MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-ninth Session
June 2, 2017

The Senate Committee on Health and Human Services was called to order by Chair Pat Spearman at 6:05 p.m. on Friday, June 2, 2017, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Pat Spearman, Chair
Senator Julia Ratti, Vice Chair
Senator Joyce Woodhouse
Senator Joseph P. Hardy
Senator Scott Hammond

GUEST LEGISLATORS PRESENT:

Assemblywoman Maggie Carlton, Assembly District No. 14

STAFF MEMBERS PRESENT:

Megan Comlossy, Policy Analyst
Eric Robbins, Counsel
Martha Barnes, Committee Secretary

OTHERS PRESENT:

Bobette Bond, Unite HERE Health
Josh Griffin, MGM Resorts International; Health Services Coalition
Chelsea Capurro, Health Services Coalition
Russell Rowe, Boyd Gaming Corporation
Jim Sullivan, Culinary Workers Union Local 226
Tom Morley, Laborers International Union Local 872
Regan Comis, Nevada Association of Health Plans

Alfredo Alonso, United Healthcare Services, Inc.
Ryan Beaman, Clark County Firefighters Union Local 1908
Jay Parmer, America's Health Insurance Plans
Jim Wadhams, Nevada Hospital Association
Todd Sklamberg, Chief Executive Officer, Sunrise Hospital and Medical Center; Sunrise Children's Hospital
Chris Ferrari, Dignity Health-St. Rose Dominican
Dean Polce, President, Nevada State Society of Anesthesiologists
Bret W. Frey, M.D., American College of Emergency Physicians, Nevada Chapter
Karen Massey, Nevada Medical Group Management Association; Executive Director, Northern Nevada Emergency Physicians
Dan Musgrove, The Valley Health System
Kathleen Conaboy, Nevada Orthopaedic Society
Catherine O'Mara, Nevada State Medical Association
Misty Grimmer, North Vista Hospital
Nick Vander Poel, Nevada Osteopathic Medical Association
Matt Griffin
Chris Daly, Nevada State Education Association
Fran Almaraz, Teamsters Local 631; Teamsters Local 986
Joan Hall, Nevada Rural Hospital Partners Foundation, Inc.
Chris Bosse, Renown Health
Janine Hansen, Nevada Families for Freedom

CHAIR SPEARMAN:
I will open the hearing on Assembly Bill (A.B.) 382.

ASSEMBLY BILL 382 (2nd Reprint): Establishes provisions governing payment for the provision of emergency services and care to patients. (BDR 40-570)

ASSEMBLYWOMAN MAGGIE CARLTON (Assembly District No. 14):
The purpose of A.B. 382 is to deal with surprise charges from hospitals. In the initial draft of A.B. 382 there were a number of different provisions addressing how we could facilitate the resolution of surprise bill charges. I have provided documents for the Committee to review, "Out-of-Network Emergency-Physician Bills—An Unwelcome Surprise," by Zach Cooper, Ph.D., and Fiona Scott Morton, Ph.D., in *The New England Journal of Medicine*, November 16, 2016 (Exhibit C); "Most doctors and nurses don't know what ER care costs," by

Lisa Rapaport in *Reuters*, May 30 (Exhibit D), and the Centers for Medicare and Medicaid Services, Hospital Charges in Nevada (Exhibit E).

A provision that had a two-prong test which was difficult to work around was amended out of the bill. Finding an actual number for a reasonable rate is almost impossible. One rate does not fit all entities. After reaching a resolution, all stakeholders agreed the patient needed to be taken out of the middle of this issue. Within the triangle of the patient, hospital and the insurer, the patients will complete their responsibilities by paying their copays and submitting their premiums. Then the sophisticated parties within the insurance companies and hospital facilities will take over from there.

Mediation arbitration language was added to the bill to ensure all parties will sit down and have a conversation. The bill was amended to state a reasonable rate because I wanted to ensure the rates are reasonable. The affected parties are still working with me in an effort to get this language right, but we are not going to agree. I hope we can still keep the patient out of the middle and make sure the arbitration provisions work well.

This bill does not apply to the University Medical Center of Southern Nevada, it does not apply to hospitals with fewer than 100 beds, and it does not apply to the Public Employees' Benefits Program. My goal with this bill is to make sure the patient is taken out of the middle and hospitals and insurers work out a reasonable price for patients.

Through no fault of their own, patients end up with huge bills full of surprise charges, either by going into the wrong hospital emergency room or having an emergency room doctor who was not in their network. I would like to have resolution for these constituents in Nevada.

SENATOR HARDY:
Who gets to decide what is reasonable?

ASSEMBLYWOMAN CARLTON:
We were trying to work that out last night. I think the arbitrator will be making the decision on what is reasonable. The insurance companies and hospitals know what is reasonable. If they make an unreasonable offer to each other, the arbitrator may look at the issue and determine they did not work in good faith.

In arbitration, both sides have skin in the game. Hopefully, this will incentivize both sides to have a conversation prior to arbitration.

In the past if people were out of network, the insurance companies and hospitals sat down and figured out a reasonable rate. I am hoping this same process can be repeated.

Assembly Bill 382 is not meant to incentivize anyone to leave existing contracts. We do not want insurers not to have contracts with hospitals. We want them to have contracts because we want patients to be protected. We want the hospital to have the stability of knowing who it contracts with, so it has a good working business model and can ensure patients are getting the care they deserve.

This legislation is for the few instances when charges are very large. Many of these cases will be settled by all sides sitting down to work out a resolution. I would not propose contracts to be eliminated. Hospitals need contracts.

SENATOR HARDY:
I see you included network physicians, so it is not just hospitals affected by this bill. A network physician will not charge as much as a hospital, so every one of these patients is an individual and every one of those physicians is an individual and each one could go to arbitration. Will this be a burden on the process of arbitration?

ASSEMBLYWOMAN CARLTON:
The anecdotal discussions we had determined 50 percent to 60 percent of these cases will probably be decided using the reasonable rate. There is the inadvertent hospital stay or the out-of-network doctor. The bill is received by the patient. The patient pays the copayment. The insurer gets the bill from the patient. The insurer then reaches out to the hospital to negotiate a reasonable rate. The insurer will make an offer, and an offer will be returned by the hospital. If there is no agreement, they will end up in arbitration. The fiscal note has been removed from the bill because we are able to use some reserve money from the Office for Consumer Health Assistance to hire a contract person who specializes in this type of case. It will be interesting to see in the future how many of these cases do go to arbitration. Because so many of these issues are anecdotal, it is hard to base anything on data. In two years, if this bill passes,

we will have data to determine the real problem and how to address it to make it better.

SENATOR WOODHOUSE:
When you were first speaking about arbitration, you also used the word mediation. Is mediation still a part of this process? In other cases, mediation is the step before arbitration.

ASSEMBLYWOMAN CARLTON:
It is full arbitration and it will be binding.

SENATOR HARDY:
It is my understanding, following the arbitration, the arbitrator determines one as the winner rather than splitting the difference, such as what might happen during the mediation process.

ASSEMBLYWOMAN CARLTON:
The discussion resulted in both parties paying their portion of whatever the cost is so both would have skin in the game. If the cost of arbitration is $1,000, each party would pay $500. Each party should plan to make its best and final offer to ensure the best standing going into arbitration. This should incentivize people to make that best offer.

SENATOR HARDY:
In essence, the payer would have nothing to lose.

ASSEMBLYWOMAN CARLTON:
The payer could have something to lose because if one party makes a low-ball offer, the arbitrator could look at the cost-to-charge ratio, usual and customary or a number of other things to help him or her make a determination. The arbitrator could also say the entity did not present a reasonable offer and did not conduct good-faith discussions; therefore, both parties will pay a certain amount based on the bill charges. In this scenario, no one would be able to get away with making an unreasonable offer.

SENATOR HARDY:
If you have an arbitrator going over something as arbitrary as a reasonable cost, how do you determine the standard to be used by the arbitrator?

