I hope that this section will give some direction to both the hospital and the consumer to make sure that the discounted policy for the uninsured is clearly understandable.

Assemblywoman Weber:
I am trying to determine between the original bill and the mockup in Section 1, subsection 1, "each major hospital in this state." I know it does not include rural hospitals, but can we define it by beds, because I think "major hospital" is a subjective term.

Chairwoman Leslie:
We changed the definition of major hospital from 200 beds to 100 beds, so the definition will be the NRS definition if we leave it the same.

Assemblyman Horne:
It came to light that Carson falls under this, and they are changing their scheme.

Chairwoman Leslie:
Ms. Parnell testified on Saturday that they are becoming a more regional hub and they are adding beds. They are becoming more of a major hospital than, perhaps, a rural one.

Assemblywoman Parnell:
I spoke with some individuals following the hearing on Saturday. They seem to feel that what is being asked for Carson-Tahoe Hospital they are already doing for the most part, so there was not an objection to having them being included in the definition.

Assemblywoman Pierce:
Can you give me that statistic that you gave, on how much charges have risen since the bill sunsetted in 1999?

Chairwoman Leslie:
Bill charges have gone up 67 percent since 1999.

Assemblyman Hardy:
The bill charges do not reflect what the hospital actually receives in payment; do we have some statute that limits the bill charges?

Chairwoman Leslie:
I am not sure what you mean by limits.

Assemblyman Hardy:
Do we have a statute that limits bill charges?

Chairwoman Leslie:
I do not think so.

Assemblyman Hardy:
If I were a hospital, I would increase my bill charges to get to where I need to in order to collect. It does not make any difference what you bill. It is what the insurance pays. The insurance does not really care what you bill.

Chairwoman Leslie:
Are you saying there is a better way to help the uninsured person?

Assemblyman Hardy:
I do not know that this really gets to where you want to go.

Chairwoman Leslie:
It is the system that we have; I am open to hearing a better way to helping the uninsured person. The best way I could come up with is to raise the 30 percent discount to 50 percent.

Jim Wadhams, Legislative Advocate, representing Nevada Hospital Association:
I have reviewed A.B. 353. I think one of the issues—and this flows from the hearing we had on Saturday when we heard testimony from the State agencies—is that some of this information is not particularly predictive of anything. I think Dr. Hardy's questions help us focus as well. To me, one of the issues of the greatest concern is the cost-shifting to our properly funded private pay programs. We had a large audience in Southern Nevada, and the vast majority of people were fully insured under a well-funded, well-organized insurance program. If we increase the cost of health care in order to provide deeper discounts for people without insurance, we collect less revenue from one place, and it will be shifted to another

place. I think the notion of meeting the unmet need, which was discussed on Saturday on A.B. 322 and A.B. 342, is really a critical piece.

[Jim Wadhams, continued.] This Committee is on the right track to look to do something. I am concerned that bills do not shift costs to those employers and their groups who collectively bargain and otherwise are willing to pay for insurance and health care, shifting the cost and thereby increasing the burden to those who do pay.

Chairwoman Leslie:
Would you be opposed to the part about posting the hospital's uninsured policy?

Jim Wadhams:
No. That has been a provision that is provided to patients on the intake. It was part of some revisions that was done many years ago. There is a Patient's Bill of Rights that has been enacted into the state law, which requires disclosure of a vast array of information to those patients.

Chairwoman Leslie:
You know what it's like if you have ever been in the hospital. You get handed a lot of things. I felt that if it were posted in a more prominent way, people would be more likely to read it.

Jim Wadhams:
I don't think there is any problem with posting those rights and opportunities on the wall in the patients' waiting room.

Assemblyman Hardy:
Trying to tie a percentage to something that we are doing does not make any sense to me. If we looked at a hospital that generates with contracts, with certain providers—Medicare, Medicaid, Sierra Health Services—people who have major contacts with the hospital in some fashion, and you recognize that the hospital receives X amount of dollars from a particular contract, if you average those, you look at the reality that the person who is uninsured has not paid insurance premiums, so they have in essence been given an advantage by having more money available to them for their day-to-day living expenses than they would have if they paid $500 to $900 per month for health care premiums. If we had a percentage of what a hospital's collections are for a given diagnostic related group with a surcharge or something, recognizing that the person had taken advantage of the money that they were given and their insurance premium allowed them to cover themselves, would that make sense?

Jim Wadhams:
The percentage of people entering a hospital that are already insured is approximately in the 65 to 67 percent range. Those people are on negotiated rates. The charge master that has a phone-book-sized catalogue of prices is really irrelevant to the worker or the insurer of health services. Their insurer has negotiated a flat per diem, ICU [intensive care unit], whatever it might be. Devising a system for those who are uninsured could obtain the benefit of an insurance program. I think this is an idea that we really should look at. If they want to break even and get less from one place, then they will have to get more from another place. In the zero gain system you have to be careful that you are not just shifting costs, when we know that price balance is very delicate for the maintenance of the solvent fund. By shifting more burdens to those providers that will increase costs, ultimately, that comes back to those employers who are willing to pay. We have to be careful of avoiding it.

Assemblyman Hardy:
If you have 100 people who come to the hospital, 65 are covered by insurance. That insurance average payment is 75 percent of your billed charges. That is because there is a negotiated rate; there is some predictability, some advantage to make a negotiated rate with an insurance company. What is unpredictable is how many people are going to come without insurance and without ability to predict what those charges are. On the average scale, you have the ability to say that if the uninsured were charged a percentage of the contractual amount, with an additional fee to cover the costs of the contracts that we knew about—so that nobody would be out of pocket—you would give a discount from the billed charges, but it would be from the collected amount that you got averaged out over 5,000 people. So, you could not say that this is what you are going to collect from the person who did not have insurance.

Jim Wadhams:
That system could very well work; it is probably more meaningful than anything having to do with the charge master. That system is not pertinent in the marketplace. You could have a markup of 120 percent of that average number, but then you have to be careful of the cost shifting.

Chairwoman Leslie:
I am not opposed to discussing it further. I am not saying that this percentage way to go is the correct way. I just do not want the uninsured people paying more than you or I who have insurance.

Assemblyman Hardy:
There is a two-sided unfairness to that. The uninsured has the potential to pay more for a given hospital bill, because the uninsured has not paid premiums for

insurance. If you are insured and go to the hospital, and the person who is uninsured goes to the hospital, their bill is going to be the same as your bill. You will not pay as much, because you have the advantage of paying insurance premiums for a number of years.

Bill Welch, President and CEO, Nevada Hospital Association, Reno, Nevada:
The hospitals would have no concern or difficulty posting the requirements of the 30 percent discount for the uninsured population. On the Senate side, there was a bill introduced to make sure that our Patient's Bill of Rights was clear to every patient admitted to the hospital. We did testify in support of that piece of legislation, and adding this would not be of any more of a concern, and if it were appropriate, we would post signs in the facility or have a separate sheet for the Patient's Bill of Rights.

It should be pointed out as we talk about the percent of increases in the bill charge; the charges are not really relevant. It is what you have typed on the services that you provide, and I believe that Mr. Duarte has provided some documentation, as has the Hospital Association. It demonstrates what the costs of our services are and their increases since the point in time of the charge master. It also shows cost controls are in place versus what our collections and reimbursement rate has been, and that is significantly different than what our posted bill charges are.

Chairwoman Leslie:
I know, during the cost containment legislation, the hospitals did provide the charge master, and that went away. What is the objection from the hospitals of making that material available?

Bill Welch:
The Hospital Association did not lobby or request legislation introduced to do away with the charge master. That was part of the original timeframe that was set in the legislation to put the original cost containment in. The charge master is a very costly process to produce and to provide, and unless it is being analyzed properly, unless you truly understand it, it is really very meaningless to an individual person. A smaller hospital can have anywhere from 12,000 to 18,000 separate line items on that charge master, whereas a larger hospital with more medical technical capabilities and broader services could have 20,000 to 30,000 line items.

Chairwoman Leslie:
Do the hospitals object to making that available to the State Division of Health Care Financing and Policy or the Office of the Consumer Health Assistance? Those people have technical people who could understand the charge master.

Bill Welch:
We would have to see how the charge master would be used and how it would be analyzed.

Chairwoman Leslie:
You are leaving the door open. You are not saying no, and you are not saying yes.

Assemblyman Mabey:
My understanding with some of the managed care companies is that they use a per diem or a DRG [diagnosis-related group], but once you reach a certain level, those two are done away with, and then you go to a percentage of bill charges. How many people fall into that category, where they are not billed under the per diem or the DRG, because the costs then go over a certain cap?

Bill Welch:
I do not have that information, but you would be looking at a patient who would be going into a catastrophic situation, and I do not think that would be the norm. I think most contracts we have in the hospital communities would be covered with those per diems or discounted rates. I do not believe that many of the patient population would fall into that catastrophic area.

Assemblyman Mabey:
Would it be less than 1 percent? When I spoke on Saturday, my impression was that everyone fell under a DRG or a per diem rate. I became aware that some of the managed care companies are not able to do that when it goes over a certain cost, and then it does become a percentage of bill charges.

Bill Welch:
I believe that the claims manager for the insurance company could give you a better idea of what percentage of their claims fall into that category.

As we talk about the uninsured population, the hospital community is also very concerned, and as you know, we have been very supportive of the HIFA [Health Insurance Flexibility and Accountability] waiver. I believe that is a mechanism in which we truly will be able to help the uninsured. This concept really does cost shifting, and that does not help anyone.

Chairwoman Leslie:
As you know, the HIFA waiver helps. It is a start in the right direction but it is not enough of a help.

Robin Keith, President, Nevada Rural Hospital Partners, Reno, Nevada:
I see that the mockup applies to major hospitals.

Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Human Resources, State of Nevada:
The complexities of comparing one hospital to another in terms of the charge master are pretty clear to understand. The Division submitted S.B. 9 (Exhibit C), which dealt with inpatient discounts. We are concerned about outpatient discounts, because providing an outpatient discount may encourage people to seek care at an inappropriate level. People may go to the emergency room or other settings where they could achieve a discount for outpatient services, and that may not be the appropriate level of care where urgent care or physician office visits may be more appropriate.

In my testimony on Saturday in regard to A.B. 322 and A.B. 342, in terms of comparing costs for hospital services, probably one of the more relevant documents the Committee would like to look at is *Personal Health Choices*, which is published by the Health Division. It looks at costs, average lengths of stay, and utilization by diagnosis-related groupings. I think in terms of looking at the overall picture, looking for trends and comparisons of costs associated with different facilities is probably a more relevant document than what the charge master can be. I would encourage the use of that.

Chairwoman Leslie:
Can you repeat the title for the Committee members?

Charles Duarte:
It is called *Personal Health Choices*. The current edition that is available is for years 1999 through 2003, the sixteenth edition.

Chairwoman Leslie:
In S.B. 9, which you submitted on behalf of the Division, you asked for the bill charge discount to be raised from 30 percent to 50 percent. What was your rationale for requesting that increase?

Charles Duarte:
The basis for that original bill was the fact that most of the discounts already being provided to payers were in excess of 70 percent. It seemed appropriate that an uninsured patient, who is accessing inpatient services and has made provisions to make payment, could be afforded a higher discount.

Chairwoman Leslie:
Is that still your position?

Charles Duarte:
Some of the voluntary discount proposals that we have recently seen from major private systems meet, beat, or exceed some of those discount parameters, and so hopefully that will continue. We have been pleased with some of the proposals that we have seen.

Chairwoman Leslie:
Would it be helpful for your staff to be able to have each major hospital's discount policies in writing?

Charles Duarte:
Yes. We are also in favor of posting the discount policy.

Chairwoman Leslie:
The only thing you are not in favor of is the charge master, because it is not as useful to get that information?

Charles Duarte:
The charge master and also to apply uninsured discounts to outpatient services and outpatient pharmacies. Currently, there are no outpatient hospital pharmacies in the state of Nevada.

Jon Sasser, Attorney at Law, Washoe Legal Services, Reno, Nevada:
I would like to speak to a few portions of the bill that affect our low-income clients. It is a debt that everybody who has a large unpaid hospital bill does not make an effort to pay the full amount of those charges. Mr. Duarte and I worked on a case where a gentleman paid off $9,000 in medical bills at $10.00 per month over a 5- or 6-year period. This gentleman was paying 100 percent of the bill charges, rather than a discounted rate, and so it did create a large hardship to that family, although ultimately we were able to resolve the problem and have Medicaid cover some of the bill.

There is a bankruptcy clinic every Tuesday in Las Vegas that is put on by the Nevada Legal Services; one or two people are always there because of a medical bankruptcy need. Medical bills do lead to personal bankruptcies. This is now the number one cause of personal bankruptcy in the United States.

Publishing the amount and policies would be very helpful. There is a lot of confusion; people do not know what those discount policies are. If they are not able to pay, then there is a very aggressive debt collection. We are in support of those portions of the bill that directly affect our clients. Having the information on a statewide basis to make those policy choices, I think, will be helpful to the Legislature as well.

Valerie Rosalin, Director, Consumer Health Assistance, Bureau for Hospital Patients, Office of the Governor, State of Nevada:
[Submitted Exhibit D.] The reason why we are in favor of the charge masters, as well as having the discount policy and procedures, is because in dealing with hospital billings, we have found large discrepancies in the bill charges. We recently were asked to look into a CAT [computed axial tomography] scan in one hospital. It was $1,300, and we were trying to find out the average cost, and we found a difference between $500 and $1,300 with that bill. If there were a means of having the charge masters—have access to or some means of finding out the average costs for certain services in the hospitals—it would certainly help us in doing our job.

Chairwoman Leslie:
I will close the hearing on A.B. 353 and open the hearing on A.B. 296.

Assembly Bill 296: Requires certain major hospitals to accept certain payments for provision of emergency services and care to certain patients as payment in full. (BDR 40-790)

Assemblywoman Ellen Koivisto, Assembly District No. 14, Clark County:
Assembly Bill 296 addresses bill charges, and the intent of this bill is to address those with insurance that still end up paying bill charges, through no fault of their own, because of contracting issues in a facility. Since they cannot control where they are transported and bill charges are not regulated, patients are left with unexpected high costs even when they have insurance. Mike Sloan in Las Vegas will explain the bill from an employer's perspective.

Mike Sloan, Senior Vice President, Mandalay Resort Group, Las Vegas, Nevada:
Mandalay Resort Group owns and operates ten properties in the state of Nevada, and we have approximately 30,000 employees. I have been an executive with Mandalay Resort Group and its predecessor, Circus Circus Enterprises, for 20 years. During that time, one of my responsibilities has included oversight of certain aspects of our health benefit plans for both our union and non-union employees. I serve as a management trustee for the Health Fund, the 50,000 culinary members in Southern Nevada and their families.

Last year our company paid more than $70 million for health benefits for our Nevada employees and their families. Health care costs are one of the fastest-growing expenses in our company, and hospital charges are leading the charge. Currently we pay between $3 and $4 per hour into trust funds for each hour that each of our union employees work, and we make similar expenditures for

our non-union employees. In many instances our union employees have agreed to forgo some of their wage increases in order to preserve health benefits at the high levels established in prior years.

[Mike Sloan, continued.] All of us recognize that neither employers nor employees in our industry can continue to absorb runaway health care costs year after year. I am talking about large corporations. Imagine the plight of the small businessperson and their employees. Mandalay Resort Group, like many others in the gaming industry, is a member of the Health Services Coalition, which represents more than 300,000 health plan participants in southern Nevada. More than one-third of all covered lives in this part of the state.

I appear before you today to support A.B. 296. The subject of high emergency room costs is nothing new to this Committee or the people of Nevada. This weekend, in Las Vegas, your Committee heard the tragic story of the Coombes family from Henderson, who faced financial ruin following Mr. Coombes' heart attack and subsequent emergency room treatment. The family was uninsured, a subject that was attempted to be dealt with by the prior bill.

This bill deals with a variation of the same problem—emergency treatment for patients who are insured, but because of the emergency are not treated at a hospital with which their insurer or other payer has a contract. Here again the threat is full bill charges, rather than the amount the hospital covered by the insurer had agreed to take for the very same type of treatment. The charge master confuses me, because every time it comes up, the hospitals maintain that it is not relevant and yet, they rely on it in establishing their prices. It seems to me if they find that perfect patient—someone who comes in with no insurance but lots of money—it is like hitting the lottery.

We are concerned with A.B. 296, to make sure that, in the case of an emergency room charge for a person who is insured and is taken through no fault of their own to a facility that is not contracted with the payer, they are not subject to full bill charges. A revised mockup of A.B. 296 (Exhibit E) was distributed to the Committee, and the bill is fairly simple. It allows for a standard payment for hospital care required at a non-contracted hospital because of an emergency. The bill provides those who are insured and their payers are relieved from uncontrolled charges, but yet given a fair return to the hospital—in this case, 150 percent of the Medicare allowable payment. We feel that this would allow the patients to receive the care and provide emergency care that can be paid for by a payer, without threatening the insolvency for either the patient or the provider. It also allows hospitals to make a profit on the care that has been provided.

[Mike Sloan, continued.] We believe that there is a precedent for this type of procedure. Medicare provides a similar payment structure in the hospital to physicians that are not contracted with Medicare. I strongly urge you to approve the bill, in order to provide a degree of protection against the extraordinarily high cost of emergency room care in southern Nevada, while providing reasonable reimbursement to area hospitals.

Patricia Allen, President, Health Strategies, Inc., Las Vegas, Nevada:
Health Strategies is a medical and managed care consulting firm. My current clients include managed care companies, as well as large self-funded employers and Taft-Hartley health and welfare plans. My role with the Coalition, to all my clients, is to help them maintain an affordable health care plan for their employees and members. This includes protecting their assets, building reserves to preserve the future of their benefits program. It is also the goal of my firm and that of the Coalition to support national and local quality initiatives, and to reduce medical errors. I have been part of the professional team for negotiations of the hospital contracts for the past 15 years.

It has become disheartening to see the negotiations become more and more contentious year after year when what we are trying to do is provide affordable health care to the working families of Nevada. I support A.B. 296, because implementing a fair reimbursement on what health plan members have to pay for emergency admissions to non-contracted hospitals will result in the following:

- It will provide us a more level playing field in our ability to negotiate and evaluate hospital reimbursement models without the threat or the hammer over our heads of being forced to pay full bill charges.
- It will protect the level and cost of benefits in the long term by making hospital costs more manageable. This reduces the need to increase employee contributions, deductibles, or out-of-pocket costs. If we wish to contract with a smaller network of hospitals that is more reasonably priced and we have a cap or minimum of what we need to pay for an emergency admission, we will be able to predict and manage these costs for both the employer and employee.
- It could create more health plan options for the small and midsize employers. Currently, many insurance companies that wish to sell health plan products for the small and midsize employer groups are subject to contracted rates. Because of the threat of full bill charges, they must raise their premiums in order to accommodate for those unexpected costs. There are many insurance companies that wish to offer benefits in the state but cannot do so. Contracting with a smaller network of hospitals that provide them discounted rate reimbursements will support their premiums is not an option.

[Patricia Allen, continued.] With the focus and threat of full bill charges gone, we can focus with hospitals on quality and service issues that we are all concerned about. This bill does not negatively impact the hospitals. What A.B. 296 recommends will actually reimburse hospitals substantially above their cost for providing the care. Reducing catastrophic bills reduces bad debt and collection agency costs. This will create a balance in what they will charge and will result in more competitive health plan pricing, making it more affordable for employers to maintain coverage, thus reducing the number of uninsured. Reducing the number of uninsured means less dependency on State and county-funded programs.

