MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON LEGISLATIVE OPERATIONS AND ELECTIONS

Seventy-Ninth Session
May 30, 2017

The Committee on Legislative Operations and Elections was called to order by Chairwoman Olivia Diaz at 1:43 p.m. on Tuesday, May 30, 2017, in Room 3142 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 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 www.leg.state.nv.us/App/NELIS/REL/79th2017.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Olivia Diaz, Chairwoman
Assemblyman Nelson Araujo, Vice Chair
Assemblyman Elliot T. Anderson
Assemblywoman Shannon Bilbray-Axelrod
Assemblyman Skip Daly
Assemblyman John Hambrick
Assemblyman Ira Hansen
Assemblyman Richard McArthur
Assemblywoman Daniele Monroe-Moreno
Assemblyman James Ohrenschall
Assemblyman James Oscarson

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblywoman Maggie Carlton, Assembly District No. 14

STAFF MEMBERS PRESENT:

Carol Stonefield, Committee Policy Analyst
Kevin Powers, Committee Counsel
Julianne King, Committee Secretary
Melissa Loomis, Committee Assistant

OTHERS PRESENT:

Carol Lynne Hansen, Private Citizen, Las Vegas, Nevada
Tanya George, Private Citizen, Las Vegas, Nevada
Matthew Griffin, representing Health Services Coalition, Las Vegas, Nevada
Bobbette Bond, National Policy Director, Unite Here Health
James Sullivan, representing Culinary Workers Union, Local 226
Ryan Beaman, President, Clark County Firefighters Union Local 1908
Thomas Morley, representing Laborers International Union Local 872, AFL-CIO, Las Vegas, Nevada
Stacie Sasso, representing Health Services Coalition, Las Vegas, Nevada
Josh Griffin, representing MGM Resorts International
Todd Ingalsbee, Legislative Representative, Professional Fire Fighters of Nevada
James L. Wadhams, representing Nevada Hospital Association
Matthew Walker, Chief Executive Officer, William Bee Ririe Hospital and Rural Health Clinic, Ely, Nevada
Lisa Farnan, Vice President, Managed Care and Integrated Health Care Delivery, Dignity Health-St. Rose Dominican
Todd Sklamberg, Chief Executive Officer, Sunrise Hospital HCA, and Sunrise Children's Hospital, Las Vegas, Nevada
Erik Olson, Vice President and Chief Executive Officer, Renown Regional Medical Center, Reno, Nevada
Mason VanHouweling, Chief Executive Officer, University Medical Center of Southern Nevada
Catherine M. O'Mara, Executive Director, Nevada State Medical Association
Janine Hansen, State President, Nevada Families for Freedom
Misty Grimmer, representing North Vista Hospital
Joan Hall, President, Nevada Rural Hospital Partners
Dan Musgrove, representing Valley Health System

Chairwoman Diaz:
[Roll was called and protocol was explained.] Welcome, everyone. This is the time of session where everyone is running here, there, and everywhere to get their bills heard before business is wrapped up on June 5, 2017. I will ask Assemblywoman Carlton to come to the table, and I will open the hearing on Assembly Joint Resolution 14.

Assembly Joint Resolution 14: Proposes to amend the Nevada Constitution to ensure access to affordable emergency medical care to all persons in this State. (BDR C-1218)

Assemblywoman Maggie Carlton, Assembly District No. 14:
Thank you, Madam Chair, and I hope that I am just as welcome as I leave the room as I am at this very moment. For the record, I am here today to discuss with you Assembly Joint Resolution 14.

The first thing I want to point out with this resolution is that it is dated May 17, 2017. I waited to do this until the last moment because this is the last issue to be dealt with. I have worked with the hospitals along with others for over a decade on the particular issue known as "billed charges" or "surprise bills." I would not have brought this to this Committee if it were not absolutely necessary. I am not the type of person who wants to amend the *Nevada Constitution* for something that I believe could be negotiated or fixed here in the Legislature. We are the people's house. The Senate does its work; the Executive Branch has its privilege; and we have a judicial system that works very well. Unfortunately, because of the way the negotiations have gone on this particular issue for over a decade, I felt it was necessary to do this.

First I would like to thank you, Chairwoman Diaz, for hearing this bill today, and I would like to apologize to the Committee members who serve on the Assembly Committee on Health and Human Services and the Assembly Committee on Ways and Means, as this will be the third time you will be hearing this issue. The third time is the charm in my world, but I do apologize that some of you will be going through this again.

For over a decade, negotiations on this issue have been going on inside and outside of this building. I believe it is time for the people of this state to speak. I will read written testimony from one patient, and then we have some patients in southern Nevada whom I will ask to testify after my presentation. In addition, I have people who are going to come up and walk through and discuss A.J.R. 14 in its particulars. Chairwoman Diaz, in the interest of time, I have a bunch of people here who are just going to say, "Me too." We know where we are this time of session.

With that, I would like to share a patient's story and why I am so passionate about this issue. This is a story from Mitchi Thomas, and I will submit this written testimony for the record [page 2, (Exhibit C)]. I will abbreviate it because it is a little bit long. Her testimony states that she is unable to be here to speak in support of A.J.R. 14:

> The birth of a child is supposed to be a joyous time, but for my family, it was terrifying. Due to the risk of hemorrhaging at 32 weeks, I was forced to have an emergency [Caesarean section] C-section and hysterectomy. Upon delivery, my baby required oxygen that tore through her fragile lungs puncturing both lungs, which then required several emergency procedures, and an even longer [neonatal intensive care unit] NICU stay than originally anticipated. My daughter, Evelyn, had to stay in NICU for 26 days. I later learned that the NICU was out of network.
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> This was frustrating because I did not have any control over which NICU I could take her to. In fact, I tried to have her moved but was told she would not survive if we moved her. The doctors at the hospital jokingly called her their "Million Dollar Baby"; my husband [at the time] and I did not

> understand why. The surprise bills that came later were even more horrifying than the labor and delivery process and shed light on that nickname. The NICU charges alone were [only] $5,000 shy of $1 million.

That was for the doctor's costs, the anesthesiologist, the hospital stay and all the battery of tests. She goes on to talk about her insurance issues and how receiving these surprise medical bills affected her family in so many profound ways. While the baby was healing and she was trying to heal, they simultaneously had to deal with what they felt like never-ending bills coming in the mail.

At one point when they were trying to negotiate with the hospital, a representative from that hospital suggested that they just go get a second mortgage to cover the cost. They ended up losing what was supposed to be their forever home, and the stress on the family was absolutely staggering—a new baby and $1 million worth of bills. On top of that, they endured constant harassing phone calls concerning debt collection. They ended up seeking out an attorney to discuss bankruptcy.

Mitchi is very thankful that Evelyn is happy and healthy, and she cannot testify here today because she is in school. That is wonderful, but she does not want another family to experience the tremendous emotional, physical, and monetary stress that this unfortunate set of circumstances—through no fault of their own—ended up almost destroying their very happy family from one of the most joyous events that they should have had.

Again, Chairwoman Diaz, I would not bring A.J.R. 14 if I did not feel that it was absolutely necessary for the people of this state to have an opportunity to voice their concerns on this particular issue. I think we all know someone who has been through something similar to this particular case. We even heard in the Senate Committee on Finance that a couple of the members have been through this particular issue. I have been very lucky that we were in network when illness or tragedy hit my family, but I think about what might have happened had we not been.

At this time, I would like to go to the patients in southern Nevada, and then I will be happy to walk the Committee through A.J.R. 14.

Chairwoman Diaz:
Of course. We will go to Las Vegas. Whoever wishes to testify first, please turn on your microphone, state your name clearly for the record, and proceed.

Carol Lynne Hansen, Private Citizen, Las Vegas, Nevada:
I urge you to support this measure to help the many Nevadans, like myself, who have faced hardship because of surprise medical bills.

I had the misfortune to be in a severe, double-rollover car accident—which required emergency medical treatment—and I needed to be transported, via helicopter, to the nearest trauma center, which was in Palm Springs. Unfortunately, this was outside of my plan's network.

After the awful accident, I received a bill for almost $60,000—that was for the helicopter—which is currently in collections. This bill came as a total shock. Surprise! I also received a bill for approximately $700, which is also in collections. This issue, despite my efforts, is still unresolved. In total, my bills were very close to $1 million.

The effects of this surprise bill have impacted my life drastically. I cannot sleep, suffered a huge emotional toll, and lost my credibility. The worst part is that it has destroyed the superior credit that I worked my entire life to build. I will be dead before this falls off my credit report. How embarrassing—and all of this occurred while I was physically recuperating and trying to regain my health. I endured a year of rehabilitation, physical therapy, and medical bills, yet I will never be physically where I was before the accident. Financially, my credit has been destroyed. I had to sell the home I worked so hard to buy, and ended up moving in with my son and his family. I know I am not alone and that thousands of other people go through similar experiences.

