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

Seventy-Sixth Session
June 5, 2011

The Committee on Health and Human Services was called to order by Chair April Mastroluca at 3:58 p.m. on Sunday, June 5, 2011, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/76th2011/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblywoman April Mastroluca, Chair
Assemblywoman Peggy Pierce, Vice Chair
Assemblyman Elliot T. Anderson
Assemblywoman Teresa Benitez-Thompson
Assemblyman Steven Brooks
Assemblyman Richard Carrillo
Assemblywoman Lucy Flores
Assemblyman Jason Frierson
Assemblyman Pete Goicoechea
Assemblyman John Hambrick
Assemblyman Scott Hammond
Assemblyman Pete Livermore
Assemblyman Mark Sherwood
Assemblywoman Debbie Smith

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Allison Copening, Clark County Senatorial District No. 6

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Principal Research Analyst
Kirsten Coulombe, Committee Policy Analyst
Risa Lang, Committee Counsel
Linda Whimple, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Bobbette Bond, Director of Public Policy, Culinary Health Fund; and representing Health Services Coalition
Rusty McAllister, President, Professional Fire Fighters of Nevada; and Chairman, Las Vegas Firefighters Health and Welfare Trust
Michelle Jotz, representing Las Vegas Police Protective Association, and Southern Nevada Conference of Police and Sheriffs
James Wadhams, representing Nevada Hospital Association
Bill M. Welch, President/CEO, Nevada Hospital Association
Dan Musgrove, representing Valley Health System
Christine Bosse, Vice President, Government Relations, Renown Health
George Ross, representing Sunrise Health
LaShannon Spencer, representing Catholic Healthcare West
Lawrence P. Matheis, Executive Director, Nevada State Medical Association
Kathleen Conaboy, representing Nevada Orthopaedic Society

Chair Mastroluca:
[Roll was called.] We are going to talk about Senate Bill 115 (1st Reprint), which we do not have. It has not been passed out of the Senate yet, but we anticipate it coming this afternoon, or this evening, or later tonight, or early tomorrow morning. We want to have a preliminary hearing on it. I feel fairly confident that all of our members are aware of the bill. I think everyone out there has been doing a really good job at doing their jobs, so I am sure everyone has heard of it. It has to do with balance billing.

I will ask Marsheilah Lyons and Senator Copening to come to the table. They are going to give a very short history of how we got here and what the bill currently looks like. We have a proposed amendment waiting for Legal staff to come, and when Ms. Lang gets here we will go over the proposed amendment, and then we will hear testimony from each side.

Senator Copening, welcome to the Committee.

Senate Bill 115 (1st Reprint): Provides requirements governing payment for the provision of certain services and care to patients and reports relating to those services and care. (BDR 40-192)

Senator Allison Copening, Clark County Senatorial District No. 6:
I am going to talk about the history that took place with this bill during this legislative session. Other than this session and part of the interim where we had the bill actually considered in the interim Legislative Committee on Health Care, it was new to me at that point.

The term "balance billing" may be new to people. It is a complex issue to get one's arms around. I will give you an idea of what the situation entails and why it has been a problem for quite a while. It is a situation where you have an insurance policy and in an emergent situation you are going to go to the first emergency room (ER) that you are closest to. You are driving down the road and you start to feel like you have a heart attack coming on. You pull into the nearest ER that you can get to. You are not wondering if this is part of your plan or not. In some cases it may be part of your insurance plan and in some cases it may not be. What we have found to happen in a situation where it may be an insured person who ends up at what is then called an out-of-network facility is that they receive the care and then they find out when the bill comes that it is a very huge bill and they are not covered for it. Some people have experienced medical bankruptcy as a result of this situation. Another example would be where you go into an in-network hospital. You think you are doing everything right, but you end up being seen by a physician who is not part of your insurance plan and again, you end up getting billed large charges. Many people cannot afford to pay these charges.

This is a bill that is very important to the Majority Leader. I took it under my wings to try to bring the parties together to see if we could arrive at something that could be agreeable. It has been five or more years in the making. The parties—meaning the Health Services Coalition, the hospitals, and the physicians—have tried to come together to try to work something out. We have not really had a lot of success. I volunteered to bring the stakeholders together and we have met on several occasions. We took input from all of the stakeholders that were involved and what they would like this bill to look like. We worked off of a beginning draft that no one liked and was especially a little harmful to the hospitals—I should not say a little harmful. The first draft was not good for the hospitals or the doctors. Essentially we would be ending up putting hospitals out of business and physicians would probably end up leaving our state. So it was not acceptable to a lot of people.

With that, I am going to let Marsheilah tell you what we have arrived at.

Marsheilah Lyons, Principal Research Analyst, Research Division, Legislative Counsel Bureau:

As a staff member of the Legislative Counsel Bureau (LCB), I may not advocate for or oppose any legislation that comes before this body, but as you heard at the request of my Chair, Senator Copening, I will be walking you through the provisions of Senate Bill 115 (1st Reprint).

Section 13 of Senate Bill 115 (R1) requires an out-of-network hospital with 100 or more beds but is not operated by a federal, state, or local governmental entity to accept 115 percent of the schedule of fees and charges established by the Division of Industrial Relations (DIR) of the Department of Business and Industry for nontrauma care provided to certain patients, and 120 percent for trauma care. This rate applies for the provision of any medical screening and emergency services and care required to stabilize the patient. Pursuant to section 14, an out-of-network physician is required to accept a similar payment for similar care. The bill also requires a patient to be transferred to an in-network hospital within 12 hours after which the third party will be responsible for the billed charges if the patient has not been transferred. That can be found in section 13, subsection 5. Section 14, subsection 6, exempts ER physicians from the provision of the measure.

The bill allows an out-of-network hospital or out-of-network physician to negotiate a different amount if the hospital or physician believes that the payment does not provide a fair and reasonable rate of return in relation to the services provided. That can be found in section 13, subsection 4, which applies to the hospitals, and section 14, subsection 4, which applies to the physicians.

The bill provides a process for submitting a dispute regarding the fair and reasonable rate of return in mediation. The parties may select a mediator, or if they are unable to agree, they may request a list of seven potential mediators from the American Arbitration Association, or the Federal Mediation and Conciliation Service. The mediator is selected by alternately striking one name until one mediator remains. The out-of-network hospital or out-of-network physician has the benefit of striking the first name.

An attempt should be made to settle the dispute within 30 days after being notified of the mediator's selection. Each party to the mediation is required to pay one-half of the cost of mediation. If the parties are unable to reach an agreement, the parties may agree to submit the dispute to arbitration for resolution, or an action may be commenced in a court of competent jurisdiction within 30 days after the completion of the mediation. That is found in section 14.5.

Section 1 of the bill requires the Administrator of the Health Division of the Department of Health and Human Services to determine whether the third party has an adequate network of providers. It also requires the third party who wishes to pay the amount prescribed in the bill to maintain an adequate network of providers and to submit certain reports regarding network adequacy and out-of-network services and care to the Administrator of the Health Division of the Department of Health and Human Services and the Legislative Committee on Health Care. An out-of-network hospital and out-of-network physician are not required to accept the amount specified in the measure if the third-party payer does not meet these and other specified requirements.

The bill provides that the third-party payer is not entitled to any additional discounts from the out-of-network hospital or out-of-network physician other than those that are in the measure. It requires payment by the insurer to be made within 30 days of receiving the bill or after the conclusion of any negotiations or mediations. It also requires the patient to make payments or arrange for payments to be made for their deductibles, copayments, or coinsurance within 30 days of receipt of the bill as well. It prohibits an out-of-network hospital or out-of-network physician from collecting from the patient any amount other than any deductible, copayment, or coinsurance which they would otherwise be required to pay had the medical screening or emergency services and care been provided at an in-network hospital or by an in-network physician.

Section 11 provides that the provision of the measure only apply to certain insurers that are organized as nonprofit entities. It exempts Medicaid and Children's Health Insurance Program from the provisions of the measure.

Senator Copening:
If the Committee is not thoroughly confused by this, then they actually should be, because I really skipped over a very important part of what this whole bill was about. We went with the problem and I did not explain. We take for granted when we are working on a bill that most people do not really understand what the situation is. As many of you know, hospitals and physicians will generally bill more than what the services cost, primarily because they need to make up for all of the care that they provide that they do not get paid for, such as Medicaid, or for Medicare or Medicaid reimbursements that are just not high enough. The situation is that the patient gets this very large bill—what are known as billed charges.

Marsheilah just went through the provisions, but what this bill tries to arrive at is what a fair payment would be to that hospital or physician if they end up in a situation with a patient that is either in an out-of-network facility or utilized an

out-of-network provider unbeknownst to them, and they end up with this large bill. We are trying to make a fair and equitable payment to the facility and to the physician and trying to make sure that the patient is removed from this. The patient would be responsible for their regular deductibles but they would not end up with a $50,000 bill unbeknownst to them. That is the gist of it.

I have a floor statement that also may summarize what I did in case I missed something. If you do not mind, I will read a little bit of it (Exhibit C).

A problem addressed by S.B. 115 (R1) is that third-party health care payers are responsible for providing members with access to appropriate, quality care at a reasonable cost. This is accomplished by engaging in contractual partnerships with hospitals, physicians, and other providers. This is critical to keep premiums and rates affordable for employer-sponsored plans and individual policyholders. The provisions of these contracts provide for agreed-upon rates that are substantially discounted. As the marketplace dictates, sometimes payers are fortunate to contract for discounted rates with all of the hospitals in a community and physicians who practice at those hospitals. Sometimes business negotiations fail and prevent payers from contracting with all hospitals or physicians. The standard practice in the majority of benefit plans is to require the members to obtain nonemergency care through their contracted physicians or preferred hospitals. The payments for these services and care are at the agreed-upon contracted rates. In situations of critical emergencies, the member is usually taken to the nearest hospital, which may be an out-of-network hospital. In these instances, the out-of-network hospital or physician bills the payer billed charges. These charges are the upper limit rates and are substantially higher than contracted rates, which results in unpredictable costs for patients.

Senate Bill 115 (R1) seeks to address the problem by requiring out-of-network physicians and hospitals to accept an established rate for certain emergency services and care. In addition, the measure requires third-party payers to maintain an adequate network of providers and report regarding network adequacy and frequency at which emergency services and care are provided by an out-of-network physician or an out-of-network hospital. That is the more eloquent description of what this bill seeks to do.

Madam Chair, at your pleasure we can talk a little bit about the payment schedule that we arrived at and how we arrived at it. It is completely up to you on how you want to proceed.

Chair Mastroluca:
I think that would be helpful.

Senator Copening:
Marsheilah Lyons will be much more eloquent than I. One of our challenges was how to arrive at what would be considered fair and much better than the billed charges. The only thing we could find in place with a set threshold was through the Workers' Compensation Section of the Division of Industrial Relations and their Medical Fee Schedule. I do not know if Don Jayne is here. I am not an expert in explaining exactly how they arrive at the fee schedule, but they have a scientific way that they arrive at their particular schedule and it takes into effect the market and various other aspects.

The amendment was taking bits and pieces of what the stakeholders wanted and trying to put them into one bill, giving each of the stakeholders different parts of what they wanted. The hospitals and physicians are not in agreement with the payment schedule and they can come up and tell you why. We are also going to make some suggestions to make that payment schedule better. We started with the DIR fee schedule and they explained how it works. They have a payment schedule and generally when they have a case they will negotiate down. So we took the very top of what that payment is and we thought it would be fair to increase for nontrauma care to 115 percent above that rate, and for trauma care up to 120 percent, because trauma care costs more to provide. The hospitals showed us a graph of how even at that rate it could be quite detrimental. It was far below contracted rates. One of the things we did not want to do was get below contracted rates, because you do not want to disincentivize contracts from being negotiated.

From there, I had a personal amendment that has yet to be adopted only because we had the committee's mock-up that needed to first be accepted on the floor of the Senate and/or the committee had to retract it and we had two competing amendments. So we decided to pass the amendment that had the 115 and 120 percent to come here and work to bring it beyond that. We agree that 115 and 120 percent is just too low. Thank you.

Chair Mastroluca:
Does the DIR schedule cover everything that can happen?

Marsheilah Lyons:
The DIR schedule will not cover everything that can happen, but it does cover most. According to Mr. Jayne, they have a formula to calculate things that are not covered, so that is how they would approach things in the Workers' Compensation Section if there was an issue that was not covered. Certainly in the measure, if you wanted to reference some other formula in the event their rate is not listed, you can do that. That would be a policy decision you would make.

Chair Mastroluca:
How is the DIR's schedule calculated?

Marsheilah Lyons:
I am not an expert on the schedule, but we did meet with them ahead of time and talked about it. In 2001, they had a national organization come in and do a review of the Medical Fee Schedule in Nevada. They looked at contracted rates in our region, area, and state. They have a good summary in here and they provided us with a document that outlines how their fees compare to other public programs as well as how the schedule was established. They conducted a review and they looked at the medical costs, billed charges, negotiated rates in our community, negotiated rates across the country for similar services, public programs and the payments there, and then made recommendations for things that they thought needed to be increased and things that maybe needed to be decreased. The study was conducted by Milliman, Inc. The final recommendations were reported in 2002.