I want to share with you some of the statistics that will support setting a cap or reimbursement model for non-contracted emergency admissions. The second page of my handout (Exhibit F), which is from American Hospital Association statistics, reports hospital bill charges by state. Nevada hospitals markup their bill charges by 206 percent, which means that on an average, charges exceed costs by 206 percent. Nevada has the fourth-highest markup of any state in the country and is 40 percent above the national average. The average costs per admission are $8,876, while the average charge per admission is $27,197. If you turn to the remaining pages of the handout, it demonstrates that between 1999, when the cost containment bill sunsetted, and 2003, charges increased by 67 percent. Nevada is ranked third-highest in both escalation of charges and charges per admission in the entire country. Nevada's bill charges per admission are 31 percent above the national average.

I would like to refer to a research article printed in 2003 in the *Annals of Internal Medicine*. It gave statistics on Nevada hospital costs in relationship to the quality of care provided to Medicare patients who receive care in the last six months of their life. This article compared all hospitals in the United States that treat Medicare patients for the most common illnesses in disease states. Nevada hospitals were more expensive than 70 percent of the hospitals in the entire country for the last six months of care to these Medicare patients. Our charges exceed Boston, which includes Massachusetts General Hospital and Harvard Medical School Hospitals; Cleveland, which includes the Cleveland Clinic; Houston, which includes MD Anderson; and Salt Lake City, which includes the University of Utah Hospitals. The article also concluded that hospitals, such as Nevada, with the highest charges did not result in a higher quality of care or better medical outcomes. You would think that if they are charging more, they are providing better care.

In a recent report on current health care trends published by Mutual of Omaha, if you combine 2002 and 2003 statistics, Nevada hospitals have an 18 percent longer average length of stay. The length of stay is the average number of days that a patient spends in the hospital for every type of admission combined. The data also reports a 30 percent higher charge per admission. A company like Mutual

of Omaha is going to think twice about how they are going to price their small to midsize products in Nevada.

[Patricia Allen, continued.] Hospital costs are rising, and it currently represents 40 to 50 percent of their total medical benefits package. We have to be concerned about doing something about hospital costs. On average, hospital costs are about one-third of what they charge, so even when a managed care company receives a 50 percent discount, they are still paying 50 percent above the costs. If you take a $100 pharmaceutical, raise it 206 percent—so it is now over $300—discount it by 50 percent, we are now paying $150 for medication that actually costs $100. Almost all managed care contracts have some provisions that require payment based on percent off bill charges—especially in the emergency room and outpatient services—and a new category of miscellaneous care, which are new services that come about after the contract is signed, which are automatically subject to bill charges until you can have a negotiated rate.

This is the first step in balancing our market and making the hospitals and managed care companies compete on a fair playing field.

Chris Campbell, Executive Director of Corporate Benefits, MGM Mirage, Las Vegas, Nevada:

I oversee all aspects of our self-insured and fully insured health plans for over 40,000 employees and family members in Nevada and other jurisdictions. For the past six years I have managed benefits for two of the largest employers in Nevada. In addition, I have experience working for an insurance claims administrator and as a contracting director for a hospital coalition. Having also been a patient, I like to think that I have experience from all sides of the health care equation. In addition to my day-to-day duties for MGM Mirage, I am also director of two boards, the Health Services Coalition and the State of Nevada Public Employees' Benefits Program.

I would like to discuss how our current environment affects patients that access non-contracted facilities and the plans that cover them. I would also like to discuss why hospital bill charges and charge masters should continue to be an important agenda item for Nevadans. In my different professional roles, I see every day how the $100 million spent by Nevada's health plans each year not only provides access to life-saving treatments, but how vital these plans are to the financial security of the employees and their families. I have seen examples of patients receiving
life-saving kidney transplants and cancer patients receiving chemotherapy. These are services that health plans pay hundreds of thousands of dollars for, yet the patients are only required to pay a few thousand at most—an amount that they are willing and able to pay—for the services they have received.

[Chris Campbell, continued.] Unfortunately, I have also seen the financial devastation that can occur when a patient ends up receiving emergency services from a non-contracted health plan provider or hospital. This financial devastation is, many times, compounded by the fact that, due to their emergent state at the time, these patients had no say or choice regarding which hospital they were taken to to receive that care. When this happens and a person with insurance does access emergency care from a non-contracted hospital through no fault of their own, there are three main scenarios in which those bill charges are typically addressed.

- The health plan will use 100 percent of bill charges to process this claim. As Ms. Allen has already discussed, the disparity between bill charges and a reasonable reimbursement can be substantial. For health plans to pay based on 100 percent of bill charges is not a viable option for the long-term stability of those plans or their participants. Making these types of payments based on 100 percent of bill charges is particularly detrimental to Nevada's small employers, who will end up being rated right out of affordable health care for their employees.
- The health plan will pay what it normally would have paid if the patient had used a contracted hospital. The health plan has provided its full benefit to the member; however, this still leaves a large portion of the hospital bill unpaid, and with no contract in place, the hospital is free to balance bill the patient for the remainder, which can be $10,000 more.
- Some health plans are set up to pay nothing for services provided by non-contracted providers. This leaves the patient with 100 percent of the bill charges to pay out of their own pocket.

Under scenarios 2 and 3, where the patient is faced with astronomical bills from the hospital, what is the likelihood that the average working person will have the ability to pay those bills? As we have heard in testimony from actual patients, the hard truth is that despite their best efforts and intentions, the bills are just too daunting and they go unpaid. The hospital spends significant resources and tactics to collect dollars from patients that simply do not have it. These patients eventually end up in collections and many of those patients end up filing bankruptcy, which in turn may impact not only the hospital's ability to be paid but other creditors as well. It also ruins the patient's credit for many years.

Assembly Bill 296 is a solution to these scenarios. It establishes a system in which the patients and health plans are protected from unreasonable bill charges for certain emergency related care. This bill also establishes a system in which hospitals are able to collect a reasonable amount of reimbursement that not only covers their costs, but also provides a profit margin.

[Chris Campbell, continued.] You can see in the example (Exhibit F) how this would work. In these examples, there are two different hospitals. Both happen to be cardiac emergency admissions to the hospital. On the first page, total bill charges were $271,393. The estimated cost of care for that episode was $58,892. The estimated cost of care is based on Medicare cost ratio for this hospital, and each hospital is provided a Medicare cost ratio based on the reports that they file annually with Medicare. You can see that out of the $271,000 in bill charges, there is an estimated cost of $58,000. One hundred fifty percent of Medicare in this case would be a payment of $71,489, leaving the hospital with a profit over costs of $12,596.00, which is a 21.4 percent margin over those costs. This is for 14 days of hospitalization.

On page 4 (Exhibit F), we have a 21-day hospitalization at a different hospital. Here is an example of a situation where a patient was in 50 percent longer than the first admission, yet bill charges were $127,000—less than half of the first claim. The cost of care was $27,000, 150 percent of Medicare would be $50,830.00, and a hospital profit of $23,444.00, setting the standard at 150 percent of Medicare. This definitely shows that it is a large percentage over Medicare.

There has been previous testimony that bill charges and charge masters are no longer an important factor in health care finance, because most insurance plans have contracts based on per diems or DRGs [diagnostic-related groups].

I would like to discuss two of the most imperative reasons why bill charges are, in fact, of vital importance to purchasers of health care in Nevada. While it is true that most hospital contracts in Nevada use per diems or DRGs to establish reimbursement for inpatient care, there are many services in current hospital contracts that are still based on a percentage of bill charges. These can include fundamental and highly utilized services such as emergency room, outpatient labs, and outpatient radiology, just to name a few. The bill charges on these services have a direct correlation of payments made by the health plans.

Another important contract division in which bill charges have a dramatic effect in determining reimbursement is the stop-loss provision. Under a normal stop-loss provision, when the bill charges for a patient exceed a certain threshold, all per diems and global rates are replaced with a flat percentage off bill charges. For example, if the hospital contract contains a stop-loss provision at $60,000 and a patient receives care of total bill charges of $59,000, then the normal per diem and other contract provisions will apply. If that same patient had bill charges of $61,000, exceeding the $60,000 threshold, then all per diems would go out the window and the plan must pay a percent off of the $61,000 bill charges. In many instances, moving from per diems to a percent of bill charges can double or triple the level of reimbursement to the hospital. Unmanaged bill charges compound

stop-loss provisions as sharp increases in bill charges not only cause patients to meet the stop-loss thresholds faster, but also cause plans and patients to pay a percent of a much higher dollar amount. Furthermore, the increase level of reimbursement due to stop-loss may not always be commensurate with any increase in the amount for quality of services received.

[Chris Campbell, continued.] We strongly believe that legislation to provide reasonable financial security to patients that require emergency health care services, while considering the business needs of hospitals, is sorely needed. The protections provided in A.B. 296 are the first in many steps towards creating a strong and sustainable health care market for all Nevadans. For these reasons we urge your support of A.B. 296.

Assemblyman Mabey:
How does the 150 percent compare to a typical contract that you would have made with another hospital? If you know that the worst you are going to have to pay is the 150 percent, then that gives you leverage when you do negotiate with the hospital. You can say, "If I don't get a contract with you, then I will go back to the 150 percent of Medicare."

Chris Campbell:
When we look at these two claims, we are just one health plan of many across the state to get reimbursement out of 150 percent of Medicare. It was actually higher than it would have been had this claim been processed in-plan. In that case, it was a benefit to the hospital to be reimbursed to this level.

The other scenario you have to remember is that this is only for a very limited type of admission. You have to be taken to the emergency room by an ambulance to a non-contract facility, which is not the vast majority of admissions to a hospital. For a health plan to take that strategy at the end of the day would not make sense, because most of their admissions do not occur through that fashion.