ASSEMBLYWOMAN CARLTON:
The goal is to take the patient out of the middle and have the two sophisticated parties sit down to negotiate what they believe to be a reasonable rate. If they cannot reach a resolution, the consultant would be making the final determination. During the Interim Finance Committee meetings and next Session, we will be able to analyze the data to understand what is actually happening with billed charges. All of the information we have now is anecdotal, except for the patients who have shown us their bills.

SENATOR HARDY:
If there is no set standard for the arbitrator to review, then it becomes arbitrary.

ASSEMBLYWOMAN CARLTON:
These are the types of parameters we have been negotiating up until last night. I believe a hired sophisticated consultant would understand how to conduct himself or herself through the process. I do not think we need to micromanage the consultant who would be the arbitrator through legislation.

CHAIR SPEARMAN:
The goal is to take the patient out of the middle and have the sophisticated parties get to a place where it is fair and reasonable. Some states have gone to a model where there is arbitration if the charges go over the threshold amount. We do not want arbitration to occur over a bill for $79. Is this relevant?

ASSEMBLYWOMAN CARLTON:
I have been asked about setting thresholds. I can provide you with anecdotal evidence of why that will not work. In a hospital setting, the doctor will come in and review the patient. The patient is in the hospital for 20 days. Every time the doctor walks through the door he reviews the patient's chart, checks his or her blood pressure, listens to the heart and charges $179 for that day. If the patient was in the hospital for 20 days, the doctor, as his business practice dictates, could charge $179 for 20 days. If a threshold is set, that patient would be responsible for the $179 per day charge because it is below the $200 threshold, depending upon how the doctor actually bills the patient since the doctor does not bill in conjunction with the hospital. The doctor bills separately. From my own personal experience in having a family member in the hospital, I was literally receiving a bill every day because of the way billing is generated. This could happen if a threshold is set; multiply the $179 times the 20 days and that patient will be responsible for that total cost. A threshold would not get the

patient out of the middle. The patient would still be liable for the dollars even though the patient had paid the copay and premium but—through no fault of his or her own—ended up with an out-of-network doctor and significant charges.

CHAIR SPEARMAN:
During the exchange with Senator Hardy you mentioned a consultant. Can you elaborate on that?

ASSEMBLYWOMAN CARLTON:
It was part of the amendment because the original bill had a fiscal note. We removed the Division of Insurance of the Department of Business and Industry because of the reporting. There was no reason to continue with reporting if we were not going to be setting rates. In order to remove the fiscal note instead of utilizing personnel, there is a reserve account that can be used to hire a consultant for a two-year period just to see how this works. It would not be responsible to hire a State employee if we do not know how this is going to materialize. After two years, if we see the workload is there and need a State employee or additional resources, I will come back and ask for them. By hiring a consultant we can get someone knowledgeable in this type of work.

SENATOR HARDY:
One of the fiscal notes was from the Public Employees' Benefits Program for $641,624. Was this fiscal note removed from the bill?

ASSEMBLYWOMAN CARLTON:
Yes. There is no longer a fiscal note attached to the bill.

SENATOR HARDY:
Would it be safe to say a reasonable cost to the patient would be equal to or less than the in-network cost to an out-of-network patient? Is the reasonable charge more than the contracted rate, less than the contracted rate or equal to the contracted rate?

ASSEMBLYWOMAN CARLTON:
This has been the biggest part of the discussion to date. When we began working on this bill in February, I could not see reasonable charges being less than the network rate because it would not incentivize people to stay in network. I think it should be more than the network rate being able to determine an actual percentage. The hospitals all have different cost-to-charge ratios. We

have hospitals that have service for high Medicaid populations, so it would be difficult for these hospitals to determine what their rate would be. We do have insurers in the State that do not contract certain things. We would not want to incentivize these hospitals to stay out of contract.

A reasonable rate would be above contract to make sure people want to go back into contract but not at the rate of the surprise charges at the end of the spectrum.

SENATOR HARDY:
We have been talking about hospitals so far, but physicians are also part of the equation. Do you expect the same type of philosophy for the physicians?

ASSEMBLYWOMAN CARLTON:
Yes.

SENATOR HARDY:
Will a reasonable cost be over and above the usual contracted rate of pay?

ASSEMBLYWOMAN CARLTON:
We do not want to set a reasonable rate that is lower than the contracted rate because people would not be incentivized to stay in contract. The contracts would be dropped, and we would have a huge problem to deal with. Contracts are good for the insurers, the patients, the hospitals and the physicians. You will know what the rate is going to be. This is a good business model with stability, and everyone knows what the cost will actually be. This is a quantifiable number.

In the original bill, Medicare was listed, and it was just not feasible. We talked to a cost-to-charge ratio, and that would not work. Every profession is a little bit different. It is different for anesthesiologists, osteopaths, other specialists and the hospitals. We could not come up with an actual rate. There were numerous proposals as both parties worked in relatively good faith. This is the closest we have come to solving this problem in over 16 years. In order to protect the patient, we set up this process in A.B. 382 to get the patient out of the middle.

SENATOR HARDY:
I am looking at this quantifiable number as a physician. I can go to jail if I tell someone else how much I charge my patients. This will not be a quantifiable

number if you focus on the physicians. The quantifiable number is problematic. One of the other problems we have is the payers have narrow networks. It is not common to have every doctor in a contract because the process of being part of the network is limited. If the idea is to get into the network with a contract, that is not the way it works for physicians. One of the advantages of the contract is the set number of patients you know you can count on. It seems you are trying to make the bottom line work without being able to predict a physician's income.

ASSEMBLYWOMAN CARLTON:
It is all about not incentivizing people not to contract. I do not want to impact current or future contracts. As far as the quantifiable rate, I understand, as that was one of the problems we had when trying to set a rate when we heard this bill in the Assembly. The ultimate goal is to never incentivize someone to go out of network. We understand there are some physicians who do not want to go into contract, and that is their business choice. I do not want this bill to incentivize people to go out of contract and give people a better deal than they deserve.

BOBETTE BOND (Unite HERE Health):
Assembly Bill 382 relates to a doctor seeing a patient after the patient unintentionally or through no fault of his or her own ends up in a hospital that is not contracted or a hospital that is contracted with a physician who is not contracted. This bill pertains to emergency health care. This type of thing does not happen when a patient can make an elective decision about how to handle his or her own care. The bill pertains to a circumstance when the patient does not have a choice because he or she is taken to the closest hospital by ambulance due to transport protocol.

Health plans already pay basic rates through the Affordable Care Act (ACA). We can pay one of three options for the services we receive now. This will not change or go away. The implication that there will be some tiny payment is not correct because we are responsible for thresholds. We are here because of this chart, Average Billed Charges Per Adjusted Inpatient Admission (Exhibit F) which is the growth in bill charges. While we are having trouble determining a rate, we all agree that bill charges are just not working. The patients Senator Hardy is referencing are those who receive their medical bills in the mailbox. This is a way for the bill not to show up in the mailbox but to be a process between the insurers and the hospitals or the payers and the doctors.

Many physicians do not worry about their networks because they are seeing these patients in the hospital and they do not have a practice on the side. These physicians are the anesthesiologists or the emergency room physicians, and they do not need to have a network.

JOSH GRIFFIN (MGM Resorts International):
We have been talking about this issue for a very long time. We strongly support A.B. 382. MGM Resorts employs over 50,000 Nevadans. Adding families to the list brings the number to over 100,000 lives that are insured. When we talk about this practice of surprise billing, the most appropriate description is patient protection. We think this bill is a good step forward to protect those patients whatever the circumstance is between a provider and a payer. We do not think the patient should be in the middle of this issue. This bill sets up a framework for the patients to be protected.

CHAIR SPEARMAN:
Tricare benefits cover military personnel all across the Country. How does what is being encouraged by this bill comport with what you do in other places where MGM has properties?