I urge you to support this bill and provide a small measure of hope and security to those who are in need. Most people do not have the financial means or mental mettle to endure such devastating events in their lives. As you are considering your decision regarding this bill, please keep in mind that this could easily happen to you or your family at any moment. Thank you for your time.

Tanya George, Private Citizen, Las, Vegas, Nevada:
My name is Tanya George. I wanted to write and urge the Committee to support this measure to help the many Nevadans like myself who have faced hardship because of surprise medical bills [page 3, (Exhibit C)].

When I needed emergency insulin treatment, I was careful to go to a hospital that was in my insurance company's network. However, while receiving medical care, I was treated—without my knowledge—by a doctor who was not part of the network.

This caused me to receive a surprise bill of $15,000 that would not be covered by my health insurance. This was a shock to me. I had been careful to maintain insurance to prevent this exact situation. It was both incredibly stressful and embarrassing to have to seek help from others to pay costs I could not afford. I had to choose between paying medical costs and my other living expenses.

I urge all of you to support this bill to prevent this awful situation from happening to others, especially the thousands of Nevadans living on fixed incomes and unable to afford these surprise costs through no fault of their own. Thank you.

Chairwoman Diaz:
Is there anyone else down in Las Vegas who would like to testify? [There was no one.] Assemblywoman Carlton, it seems like the patients have shared their unfortunate events. Life happens, and sometimes you are then left with more than you anticipated.

Assemblywoman Carlton:
I want to make sure everyone is on the same page. I heard one patient talk about how she was in network at the facility, but out of network with the doctor. I have to say, unfortunately, that A.J.R. 14 does not address doctors; it only addresses hospitals and facilities. We want to take the issue of hospitals and facilities to a vote of the people.

We understand that doctors have many, many issues that will need to be worked on and dealt with, but we did not think it was fair to include them in A.J.R. 14. Therefore, we are only addressing hospitals and facilities in this particular measure. I apologize that this measure will not be able to address the patient's particular concern. There is another bill that is still being negotiated in this house [Assembly Bill 382 (1st Reprint)], and it is my hope that we will be able to address that issue for patients through that bill.

I would like Mr. Griffin to testify next and walk the Committee through A.J.R. 14, at which point Ms. Bond will give testimony. I will then give closing remarks, after which we can open the meeting up to questions. Thank you.

Matthew Griffin, representing Health Services Coalition, Las Vegas, Nevada:
I will walk you through A.J.R. 14. This will not take very long as it is not a lengthy measure. Assembly Joint Resolution 14 has three primary components. First, it provides the constitutional right to emergency medical service and care regardless of a patient's ability to pay for the care and regardless of whether a person is insured or underinsured. Second, this resolution requires that the cost of care a person receives must be reasonable and cannot exceed 150 percent of the amount that the facility has agreed to accept from a federal public insurer. Finally, subsection 3 provides for the establishment of a commission, should the Legislature want to deviate from the 150 percent threshold. This commission would have the ability to set rates they deemed to be fair. In summary, that is what A.J.R. 14 proposes, and as I said, it is not very lengthy at all. I am happy to answer any questions the Committee may have about the language included in this measure.

Chairwoman Diaz:
Thank you, Mr. Griffin. Does the Committee have any questions about the language in A.J.R. 14 at this time? Before we go to questions, I want to inform our audience that we set up an overflow room in Room 4100.

Assemblyman Elliot T. Anderson:
I want to confirm, specifically, that subsection 3 of the proposed measure will allow the Legislature to alter, by law, the provisions pertaining to specified rates in subsection 2. Is my assumption correct?

Matthew Griffin:
That is correct. I also want to note that the framework of that commission is left to the Legislature's prerogative, and subsection 3 does not specify how many members will serve on the commission. Subsection 3 merely states that the Legislature will set qualifications for service on the commission.

Assemblyman Elliot T. Anderson:
I appreciate that. As you know, I am careful about what we include in these measures to ensure that the Legislature does not become too tied down. Thank you for including that provision; I think it is important.

Matthew Griffin:
It is my pleasure.

Chairwoman Diaz:
Mr. Powers, do you concur with that assessment?

Kevin Powers, Committee Counsel:
I concur that the provisions of subsection 3 do provide the Legislature with the flexibility to provide, by law, a mechanism to adjust the rates specified in subsection 2. That mechanism, as Mr. Griffin testified, would be a commission established by the Legislature. This mechanism also provides that the Legislature will fix the members and their duties by law and creates a system wherein the Legislature can provide for the future if it elects to do so.

Chairwoman Diaz:
Thank you, Mr. Powers. Are there any further questions from the Committee? [There were none.]

Bobbette Bond, National Policy Director, Unite Here Health:
I am the National Policy Director for Unite Here Health, an organization that deals with coverage that is affordable and high quality for members in the hospitality industry.

Hospital billing is completely irrational. In an emergency, a patient often has no control over where they go for care. They often end up in the hospital closest to them, but in some cases, they are transmitted to a specific hospital through emergency medical services (EMS) transport protocols throughout the state. High-level trauma patients in Clark County may be taken to one of two locations, and that can make all the difference in the financial future of a patient who has insurance that covers them at one hospital but not in the other. In cases in which a patient has no control over where they go for emergency care, the patient may end up in a situation with bills that cost seven, eight, or ten times—or even more—what it would have cost at a contracted hospital. These are surprise bills, and they are based on what hospitals refer to as "billed charges."

The irrational prices that hospitals charge is a national issue. There have been several articles and news stories about it, but Nevada is a special case study, in my opinion. I submitted a handout to the Nevada Electronic Legislative Information System (NELIS) that shows what has happened with increases to billed charges in Nevada since 2008 (Exhibit D). As you can see from this basic graph, the increases are not based on Medical Consumer Price Index nor are they based on anything else that we would be able to pinpoint, mark, or tie as a baseline. The increases are not based on anything that we understand.

The other example of irrational price increases that I want to share with the Committee comes from the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services, which controls the way Medicare and Medicaid are paid throughout the country. This chart illustrates what has happened with billed charges in Nevada compared with the rest of country (Exhibit E). I think the second page is helpful in showing how much the south and the north are above the national average for billed charges around the country and what is happening here in Nevada.

Eight years ago, patients may have found themselves in a situation where they had to pay the ridiculous price of $200 for an aspirin. That price has doubled since then, so in Clark County that same aspirin would now cost $400. This is where we are. When this issue is raised at the policy level, hospitals often point fingers and say that health plans are the problem—that health plans should pay every bill and contract with every hospital. However, our experience over the past 12 years has been that contracting with the hospitals has become increasingly difficult. Frankly, hospitals have the upper hand. Hospitals know that patients will end up in their emergency rooms—whether the patient's insurance contracts with them or not—through the processes that create emergencies, and they will be subject to their charges [page 1, (Exhibit E)]. A patient will be subject to these sky-high, irrational prices in any place where contracts are not in place.

Negotiations are not even-handed between the plans and the hospitals. We have experienced demands, in the last two negotiation cycles, for rate increases that are double or triple the Medical Consumer Price Index. Our response has been to negotiate our contracts in good faith—as well as here in the Legislature Building. Our strategy has not been effective, however, in the years we tried to legislate a solution for people who end up in out-of-network emergency rooms and face these prices.

I am aware that some members of the Committee have already heard this presentation, so I will go through this next section very briefly. In 2005 and 2007, we introduced legislation that did not pass. In 2009, we did the same thing, and it resulted in a study that we created over the interim to determine how to solve this problem. We reported how we were doing with this research and studied the impact on patients over every single interim health care meeting throughout the 2009 to 2011 biennium [Legislative Committee on Health Care, *Bulletin No. 11-18*, pp. viii-x].

In 2011, we brought our findings to the 76th Session and tried to work with hospitals on legislation. We worked all session on a bill that finally passed [Senate Bill 115 of the 76th Session], that we thought was a collaborative effort that the hospitals supported. Governor Sandoval vetoed that bill, we believe at the request of the hospitals with which we had been trying to negotiate. During all of this time, Nevadans continued to face a situation in an emergency. Nevadans are still facing this. Now, six years later, we are again trying to wrap it up.

This session, we have spent months trying to negotiate with the hospitals on A.B. 382 (R1) and have been frustrated. The hospitals rejected offers of rates, but we have created a bill that gets patients out from under billed charges when they occur, in an emergency, through no fault of their own. The bill requires patients to pay only what their plan requires, and once the plan makes payment, if the hospital disagrees with that payment, the parties mediate and enter into binding arbitration. We feel this is great progress for patients, and we are extremely frustrated that the hospitals introduced their own amendment last week and now seem to be opposing this bill.