Assemblywoman McClain:
I am curious, since we are defining "major hospital" differently in this bill than the other two that we heard on Saturday. Will that all be taken care of, or do we need to fix this also?

Barbara Dimmitt, Committee Policy Analyst, Legislative Counsel Bureau:
If you will look at the mockup (Exhibit E) Section 1, number 3, line 14, it should say, "for purposes of major hospitals."

Chairwoman Leslie:
Tell me again where that information came from.

Patricia Allen:
We have a health care consultant who works with the Coalition, and he pulled up the published statistics from the *2003 American Hospital Association*.

Chairwoman Leslie:
Did they use the same criteria across states to come up with this?

Patricia Allen:
Correct.

Assemblyman Hardy:
Could you explain the Medicare cost ratio for this hospital? Does anybody know that hospitals actually make money or break even with the Medicare cost ratio, or do they depend on other insurances or those who do not have insurance to break even or make a profit?

Valerie Rosalin, Director, Consumer Health Assistance, Bureau for Hospital Patients, Office of the Governor, State of Nevada:
The Medicare cost report requires the hospitals to produce all their costs providing services to all patients, as well as Medicare patients. When they produce the cost report, a true reflection of costs provide care for all hospital admissions; therefore, the cost report can clearly reflect what profit margins can be made on admissions, whether it be a Medicare patient or a commercial member.

Assemblyman Mabey:
Many of these states that you have ratios on are southern states or southwestern. Do you think there is anything in this that would be due to the illegal aliens? It says that the summary of hospital markup and bill charges in Arizona is 201.9, Alabama is 203, Florida is 204, Nevada is 205, and California is 231.

Patricia Allen:
Managed care has evolved in each state, along with the cost of living in those states. Obviously, California has a large managed care industry. Bill charges were probably increased for the same reasons that we see them being increased in Nevada—to offset the discounts being given—but unfortunately, unlike California, we do not have the competition in Nevada, so we do not have different options and choices for health plans and services, because of our geographic access needs in northern and southern Nevada. We are required to contract with all hospitals. In California, you can go with a smaller hospital network without the fear of these high bill charges. There are many reasons why these things evolve the way they do. We also react to what happens, and we need to react to what is happening in Nevada.

Chairwoman Leslie:
The disparity is pretty shocking between the top list or average across the U.S. and where Nevada is.

Robin Keith, President, Nevada Rural Hospital Partners, Reno, Nevada:
I have a technical issue with the mockup (Exhibit E). Section 1, line 3, it says "A major hospital shall," and then it goes through the provisions of the bill. On the second page, line 23, it defines major hospitals as a hospital in a county whose population is 400,000 or more, which has an emergency room or a designated trauma center, and which is not federal, state, or local governmental. This by accident takes in the hospital in Boulder City, which has 20 acute beds, and also the hospital in Mesquite, which has 15 acute beds. I am not sure that was intended, and I would ask that consideration be given to changing this definition to just insert the words "with 100 beds or more," to bring it in line with the other definitions.

Jim Wadhams, Legislative Advocate, representing Nevada Hospital Association:
I was under the impression that Medicare across the board collected the data for Medicare services only, which seemed to be consistent with some of the proponent's testimony on the bills we heard on Saturday, that there is not a way to determine the actual costs so they can calculate the profits for purposes of negotiation. Something is not quite fitting in the testimony between the two days. If, in fact, Patricia Allen is correct, then that element does not need to be reproduced by statute since it would be available otherwise. I think the Committee is hopefully desirous of avoiding redundancy in information in trying to focus on the pertinent information that may be helpful.

This provision has a salutatory effect for third-party payers. I ask that this notion of shifting of costs is one that has to be borne in mind. During the testimony that we heard on Saturday, Speaker Perkins said that the percentage of beds in Clark County controlled by public hospitals was less than 17 percent. It was presented in a fashion that he thought was an insufficient percentage of public beds, which raises the points that we discussed on Saturday: competition, the lack of public funding for public facilities, and public health care. These issues all tend to circle back to the lack of will in the state and local governments of stepping up to the plate and dealing with the public side of the issue.

Bill Welch, President and CEO, Nevada Hospital Association, Reno, Nevada:
I would like to point out, with respect to patients transported to the hospital from an ambulance service, there was testimony by the EMS [emergency medical services] and ambulance services on legislation that is being heard in the Senate with respect to wait times. It was pointed out by the ambulance services that only 10 percent of the patients that they brought to the hospitals were of true emergent

need. The balance of those patients were either urgent or primary care—patients who did not have other means of transportation and were brought to the hospitals—and probably medical services could have been otherwise provided at other locations.

[Bill Welch, continued.] The ambulance services testified that Clark County no longer has a divert system, that the majority of patients are transported, unless they are designated as a trauma patient, to the hospital of their choice. The patient is choosing the hospital in which they are being transported to, unless they are designated as a trauma patient based upon their medical condition, which would require them by law to be taken to a designated trauma center. I think that should be noted, along with the testimony that Mr. Wadhams just presented.

Chairwoman Leslie:
Speaking as an insured person, my insurance changes according to the deal my employer makes every year. Do you have an explanation as to why Nevada is at the bottom of these statistics from the American Hospital Association?

Bill Welch:
Nevada is at the wrong end of how many individuals are utilizing the hospital for primary care in urgent care services versus what they are designed for. We are at the wrong end as far as pace of growth in this state versus the availability of adequate services—not only hospital, but all of the medical services. We are at the wrong end of lifestyle choices. If you look at healthy Nevadans, and look at the status of the average citizen, we rank the worst in most areas that we are rated. The patients who are presenting themselves to the hospitals in this state are in a different medical condition than they are in other states.

Chairwoman Leslie:
Does the American Hospital Association do any analysis when they release these kinds of statistics across states to point out those things—or profit margins, or anything else—that would go into these ratings?

Bill Welch:
That is our concern with the data that the American Hospital Association puts out. They take raw data, and they produce averages and publish the information, but it is not weighted based upon circumstances.

Chairwoman Leslie:
That's too bad. I'd like to see some real analysis of this.

Assemblyman Mabey:
Let's say that we process the bill. Is there a better number than the 150 percent of current Medicare rate that would be acceptable to the hospitals?

Bill Welch:
We are concerned with this legislation. We believe that it begins to set the wrong precedents, and this is asking the Legislature to serve as a messenger or as the negotiator for contracts. We believe that is an inappropriate function for this legislative Body.

Chairwoman Leslie:
I will close the hearing on A.B. 296 and open the hearing on A.B. 545.

Assembly Bill 545: Requires medical facility to provide estimate of cost of medical procedure to patient before procedure occurs. (BDR 40-1378)

Scott MacKenzie, Executive Director, State of Nevada Employees Association (SNEA), American Federation of State, County and Municipal Employees Local 4041, Carson City, Nevada:
Assembly Bill 545 requires the medical facility to provide an estimate of cost of the medical procedure to patients before the procedure occurs. "An act relating to health care; requiring a medical facility to provide an estimate of the cost of a medical procedure to a patient before the procedure occurs; prohibiting a medical facility from charging more than 10 percent more than the amount estimated; providing certain exceptions; and providing other matters properly relating thereto."

[Referred to Exhibit G.] The bill has four Sections. All relevant language changes to this bill are in Section 1. "Except as otherwise provided in subsection 3, a medical facility licensed pursuant to NRS 449.001 to 449.240, inclusive, shall, before performing a medical procedure, provide the patient or person authorized to make health care decisions on behalf of the patient with an estimate of the total cost of the procedure."

In subsection 2, "Except as otherwise provided in subsection 3, a medical facility shall not charge a patient more than 10 percent more than the amount estimated pursuant to subsection 1. If the amount of the bill for the procedure exceeds the amount estimated pursuant to subsection 1, the bill must separately identify and explain the increased charge."

In subsection 3, "A medical facility is not required to provide an estimate of the cost of a medical procedure pursuant to subsection 1 if the procedure is performed

in an emergency. A medical facility may charge more than the amount authorized pursuant to subsection 2 if the medical procedure has unexpected complications that require additional care or treatment, but the bill must separately identify and explain the additional care or treatment and the charges."

[Scott MacKenzie, continued.] In subsection 4, "The Board shall by regulation define the terms 'emergency,' 'medical procedure,' and 'unexpected complications' for the purposes of this section."

This concept came from SNEA General Council—which is the governing body of SNEA—where it was debated that different medical facilities charge different rates for similar procedures without prior notification of service. Members complained that they had similar procedures at different facilities and experienced different costs without seeing corresponding changes in quality of care. In some cases, members complained that charges exceeded what the insurance is willing to pay for a given procedure, leaving the patient with unexpected additional costs. This concept seems to be similar to the discussion that took place in Las Vegas over the weekend. Some might argue that health insurance does not work that way. It is true that many insured are limited in access according to their insurance provider contracts.

Although some doctors have multiple hospitals they deal with, we all know medical access has built-in limitations. At the same time, over 426,000 men, women, and children in Nevada have no health insurance coverage at all, as of 2003. Cost containment could be achieved by giving the consumer advanced notification of costs involved in any given procedure. It would create open competition in the marketplace among health care providers. The consumer would have the ability to shop for the most competitive price service.

I myself have never known the costs of medical procedures prior to receiving treatment; yet, as stated earlier, when I take my car for repairs, I receive a written estimate of charges before the decision to go forward with the repairs. Unfortunately, health insurance costs and the corresponding effect on society have evolved where we must change the way we think about how health insurance is being paid, and how much it costs before access. We can no longer just be concerned with the cost of our copay or our deductible.

During the 18th Special Session, the Legislature passed A.B. 1 of the 18th Special Session, creating the Sentinel Events Registry. We must expand the availability of information to the public and give public access to all information generated by this mandatory reporting system. In Pennsylvania, as an example of what many states are attempting to do, a system has been created, the Pennsylvania Health Care Cost Containment Council, or PHC4.