The Medical Fee Schedule is adjusted with the Consumer Price Index (CPI), Medical Care Component, and that is done every year in February. It was adopted in 2004. At a minimum the rates are 10 percent above Medicare reimbursement rates. That is where they were in 2004, but because of the consumer price index adjustments, they indicated that that has increased.

The fee schedule, as Senator Copening mentioned, is the maximum payment allowable for workers' compensation, so normally for workers' compensation cases those payments are reduced. This is starting with that maximum payment and moving up. As a result of a study that was done—and the Nevada Hospital Association could speak to this better—a couple of years ago they instituted a trauma activation fee because they recognized the additional cost of the trauma activations that need to happen at certain hospitals, so they did add additional costs. They do review it annually. It is not to the same extent as the Milliman study, but annually they do review the workers' compensation schedule.

Assemblyman Livermore:
I do not know if you have considered this. I do not find anything in the bill that addresses this but in some cases buyers of health care insurance, if they travel a lot or do not live within the service area, can buy an out-of-network premium policy. The policy that I have—and I am a retiree and a citizen of Carson City, and if you retire and move, you pay a premium for out-of-network. Now how do you adjust for people who pay premiums for out-of-network? The company is being paid to provide that payment to out-of-network hospitals. How does that function?

Marsheilah Lyons:
I am not sure if your question is a question of fairness or equitableness with having an out-of-network policy or . . .

Assemblyman Livermore:
It is probably an equity basis because of the holder, the individual who purchases health care insurance. He has gone to Arizona for six months or so and he pays a higher premium for out-of-network coverage. How does this bill affect the people who pay premiums like that? When a patient comes into a hospital with out-of-network coverage, does this bill circumvent that? What does it do to it?

Marsheilah Lyons:
I do not believe that this bill will impact that, because this deals with individuals who have no coverage. If you are talking about the relationship of this bill to that type of plan, I think they are two different types of plans. Now how it may affect the contracting market, I do not know.

Assemblyman Livermore:
Why purchase it at a higher rate if you are going to have a plan negotiated where you will receive a payment for in-network—I understand that the premiums are being paid and the arrangements are out there. But you are going to prohibit people from paying for plans that they would have paid for at the expense of a hospital or physician.

Chair Mastroluca:
Within the bill there is a provision that says that this only applies to insurance plans that currently have a contract with the hospital. If it is an out-of-network hospital, then they would still be using the exact same plan that they had. This would not supercede it or impact it in any way.

Assemblyman Livermore:
But the point is—I am going to use a hypothetical number. Let us say you pay $500 a month for your health insurance plan for in-network hospitals. If you know you are going to reside somewhere else out of network, you will pay $600 for your premium. So you are paying a higher premium to your insurance company and you will have coverage. Now you have coverage for out-of-network hospitals. This bill makes a different arrangement to people buying out-of-network premiums if they can afford it and wish to do that.

Senator Copening:
That is the first time we have heard that, Assemblyman Livermore. It may be something that we need to get a carve-out of some sort. We will get the minds thinking. I do not know how to answer that. We have not had that come up.

Assemblyman Livermore:
Just yesterday Carson City negotiated a new contract for next year. I just happened to have what my premium is going to cost and the selections of health maintenance organizations (HMO), preferred provider organizations (PPO), and the like. All of that contributes to an out-of-network cost, too. So there are components and elements to a rate plan that covers it. That is why I said it.

Chair Mastroluca:
Thank you for your question, Mr. Livermore. It always helps to have someone with experience in these kinds of matters. Are there further questions from the Committee? [There were none.] Do you have any other comments that you would like to make at this time, Senator?

Senator Copening:
I do not know if you wanted to talk more about some of the things that we have discussed. I do not know if it might be an appropriate time prior to taking any testimony so people understand what we are doing.

Chair Mastroluca:
If you would like to go through your amendment and then I was going to have Ms. Lang go through the additions that we have made over the course of the day.

Senator Copening:
I believe that my personal amendment—and Marsheilah can correct me if I am wrong—took the percentage from 115 percent to 200 percent and the 120 percent to 210 percent for hospitals only.

Chair Mastroluca:
We have copies of my proposed Amendment 7480 to S.B. 115 (R1) (Exhibit D). I will have Ms. Lang walk us through this amendment and highlight the changes that have been made.

Risa Lang, Committee Counsel:
In this bill there are basically two sections that address the rates that are going to be paid for out-of-network hospitals and out-of-network providers. Section 13 is the one that deals with out-of-network hospitals. You will see on the mock-up that you have been provided with that there is some new language

in green in section 13, subsection 1, paragraph (d). Basically subparagraph (1) is outlining the conditions for this section to apply. It adds a new condition that in order for this section to apply so that those rates would be applicable, the out-of-network hospital would have had to have a contractual agreement with the third-party insurer at some point to be an in-network provider hospital for that third-party insurer. There must have been a contract at some point.

The amount of time that has passed since the expiration of the contract does not exceed one-half of the time that they had a continuous contract. If they had a contract with the hospital for a year, not more than six months has passed since that time. During that window of time they would have the benefit of this section that would set out what rates they would pay. At the end of that period, if they have not entered into a new agreement, then they would go back to the billed charges.

If you look on page 4 of the mock-up (Exhibit D), the other thing in section 13 that has changed is it sets out the rates that would be paid based on whether the services are related to trauma or not. In subsection 2, paragraph (a), as the Senator indicated, the bill currently provides that they would be paid 115 percent of the amount in the schedule of fees and charges from DIR. This increases that rate from 115 percent to 200 percent. In subsection 2, paragraph (b), it increases it to 210 percent for trauma services.

On the next page, there is a provision in subsection 5 that is basically addressing how long these charges will apply. Once the out-of-network hospital becomes aware that a patient is covered by a policy of insurance, they have a duty to notify the third-party insurer that the patient has been transported to this out-of-network hospital. They have a duty to inform the third-party insurer once the patient has been stabilized so that the patient can be transferred to an in-network hospital within a certain period of time. In this proposal, it would reduce that period of time from 12 hours to 8 hours after the out-of-network hospital informs the third-party insurer that the patient has been stabilized.

During the period that the patient remains in the out-of-network hospital for that 8 hours, they would continue on the 200 percent which is the amount of the charges for nontrauma services. After that time they will either have to negotiate a rate and keep the patient there, or transfer the patient. If none of those things have applied, then they would revert back to the bill of charges. There is a similar change on page 7 that is basically providing for that same limitation on the 8 hours if the patient is being treated by a physician.

Chair Mastroluca:
So in short the difference is that the rate has been increased from 115 percent to 200 percent for emergent care, and from 120 percent to 210 percent of the DIR fee schedule for trauma. The patient, after he has been stabilized, should be transferred to an in-network hospital within 8 hours. Previously that was 12 hours. Also if they have a previous contractual agreement then this period only applies to one-half of the amount of time of the previous contract. So those are the changes that we proposed based on the conversations that have been had in trying to come to an agreement with the parties.

I would like to start the testimony in support for S.B. 115 (R1) and we will have Ms. Bond come up.

Bobbette Bond, Director of Public Policy, Culinary Health Fund; and representing Health Services Coalition:
I think Marsheilah and Senator Copening have done a great job of trying to review what is happening with the bill. I want to give you some information about why we care about the bill. One of the handouts is a slide presentation that I think will help illustrate our main point (Exhibit E). On slide 3 you can see the issue of what billed charges are. If you look at this handout and the one that looks like it was presented by Dan Musgrove (Exhibit F)—this is the first time we have seen this handout—I think it helps you understand why there is an issue.

Billed charges are not regulated. Senator Copening said that billed charges are the price they are because they have to make up for the people that have uncompensated care and are on Medicaid and Medicare. In fact, billed charges have escalated over the last 10 years at the rates you see on the chart on slide 2 compared to the yellow which is the consumer price index increase over 10 years. You can see that there is a 10-fold increase in billed charges and they are not related to anything that we have been able to track. When the cost of health care goes down, these still go up. When the hospitals are making a high profit, these numbers still go up. When the hospitals are making less profit, these numbers still go up. So these numbers have gone up regardless of what is going on with the hospitals, payment mechanisms, Medicaid, or Medicare. They are just not very well tied to anything that we have been able to find. That is our main issue.

If you look at Mr. Musgrove's document, you can see the examples of charges. These would be the billed charges that I am talking about in this document. There are five different charges. If you look at the charges in the first example for patient 8358848, you see a charge of approximately $32,000 as the billed charge, and then you see the payment that a health care plan with insurance

would make of $12,200. That is really the discrepancy that we are trying to figure out. Other than that, I think that they will have to speak to what else these numbers mean. We have no way of analyzing this data. When we ran it for the Health Services Coalition, our numbers were that workers' compensation payment schedule at 120 percent is similar to our average contracted rates. That is why we think anything above and beyond 120 percent of the DIR schedule is quite profitable for the hospitals and so we were happy with the original bill. We certainly want to take into consideration the amendment and, if these numbers hold true for the Medical Fee Schedule at 200 percent, would want the hospitals compensated fairly. We probably will not have time to get a deep analysis back to you before the session ends, but we are working on this.

We have heard a lot from the doctors and hospitals, and we have heard that we do not have a serious issue regarding the impact of billed charges on health plans and patients. When a patient with insurance receives care that is not part of their network, they pay these full charges which are called billed charges. They are not based on anything real, they are highly inflated, and they are diminishing limited health care dollars. We are really focusing on nonprofit health care plans, because while United HealthCare Services and Aetna may have the ability to raise their premiums or create a premium as Assemblyman Livermore talked about for out-of-network care, nonprofit health plans are struggling more with how to contain that. Going forward, we are trying to find ways that nonprofit plans can stay viable alternatives to for-profit health care as exchanges come on board and as health care moves forward. It is less expensive, it often has a higher medical loss ratio, but right now we are thrown into the bucket with commercial care and it is causing a lot of stress, particularly on the nonprofit plans. This bill is entirely restricted to the nonprofit plans. It also mandates that it is only available to a plan that has a contracted hospital in Nevada already. We could, within the scope of the LCB, limit the impact on the hospitals to both nonprofit plans and to residents in Nevada.

I would like to respond to a couple of things that you may have read in handouts that we saw from the hospitals that we are really trying not to have to pay our bills and that is why we are here. In fact, we are trying to figure out a manageable and affordable way to pay our bills. We are responsible for paying a patient for true emergency care and if a patient ends up out-of-network for a true emergency, we often end up either paying the billed charges that you are seeing or sometimes we can talk the company down from that, but it is the billed charges number that we live with.

I also want to make sure we get on the record that we are not trying to not contract. We are trying to stay solvent. Paying five to six times the contracted rates for care is just not sustainable for us. This bill would help us only with

cases when the patient has no choice about his care. It only starts with an ambulance transport, which is about 20 percent of our cases. This bill does not apply at all for the other 80 percent of the cases that happen in the hospital where a patient drives himself or it is an elective, or a scheduled surgery of some kind. The hospitals are still getting billed charges in all of those cases, and that really is in our data about 80 percent of the time. It is a very restricted bill. It has really been carefully limited to the times when patients had no control of where they end up. In the presentation that happens with my little crazy graphic picture of the ambulance, this is really the scenario. A patient can be transported by ambulance to a hospital that is not contracted or a patient can go to the right hospital that is contracted, but they end up with a noncontracted doctor like an anesthesiologist or a surgeon that has to do the surgery there that does not have contracts with our plans.

We have tried to do this in a nonlegislative way. We have asked in contract negotiations in the past with the hospitals for them to make sure that we get to use contracted doctors in a contracted facility, and we have also tried to make sure that the hospitals require the doctors to accept our contracted rates. We have not been able to work that out with the hospitals in a nonlegislative way. That is why this bill has been going on for—I think this is the fourth session. We are trying to make sure that all parties are protected. We started with 200 percent of the Medicare reimbursement rate and the hospitals did not like that. That was substantial profit for them. We offered a percent of our contracted rates, and that was rejected. We offered a percent over our average bonded rate and that was rejected. The only mechanism the hospitals have negotiated on is a percent off of billed charges. We have had trouble with that because, as you see, the escalation of billed charges would mean that any percent of billed charges we cannot get to a resolution for very long because they keep escalating. That is the state of where we are at.

I think Marsheilah told you that the DIR fee schedule was created by Milliman, and they testified in the Senate Committee on Finance that there will be another study in the next two to four years to readjust the rates again.

The other thing we have heard is the Nevada Medical Association has stated that the solution is for patients to be informed of the cost of out-of-network care and we totally agree to that, and we do do that. We have our website, we have our PPO directories, we keep them updated all of the time, patients can call and find out where their doctors are contracted, we send out notices when we terminate a doctor or when they terminate us from the network—we have a pretty stable network—but again, that does not help in these situations when a patient is transported by ambulance or it is an emergency, and that is why the

bill is restricted to that. In other cases, it is totally our responsibility to make sure patients know how to use their network.