That is why we are here. We all need a solution. We have been unable to reach one, until now. It is our hope that A.B. 382 (R1) will pass this session so that—for the next three years while this ballot initiative moves through the system—patients are out from under this billed charges hammer. Even if A.B. 382 (R1) passes, however, it could be vetoed again. We hope that the Committee will support this resolution, so we can move forward on resolving the issue of irrational, billed charges in Nevada, and we hope to come back to you with a solution in 2019. Thank you.

Chairwoman Diaz:
Thank you, Ms. Bond. Are there any questions from the Committee?

Assemblyman Ohrenschall:
Thank you for bringing this measure forward. We talked about this issue—insured versus uninsured—years ago. I thought that the Affordable Care Act (ACA) was going to try to address the disparity in billing on the federal level, but I guess it did not, so we are still facing the same problem. Our constituents are still facing this problem, and I am glad that you are trying to address it. We owe it to our constituents to try to correct this. Thank you.

Assemblyman Oscarson:
I have a quick question for you, Ms. Bond, and I want to make sure we are clear for the legislative record. There never was any proof that the Nevada Hospital Association killed the bill or had it vetoed. Is that correct?

Bobbette Bond:
That is true.

Assemblyman Oscarson:
Thank you very much.

Assemblyman Daly:
I want to clarify a couple of things. If I understood you correctly, there is no rule, law, or anything else that determines how hospitals bill charges—there is no baseline or a maximum. Hospitals can more or less charge whatever they want to if the patient's health plan does not have an agreement with them or the patient is not in network. Did I understand you correctly, and is that what you said?

Bobbette Bond:
That is true. I am sure the hospitals will have the opportunity to explain how they set prices, but their pricing does not seem rational to us, and there are no federal laws—and there are no requirements—for what they charge.

In response to Assemblyman Ohrenschall's comment, the ACA does require health plans to pay certain amounts. There are three different ways that health care plans can pay for care in these situations, but there is nothing in state or federal statute at this time to limit what hospitals charge patients.

Assemblyman Daly:
I am sure I will have a follow-up question for the hospitals when they come to the table, but I have one more question for you. It is my understanding that hospitals interpret *Nevada Revised Statutes* (NRS) 439B.260 to say that the required 30 percent discount off billed emergency care charges only applies if a patient is without insurance. Therefore, if a patient has insurance but is seen out of network, the fact that the patient has insurance—even though that insurance is going to say, Hey, you are out of network, and we are only paying a lower rate—the insured patient is still not entitled to get that 30 percent discount. In fact, that patient is essentially uninsured at that hospital. Is my understanding of this correct?

Bobbette Bond:
Yes, that is our understanding as well.

Chairwoman Diaz:
I am sorry. My Legislative Operations and Elections Committee members who also serve on the Assembly Committee on Transportation are being summoned to a work session for Transportation. I apologize for trying to juggle a few things behind the scenes. I want to let our witnesses know that these members are being excused to attend that work session; they are not walking out on the hearing.

That being said, are there any further questions or comments from the Committee for our panel of presenters? [There were none.] I want to go over some protocol before we start taking testimony in support of A.J.R. 14. I am going to limit testimony to two minutes, and if you can keep comments under two minutes, I would greatly appreciate it. We have a lot of people signed in for both support and opposition, and I want to allow as many people

to testify as possible. If there is anyone in Las Vegas wishing to testify in support of A.J.R. 14, please come up to the table as well. We will start with supportive testimony in Carson City, and then we will go to Las Vegas.

James Sullivan, representing Culinary Workers Union, Local 226:
The Culinary Workers Union fully supports A.J.R. 14. Nevadans should not have to face crippling medical debts for being brought to an out-of-network hospital, especially when these same hospitals are making millions of dollars in profits. Assembly Joint Resolution 14 is a necessary step towards protecting Nevada's patients from medical bankruptcy and debilitating debt. Please take a stand for patients and pass A.J.R. 14. Thank you.

Ryan Beaman, President, Clark County Firefighters Union Local 1908:
We run our own self-funded insurance trust for our members. We appreciate Assemblywoman Carlton for bringing this important piece of legislation forward for us. We support the bill. Thank you.

Thomas Morley, representing Laborers International Local 872, AFL-CIO, Las Vegas, Nevada:
I am just going to add a "Me, too," in order to save time. Thank you.

Chairwoman Diaz:
Thank you, gentlemen; your testimony is greatly appreciated. Is there anyone else here in Carson City who wishes to testify in support of A.J.R. 14? While you are coming up to the table, I will go to Las Vegas, and we will take testimony in support there.

Stacie Sasso, representing Health Services Coalition, Las Vegas, Nevada:
The Coalition is composed of 21 employer and union health funds in Southern Nevada and we cover just under 300,000 lives [page 1, (Exhibit C)].

I am testifying today in support of A.J.R. 14. The impact surprise bills have on unsuspecting patients and households can be devastating. Patients access emergency rooms at no choice of their own to seek medical treatment. At the time of their health crisis, patients do not stop to ask the ambulance driver if they can drive to the nearest contracted facility; they simply want to get the care they need in the quickest way possible. It is not until long after treatment is over that the patient may learn he or she was taken to an out-of-network facility and is now receiving outrageous surprise bills.

Steven Brill wrote an article in *Time* magazine that highlighted the irrational billing situation. There have actually been numerous articles reviewing this topic and the concern for the patient, yet no legislation currently exists to protect the patient on either the state or federal level.

By passing this measure today, you are moving Nevada forward in protecting patients from surprise bills that often end in medical bankruptcy. Thank you.

Chairwoman Diaz:
Thank you, Ms. Sasso. As the camera pans out, I see there is a lot of support for A.J.R. 14. I want everyone in Las Vegas who is in support of the resolution to please stand, even if you are not speaking, so that the Committee gets a good visual as to who is there in support of this measure. Thank you. At this time, we will come back to Carson City for additional testimony in support.

Josh Griffin, representing MGM Resorts International:
I am here on behalf of MGM Resorts in support of A.J.R. 14. I think the Committee has heard some of this issue's history—and has probably lived some of the history in other committees—this session as this issue has been discussed. As the sponsor of A.J.R. 14 said, we are trying to find a solution to this problem. I think that this particular resolution creates several opportunities to find solutions. We are the largest employer in Nevada with over 50,000 employees, and when you add family members to our health plans, there is always the risk that our employees and their families could find themselves in a circumstance where they are out of network or where the billed charges can be prohibitive.

I do want to address one thing. These solutions come about as a result of this bill—if it passes, or if we continue our work in the interim—there are advantages to tethering billed charges to something that is fixed, which is how the language is articulated in the bill. One of those advantages is that Medicare gives us a little more predictability. It gives your constituents, our employees, and their families more predictability. When you purely look at a "discount of billed charges" or "billed charges," they are not predictable. I know that was brought up earlier, but I wanted to verify that A.J.R. 14 at least addresses those problems. Again, if there is a way to create a regulatory infrastructure, as I think subsection 3 allows for, we certainly want to be part of that discussion as well. Thank you.

Todd Ingalsbee, Legislative Representative, Professional Fire Fighters of Nevada:
We support this bill, on not only our members' behalf, but also, we run hundreds of thousands of calls to citizens in our communities every day who obviously get charged. Sometimes, we have to take patients to the closest facility, and we would like to help them and prevent surprise bills from happening. Thank you.

Chairwoman Diaz:
Thank you. Is there any further testimony in support of A.J.R. 14, either here in Carson City or in Las Vegas? Seeing none, we will go ahead and open the meeting for testimony in opposition to A.J.R. 14.

James L. Wadhams, representing Nevada Hospital Association:
Thank you, Chairwoman Diaz. With your permission I have five hospital executives who represent a cross-section of the state—north, south, metro and rural—whom I think can give the Committee some perspective.

Let me say a couple of things. The sponsor, Assemblywoman Carlton, has been critical this session in bringing the issue of how we can address the problem of persons who find themselves out of network. I will not spend any time talking about "skinny networks" and "gaps" because the real issue is the circumstance and the patient. Assemblywoman Carlton pulled together a group of people, and with the participation of Bobbette Bond, I think—for the first time in my long history of dealing with this issue—we saw the beginning of a real solution.

I would like to compliment Assemblywoman Carlton again for moving A.B. 382 (R1); I believe it is heading to the Senate shortly, and she is as committed as I am—on behalf of the hospitals—to continuing discussions. I think we can come to a resolution.