[Scott MacKenzie, continued.] Paying for performance, or the business case, could enhance the current Sentinel Events Registry. Giving the public access to the information generated by Nevada Sentinel Events Registry is an important step in containing costs associated with medical errors. Rewarding for performance while giving the public access to information is the best way to contain medical errors, create efficiencies within the health care industry, and contain costs for consumers. We are advocating, as the next step in the development of this containment system within Nevada, for A.B. 545. This legislation mandates the disclosure of medical costs in advance of agreeing to a medical procedure.

We also recommend this Body look at disclosure policies and the way data is currently organized within the Nevada Sentinel Registry. This information could lead to additional important legislation regarding informing the public about medical errors. Its applied use for the purpose of rewarding medical deliverers or providers who have learned to contain medical errors and save consumers—the public—additional costs due to medical errors. In other words, reward for performance.

Sally Tyler, Health Policy Analyst, Public Policy Department, American Federation of State, County and Municipal Employees, Washington, D.C.:

[Read from Exhibit H.]

I am here at the request of the State of Nevada Employees Association, which is a state affiliate of our union. They have asked me to speak about A.B. 545, in the context of national legislative and policy trends and how this fits into the overall goal of health care reform.

Assembly Bill 545 represents a crucial step forward in helping Nevada consumers as they make health care decisions for themselves and their families. This bill requires a measure of transparency and disclosure around pricing. Information on pricing is a key factor to help consumers make sound health care decisions, but it must always go hand-in-hand with information on quality in order to be truly useful. If there is a theme to my testimony today, it would be that efforts to pursue cost transparency and disclosure must mirror and track efforts around quality.

To give you a sense of national trends surrounding price transparency, fifteen state legislatures have already passed measures requiring hospitals to disclose prices. They include California, Washington, Arizona, South Dakota, Minnesota, Illinois, Indiana, Maine, Vermont, Massachusetts, Pennsylvania, West Virginia, Virginia, North Carolina, and Florida. Another four states have voluntary price reporting programs. It should be noted that most health care consumer groups

think that the voluntary programs are less effective since all hospitals in the states do not participate, so it's impossible for consumers to get a comprehensive snapshot of pricing in their area.

[Sally Tyler, continued.] There are a variety of ways to release information about costs and pricing, and the fifteen states that have passed disclosure bills cover the gamut in what they require. While pricing information can be key for consumers, it must be released in a user-friendly manner in order to be truly useful.

For instance, it is not particularly helpful to the consumer if the entire detailed charge master list of a given hospital is released. These so-called charge masters generally have thousands of line items and can only be accurately interpreted by specialists in hospital administration. It is also not particularly helpful if pricing information is released in a manner that requires consumers to know diagnostic-related group codes in order to access the information. Health care consumers have to be pretty savvy these days, but they shouldn't need an advanced degree in hospital administration just to understand a list of charges.

As I noted, the states that have passed similar measures require a variety of reporting. For instance, California requires that the full charge master be released. Others, such as North Carolina, require that hospitals give price information for only the most common procedures in their facilities. That state has the top 25 most common procedures.

Also, the question of what is reflected by price is far from uniform and varies widely by hospital. What many hospitals and health facilities refer to as "cost" frequently has little relation to what the consumer would be expected to pay for a given service. The notion of price could include the official charge, the discounted amount that health plans pay to hospitals, or the Medicare/Medicaid reimbursement rates.

For this reason, I would suggest clarifying or amending the bill from its current disclosure requirement for the "total cost of the procedure" to "the total cost that the consumer would be expected to pay." This will help keep the issue in focus for the consumer.

> [Sally Tyler, continued.] Also, the issue of uninsured or insurance has a big impact on pricing. Throughout the nation, states are grappling with the issue that the uninsured are frequently charged more than the insured for the same procedure, and we are trying to figure out what to do with that. This information can also help Nevada as you are struggling with those same decisions.
>
> Getting accurate and in-depth pricing information for Nevada hospitals will help you as you grapple with the initiatives to address the high rate of uninsurance here. This year there are approximately 700,000 uninsured, and they represent 37 percent of your state's population. And 83 percent of the uninsured are in working families. It will be important for policymakers to know if the uninsured are routinely being charged more than their insured counterparts.
>
> Nevada did make a great stride forward in 2002 by passing the requirement of sentinel events reporting. It is our union's hope that we can build on the efforts begun by that database to help health facilities reduce their rates of medical errors. In order to truly inform consumer decisions, information about quality must be made available to the public.

There are some encouraging national models regarding consumer access to quality information, including the Hospital Compare Initiative and website that just went online last week—sponsored by CMS [Centers for Medicare and Medicaid Services] to provide information on hospitals around the country—as well as similar quality information that can be obtained through the JCAHO [Joint Commission on Accreditation of Healthcare Organizations] website. Hopefully, the State of Nevada will use these national models to help develop the Sentinel Reporting Database as a useful resource for the public that will compliment cost disclosure efforts.

[Read from Exhibit H.]

> To echo my overarching theme today, the quest for cost containment and quality improvement must be interlinked. Increased transparency around quality will actually help contain costs by reducing medical errors. These efforts must move forward together in order to be successful. The State's future efforts should also address such issues as effective implementation of health care information technology in order to increase quality control costs, and the role that understaffing and mandatory overtime for health care professionals plays in the realm of quality.

> [Sally Tyler, continued.] This bill is not intended to be a "gotcha" measure in any way, no more than the Sentinel Events Registry reporting requirement is. While we recognize that the issue of cost and price is a complex one from the standpoint of hospitals, we believe it is important that both the public and policymakers have more information around costs in order to make sound individual health care decisions and to craft effective health reform efforts. It is our hope that hospitals and the health care community will work with labor, consumers, and policymakers here in Nevada to make this a reality by passing A.B. 545.

Chairwoman Leslie:
Would you recommend in Nevada that we start with the top 25 medical procedures?

Sally Tyler:
That can be a useful way to organize it.

Assemblyman Mabey:
In Section 4, where it says "unexpected complications," every complication is unexpected, and so how are you going to decide whether it was an expected or unexpected complication? When I operate on somebody, I hope that there is not a complication, and so every complication would be unexpected. They may get an infection afterwards and have to be in the hospital longer, or they may develop a hematoma or a blood clot in their leg. I just do not know how we can explain what an "unexpected complication" is.

Scott MacKenzie:
The way this is laid out, there would be a base for the procedure that you would deal with, and if there was something to complicate it, the only consequence was that the billing would be explained separately as to what would occur.

Assemblyman Mabey:
That would be a very difficult thing to work through.

Assemblywoman Gerhardt:
I have a real-life scenario, maybe you could respond. If a young woman went into a hospital for labor and delivery, and the policy of the hospital was to charge patients for a private room if the second bed in a two-bed room was not filled, would this bill mean that the patient would be apprised of that policy prior to admission?

Scott MacKenzie:
I do not see anything in the bill that addresses that, because that would not be something that happened separately medically. That would have more to do with the facilities.

Assemblywoman Gerhardt:
The policy of the hospital is that there is a two-bed room, and if they do not fill the other bed, that one person left in the room is charged for a private room. Would policies like that be disclosed?

Sally Tyler:
I would assume in that case that the estimate of the bill would assume that they would be billed a private charge, and then if both beds were filled, they would actually be billed at a lower rate. The estimate would include the high charge.

Assemblywoman Gerhardt:
Would the patient be apprised of those kinds of policy issues when they receive the estimate?

Sally Tyler:
Yes.

Bill Welch, President and CEO, Nevada Hospital Association, Reno, Nevada:
With regard to the sentinel event—which this bill does not pertain to, but it has been brought up in a number of the bills today—I would point out that the Nevada Hospital Association and all of its members voluntarily signed off onto the CMS Hospital Compare Program. We were one of a number of states that were in the position to announce that every one of their hospitals is participating in that program on a voluntary basis. In addition, there are many other functions we are doing with respect to quality care issues.

With respect to the analysis that has been used on this bill, an auto repair shop would give you an estimate of services that you would expect to pay. I just recently got my vehicle out of the shop. I described what I believed to be the problem and they gave me an estimate. They did not repair the vehicle to its entirety, because once they got into the mechanical problems they found that it was much more than they had estimated, so they stopped working on my vehicle. My vehicle ended up being in the shop for another day; they had to call me first to get my permission to go further.

I know this bill makes provisions for emergency situations. I would believe that most patients are admitted to the hospital for medical emergent situations—if not emergent, then urgent—otherwise, they would not be in the hospital. As Dr. Mabey

has pointed out, I believe that this bill will create a horrendous amount of paperwork that will be necessary to demonstrate what a cost is once a patient is discharged, beyond what is already required by Nevada law. This cost is passed on, and it will increase health care costs versus lowering health care costs. We need to remember that Mr. [Charles] Duarte has pointed out a publication that is available that gives the average prices on many procedures that are performed within the hospital. *Personal Health Choices*, the consumer health assistance manual, does by various diagnosis give what the average cost by individual hospitals would be. The cost of those procedures are listed so that a consumer can go to that book and determine if they wanted to have their baby in hospital A versus hospital B, solely on the basis of costs. Disclosure with the charge master would be very difficult.

[Bill Welch, continued.] There are a lot of things talked about today, and much of this information is available. I am not saying we should not disclose policies, because policies and procedures should be available to a consumer. The intent of this bill would be very difficult and, I believe, costly to implement.

Chairwoman Leslie:
We have heard that 15 other states have managed to do it, so it would be very interesting to see how they got around those issues that you brought up.