We have made several rounds of concessions in these amendments. More and more concessions are being made, but we are not reaching an agreement with the hospitals. That is where we are today. If it is okay with you, Madam Chair, it would probably be good for Rusty McAllister to talk and then I will come back with anything else we missed.

Rusty McAllister, President, Professional Fire Fighters of Nevada; and Chairman, Las Vegas Firefighters Health and Welfare Trust:

Ms. Bond talks about the concept of patients being transported by ambulance and having no choice. As an emergency medical services (EMS) provider myself, when a patient is put into the ambulance, if he is capable and he is not in an emergent situation where he has to be taken somewhere specific, it is by patient choice. The patient will make a decision and he will say, "I want to go to hospital X." Where the problem lies is in many of those instances, either the patient is not capable of making that decision because he is not coherent, or protocols decide where the patient is going. As an example, for those of you who live in southern Nevada right now, if you were in an auto accident in southern Nevada and needed some type of trauma care, the decision about where you would be going would be geographical. If you are injured or in an accident west of Interstate 15, you will go to University Medical Center of Southern Nevada (UMC) Trauma Center; if you are injured on the east side of Interstate 15, you will go to Sunrise Hospital Trauma Center; and if you are on the south end of the valley and only require a level III trauma center, you will go to one of the St. Rose Dominican Hospitals. So geography will decide where you go. You may not be contracted with that hospital, and you may not be able to have a choice in the matter because the paramedic has a standard of care, and if he violates that standard of care, he will be liable. So if you are in a cardiac situation and there are two hospitals—you cannot pass one hospital to take you to a contracted hospital. Even if you are conscious and say, "Listen. I need to go to Hospital Y because I do not have insurance at the one you are going to take me to," if I take you to that one and something happens, I am liable because there is a standard of care and I violated that standard of care. Physicians are under the same standard of care ethic. We cannot violate that standard of care.

There is an instance of one of your colleagues that has had this happen to him with his spouse: cardiac situation, needed to be taken to a hospital, told him, "Cannot go to that hospital. Sorry. Your emergency condition warrants that I am going to take you to this hospital even though you do not have insurance here." When the bill came, your colleague was really, really unhappy. That is

the situation. This would help fix that. It is only for emergency transports. In most ambulance transports, the patient is capable of making a decision about which hospital he needs to go to, but in some instances, some cardiac situations, some breathing, we have designated stroke centers now in the state. They have set these protocols up so that you have to take patients to certain hospitals. Trauma situations, again, are geographic in nature. Certain hospitals have specialties and then they get protocols established to match those specialties. So we are obligated as EMS to take them to those specialty hospitals. I would be happy to answer any questions.

Assemblyman Sherwood:
For the sake of argument, let us say you have an arrangement with one hospital in southern Nevada, and whatever contract rates you have with them would have to be honored by all of the other hospitals plus either 120 or 200 percent—that is basically the simple way to understand this bill, correct?

Bobbette Bond:
No. In the absence of the contract, yes, we would be paying the DIR rates that we end up with in statute. Under the current formula we would be paying the 120 percent of DIR rates or whatever we end up with as the final amendment instead of the billed charges which are in that handout from Mr. Musgrove.

Assemblyman Sherwood:
So you are basically mandating the rate to whichever hospital. You are saying, "Here is an index. You are going to pay this rate on emergency transfers."

Bobbette Bond:
Correct. Then the Medical Care Component CPI gets built into that rate increase, and it is for those cases. There is language that the hospitals are still working on about how long we have to get the patient into a network facility once he is stable. The ER doctors are exempt from this because they have to take all comers. We also have a couple of other provisions that limit the scope of the bill.

Assemblyman Sherwood:
How would it affect the noncontracted people like anesthesiologists?

Bobbette Bond:
If you are in a contracted facility or a noncontracted facility but you end up with a physician, surgeon, or anesthesiologist who is not contracted, in the bill right now they would be paid 120 percent of the DIR rate—I think it is 120 percent that is in the current version—in the same way.

Assemblyman Sherwood:
It will be interesting to hear why they would be opposed to that and what happens with their profits with that index.

Bobbette Bond:
Our goal was not for the hospitals or the doctors to lose money. Our goal has been to find something that is above our contracted rates but below billed charges. In Mr. Musgrove's handout (Exhibit F), if you look at the "charges" and "average managed care" columns, you can see the discrepancy between them, so we are trying to find a middle ground where we do not have to pay the billed charges. The billed charges are kind of like flying first class or taking a luxury liner and ending up in a first-class cabin. It works for travel, but it does not work very well for health care. It is kind of like the sticker price, and for health care, people need it if they can afford it, and if they can go first class or not, they are going to end up in the hospital and needing some kind of treatment. So while health care is structured as a regular market, it really cannot offer it like a free market in a lot of situations in emergencies, and we are trying to figure out alternative solutions.

Chair Mastroluca:
I would ask the Committee to keep in mind that the whole point of this as far as I see is consumer protection. We want to make sure that the residents of Nevada receive the best health care they can possibly get in a way that they can afford to pay for it. What is sad is if there is not an agreement, if there is not a contract, if it is being negotiated, the patient loses out. So if they have insurance and they have been paying their premiums and that insurance company is negotiating with a hospital and they have not come to an agreement, and that patient gets into an accident, and they go to a hospital and it happens to be a hospital that they are negotiating with but they do not have a contract with, then the patient is the one who gets stuck holding the bag. I think that that is the overall goal of correcting this. Also, in a perfect world, if everyone was in a contract, this would never be used. So the reality is we could be creating legislation that hopefully we do not have to use, which is ironic considering how long it has taken to write it. I just wanted to make that point.

Assemblyman Hambrick:
Looking at the basic write-up of the bill, we are primarily talking about emergency care. From this point forward, we only have to ask one type of question. I do not mean to limit them, but I think occasionally we are getting into the discussion with contract, noncontract, and rates. Let us pretend that all of our questions will be on noncontracted. Mr. Livermore talked about people who are traveling. I think for us to understand this situation, all of

my questions will be noncontracted. Mr. McAllister said that particularly in southern Nevada, you do not have a choice where the ambulance is going to be taking you. I understand that. I think we need to start talking apples and apples and similar questions. Occasionally when we start talking contracted rates and noncontracted rates, there might be some mix-up and misunderstandings. So for the point of this discussion, it would be nice if we all would say noncontracted rates. This is where the consumer is really going to get pinched.

Mr. Livermore talked about travel, when a person comes up from southern Nevada to Carson City. It is a beautiful metropolitan area, which I happen to love, and Carson Tahoe Hospital, I presume, is noncontracted. Wherever. Arizona was mentioned a little while ago. Other state laws coming in—earlier in the testimony you or Senator Copening mentioned—I see this bill as trying to see whether or not the doctor or the ER will recover their overhead, and we could delineate that by a bunch of different words, but it should be lumped together from my aspect as overhead to try to recover their costs. In your opinion, the cost needs to be negotiated. The bill delineates how you can go through the labor relations. I mean you keep on going and eventually go into court. But for the consumer who is automatically in a noncontracted facility—regardless of where that is—how can you best describe how this is going to work? Forget about transport. Explain to me purely, if you would, only on noncontractual people who travel. Almost all of us travel.

Chair Mastroluca:
We could ask them to do that, but I do not know if they would have any better answer than Senator Copening. We will put Ms. Bond on the spot.

Bobbette Bond:
I will try to answer what I think you asked. If you are a patient—from the patient's perspective what he would have to do from this bill is always pay whatever the insurance company left him to pay, unless it is a nonprofit health plan with a contract with a facility in Nevada and it is an emergency that took him by ambulance to that facility. In that case, he would only pay what he would pay at an in-network facility. Everything else would not be his responsibility. He would be treated exactly like he would if he had gone to an in-network hospital.

Assemblyman Hambrick:
I am in Boise, Idaho.

Bobbette Bond:
This is a Nevada bill.

Assemblyman Hambrick:
Only?

Bobbette Bond:
Yes.

Assemblyman Anderson:
I am looking at the chart you handed us. Until reading that and reading the bill, I did not realize there was such a thing as an out-of-network physician at an in-network hospital. Let us say just for the sake of getting into the bill, I am perfectly well and healthy and I go in there for something routine, how would I know that they are out-of-network at an in-network hospital?

Bobbette Bond:
I think people do not know. I think that this is a middle ground because we are trying very hard in those cases to schedule your care, find the right hospital, your surgeon refers you, and you are doing the best you can. It still happens that people end up with noncontracted doctors, and it happens to our plan. I think you will hear from the representative for the orthopedic surgeons that this is not a problem, but the Culinary Health Fund has one of the widest networks in the valley and it happened 400 times this year to our patients, where they end up with a noncontracted doctor in a contracted facility. Now a lot of those were not emergencies, but it happens often because the hospitals cannot control the contracting privileges of the doctors who have privileges at their hospital. So you always have to be very careful.

Assemblyman Livermore:
To my colleague from Las Vegas, if you read section 16, I think it kind of describes that process of where you get a list from. My question goes to section 14.5, subsection 6, where it talks about the arbitration and mediation process. Does the facility get to bill for that? It is an extra cost to a facility that goes through this process, to go through the arbitration, staff time, and preparations. Who compensates the facility for that?

Bobbette Bond:
The way that the bill is structured is we did not want there to be a state impact, and we did not want there to be a patient impact. We tried to work this out through the interim health committee and through several meetings. So the hospitals proposed that the provider, the payer, and the patient—all three of them—split the cost and we have changed that so it is only the provider and the payer. We split the cost of that so there is no impact on the state and there is no impact on the patient.

Assemblyman Livermore:
As you described your point about the hospital's bill, do you believe that maybe hospitals calculate this as part of their payment, or part of their schedule of charges? This is what you are creating. You are creating another layer of cost to a facility. Now I do not know how many of these may happen in a year—hopefully none. But if you had 10 and it cost you $5,000 each, that is $50,000 that a facility is out of pocket.

Bobbette Bond:
I am not sure if that was a question or not. I think that is why we wanted to make sure the rate is fair enough that those are outliers instead of routine.

Assemblyman Livermore:
I understand that. I am not trying to debate this. I am just adding that as you start a due process about how hospitals generate their bills, this is going to be a bill generator calculation by a facility.

Assemblyman Goicoechea:
If you are in a car accident out of state, whether it be Utah, Idaho, or wherever, clearly you are out of network. Do I anticipate that I am going to get charges that exceed this 210 or 200 percent? Saint Alphonsus in Boise typically might be cheaper, or somewhere in Salt Lake City. I guess it concerns me that you have to pay twice as much if you are out-of-network. What can I anticipate if I went to an out-of-state hospital? I can anticipate paying twice as much? That is what this bill says.

Bobbette Bond:
I am not exactly sure what you are saying. This is happening to people now in these emergency situations. They are getting these full billed charges when an accident happens in another state. I do not know how other states are handling it across the board. There are at least 12 states that are limiting the impact of billed charges in different pieces of legislation for different insurance plans. They are kind of all over the map. If you, as a Nevada resident, get into an accident in Idaho, this bill does not apply at all. Actually, this bill does not apply if you get into an accident in Ely, because all of the rural hospitals are exempt.

Assemblyman Goicoechea:
Yes, I understand that, because they are clearly not over 100 beds. I am trying to get a hold of this and why it would be so much more expensive if I ended up at UMC, Sunrise Hospital, or St. Rose Dominican Hospital than it would be in Ely or Elko. Typically they would be higher. I am trying to get a handle on what it would cost me if I ended up at St. Mark's Hospital in Salt Lake City.

Rusty McAllister:
From our experience with our trust fund, as an example, one of our members was severely injured in Utah, flown to the trauma center at the University of Utah Hospital, treated, and ultimately brought back to Las Vegas. When the bills arrived, they were billed charges. We employed a company to negotiate with the hospital to reduce their charges, and they were willing to negotiate to bring the charges back to at least a reasonable rate.

Assemblyman Goicoechea:
Thank you. That leads to the next question of why we cannot be doing that here.

Bobbette Bond:
I think the intent of this bill is to try to set some parameters away from the billed charges. If you look at the "average managed care" column, that is profitable for the hospitals. The hospitals negotiate those rates because they are going to make money at that level. So the billed charges, the difference between that profit and the total amount that a billed charge would be is the point that we are so concerned about in general. I know I am not really answering your question, but billed charges are a national concern and there are many states trying to figure out how to address them.

Assemblyman Goicoechea:
We understand that no matter what you do, there are billed charges versus the actual cost. There has to be some room there.