The issue before you today, however, is A.J.R. 14, which is a proposed amendment to the *Nevada Constitution*, rather than legislation. We tend to think that legislation is far more dynamic, and the Legislature has the ability, at least every two years, to make adjustments in the law as they see it develop. Quite frankly, in our discussions on A.B. 382 (R1)—which I promised I would not talk about anymore—one of the ongoing features was that certain data would be developed and the Legislature could make adjustments as they met in successive sessions. Constitutional amendments do not necessarily lend themselves to that flexibility. If this measure were to pass, it would lock into the constitutional floor. As was said by Mr. Griffin and confirmed by Mr. Powers, there is an opportunity for the Legislature to make adjustments subsequently, but not necessarily contemporaneously, and I think that represents a significant problem.

We have had discussions about billed charges, and I will agree with one of the prior witnesses that our circumstance in Nevada is rather extraordinary. Part of it is driven by the unfortunate financial situation present in our state. The reimbursement rate for Medicaid is about 52 cents on the dollar, which puts us either forty-ninth or fiftieth in the nation. What that then produces is an overall rate—which we are required to maintain by federal and state law—that is disproportionately higher because of the underfunding of government programs. It causes a distortion in billed charges. The solution to that is to find adequate funds to finance Medicaid. Senate Bill 509 would raise about $350 million in taxes on the hospitals and would hopefully leverage additional federal monies that could potentially alleviate that disparity.

That being said, we are in opposition to this resolution. We continue to support Assemblywoman Carlton's efforts with A.B. 382 (R1), and we look forward to working with her in the future. At this time, I would like to quickly introduce five people who will give the Committee a perspective from their hospitals. The first witness is Matt Walker with William Bee Ririe Hospital in Ely, Nevada.

Chairwoman Diaz:
Mr. Wadhams, can we hold off for just a minute? Two Committee members have questions for you, and I would like them to ask their questions before we go to Mr. Walker.

Assemblyman Araujo:
Thank you for the presentation. I realize that this might be a bit of a loaded question, but as we have hospital executives here, I think this is the right time to ask the question in the event they have the answer. I am trying to gain a better understanding of how each hospital determines their set charges and rates on some of the emergency medical services they provide. I will let that sit because I imagine there may be individual responses that accompany that question. Can you guide us a little bit more as to how rates and charges are established? If so, that would really help our Committee.

James Wadhams:
If you do not mind, I would like to hold that question. If it is okay with you, I will have the individual hospital representatives address it at the end of their comments. I will make sure your question is addressed before we leave the table.

Assemblyman Daly:
You said that the Medicaid or the Medicare reimbursement is 52 cents on the dollar. The logical question, then, is this: Is the 52-cent reimbursement rate based off unknown, billed charges, or is it based off 52 cents on a negotiated contract rate? How did you arrive at those 52 cents on the dollar? We all know hospitals have a billed charges rate but sometimes give certain providers a discount off the billed charges. I understand that some plans—such as federally funded government programs—more or less dictate the reimbursement rate, and with other plans, you negotiate a flat rate that is similar to Medicare or Medicaid. Again, is it 52 cents on the dollar from billed charges or a negotiated rate?

James Wadhams:
Those are excellent questions. The simple answer is that it is 52 cents off the cost of the service, not off the billed charges. It is definitely not off a negotiated rate. There is no negotiation on Medicaid; that is set under the state Medicaid plan by the Executive Branch. Medicare reimbursement, of course, is set federally, and that percentage is slightly higher. I believe it is somewhere between 87 and 89 cents on the dollar of cost.

Assemblyman Elliot T. Anderson:
I obviously share a lot of your sentiments with being careful about putting things into the *Constitution*. I am also a bit frustrated because I know that this has been an issue that we have tried to resolve over and over. What recourse do we have beyond amending the *Constitution* if we cannot get the Governor to sign the measure?

James Wadhams:
Thank you, Assemblyman Anderson. That is an excellent question. My answer is, hopefully, what I led with in my opening remarks, and that is to keep Assemblywoman Carlton focused on this issue. She has been relentless in holding our feet to the fire. Even though we are late in the session, I have little doubt that we will come to a resolution that will be signed by the Governor.

Assemblyman Daly:
I have a follow-up question about cost. It seems to me that we could take a Medicare reimbursement rate off anything, figure out what the other 48 cents is, and establish a cost. Of course we would then have to figure out what hospitals are including in costs—and various things—but then we could look at what hospitals are including in billed charges to determine a reasonable rate beyond that.

If I heard some of the prior testimony correctly, it seems that billed charges are sometimes several multiples of the Medicaid cost. I heard as many as ten times the cost of Medicaid, and I think that is the problem we are trying to get at. How do hospitals justify that, and how do we set those rates? You gave us a starting point based off the 52 cents and Medicare costs; now we can work the math, see actual costs, and compare that to what is charged for some services. You do not have to answer that, Mr. Wadhams; I will ask one of the hospital representatives when they come up.

James Wadhams:
Thank you, Assemblyman Daly, I would be happy to take that up.

Chairwoman Diaz:
Just as Assemblyman Oscarson clarified the record when Ms. Bond spoke about the bill that was vetoed and who initiated the veto, I did not appreciate the comments made about pending legislation and the possible veto thereof. I want our conversation to be consistent. If we are going to apply it to one side, then we are going to apply it to the other side, so please refrain from making such remarks. We are here to discuss A.J.R. 14.

I also want to note that if you are testifying in Las Vegas, make sure you leave your business card with a staff member in Las Vegas; if you are testifying in Carson City, make sure you leave your business card with my committee secretary, as it helps for clarity in our minutes.

Matthew Walker, Chief Executive Officer, William Bee Ririe Hospital and Rural Health Clinic, Ely, Nevada:
I am the Chief Executive Officer of William Bee Ririe Hospital in Ely, Nevada. For those of you who have not been out to Ely, it is a little ways away. It is a little rural, but it is a great place. In fact, it is so rural that if you had to run to Walmart for milk, it would take a 400-mile round trip to get to the nearest Walmart.

My purpose in coming here today is to convey my concern for the proposed changes suggested by A.J.R. 14. My concerns are twofold. First, I think legislating how much a hospital can be reimbursed is a dangerous precedent that will have overarching and problematic implications. Second is the issue of unintended consequences. As you all know, changing one thing—believing that one change will solve an issue—will cause other negative, unintended consequences, one of which would be putting critical access hospitals and rural health care in financial ruin.

William Bee Ririe Hospital is only 1 of the 13 critical access hospitals in Nevada, but A.J.R. 14 would certainly hurt us financially. In the 1990s, CMS changed the reimbursement structure to protect critical access hospitals. I feel that A.J.R. 14 defies that objective and will put our critical access hospitals back in harm's way. We struggle to sustain financial viability in rural, underserved areas such as Ely, and if this legislation passes as is, William Bee Ririe Hospital will cease to exist. That means that the nearest health care would be over 200 miles away. This means that traumas, pregnancies, strokes, heart attacks, and psychiatric patients will all have a four-hour drive to the nearest treatment center. Imagine the effect this would have on morbidity and mortality rates in rural Nevada. The citizens of rural Nevada deserve more.

My argument is not about profits; it is about being there for patients as a critical access hospital. We receive tax subsidies, but unfortunately—even with A.J.R. 14—there are not enough tax subsidies to make us whole and keep us financially viable. Thank you.

Chairwoman Diaz:
Mr. Walker, are you able to answer any of the questions that were raised by the Committee members about transparency and consistency in billing charges?

Matthew Walker:
Sure. I can give you my perspective. It is a difficult question because costs differ depending on the area. It is very difficult to entice physicians and other professionals to rural Nevada. Costs are far more complicated than that, but to give you the general idea behind how it works, we need to look at the cost of something such as an intravenous (IV) start. You have to calculate the nurse time, the physician time, the IV, the materials—all those things have to be considered. It is not just inserting the needle and being done. A doctor must assess the patient and decide to put the order in. The nurse has to take time to do it. The pharmacist must have the equipment and materials on hand. There are a lot of factors to consider. We try to take all of those costs and combine them into each charge master item across the board. I do not know if that answers your question, but that is the idea behind cost calculations.

Chairwoman Diaz:
Unfortunately, Assemblyman Araujo is not here to hear that. The subsequent question I have is, are patients A, B, C, and D—who are all receiving the same treatment—going to be billed the same amount?

Matthew Walker:
Yes. We have the same charge master. I guess it depends on where the patients are treated, though. For instance, the emergency room (ER) is more expensive because critical access hospitals have to maintain 24/7 coverage. Sometimes we only have one or two patients an hour, or less, but we still have that cost burden of having 24/7 coverage. Sometimes the cost is a little bit more in those areas.

Chairwoman Diaz:
Mr. Wadhams, do we want to go on to the next person?

James Wadhams:
Yes, thank you very much. The next witness I would like to introduce is Lisa Farnan.