MR. J. GRIFFIN:
I am addressing Nevada specifically because the bulk of the properties are here.

CHELSEA CAPURRO (Health Services Coalition):
The Health Services Coalition is comprised of 21 employer and labor health funds covering just under 300,000 lives. Assembly Bill 382 is a measure which ultimately recognizes the most important part of the process, and that is the patients. It takes them out of the middle and keeps them from receiving surprise bill charges. These surprise bills can have a devastating effect on patients and their families at no fault of their own at a time when they have no choice in the matter. This bill simply takes the patient out of the process, and we appreciate the community support.

I will also point out that section 21.5 requires a report to be presented to look at issues like the results from arbitration and how often it got to that point. There is a mechanism in place to help identify the problems and provide data for the Legislature to review in the future.

RUSSELL ROWE (Boyd Gaming Corporation):
Boyd Gaming has roughly 10,000 employees with their insured families covered in southern Nevada. We strongly support this legislation.

JIM SULLIVAN (Culinary Workers Union Local 226):
We support A.B. 382. The Culinary Workers Union believes Nevadans should not have to face crippling medical debts when being taken to out-of-network hospitals, especially when these same hospitals are making millions in profits. We ask you to take the patients out of the middle of this process.

TOM MORLEY (Laborers International Union Local 872):
We support A.B. 382.

REGAN COMIS (Nevada Association of Health Plans):
We also want to register our support of A.B. 382. We feel the most important portion of this bill is to remove patients from the middle, so they no longer receive surprise bill charges.

ALFREDO ALONSO (United Healthcare Services, Inc.):
We are in agreement with the interpretation of the Committee that the ACA has created a floor for the Medicaid or network rate or for usual and customary charges. We support the bill.

RYAN BEAMAN (Clark County Firefighters Union Local 1908):
I am representing our self-funded insurance trust. We support A.B. 382.

JAY PARMER (America's Health Insurance Plans):
We support A.B. 382.

JIM WADHAMS (Nevada Hospital Association):
The sponsor of the bill has kept stakeholders in discussions throughout the Session. We have spent a great deal of time on this complex issue. We had come to some critical agreements early on when we were trying to keep the patient out of the middle. We also needed to identify a fair way to resolve the differences between the payers and the providers. Mention of the ACA is interesting but not necessarily compelling because it does not address the balance. The ACA allows the balance to be billed to the patient, and that is what we are trying to avoid. Finding the process to resolve this is critical. We have discussed several options and think arbitration is appropriate. The bill

refers to mediation. Some of the questions asked by the Committee focused on the possible differences and may have provided some of the confusion.

One of the early agreements was for the compensation to be more than it is under contract. Contracts are priced with comprehensive services including both the emergency room and inpatient services. When we isolate one that is not in a bundled volume contract, we need to be careful to determine what would be a fair market price to reimburse the service provider for that single standalone service.

CHAIR SPEARMAN:
Did you state the services are bundled?

MR. WADHAMS:
Yes. We are fortunate to have a hospital executive who can provide the Committee with more detail. When the contracts are negotiated, they are negotiated based on the potential volume of patients that may come through the door for service. If the insurer-payer has 300,000 patients, that hospital could statistically estimate how many would be coming through its facility. The hospital would be able to price emergency room services as a component, then inpatient services as another component. The distinction becomes critical because if the patient is only here for the emergency room visit and does not go into the inpatient for remaining services, the balance of the contract negotiation is undermined. There are facilities that negotiate contracts for emergency or trauma services only. Those would be the contracts that should be based upon, not a volume-bundled contract.

TODD SKLAMBERG (Chief Executive Officer, Sunrise Hospital and Medical Center; Sunrise Children's Hospital):
I am here to share the significant impact A.B. 382 would have on Sunrise Hospital, the health care community and the residents of Nevada. Sunrise Hospital and Sunrise Children's Hospital is a 690-bed tertiary, full-service hospital serving patients from the entire State and surrounding southwest region. Our average daily census is over 640 inpatients; last year we served over 167,000 patients in our emergency center. We are the largest emergency room in the State and one of the top 15 emergency rooms in the Country.

We are the State's largest Medicaid provider with 42 percent of our inpatients and 57 percent of our emergency room patients covered by Medicaid. That is

over 95,000 emergency room patients covered by Medicaid. We commit to serving this population when we get reimbursed slightly more than half of our costs. Despite the financial constraints due to Medicaid reimbursements, Sunrise Hospital has made a commitment to our community and is vested to bring the latest technology and procedures to our patients. We provide all of the pediatric heart care for children and are the only accredited rehabilitation program. We operate the largest and most comprehensive adult cardiac program in the State. Providing these programs and access to care requires investment and the ability to recruit and retain the best physicians, nurses and staff.

Legislation contained in A.B. 382 as written today will 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 significantly impact our ability to bring physicians or expertise to Nevada. Bringing new technology to the State would stop. I along with my colleagues would be forced to continue to close programs, eliminate high-cost procedures and drugs. This is not a threat but a reality. In fact, Sunrise Hospital closed our infusion center two months ago. We also had a reduction in force of more than 50 positions last month. This was not due to volume, as our volumes remain at record levels, but as a result of the underfunding of Medicaid reimbursements and continued growth of uncompensated Medicaid care.

The bill in front of you today is intended to protect patients from out-of-network fees. I support the intent and remain consistent with my objective of striving to be in-network with all payers. However, the intent of the bill and content in the bill are not consistent. The language you are considering today is aimed at chiefly reducing the financial burdens of the payers at the expense of access to care. For this legislation to be effective, all parties must equally share in the pain. This bill's language provides little incentive for payers to contract with health care providers once they go out of network. What it will do is further reduce hospital revenues necessary to provide comprehensive and high levels of care. This bill is an acknowledgement that is satisfactory for the State to remain 51 out of 50 states in the number of physicians per capita.

SENATOR HARDY:
How many of the physicians caring for these 640 patients every day are actually hired by the hospital? Do these physicians have their own practices? Where will these physicians be if the hospital cannot meet its obligations?

MR. SKLAMBERG:
Sunrise Hospital only employs four physicians, the rest of the physicians who provide service at the hospital are contracted. The emergency room physicians, hospitalists and subspecialists are independent practitioners.

SENATOR HARDY:
Would all of those physicians have to go to arbitration if they do not like the payment they received as a reasonable payment option?

MR. SKLAMBERG:
I cannot speak for the physicians but based upon my background and experience, I believe that would be the case.

SENATOR HARDY:
The physicians would not be partnering with you because you are not their employer.

MR. SKLAMBERG:
That is correct.

CHRIS FERRARI (Dignity Health-St. Rose Dominican):
We are in opposition to A.B. 382. Dignity Health-St. Rose Dominican is a not-for-profit health hospital provider founded 70 years ago. We came to Henderson, and our nonprofit status allows us to turn excess dollars into community benefit. Last year, St. Rose provided $113 million in public health programs in southern Nevada for those most in need. The forecasted budget impact to our three primary hospitals with the passing of Assembly Joint Resolution (A.J.R.) 14 is $100 million per year. We are still crunching numbers for A.B. 382. I have submitted a FAIR Health Spotlight on Nevada document (Exhibit G) and a FAIR Health Snapshot document (Exhibit H) for the Committee to review.

ASSEMBLY JOINT RESOLUTION 14 (1st Reprint): Proposes to amend the Nevada Constitution to ensure access to affordable emergency medical care at reasonable rates to all persons in this State. (BDR C-1218)

Lost in part of this debate is the human side. We certainly all understand what we are trying to accomplish, but hospitals and doctors serve Nevadans. They provide medical care in an emergent, life-threatening situation on a daily basis to

ensure we are all safe. The bill says that hospitals and doctors shall accept a reasonable rate offered by the insurance company. I think the term reasonable can be debated, but the proposed law creates an uneven playing field allowing insurance companies a benefit in contracting and negotiating. Hospitals have a very low reimbursement rate of 53 cents on the dollar for Medicaid, 80 cents on the dollar for Medicare. How many businesses can operate at a net deficit, charging their customers less than it costs to provide the actual care?