Assemblyman Brooks:
I had an opportunity to meet with both parties before this bill actually came on the floor, and hopefully I can clarify some things. This bill is projected for a nonprofit organization that has been in a contract already with a hospital. You may have 270,000 people in your group, or 5,000 or 2,000. To be able to go to a hospital in an emergency situation and granted, you might get an ER physician, but you would pay his cost, but you just do not want to pay the anesthesiologist and everyone else's cost. That could be very, very expensive. It also protects you if you go to one of your hospitals that you are already contracted with and they give you a noncontracted physician that can charge you $5,000 as opposed to $500 or whatever it may be. It is just a lot more expensive than what it normally would be, and I am being facetious. Then the hospitals are saying that they want to be kept whole because they take care of a lot of indigent and Medicaid patients, and when they look at the DIR schedule, there is a certain amount of money that they need in order to fill the gap. So what we are trying to do here is bring the two parties together to see what will work under the stipulation that this contract only goes toward those particular

individuals that have been contracted or have tried to contract in the past in good faith and what the hospitals can endure without going totally under, based on what they are saying they cannot afford to do. The first mock-up said that they can do 120 percent of the DIR rate and it was 115 and 120 percent, which is a payment schedule that is based on workers' compensation. In this new mock-up, it is 200 and 210 percent of that, which I understand gives you heartburn but also still gives them heartburn. At this point in time, this is just for companies that have been contracted in Nevada, so this is to try to do some cost containment so that when you get an ER bill, if it is $100,000, if you are paying 80 percent as the insurer and the insuree has to pay 20 percent, he still has to pay $20,000. It is trying to cost contain and bring things back in order.

Chair Mastroluca:
Thank you for sharing with us that you understand this bill, Mr. Brooks.

Assemblywoman Benitez-Thompson:
Is this primarily a Clark County issue, since the language does not apply to the rural hospitals?

Bobbette Bond:
It is a statewide bill. I think that there are 10 hospitals completely exempt either because they are public or rural hospitals, so it would really be impacting Clark and Washoe Counties.

Assemblywoman Benitez-Thompson:
Who meets the definition of nonprofit insurer?

Bobbette Bond:
That is new language that LCB came up with at the request of the hospitals to try to limit the scope of the bill, and we agreed to it because we want to limit the scope of the bill as well. If you look at the Health Services Coalition's membership, we are still very much supportive of this bill, but not all these plans are nonprofit plans. They are all self-funded, so right now we are trying to figure out how many of our plans would actually have access to this bill, but we are supporting the bill anyway because we spent a long time on it and we want to move forward and we want to support the nonprofits. I am not sure how many nonprofits will have access to this.

Assemblywoman Benitez-Thompson:
I am a Washoe County person, and we just have the two big hospitals up there, and they are within a mile of each other, so I was trying to think for my constituents how likely they would be to end up in an out-of-network hospital in

an emergency situation versus my southern Nevada colleagues and what their constituents face.

Rusty McAllister:
I am the chairman of a nonprofit health insurance trust fund. We have approximately 600 active members, 180 retirees, and about 1,300 dependents. So we cover about 2,000 bodies. We allow our retirees to stay on our plan. Most of our retirees, because they started in the department before 1986, are not Medicare-eligible, so they stay in our health care plan. We do not pay salaries. It is not for profit. No one makes a profit. There are no shareholders. The plan is just a plan to pay the trust fund. We take revenue in and we pay bills with it.

Bobbette Bond:
Madam Chair, I need to make a clarification on my testimony. I think I stated that the Culinary Health Fund has had 300 or 400 cases this year of noncontracted doctors in contracted facilities, and I said a lot of them are not emergencies. I think those numbers are correct. They are very similar, though, to the numbers that the Office for Consumer Health Assistance gave. They testified that they have had between 400 and 600 cases of this noncontracted care and billed charges problem for which they have received complaints that they are working with in the last year. So I am going to go back and make sure I have the right numbers, but I think my 400 is right for this year so far. I just need a disclaimer if I have to verify.

Chair Mastroluca:
Is there anyone who would like to testify in support of S.B. 115 (R1)?

Michelle Jotz, representing Las Vegas Police Protective Association, and Southern Nevada Conference of Police and Sheriffs:
We represent 11,500 total insured, 4,626 primary insured. We are a nonprofit health trust. We would like to thank Senator Copening for the immense amount of work involved in this bill. Senate Bill 115 (R1) will be beneficial to our members who are in emergent situations wherein they are not capable, whether or not they are involved in a protocol that does not give them the opportunity to go choose an in-network hospital. We believe that this will save our health trust money and we ask for your support on S.B. 115 (R1).

Assemblyman Livermore:
As retirees that select, evidently their HMO or PPO, do you have out-of-network fees?

Michelle Jotz:
Yes, we do.

Assemblyman Livermore:
So you understand what I asked.

Michelle Jotz:
Somewhat. I would be lying if I said I completely understood the question.

Chair Mastroluca:
Is there anyone else who would like to testify in support of S.B. 115 (R1)? [There was no one.] We will move to opposition.

James Wadhams, representing Nevada Hospital Association:
As the questions from your Committee have shown, this is a complex question. I want to start by making it clear that the Nevada Hospital Association is opposed to this bill. We are opposed to the bill because of the policy it represents. We are certainly prepared to talk to some of the detailed questions that have been raised by the Committee, but the policy problem that is inherent in this bill creates a legislated rate between two private parties for the rendering of service from one to the other. It is not setting what Medicaid is going to pay providers for a government program. It is simply the rate between two private parties.

I think it is really important to commend Senator Copening and the Chair of this Committee for the tremendous amount of work they have expended to try to make this rate setting as rational and fair as possible. I think the witnesses you have heard have acknowledged that to the extent the Committee would pursue this sort of policy, it has to be for the purpose of inducing those parties to come back to a contract. I think that is why the amendments your Committee Chair has identified are helpful in that regard, because there is a shorter period of time for this legislative rate to exist. That is only there for a period of time until you can come back or at least try to bring the parties back to contract.

Let me address the problem with the policy. The bill bases this rate on a per diem charge for services that are specific to the patient who is in the facility. It is not, "I am going to spend a day in the recovery room and what is rendered to Mr. Sherwood or Mr. Hammond would be the same that is rendered to me." This is emergency service. So what is rendered to me, the patient, on that day in that facility is going to be specific—hopefully very specific—to the condition in which I arrive. So the service rendered to me that day could be cracking open my chest and massaging my heart, whatever else happens, or it could be as simple as, "Well, you really did not have a heart attack. We verified that you

were just feeling that way." So the value of the service performed on any given day is going to vary widely. The fundamental problem with this rate is it is a one-size-fits-all.

The bill was drafted very carefully. Not only to Chair Mastroluca and Senator Copening, I also want to commend the staff for their efforts in this, because they have designed this so that it is recognized that this legislative rate is only a starting point on each individual claim. If the reimbursement is not sufficient to pay that hospital that had to crack open my chest, they can go to mediation and then arbitration. The ultimate goal as expressed in the bill is that the hospital be fairly paid for the service it rendered. The problem I want to warn the Committee about is the policy of starting with a one-size-fits-all rate and that any level of services that are rendered to any single patient that exceeds that starting rate will go into the dispute process. Ultimately, the amount that is obligated to be paid by the plan will be greater than that rate. So while it is a rational starting place, in the final analysis it will probably end up generating more time and more expense to resolve the disputes to get to the value of the service that was rendered to any individual patient.

There are a couple of other elements to this that need to be recognized. Several of the Committee questions seem to be, "What does an insurance company do?" Now we are talking about nonprofit private insurance companies. What about a public insurance company? A public insurance company is regulated by a whole other set of statutes. The rule for Aetna or United HealthCare Services is that if I, as one of their insured, end up in a noncontracted hospital, the law says that that insurance plan must pay billed charges. I, the patient, have to be held harmless. The theory being is that it is the insurance company's responsibility to make sure it has sufficient contracts so that I do not end up someplace where I do not. So for those regulated insurance companies, this is not an issue. What we were trying to do is begin working with Assemblywoman Mastroluca and Senator Copening and try to only identify that portion of the insurance world that is not already regulated by a law that has answered the question otherwise.

I do not want to take too much time; I think the Committee has a lot to do and we have 28 hours to do it. I will try to be brief and answer any questions. This has been a tremendous effort; however, again, a one-size-fits-all solution is only going to work to the extent that it is set at a size we can all get into. Anyone who does not fit will go into the dispute process, and if we do not set that number right—and your Chair has tried to find that adjustment point—that it is more time and money just to get back to the point of value for their service. Thank you.

Assemblyman Sherwood:
Your objection to the bill that is before us is primarily that now legislatively we are regulating the private transactions between two parties as opposed to 120 percent is not enough and 200 percent is not enough. You are not even accepting the premise that we should be in the business of regulating the transactions. Is that accurate?

James Wadhams:
I am trying to point out the difficulty of this particular form of regulating that private transaction. As this Committee is well aware, the state regulates the private transaction between public utilities and their customers. To be a little specific, if we wanted to declare emergency rooms as public utilities, then each hospital would submit to a utility commission data to document and justify a rate. The whole concept of this is what is expressed in this bill. Ultimately it has to be a fair reimbursement for the service rendered. We do it for utilities in a public setting with a regulatory process with evidence and public participation. Here I think the bill drafters and committee Chairs were trying to start at a point that they, I think, hoped would eliminate most of the disputes. I want to point out that that level of rate regulation may only work to the point that it satisfies that claim. Under the DIR fee schedule, two days in the ER is worth about $5,700. If I am the guy who got run over and they had to crack my chest open and deal with it, that claim will go into the dispute resolution because that $5,700 will not possibly equal—under any calculation—the level of service that was rendered to me as the patient.

Assemblyman Sherwood:
How do the physicians who are not contracted to the hospitals get paid from the lump sum of $5,700? You have an anesthesiologist, physician, and whoever else has to get paid.

James Wadhams:
It is my understanding that the answer to that is no. Those physicians that are performing services on-call that come in would be—there is a fee schedule in the DIR Medical Fee Schedule based upon codes, and it would be calculated on their relative values. The physicians are here, Mr. Sherwood, and I am sure they could address that more accurately.

Assemblyman Frierson:
You suggested that at least one of the concerns is that we might get the number wrong, whatever that number is. In an effort to simplify this as much as I can for the purposes of this hearing, this sounds to me like an issue of the hospitals' costs and on the other side of the table the greater good of dealing with the folks who cannot afford the $20,000 hospital bill. I get the concern of

the actual costs and some third-party folks that contribute to this that the hospital has no control over. Is there a number? Conceptually we are talking about getting the number right, and I think there have been some significant efforts to try to figure out what that number is. Is there a number that would be more reasonable in light of the goal of trying to deal with the bigger picture of the greater good? I am wondering that if the number were 800 percent, would the industry still be opposed to it? Is there a number we are talking about, or is it just a philosophical difference on the policy?

James Wadhams:
It is fundamentally a policy problem, precisely. We believe that the managed care organization ought to have sufficient contracts in its geographic territory with the ERs to avoid their members ending up in a place where they do not have a contract. That is the policy answer to your question. Senator Copening and Assemblywoman Mastroluca I think have done a great job in the last 72 to 96 hours trying to find that strike point that will achieve the maximum fairness. Again, Mr. Frierson, the problem is not so much—you have to get it at a point where it is not too high but where it is high enough that it cuts off most of the claims that would go into the dispute mechanism. If they go into the dispute mechanism, they will simply add cost to health care without fairness and resolution. I cannot give you a precise number, but I think you precisely identified the problem that your Chair and Senator Copening were trying to find. How do we eliminate as many of these claims going into the dispute process as possible? I apologize; I do not have a specific answer, but that is the effort the committee Chairs have been after.

Chair Mastroluca:
I also want to make sure that it is very clear that while I understand the response that you had to Mr. Sherwood's question and in discussion about the amount of money that the hospitals get paid, I think that everyone in the room agrees that we do not want to break the hospitals. We want the hospitals to be paid for the services they provide. The insurance companies have an obligation to pay for what is being provided. What we are talking about within this legislation is for a very finite period of time. We are not saying that the Legislature is going to go in and set rates for the hospital for 365 days for the next 100 years. We are saying that for a very specific amount of time and for a very specific reason and for a very specific opportunity of someone not in contract, in that period of time, if you happen to get patients, then this would apply. Hospitals have every right to make money, to provide service, and to charge fairly for that. No one is disputing that. But I just want to make it very clear. We are talking about a very specific situation in a very specific period of time, not about setting rates for the hospitals and the insurance companies for the rest of their lives.

James Wadhams:
I want to compliment you on the amendment that you described today, which does precisely that. I think the period that this rate exists is for one-half of the prior contract period. I appreciate and recognize what you are saying. The issue that still becomes important is that no hospital is the same. We cannot talk about bringing two sides together because each hospital will have its own structure, and quite frankly, they cannot come together and negotiate with the Health Services Coalition, just to be blunt, about rates because that is an antitrust violation. So I think the effort that you have worked at specifically is to try to address on a temporary basis—I commend you on that. It is a difficult issue, and the process is much better today than it has been. You have protected the due process rights of both parties.