Robin Keith, President, Nevada Rural Hospital Partners, Reno, Nevada:
Nevada Rural Hospital Partners is opposed to this bill for some of the reasons already mentioned by Mr. Welch. What I am not seeing here is how we would actually do this. If you come into a small hospital with pneumonia, and you would like to have an estimate prior to your admission, our hospitals would always be open to saying we charge this much for an IV [intravenous injection], this much for an X-ray, and getting the charges I do not see as a major problem. The problem is that you can say to us, "What will you charge?" We will say to you, "What do you need?" And you will say, "I don't know; my doctor will decide that." To do this prospectively, we are going to need to know how many days are you staying, whether you are going to need 1, 2, or 5 X-rays, whether you will be using the less expensive antibiotics that might work for some types of pneumonia, or whether you will be needing the horrendously expensive antibiotics that are helpful in treating some of the more virulent strains of pneumonia. Will you be in intensive care or not? Are you going to need respiratory therapy for one day or four times a day for a week? Some pneumonias are very easily taken care of and are out in two days, and others become significant problems.

In trying to respond, how we would extract from a patient's bill those portions of the charges that were not included in the original estimate would seem to be a difficult and expensive administrative process.

Chairwoman Leslie:
I will close the hearing on A.B. 545.

Vice Chairwoman McClain:
I will open the hearing on A.B. 523.

Assembly Bill 523: Revises provisions governing jurisdiction of local boards of health. (BDR 40-1123)

Assemblywoman Sheila Leslie, Assembly District No. 27, Washoe County:
I brought this bill forward after a series of articles appeared in our local paper, beginning last December, with problems in the College of Agriculture of the University of Nevada, Reno (UNR). You are being given some of the articles and an amendment to A.B. 523 (Exhibit I). These articles lead to my concern that the statutes are perhaps not clear enough in our state in regard to the authorization of oversight by our local public health authority.

There are other allegations that have arisen as a matter of these articles being published: allegations of animal abuse, discrimination against the whistleblowers at UNR, and the secret camera fiasco. You may have heard about those issues that came as a result of this series of articles. There are current investigations taking part to cover all that by the USDA [United States Department of Agriculture], the NDI [Nevada Division of Investigation], and UNR has also appointed a committee. If you are interested in reading more about that, you can consult the full series of articles on the *Gazette-Journal* website.

Assembly Bill 523 focuses solely on the issue of protecting the public's health. I do not doubt that UNR is doing very important research in this area in the College of Agriculture or that there are many fine professors and students. This is not about that, but I do not have a personal comfort level that all the public health standards are being met. This bill provides that comfort level by giving our local public health authorities clear jurisdiction over complaints related to public health, as well as authority they have everywhere in Reno, except the University's agricultural farm. The packet I have provided you (Exhibit J) includes several articles of the series over the past few months, which I believe illustrates this point, and I would like to walk you through that so you will know what is there. The first article was published March 30, 2005, and the packet is entitled "From Research to Waste?" This article talks about ewes that were used in stem cell research that were later converted to farm animals for use in a weed control project along the Truckee River. Many of these sheep were driven into the river by coyotes or wild

dogs, and they drowned. Others were buried in a pit that became inundated by water, washing away their remains.

[Assemblywoman Leslie, continued.] I have highlighted the public health question on the second page. Are the dead research sheep a danger to the environment? The newspaper asked scientists and researchers at other universities what they thought about this, and the general feeling is outlined in another article later in the packet. I tried to highlight these sections so that you can easily find them. This article is entitled "Sheep disposal no threat to the environment," but questions are still raised. One of the outlined paragraphs in this article says:

> Allowing the carcasses of some mother ewes from UNR's human stem cell projects to be eaten by animals and get into the Truckee River probably poses little or no danger to the environment. The researchers said the human stem cells cannot cross the biological barrier between pregnant ewe and her fetuses. Although not all scientists agree with that determination, ethicists said incineration of carcasses of animals used in stem cell research is the only way to be sure no new diseases are unleashed on humans.

I bring this up as an example of a complaint. That is a question a person would ask, and who would you call in your community to ask if there is a public health hazard associated with an experiment like this? I would call our public health authorities. If you did call them, they would tell you, "Because of the agricultural exemption on UNR's urban farms, they don't have clear authority to investigate that complaint." So, that is the purpose for the bill.

Later in the next article, dated January 9, 2005, the headline there says, "Dead animals seen recently, students say." Another article following that says, "Improper disposal can pose health risks." These articles talk about the rotting of whole dead animals on the UNR farm property, which is located north of Hidden Valley, and the use of waste animal parts to attract coyotes to the area so they could be killed. I have highlighted a paragraph for you there that says, "Health officials say leaving animals rotting in the open spreads disease and pollutes water supplies, but because the UNR farm is exempt from local health and environmental laws, officials cannot intervene."

At UNR, the Department of Environmental Health and Safety is supposed to oversee operations at the Main Station Farm. Provost John Frederick said in June, "That is not happening because that department mostly handles incidents on campus and relies on our experts at the station to ensure safety there."

[Assemblywoman Leslie, continued.] Another article in the series ran on January 9, 2005, and is titled "Humane Society seeks investigation into abuse allegations." I have highlighted a few more sentences that support the concept documenting that farm properties are exempt from local health and environmental laws, and UNR's animal facilities appear to be unaffected by local regulations. A district attorney in Washoe County noted in the article, "When there is a problem, local authorities should be able to go in and take any action that is appropriate." District Attorney Richard Gammick and I are in agreement on this.

The last page in the packet (Exhibit J) is a solutions section that highlights a need for independent oversight of these problems in a number of areas. On the very last page there are some highlighted sentences relating to the public health hazards. It is noted that law in our adjoining state of California bans open-pit burials or composting of dead animals, requiring instead that they be incinerated or sent to a commercial rendering firm. Local health agencies in California do have jurisdiction over university facilities, something that is not the case in Nevada.

After Assemblywoman Giunchigliani is finished, I do have an amendment that I would like to present, with the State Division of Health and the Washoe County Health Department, to clarify the joint supervision issue. I am not asking them to do regular inspections or to add substantially to their caseload. I just want them to have clear authority to go investigate a public health complaint.

The bottom line question the Committee needs to ask is, if there is a question or complaint about a practice on the university's agricultural holdings in our state that relates to public health, do we think the agricultural people or the public health people should have authority to investigate the problem and determine what, if anything, needs to be done? With no disrespect intended to the agricultural people, my personal comfort lies with the public health authorities.

Assemblywoman Chris Giunchigliani, Assembly District No. 9, Clark County:
I am in support of A.B. 523. Ms. Leslie put together an excellent exposé of the issue that frames it. I think it was absolutely inhumane treatment of animals that have been used for the purposes of proper research. The policy used to be that they were incinerated. Somehow, that was changed, and everyone ignored that. When calls were made about looking at this, they did not have access to the property. With no disrespect, this is a public institution, funded with public tax dollars, and we have every right to have individuals and a properly-certified agency to go in and make sure that they are protecting the public health. To me, that is not the Department of Agriculture. That is under the jurisdiction of the Health Division. Currently, they are the only portion of the University System that has their own farm, and they also have their own Wolf Pack Meats. There was an article

that questioned whether or not these sheep had possibly gone into some of their repository.

[Assemblywoman Giunchigliani, continued.] I think we need to err on the side to making sure that we have a check and a balance. This is a case in a particular issue of health, and a question of health matters and public safety that the Health Department and the Health Agency should have access to the property, any property regarding it, not just the Department of Agriculture, and this would expand it to that. If UNLV [University of Nevada, Las Vegas] wants to get into this market as well, they should also have jurisdiction. It should not be written so narrowly, and it was written to cover the institution itself.

This is about management as well, and I do believe there has been a great deal of mismanagement that has gone on in—not just this Division, but in various other areas that Ms. Leslie mentioned in the beginning. That is there for your reading opportunity, but at this point it is simply about protecting the public health.

Assemblywoman Leslie:
You should have an amendment in front of you (Exhibit I). As you know, Washoe County, Clark County, and now Carson City will have their own public health authorities. Anywhere else in the state where there is a public health issue, the State handles it. We just got rid of the bifurcated system in child welfare, but we are not getting rid of it in health. What we are trying to do is come up with an amendment that allows for joint supervision. We are proposing to the Committee that we change the current language—amend it—and add a new section to read as follows: "A local health authority may investigate complaints pursuant to NRS [*Nevada Revised Statutes*] 439.350 relating to the operation of any agricultural program administered by the University and Community College System of Nevada." We want to delete the language in Section 2.

The purpose of this is to clarify the concept of joint supervision, to give the local health authority the authorization to investigate complaints. The new language allows the local health authority to respond to local complaints by investigating the complaint and/or passing it on to the Health Division if that is more appropriate.

Assemblyman Hardy:
On page 2, lines 1 and 2, where it references Nevada children's homes, they do not exist. Is there any other reference?

Assemblywoman Leslie:
I do not think we want to change that because that already provides you authorization. That is already an existing law.

Assemblyman Hardy:
We do not have Southern Nevada Children's Home in Boulder City anymore.

Assemblywoman Leslie:
I understand what you are saying; we might want to delete that.

Barbara Hunt, District Health Officer, District Health Department, Washoe County, Nevada:
I am here with Richard Whitley from the State Health Division to simply indicate that we are satisfied with the bill and the amendment, and we feel that this will work well for us.

Douglas Busselman, Executive Vice President, Nevada Farm Bureau, Reno, Nevada:
Nevada Farm Bureau is opposed to A.B. 523. Our organization's opposition to this proposed measure is based on several reasons. We believe that any regulatory oversight, as proposed by A.B. 523, should be based on scientific bases with known standards for performance. We are not aware at this time of the foundation for regulatory oversight to be used by the Health Division or local boards of health. There is a vast difference between agricultural operations by way of sanitation, healthfulness, and cleanliness, and most facilities are under the watch of the Health Division and local boards of health.