Lisa Farnan, Vice President, Managed Care and Integrated Health Care Delivery, Dignity Health-St. Rose Dominican:
My primary responsibilities for the state of Nevada are negotiating health plan contracts. I am here today in opposition to A.J.R. 14, which would require our hospitals to accept 150 percent of Medicare as payment in full for any patient receiving emergency care (Exhibit F). I want the Committee to know that St. Rose is the only not-for-profit, faith-based health system in Nevada with three hospitals, and the only trauma center in the City of Henderson.

St. Rose is not for profit. We have served our community for over 70 years, and we came to Henderson to run a small, formerly government-run hospital. We return almost all of our profits to our community as a benefit. Just last year, St. Rose provided the community $113 million, which included access to public health programs, services, and care for those who cannot afford it.

I want to mention that, as I understand it, there was a hearing on Saturday about the complexity of our health plan negotiations. As a person who sits at the table, I can tell you that A.J.R. 14 is unnecessary and inappropriate. We spend months, if not a year or more, in negotiations with our payor partners to come up with fair and equitable rates for not only emergency services, but also for inpatient and trauma services. When we walk away from the table, we are satisfied that they are fair and equitable.

For the record, we never turn our backs on patients if they are uninsured or underinsured. We consistently work with patients, whether they are contracted with our hospital or not, to negotiate a fair arrangement. Therefore, I estimate that very few of our patients pay billed charges. I am responsible for negotiating contracts between the health plans and myself for individual patients when they are caught out of network. We are very fair about this because we do not want our patients in the middle, either.

Assembly Joint Resolution 14's stated purpose is to ensure access to affordable emergency care for all Nevadans, but we do not believe it benefits the members in the least and is really for the benefit of the health plans to not pay more. Therefore, we encourage a meaningful study process that involves all parties to find the best solution for patients. Thank you.

Assemblyman Araujo:
Mr. Wadhams, I was not clear if we were going to ask each hospital representative to answer the question that I posed earlier, or if you wanted to wait and address it at the end of the presentation.

James Wadhams:
I am certainly happy to address that. Ms. Farnan, can you explain your hospital's approach to how you set billed charges?

Lisa Farnan:
As most of us know—and probably did not want to know—a charge master is an extensive way for us to actually report our billed charges to state government. We look at the charge master every year and at ways in which we might be able to adjust it based on the cost of care. It is a very arduous process, and as we look at our charge masters each year, we neutralize the impact of our charge master with all of our health plans, so they know what they have negotiated, and they know what they are going to be paying over the year to come. From my perspective, our charge master is a painstaking process where we look at costs for each individual line item, and we take that out to the health plans to make sure that they are not paying more than we negotiated.

James Wadhams:
The next witness I would like to ask to comment is Todd Sklamberg.

Todd Sklamberg, Chief Executive Officer, Sunrise Hospital HCA, and Sunrise Children's Hospital, Las Vegas, Nevada:
I am Chief Executive Officer of Sunrise Hospital and Sunrise Children's Hospital. I have had the pleasure to meet many of you, and I thank you for your commitment to this state and all of your hard work during this legislative session. I am here this afternoon to share the devastating impact A.J.R. 14 would have on Sunrise Hospital, the health care community, and most important, the residents of Nevada who rely on our health care community.

Sunrise Hospital and Sunrise Children's Hospital is a 690-bed, tertiary, full-service hospital, serving patients from the entire state and the surrounding Southwest region. Our average daily census is over 640 inpatients, and last year, we served over 167,000 patients in our emergency department—the largest ER in the state and one of the top 15 ERs in the country. We are also the state's largest Medicaid provider with over 42 percent of our inpatients and 57 percent of our ER patients covered by Medicaid. That is over 95,000 ER patients covered by Medicaid, and for all the resources we commit to this population, we are reimbursed for about half of our costs.

Despite the financial constraints due to inadequate Medicaid reimbursement, Sunrise Hospital has made a commitment to our community and invested to bring the latest technology and procedures to our patients. We provide all of the pediatric heart care from catheterization laboratory (cath lab) to open-heart procedures for the state. We are the only Commission on Accreditation of Rehabilitation Facilities (CARF) rehabilitation program in the state. We operate the largest and most comprehensive adult cardiac program in the state. We provide the most comprehensive care for stoke patients in the state. We care for one in every four children requiring ER care in the state. We are only one of two American College of Surgeon's Commission on Cancer programs in the state. I could go on.

Providing these programs and access to top care requires investment and the ability to recruit and retain the best physicians, nurses, and staff. Legislation such as A.J.R. 14 and A.B. 382 (R1)—which is under consideration—will completely cripple Sunrise Hospital and the health care system my peers and I have worked to enhance over the past ten years. It will lead to an exodus of physicians and will severely impact our ability to bring new physicians and their expertise to Nevada. Capital investment, such as the $140 million planned expansion of Sunrise Hospital, will stop. Our ability to attract any physician or clinical expertise from out of state will stop, and I—along with my colleagues—will be forced to close programs and eliminate the high-cost procedures and drugs. This is not a threat—it is a reality. In fact, if the reimbursement of ER services, as this bill suggests, are capped at an amount equal to 150 percent of the lowest agreed-upon rate from a federal public insurer, Sunrise Hospital will no longer be financially viable to operate. We are dealing with legislation that will require hospitals and physicians in the state to ask themselves if it makes sense to operate in a Nevada that is not committed to health care. The question is that simple.

Let me share four stories from the past few months at Sunrise Hospital. First, there is Gary Wilson who came to Sunrise Hospital from Pahrump, Nevada. In November, he was the first patient in the state to have a MitraClip implanted. Mr. Wilson, who was 79 years old, had a leaky heart valve, but was not a candidate for surgery. He could not even walk or cross the room. Sunrise Hospital invested in MitraClip technology, and Mr. Wilson received this life-saving procedure. I visited him the same day of the procedure, and he was eager to go home. The next day, he walked the longest distance he had walked in months. He was discharged in two days and now leads an active life.

Next, there is Kailey, who was born with a heart defect and is four years old. Earlier this year, she went under a life-saving cardiac catheterization procedure, followed by additional open-heart surgery. She now calls her scars her "badge of courage."

Here is Stephanie, age 23, along with baby Jackson. Even while baby Jackson was thriving in his first days of life, Stephanie was struggling. Pneumonia set in and, despite efforts to get her back on track following her C-section delivery, it was clear that extreme measures were going to be required for the young mother—whose lungs were no longer able to pull fresh oxygen into her body.

Fortunately, a physician in the Arizona hospital where Stephanie gave birth knew about extracorporeal membrane oxygenation (ECMO), and Stephanie is receiving life-saving lung and heart bypass treatments. She was transferred to our cardiovascular intensive care unit, where our operating room team met her. Our team did for Stephanie what they have done for many Sunrise Children's Hospital patients—and five other adults. They bypassed Stephanie's lungs for six days. Her lungs rested as the external ECMO device took over for her lungs' key functions. I am glad to report that Stephanie now is doing extremely well and enjoying life with Jackson and her husband. If not for the comprehensive ECMO technology that Sunrise Hospital offers, baby Jackson would not have a mother.

Finally, there is Mrs. Nixon. Virginia, who celebrated her fifty-seventh anniversary with her husband, is a housekeeper in this region. She visited Sunrise Hospital's ER on January 4, 2017, with a blister on her leg. She was then diagnosed with necrotizing fasciitis, which is commonly known as "flesh-eating disease." This disease, according to medical literature, has a mortality rate of over 50 percent. Respecting her religious beliefs as a Jehovah's Witness, our team worked for more than 111 days to cure her without amputation and without other, residual issues. She walked out of Sunrise Hospital earlier this month.

The stories I just shared are repeated each and every day in our hospitals. If A.J.R. 14 passes, these services will stop and our patients' outcomes will be dramatically different because of the significant investment in technology necessary to provide care. By capping reimbursement to health care providers, the Legislature is saying no to investment in health care and no to providing access to health care—and that it is satisfactory for Nevada to remain fiftieth out of 50 states in the number of physicians per capita. The decision is yours and that of your colleagues. I am happy to address any questions you may have.

James Wadhams:
Mr. Sklamberg, would you address Assemblyman Araujo's question about how Sunrise Hospital sets its charge master?

Todd Sklamberg:
Our process is very similar to that of the last two responses, and it is a painstaking process. The cost for any item is inclusive of all of the care that is required, not just for the drug or procedure, nurses, pharmacists, and support necessary to deliver the item. In addition, we are required to have a single charge master. It is updated every year, but as you know, we contract with managed-care payors to negotiate rates particular to individual services and care.