Assemblyman Anderson:
If you would give me a little personal privilege here, I have a question that I am not trying to advocate either way for, but just trying to get into the policy. One thing I keep thinking—because I can tell you if I got a big bill, I do not have the money to pay it, it could bankrupt me—is it is very personal and something that could happen to me, so obviously it could happen to any one of my constituents or any of our constituents. What would you recommend to protect ourselves if we went and got into a situation where we had a lot of these billed charges to make sure, using our own initiative, we could protect ourselves in that case so we do not go bankrupt by a really big billed charge?

James Wadhams:
Thank you for the question. I will try to answer it briefly. I used to be in a state agency where I answered those questions for a fee paid by the taxpayers. In those days we did not have managed care, but we do now. I just helped my daughter who is currently pregnant with my fifth grandchild, and she asked, "What kind of plan should I pick?" In a sense, that is the question you asked me. I said, "Pick the plan that will give you the coverage at the most places." She had a very narrow plan option that was obviously somewhat cheaper, and a broader plan option. You do not know where you are going to end up going. Get the one that has the most contracts with the most facilities. In part, Mr. Anderson, that is the answer. You want to select an insurer, or deal with a managed care organization that optimizes contracts with physicians and hospitals in your area, so you are covered in most situations.

Assemblyman Anderson:
I do not have a choice, I believe. I could be wrong, because thankfully I have not had to have a lot of experience with hospitals or health insurance because I am pretty healthy. I am very thankful for that. I do not believe that I necessarily have a choice when I get my insurance from work. With what

I make, I cannot afford to buy supplemental insurance. Even here, I have chosen not to buy the state unsubsidized because it is $600 or so per month. If I am going through that, I am wondering how people who are less fortunate than me are going to protect themselves by their own initiative? You do not have to respond to that. It is just a concern I am thinking of.

Bill M. Welch, President/CEO, Nevada Hospital Association:
I appreciate the opportunity to speak to you regarding this matter. Like Mr. Wadhams, I want to acknowledge your efforts and Senator Copening's efforts to try to make this legislation as palatable as possible, and it certainly has come a long way and looks far better than it did when it was originally introduced.

The proponents talked a little bit about the history and some of the issues, so there are a couple of general comments that I would like to put on the record, and then I am going to try to respond to some of the questions and some of the testimony that I have heard at this point. The issue has been very well explained. It is about balance billing and when the patient receives a bill if they are out-of-network or even in-network, it is about the balance bill. We need to talk about the insured population and who makes the determination on what the patient's responsibility is going be. The benefit plan determines the benefits. They determine what the provider network is, and they determine what the enrollee's financial responsibility is going to be. Not the provider. Who decides where the patients go? As Mr. McAllister testified, it is not the hospital. It is not the physician. In these particular cases that would be governed by this piece of legislation. It would be the ambulance. The ambulance, as Mr. McAllister testified, is going to make that determination based upon the medical condition of the patient. The patient, when possible, will have the opportunity to advise the ambulance where he would like to go and that, I am sure, would be taken into consideration whether that was an in-network hospital or not. But it should be clear that it is the ambulance and then the patient who will be making the determination as to where he will be delivered for his care in these particular situations. However, even though the health plan makes the determinations that I mentioned, it is the ambulance service and the patient who will determine where he is going, we are being asked to accept the financial responsibility, and it has been painted as though we have created the financial burden that is generated as a result of not being in-network. That is concerning to me because I feel like our responsibility is that when the patient is presented, our responsibility as the provider, hospital, and physicians is to treat the patient's medical condition as best we can and make sure there is as successful an outcome as possible, regardless of any factors. It is to treat the patient.

This bill has been coming around since 1999, but the current proponents of this legislation asked for and, I believe, took the lead in this legislation in 2003. The rationale behind it that was argued in 2003, 2005, and 2007 was we need to ensure all of our enrollees have access to the ERs in the entire community so that in an emergent situation they can access health care without any negative financial outcomes. That was the rationale that we have heard. Since the beginning of 2009, the rationale now is that we recognize that all the hospitals are under contract. It should be noted that since 2003 or 2004 the proponents of this have had a contract with all the hospitals, they continue to have a contract with all the hospitals, and just recently in the last few months they finalized a contract with all the hospitals in the community going out multiple years. Now the testimony is that we may not want to contract with all the hospitals.

Chair Mastroluca:
I would caution you about putting words in people's mouths. We have not heard that testimony in this room and I do not want you to put yourself in a position that you are speaking on behalf of someone else.

Bill M. Welch:
Thank you, Madam Chair. The determination of who they have contracts with is clearly in their power, and I believe the hospitals have demonstrated their willingness to continue to contract and are very interested in contracting.

A couple of questions that were raised—and I do not know that I should say these based upon your advice, Madam Chair—but ER doctors are exempt because they have to take all comers. The ER doctors are exempt to take all comers, and I am not trying to suggest that it should be any different. They are required to do that because they are working in the hospital ER, which is also required to take all comers. If that is a factor for exemption from the bill, I throw that out as an issue. The doctors under contract was the question that came up. The hospitals, for the most part, do not employ the physicians. They are privileged to work in our hospitals. That is a voluntary choice on their part. If they apply at our hospitals, they have to meet our credentialing processes which include standards and education and a number of other factors, but one of the issues that we are not in the position to mandate is who they have a contract with in their private practices. It is very difficult for us to ensure that a patient who presents in these emergent situations is under contract. We will do our best, and have always done our best, to try to make sure in working with the enrollee or the patient, to meet that requirement. We do not control who the doctors have a contract with.

It should be noted—and Mr. Wadhams spoke to this—that the DIR fee schedule is based upon a per diem rate. The bulk of the costs associated with care is going to be when the patients present. The diagnostic evaluation and the medical services that they will need in order to address and stabilize that condition are all going to be incurred within those first few hours. The DIR fee schedule is based upon a per diem rate. So while there are multiple factors of that DIR fee schedule being considered, the fact is that we will get one day's per diem and yet we will have absorbed the bulk of the cost that will be necessary to address that patient's medical condition. Once they are stabilized, they are there for nursing care to ensure that they maintain that status and then they will be discharged. But the bulk of that cost is going to be incurred up front.

Chair Mastroluca:
I have heard you say this and Mr. Wadhams mentioned it also, but I am a little confused. I had staff come up here to try to help me understand this, and Mr. Musgrove, I am going to be using your chart (Exhibit F), so I am hoping you can help. In the chart that Mr. Musgrove provided, it shows the average managed care, which I assume would be the contracted rate, workers' compensation at 115 percent, workers' compensation at 200 percent, 300 percent, and out-of-network would be obviously no insurance and you would pay the entire amount.

Dan Musgrove, representing Valley Health System:
What I wanted folks to understand—because even Ms. Bond passed over it—the out-of-network column at the end is actually what we collected from those folks that have insurance but we are the out-of-network provider. So it is very important to realize that they did not pay billed charges. We negotiated a rate just as we would have if this bill did not apply but if one of Ms. Bond's Health Services Coalition folks showed up at one of our hospitals, that is what that out-of-network column really means.

Chair Mastroluca:
Thank you, but that is not where I am going. I appreciate the explanation; that is helpful. I am looking at the chart with the patient that has billed charges of $32,000 and the contracted rate would have been $12,000 and workers' compensation at 200 percent is $17,000. So the goal of coming up with a rate was that it would be higher than the contracted rate, but obviously lower than the out-of-network rate or the full charges. The goal is to get the two sides to negotiate. We do not want to make it comfortable for either one of them. We want the hospital to get paid; we want the insurance company to have a good solid contract with the hospital. That was the goal. Mr. Wadhams made a comment earlier about a per diem of about $5,000 per day, but I am looking at

this and it looks to me like workers' compensation at 200 percent is higher than what you would have been paid had this patient been in contract. Can you explain the difference to me? Are we talking about two different things? Are the per diem and the DIR payment schedule two different things? Are we overlapping them? I am a little confused.

Bill M. Welch:
Again, we do appreciate your efforts to try to make this as fair as possible, and we do acknowledge that. What we have laid out in these various scenarios that we have demonstrated and provided to you is if the patient had been reimbursed for the entire stay at the DIR fee schedule. We have given you the best of the worst case scenario. So in reality, what is laid out on these sheets that have been shown to you is not what the hospital would collect under this legislation. It just showed you what the hospital would have collected if that patient had been there through that patient's entire hospitalization. In reality, we would only be getting one day of that rate versus whatever the average length of stay would be, which collectively would drive what those numbers would be. Hopefully that answers your question.

Chair Mastroluca:
It does answer my question. Then I would ask that—well, then let us look at No. 3 on this list, which is a patient who was in for one day, with billed charges of $11,000, contracted charges of $2,440, and workers' compensation at 200 percent is $3,500. Again, it would appear that while you are obviously not making anywhere near the full charges—we understand that—it is not the goal to break the hospitals. The goal is to have the hospital get paid fairly. Explain to me why that scenario would not work.

Bill M. Welch:
One size does not fit all. In that patient's particular case, their acuity may have been such that the cost was different than another patient who will come in and their medical condition would be completely different and the costs and services associated with meeting their needs is going to be completely different. There will be scenarios with the patients who would qualify under this scenario that we may be financially fine. There are going to be many other cases where that will not be the situation. The higher the acuity of the patient, the more likely we are not. So if the acuity is at the lower end, we will probably be okay with this. If the patient's acuity is at the higher end where there is a lot of cost associated with care, then we are probably not going to be okay. The DIR fee schedule is based upon one per diem. There are per diems for different areas within the hospital, but you are going to get that one per diem. So whether that per diem fits or not is really going to be based upon the acuity of that patient. That will vary from patient to patient. In that one example, we are

okay. I know that we can show a multitude of other examples that it might not be okay.

Assemblywoman Pierce:
So under the DIR schedule, there is just one cost per diem if you are getting open-heart surgery or if you are getting a wart removed. It is the same?

Bill M. Welch:
I would prefer someone in the financial world to answer that, because now you are getting into some technical questions that I do not feel comfortable with, so if we could have Christine Bosse answer, I would appreciate that.

Christine Bosse, Vice President, Government Relations, Renown Health:
The DIR fee schedule rates are basically based on level of care. There is an intensive care unit (ICU) rate, a medical-surgical rate, I believe there might be a separate cardiac rate, but there are only four levels of care per diem rates established. Then there are specific fee schedules to address physician services and a limited scope of emergency services and radiology services.

Assemblywoman Pierce:
So it is not one rate. It is not one rate per diem.

Christine Bosse:
Four.

Assemblywoman Pierce:
Okay. It is four, and there are all kinds of other mitigating factors. So the way we deal with the no-one-size-fits-all is with percentages.

Christine Bosse:
The way that the fee schedule is administered is that the actual time after you are admitted into the hospital, the only rate that applies is the per diem rate. I have an example I am going to share with you. Being a trauma center, my organization receives many high-end and very costly cases with lots of varying needs. Patients have lots of varying needs, as Mr. Wadhams was suggesting. It would be a very easy scenario for someone to be in a car accident and come to my facility noncontracted, because in the north many of the payers choose to have exclusive contracts. In many cases, I do get patients that are noncontracted at this point, or if selected, to contract with me only for trauma services. In my case, I would have a trauma patient come to my facility with internal bleeding, for example. We would give him blood in the emergency room, we would do a number of computerized tomography scans, identify the places he was bleeding, rush him to the operating room, call in our standby

surgical team, maybe do a six-hour surgical procedure on this patient. He would go to the ICU, and hopefully, if we did our job, he would be stabilized and he would no longer be bleeding internally and he would be discharged after about 12 hours. I would be able to collect $2,888—that is the current per diem. So if we have a multiple on that, you could multiply it times 1.2 right now or possibly 200 percent—so multiply it times 2, and I would also get a trauma activation fee. That would be all I would collect. Just roughly, I am guessing, my direct cost on this, would be somewhere in the $30,000 range. In addition, I would have collected from a contracted payer on this patient somewhere in the range of $15,000 to $20,000.

Assemblywoman Pierce:
I will have to look into that.

Assemblyman Sherwood:
What works for your business model and what works for the folks who are seeking the legislation makes me uncomfortable. Get an actuary and say, what is the average? We are going to see this many people and here is the rate. It seems like you could figure that out. I had a little bit of a problem with the testimony about apparently the hospital not wanting to negotiate. I would feel a lot more comfortable if you would just work this out on your own with a trauma contract, which is what we are talking about—trauma. An ER can do whatever the nomenclature is for that and call it a day. Do the rates that have been kicked around in the amended version of 200 and 220 percent work for you? If they do, would you please sign a contract so we do not have to legislate this every year?

Bill M. Welch:
Many insurance companies do that. When they recognize that they will need to have services beyond just one hospital, they will go out and negotiate contracts with hospitals specific for either trauma services or for the emergency room only and not all other services. That is a practice that does occur. Hospitals in pairs, both have demonstrated their willingness to do that, and we are willing to do that.

Assemblyman Sherwood:
That would just make certain that the costs are fixed for the nonprofit. Now this does not affect everyone obviously, but there is a big chunk of people that this would help if they had some sort of certainty that their rates would not keep going up. So your testimony would be that if they entered into a contract with you, there would not be any “surprises” as far as their cost is concerned?