Dignity Health-St. Rose Dominican is also in the process of opening four neighborhood hospitals around the Las Vegas Valley, the first of which will open later this month at Martin Luther King Boulevard and Craig Road. The microhospitals will provide full emergency services to areas in need and provide significant benefit to the community. The bill sponsor talked about negotiations and the bill bringing valuable data forward. During the negotiation process, we offered a way to find conflict-free, independent data from the nonprofits' database with 23 billion records to review rates set. Sanctioned by the Centers for Medicare and Medicaid Services, the database consists of all Medicare data used by the U.S. Department of Health and Human Services, the Government Accountability Office, and the Center for Consumer Information and Insurance Oversight in about 15 states.

SENATOR RATTI:
The compelling testimony from the sponsor of the bill is that we have been trying to fix this problem for 16 years. During those years, the patients have been in the crossfire between the insurance companies and the providers. We cannot go another Session with this being the case. If not this bill, then how do we fix it? What are the barriers?

MR. FERRARI:
No policy would be better than bad policy. The way this bill is written, we do not believe it is in the best interest of the patient. The process is complicated because of percentage-of-cost charges, bill charges and a percentage of a particular indicator. States are looking at ways to do this creatively by use of such determinants as FAIR Health with 23 billion health care records.

SENATOR RATTI:
You quoted some data figures, and I heard from the sponsor that this bill has been narrowed exclusively to patients who have no choice. It will not be me when I wander in after midnight with my sprained ankle. This is somebody

through no choice of his or her own is transported in an ambulance, to an unchosen hospital, but the decision is based on ambulance transport protocol. Does this narrow the economic impact for your properties?

MR. WADHAMS:
The bill now applies to anyone who presents at the emergency room for a medically necessary emergency service. That may very well be a sprained ankle, but it might not cover strep throat. Clearly, an ambulance transport would be included. The scope of the people who will access this system is much broader than the unconscious ambulance transport.

In fairness to the marketplace, we refer to an ever-increasing narrowing of networks as skinny networks. The more narrow the network, the more opportunity for being out of network. That problem is not particularly well addressed in this bill.

SENATOR HARDY:
How many networks do you have? How many contracts do you have? How many plans do you find for people being treated in your facility who are not covered by the network? Is one of your challenges to find a certain percentage of people who are out of network that come for emergency care?

MR. SKLAMBERG:
We have approximately 30,000 patients who presented in our emergency room as out of network.

SENATOR HARDY:
Out of how many?

MR. SKLAMBERG:
The 30,000 patients are out of a total of 167,000.

SENATOR HARDY:
You have about one-sixth of the total that are out of network. Are these patients who have insurance coverage but it is out of network or do they not have insurance?

MR. SKLAMBERG:
Those individuals have their own insurance and their own networks. If they show up at Sunrise Hospital or Sunrise Children's Hospital for care, we service over 22,000 patients in our emergency rooms who are uninsured, self-pay and do not have a network.

SENATOR HARDY:
When I hear the numbers, you would be conducting a lot of arbitration and figuring out what reasonable is. It would nice to have some clue as to where reasonable begins rather than having to negotiate it each time with an arbitrator.

MR. SKLAMBERG:
With 30,000 out-of-network patients, although the offers should be reasonable, based on experience, our expectation is that we would arbitrate 30,000 cases. We would need to bring on dozens of resources to write the appeal and go through the arbitration process in addition to revenue being tied up for months as we go through the process.

SENATOR HARDY:
The process would take you away from your mission of taking care of the people who are poor.

MR. SKLAMBERG:
The resources needed to provide emergency care and services for the needy would be diverted.

SENATOR RATTI:
Not all of the 30,000 patients will show up at the emergency room, but your interpretation is that all 30,000 out-of-network patients will fall under this bill? You think they will meet that medically necessary definition.

MR. SKLAMBERG:
When a patient comes to an emergency room and tends to emergency services, using the layperson's definition of emergency services based on the current situation, it is an emergency. If they show up in an emergency room, resources are expended to provide care in a timely fashion. We provide high-quality care to all of those who seek services in our hospitals.

SENATOR RATTI:
I understand as a hospital you have certain federal laws and ethical standards that if a person shows up you cannot say certain things to them, you cannot turn them away and you must provide service. I understand that. I am not clear this law then applies to all 30,000 patients to trigger this process.

MR. SKLAMBERG:
Of the 50,000 patients, 20,000 are uninsured. We have a whole policy relating to discounts and charity care. Any patient presenting to our hospital under 200 percent of the poverty level receives a 100 percent poverty care discount and has no financial responsibility. The additional 30,000 patients presenting are receiving emergency services.

SENATOR RATTI:
I understand the charity system. This population is insured but out of network. Are you saying all 30,000 patients will be swept in under this bill?

MR. SKLAMBERG:
What I am saying is that all 30,000 who show up at the Sunrise Hospital emergency room are receiving the same level of emergency room service regardless of their diagnosis. They are triaged the same way, they are seen by the same doctors, nurses and respiratory therapists and receive the same level of care regardless of what the emergency is.

SENATOR RATTI:
So that is your standard operating procedure and standard of care. Is it your interpretation that these patients trigger the provisions in this bill?

MR. WADHAMS:
I will defer to Committee Counsel, but section 16.5 describes who is covered and section 11.5 references another statutory provision that defines medically necessary. As I understand the intent of the bill, this will apply to anyone who is covered by an insurance policy for which this hospital is not under contract. A person has insurance, but they are out of network. The person must be a resident of Nevada and the service must be medically necessary. If I have a headache and stop by the emergency room, that probably does not meet the definition in *Nevada Revised Statutes* (NRS) 695G.170. It might not be everybody, but true out-of-network emergencies means there is an insurance contract at some other hospital. One of the criteria is to have two contracts

with a hospital in Las Vegas or in Reno in order to activate the provisions in this bill.

SENATOR RATTI:
That explanation got to the heart of the question. I am trying to understand the impact. If it really is going to be all 30,000 patients going to arbitration, it is a significant burden. What I heard from the sponsor is that this bill is focused on people in crisis who have ended up at a hospital through no choice of their own.

ERIC ROBBINS (Counsel):
The bill goes into effect when someone is presented at a hospital or an independent center for emergency medical care for the provision of medically necessary emergency services. There is a reference to NRS 695G.170 for that definition. The section provides that medically necessary emergency services means health care services that are provided by a provider of health care after the sudden onset of a medical condition that manifests itself by symptoms with such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in serious jeopardy to the health of the patient, serious jeopardy to the health of an unborn child, serious impairment of a bodily function or serious dysfunction of any bodily organ or part.

SENATOR HARDY:
Along the same lines, when looking at the emergency room, could FAIR Health be reviewed? Is this something that could solve these challenges as an alternative?

MR. WADHAMS:
We had some very serious negotiations while trying to find a balance in the system that will be fair to both sides yet create some tension so that people would prefer to be payers, and providers would prefer to be in contract rather than benefit from being out of contract. There is certainly a database that could aid in the calculation of what an original and reasonable offer might be. It could be used by the arbitrator to determine whose argument is more persuasive at the end of that day.

SENATOR HARDY:
Does an arbitrator rule in favor of one or the other of the parties?

MR. WADHAMS:
There has been an evolution in alternative dispute resolution. This bill actually speaks to mediation with a binding determination at the conclusion. This is a new process and different than the traditional form of arbitration. There is a provision that the Governor's Consumer Health Advocate will draft regulations. I suspect that should the bill be processed, the regulations in the style, manner and contracting for arbitrators will be dealt with through that regulatory process.