Assemblyman Araujo:
I am hearing a common trend with these answers, and that has prompted another question in my mind. Where would a patient turn if he or she wanted to check to see which hospitals have increased their rates, which hospitals have remained steady, and which have decreased their rates?

James Wadhams:
There are two places patients can turn. I cannot give you the direct hyperlink, but the Nevada Hospital Association has a price transparency website, which I believe covers every hospital in the state [http://www.nvpricepoint.net/], and the state of Nevada maintains a slightly less comprehensive website that can be accessed through the Department of Health and Human Services. I apologize for not having those links, but I will obtain those and submit them to the Committee.

Assemblyman Araujo:
The reason why I asked is that I remember hearing that the charge master is what is used to set prices. Does the public have access to charge masters?

James Wadhams:
I believe we have a state law which requires that any patient who wants to see a charge master be given access.

Assemblyman Daly:
I want to follow up on Assemblyman Araujo's question. I want to get something clear for the record in reference to the comment you made about all the factors that are included in creating a charge master. I hope you can answer this question. You said that the charge master takes into account all of the fees for a service such as an IV: the bag, the needle, the support, the paperwork that has to be done, the physician—unless the physician is charged separately—the nurse, et cetera. I am sure you also included hospital administration and various other expenses. Do you then charge the margin plus one more procedure? Is the fact that your hospital performed 7,000 of the same procedure—some in-network, some out-of-network—over the last year factored into the charge master rate?

Do you account for the fact that some procedures are reimbursed at different rates—such as Medicare—while other procedures are not reimbursed at all or are paid for by the county? If so, do you then say, "Here is the 7,000 I did. This is what I was paid for them. This is what I should have been paid for them," and then create your charge master including the uncompensated care? Do you understand what I am saying? I want to make sure that when you say you only charge "what it costs "—is that true or does the cost include uncompensated care? That is what I need to know because that is an issue we need to address.

Todd Sklamberg:
When we look at charges, we look at the actual item that we are charging as well as the cost associated with running a hospital. Operating costs include all of the elements that you referenced from bad debt to uncompensated care. As you know, only a handful of patients pay off the actual charge master. The overwhelming majority have a contracted rate for specific services through Medicare, Medicaid, and through other managed-care organizations.

Assemblyman Daly:
That is what I am trying to get at. You have to include bad debt and various other factors in your cost. I understand that you factor in what insurance providers will pay as well as what a reasonable person can pay. In addition—and whether we want to admit it or not—there is a shift from the people who cannot pay. Obviously, hospitals negotiate what they believe is a fair deal to help cover all of the costs for various factors when they negotiate prices, and they know they are going to be compensated. Based on my experiences in my normal job as a trust fund trustee, I know that prices are a little bit higher because we are paying for some of the bad debt and uncompensated care, but we ask if it is a reasonable price.

It seems to me that in the emergency care situations Assemblywoman Carlton and Mr. Wadhams have been attempting to address, there is a deal to be made where hospitals can recoup a reasonable sum without shifting the burden of cost to those who are uninsured, and without charging the uninsured 300 percent of the actual cost because they happen to find themselves in an unlucky situation. Instead, these patients are told that they are not covered by insurance, they are out of network, and there is no way for them to make a deal. They are not covered by Medicare. That is the issue that I am trying to get to. We need hospitals to get away from this "luck of the draw" for the person who comes into the emergency room through no fault of his own and pays what he believes—and we have seen and experienced—is an unreasonable rate.

Todd Sklamberg:
I want to respond to a couple of things. First, as Mr. Wadhams mentioned, we remain committed to working with Assemblywoman Carlton on A.B. 382 (R1), and we are going to work diligently. We will try to work out an arrangement that meets everybody's needs, and we are very committed—through the Nevada Hospital Association and through Sunrise Hospital—to put in 100 percent effort.

Second, I would like to reference an item I mentioned it in my testimony. At Sunrise Hospital, 42 percent of our inpatients and 57 percent of emergency room patients are covered by Medicaid. We are very proud to be a partner and very proud to be the largest Medicaid provider in the state, but Medicaid—as Mr. Wadhams expressed earlier—only pays us 52 cents on the dollar of cost for services. If we just relied on reimbursement of 52 cents on the dollar to our cost, we could not remain financially viable, and we could not provide care for patients who need those services.

Chairwoman Diaz:
Before we go to the next person, I want to remind the Committee not to lose sight of the intention of A.J.R. 14, which is seeking to make sure that all Nevadans receive treatment in emergency situations where they do not have a say as to what hospital they are landing in or what doctor is treating them because their life is at risk. I do not think it is fair to say that because I went to a hospital that is out of my network that my IV treatment, the medication, and the treatment I receive from the doctors and all of the staff is going to be superior or higher than had I gone to a provider that is in my network. It sounds to me like we are gouging patients in emergency situations that are beyond their control because hospitals are trying to make up for a deficit. That is how this argument is coming across, and I hope that that is not accurate or true because we are doing a great disservice to Nevadans if that is the case.

Assemblyman Oscarson:
Mr. Sklamberg, forgive me if you stated these numbers, but I would like to hear them again. How many hospitals do you represent in Las Vegas?

Todd Sklamberg:
I am CEO of Sunrise Hospital and Sunrise Children's Hospital. We are a part of HCA Healthcare system, which has a total of four hospitals in southern Nevada, with Mountain View Hospital and Southern Hills Hospital and Medical Center being the other two.

Assemblyman Oscarson:
How many total emergency room beds do you have in those hospitals?

Todd Sklamberg:
I can get you the exact number, but we probably have close to about 175 beds.

Assemblyman Oscarson:
Do you have an idea of the average number of patients you see in your emergency rooms on a daily basis?

Todd Sklamberg:
I believe we see about 300,000-plus patients per year.

Assemblyman Oscarson:
Out of the approximately 300,000 patients who come through your hospital every year, how many are out of network?

Todd Sklamberg:
At Sunrise Hospital, approximately 20,000 are out of network, and approximately 20,000 do not have any insurance at all.

Assemblyman Oscarson:
What is the process when an out-of-network patient comes to your hospital? What is your billing or accounting department's process to try to resolve the bill for that patient?

Todd Sklamberg:
If a patient comes in out of network, we submit a bill to the insurance company. The insurance company sends in reimbursement, and then we work very closely with the patient to determine what additional copays, deductibles, or amounts are due. Based upon their ability to pay, we structure a payment program for the patient. As Sunrise Hospital, for instance, anyone under 200 percent of the poverty level receives a full write-off of the bill. Beyond that, we have a sliding scale based upon ability to pay.

Assemblyman Oscarson:
I want to make sure there is an opportunity, if patients meet certain criteria within your entity, that you work with them to make sure that those bills are taken care of. Is that correct?

Todd Sklamberg:
Correct. We work with patients based on their financial resources. We do not go after patients' homes or put liens on their property. We work with individuals based upon their ability to pay.

Assemblyman Elliot T. Anderson:
Mr. Sklamberg, I want to welcome you to this Committee. Your hospital serves a number of my constituents, so it is nice to have you here. I wanted to check your position on the Medicare reimbursement rate. In a perfect world, how much would you raise it on a percentage basis?

Todd Sklamberg:
Could you give me a little more detail, so I can properly answer your question?

Assemblyman Elliot T. Anderson:
Of course. Page 2, line 36 of the resolution references "a federal public insurer," which I believe is Medicare. In a perfect world, if you could go to Congress and ask them to raise the Medicare reimbursement rate, how much would you raise it if you could? I assume there are always fights over the Medicare reimbursement rates in Congress.

Todd Sklamberg:
With Medicare, as with many other payors, reimbursement varies depending upon the service provided to the patient. In total, Medicare reimburses hospitals at 89 percent of their costs. That is all-inclusive—from the ER to inpatient to surgical services. For the emergency room though, Medicare pays just a fraction of the cost that it does for inpatient services. That amount, for the hospital, is less than a quarter of our costs for Medicare. Inpatient Medicare pays a little higher, but if your question is specific for emergency room care, we get less than a quarter of our cost for Medicare for emergency room services.

Assemblyman Elliot T. Anderson:
In that case, you would need to increase the reimbursement rate about threefold to make up your costs. Am I doing the math correctly?

Todd Sklamberg:
I would need to run the numbers, but probably four- or fivefold if we are talking about Medicare reimbursement for emergency room services.

Assemblyman Elliot T. Anderson:
Thank you for the information.

Chairwoman Diaz:
I would like to hear from the other two hospital representatives and then my intention, Mr. Wadhams, is to take one-minute testimony from the rest of the witnesses because we are running out of time. I gave the proponents of A.J.R. 14 fifteen minutes to speak, and I think, because the Committee members have had questions, I have indulged them, but we need to move on.

James Wadhams:
I appreciate the opportunity to have the questions directed to people who know the answers, rather than to me, who has to go find them.

