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

Seventy-Seventh Session
May 23, 2013

The Joint Assembly Committee on Health and Human Services and the Senate Committee on Health and Human Services was called to order by Chair Marilyn Dondero Loop at 2:16 p.m. on Thursday, May 23, 2013, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, 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 nelis.leg.state.nv.us/77th2013. 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).

ASSEMBLY COMMITTEE MEMBERS PRESENT:

Assemblywoman Marilyn Dondero Loop, Chair
Assemblywoman Ellen B. Spiegel, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblyman Wesley Duncan
Assemblyman Andy Eisen
Assemblywoman Michele Fiore
Assemblyman John Hambrick
Assemblyman Pat Hickey
Assemblyman Andrew Martin
Assemblyman James Oscarson
Assemblyman Michael Sprinkle
Assemblyman Tyrone Thompson

SENATE COMMITTEE MEMBERS PRESENT:

Senator Justin C. Jones, Chair
Senator Debbie Smith, Vice Chair

Senator Tick Segerblom
Senator Joseph P. Hardy
Senator Ben Kieckhefer

COMMITTEE MEMBERS ABSENT:

Assemblyman Joseph M. Hogan (excused)
Assemblywoman Peggy Pierce (excused)

GUEST LEGISLATORS PRESENT:

Assemblywoman Maggie Carlton, Clark County Assembly District No. 14
Assemblywoman Marilyn K. Kirkpatrick, Clark County Assembly District No. 1

STAFF MEMBERS PRESENT:

Brenda Erdoes, Legislative Counsel
Kirsten Bugenig, Committee Policy Analyst
Risa Lang, Committee Counsel
Terry Horgan, Committee Secretary
Janel Davis, Committee Secretary
Macy Young, Committee Assistant

OTHERS PRESENT:

Jeff Ellis, Vice President and Chief Financial Officer, Human Resource Services, MGM Resorts International
Danny Thompson, representing Nevada State AFL-CIO
Patrick T. Sanderson, representing Laborers International Union Local 872, AFL-CIO
Karlos R. LaSane II, representing Caesars Entertainment
Rusty McAllister, representing the Professional Firefighters of Nevada
Ryan Beaman, representing Clark County Firefighters Local 1908
Virginia Valentine, representing the Nevada Resort Association
Kelly Taylor, Health Plan Director, Employee Health and Welfare Trust, Las Vegas Metropolitan Police Department
Christine J. Carafelli, representing Health Services Coalition
James Wadhams, representing Nevada Hospital Association
Bill Welch, representing Nevada Hospital Association
Karen Massey, representing the Northern Nevada Emergency Physicians and Medical Group Management Association

Lawrence Matheis, representing the Nevada State Medical Association
Larry Hurst, representing Anthem Blue Cross & Blue Shield
Kathleen A. Conaboy, representing Nevada Orthopaedic Society
Denise Selleck Davis, representing the Nevada Osteopathic Medical Association and the American College of Osteopathic Family Physicians, Nevada
Lesley Pittman, representing the Nevada State Society of Anesthesiologists
John Wagner, representing the Independent American Party
Dean Polce, Private Citizen, Las Vegas, Nevada; Member, Nevada State Society of Anesthesiologists

Chair Dondero Loop:
[Roll was taken. Committee rules and protocol were explained.]

I would like to welcome our Senate colleagues, the public, and those viewing over the Internet this afternoon, and thank you for your patience. I will now open the hearing on Assembly Joint Resolution 9. This afternoon, we welcome Assemblywoman Kirkpatrick and Assemblywoman Carlton.

Assembly Joint Resolution 9: Proposes to amend the Nevada Constitution to ensure access to affordable health care in an emergency to all persons in this State. (BDR C-1227)

Assemblywoman Marilyn K. Kirkpatrick, Clark County Assembly District No. 1:
Assembly Joint Resolution 9 addresses emergency services and the costs our constituents are paying. I brought this joint resolution today because many of our constituents are already in tough financial spots; however, medical expenses are something they cannot eliminate. Over the last year and a half, many constituents have called to talk about items in their bills that had become problems. These are items they thought were covered by their insurance policies. An example is having a heart attack, being rushed to the closest emergency room, and finding out a month later when the bill arrives that a lot of the charges were not covered. This does not happen to one category of constituent more than another or whether they are young and have been in an accident and been sent to the nearest hospital to ensure there is care, or whether it is one of our senior citizens who maybe had a stroke or heart attack. Our main goal as public servants is to get them to the closest hospital in the quickest amount of time to ensure that their life and safety issues are addressed.

Assembly Joint Resolution 9 is not new to this building. It has been talked about for a very long time through statute; however, since the late 1990s, we have not been able to make any progress on how we get this done and how we have conversations concerning what is fair billing for our constituents. Sixteen other states have it in statute. We tried to put it in statute. Knowing that, language in section 17, subsection 3, reads that the Legislature can come back and make changes. Subsection 2 of the bill says you have to ensure that the patients are getting the adequate service for the same price as everyone else.

I worked with a fellow who was hurt in a motorcycle accident far from town. He crashed and was sent by helicopter to a hospital. He had insurance, but he was in the hospital for some time. He got the bills, it was very expensive, and the out-of-pocket costs put him into bankruptcy. He did not know how he was going to be able to pay that $30,000 bill, even with his insurance.

I can tell another story about someone going to the hospital and being charged for things such as $7.50 for Gatorade. That is not covered by your insurance and we all know that we can pay $0.89 for that Gatorade. This is a discussion regarding giving the voters a choice about what the costs should be and how those costs can be controlled so that they can pay those costs and that they get the proper insurance coverage. We have a fabulous Health Division within our state, and they spend a lot of time trying to negotiate hospital bills down for folks who have insurance who believe they are covered. With that, I will turn this over to Assemblywoman Carlton.

Assemblywoman Maggie Carlton, Clark County Assembly District No. 14:
Almost every session I have been in this building, I can remember having this topic of discussion. In 1987, the Nevada Legislature passed, and the Governor signed, Assembly Bill No. 289 of the 64th Session. That bill established a comprehensive set of provisions designed to reduce health care costs by placing limits on what hospitals could charge for medical care. I do not think there is one person in this room, or in this state, who would say that people who walk through the doors of emergency rooms should not get care. We all believe they should get care; no one should be turned away based on ability to pay. That is in our statutes right now.

The limits remained in place until 1999 when that bill expired. Upon that expiration, almost every year we have tried to address this issue. In some years it would make it out of one house, get halfway down the hall, and hit a wall. Another year, it would make it out of the other house, and the same thing would happen. In 2011, Senate Bill No. 115 of the 76th Session passed the Assembly and the Senate but was vetoed by the Governor. We finally got what

we thought was comprehensive compromise legislation; however, when I talked to folks during the interim, they said that maybe the bill was not as good as we thought.

We are having a hard time as a state dealing with this issue, and our constituents are being hurt while we are trying to figure out how to address it. In 2011, during the hearing on S.B. No. 115 of the 76th Session, we heard the interim director of the Office for Consumer Health Assistance's Bureau for Hospital Patients testify to some of the egregious billing practices in Nevada. She identified times when patients were billed up to 900 percent of Medicare-allowed charges, sometimes forcing our constituents into bankruptcy. This needs to be addressed, and I believe A.J.R. 9 does it appropriately. I know there are going to be questions and comments such as, "Why the *Nevada Constitution*?" and, "What happens if it is over 200 percent?" I believe the 200 percent in the bill is fair and equitable and addresses a cap that would be reasonable to protect our constituents.

Why the *Nevada Constitution*? Our *Constitution* already governs how we can contribute in a number of different ways, and it regulates us in a number of different ways. I believe the regulations and the public policy that are stated in A.J.R. 9 comport with our *Constitution* and allow us to send a clear, decisive message that access to emergency rooms during a medical emergency is a right secured by federal law to all Americans. It is in our statutes, and whether you have insurance or not, you should be treated and you should be treated fairly.

The profit issue is going to come up, so what is the decision? Do we allow people to make a profit off the emergency room? Is that where profit needs to be derived? With the 200 percent, I do not believe profit will be that inhibited because those rates, I believe, are very, very fair.

I will tell you how this bill would impact my family. Before the last session, my husband had been out for the evening and he woke up in the middle of the night with cold sweats, was uncomfortable, and his shoulders were hurting—all the signs of a classic heart attack. He would not listen to me, nor would he do anything. He sat awake all night because he could not go back to sleep. Finally, I talked him into going to the doctor. If it had progressed even further and we had just gone to our nearest emergency room, it was out of network. We would not have been covered for the $250,000 bill. Out of network it could have been over $500,000, and I have to say, there is not enough in my nest egg for that. Thank goodness we got him to the doctor. He had the tests, they fixed him, he feels great, and I love my insurance. They did a great job, but if that had not been an in-network hospital, I cannot tell you where I would

be today. With that, thank you for letting us share this with you and I look forward to taking any questions.