DEAN POLCE (President, Nevada State Society of Anesthesiologists):
We are opposed to this bill. I am sensitive to extremely high bills incurred during emergency situations. It happened to my family; the difference is we were completely in-network with everything, but the insurance companies decided not to cover any of the services. For all of the patients who have been in this position, I condemn it in totality. I agree the patients should be taken out of the middle. It seems like the bill is hung up on the point of what can be paid for the out-of-network physician. I concur with the comments already made by previous testifiers.

In section 18, subsection 2, the initial offer for services already rendered—in all my experiences I have never seen anything worded like that—is problematic. Section 20, subsection 1 states that a third party review the in-network hospitals and in-network independent centers. Why would they need to do this? Why does the network need to be defined? For the anesthesiology community, we probably have more than what would be defined as a network because of the service and the way we have to cover surgeons and referrals. You will always need more. As soon as you allow the payers to define the network, you will have problems immediately.

Looking at section 21.4 in reference to mediation, as this bill is written, our group of anesthesiologists, which is the largest group of anesthesiologists in the State, would lose all of our contracts immediately. The bill says to consider as payment the average of the amount the third party pays, but the bill does not indicate who defines that amount, and we are already higher than the average amount. If you want this to be higher than the average contracted rate, this would eliminate half of the people who are contracted. The average for Medicare would be cancelled. Who will define the usual and customary? Who has that database? This needs to be defined. I will submit my written testimony (Exhibit I).

BRET W. FREY, M.D. (American College of Emergency Physicians, Nevada Chapter):
I am an emergency physician in Reno. I represent the American College of Emergency Physicians, and we service 1.5 million patients each year in Nevada. We, too, applaud the protection of patients as it is what we do all day long. It takes a lot to keep the doors open 24 hours a day, 7 days a week, 365 days a year, all day and all night for any problem at any time.

I have a call list of 29 specialists (Exhibit J) that I have the ability to call any time day or night to service my patients. It is a daunting task to keep this call list intact. These specialists need a fair and level playing field or they will not take calls. This has happened time and again statewide. It happened at the trauma center at the University Medical Center in 2002, creating a crisis. It has happened time and again with sensitive call issues, such as vascular, hand surgery and neurosurgery where patients had to be shipped out of state because those call services are not available in Nevada. This causes a great problem for the vulnerable populations of Medicare and Medicaid, especially Medicaid. I am very concerned about these vulnerable patients.

The reason the patients are caught in the middle is because their insurance companies chose not to cover them in their time of need. The patients were placed in the middle. We care for the patient and then on the back end, we are essentially demonized for sending a bill.

These surprise charges are not a surprise to me at all. They are actually due to a surprise gap in coverage. At the American College of Emergency Physicians, we believe that fair access is the result of fair coverage and, ultimately, fair payment. I would encourage the bill sponsors to take this into account. The stability of the system is at hand and patients' lives are at stake. I have also submitted my written testimony (Exhibit K).

CHAIR SPEARMAN:
I also received two additional documents, "Guidelines for Effective Policy Solutions to End The Surprise Insurance Gap" (Exhibit L) and "The Campaign to End the Surprise Insurance Gap Recommends FAIR Health" (Exhibit M).

SENATOR HARDY:
Are you employed by the hospital?

DR. FREY:
I am not employed by the hospital, and I have contracts with 99.5 percent of payers in my market.

SENATOR HARDY:
How often does the issue of out-of-network surprise bills come up and affect you?

DR. FREY:
It is a rare event that I would send a patient a bill that is not in-network because my out-of-network rate percentage of business is very, very low.

SENATOR HARDY:
Is that the same for other emergency room physicians?

DR. FREY:
Out of 1.5 million emergency room visits, there were about 360 out-of-network events in emergency medicine based on data collected by the Governor's Consumer Health Advocate.

SENATOR RATTI:
If the high percentage of patients you are seeing are in-network, then why are you opposed to this bill? It does not sound like it would even affect you.

DR. FREY:
I believe the contracted environment simply falls apart with this bill. The word reasonable has no merit when it comes down to brass tacks. When services are rendered and you are trying to get payment, who determines reasonable? I helped put forth legislation earlier this Session to solve this equation that is effective in New York and Connecticut. The database being used by these states is called FAIR Health.

SENATOR RATTI:
Are you saying this will not affect you directly, but you are afraid it will affect the system?

DR. FREY:
I am afraid for my patients and for the 1.5 million patients who receive emergency room services in Nevada every year.

SENATOR RATTI:
Referencing the database that indicates all of the out-of-network emergency room visits, the number was 300 or so per year?

DR. FREY:
That was the number of complaints sent to the Governor's Consumer Health Advocate.

KAREN MASSEY (Nevada Medical Group Management Association; Executive Director, Northern Nevada Emergency Physicians):
Emergency room groups and anesthesiologist groups absolutely contract for the networks. Our particular group is in-network with all of the contracts we see in our market. We have one insurer that is out of network. The reason we are out of network with that insurer is it has offered a rate far below the market. When we do not take the offered rate and a patient comes in with that insurance, they are out of network. On the back end, we try to discount the rate but do not have the ability to require the insurer make the patient in-rate. This is how the patient ends up being out of network in our particular scenario.

Our concern with the market dynamic in this bill is that if that patient is now able to enjoy a better rate through this legislation than the contracted rate we have with our good partners in our marketplace, the current environment of contracting will be destroyed. We are generally in-network for almost everything, but our concerns are the bill as written, will affect the incentives in the marketplace and drive more patients out of network. This will cause people to have an incentive to reduce the contracts.

Our group average bill is $800. When we talk about the arbitration being $500, and I am the sophisticated party, and we need to retain people to participate in this process, it creates a whole new regulatory structure for us. It also creates some strange incentives about how we might need to write off bills or decide to go through arbitration. That does not make business sense. A routine part of my job is to participate in interviews with physicians. This will affect their decisions about moving to Nevada. I have submitted my written testimony (Exhibit N).

SENATOR RATTI:
Did you say the crux of the problem is this bill will force you into relationships with people that you chose not to have relationships with?

MS. MASSEY:
It is not a concern that we are forced into the relationship, it is when the legislation forces us to give a favorable deal to someone who has not contracted with us, our good partners will wonder why they need to stay in contract with us. I am being foolish because my competitor who has low bid for years and left its patients out in the cold now enjoys the benefit of this legislation—perhaps I should too. The insurers have to go to an employer to sell their product. When those good partners have a higher cost structure than the one who got to enjoy some of the provisions of this bill, now we have encouraged our good partners not to continue to contract with us. This is our primary concern. Our biggest concern is not the rate that is set for 0.5 percent of the patient population but the potential dynamics this bill will impose on the contracting environment.

DAN MUSGROVE (The Valley Health System):
We have 8 hospitals statewide with over 177,000 emergency room visits and 1,800 licensed beds. This whole situation for the past 16 years has all been about perception. I want to give you one more look at what potentially is the surprise. Dr. Frey talked about the surprise gap in coverage and the proponents talked about the surprise about the bill charges.

A patient presented at Centennial Hills Hospital Medical Center just last year and received $3,000 in charges for a 1-day stay. The insurance reimbursement was $13, so the hospital now has to chase the remainder with the patient. The great thing about the exercise we are trying to accomplish today is to take the patient out of the middle. We should not have to go after the person for that kind of surprise gap in coverage. It is not fair to the person who is paying insurance and it is not fair to the hospital to have to collect from those folks if we can come to an agreement about what is fair and reasonable and what keeps people at the table, what keeps us contracted, because the object is to have everyone in contract. You heard the doctors talk about the imbalance.

A person was at Spring Valley Hospital for 1 day and the charges were $13,000, and the insurance company reimbursed the hospital $250. Once more the hospital had to go after the patient in an attempt to get paid. We want to work with the sophisticated party and receive a reasonable and fair market value offer.

SENATOR HARDY:
Would the data from FAIR Health help?

MR. MUSGROVE:
I do not think the hospitals have ever looked at the FAIR Health information like the physicians have. It sounds as if it could be a third party, that might be able to help us determine a fair rate of compensation for the market and service. You have heard that Medicare does not cover emergency services the same way that we do when we contract with providers. What is going to be fair compensation? It is worth talking about.