Erik Olson, Vice President and Chief Executive Officer, Renown Regional Medical Center, Reno, Nevada:
I am the CEO of Renown Regional Medical Center, a private, not-for-profit, locally owned, 808-bed, level II trauma center located in Reno, Nevada. For those of you who are not from northern Nevada, we operate the region's only trauma center and dedicated children's hospital—which includes a pediatric emergency room that operates 24 hours a day, seven days a week, and sees more than 23,000 annual visits. Two-thirds of our pediatric patients are Medicaid or self-pay patients. We also have a level III NICU and a pediatric intensive care unit.

Renown Regional is the largest provider of health care in northern Nevada. We accommodated nearly 100,000 emergency room visits last year. Nearly 50 percent of these patients were Medicaid or self-pay patients. In many cases, these are the only safety-net services available to these most vulnerable Nevadans. In addition, we see approximately 3,500 patients every year who need trauma care.

For the most recent reporting period, Renown provided over $78 million in community benefits; $65 million of which related to uncompensated care. We oppose A.J.R. 14. We believe this ballot initiative will significantly impact our ability to contract and collect for our most costly, time-sensitive, and life-saving services. Since 71 percent of the emergent trauma care we provide is provided to patients covered by government programs or individuals without insurance, further limiting our ability to bill and collect for these services will directly impact the service we are able to provide. As a reminder, on average Medicaid pays 52 percent of a hospital's actual cost to provide care. Medicare pays 89 percent of a hospital's actual cost to provide care. Both of these programs pay even less for trauma services. Medicaid and Medicare programs do not cover the significant costs incurred by trauma centers such as physician standby and on-call costs, which result in tens of millions of dollars in unfunded costs annually.

As a nonprofit, charitable organization, we remain committed to our mission to care for all who need us. Our primary concern is the significant negative impact A.J.R. 14 will have on our ability to provide the safety net services our community needs.

James Wadhams:
Mr. Olson, will you answer Assemblyman Araujo's question about how your hospital develops its charge master?

Erik Olson:
I do not know that I have much more to add than what my colleagues already mentioned. Our charge master is based on our labor and supply costs, along with other costs. I would say that it is a systematic approach that employs industry standards. We also work with the Healthcare Finance Management Association, which offers tools to hospitals to help set charges. I would just add that it is a systematic approach using industry-accepted standards.

Assemblyman Araujo:
Mr. Wadhams, I had to phone a friend because I was looking specifically for access to the charge masters. Obviously, here at the Legislature we have a wonderful team behind us that knows the policy in and out. I received clarification that subsection 4 of NRS 449.490 states that the charge master portion of this must be public, but it has to be public, in person, during normal business hours. My question had to do with online access and accessibility to the average person who is looking to go the emergency room.

As I was preparing to ask the question, however, I received another piece of information that offers greater clarity in terms of what the Nevada Hospital Association makes available. I wanted to make clear for the record that I was looking for clarity in terms of the charge master being available online. I will do my homework and look at the Nevada Hospital Association's database to see if that will satisfy my question in terms of accessibility and transparency when it comes to those rates.

Assemblyman Oscarson:
I want to ask you the same questions I asked Mr. Sklamberg. How many emergency room beds do you have?

Erik Olson:
We have approximately 80 emergency room beds.

Assemblyman Oscarson:
How many encounters do you have each year in your emergency room?

Erik Olson:
Last year, we had 94,000 emergency room visits.

Assemblyman Oscarson:
How many of them were uncompensated?

Erik Olson:
I do not know the exact number of how many were uncompensated, but approximately 50 to 60 percent.

Assemblyman Oscarson:
How do you work with out-of-network patients, and how does your billing department work with them?

Erik Olson:
Our process is similar to what Mr. Sklamberg articulated. We will handle every patient on a case-by-case basis and work with patients, individually, based on their financial situation.

Assemblyman Oscarson:
Do you have sliding payment scale? Do you have tools to address those situations when patients arrive and they have no means to pay, or it is very difficult for them to pay?

Erik Olson:
Yes, we work with individuals as needed, based on their situations and their finances.

Mason VanHouweling, Chief Executive Officer, University Medical Center of Southern Nevada:
I am the Chief Executive Officer of the University Medical Center (UMC) in Las Vegas. I appreciate the opportunity to speak to you in regard to A.J.R. 14. University Medical Center has historically had high bonafide uncompensated care costs, as measured and audited by the federal Disproportionate Share Hospital (DHS) programs, which will likely be negatively impacted by the impending changes to the ACA. In the four years prior to the ACA—2010 to 2013—UMC had a total net of uncompensated care, after DSH payments, of around $200 million.

As you all know, there are many developments occurring in health care that will potentially increase the tax burden for Nevadans. If ACA reform plays out, the result is that current enrollees could lose Medicaid coverage. That burden will be shifted to the Nevada taxpayers. If the ACA reduces DSH payments for truly uncompensated care at hospitals such as UMC, the burden will shift to Nevada taxpayers.

If A.J.R. 14 is implemented, rates will only cover a portion of true cost and the federal government will not provide supplemental funding to UMC for underreimbursed services that are rendered. Again, that burden will be shifted to Nevada taxpayers. My major concern, from a public hospital perspective, is that A.J.R. 14 will discourage emergency room investment and expansion, and may possibly lead to closures. Unintended consequences could cause inconvenience and potential harm to patients who will need to travel farther from home for emergency care.

If UMC was forced to greatly expand its emergency room services due to its status as the safety net hospital, our other services may need to be reduced, causing access challenges for patients with nonemergency illness who may not have insurance or other access to care. This could also potentially prohibit UMC's ability to support academic medicine and create an academic health center for the state of Nevada, restricting our ability to support the

University of Nevada Las Vegas, School of Medicine as well as other academic training programs and clinical research. If UMC's emergency payments were restricted due to the limits within A.J.R. 14, we would expect reductions of about 31 percent of services in our revenue for the emergency room, but also a greater number—43 percent—in our trauma center. I want to make the Committee aware that UMC is the only level I trauma center in the entire state of Nevada.

With that, I am open to any questions the Committee may have. In anticipation of Assemblyman Oscarson's question, UMC has a little over 100 emergency room beds—we have about 55 adult beds and a separate pediatric hospital, and our level I trauma center has about 20 beds. We see over 100,000 patients on an annual basis in our emergency rooms combined. Thank you, and I appreciate your time today.

James Wadhams:
Unless there are any follow-up questions, that concludes our presentation.

Chairwoman Diaz:
We will begin taking testimony in opposition, and we will only accept testimony less than two minutes. At this point, we have prevented our floor session from starting, so we need to get out of here as soon as possible to make that happen.

Catherine M. O'Mara, Executive Director, Nevada State Medical Association:
As the sponsor noted at the beginning of this hearing, the physician community is not in support of this resolution, and we appreciate Assemblywoman Carlton's sensitivity and acknowledgment that this resolution is not the appropriate approach for physician payments. We are in opposition to the measure, however, because we are concerned about what it will do to the health care delivery system in Nevada, particularly our ability to provide care for patients in the hospitals but also to negate all of the hard work the Legislature has done to invest in our workforce. As a reminder, you have been working very hard to fund graduate medical education and to fund the establishment of a new medical school. The Legislature just passed a law—I believe it was Assemblyman Oscarson's—to look at Medicaid reimbursement rates over time. All that work demonstrates a commitment to physicians in Nevada, and we believe these will be good recruitment tools when we try to bring physicians to our state.

This measure will have the opposite effect. We just heard the hospital CEOs say that they are very concerned about their ability to recruit and retain physicians, and we are here to lend credence to that. We are hearing from our physicians and our physician recruiters that this issue is an issue that prospective physicians ask interviewers when they come to get jobs in Nevada. We are appreciative that we are not part of this resolution, but we hope that this measure does not pass. Thank you.

Janine Hansen, State President, Nevada Families for Freedom:
If the government can mandate something, they can and will—by law or by natural consequences—limit access to the market. We know that this has happened with Medicare. Many physicians do not accept Medicare patients because the reimbursement rate is not great enough. Many of my friends, and some of my family, do not have Medicare Part B because doing so would limit what they can do with their health care. If a doctor accepts Medicare, you cannot, as the patient, pay more than Medicare will pay to receive a treatment or service that you need or want. Therefore, access is already limited because of current laws that mandate certain kinds of health care.

This is what happened in California. Their system of hospitals and health care is under siege. A large percentage of California hospitals are losing money. Hundreds of medical clinics have closed or gone bankrupt while most others are in financial trouble. Some 84 hospitals in California have closed in the last dozen years, many due to overuse of emergency rooms by illegal aliens, unpaid medical bills, and by others without insurance.