Without agriculturally based standards, we believe that this regulatory scheme could be completely based on regulation for the sake of regulation. We do not believe that the Health Division or local boards of health currently have the necessary background or scientific basis to evaluate agricultural practices and make determinations of whether sanitation, healthfulness, or cleanliness situations have created negative effects. In reading the legislation, we understand the scope of this bill is the agricultural programs administered by the University and Community College System of Nevada. At the same time, we do not believe that it is likely such a regulatory approach will only be directed at one or two enterprises.

Agricultural activities and agricultural waste are already currently exempt from solid waste requirements in NRS 444.620. Despite this exemption, we have been involved in working with Washoe County's Health Department to make corrections in their local ordinances, which have resulted in permit requirements for hauling livestock waste.

Our point in raising this matter is to reinforce our contention that regulatory expansion, even beyond stated NRS requirements, is not unheard of by those who have been placed in charge of the oversight of the university and community college agricultural programs.

[Douglas Busselman, continued.] We also wish to raise concerns over the impact of such regulation over agricultural programs for the University of Nevada. We support the research work of the agricultural research branch of the University. Current controversy directed at the agricultural research facility is triggering consideration on an overall decision making process with the potential of closing the main station research facility in Reno. Such a move—relocation of the agricultural research facility further from the UNR campus—will further erode the ability for researchers to engage in the types of agricultural research we believe is needed. When you remove this critical infrastructure component, you substantially reduce the ability for meaningful research into the future.

Having toured the University's main station research facility, I can speak to the quality of the agricultural practices that I have seen. One could easily make the case that their facilities and production practices are as good as any agricultural facility in the state. They have financial resources behind them that normal agricultural producers do not have, as well as fewer requirements for showing a profit. If the main station agricultural research facility cannot withstand the burdens of urban encroachment and city neighbors who do not wish to accommodate agricultural practices, then it is highly unlikely that any other agricultural operation can be maintained and remain viable with such encroachment. The wisdom of long-term agreements to keep agricultural lands locked into agricultural land uses should be reevaluated, and possibly discontinued.

In summary, we believe that A.B. 523 should not be adopted and the regulatory oversight spelled out in this bill should not be expanded to encompass agricultural practices. When we prepared our comments, we were not aware of the Chairwoman's proposed amendments, although I do not know what those exact amendments say or how they fit into the context. We do appreciate the possible changes.

Vice Chairwoman McClain:
Have you seen a copy of this amendment?

Douglas Busselman:
Not yet.

Vice Chairwoman McClain:
It should address your concerns, because it is not giving them joint supervision anymore.

Douglas Busselman:
As I heard the discussion, it somewhat triggered in my mind there are currently, in the section of law dealing with nuisance lawsuits, provisions where certain

agricultural practices can be overseen by health bodies. In the statutes there is a recommendation or almost a requirement, if there is a question on whether or not the agricultural practice that is being carried out is appropriate, the health bodies are directed to go to either the Department of Agriculture or to the Natural Resource Conservation Service to determine and find out from those folks who are knowledgeable on agricultural practices whether or not the practices that are being carried out fit within management practices. I think that would address much of our concern, in having somebody who knows something about agriculture being involved in the process to determine whether or not an agricultural practice is being carried out as it should.

Vice Chairwoman McClain:
All it says now is that they can respond to local complaints, and pass them on to the Health Division. That is part of the problem that we have with all these local governments and half a dozen different entities, so people do not know who they should be contacting. Giving them another avenue is good public relations.

Trudy Larson, Assistant Chancellor, University and Community College System of Nevada:
I support this bill in concept, because I think being a good neighbor is very important. I think it is critical that the local authorities make it well known what kind of rules and regulations they intend to operate under. As you know, the UNR agricultural farm programs are oftentimes done under federal research projects. They are overseen by federal agencies. We have concerns that any local jurisdiction not be in conflict with the federal guidelines that are actually essential for the continuation of these grants.

Assemblywoman Leslie:
This is about public health. It is not about research; it is about whether there is a public health hazard.

Trudy Larson:
That is why I agree with the intent of this bill, for people to have a place to call.

Assemblywoman Leslie:
I do not know what the conflict would be with federal law. Since it is a public health law, I think the conflict would already exist.

Trudy Larson:
I think you just heard a description of some of the concerns, which are that agricultural practices and best practices may conflict with urban areas, and that there may be a misunderstanding. I think the whole operation may have some conflict. I think we have no problems being a good neighbor, and it is very

important for there to be a place for local complaints. It would be a matter of making sure that we all understood what the rules and regulations are.

John Lilley, President, University of Nevada, Reno:
It is my understanding that this legislation aims to extend the jurisdiction of the county health departments over the university agricultural operations, and this legislation would do so throughout the state.

It is inevitable that as urbanization spreads, there will be friction between the traditional land uses, such as farming, and those of residential and commercial areas. We deal with those issues directly through communication and through listening to the concerns of those impacted by these changes. It is very important for me to drive home the point that you already have heard. We work in a highly regulated environment, and the federal government, our chief regulator, is a frequent visitor, sometimes announced and sometimes unannounced. If this bill passes it will add an additional oversight layer to those which we already comply with, and let me point out that our record of compliance is excellent.

I have two concerns. I am not speaking for or against the bill. My first concern with this legislation is that should it pass, the local agencies that take on this regulatory responsibility must have the necessary budgets to achieve what is expected of them. My second concern is that there be a clear understanding between overlapping jurisdictions that will be created should this bill pass.

David Thawley, Dean, College of Agriculture, Biotechnology, and Natural Resources, University of Nevada, Reno; and Director, Nevada Agriculture Experiment Station:
I am a veterinarian with a graduate degree in microbiology and veterinary public health. I am also a diplomat of the American College of Veterinary Preventative Medicine. For ten years I taught courses in veterinary public health to veterinary students and, for several years, epidemiology to students of public health at the University of Missouri. I believe that I am well qualified to address issues relating to the protection of public health associated with livestock operations at the University. I can also assure you that certainly, in recent years, the College of Agriculture and the University have taken steps well beyond those stipulated by government statutes to protect the health of its employees and the public in general.

Initially, I saw this bill as rather innocuous. It lied about the regulatory authority's process and procedures to which these operations must answer. Our research facilities are regularly inspected by the USDA [United States Department of Agriculture] animal, plant, and health inspection service, who arrive unannounced. Wolf Pack Meats has a resident federal inspector, and our facilities are also subject

to inspection by the American Association of Laboratory Animal Clinicians for their certification process. Additionally, the University has the Department of Environmental Health and Safety, and we also come under the supervision of the Nevada Department of Agriculture.

[David Thawley, continued.] My initial reaction to this bill was that it would provide another authority to further inspect and regulate these facilities, and we would be open to this. However, upon further reflection and discussion, I have come to believe that this bill warrants further consideration. I ask you to consider these questions:

- What regulations above and beyond those already in place would health departments enforce?
- How would any new regulations be formulated, and on what science would they be based?
- Who would be qualified in the local health departments to develop such regulations, and then to have the veterinary public health expertise to conduct investigations?

Let me give you one example. A federal inspector is present every day in our main station to oversee our Wolf Pack Meats. If any of you are concerned about those sheep you heard about earlier, every animal that passes through Wolf Pack Meats is inspected before and after slaughter. This individual is trained specifically to examine our animals before and after slaughter, as well as the sanitation of the operation. Other aspects of the main station are inspected regularly and are unannounced by federal inspectors, at least one of whom at each inspection is always a veterinarian. I question how several county health departments will be able to mount an inspection program with equally qualified expertise. If not, what useful purpose could they serve?

It is important the Committee be aware that currently, the University runs agricultural operations in several counties, including Washoe, Churchill, Lander, and Lyon, and also Lassen County in California. Several of these operations are extremely remote, and an aggregate account for over 250,000 acres. For at least two of these facilities, the nearest neighboring house is many miles from the University operations. To pass this bill and blanket all these agricultural operations would place a considerable burden on these rural health departments, and it would be difficult to see how this could work.

If this bill is a reaction to allegations that dead animals have been improperly disposed of at our main station, I can assure you that is not true. Consistent with standard farm practice, we have a disposal or burial area on that farm. It is true that prior to eight months ago, there may have been times when the main station

farm's deep disposal may have been left uncovered. When this was reported, we immediately implemented a policy to ensure that this could not be repeated by documenting the management of this site, requiring that all materials placed in it be documented in a log with the date and signature to confirm that these materials were covered. We have now also instituted a policy of daily inspection of that site. These requirements far exceed those required.

[David Thawley, continued.] I cannot sit here and assure you with the passage of time that new issues will not appear. Agricultural operations, more than most enterprises, are subject to the vagaries of the weather and the climate, predator populations, and an always-changing labor force, and as you have seen, changing expectations in an increasing urban society also affect agriculture operations. However, I can assure you that when we learn of concerns, we take them seriously, and we make changes. Considering all of the above mentioned, I would ask the Committee to thoroughly research the need and ultimate consequence, should this bill be passed.

Assemblywoman Leslie:
I want to respond, while we have the public health people here, regarding whether they have the budgets. I have talked to them about it, and they have assured me that there is no substantial impact needed on their budgets. They are not going out to regulate. This is not for regulations, we are talking about if they have a complaint that the water in the Truckee River is unsafe to drink because there are sheep dying in the river, that they have the clear authority to go out and investigate that complaint.

Vice Chairwoman McClain:
I will close the hearing on A.B. 523.

Chairwoman Leslie:
I will open the hearing on A.B. 444.

Assembly Bill 444 Revises provisions governing solid waste disposal sites. (BDR 40-307)

Assemblywoman Peggy Pierce, Assembly District No. 3, Clark County:
Last summer there was a local report on the public radio station, and it said that Nevada is on the verge of becoming a big importer of solid municipal waste. This is not nuclear waste. It is the waste that you put on your curb, and we are going to receive lots of it as Nevada continues to grow. There are companies in rural Nevada trying to set up large landfills, and some of them are on rail spurs. We live

next to a very large state that would like to have their garbage go somewhere else, and there isn't any way to stop that. What the report said is that at the moment, we do not require our landfills to be lined, and the federal regulations allow our regulatory people to designate that some landfills do not need to be lined.