KATHLEEN CONABOY (Nevada Orthopaedic Society):
We have consistently worked on the provisions in A.B. 382, but we remain in opposition to the bill. There were three things we were trying to accomplish in meeting with the sponsor of the bill. We wanted to ensure the patients would be held harmless after they paid their copay and their deductible. The bill does not address what level of copay or deductible would be paid. There is often a huge difference between the out-of-network copay and deductible and the in-network copay and deductible. These items are not defined in the bill.

The solution is supposed to be designed not to undermine the stability of the medical marketplace. This has not yet been accommodated in the provisions of the bill. The incentives are supposed to remain intact or be strengthened to maintain the process of contracting between insurers and physicians and between insurers and hospitals. I was asked, why after all these years is there no solution? In the many years we have been discussing this issue, the suggestions for solutions have consistently been the same suggestions. They have all been reiterations of some federally resourced barometer like Medicare.

We tried to be innovative and presented a market-based approach very different from a resource-based approach like Medicare. The resources of the federal government are divided among the number of patients served.

CHAIR SPEARMAN:
When the contracts are negotiated, are they negotiated with hospitals and insurance companies? How do they get to those contracts?

MS. CONABOY:
The physicians I represent contract as groups with an insurance company for a spectrum of services. The physicians like to be contracted with an insurance company. The contract ensures a flow of patients who are covered by that insurer. The physicians know what they will be paid. The patients who visit a contracted doctor feel confident their bills will be covered by their insurance companies. It is a good practice because it keeps the marketplace stable. Our physicians seek out contracts just like the insurers seek out physicians to fill out their networks.

SENATOR RATTI:
If that is the case for the process, how do we end up with thin networks?

MS. CONABOY:
Networks are thin because the insurance company sees it as a way to manage costs. The insurance companies deal with physicians who they feel are effective in the way they provide care and in what they charge. There were some provisions when the medical community worked on the network adequacy regulations which took about two years to accomplish. We had asked for consideration to be given to parameters suggested by the American Medical Association which are not evident in the Nevada regulations. Things like what are the quality parameters being used to evaluate a physician when allowed or disallowed in a network.

CATHERINE O'MARA (Nevada State Medical Association):
I would like to ask the Committee to look back at the testimony provided when this bill was heard in the Assembly. There was a lot of testimony with pertinent information provided in those hearings that cannot be duplicated here because of the time constraint.

The goals that have come out of this process are to protect patients but also to continue to encourage contracting. Nothing in this bill is intended to discourage contracting. Incentivizing contracting is good for Nevada patients. We wholeheartedly agree with these goals. This bill does not get us there. This bill takes the patient out of the middle which is the first goal, but it does not encourage contracting; in fact, we believe it discourages contracting. Constituents are very concerned about the impact on the medical community in Nevada and our ability to recruit and retain physicians to this State. This bill does not just affect the emergency room physicians but also the on-call

physicians. We are fifty-first in the Nation for most of these specialties. We have a physician in Las Vegas, a pediatric gastroenterologist, who is one of six in the State. It takes him years to recruit physicians to Nevada. If he is unable to negotiate contracts for the times when he is on call and deals with emergency care, he will not be able to offer a good environment for other recruits who he would like to bring here.

A University of Nevada, Reno, School of Medicine student contacted me to provide a letter of opposition to the Committee regarding A.B. 382 (Exhibit O). This student would like to be an emergency room physician and come back to Reno. He is very concerned about the impact of this bill and other pending bills that deal with similar issues on our health care delivery system. While you are trying to protect the patients, we need to understand the problem first. What is the problem with out of network as it relates to the physician services bill? I do not think we have a good handle on this yet. As you are trying to solve that problem, do not create another problem which is access to care.

MISTY GRIMMER (North Vista Hospital):
We are the only hospital in North Las Vegas and are in opposition to A.B. 382. Much of what has been said today is complicated. We agree the patient should not be in the middle. The patient ends up in the middle because somebody made a choice. The hospital has to treat the patient, the physician has to treat the patient. We have an obligation by federal law to treat the patient, and we often do it by saving someone's life. The party who made the choice to put the patient in this circumstance is the insurance company. This is the company that has a contract with the patient. Either the person or his or her employer pays premiums to the insurance company for coverage. Based on these premiums, the person presumes coverage when he or she presents at a hospital. The person assumes that when seeking emergency care, the cost will be covered by his or her insurance plan.

NICK VANDER POEL (Nevada Osteopathic Medical Association):
We are in opposition to A.B. 382. Dr. Bruce Fong, President of the Nevada Osteopathic Medical Association testified in the Assembly Committee on Ways and Means on May 27 and presented a document I encourage you to read.

SENATOR RATTI:
There have been many references from the testifiers regarding this database called FAIR Health. I am assuming through the conversations that this was considered. Is there a reason you chose not to go with FAIR Health?

ASSEMBLYWOMAN CARLTON:
I did not consider FAIR Health. When I looked at the bill charges and the percentage of bill charges, it would not get the patient out of the middle. Patients would still be responsible for something that through no fault of their own happened to them.

SENATOR RATTI:
I thought I heard you say through the process of negotiating on this bill that it was your intent to narrow the bill to only those people who presented to an emergency room by no fault of their own. We talked about the person presenting with a headache or a rolled ankle. Did you say the bill did not sweep in these people?

ASSEMBLYWOMAN CARLTON:
The way the health plans work, if the service is not a true emergency, it is not covered. This is for emergencies only whether you walk in or come in by ambulance. By ambulance, you may not have a choice; because of transport protocol, you will be taken to the nearest hospital to where you were picked up. I live on the east side of Las Vegas, and my kids are playing soccer on the northwest corner. If someone breaks an arm or leg or needs stiches, I am not going to drive all the way over to the east side of Las Vegas. I am going to take that child from the soccer field to the nearest hospital for care. Through no fault of their own, the family is taken to the emergency room and either the hospital or a doctor is out of network.

SENATOR RATTI:
Did you say the rate offered should be higher than the contracted amounts so there is no reason for people to avoid contracting just to get this rate?

ASSEMBLYWOMAN CARLTON:
Yes. Nobody wants to incentivize bad behavior. We want people to negotiate a contract. If we could have every hospital and network, it would be great. But we cannot make people contract. A number of proposals were made at 110 percent of network and more. The problem is how complicated the issue is,

and there is no magic solution to solve this problem for anyone. The magic solution takes the patient out of the middle and puts the two sophisticated parties at the table through arbitration with the guidelines in the bill. Usual and customary can be billed charges, and the arbitrator can use that information. They must weigh all of the options. The patient will be out of the middle and the insurance company will take care of the charges. It is not the fault of the insurance company that one of its members ended up in an out-of-network hospital or was treated by an out-of-network physician. It is an emergency and what insurance is for. Technically, the insurance does not have to cover the costs for service. I know through experience that most insurance companies will try to help their customers because that is what we pay a premium for.

SENATOR RATTI:
Is there a way to put in instructions to the arbitrator that it should be no lower than the lowest contracted rate?

ASSEMBLYWOMAN CARLTON:
Section 21.4, subsection 2, states the procedure established by regulation that there is a three-prong test the arbitrator will consider utilizing paragraphs (a) the average amount the third party pays; (b) the average amount paid by Medicare; and (c) the usual and customary charges for the same or similar emergency services. We have offered many different schemes to every one of the stakeholders trying to address all of their issues. I have not found a universal formula. Having these three options for an arbitrator to consider in dealing with these bill charges gives the parameters to make a fair and just decision. Hopefully, everyone will bring their best and final offer to arbitration.

SENATOR RATTI:
Your intent is to provide the arbitrator enough direction with these guidelines and enough flexibility to say it does not have to be the highest of these three guidelines.