A couple of years ago, I was in a situation where I was without health insurance, and I ended up in the hospital with a ruptured appendix. I was ultimately able to negotiate with the hospital in Elko for a 70 percent reduction in cost, so that I was able to pay the bill. My bill was over $25,000 for the hospital stay alone, not to mention everything else.

Going on with more information about California, it is estimated that illegal aliens utilize hospital emergency rooms at more than twice the rate of the overall United States population.

Chairwoman Diaz:
Ms. Hansen, I would appreciate that we limit our discussion to the scope of the bill. I also do not appreciate choosing immigration as a focal point.

Janine Hansen:
I am sorry, but it is a great cost. One of the things pushing our hospitals out of business is unpaid emergency visits. That is obvious—and we already know who is responsible—but this is the problem we have. If we impose unreasonable limits on hospitals, hospitals will go out of business, and they will not be able to serve those who have insurance. They will not be able to serve Medicare or Medicaid. They will not even be able to serve people—like me—who do not have insurance. It is very important that we are reasonable in what we mandate because mandates limit the access that we have, either by law or by natural consequences. If you think you are going to fix access by mandating it, this will create a huge problem. Thank you.

Chairwoman Diaz:
Thank you, and I just want to make clear that not only undocumented populations lack health insurance coverage in our state. There are many residents and hard-working Nevadans who do not have appropriate access to care and health care coverage. We need to make sure we are not saying only "these individuals" in our state that lack coverage, and that they are the only ones who are using our emergency services.

Janine Hansen:
I said that I was one, Madam Chairwoman, who did not have any insurance myself.

Misty Grimmer, representing North Vista Hospital:
I represent North Vista, the only hospital in North Las Vegas, and we are in opposition to this resolution. I will be very brief in my comments. In all of the conversation about costs and how they are established, the issue has become a little confused. I would like to simplify it by reminding the Committee that this debate is really about choice, and that the choice is not currently up to the patient. Patients do not end up in an emergency room by choice or end up in the hospital they ended up in by choice. It is also not the choice of the hospital. When somebody arrives in an emergency room, we treat them and get them well regardless of the circumstances. Federal law prohibits hospitals from saying, Sorry, you are uninsured; you cannot be served here. The only choice made here is made by the payor, who decides against covering a patient they insure. Thank you.

Joan Hall, President, Nevada Rural Hospital Partners:
I will be brief. I represent the 13 critical access hospitals in rural and frontier Nevada. These are the safety net hospitals for 90 percent of the land mass in Nevada. We only cover 10 percent of the population, but we are critical. The Centers for Medicare and Medicaid Services and the federal government recognize the difference and importance of rural hospitals. As Mr. Walker stated, in 1997 CMS put a different certification process together for us. They also pay rural hospitals differently. We are paid cost for Medicare, but even at cost, it is not enough to keep our hospitals viable. Cost is based on the cost report and what Medicare allows, and I could clarify that later for you, off-line, if you would like.

We believe that because we are different, it would be very difficult for anyone to understand how we could meet that federal insurance level because it changes annually for our members. Each member is different, and it would be very difficult for us. It would be a travesty for Nevada to lose its rural hospitals. We request your support in considering us in this discussion. We think A.J.R. 14 would have a negative impact on the 81,000 emergency room patients served by our rural hospitals. Thank you.

Dan Musgrove, representing Valley Health System:
I am here on behalf of the Valley Health System of Hospitals. We have eight hospitals statewide. We have one up here in northern Nevada—the Northern Nevada Medical Center. We have a critical access hospital in Pahrump and six hospitals in Clark County. Each year we have more than 177,000 emergency room visits throughout the state, not including our new hospital in Henderson. We have 1,800 licensed beds, and we are completely in opposition to A.J.R. 14.

Chairwoman Diaz:
Thank you. Is there anyone else, here or in Las Vegas, who would like to testify in opposition to A.J.R. 14? [There was no one.] Is there anyone here wishing to testify in the neutral position? [There was no one.] Assemblywoman Carlton, would you like to make some final comments for the record?

Assemblywoman Carlton:
Thank you very much, Chairwoman Diaz. I will keep my closing comments brief. I listened to the opposition while I was working on some other issues. I listened to the hospital CEOs, and I applaud the care that Nevadans get in this state. This resolution is not about the care that patients receive. I would like to address Mr. Sklamberg in particular. When my daughter was sick last year, she was in Sunrise Hospital for over three months, and I believe she received excellent care. Mr. Sklamberg oversees a very well-run hospital. This measure is not about quality of care; I appreciate the care that we get. This measure is not about the doctors; again, we took the doctors out of this. Remember, section 3 gives the Legislature an opportunity to address this issue in the future.

As a bit of history, Governor Bryan capped charges back in the 1980s; this policy has now sunsetted. I am not talking about capping charges. I am not talking about adversely affecting hospitals' profitability, of which we have heard so much about today. What I am trying to do is this: I am trying to figure out a way for the public to have input on an issue that the Legislature has tried to resolve for the last 14 years. I am trying to get the patient out of the middle of this mess and allow the sophisticated hospitals and the insurers to take care of the bills that happen to people through no fault of their own.

I want to once again point out the date at the top of A.J.R. 14—May 17, 2017. I negotiated this issue for over 15 meetings and for hundreds of hours. I have spent as much time on this resolution as I did on 488 budgets for the state. This is important for the patients of this state, and it needs to be solved, and if we cannot negotiate something in A.B. 382 (R1), then we need to take it to the public, and the public needs to speak. We know full well that, depending upon how the public would vote the first time, it might come up for a second vote. Then, if we came up with a solution, maybe we would not have to do it the second time. But sooner or later, this problem needs to be resolved and it needs to be resolved now.

Thank you very much for your time. I apologize for the length of this discussion, but I am very passionate about getting the patients out of the middle of this issue. Thank you very much.

[(Exhibit G) and (Exhibit H) were presented but not discussed and are included as exhibits for the meeting.]

Chairwoman Diaz:
Thank you, Assemblywoman Carlton, for your persistence and perseverance in this matter. With that, we will close the hearing on A.J.R. 14, and we will open up to public comment. Again, I am reminding everyone that public comment means anything you want to bring up to this Committee that is not associated with what we just had the lengthy conversation about. Seeing none, the business before this Committee is over, and we are adjourned [at 3:21 p.m.].

RESPECTFULLY SUBMITTED:

_____
Julianne King
Recording Secretary

_____
Devon Isbell
Transcribing Secretary

APPROVED BY:

_____
Assemblywoman Olivia Diaz, Chairwoman

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a collection of various testimonies in support of Assembly Joint Resolution 14, submitted by the Assembly Committee on Legislative Operations and Elections, consisting of the following:

1. Written testimony in support of Assembly Joint Resolution 14, submitted by Stacie Sasso, representing Health Services Coalition, Las Vegas, Nevada.
2. Written testimony in support of Assembly Joint Resolution 14, authored by Michelle "Mitchi" Thomas, Private Citizen, Las Vegas, Nevada, and presented by Assemblywoman Maggie Carlton, Assembly District No. 14.
3. Written testimony in support of Assembly Joint Resolution 14, submitted by Tanya George, Private Citizen, Las Vegas, Nevada.

Exhibit D is a chart in support of Assembly Joint Resolution 14 titled "Average Billed Charges Per Adjusted Inpatient Admission," presented by Bobbette Bond, National Policy Director, Unite Here Health.

Exhibit E is a document in support of Assembly Joint Resolution 14 titled "Top Inpatient Categories Billed in Nevada," presented by Bobbette Bond, National Policy Director, Unite Here Health.

Exhibit F is written testimony in opposition to Assembly Joint Resolution 14, authored by Eugene Bassett, Senior Vice President of Operations, Dignity Health-St. Rose Dominican Nevada, and Lisa Farnan, Vice President, Managed Care and Integrated Health Care Delivery, Dignity Health-St. Rose Dominican, Nevada; presented by Lisa Farnan, Vice President, Managed Care and Integrated Health Care Delivery, Dignity Health-St. Rose Dominican, Nevada.

Exhibit G is an article in support of Assembly Joint Resolution 14 dated November 17, 2016, from the *New England Journal of Medicine* titled "Out-of-Network Emergency-Physician Bills—An Unwelcome Surprise," authored by Zack Cooper, and Fiona Scott Morton, and submitted by Assemblywoman Maggie Carlton, Assembly District No. 14.

Exhibit H is a letter dated May 27, 2017, in opposition to Assembly Joint Resolution 14, to the Committee on Operations and Elections, authored by Aviva Gordon, Legislative Committee Chairwoman, Henderson Chamber of Commerce, and Amber Stidham, Director of Government Affairs, Henderson Chamber of Commerce.