Bill M. Welch:
There are contracts that are specific between payers and hospitals that are only for emergency room services or only for trauma services. That would protect the patient from being responsible for anything outside of their health benefit plans other than their copay and deductible.

Chair Mastroluca:
Mr. Welch, I would say that in the latest version of the bill, those plans are exempt from this legislation and you still have the exact same issue of when the contract is over, we are back to square one at any period that you are out of contract. I like the way you are thinking, Mr. Sherwood. Let us keep trying to find something that will make everyone happy.

Bill M. Welch:
What I just described does happen, both in the health benefit plans that would qualify under this legislation as well as insurance products that are outside of this legislation. That is a standard practice regardless of whether you are a not-for-profit benefit plan or you are a for-profit benefit plan, so that does occur in the real world today in both scenarios.

Chair Mastroluca:
Ms. Bosse, I am going to ask that you please do not repeat anything. We only have about 40 to 45 minutes left. We still have a bill to work session, so I want to make sure that I get as many of your colleagues to give their opinions as possible.

Christine Bosse:
I represent Renown Health, a locally owned private not-for-profit organization. We are actually the only trauma center serving northern Nevada and northeastern California. I will skip the duplicative piece. I think one of the core messages I wanted to make sure that I got on the record relates to the comments that I have heard today about figuring out a rate. While we talk about a multiple of contracted rates or a multiple of a fixed fee schedule like the DIR fee schedule—which we have just been over that is based on a fixed per diem—the key problem with using anything like that as a basis has to do with the volatility of services that patients need, especially this population that will be delivered by ambulance that may have from soup to nuts wrong with them. Based on my experience, we have a broad range of services that we provide in a very short period of time, and most of these contracts are either contracts or the DIR fee schedule. Those have been developed based on a broad range of services and they count on a whole book of business, so in the average you end up okay. My facility as a trauma center, though, if I am going to get all of those traumas and I am going to get some multiple of a fixed rate and I am only going

to get the traumas, there is not a fixed fee schedule that pencils out. I wanted to make sure that everyone understands that there is not a multiple of a per diem that covers that broad range of services.

The second piece that I wanted to make sure that everyone understood is the difference between the southern market and the northern market relative to hospitals and providing care. As I think many people have discussed in the south, all of the hospitals are currently contracted with the Health Services Coalition, so there really would not be an immediate impact on the southern market until or unless a contract expired. In the north, however, there are a number of exclusive contracts, so there are payers who choose to take all of their volume, negotiate the best rate that they can, put them with one hospital, and then they make a business decision because they think that that is the best financial outcome for them. As a trauma center, we do negotiate specific contracts for trauma only. I will tell you those trauma contracts are based on a discount off of charges because of the volatility of services that I just described a minute ago. I will tell you in those contracts we insist that only the amount of the in-plan share of cost is shifted to the members. In other words, if we contract for a percent off charges in those agreements, when we sign those we insist that the payer protects the patient and only shifts to the patient the share of cost as though they were in-plan. I think that that is really important to note the payer takes on that financial responsibility.

The other component that I wanted to make sure that we have been having a fair amount of conversation about is hospital charges, and I think we all agree that hospital charges are significant. They are significant for a number of reasons, and we have talked about a lot of those today. The piece that I want to make sure that everyone understands is that hospital charges in Nevada have increased a little more than 14.6 percent on average over the last nine years. If you were to look nationally with what has happened to hospital charges, the average is 14.2 percent. It is a nationwide problem. I wanted to make sure that people knew Nevada hospitals are not any different. We are all struggling to find ways other than just cost cutting and closing services, to be able to collect enough to make up for all of those people—the 69 percent of our population that currently is not paying us cost. We are struggling to do that, and charges are our only other mechanism other than reducing cost and reducing services, and of course we always work on the reducing cost piece.

The final piece I wanted to make sure that I shared with you is that I have heard comments made about the medical bankruptcy issue, and I am positive it happens. I want to point out that people raising those issues have contracts with everyone, so I do not think there has been a balanced bill in Las Vegas that came from a hospital where a large balance was shifted to a member in the

Coalition because they have been contracted for a long period of time, so I do not think it is hospital related. I will tell you that as hospitals, whenever there is a large balance bill that happens, we work with people, we have medical financial hardship or charity policies, and based on people's ability to pay, when they come to us and say, "I have this $30,000 bill," if their payer has not protected them adequately and has allowed a large balance to be shifted to the member, we sit down, we work with them, we make reasonable payment arrangements, and we write off large balances if they are truly unable to pay those bills.

Finally, I want to say that my organization is currently struggling to remain viable. I am struggling with the concept that we are going to look at more ways to press the payer's responsibility to hospitals. I am happy to answer any questions.

Assemblywoman Pierce:
The No. 1 cause of bankruptcy in this country is medical bills. That was an impassioned defense of your industry, but it does not hold so much water. Obviously there is a problem.

Assemblyman Brooks:
I will go back to what my colleague stated to Mr. Wadhams earlier, because I do not believe he received a good answer, or an answer at all for that matter. What percentage of the DIR fee schedule are you comfortable with?

Christine Bosse:
I think the reason you did not get a direct answer is it is a fixed fee schedule that you can come up with an average over large populations, but when you are going to get the worst of the worst, the fixed fee schedule does not really work.

Assemblyman Brooks:
So if you look at the proposed amendments that Senator Copening worked diligently on for quite some time, and you look at section 13, subsection 2(a), it says, "For costs associated with services and care provided to the patient for treatment other than treatment of a traumatic injury, 200 percent of the amount set forth in the current schedule of fees and charges . . . ." Is that acceptable to you?

Christine Bosse:
There are a number of components in this bill that makes this very narrow. I am very appreciative of the work that both Chair Mastroluca and Senator Copening have put together to make this as narrow as possible. Those pieces are very valuable—the fact that you have to have an existing contract, and the fact that

it does not go on forever. Those are very important, but there really is not a rate that I would look at you and say, this rate will work. The conversation we are having now is that it is all about minimizing the harm.

Assemblyman Brooks:
Okay, never mind. If you do not want to talk about it, I will not talk about it.

Assemblyman Livermore:
Do you contract with the Health Services Coalition? The Coalition is just a coalition of the people who have plans that will contract with you.

Christine Bosse:
I do not believe that I have seen the list this week, but I do not believe that we have a contract with the Health Services Coalition. There is a similar coalition in the north, and that coalition is exclusively contracted with Catholic Healthcare West.

Assemblyman Livermore:
Let me just say that Ms. Bobbette Bond just sent us an email. She sent me a list of names of people within this coalition and there are 22 on this list. So I guess this 22 would all have to have some arrangement of a contract for your or like facilities.

Christine Bosse:
I believe that the Health Services Coalition—I guess Bobbette would have to come up and clarify—but it is my understanding that the power of the Coalition is to contract as one, and I was always under the impression they did that. Being in the north, I am not positive.

Assemblyman Livermore:
I was just going to state that if you look at some of the names in here, City of Las Vegas, Clark County Firefighters, Construction Industry and Laborers Health and Welfare Trust, Golden Nugget Hotel and Casino, Culinary Health Fund, and on and on. It is not like you are a nonprofit organization. It is not like they cannot afford to provide their workers with fair health insurance plans, and I think that is the issue. What is the Coalition in the sense and the fact separating the hospitals from these individuals? You do not have to answer that.

Chair Mastroluca:
Ms. Bosse, I do not think you have been involved in these conversations over the last six or seven years, but I wanted to say that it is my understanding that some of the other rates that have been offered were Medicare at 200 percent,

contracted rates at 200 percent, and average contracted rates with a rider. Is there anything that is going to make the hospitals happy other than billed charges?

Christine Bosse:
Speaking on behalf of my own organization, we had some discussion earlier this session about a fairly significant discount off of billed charges, recognizing that billed charges are what correlate to the services we provide and the costs we incur. That was the direction we were talking about earlier. There is not a fixed fee schedule that I am aware of that would work for my organization.

Assemblywoman Pierce:
So using the DIR's fee schedule is just an impossibility? Do you not accept anyone at your hospital who is being paid under this system? So you do not accept anyone who is on workers' compensation?

Christine Bosse:
We absolutely accept the entire population in the north. We operate an emergency room and a trauma center. Under the Emergency Medical Treatment and Active Labor Act guidelines, we are required to take care of anyone who presents and needs emergency care. We do accept that entire population, but by describing it I hope I have demonstrated for you it is the entire workers' compensation population. I will also tell you that the last time I looked, it did not even cover our cost let alone approach contracted rates. So it is much lower.

Assemblywoman Pierce:
That is why the multiple is there. You do understand the whole math part?

Christine Bosse:
Yes, I do understand the math part. The piece that I wanted to point out is we are talking about providing all of the service on day one, possibly day two, and transferring the patient. So the multiple for one or two per diems does not begin to cover the impact of the service.

Assemblyman Sherwood:
You cannot spread your cost out over time. The problem that I have—assuming that we accept the premise—is there are a bunch of folks that do not fall into the level of indigent care, but they do not fall under nonprofit. I have insurance. I do not know if my insurance contracts with every hospital in the county where I live, but if we are going to pass this, I would think that we would want to pass this for everyone who has insurance. It is not indigent care, right? Did I understand it earlier that all health insurance plans were on the table and in

negotiations the Nevada Hospital Association took them off the table? Why are we doing legislation for just one health insurance plan and not everyone who has health insurance?

Christine Bosse:
I believe that this bill covers all not-for-profit benefit plans. I think that is the right term. That was an attempt to make it as narrow as possible. We are all very appreciative that we have narrowed it to not-for-profit health plans.

Assemblyman Sherwood:
That is great, except most of the people that I represent are not members of that not-for-profit health plan. So when they go to a hospital that does not have a contract, they are going to be stuck with a huge bill. Why would we narrow it? If it is good and we can come up with a multiplier, it should be good for everyone, right?

Christine Bosse:
Yes. I appreciate your question. I think the issue is in the for-profit health plans and the for-profit payers, especially the ones that are Nevada-based that do cover their members. So there is not a significant balanced bill that gets shifted to those individual members. We do have a *Nevada Revised Statute* that requires payers to cover their members. I am not sure how if it determines at all what the patient's share of cost is. I will tell you I am familiar with most of the large insurance companies in the state and they either contract or they pay the bill when they decide from a business perspective that they do not want a contract.

Assemblywoman Pierce:
If you look at the Coalition that is in support of this bill, it is hundreds and hundreds of thousands of people in southern Nevada. This is a very long list and very big employers. This is many people and they live in all of our districts.

Chair Mastroluca:
Ms. Bosse, did you want to respond to that?

Christine Bosse:
I agree with Assemblywoman Pierce. It is a very large group, which is why I think that both the payer as well as the hospitals very much want to have the opportunity to contract. They have a lot of leverage in the market in terms of negotiating contracts, and hospitals really want to have that volume in their facilities. I think it is kind of a match in terms of both sides will always want to be at the table.

Chair Mastroluca:
Back to my original point. If both sides were at the table, we would not be having this conversation right now.

Dan Musgrove:
Congratulations and thanks to Chair Mastroluca and Senator Copening on the work to try to make this as palatable as possible. The trouble is, this bill is not addressing the core issue that so many of the questions that have come from each one of you have tried to address. I will use the exact words of the proponents, "What the insurance company left them to pay." That is the key issue here. Instead of grilling the hospitals, I am wondering why you are not asking the insurers—the third party in this bill—as to what responsibility they leave on their employees, their covered members. That is really what happens. When someone comes into our hospital, we issue a bill. Remember we are talking about people who have insurance. There are lots of laws already on the books for those who are unable to pay, and hospitals are required to automatically cut their bill 30 percent. That is in statute. We have the indigent who are covered by Medicaid. These are people who have insurance. So when the person shows up at a hospital where there is a noncontracted rate, then what we need to be asking is what responsibility are they going to put on Mr. Anderson to pay his copay and deductible, or whatever they will not cover. This bill does do one great thing. It says that the most that we, the hospital, can do is charge the individual their copay and their deductible. But it does not address what the insurer is going to ask them to cover.

I am on my wife's insurance. It is the Teachers Health Trust. She is a middle school counselor. I had an accident a couple of weeks ago where I cut my thumb pretty bad. I did not go to a facility. Let us say I cut it off, and I had to be taken to Renown Regional Medical Center. I looked it up, and if it was a day's stay, I would be responsible for almost $30,000 worth of charges. That is the Teachers Health Trust, and something that would be covered by this bill. That would be my responsibility. This bill would fix that, because all I would be paying is the copay and the deductible. That is a great thing. That is the best part about this bill.

The Chair talked about how this needs to be a consumer bill of rights. This needs to be looking at the consumer. So why are you not asking the insurers what responsibility they are going to put on their covered members when they show up at an out-of-network hospital? That is the important question. Then let us figure out what the relationship is between the insurer and the hospital. The thing that really concerns us is the setting of rates. I am here to answer any questions you have about my graph. These were specific cases that we had at the Valley Health System that came in through the ER and then they

were transported. As you can see, I granted the best example of the conditions under this particular bill because of the hard work by Chair Mastroluca and Senator Copening to narrow the focus as to what this covers. It would probably be example No. 3: one day's stay.