[Assemblywoman Pierce, continued.] There are two reasons landfills over a certain size need to be lined. One is because I would not like to see a garbage race to the bottom, where folks in the West look around and say, "Everybody requires linings except Nevada." Lining landfills is pretty much state of the art, but it's not a new idea. It is required. My understanding is that there are no other states that allow large landfills not to be lined. The other part of it is that we know in southern Nevada there is a plan to go out into the rural counties for groundwater to be used for drinking water in Nevada for the next 100 years. I think if we are going to be getting drinking water for southern Nevada out of the rural counties, we should do everything that we can to make sure that is good drinking water.

I have an amendment (Exhibit K), and it basically replaces everything that is in the bill under Section 1, parts 2(a) and (b). This bill asks the State Environmental Commission to adopt regulations establishing standards for the construction of an engineered liner and leachate collection system for all new municipal solid waste landfills and all lateral expansions of existing municipal solid waste landfills if either dispose of more than 100 tons per day of solid waste on an annual average basis, and requiring the installation of an engineered liner and leachate collection system for all new municipal solid waste landfills and all lateral expansions of existing municipal solid waste landfills if either dispose of more than 100 tons per day of solid waste on an annual average.

I called Apex Landfill in Clark County, and I asked for a tour. What they do is literally build a mountain from garbage over about 100 years, and then they cover it when it is closed. They will then put dirt and plants on it and try to make it look like a regular mountain. It is a tremendous amount of garbage, and these are designed to be open for 100 years or more. They put a lining on the bottom, and then they put a leachate collection system over the top of this lining. This is a system of pipes that sucks up any moisture that gathers down at the bottom. In some landfills it is pulled out and burned off. It basically keeps moisture from collecting on the lining.

My bill says that if you open a new landfill that is going to take in more than 100 tons per day, you line it and put a leachate collection system down. The other part of it says if you expand your landfill—if there is a landfill in rural Nevada that is small and under this threshold, but you have decided that you are going to expand it and become a large landfill—that the expansion be lined and have a collection system. This document (Exhibit L) lists the landfills in Nevada and will show you

that there are a few large ones and many small ones. I tried to put in a threshold that didn't catch all of the small municipal waste dumps in rural Nevada, but these are basically the large landfills. The Apex Landfill that I visited is fully lined. It's state of the art, and I am aiming for all the large landfills to be state of the art, to be the best that the technology can provide.

Assemblywoman McClain:
I am curious how we came to the threshold of 100 tons per day.

Assemblywoman Pierce:
Landfills come in classes. There is a class II and class I, and that threshold is 20 tons per day. When I looked at 20 tons per day, I was catching some very small landfills, and that wasn't my aim. I chose 100 tons per day, because I decided not to go with that 20-ton-per-day threshold.

Assemblywoman McClain:
Is this actually 1,000 tons per day on your chart (Exhibit L)?

Assemblywoman Pierce:
Yes.

Assemblyman Horne:
On the area of expanded landfills, what other jurisdictions have expanded their landfills and then upgraded to have these liners, and if so, what were the costs in doing that?

Assemblywoman Pierce:
This will require that these businesses have some expense installing this lining. Whatever the expense, it will be stretched out over 100 years. These are long-term operations.

Assemblyman Horne:
I would also like to know the costs involved in creating a new landfill with these types of liners.

Assemblywoman Weber:
Did you say Lockwood and Ormsby have this liner that you are referring to?

John Pappageorge, Legislative Advocate, representing Republic Services, Inc.:
Lockwood currently has a clay base, which meets the federal standards and either meets the standards of a liner or exceeds the standards of a liner. That issue has come up many times in years past, and the state and local people will also answer and agree that it does meet the standard of a lined landfill.

Assemblywoman Weber:
What about Pahrump? Does it meet that threshold of 100 tons per day, and if it applies—it's prospective primarily in the legislative intent—is that correct that any time into the future one that is expected to meet that threshold be required to provide the liner?

Assemblywoman Pierce:
Yes.

Chairwoman Leslie:
Where is the cutoff line of this chart?

Assemblywoman Pierce:
I choose 100 tons per day; I think Pahrump and Ormsby would be included in that figure. I would be willing to work with anyone on this threshold figure.

Assemblyman Hardy:
When I look at the chart, it looks like 200,000 all the way up to Mesquite, where it becomes 150,000. If we were to start those anew, this would affect that, but we are grandfathering in the ones that already exist according to the statute, as I understand it.

John Pappageorge:
If I am looking at this chart right that is 1,000 tons per day, not 200,000.

Assemblywoman Pierce:
I just received a more up-to-date chart (Exhibit M), which says that the 100 tons per day does catch the City of Elko, and as I said, that was not really my intention.

Chairwoman Leslie:
What was your intention? It might not be a bad thing to catch the City of Elko.

Assemblywoman Pierce:
I wanted to make sure that Apex and Lockwood are lined, and any other large landfill that is going to be in the business of collecting municipal solid waste from other states be included.

Assemblyman Hardy:
Are we tying any of this to recycling, and what are the statistics on these particular landfills—Apex, Lockwood, et cetera?

Assemblywoman Pierce:
I am not making recycling a part of this. The statistics go county by county, not necessarily landfill by landfill. Northern Nevada has done a good job of recycling, and in the south we have some catching up to do. That doesn't necessarily have anything to do with landfill or landfill design.

Assemblyman Hardy:
The more you recycle, the less you put into the landfill, and I think there is a connection.

John Pappageorge:
We do support A.B. 444, and I wanted to point out that we now do line our landfills. Actually, we did when the landfill was put into effect several years ago, before the requirement for lining was definite, knowing that it does protect groundwater, and they thought it was a good idea.

Ed Allison, Legislative Advocate, representing Waste Management, Inc.:
Lockwood's method, instead of lining—with clay and rocks—not only meets, but exceeds the federal standards. It does not make a lot of sense, when the wells are drilled and tested constantly to require a liner system when the system is actually better than the existing one. We certainly agree with Assemblywoman Pierce that you should have that kind of system where the end result is as good as or better than what is required. I would like to have the technical people sit down with her and go over this, because I think you would find it compatible with the goals of the bill.

Chairwoman Leslie:
We would ask you to do that, but our deadline is approaching. My intent is to process this bill, so we need some amended language.

Kaitlin Backlund, Political Director, Nevada Conservation League, Reno, Nevada:
We would like to go on record in support of this bill, and would like to be a part of assisting Assemblywoman Pierce in working out final language.

Chairwoman Leslie:
We were having a side conversation about whether this would even affect Lockwood, since it's grandfathered. I still think it would be good to have that language in there so that there is an alternative, if the clay system really exceeds the standard.

Assemblyman Horne:
I think that even though clay may meet the federal standards, that would not bar the jurisdiction from setting the standard higher.

Joe Johnson, Legislative Advocate, representing the Toiyabe Chapter of the Sierra Club:

On the recycling issues and landfill issues, these are reoccurring issues that I have had personal experience with since 1991, when I served in the Assembly. We dealt with this issue from a standpoint of meeting standards for qualifying this bill, which is to be prospective in the threshold of 100 tons, which was a threshold to qualify for future lining on expansions. I believe that is probably an appropriate level, and if some of these rural landfills choose to accept much larger disposals, they then should qualify to be lined.

Nancy Howard, Assistant Executive Director, Nevada League of Cities and Municipalities, Carson City, Nevada:

I want to express a concern about the landfills here—specifically, Boulder City and the City of Elko, and the impact that it may have on them. We would be more than happy to work with Assemblywoman Pierce and other interested parties to see if we can make this work.

Leo Drozdoff, Administrator, Division of Environmental Protection, Department of Conservation and Natural Resources, State of Nevada:

It is our series of charts that Assemblywoman Pierce has been working from. The Division is neutral on the bill. The reason for neutrality is when we went forward on our draft solid waste management plan, asking a similar question of whether all facilities were lined, a number of the small communities came out and talked about the economic hardships involved. A liner costs about $150,000 an acre, so there was a cost issue, and then some sentiments were expressed that there are other alternatives that can do an equal or better job. We certainly wanted to provide Assemblywoman Pierce all the information that she needed.

Chairwoman Leslie:
There being no further business, the meeting is adjourned [at 3:53 p.m.].

RESPECTFULLY SUBMITTED:

Joe Bushek
Recording Attaché

RESPECTFULLY SUBMITTED:

Mary Garcia
Transcribing Attaché

APPROVED BY:

Assemblywoman Sheila Leslie, Chairwoman

DATE:

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: April 11, 2005 **Time of Meeting: 1:04 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda (1 page)
A.B. 353	B	Chairwoman Leslie	Mockup of proposed amendment (3 pages)
A.B. 353	C	Charles Duarte / Division of Health Care Financing and Policy	2-page testimony
A.B. 353	D	Valerie Rosalin / Consumer Health Assistance, Office of the Governor	Binder (16 pages)
A.B. 296	E	Mike Sloan / Mandalay Resort Group	Mockup of proposed amendment (2 pages)
A.B. 296	F	Patricia Allen / Health Strategies, Inc.	Summary of billed charges (4 pages)
A.B. 545	G	Scott MacKenzie / SNEA	Testimony (5 pages)
A.B. 545	H	Sally Tyler / AFSCME	Testimony (4 pages)
A.B. 523	I	Assemblywoman Leslie	Proposed amendment language (1 page)
A.B. 523	J	Assemblywoman Leslie	Newspaper Articles From Research to Waste (22 pages)
A.B. 444	K	Assemblywoman Pierce	Amendment (1 page)
A.B. 444	L	Assemblywoman Pierce	Disposal Rate in tons/day (1 page)
A.B. 444	M	Assemblywoman Pierce	Class I and Class II landfill facilities (1 page)