Assemblywoman Kirkpatrick:
I want to follow up, because there are a lot of new faces in the building. If this bill passes this session, it would have to come back next session and pass again before going to our voters. The hope is that people are clear that this does not take effect tomorrow; there is time to have real, meaningful discussions. This also proposes a level that is 200 percent of the cost of Medicare. I have heard that is a revolving number—a target that is always moving. Other states use 120 percent or 60 percent. Having 200 percent was more reasonable, understanding that profits play a role in how our hospitals run. I understand that hospitals, as businesses, have to cover their costs. I understand that they have to take the risk for the equipment they have to have to be on the cutting edge. I understand all those things, and that is why 200 percent was much more generous than many other states. There has to be some kind of resolution, and the only way to have one at this point is to let the voters decide, because we cannot seem to do it in this building. Although we try, we just cannot seem to get it done. Bankruptcy is No. 1 for our voters. We need to have some kind of resolution for them.

When my husband had his heart attack, they said they were taking him to Hospital X, and I said, "No, I think our insurance covers this other one." They told me, "Ma'am, we're taking him to the closest hospital if you want him to live." It is not at the forefront of everyone's mind, although it happened to be in mine at that time, but I did not think twice about it when they told me I had about 20 minutes to get my husband to the place he needed to be. This story is not untold in many households because people just want to ensure the safety and best care for their household members. We have a lot of great hospitals within our state, and I believe everyone wants the same thing, but I just do not know how to ensure that out-of-network hospitals do not become a choice when people decide on safety-of-life issues.

Chair Dondero Loop:
Are there any questions from the Committee at this time?

Senator Hardy:
We have heard 200 percent of Medicare, but the way the bill is written, on line 34, page 2, would that not be either Medicare or Medicaid? If the Silver State Health Insurance Exchange does some other partnership with a federal public insurer, would that not also fit in there?

Assemblywoman Carlton:
In the discussions I had, it was always in the back of my mind that we were trying to describe Medicare. If we missed the mark, we would be happy to have a lawyer tell us in which direction to go.

Senator Kieckhefer:
The bill mentions this situation happening to people who have no insurance or are underinsured. Do you feel as though you are underinsured?

Assemblywoman Carlton:
If I walk into an out-of-network hospital, basically I am uninsured.

Senator Kieckhefer:
Part of my struggle with this issue is that ultimately, that is a plan choice. It is the choice of the plan you are on. Looking, for example, at the state's preferred provider organization which is what we offer to our employees, under the description of benefits, it says, "In the event of a medical emergency in which a participant uses an out-of-network provider, benefits will be paid at the in-network benefit level." I had a similar situation. Our twins were born at 30 weeks in an out-of-network hospital. As soon as we could get them stabilized and transported to an in-network hospital, we did. Those were the provisions of my health insurance plan.

Having something in statute is one thing; it is an entirely different thing to have it in the *Nevada Constitution.* We can talk about that, but the government should not interject into what is ultimately a relationship between two private entities and dictate how much can be charged. We mandate that they take everyone who walks through the door. We, as Medicaid, pay less than half their actual cost. I have a lot of issues with it. I think it is a plan design issue on the part of your employer or whoever provides your insurance.

Assemblywoman Carlton:
I understand the plan design concerns but I am here in Carson City. I am not sure my health maintenance organization (HMO) has an in-network provider here. If something happens to me here, I go to Carson Tahoe Regional Medical Center. Yes, I have great insurance, but if they do not contract with my insurance company, I am left out in the cold. Not every plan can contract with everyone in the state.

As far as the government intruding on this, I look at this as the government giving protection to folks who, through no fault of their own, are put in a position to where life and death depend on what emergency room door they go

through. Once they go through that door, they could be susceptible to bankruptcy because of the way the system works right now. We just want to give them a level of protection. If you are on the soccer field and all of a sudden you have a young one in the back of the ambulance, and the closest hospital is around the corner, you do not want to have to say that you want to go somewhere else. I do not want that family to get a $500,000 bill because they were out of network. I have helped people I worked with navigate these things. When they get that bill, they are devastated. We had one of the best insurance plans in the nation where I was employed. It was excellent, but if you ended up in an out-of-network hospital, you were at a loss. We were very lucky. We had a great team of folks at the top who would sit down and evaluate and help the employees work through it in some way, shape, or form. The fact of the matter is, why do we penalize a family for doing what they think is right for their children because of a contract between an insurance company and a hospital?

This is to protect them and keep the rates at 200 percent. I do not want to intervene in plan design. I do not want to intervene within their contracts. If they do not want to contract with a hospital, that should be their choice, but my family and my constituents' families should not be harmed by it. They are willing to pay, they just want to pay a reasonable amount.

Assemblyman Thompson:
How many people will be coming on with the Medicaid expansion in our state? That will bring on more people who have some form of medical insurance. It would be interesting to know who would be left.

Assemblywoman Carlton:
Medicaid eligibility is being raised to 138 percent of the federal poverty level. There are a lot of estimates about how many more people will have insurance, but keep in mind, this addresses folks who go into a hospital where their insurance is not recognized. Even if everyone had 100 percent insurance in the state, that does not guarantee that the hospital they walk into will be in-network for that insurance plan. I believe this will always be an issue in an emergency room. This is purely at the emergency-room level. This is not for someone who uses the emergency room for their primary care. That was never the intention. This is about folks who have no choice but to go through those doors.

Assemblyman Sprinkle:
I do not even pretend to be an insurance expert, but it is my understanding that if a person is transported to one of these facilities and it is not in their network,

insurance is going to pay a certain amount, because that is the agreement the patient has with the insurer. Who is going to pay the rest of that bill? Could you explain that to me? It seems to me that, ultimately, that is what we are talking about as far as the impact on these patients. They are going to have to cover the rest, because the hospital is not just going to write off the other part of that bill. Is that correct?

Assemblywoman Kirkpatrick:
You are absolutely correct. That is exactly what we are trying to address, and some of those costs exceed two-thirds of the original bill. In some cases the insurance does pick that up, but in many cases it does not.

Last session, I brought one of my constituents, who was a state employee and whose husband was very ill, to testify. She came before us and told us that the medical bills, based on the emergency services she had received, were enough to cause them to let their power go out—they had to make choices. In good faith, they wanted to pay on all those charges, but it became too much for them. Her husband has since passed away and she has been paying on her medical bills for eight years. There has to be some balance, some fairness. It is a benefit to the hospitals that people be able to pay for the additional services they have received. I do not believe that doctors or nurses determine whether they are going to render care in emergency situations based on what insurance a person has. They are not in that type of business, but this problem is causing long-term effects. That constituent told us they were skipping meals in order to pay some of the additional costs. This is an extreme case, but it is a real case right in my own neighborhood. This state employee lives three blocks from me. People are proud and want to be able to pay, but when you get into not giving them any alternatives, the bigger issue becomes how we get to that balance. You are absolutely correct in your assumption that some insurances will pay; others do not, but there is still an outstanding balance.

Assemblyman Sprinkle:
In that worst-case scenario, with an outstanding balance and an individual not able to pay, that bill does not just go away. I would assume that it ultimately ends up in the laps of all the taxpayers, is that correct?

Assemblywoman Kirkpatrick:
It does in a sense that we have to make that up. If it is a private hospital and it does not get paid, it probably goes through collection and probably forces a family into a bankruptcy situation. Someone could lose everything over one medical bill. This is not the first session during which we have heard about people not even being able to get employment because of their medical bills.

It does have a bigger effect on the everyday constituent. Some of it does fall on the backs of the taxpayers, trying to make up for those additional services, or at the county hospitals.

Assemblyman Eisen:
I want to be clear that what we are talking about is care provided in the context of an emergency. That is a really important distinction to make. The stories you have related have to do with delivery to the emergency department in a life-threatening situation by emergency medical services, but I want to make sure I am clear about how we define emergency. Under the Emergency Medical Treatment and Labor Act (EMTALA) the hospital is required to provide treatment for a patient who has an emergency medical condition, but an emergency medical condition is defined as the patient indicating that they have an emergency medical condition. If someone has a sprained wrist and says he has an emergency medical condition, it is an emergency medical condition. If he has a hangnail and says he has an emergency medical condition, it is, and they are required to provide that care. I want to make sure that we are very clear at the start of this discussion about what situations we are talking about.