ASSEMBLYWOMAN CARLTON:
It is all about fairness. Every hospital will be different. Every patient is going to be different. Every instance is going to be different. We hope after a few years, a pattern may develop. We have some anecdotal evidence that some insurers do not contract as well as we would hope. We are going to identify the good actors and the bad actors so we can make better decisions for the constituents

of this State. We do not want our constituents to receive threatening phone calls. We have heard some horrendous stories about bill charges.

SENATOR HARDY:
Could you look at the reasonable offer as one of the criteria along with the other three? It could be used by the arbitrator or the initial offer for the insurance to pay by using a database such as FAIR Health. Are you interested in doing that?

ASSEMBLYWOMAN CARLTON:
I did not feel comfortable with one scheme provided by FAIR Health. There needs to be more options. When the bill was heard in Assembly Ways and Means, the original term was offer and in response to the folks in opposition, I added the word reasonable to the bill. All of the offers were above contract, and they were all denied.

SENATOR HARDY:
Someone has to determine what the contract is, and it becomes problematic with the law.

CHAIR SPEARMAN:
I also received letters of opposition from Kerry Novak, M.D. (Exhibit P), Amy Sue Hayes, M.D. (Exhibit Q), David Strull (Exhibit R), Aviva Gordon and Amber Stidham of the Henderson Chamber of Commerce (Exhibit S), and Eugene Bassett, Dignity Health-St. Rose Dominican (Exhibit T).

I will close the hearing on A.B. 382 and open the hearing on A.J.R.14.

ASSEMBLYWOMAN MAGGIE CARLTON (Assembly District No. 14):
Assembly Joint Resolution 14 addresses the issue of access to affordable emergency medical care at reasonable rates to all persons in this State. It is a simple resolution. An amendment was added at the request of Legal Counsel of the Assembly Committee on Legislative Operations and Elections. The amendment requires that rates are not confiscatory.

When we realized that A.B. 382 may not be adopted, we introduced A.J.R. 14. The goal is to be certain all parties stay at the table and continue to work in good faith on this issue.

MATT GRIFFIN:
We are cognizant of the seriousness of amending the State Constitution. As a constitutional amendment, A.J.R. 14 will need to be passed in two Sessions of the Legislature and will be submitted to the voters at the election thereafter for approval.

SENATOR HARDY:
Where are we starting in the bill?

MR. M. GRIFFIN:
Assembly Joint Resolution 14 as presented today is as it would appear in the Constitution.

We have been working on a resolution for the issue of affordable emergency medical care for many years. This legislation attempts to set a rate in the Constitution while allowing flexibility. Bringing bills every Session has not provided a solution. It is time to create rights in the Constitution.

Section 17, subsection 1 creates a right to persons who arrive for emergency care to receive treatment regardless of the persons' ability to pay. Subsection 2 requires that care be provided at a reasonable cost, not to exceed 150 percent of the agreed amount with a federal public insurer.

Section 17, subsection 4 goes on to state that the provisions of subsections 1, 2 and 3 are self-executing and may not be waived in any manner or altered or varied by agreement. The rights may be enforced by the State or a political subdivision of the State as well as patients receiving care.

Section 5 allows the Legislature to appoint a commission. Details of membership are not set forth in the bill. The Legislature has complete authority to establish law for the appointment of the members of the commission and the commission's power and duties. The Legislature can deviate from the 150 percent provision of A.J.R. 14 through the commission. People will be forced to participate through the commission to set rates.

The amendment provides that if there is no commission created, then under no circumstances will the 150 percent rate drop below the cost of care.

SENATOR RATTI:
We are discussing 150 percent of the federal insured rate. Is it possible that 150 percent of the federal insured rate will be below the cost of care?

MR. M. GRIFFIN:
Yes. If 150 percent is below cost and no commission has been formed, A.J.R. 14 provides that upon proof, the cost of care supersedes the 150 percent requirement.

SENATOR RATTI:
If no commission is formed, providers will receive the billed amount. If a commission is formed, the rate can be adjusted beyond the 150 percent. Is that correct?

MR. M. GRIFFIN:
Yes.

CHAIR SPEARMAN:
Is 150 percent the minimum?

MR. M. GRIFFIN:
Yes. It is the minimum so long as it is not confiscatory. The minimum is 150 percent or the cost of care, whichever is greater.

MR. MUSGROVE:
I can provide an example of a patient's admission to our emergency department. The patient was out of network. We billed $3,000 and were reimbursed $13.

MR. ROBBINS:
Assembly Joint Resolution 14 provides for the prospect of a commission not being created by the Legislature. In this case, 150 percent of the lowest rate agreed to by hospitals or medical facilities would be the rate paid for services. It is not the minimum, it is the maximum. Subsection 3 provides if that rate is confiscatory under the Constitution of the United States, the rate can be changed to be not confiscatory under the U.S. Constitution.

To avoid a Takings Clause issue, the U.S. Constitution requires not only that facilities be able to recover their costs but that they be able to earn a reasonable return. That is the standard in subsection 3 of A.J.R. 14. If 150 percent does

not provide a reasonable return on investment, facilities would be able to charge a higher rate.

CHAIR SPEARMAN:
In Mr. Musgrove's example, the total cost of care was $3,000. The hospital was reimbursed $13. If A.J.R. 14 was in effect, how would this example be different?

MR. ROBBINS:
It would depend on the relationship between the cost of $3,000 and 150 percent of the rate agreed to by the facility. If $3,000 is equal to or less than the 150 percent amount, the facility could charge the full amount. If $3,000 is greater, the facility would be limited to 150 percent of the lowest rate provided by a federal public insurer.

SENATOR RATTI:
How does the establishment of a commission change this situation?

MR. ROBBINS:
A commission can create a number other than the 150 percent amount. The commission could establish the maximum rate allowed to medical facilities.

CHAIR SPEARMAN:
Could a commission either increase or decrease rates?

MR. ROBBINS:
The commission can set any rate. If the commission sets a rate, the 150 percent number goes away. It could be higher or it could be lower.

MR. M. GRIFFIN:
I agree with Mr. Robbins' assessment. Our proposal is to set the 150 percent rate into the State Constitution subject to a commission created by the Legislature. It is designed to bring people to the table to resolve issues brought before a commission.

CHAIR SPEARMAN:
How would medical facilities be compensated for costs beyond 150 percent?

MR. ROBBINS:
If the reimbursement is determined to be confiscatory, the costs would be billed to patients or their insurer.

SENATOR HARDY:
I do not see this as helping the patient.

MR. M. GRIFFIN:
When we say 150 percent, we mean to say 150 percent as long as it is not confiscatory. We propose to amend the State Constitution to say that patients cannot be denied services and are guaranteed reasonable costs. If no commission is created, uninsured patients have an understanding that if they are sent to a hospital they will not be charged 500 percent.

If the Legislature establishes a commission, the commission may change the 150 percent number. It does help patients because terms are set in advance and they can have an idea of the cost of care.

SENATOR HARDY:
Where is it outlined in A.J.R. 14 that the insurance company is the only party to pay and not the patient? Patients may still have to pay for services.

MR. M. GRIFFIN:
We are not advocating to remove patients' financial responsibility for the cost of care. We are saying there should be a set amount over which providers cannot charge patients.

MS. BOND:
Reimbursement of health care costs is a complicated issue and is difficult to resolve. There is a lack of will to change the system, mainly on the part of hospitals. Bill charges in Nevada have increased 100 percent. They have gone from $50,000 to $100,000 since 2008. This conversation highlights the value of a commission which can address the issue of health care costs.

Assembly Bill 382 relates to insured patients served in an uncontracted facility. This proposed constitutional amendment relates to patients protected from unreasonable charges, whether they have insurance or not. Bill charges are sometimes seven, eight, nine or ten times higher for uninsured patients.