What is the number, Mr. Brooks? That is a good question. I think the better question is, what are you, as the individual, going to be responsible for? That is the one good thing about this bill. If anything else stays in this bill, I would certainly like to see that the individual is covered for copay and deductible. Everything that my colleagues have said I agree with. What is the number? There is not a good number, because we do not believe in the fact that the Legislature should be mandating between us. If you really want to protect, let us set a number for the individual and what their responsibility is. Let us decide what that number is first: what you as individuals should be required to pay by your insurance companies. But the trouble is, we cannot even get that out of this Legislature because these plans are covered by the federal government. So we would have to ask our congressional delegation to try to make that decision. I stand open for any questions.

Assemblyman Brooks:
With all due respect, Mr. Musgrove, I agree that this is two private parties coming together to bring forth a contract, and we probably should not be involved, but we are. So having said that, I was referring to the DIR fee schedule. In your mock-up it seems like you have 200 or 300 percent. I am particularly referencing that question to Ms. Bond, I believe it was, because I have an amendment from her that says she would be comfortable with 200 or 300 percent, although she does not feel that any fixed fee schedule would ever cover the widely varying range in services. I do not know—you have come this far to want to continue to play games around the DIR fee schedule.

We are at the DIR fee schedule, we are trying to figure out a percentage that is good for you, and we are getting nothing. If we cannot get anything, I think it is going to be up to the Chairwoman and the Senator to sit down and mock up something for you again. I do not think you are going to be happy with that. So in good faith we are trying to figure out how do we make this bridge for you. I understand you really do not want us to make the bridge, but the issue is on the table. How do we make the bridge and try to give you the benefit of the doubt so that you can give us the information we need as opposed to someone giving you what you do not want. Let us be very transparent. I am very familiar with this issue because they have been talking to me all week about it. Does 300 percent of the DIR fee schedule work, does 400 percent work, does 200 percent work? Something has to work. If it does not, do not offer any amendments to the contrary. Because when you offer amendments to the

contrary, it confuses the matter and quite frankly we are going around in circles now. The question is, what percent of the DIR fee schedule is acceptable?

Dan Musgrove:
You have to understand is that I am speaking on behalf of five hospitals in southern Nevada and one extra hospital that Mrs. Benitez-Thompson did not realize exists—Northern Nevada Medical Center, a cute little hospital up on the hill in Sparks. The southern Nevada market is very, very different. I will say that on behalf of the five hospitals in southern Nevada, I have been told that we would accept 300 percent begrudgingly, but we are a nontrauma center. That is for my system. Now Northern Nevada Medical Center is in a very different situation because, as Ms. Bosse has testified, there are exclusive arrangements with single hospital systems that leave others that are not covered. I do not have a number for them, but for southern Nevada we would be willing to begrudgingly accept 300 percent.

Assemblyman Brooks:
Thank you for finally answering the question.

Assemblywoman Pierce:
Well, using your own example of cutting your finger off, the whole point of this bill is that these are people who at that moment are not able to make a responsible decision. You have cut your finger off. You are going to sit there and go back in your house and figure out what is in your network? That is the whole point of this bill.

The other part I want to say is that I am more than a little offended by your scenario about what the responsibility of the people covered is. I am covered by a collective bargaining agreement, and in the last 22 years with every single contract I have taken a tiny raise so that I could keep my health care. Every single time for 22 years. That is what negotiations are. So the idea that somehow I am sort of irresponsible out there, that is the other part. There was no question in there.

The other thing I want to say is that medical costs across the board affect the medical costs of everyone in the community. My union has done a very, very good job of trying to keep medical costs low; we have done all kinds of things. We work very hard to get our members to use generic drugs, all kinds of things. That affects the medical costs in the whole community. This idea that somehow all these people who just irresponsibly went bankrupt because they had medical costs and that somehow that is sort of mass irresponsibility, but otherwise everything is just fine, that is offensive.

George Ross, representing Sunrise Health:
Before I go on and even though it is repetitive, I want to say thank you, Madam Chair, thank you to Senator Copening, and thank you to several Senators who will remain unnamed who assisted her as well, and the staff in trying to make this whole concept a better bill. We really appreciate that. We are not totally naïve. We understand the politics surrounding this. I have had it made abundantly clear to me that there would be a bill. We tried very hard to negotiate, and we negotiated for some time. We ended up in a place that clearly left the proponents of this bill in a much better spot than they are without the bill, but it was apparently somewhat short of where they hoped to be. I will say that we have made some very significant concessions.

If I may reference something Ms. Pierce said—and she hit the nail on the head as she usually does. One comment was that there is a very, very long list of supporters of this bill with a very long list of members and employees. That is in fact why we pay so much attention to this. It may apply to nonprofits, but it is a very, very large population that will have a tremendous impact on the hospitals. I will say up front that the Health Services Coalition is an extraordinarily valued customer of all of our southern hospitals, so we terribly hate to have this biennial exercise in which we get mad at each other. We do our best not to get mad at each other, but we do get antagonistic occasionally.

What is really happening here is—and I will try not to be repetitive—but this whole issue right now is really a function of how the State of Nevada, in conjunction with the federal government, has chosen to do health care financing. Essentially we have 10 percent of our population uninsured. They do not pay much. We have Medicaid, Medicare, and we have some county. If you take 100 as being a hospital's costs, collectively 69 percent of those patients pay somewhere around 43 percent of the total costs that the hospitals incur. So the other 31 percent of the patients have to pay the other 57 percent of the hospital's total costs as well as whatever the hospital adds above that, which goes to invest in the new high quality care that does not come free. My hospital client takes great pride in having been named the No. 1 hospital in Las Vegas by *U.S. News and World Report*, but that does not come free. That hospital tries very hard to stay right at the cutting edge of new technology and new approaches and provide the best quality as it possibly can, both in terms of doing things right and in terms of the kind of care we are able to offer. It does not come free. So essentially what happens is when we have to cost shift, when we look at schedule of costs, which we have talked about, that really is only a tiny piece of the picture. It is almost myopic, because you can only understand why we say the numbers in this proposed bill are insufficient in the context of the overall financial structure of hospital health care in Nevada and our own health care. We have to charge those higher numbers in order to cover

the costs that do not get covered. It is as simple as that. Unfortunately, the way we have structured things, we have essentially implicitly said, as a state, to all of those groups who provide coverage for their employees, and to the nonprofits and the private insurance companies, your role in this community is to help cover those costs that are incurred by those parts of the community where we do not get them covered. The hospital's role is to cover whoever comes through that door, and then try to make sure they have enough revenue coming in that they stay open and to provide the best care they possibly can. I know you understand that. The beneficiaries of this legislation have a tremendous number of patient lives, so their community role in that perspective is very significant. They are essentially saying in this bill—because it was testified very clearly in the interim health committee that they want to have the option of not contracting with one plan. In reality, they get all of the benefits of the plans without having to pay for them.

This goes back to a different way of looking at what Mr. Musgrove just said. I think it is really ironic that this particular bill turns the Patient Protection and Affordable Care Act (PPACA) on its head. That plan, that bill, more than anything else, would reform the regulation of insurance coverage. If you read the regulations that came out dealing with emergency care to implement the act, they explicitly say the way we have this structured could still potentially lead to balance billing. Balance billing is essential and very important to make sure that hospitals have enough money to continue to operate and offer quality care. Ironically, this Legislature cannot make the proponents of this bill do anything about what they offer. There is a conscious choice. It is a financial choice made as to how much of an individual's care a planned coverage is if the individual gets out-of-network care. What we are really seeing here is a reason why the particular people who appeared before me appeared before me. Because, as we all know, those health plans are paid for by the employers. Not the public sector ones, but the major private sector ones involved in this coalition that are paid for by the employers. What is clearly happening here today is that one set of private actors are trying to shift their costs to another set of private actors, but the second set of private actors has the obligation to serve the whole community as well as it possibly can. Not just the legal obligation but the moral obligation as well. That is why we are here today, asking that if we do have a bill, it would be something that we can live with. We have had negotiations that broke down, but we made what we thought was a fair offer, and we were still open to further negotiations when they were broken off.

Chair Mastroluca:
What was your offer?

George Ross:
At that time we offered 65 percent of billed charges with 90 percent of billed charges for trauma, or 60 percent of billed charges and trauma exempted from the bill. The reason for that being the trauma center is much more expensive to operate because you must maintain all of those services at an instant's notice.

Assemblyman Sherwood:
For the constituents that I represent who do not fall under the Coalition—and it is an impressive coalition; no one can deny that—there are thousands of people who are covered and there are thousands of people who are not covered. What kind of deal would they have through their insurance? I am not talking about people who are uninsured, but if you are using Sierra Health and Life, United HealthCare, or someone else.

George Ross:
In light of the fact that the amount of costs, which the hospitals must shift, will not have changed, you still have to get that revenue to cover it. So the next time those contracts are renegotiated with each of those coverages with the hospitals, the hospitals will have to try to push harder to get a higher rate in order to cover that. One way of looking at this economically—I do not think it is anyone's intent, I want to make that clear and am not accusing anyone of intending for that to happen—is that the revenue would have shifted from the nonprofits or to the commercial carriers, and they would have to pay higher rates and you would have to pay a higher rate.

Assemblyman Sherwood:
They would pass that on to me.

George Ross:
Yes.

Assemblyman Livermore:
As you described the dynamics of ratepayers and providers, I know there are antitrust issues dealing with providers collectively bargaining together against insurance companies or ratepayers. Is it unfair for ratepayers to bargain to gather together to drive hospital costs down?

George Ross:
Although I work for a law firm, I am not a lawyer, although I have done a lot of antitrust work. I would only say that there are two very large plans in southern Nevada, and could posit that as a result of their market power, the overall rates, at least for those two plans, are quite favorable compared to rates in the rest of the country. I have been told that by my client. In terms of the rest of it, it

would have to be a legal question and you would have to consult with the antitrust experts.

Chair Mastroluca:
Let us not put Mr. Ross on the spot and get him in trouble.

George Ross:
I cannot practice law without a license.

Chair Mastroluca:
Oh, but we try, we try.

LaShannon Spencer, representing Catholic Healthcare West:
We have three facilities in the south: St. Rose Dominican Hospitals, Siena Campus, and the San Martin Campus. I also represent Saint Mary's Regional Medical Center in the north.

I have to applaud both of the committee Chairs for doing such an exceptional job of being able to pull all the stakeholders together. It is amazing that women have had to deal with such a tough issue like this during this legislative session.

My colleague, George Ross, articulated that Sunrise Hospital, the hospital that he represents, was named one of the top hospitals according to quality measures in *U.S. News and World Report*. St. Rose Dominican Hospitals in the south are three of the five top hospitals in the state for quality measures and nationally ranked as well. I want to pay attention to quality care. We would like to continue to be able to provide quality care to the Coalition. Quality care is very important to us. As the community's only not-for-profit hospital that is religiously sponsored, St. Rose is guided by the vision and core values of the Adrian Dominican Sisters. Our mission is to serve people in need. But how can we continue to serve people in need when this proposed legislation can be a hindrance based on the PPACA? How can we serve and provide equal access to quality care at a reasonable cost and rate? How can we continue to serve and promote an adequate supply and distribution of health care resources? How can we continue to promote and encourage distribution of health care human resources? I was the person that was responsible for working with mediation and the Service Employees International Union Local 1107 and the California Nurses Association. Laying off over 220 people at our Rose de Lima Campus was not an easy job. But that was something I had to do. This type of legislation would propose a hindrance for my system to be able to provide quality care for the Coalition. Thank you, Madam Chair.

Chair Mastroluca:
Are there any questions? [There were none.] Thank you very much. I appreciate your time, and thank you for waiting.

As the hour is getting late, our members may feel like we are in the "me too" stage, but we are actually shifting from hospitals to doctors, so the conversations will probably sound a little bit different, but we also want to get your point of view on the record.

Lawrence P. Matheis, Executive Director, Nevada State Medical Association:
I appreciate you all sticking it out here to the bitter end of a long session and taking up a hugely complex subject right at the end. I do not think it is actually fair to ask you to master the nuances of this. I want to thank Madam Chair, Senator Copening, Risa Lang, and Marsheilah Lyons for the work they have done, admirable jobs of pulling from very different places the positions that physicians, hospitals, and health plans have raised over a long period of time. I think that the bill, as it is gelling, is a much clearer and much more focused effort at defining a problem, which has been very difficult to do throughout this process, and defining a particular pathway to dealing with it.

We are not, however, in support of the product as it stands. That is because of that fundamental issue. It is late in the session, but let us be clear on this. The Legislature has not established by law that there are statutory requirements for private contracts privately entered. If you pass a bill to do that, it will be the first time you do it. This has nothing to do with public contracts, public agencies, or public services. It is private contracts among private parties. If the *United States Constitution*'s protection about the right to contract has any meaning, it also has to mean that you have the right not to contract if you choose not to. I think that that is an important issue for physicians. It has been something that we have raised from the beginning.