Assemblywoman Carlton:
In the discussions we have about this bill, it truly is about emergency care. I know there are a number of different definitions out there as far as "emergency care" goes. There may be some other folks who could define it a little bit better, but remember that there is going to be a regulatory process that will define the structure of this. I would be more than happy to let the experts give you a better answer on that, but it always has been our discussion that, if people use the emergency room for their primary care, this is not what we are talking about.

Assemblyman Eisen:
I appreciate that clarification. Another piece of that has to do with the out-of-network issue. Senator Kieckhefer made a comment earlier about one of the state plans and mentioned that, in an emergency situation, an out-of-network hospital is treated as an in-network hospital. I wonder whether the intent was that a plan of insurance that provides coverage for emergency care, if a patient is taken to an out-of-network facility in one of these emergent, life-threatening situations where the patient would have no ability to choose, that they would be required to provide that coverage at an in-network level.

Assemblywoman Carlton:
I am uncomfortable telling insurance plans what they have to do. If that needs to be a discussion point, I would be more than happy to have that discussion

with the appropriate folks in the room. I would not want to opine on something that I have not thoroughly thought out. The ramifications of that type of discussion may have much further reach than we would see today, so I am not sure how to address that, but I am happy you put it on the record.

Senator Hardy:
The EMTALA says that, as an emergency room physician, I have to treat somebody. It used to be, and may still be, that you cannot transfer somebody out of the hospital unless it is to a higher level of care. The way I read the bill, the person comes into the emergency room and it is the emergency department that is the issue, yet the transfer may not happen. If it is a life-threatening condition, then the emergency room costs are multiplied by the admission to the hospital through the whole process of doing the cardiac bypass, coronary artery bypass, or whatever else that hospital can do. The bill seems to address the emergency department more than any continued care thereafter. Has that been a topic of discussion when you start looking at that?

Assemblywoman Carlton:
We know that here in the state, no one can be denied access to the emergency room and they do have to be treated. As far as the transfers go, I believe once a patient is stable, they are allowed to be transferred. They cannot just be shuttled around from one hospital to the other because of their insurance or for testing. I believe there are *Nevada Revised Statutes* (NRS) and hospital regulations that address moving patients around. It is my understanding that, once a patient is stable, choices can be made, and then a choice can be made to take that person to an in-network hospital. I believe this truly addresses that time in which there are survival issues.

Chair Dondero Loop:
I want to take further testimony in support and move this hearing along. We are all under time constraints, and I know we have a lot of people who want to talk.

Jeff Ellis, Vice President and Chief Financial Officer, Human Resource Services, MGM Resorts International:
We spend in excess of $300 million a year on health insurance. We are in support of this bill. There are a lot of unknowns in the health care community at this point in time. The Affordable Care Act (ACA) is going to put a tremendous amount of pressure on the delivery system in the very near future. I believe this bill addresses the fact that when someone is transported in an emergency situation without an ability to direct, and goes to the hospital based on a particular illness or injury, it could end up in a noncontracted situation.

A lot of insurance companies, and our policies are drafted somewhat similar, will pay in-network-level benefits for a potential out-of-network provider. More times than not, our patients have a choice and can redirect their care to an in-network provider. In situations we are discussing here, by ambulance transport with no one having the right to redirect that patient, if we even pay at an in-network level, that network level would be the same network level as other contracted hospitals. If we do not have a cap or some limit on what a hospital can charge, the differential currently between our contracted rates and bill charges can be three or four times what our payment rate is.

The issue this bill is trying to address is the fact that bill charges in this state have been uncontrolled for many years, continue to be uncontrolled, and really have no relation to what a contracted rate is or what a fair and equitable payment is. I know we have talked about the 200 percent which was targeted at Medicare. Obviously these hospitals get a tremendous number of patients, and at 100 percent of Medicare, doubling that rate should be at least fair and reasonable reimbursement and a cap level that the hospitals can operate within. Insurance companies and constituents can have some limit on what the excess amount could potentially be for a situation that is uncontrollable by either the insurance company or by the constituent being delivered to a hospital or an emergency-room situation that no one has control over.

Chair Dondero Loop:
Are there any questions for Mr. Ellis?

Senator Hardy:
Mr. Ellis, have you looked at the actuarial issue of that 200 percent and how it would affect your insurance product, how it interacts with the ACA and the exchanges, and how we would put that into effect?

Jeff Ellis:
We have looked at that. Obviously, 200 percent in a noncontracted situation is more attractive to what our potential participants may have to pay or what the insurance company has to pay.

The exchanges are all going to be established, from what I understand, with existing insurance companies in this state. They also have in- and out-of-network hospitals as well. For the Medicaid expansion and the commercial side of the exchange, their rates are not going to be tied to anything. They will just be whatever the insurance companies currently are paying the hospitals. I believe this will also have an overall impact on the rate schedules for the people who go to the exchanges who now have to buy

insurance. Any leakage that ends up in a noncontracted hospital through emergency transport will keep the overall rates in this state affordable and more competitive.

Assemblyman Oscarson:
For my information, I would like to know what hospitals you are contracted with in the north and in the south and what your plan benefit definition is for emergency care—in and out of benefit. If you could provide that for us, I would appreciate it.

Jeff Ellis:
We are currently contracted with all of the hospitals in the south. We do not have any self-funded lives in the north, so we rely upon the Sierra HMO network in the north. They may or may not have contracts with all the hospitals in the north, but I do not know. If we have an emergency situation where someone goes out of network, and that is rare, our plan would provide 100 percent coverage, which puts our plan at risk for a tremendous amount of reimbursement in a situation where, if we had a contract or could control the situation, it would probably be 20 or 25 percent of what the bill would be.

Assemblyman Oscarson:
If I understand you correctly, you are contracted with 100 percent of the facilities for emergency care in southern Nevada?

Jeff Ellis:
Yes, currently, we are.

Chair Dondero Loop:
Are there any additional questions? [There was no response.] We are going to ask those in support in Carson City to come to the table.

Danny Thompson, representing Nevada State AFL-CIO:
I was here in 1987 serving in the State Assembly when then-Governor Bryan proposed a very similar cost control on hospitals. It passed. The wheels did not fall off the car; everyone did not leave the state of Nevada, and it worked for all those years, but now it has come to an end. In fact, one of our lobbyists this session had an incident. He now finds himself in a situation where, because he is out of network and in Carson City, he is stuck with the entire bill. That is what our trust funds do. They negotiate a reasonable fee. That is why it is important that it be put in the *Nevada Constitution*. Health care is something everyone has to have. The safety valve in this resolution is the fact that the Legislature can, even though it is in the *Nevada Constitution*, adjust the

rate. If the rate is not right, according to this, they would have the ability to adjust that rate.

Talk to any of your constituents who have found themselves in the unfortunate circumstance that they were taken to an out-of-network facility. They were insured but ended up financially ruined. That is why it is important for the citizens of the state of Nevada to have some protection against this possibility. On behalf of the AFL-CIO, we are 100 percent in support of this resolution.

Patrick T. Sanderson, representing Laborers International Union Local 872, AFL-CIO:
I have had insurance since 1967. It has never lapsed and I have it today. I am also on Medicare. In 1967, you could go to any hospital or to any doctor, basically, and be insured in an emergency. Times have changed and now you cannot. Now that I am a senior, the scariest thing in my life is worrying about whether, when I become injured and have to go to emergency care, it is going to bankrupt me. I have worked all my life, paid all my bills, and paid my own way, but the one thing I worry about is medical bankruptcy.

I have a nephew who was kicked in the head by a horse and admitted to Renown Health. He was in a coma for 30 days and now he is in rehab. They flew him to the hospital from Winnemucca, which cost $37,000. Luckily, he has insurance, but you have to protect yourself. I have been injured and refused to go in the ambulance because they were not going to take me to someplace I knew I could afford. One time I drove myself, which could have killed or injured someone else because I was badly injured. Another time, I was in a car wreck and I refused the ambulance until my wife could pick me up and take me to the hospital of my choice. I could have died, but I was more worried about the effect to me and my family and what would happen if I could not afford to pay the bill. We should not be in such a situation. We should try to protect everyone in the state of Nevada. Give them a right to regular charges, not extreme charges, and help protect us as a society here. If we have to go to the *Nevada Constitution* to do this, then I am in favor of it because we have to do something. You cannot get the people you will hear later to give us affordable care—something we can pay as we go along. Take a look at this, think about the alternative, and please, pass this bill.

Chair Dondero Loop:
Does anyone have any questions for Mr. Sanderson? [There was no response.] Is there anyone else in support?

Karlos R. LaSane II, representing Caesars Entertainment:
Caesars Entertainment employs over 33,000 Nevadans. We provide health insurance for our employees, and we are proud of that. It is one of the largest costs we have as a company. Health care is expensive and it is often complicated, but Nevadans deserve reasonable access to our emergency rooms during an emergency when a person is most vulnerable. The *Constitution* protects our citizens, and our citizens need protections during an emergency. For ten years, the Legislature has sought a solution to exorbitant billing practices in our hospitals. Today is the first step in giving the voters an opportunity to decide if reasonable access to emergency rooms is a right that all Nevadans should enjoy. This resolution allows hospitals to charge well above their cost, double the cost of Medicare, but it does not allow them to charge more than double the cost of care for emergencies such as cardiac arrest, car accidents, et cetera. I am here to say to you that Caesars Entertainment is proud to support A.J.R. 9.

Rusty McAllister, representing the Professional Firefighters of Nevada:
We are in support of A.J.R. 9. Anything you can do to help in long-term cost containment would be beneficial to the members I represent. I have been one of those patients who, at one point in time, was transported to a hospital through no choice of my own. I am very thankful for the treatment and care I got, but we did not have a contract with that hospital and the costs were extremely exorbitant.

Ryan Beaman, representing Clark County Firefighters Local 1908:
We are in support of A.J.R. 9. We appreciate Assemblywoman Kirkpatrick's bringing this bill forward. We are fortunate enough in southern Nevada with our members to have contracts with all the hospitals. What this bill does for our members is address the high costs being charged by the hospitals. Under the ACA, if you go out of network, plans are going to pay in-network charges but that does not stop the out-of-network charges being billed to that member. We appreciate this being brought forward to address the high costs being charged to our members.

Chair Dondero Loop:
Are there any questions?

Assemblyman Sprinkle:
Having been involved in prehospital emergency medicine for over 20 years, and working in several different cities, I have a pretty good understanding of protocols in place when talking about transporting patients to different hospitals. However, never having worked in Las Vegas, I was able to obtain a

copy of some of their protocols. I am looking at page after page of highlighted areas that specifically define the emergency rooms where patients in Las Vegas have to be taken depending on acuteness, severity, or the definition of whatever is ailing them. That is a fundamental part of what we are talking about today. For the record, could you describe in general reasons why a patient, even if conscious, may not be able to choose the emergency room they go to?

Rusty McAllister:
I provided an abbreviated copy of different protocols within the Clark County Emergency Medical Services treatment guidelines that is on the Nevada Electronic Legislative Information System (NELIS) (Exhibit C). The things I included have specific destination protocols saying that the patient shall be transported to a specific facility for certain conditions, for instance, trauma. In Las Vegas, trauma is not based on where you want to go, it is based on where you get injured. If you get injured east of Paradise Road, you go to Sunrise Hospital and Medical Center. If you get injured west of Paradise Road, you go to University Medical Center (UMC) and, if it is a Level 3 trauma and it is below Sunset Road, you go to Saint Rose de Lima. You do not have a choice. You are taken to a facility based on where you are injured, where you are in a car accident, or where you have trauma.

Another protocol listed concerns if hospitals go on what they call "internal disaster." That means they are full; their emergency rooms are overloaded. If you look at the protocol, it says that that hospital will be bypassed under all circumstances unless the patient is in cardiac arrest. Unless you have a cardiac arrest, you have to take that patient somewhere else and that may mean to a hospital where the patient is not insured. Those are the protocols we work under. The guidelines say that you cannot go outside the scope of your practice, which means you follow the protocols. As long as you follow the protocols, you can do no harm.

The form I sent to NELIS lists a bunch of different guidelines for various things including burns, pediatrics, neonatals, the chronic public inebriate, or trauma. There are a number of different things where we have to take the patients to specific places.

Assemblyman Eisen:
Who does have a choice in these situations? The patient clearly does not have a choice where he goes; the emergency medical technicians (EMTs) do not have a choice where they deliver the patient; and the hospital does not have a choice about which patients are brought to the door. Who would have the power to

choose now? Who would have the power to choose if this becomes part of the *Nevada Constitution*? Who gets to pick where someone ends up and whether that is an in-network or out-of-network hospital? I am not sure who has the power over that, and who ends up footing the bill for the lack of choice.

Rusty McAllister:
The patient always has the choice, unless it is a specific protocol that says differently about what hospital destination it is for that particular circumstance. There is a release from liability form. If the patient says, "I would like to be transported to X hospital," as an EMT or as a paramedic, I would say, "Your medical condition warrants that you go here. My protocol says you go here because that is the facility that can best treat you for this condition." If they say they do not have insurance at that facility and that they want to go somewhere else, they can sign that release from responsibility that says, "I do not want to go here; I want to go there and I am accepting all responsibility if I die." If the patient is unconscious, in a cardiac situation, or unable to respond, at those times we follow protocols. There have to be some guidelines, and those are the guidelines we follow.

Assemblyman Eisen:
We are trying to define what emergencies are and talking about situations in which a patient may be in cardiac arrest, or otherwise obtunded, and not even in a position to request he be taken somewhere else even if, under better circumstances, the person realized he had the choice. I am not even sure everyone knows they have the option to say that to an EMT, or that it would be the first thing that comes to mind for them. In a lot of the situations we are talking about, the patient is not capable of that communication at that time.

To me, we are restricting one party in this process when they are one of many parties that do not have a choice in what happens—which patients are delivered to which facilities and by whom. It is not up to you as an EMT where you take the patient in these situations, because of what the protocols are; it is not up to the patient because he is obtunded; and it is not up to the hospital, because they are directed by the same protocols as you are. They do not have the option of saying no. I am not clear who has a choice in these situations and who bears the burden.

As Assemblyman Sprinkle asked earlier, who pays the cost? Who pays the remainder of the cost? I am trying to understand who has a choice and how we address that. If this is a responsibility of the State, then we need to talk about that. I just do not know if I am missing something. Am I missing somebody who gets to pick when these emergencies occur?

Chair Dondero Loop:
If one of you has an answer, you are welcome to respond. [No one replied.]

Senator Hardy:
I served on a committee that dealt with where trauma patients go. One thing hospitals deal with is uncompensated care, so there are public meetings, with the Southern Nevada Health District for instance, that determine where the boundaries are that Mr. McAllister alluded to. There are a couple of reasons for those meetings. One is to decide who is going to take care of the people on this or that side of the street so the taxpayer does not pay for all the uncompensated care at one institution. There are public meetings that determine some of that through the Open Meeting Law, so it is not done in a vacuum, at least for trauma. They try to figure out how to even out the uncompensated care so no one takes as big a hit as they might otherwise—for instance, the burn unit in southern Nevada. All burns go to UMC.

We have alluded to the high charges today, but usually with high charges there are also discounts given or the costs are negotiated. Were the people who had the high charges also expected to pay them, or were there discounts or a negotiated amount that was settled on?

Rusty McAllister:
For me, the hospital negotiated with my health insurance company to reduce some of the uncompensated charges for out-of-network care.

Senator Hardy:
Do you have any experience with any of the others?

Rusty McAllister:
I do not.

Ryan Beaman:
Our health plan has been successful in negotiating with the hospitals if it is out of network. At the end of the day, whatever is left owing goes back to that member, who is expected to pay.

Chair Dondero Loop:
We will go to Las Vegas and take further testimony.

Virginia Valentine, representing the Nevada Resort Association:
I am here today testifying in support of A.J.R. 9. The Nevada Resort Association represents the state's largest employer. The top six employers

in the state of Nevada are gaming companies, and combined, they employ about 125,000 people.

I agree with the comments made by Mr. Ellis of MGM and Mr. LaSane from Caesars. We agree there needs to be some kind of cap on billed charges. Unfortunately, in many situations, the patients do not have much of a choice concerning where they are presented for emergency treatment.

Kelly Taylor, Health Plan Director, Employee Health and Welfare Trust, Las Vegas Metropolitan Police Department:
I am here representing our trust and our 12,000 participants. We are in favor of A.J.R. 9, and I agree with the testimony from Mr. Beaman, Rusty McAllister, Mr. Ellis, and the gentleman from Caesars.