The limits of this bill are that the insured patients who are brought by emergency vehicles to an emergency department, until that patient is screened, stabilized, or transferred to an in-network facility and in-network doctors, it is that exposure of insured patients. The insurers that are being talked about here, we have grappled with this for years about how to define the entities we are talking about. The issue is about self-insured and trust plans, and I think the nonprofit is the selected way to define that. A problem there is that with the exception of Hometown Health, which is regulated by the state Commissioner of Insurance, we cannot identify who else is on the list of these plans that would be covered by this. At some point, if you do go ahead with processing this bill, someone is going to have to come up with an official list so that we know what cases are actually covered. As far as I know, there is no list of

nonprofit plans other than the ones that are regulated by the State of Nevada through the Commissioner of Insurance. That is one issue, and coming up with that list is going to be important. For doctors, a fundamental issue that is different than with the hospitals, is that contracting is really by medical specialty and medical specialty practice. So there are contracts by individual physicians or by their practices with hundreds of different insurers as well as in terms of the staffing arrangements with hospitals. It is a complex situation that physicians who are on staff at hospitals have to contract individually with the plans that their patients may be covered by, and in some cases they are not. In some cases, insurers can have five, six, or ten different plans that they offer, and they contract for some of their networks and do not contract for others. It is a complex area that has grown as managed care has grown. One of the things that is managed in managed care is the network of physicians and other providers.

At the heart of the problem is that this binds private parties to contracts that they have not signed and as far as most physicians feel, it is to the advantage of one of the parties rather than to all the parties. That is the underlying problem that they face. The challenge in coming up with a payment system of any sort is that there really is none out there that is fair for all services and for all occasions. The DIR fee schedule for workers' compensation has been created for the purpose of patients who will derive their condition from their employment. For many physicians, that will be an appropriate standard they live by. But for some, they have no experience with it at all, for example, obstetrics. There are very few workers' compensation cases involving the delivery of babies.

Chair Mastroluca:
We have had that discussion, and there is a provision available that is not necessarily in the DIR fee schedule but is part of that group.

Lawrence P. Matheis:
Then that would have to be very clearly stated in the bill. I think in the case of pediatric specialties, which is the other concern, I think that the actual specialty services probably provides that same thing. Obstetrics is the one issue that does not come up.

Assemblywoman Pierce:
Let us look at the legislation we have had in this session—homeowners' association legislation. It is about a contract between two private parties. All kinds of consumer regulations are about us regulating things that happen between private parties. Not only are we not stepping into an area that this

Legislature has never stepped into before, this is the 800th time we have stepped into this area in the last 120 days.

Lawrence P. Matheis:
I respectfully disagree that what you are doing is to actually invoke contract elements into statute. I think that what you are doing in most of those cases is really consumer-based legislation, and that is worthwhile. I think that is the issue that has kept this issue on the table and why there have been negotiations and so far we have been able to agree.

Kathleen Conaboy, representing Nevada Orthopaedic Society:
I am here to object to S.B. 115 (R1). Doctors live by the maxim to do no harm, and in order to do no harm, doctors have to carefully evaluate, diagnose, ask a lot of questions, and make a diagnosis that leads to a certain kind of care. I am afraid that we have missed a couple of essential questions, even though we have indeed, as many others have said, been discussing this question and this issue for a very long time.

Some of the concerns the Nevada Orthopaedic Society have about the root concepts of this bill have been touched on by many people this evening, so I am going to address them if you allow me to. I think the bill confuses three distinctly different kinds of contractual relationships. We use the word "contract," but I would like to suggest to you that there are three different kinds of contracts at play here.

The first is an insurance contract between a commercial, self-funded, nonprofit, government insurer—the third-party payer as we call them—and the people who are covered by the contract that that group offers to their enrollees. This is a business contract. In exchange for the premiums that a person, an enrollee, pays or that their employer pays, the insurer guarantees coverage for certain negotiated benefits. That is very important—for negotiated benefits. The package is clearly defined and the cost is clearly defined. Any services rendered outside this set of negotiated benefits are not covered by the contract. In no way is the physician a party to this particular agreement. This agreement is between the third-party payer, the insurer, or the employer and the enrollees.

There is a second kind of contract, and that is the social contract. In an emergency situation, under federal law and also by ethical and moral guidelines, physicians provide services to people who present with symptoms in need of immediate care. They are not allowed to say, "No, I will not see you today; I am not on your provider list." They are simply not allowed to do that. It is a social contract, and this is far outside the parameters of the insurance contract that the enrollee has with their insurance provider.

There is a third kind of contract. Insurers cannot provide care to their enrollees without having an adequate network of hospitals and physicians who provide that care. So the insurers need to create this balanced network of physicians and hospitals to provide the services that they have negotiated with their enrollees. They need to provide access to an adequate number of primary care and specialty physicians, and they need to provide adequate access on a geographic basis. Insurers will approach physicians and hospitals, or vice versa, and they will offer varying rates because they determine certain rates for reimbursement are reasonable. As in all contracts, if the parties disagree, then either party can refuse to execute that agreement.

So we have three kinds of contracts. We have the insurer-enrollee relationship, we have the physician-patient social contract, and we have the insurer-provider relationship. These are separate and distinct. It is either covered or it is not covered by the contract you have with your insurance company. Putting doctors in the middle of a dispute about covered services—which is what out-of-network is—is ill advised. Unless the physician also has a contract with an insurer, really the only contract we are talking about today is in effect the business relationship between the third-party payer and their enrollee beneficiaries, not the beneficiary and the physician who provides services.

The Nevada Orthopaedic Society has a long-standing concern with S.B. 115 (R1). Indeed we add our thanks to you, Madam Chair, and to Senator Copening and many others who spent many, many hours at the table discussing this issue. However, going back to where I started, in the maxim of to do no harm, we have asked repeatedly—last session, in the interim, at the beginning of this session, in the Senate—that there be a formal objective review of the scope of this problem. There is a perceived problem out there, but I can diagnose that your back hurts because you gardened yesterday and you bent down too much and that is why you hurt. If I do that without really studying the problem, I can miss the fact that you have a metastatic cancer in your spine. It is incumbent upon all of us to define this problem very, very carefully. We suggested in great detail the elements that we thought should be included in the study, and unfortunately that study is not included in any version of the bill. We agree with the Nevada State Medical Association and we believe sincerely that this bill interferes in the right to negotiate a fair contract. In private contracts, parties sign when they are willing to sign because the terms of the contract are acceptable to both sides.

An unintended consequence of this bill, we fear, may be a drop in physician participation on hospital call panels. This will cause delayed care and will create an enormous frustration for the triaging physicians—the ER doctors who need specialty physicians like the orthopedic physicians I represent—to take care of

the people who come by ambulance to the hospital because they have an orthopedic problem.

In conclusion, I would like to read an email that our physicians sent to the members of the Senate as they were considering this bill today. This is signed by Dr. David Silverberg, who is the Vice President of the Nevada Orthopaedic Society. Interestingly, Dr. Silverberg is a double board certified orthopedic surgeon. He is board certified in trauma and orthopedics. He is one of two such physicians in the entire Las Vegas Valley, and it took him many years to be allowed to join the coalition network. That is another reason that we in the Nevada State Medical Association have long discussed the issues of adequacy and transparency of networks.

Dr. Silverberg wrote to the Senate today, "This bill now punishes the greater good for the lesser evil and has many unintended consequences beginning with the disincentive for physicians to cover our already overstuffed emergency rooms. The bill will disadvantage physicians, negotiating with self-funded plans because the plans now have a safety net rate if they choose to reject a physician who is requesting to become in-network. The metric proposed is tied to changes in Medicare reimbursement and therefore inherently unstable. Any metric infringes on the rights and freedom of doctors to be competitive small business owners."

I think all of you who are watching what is happening at the federal level all know that Medicare is a very unstable metric. Doctors at the beginning of this year were going to be subject to a 20 percent cut in Medicare reimbursement, and unfortunately the Senate and the House keep kicking that problem down the road. If that had happened, the DIR rates—which are benchmarked Medicare—would have dropped precipitously. That is why we oppose the concept of tying reimbursement to a metric such as Medicare.

Dr. Silverberg continues, "Physicians remain out-of-network because self-funded plans sometimes limit their directories to a specified number of physicians and they reject offers from additional physicians to join the network. Another reason they stay out-of-network is because the plans sometimes offer exceedingly low reimbursement rates during negotiations. Physicians do not remain out-of-network as an abusive billing tactic. Self-funded plans could draw down the list of out-of-network physicians with good faith negotiations and by expanding their directories. This is our suggested solution to the perceived problem." Thank you.

Chair Mastroluca:
Are there questions from the Committee? [There were none.] Thank you very much for your time, and thank you for being here so late.

Is there anyone else who would like to make a comment on S.B. 115 (R1)? [There was no response.] I appreciate everyone's patience and participation, especially considering the fact that we do not have this bill yet, so this could all be for naught, although hopefully it will not be. A lot of time and energy has been put into this. I want to thank everyone and all of the parties who have been willing to come to the table and have the conversations, and all the people who have offered solutions. This is not perfect. We all know that there are very few pieces of legislation that ever are. We will continue to persevere for the next 31 hours and see where we end up. With that I will close the hearing on S.B. 115 (R1).

Senate Bill 340 (1st Reprint): Revises provisions relating to programs to increase public awareness of health care information. (BDR 40-663)

Chair Mastroluca:
Committee, we are going to move into a quick work session with Senate Bill 340 (1st Reprint) that we heard yesterday. Senate Bill 340 (R1) requires hospitals and surgical centers to report certain data containing the names of physicians who perform surgical procedures and other data relating to surgical procedures to programs to increase public awareness of health care and requires the Department of Health and Human Services to post the information on an Internet website.

I would ask the Committee if you would give me the ability to entertain a conceptual amendment to this bill. While I think that the testimony yesterday said the bill was valuable, it did bring a lot of help to the consumer and transparency. There is a substantial fiscal note to this bill, and money is currently not available to cover it, and I do not want the policy to die. I would ask that the Committee consider an amendment that would say when money is available, we would be able to implement this program. So it would put this bill on hold until a federal grant would come up, and we would still have the policy in statute that would allow for the Health Division to do this when the money exists.

Is there discussion or comments?

Assemblyman Sherwood:
On the bill itself, the testimony I recall said there was no next step. So what we are going to basically say is how many procedures you have done but not connect it to errors or anything else? So it is just a glorified scorecard?

Chair Mastroluca:
Correct.

> ASSEMBLYWOMAN PIERCE MOVED TO AMEND AND DO PASS SENATE BILL 340 (1st REPRINT) WITH THE RECOMMENDED CONCEPTUAL AMENDMENT.
>
> ASSEMBLYMAN FRIERSON SECONDED THE MOTION.

Is there any discussion?

Assemblyman Goicoechea:
How do we determine when the money is available? Who is going to make the call that we go ahead and fund this program?

Chair Mastroluca:
I believe the Health Division would do that.

Assemblyman Goicoechea:
You would leave it up to their discretion? If they felt it was critical or essential, they would float it to the top?

Chair Mastroluca:
Yes. I would ask that the Chair of the Assembly Committee on Ways and Means would verify this, but I would assume that if money became available, say through a federal grant, that they would bring it to the Interim Finance Committee and say, "We have this ability in statute, we now have the money; do we have permission to do this?"

Assemblyman Goicoechea:
Okay. It would be through a work program. That would be fine, as long as they have the ability to make that call. Thank you.

Chair Mastroluca:
Is there any further discussion on S.B. 340 (R1)? [There was no response.]

> THE MOTION WAS PASSED. (ASSEMBLYMEN LIVERMORE AND SHERWOOD VOTED NO.)

Chair Mastroluca:
Committee, we will adjourn for this evening. It is my understanding the Senate still has not gone back to the floor. I think they are still in the Senate Committee on Finance. Until they go back to the floor and pass the bill out, either in the form that it was amended yesterday or in another form, we are in a holding pattern. I do not think we have any other bills that we are expecting to come over other than this one. So if the bill comes over, we will have a meeting tomorrow at the call of the Chair. We can have further discussion tomorrow, but I would ask that we do not rehash this bill. We have spent about 3 1/2 hours on it.

The meeting is adjourned [at 6:59 p.m.].

RESPECTFULLY SUBMITTED:

_____
Linda Whimple
Committee Secretary

APPROVED BY:

_____
Assemblywoman April Mastroluca, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: June 5, 2011 **Time of Meeting: 3:58 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
S.B. 115 (R1)	C	Senator Allison Copening	Proposed Amendment
S.B. 115 (R1)	D	Risa Lang	Proposed Amendment Mock-up
S.B. 115 (R1)	E	Bobbette Bond	"Billed Charges and Patient Impact" Presentation
S.B. 115 (R1)	F	Dan Musgrove	"Actual Case Comparisons"