Christine J. Carafelli, representing Health Services Coalition:
The Health Services Coalition is an association of 21 member groups and includes self-funded employers and union-based health trusts. We are also in support of A.J.R. 9. We are looking for hospitals to be fairly compensated, but we are also looking for protection for patients that do not have insurance coverage and for insurance payers. We believe the 200 percent of Medicare reimbursement rate for emergency services that are rendered in these cases is fair. In some cases, it is in excess of what the hospitals agree on mutually with insurance payers. We support this bill and feel that it is fair compensation.

Assemblyman Oscarson:
My question is for Ms. Taylor. Can you tell me how many hospitals your organization is contracted with in southern Nevada, and are there any in northern Nevada?

Kelly Taylor:
In northern Nevada, I am unsure. In southern Nevada, we are currently contracted with all, but that could change. Negotiations occur about every three years.

Chair Dondero Loop:
Are there any additional questions? Thank you very much to all of you in Las Vegas. Is there anyone else in support in Carson City or in Las Vegas who would like to come forward? [There was no response.] We will hear from those in opposition.

James Wadhams, representing Nevada Hospital Association:
This is a very complex issue and the testimony today has highlighted some of those complexities. I think the entire health care community would appreciate this body to look very carefully at the broader issues of compensation and maintenance of this system.

To quote Mr. Ellis, with the ACA, there will be extraordinary pressure placed on the health care delivery system. I think it is going to be incumbent upon this body to ensure that all health care providers are paid a rate at which they can sustain themselves so that the care continues to be accessible to all citizens. In that regard, I would point out that the EMTALA law is in place, is active in Nevada, and requires that every hospital with an emergency room accept all comers without regard to their ability to pay. So, every citizen currently has access to the emergency room.

A question raised by Dr. Eisen is particularly important to identify at this point—who has the choice? Certainly the patient who is, perhaps, unconscious has no choice. The protocols of the emergency delivery system, generally speaking, allow no choice. The hospital to whom that patient is delivered has no choice. There is one element where choice exists, and Assemblywoman Carlton identified that—those entities that engage in contracting. I would like to point out that this is not a brand new policy in the state of Nevada. In 1997, led by the efforts of then-Assemblywoman Barbara Buckley, the state adopted a very specific policy in this regard. It applies to commercial insurance companies—those licensed entities that sell health insurance in the state. You can find that in NRS 695G.170, and it answers the question raised by Dr. Eisen. As a matter of law adopted by this body in 1997, it provides that emergency services have to be covered as if they are in network. So a choice was made by this body that the entity that has the power to contract, bear the risk of where that patient may be delivered—that hospital where that patient would have to be accepted. That policy is an important predicate that this body, as it begins to deliberate on these issues, needs to take very seriously.

Assembly Joint Resolution 9 raises a whole host of complex issues, such as reimbursements of hospitals. You have a state agency that compiles data about hospital profitability. The current, overall health of that industry, is -2.2 percent. That negative percentage raises some questions about some of the "whereases" in this resolution, which you might want to reconsider if this body has the time. Perhaps during a work session you could look at some of the numbers concerning their profitability. Health care today is, indeed, expensive. As the grandfather of twin boys who were born at 28 weeks, I am

very grateful to the technology and skill of those physicians who sustained those two lives.

It is also important to pause for a moment and think about the aspect of placing what really should be a pretty healthy statutory action and consideration, similar to what was done in 1997, in the *Nevada Constitution*. Placing rates in the *Nevada Constitution* is an issue this body is somewhat sensitive to, particularly today. I would suggest that memorializing the rates paid between private parties and among private parties in the *Nevada Constitution* is an element of change that we might be wiser to leave to this body to be able to deliberate, taking into consideration all the aspects of those issues. In the parlance of this business, bringing all the stakeholders to the table so the Committee can have the full array of information.

Assembly Joint Resolution 9 definitely identifies a problem, but I think the body needs to carefully look at the solution that is proposed. At this point, it deals with the symptoms of the problem, not the underlying problem. As those of you who sit on these committees and the money committees have heard, the reimbursement rates for state Medicaid are well below the actual cost of services. The reimbursement rates for federal Medicare are below the cost of services. If you couple those two facts with the overall negative operating margins of the hospitals as a whole, one has to wonder where the money comes from. I suggest, before this body makes a decision, that it takes the time, as I suspect it will, to investigate some of the information and bring all elements into consideration. I commend the Committee's attention to review the action led by Assemblywoman Buckley in 1997 to make that decision Dr. Eisen raised—those who have the power to contract, should.

Bill Welch, representing Nevada Hospital Association:
As Mr. Wadhams stated, on behalf of the Nevada Hospital Association we are opposed to this resolution. We recognize and appreciate the concerns this brings before this legislative body and the discussion that needs to take place. We believe this is treating a symptom but not the cause. We would be happy to participate in a process that would address, review, and consider all the elements that drive the complexity of the issue before us.

We have already talked about insurance benefit coverages, and most of the issues and concerns I heard presented today were a result of the coverages those individuals had. The financial status of the hospitals was pointed out by Mr. Wadhams. I want to emphasize the seriousness of this issue. More than 50 percent of the admissions that present to the hospital come through the

emergency room, so this has the potential to have an impact on a significant number of patients who present to a hospital.

Referring to testimony regarding the 200 percent, generally, when you enter into a contract with a party, you look at the entire book of business. One value of entering into a contract with a provider of health care, for example, is that you can spread your costs and your risk over all of your potential patient mix. When you do that, you are able to help lower the cost in some high-cost areas such as the emergency room. You can spread that cost over other patients whose costs would not otherwise be as high. When you single that out and say you will only be reimbursed on the emergency portion of that reimbursement scheme, you are not factoring in the full book of business. That can have significant impacts on reimbursement and financial viability.

We are happy to work with the sponsors of this legislation and with this Legislature for solutions, but we feel it is important that all of the players are brought to the table and that any resolution ensure that all contributing factors are addressed.

Karen Massey, representing the Northern Nevada Emergency Physicians and Medical Group Management Association:

I am here wearing two hats today. I am the Executive Director for Northern Nevada Emergency Physicians, the emergency room (ER) group that covers several hospitals here in the north. We have about 45 physicians and several are here with us today. I am also the volunteer legislative liaison for the Medical Group Management Association, the professional organization of practice executives for medical groups. Your constituents are our patients, so this feels very personal to us as well. I want to share the frustrations we experience on the other side of what I would describe as a broken contractual relationship.

We want to be part of the solution and are motivated to take every insurance contract that is reasonable. I say that because we are much more likely to collect based on a good insurance contract, a good insurance relationship, than patients who have to pay us out of their pockets—whether for the deductible or any other balance that remains.

I would also like to point out that a lot of conversations today have concerned out-of-network situations. As I read the language in the resolution, it does not make that distinction, and I think that is important to recognize as well.

I would like to describe one experience we have with insurers. When an insurer comes to us with a rate that is not sustainable for us, and we feel we are not able to enter into that contract, that does not prevent the patient from arriving or presenting at our emergency room. The physicians working there are available to take everyone who walks in. As Assemblyman Eisen was saying earlier, we are often in a position of providing the care, and share the frustration with the patients when they discover their insurance does not cover what they thought it was going to.

We would like to partner with you in any way we can to address this important issue. As many of you have experienced with your constituents, I have personally taken those phone calls when patients find their insurance did not cover what was expected of them. Currently in NRS, health maintenance organizations and other products that are regulated by the state are required to pay for emergency circumstances, so there is a disparity in what happens in the state right now among people who have insurance. Some plans do cover out of network and some do not, and that is an important distinction to make.

Wearing my other hat with the broader specialties within the house of medicine, I will say that access to emergency rooms and emergency care is really critical and there is a lot of discussion around that right now. We spend a lot of time discussing how that integrates with the ACA. One of the challenges is what that access looks like when it happens and the more financial pressure we see through the ERs diminishes the access to specialties. Our physicians in the ERs right now are sometimes faced with transferring patients out of state because some specialists are not available, so it is a grave concern to us that, as these financial pressures flow through the emergency departments, we will essentially transfer costs by taking Medicaid and Medicare patients and transferring them to more expensive levels of care when that is not necessary.

We are eager to be a part of the solution. Assemblywoman Kirkpatrick indicated there is data available. We would like to have an opportunity to look at that and be a part of crafting something that is cogent, that helps our patients, that helps your constituents, and helps the citizens of Nevada.

Lawrence Matheis, representing the Nevada State Medical Association:
The Nevada State Medical Association does oppose the resolution as it stands, but acknowledges the issues compacted into it. We have worked for many years in good faith to find ways to resolve what have become more complex problems, partially because of the way we created insurance coverage, partially the way contracting is done, and partially because of how complex our system has become. It is not likely to get any less complex as we move toward health

care reforms. However, some issues we have talked about over the years, like inadequacy of networks that drive some of the most significant costs to patients, are in many cases conscious policies. The issue of adequacy of networks is now a part of the ACA. There is a bill still being processed that will have network adequacy evaluations as time goes on. That is going to be something that will change some of the aspects of this and is a tool that has not previously been available.

It is the same with making sure everyone understands what the in-network and out-of-network policies are. We have talked about the need for transparency so as to have a better understanding of what are in these rather complex policies of coverage. We are in the process of setting up a real, live experiment on that with the Silver State Health Insurance Exchange. That is a portal through which people will be entering and purchasing health insurance. Policies will include more and more of that information and what it will mean in real life. We will be testing how to communicate those things. Many of those things have been talked about in discussions of these subjects over the years, but it seemed like they were too difficult to manage. Now, because of federal health reforms, we are going to see efforts at managing some of those. Some of the outward appearances of emergency-based care and the confusion about coverage for services that are provided will change.

If you want to put this into the *Nevada Constitution*, it could be there—saying that no hospital can refuse to provide emergency care—but that is the law now. Maybe we want to enshrine it as a right, but to enshrine a right that you cannot then follow through and really explain how it is going to be paid for, how is that going to be defined? We did define emergency care in the Nevada Patient Protection Act in the late 1990s as what a prudent layperson would define as an emergency. It was a good way of resolving what could otherwise be a very difficult question. I think there are substantive issues here that have to be dealt with. Every two years, efforts at dealing with them have gone a long way and then failed for different reasons.

There is room for discussion and for coming to some agreements on some basic points, and the Nevada State Medical Association is happy to participate in those discussions. We would like to see as many stakeholders as possible participate, including patients who have faced the problem of expectation of what they were covered for and not seeing it, and those who have received services they know saved their lives and want to make sure that continues to be available and that we do not create a system that begins redefining availability.

Assemblywoman Spiegel:
Mr. Welch, you mentioned your book of business and your patient mix. From my times on this Committee and others, it seems your patient mix consists of privately insured patients in network, privately insured patients who are out of network, Medicare patients, Medicaid patients, and uninsured patients. Is there a pie chart showing the patients who visit emergency rooms and how they would stack up?

Bill Welch:
We can provide that information for you. Generally, of the patients who present at the hospitals, 75 percent are under some form of government-funded program or are uninsured and these do not cover the cost of care. In 2012, that cost of care was approximately $1 billion. If we could address that issue, that would reduce the cost of health care by $1 billion annually. Right now, only 25 percent of our patient mix has some form of insurance—the various types you mentioned. The demographics are very similar for the ER, and, of course, the majority of our admissions come through the ER. I would be happy to get that data for you.

Assemblyman Sprinkle:
I like the direction this discussion has gone and the willingness of people to sit down and talk about something that is off the issue. I am coming to the realization that this issue is probably bigger than what we are talking about here today. That being said, one thing that keeps gnawing at me is no one having any choice. The one entity that has been mentioned several times is that the hospitals have no choice. It seems as though they have the choice concerning how much they are going to charge for a treatment, a procedure, a medicine. That gets to the heart of what we are talking about here in this bill. Would one of you like to address that? In my opinion, they have that choice.

Bill Welch:
Yes, the hospitals do have a choice about what they charge for services. The hospitals in the state of Nevada and we as Nevadans have made a choice that we want to be predominantly dependent upon the private sector to provide hospital care to the citizens of the state. A number of years ago, almost every community had a public hospital; today, we have half a dozen or possibly a dozen rural communities that have public hospitals, and we have one public hospital in Clark County. The remainder of Nevada hospitals, which represent more than 95 percent of the beds, are private. Those private hospitals must make a significant investment to make that hospital service available. Construction costs are approximately $1 million per bed to build a facility.

So, while they have a choice, they have to make sure they cover their cost and they try to spread that cost over all the various services they provide.

Mr. Wadhams provided the number for 2012, but the hospitals have been operating at a negative margin since 2008 in the state of Nevada, while on the national level, hospitals are operating at between a 5.3 percent to 5.5 percent profitability. We have some significant challenges in the state that we have to try to address. As we have testified before this legislative body in the past, hospitals are having to make decisions on costs that are predominantly driven by this patient mix that are no longer sustainable. They are making choices in their efforts to manage their cost and to keep their prices down; they are having to make choices. I can provide that for you, Mr. Sprinkle, on services that in 2010 and 2011 were closed as a result of the economic environment we have. In Clark County, we had several hospitals close obstetrical services. It is hard for me to imagine that we would not have hospitals that would provide obstetrical services, but those are some of the challenges we have.

University Medical Center had to close, on a temporary basis, their oncology outpatient services and their kidney dialysis services because of some of the economic challenges we have. While we have the ability to control what our costs are, we also have the responsibility to ensure that we have an operating margin that allows us to sustain operations. Since 2008, we have been very pressed to do that.

Senator Kieckhefer:
Under the ACA, one thing it sets up is the Independent Payment Advisory Board (IPAB) that is charged with dealing with Medicare costs. Part of their charge includes rate provisions. What is the long-term expectation concerning reimbursement for Medicare expenses as we move forward? Also, the way I see it, this resolution limits what you can bill, not necessarily what you can collect. What percentage of your bills do you collect, on average?

Bill Welch:
I do not have all that information today but I can get it for you. Medicare, as a whole, reimburses hospitals at approximately 80 percent. That varies from hospital to hospital and from service to service, but in the state of Nevada, Medicare's level of reimbursement today is about 80 percent of cost. Regarding how the ACA is going to affect Medicaid rates, I think it is anyone's guess. I will try to bring to this legislative body people who are better prepared to answer that question. What we saw as the health care reform went into effect is a freezing of Medicare rates to hospitals, and that is projected to last for ten years. I would like to say that my costs will also be frozen for the next

ten years as far as technology advancements, increases of employee costs, et cetera, but I know that Medicare for hospitals has been frozen for ten years and is projected to actually decline. I will try to get you more specific data on that. Using a methodology that is controlled at the federal level that is on a decline in today's economic environment is very concerning to us.

Senator Kieckhefer:
What percentage of your charges do you actually collect?

Bill Welch:
I will have to get you that information. For only 25 percent of our business do we collect our charges. For 75 percent of the business that we incur in the hospitals, we do not collect our full costs. For the uninsured, we collect only 3 percent of our cost. On the Medicaid population, we are collecting 57 percent of our cost and on the Medicare population, we collect about 80 percent, and this is on average, statewide, for our hospitals. That will vary from hospital to hospital, but those are the average portions of our actual costs. Those are not the charges; these are the actual costs incurred to provide that service. I would have to come up with a calculation to tell you what the mix is in its entirety, but that gives you an example. Again, we collect only 3 percent of uninsured, 57 percent of Medicaid, and 80 percent of the cost for Medicare.

Chair Dondero Loop:
Thank you very much. Would you please make sure you share that with the entire Committee?

Assemblyman Hickey:
Mr. Welch, you have indicated, on a couple of different occasions, that for about 75 percent of the services you currently offer, patients are providing a portion less than your actual costs. If A.J.R. 9 or some future version of this resolution were to pass, how would the industry go about recouping those uncompensated costs, and quite possibly any additional ones that might come as a result of this resolution?

Bill Welch:
I do not know that I have all the answers for you today, but I can tell you how hospitals have tried to manage that situation retrospectively. The first thing we do in the hospital setting is try to manage our internal costs, so you will see elimination of any fixed cost that can be eliminated. We have tried to standardize as much as possible so that we can reduce costs that way. We have deferred renovation and/or expansion projects. Ultimately, we look at costs we can no longer financially sustain, because maybe the patient

population is predominately uninsured and/or on Medicaid and we can no longer afford those costs, so we eliminate those. Some of the costs are absorbed in the bottom line, and that is why, since 2008, our hospitals have been operating in a negative position.

Some of the cost is shifted to other payers. As I look at A.J.R. 9, just as in any other business, and no one likes this, but there is cost shift. You shift some portion of uncompensated cost to those who do cover the cost of care. As I understand it, what A.J.R. 9 will do is shrink the population that is not regulated and controlled so there will be fewer and fewer people who will be looked at and asked to help cover the cost of that uncompensated care, which only continues to expedite the spiral down and some issues I mentioned earlier.

Senator Segerblom:
Are you saying you pay for your hospitals by overcharging the small group of people who are coming to you out of network?

Bill Welch:
As in any business, you spread your costs and try to recoup them. You try to manage your cost first. That is the No. 1 thing we do. In comparison to the national average, we have managed our cost far better than the hospital industry as a whole, and I would be happy to share that data with this Committee. But we first try to manage our cost and then we try to eliminate high-cost risk centers and then, yes, there is a cost shift that would be the same as in any other business.

Senator Segerblom:
It seems insane that people who come to your hospital involuntarily, because they had an accident and you are the closest place, end up having to pay for everything else in your hospital. That is the profit center. I do not see how we can justify that.

Bill Welch:
I guess that is the choice we have. Do we want hospitals and do we want these hospitals to be full-service hospitals? They do have to recoup their costs for providing those services, if we are going to be dependent predominantly upon a private health care hospital delivery system. That is not to say that we do not have public hospitals, because we do. They play a critical part in the health care delivery system, but we are heavily dependent upon the private sector to provide hospital services. If we are saying that this private sector cannot get a return on their investment in the community, and they have not for five years, but if we are going to pass legislation that ensures that they do not

going forward, then I think that is a pretty clear message that would be communicated and could have significant impact on what hospital services would be available going forward.

Assemblyman Martin:
Obviously, no one likes price controls, but something like A.J.R. 9 is probably needed. There is no dancing around it and I do not see anyone here from the insurance industry, because this question is really for you. I hear from constituents, and have my own experience, but I am going to focus on one part here. Granted, there are a lot of moving parts, but the insurance companies are engaged in a strategy of changing the playing field on all of us. Suddenly you can be out of network and out of pocket a tremendous amount of money. As has been noted, you do not have a choice where you are going sometimes. If you are unconscious, it is very hard to make a decision.

Of course, the insurance companies are adjusting the deductibles. I heard this morning from a constituent who said that a simple outpatient situation cost $1,200, and then the doctor had them keep coming back. It was $3,600 for a relatively simple procedure. This begs the question about what kind of auditing oversight is going on concerning the cost controls of the hospitals and what kind of insurance coverage are we really talking about. It is a systemic problem we are dealing with here. It is not just 200 percent of whatever rate we are talking about; it is a wholesale situation. Something like A.J.R. 9 could actually snap everyone into reality. We have time to possibly deal with this, but I am very concerned about how the insurance companies have handled themselves in terms of their quest for profitability. Some of these plans are very confusing. I used to be a controller of a medical consulting group, so I do know something about this, but I would like the insurance companies' perspective on this.

Larry Hurst, representing Anthem Blue Cross & Blue Shield:
We offer a wide variety of products, and most of them are purchased by the employer. The cost of those products depends on how much the deductible is going to be and the coinsurance/copayment. The higher those numbers; the lower the cost for the health plan. The cost of health insurance is because of the cost of health care. We can price and cover anything. The mandates we are seeing in this and others such as oral chemotherapy parity and autism therapy among others, we cover everything but there is a cost involved. We bake that cost into the rates. The more coverage paid for by the employer, the higher the cost for the individual. The more that comes out of pocket for the individual, the lower the cost for the employer. We are trying to make it affordable by offering a wide range of products so people can get some form of insurance and something that is affordable.

The cost of health insurance reflects the cost of health care. Our profitability is somewhere below 3 percent. Everything else goes to the cost of health care claims, paying for prescriptions, regulations and oversight, and things of that sort. At the end of the day, we are bringing home less than 3 percent. It is not a big, money-making industry for health insurance. You see the ACA, we have a lot of transparency, we have rates posted on websites, we pay a lot of taxes such as the premium tax that goes to the state budget. We are here to offer affordable health care and some very good jobs to a lot of members here in Nevada. We are just here to find a solution. We are neutral on the resolution and looking forward to being a part of the stakeholders that come to the table to help find a solution.

Assemblyman Eisen:
With regard to all the coverages you provide, the calculation is based on what you have to provide to everyone. How is that different from cost shifting in the hospital?

Larry Hurst:
We offer a wide range of services, and we offer a wide range of providers. I believe we have a contract with every hospital in Nevada at this point in time. That can change with negotiations. As we heard, every three years there are negotiations. Those negotiations, when a contract is signed, dictate the cost of the health insurance policy. The more coverage someone wants, the wider the network, the more services, the richer the products, and there are costs to those. It is attainable but we are seeing people want affordability and not the top of the line for health insurance products.

Chair Dondero Loop:
Are there any additional questions for these guests? [There was no response.] Is there anyone else in opposition?

Kathleen A. Conaboy, representing Nevada Orthopaedic Society:
We are very interested in this issue because orthopedic surgeons provide a lot of emergency care. Our society believes it is ill-advised to put the process of rate setting into the *Nevada Constitution*, and possibly the timing of this resolution is unfortunate. As you have heard, the delivery of health care is changing rapidly.

In preparation for this afternoon, I looked on the Centers for Medicare and Medicaid Services' (CMS) website under the ACA regulations. There are 67 separate regulations on that website page. Some are new, some are notices of proposed regulations, some are regulations open for public comment, some

are past regulations, and some are guidance documents. My point is, the ACA is a sea change for every component of the health care delivery system. There is a lot of change to come. Some of it is going to start on January 1. You have heard references to the Silver State Health Insurance Exchange, which will become effective. Many more of our citizens are going to have access to insurance coverage, but no one knows for sure yet which patient or payer mix of citizens will actually buy into the exchange.

Other changes that are underway include doctors and hospitals grappling with the costs and learning curve of electronic medical records systems. They are looking at reimbursement at the federal level. If we are tying to 200 percent of a federal reimbursed rate, right now in Congress there is an issue being debated called the Sustainable Growth Rate (SGR) in Medicare. This has been debated for roughly the last 10 or 15 years since the Balanced Budget Act of 1997. If it is not fixed this time, and it has not been fixed yet, doctors will be subject to a 27 percent decrease in Medicare reimbursement rates.

Senator Kieckhefer mentioned the IPAB. I was in Washington, D.C., several weeks ago with the orthopedic surgeons, and we visited every office of our Congressional delegation. The IPAB is a board that is found in the ACA. It has not been populated yet; it is political appointees. They will have the responsibility and authority to cut Medicare spending. Unless Congress acts to stop those cuts, the cuts will go into effect and physicians will be subject to those cuts immediately. Hospitals have a reprieve of five years. Again, that is another pending issue that will change the landscape of the way health care services are reimbursed.

Over the past couple of years, the Nevada Orthopaedic Society has engaged in the discussions about out-of-network billing. Some of the issues we have discussed in public meetings have to do with transparency and adequacy of insurance networks, which you heard addressed today. We have asked about the data so we could really define the scope of the problem. Last night when we met with Assemblywoman Kirkpatrick, she referenced some data that might be available for us all to study and deliberate about. We have talked about transparency and having the payers literally communicate. I do not mean just in writing, I mean communicate effectively with their covered lives about what is available to them in and out of network.

We stand ready to participate in what we hope will be an ongoing dialogue on this topic.

Denise Selleck Davis, representing the Nevada Osteopathic Medical Association and the American College of Osteopathic Family Physicians, Nevada:
One thing our members are most aware of is the fact that all of us are, first and last, patients. These things affect everyone regardless of where you fall within the health care spectrum. The things we want to be assured of are quality health care for all patients and access to those things one needs.

Last weekend, my younger brother had a heart attack. He was very fortunate in that he chose a good place for it—outside a tent at a fun run. In 30 minutes, his stent was completed at a hospital he had never seen before. My brother is an accountant, working for a large organization, and his first question was, "What am I paying for?" not, "How quickly are they going to get here; am I going to live?" He was worried about what he was paying for, so this is very real to all of us who have ever been in these kinds of situations, and we are aware of that. But the physicians are also very aware that this creates a terrible stress and strain on their patients and on the care they provide.

We want to make sure patients have the access they need. We constantly try to recruit physicians to the state of Nevada. We constantly work with our residents at Touro University Nevada and at University Medical Center trying to get them to stay in the state of Nevada. When they can look at other states and be assured of an opportunity to pay off their student loans through their paychecks, they may choose to go to Indiana over Nevada. We want to make sure they know they can be paid for the service they provide, and appropriately so.

This is an extremely complex issue; it brings in a lot of situations most of us do not ever think twice about. A lot of people have come to the table telling you that they will provide you with more information. Through the years of working on this myself, I know I have reams of it back at my office and I am happy to share it. It will take hours and hours to scan, but we will be happy to send it to you.

The SGR Ms. Conaboy talked about is a very real situation. Every year, our physicians face a potential federal pay cut. Think about the fact that every year they get more experienced and more knowledgeable and yet are facing a potential pay cut. All reimbursement is based on SGR.

I do not want this to sound as though it is strictly an economic issue, although for all of us, our paychecks are economic issues, but it is also an issue for patients. Our physicians do less and less pro bono work as their reimbursements go down, so the things they used to do for free, the things that

my grandfather used to do for patients for free, can rarely be done anymore. There are even laws that stipulate if they do it free for one patient, they have to do it free for all patients, so this becomes a more complex issue as we talk about it.

We want to be part of the solution. We would like to discuss this. We think it takes a lot of thoughtful intervention on this situation to reach the solution we need. We need patients to know what they are responsible for and what they are covered for. My insurance changed just as I came here to the Legislature, and right now, I cannot tell you which hospital is in my network, and I work in health care. I wonder if all of you know.

Health care providers can continue to provide services and they want to meet the important needs of their patients. We need your help to see to it that they can continue to do so.

Lesley Pittman, representing the Nevada State Society of Anesthesiologists:
I am here today reluctantly in opposition to Assemblywoman Kirkpatrick's bill, although I spoke with her about it last night.

Obviously this has been a long discussion, but it demonstrates that the issues associated with A.J.R. 9 are enormously complex. Our position is that there are models that exist we can utilize via more lengthy discussions with all the stakeholder groups that will address out-of-network billing situations and the need for greater transparency on the part of insurers. We believe these should be looked at and appropriately considered by this legislative body for more than the ten days that are left in this session, particularly when you consider that there are 20 new members here, and without amending the *Nevada Constitution*. You just spent several hours debating the need to take out a couple of provisions of our state's constitution because they were not appropriate there. I would present to you that this language is inappropriate and this issue is not appropriate in the *Nevada Constitution*.

Assemblywoman Kirkpatrick indicated that constituents of hers are getting bills for things they thought they were covered for. I think that speaks to a need for greater transparency on the part of the insurer to those who are covered under their policies. In A.J.R. 9 as written, there is no reference to the responsibility of the insurance industry.

John Wagner, representing the Independent American Party:
I represent the Independent American Party. My training was as an engineer and we always look for the problem, so what is the problem?

Well, the problem has been pretty well defined here. I think the insurance agent, Larry Hurst, wants to get to the table. This is an excellent way to solve a problem. Get the primary people, the hospitals, the insurance companies, the health providers, together and come up with a solution. There must be some way to take care of the problem, but putting it into the *Nevada Constitution* is a bad precedent. Government should stay out of a lot of these things, but give the industry a push to get it moving. Now we know what the problem is, now we need to get it solved. I do not think A.J.R. 9 is the way to do it.

Chair Dondero Loop:
Are there any questions from the Committee?

Senator Segerblom:
I think it is ironic that for four months people have told us we cannot take major mining corporations out of the *Nevada Constitution*, and now, when we are trying to put people into it everyone is saying it would be terrible to do that. I think people deserve a few years in the *Nevada Constitution*.

Chair Dondero Loop:
Are there additional questions or comments from the Committee at this time? [There was no response.] Is there further testimony?

Dean Polce, Private Citizen, Las Vegas, Nevada; President, Nevada State Society of Anesthesiologists:
I speak on behalf of all the anesthesiologists in southern Nevada. We agree in content with the intent of this amendment to the *Nevada Constitution*. However, what has mostly been debated today are things that are not specified in A.J.R. 9. For example, this bill talks about emergency services. It does not mention anywhere about in network or out of network. It does not mention insured, it does not mention uninsured. From a provider standpoint, when I hear what hospitals can be paid, it gets tricky. The actual care is done by health care providers—nurses, nurse practitioners, physicians. I think I understand the intent, but what is written is not very clear.

It becomes more confusing when you consider the nature of emergency services. For example, the heart and neurosurgeons and the obstetricians take call. They cover the emergency rooms. There is a stipend involved in that paid for by the hospitals. After that it becomes more confusing as to where that revenue is generated. When I read this bill, I see 200 percent of Medicare for a rate that is already contractually negotiated. If I get called in for emergency heart surgery tomorrow, and that person is 57 years old and has Blue Cross/Blue Shield, I already have a negotiated rate. Because of the grossly

discriminatory payments that exist from our commercial rates to our Medicare rates in anesthesia, that 200 percent would lay the ground for a totally renegotiated rate at a substantially lower rate than we are currently paid.

As far as bills are concerned, there are two different bills—Medicare A and Medicare B. When you say "bill," which one is being submitted? The one to the insurer or the one to the patient? I can think of almost no anesthesiologist who takes call for emergency services who does not already have contractually negotiated rates, so a definition of the problem or the scope would help as well. Solo practitioners may bill out of network and may stick patients with a bill, but they do not take ER call.

I am with everyone else. I am happy to come up with solutions for this. I think it is appalling that someone would be stuck with a bill that is eight times higher than usual and customary rates, but what I do not understand is, why can you not just take the mediation process between those people and come up with a reasonable amount? No one wants to put anyone into bankruptcy, but this bill is far more encompassing than what I think the problem is. I am not trying to minimize the suffering of people who have been stuck with these bills. I think it is ridiculous and appalling.

Thank you for your time, and I hope to help in any way I can.

Chair Dondero Loop:
Seeing no questions, we will move from those in opposition to neutral. Is there anyone who wants to speak as neutral? [There was no response.] Does anyone else want to comment?

Senator Smith:
During the hearing, I was thinking that this all sounds vaguely familiar. It is reminiscent of the discussion we had on the nurse staffing issue. In my time here, and this is my sixth session, we keep having this conversation. There is no progress, and then we get to a legislative session, there is a crisis, and I am really frustrated about that. Basically, the same parties came to the table and solved that other long, lingering issue. I know the time is short, but this issue really needs to be fixed so we are not doing this in every legislative session, and our constituents are not suffering in the interim. I worked in that world in my private job for a long time and I saw many people who suffered with this issue. Sometimes they got stuck with the total balance and sometimes their insurer got stuck with it at a higher rate. Maybe there would be an appeal, so some would be paid, but rarely did the person who was insured ever get made whole. It can be very devastating. Trauma situations were where I saw this the most,

and it was very sad to see. Oftentimes you see people get stuck with those big bills when their loved one died. They wind up still paying for a very long time, or they file bankruptcy, and we all know what the medical bankruptcy rate is like.

I just want to express my frustration. I cannot imagine that there cannot be a resolution to this. To all the people I heard, every single person who said they want to come to the table; well, come to the table and get this thing done.

Chair Dondero Loop:
Thank you. Would you like to make any closing remarks?

Assemblywoman Kirkpatrick:
It is an issue we have to resolve. It is unfortunate that we are looking at it ten days before the session ends. I do not know when it is ever the right time. We start early and we do not get it done. There is too much time for people to try and pick folks off in this building; it is no different than other issues.

I am asking each and every Committee member to go on CMS.gov, which was referenced. Look at just one piece of data, and then tell me everyone is consistent on what they charge. I pulled up "heart failure," but you can sort it based on whatever you like. Eighteen different hospitals within the state of Nevada all billed Medicare the exact same for heart failure with shock. The average billing was from $10,000 in our rural hospitals to $40,000 in our urban areas. So, for the exact same thing, there was a wide variety of actual charges. Medicare paid anywhere from $4,000 to $5,500, so the payments were pretty consistent. That was an average of from between 400 percent and 700 percent of what Medicare was billed.

That is a government transparency document and it is very enlightening. I am working on getting all of the data to give to these folks. The ironic part is, I understand hospitals have clusters and they all bill completely differently. There has to be some real definition of what we are billing, why we are billing it, and how do we get the most for our constituents as well as for the hospitals so they can run their business.

Thank you for the opportunity to be here today, and I look forward to hearing from more folks in the next few days.

Assemblywoman Carlton:
As I said earlier, I have dealt with this issue since the beginning of my career in this building and have watched this issue take its toll on this state in numerous

different ways. If this resolution creates the inspiration to finally do something about this so we can put our minds at ease, and people will not be hurt by these types of practices, then that is the perfect reason to pass this resolution.

Chair Dondero Loop:
With that, I will close the hearing on A.J.R. 9, and I will ask for any public comment. [There was none.] Are there any comments from the Committee? [There was no response.] Thank you very much.

This meeting is adjourned [at 4:21 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblywoman Marilyn Dondero Loop, Chair

DATE: _____

_____
Senator Justin C. Jones, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Health and Human Services

Date: May 23, 2013 **Time of Meeting: 2:16 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
A.J.R. 9	C	Rusty McAllister, rep. Prof. Firefighters of Nevada	Clark County Emergency Medical Services Protocol Manual