We have proposed legislation over many Sessions. Patients are continuing to struggle to pay their bills. When issues are raised at the policy level, hospitals point their fingers and say it is because plans have narrow networks and do not want to pay. If a patient does not have a contract, he or she may still need to be admitted to an emergency room and will be subject to increasing bill charges. We have suggested a 200 percent figure of care costs as a payment method. We offered a percent over contracted rates as a payment method. We did not offer FAIR Health because it is based on a percentile of usual and customary bill charges. We can never get to a rate cap because charges are undefined, uncontrolled and ever-escalating.

SENATOR RATTI:
Does FAIR Health provide an artificial incentive for providers to continue to increase their rates, because it is based on a percentile of rates charged?

MS. BOND:
Possibly, and we would never have a contract again.

SENATOR RATTI:
We are discussing 150 percent of costs, but this is not accurate. It is 150 percent of a federally insured rate.

MS. BOND:
I do not know the exact amount of Medicare payments. There is a cost-to-charge ratio built in by Medicare which is a fraction of the costs. There is a method for calculating through the Medicare cost reports how much care costs. That is the top number. The bottom number is the amount hospitals charge and is a fraction of the top number. Every hospital charges differently. We could not reach agreement, even though we proposed setting payments at twice their care costs.

CHAIR SPEARMAN:
If $13,000 is the cost of care, under A.J.R. 14 would payment be twice that number?

MS. BOND:
We need a commission to make determinations like this. It is not easy to differentiate a cost from a charge in a hospital bill. This amendment would authorize payment of 150 percent of Medicare costs. If Medicare is paying

90 percent of the cost of care, the hospital makes a profit. Section 3 of A.J.R. 14 provides relief if payments are confiscatory.

CHAIR SPEARMAN:
If A.B. 382 and A.J.R. 14 pass, how will costs be calculated? If this is about protecting proprietary information, how can you have rates that do not cause a disincentive if you do not have information about rates? If I am an insurer and am working with you, how would, say, Senator Ratti know the details of our contract?

MS. BOND:
Is Senator Ratti a patient or a doctor?

CHAIR SPEARMAN:
We are both insurers.

MS. BOND:
Insurers do not know what other insurers are paying. Doctors know the amount of payments from insurers. They know how much he should be paid. If they are paid less than they charge, mediation will be triggered. I do not believe there will be 30,000 cases arbitrated. Payments will be adequate to charges. Insurance companies do not want to go to expensive arbitration. There will be a small group of people charging more than they should, and there will be a small group of people who pay less than they should. Over time, payments will normalize and become more stable. We will have data on actual rates rather than anecdotal evidence.

JOSH GRIFFIN (Health Services Coalition):
Assembly Bill 382 does not exist in tandem with A.J.R. 14. Assembly Joint Resolution 14 exists because of the presentation of A.B. 382. This is a presentation that has taken place over the past 15 years.

Assembly Joint Resolution 14 is necessary because Nevadans need to have some reasonable expectation of knowing the cost of emergency care. There are many ways to calculate costs. This resolution provides for a commission that can work through this complex issue.

The way to remove patients from the middle of the process is by creating a right for the patients to expect manageable and predictable costs. We all want

to have predictability for payers, patients, hospitals and doctors' groups. We want to work together. We can all agree that patients have the right, regardless of their circumstances, to know the cost of care.

MR. SULLIVAN:
Culinary Workers Union Local 226 supports A.J.R. 14.

MR. BEAMAN:
Clark County Firefighters Union Local 1908 supports A.J.R. 14.

CHRIS DALY (Nevada State Education Association):
We support A.J.R. 14.

MR. J. GRIFFIN:
MGM Resorts International supports A.J.R. 14.

FRAN ALMARAZ (Teamsters Local 631; Teamsters Local 986):
I am representing over 50,000 Teamsters who work in Nevada, and we support A.J.R. 14.

MR. WADHAMS:
Nevada Hospital Association opposes putting rate setting in the Constitution. We respect the power of this Legislature to debate, decide and set State standards. We have concerns about the unintended consequences of some initiative petitions. We have a district court injunction pending on an initiative petition relating to recreational marijuana. I was involved in litigation over the initiative petition on the Nevada Clean Indoor Act. We debated the definition of a gaming floor in court.

As difficult as the process may be, we prefer this issue be decided by the Legislature. We oppose A.J.R. 14.

JOAN HALL (Nevada Rural Hospital Partners Foundation, Inc.):
Critical access hospitals are reimbursed by Medicare based on an allowable cost base. I have submitted a chart outlining cost report data (Exhibit U). Thirty percent of our patients are Medicare recipients. Seven of our facilities operate at a loss. Commercial payers will not be required to pay at 150 percent. Assembly Joint Resolution 14 could have unintended consequences which could result in hospital closures.

We serve 81,000 patients in our rural hospitals' emergency rooms, and closures would cause serious difficulties. We have submitted charts outlining comparative hospital bill charges (Exhibit V) and the most common emergency room diagnosis and the price point costs of care (Exhibit W). I ask that the Committee consider the complexity of hospital billing while deliberating on A.J.R. 14.

MR. FERRARI:
Dignity Health-St. Rose Dominican are not-for-profit hospitals. The forecasted cost of A.J.R. 14 to our hospitals is $97 million. A posting on social media reported that our hospitals received $1 billion in revenue and $140,000 in profit.

We are opening four neighborhood hospitals with full emergency services in underserved areas. We will significantly increase access to emergency care. Assembly Joint Resolution 14 will create a significant disincentive to attracting new providers or limit and close emergency services.

MR. MUSGROVE:
I represent the Valley Health System of Hospitals, and we oppose A.J.R. 14.

MR. SKLAMBERG:
The Sunrise Hospital and Medical Center and Sunrise Children's Hospital oppose A.J.R. 14. We need to ask ourselves about the sustainability of hospitals in Nevada. During testimony today, I have heard the words "schemes" and "experimenting." When we consider providing health care to our community, experimenting and payment schemes are not consistent with our goals of providing first-class health care and access.

CHRIS BOSSE (Renown Health):
We oppose A.J.R. 14. I urge you to consider access to health care in Nevada.

JANINE HANSEN (Nevada Families for Freedom):
Assembly Joint Resolution 14 would impose price controls which do not work. Price controls make goods and services less available. It is difficult for Medicare patients to find doctors who will provide services.

California's health care system is suffering. Many hospitals are losing money. Hundreds of medical clinics have closed or gone bankrupt, and many others are

in financial trouble. At least 84 California hospitals have closed in the last 12 years. There are many reasons, one is the use of emergency rooms by illegal aliens who do not pay their bills.

MR. J. GRIFFIN:
This is not an initiative. This is a proposed constitutional amendment that guarantees the rights of citizens. Assembly Joint Resolution 14 is flexible and creates several options. It would be impossible to predict costs.

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CHAIR SPEARMAN:
We will close the hearing on A.J.R. 14 and adjourn the meeting at 10:00 p.m.

RESPECTFULLY SUBMITTED:

Martha Barnes,
Committee Secretary

APPROVED BY:

Senator Pat Spearman, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	1		Agenda
	B	7		Attendance Roster
A.B. 382	C	4	Assemblywoman Maggie Carlton	*The New England Journal of Medicine* Article
A.B. 382	D	2	Assemblywoman Maggie Carlton	*Reuters* Article
A.B. 382	E	4	Assemblywoman Maggie Carlton	Nevada Hospital Charges, Centers for Medicare and Medicaid Services
A.B. 382	F	1	Bobette Bond	State Report Billed Charges Chart
A.B. 382	G	18	Chris Ferrari / Dignity Health-St. Rose Dominican	FAIR Health, Spotlight on Nevada
A.B. 382	H	10	Chris Ferrari / Dignity Health-St. Rose Dominican	FAIR Health Snapshot
A.B. 382	I	2	Dean Polce / Nevada State Society of Anesthesiologists	Written Testimony
A.B. 382	J	1	Bret W. Frey / American College of Emergency Physicians, Nevada Chapter	Call List
A.B. 382	K	1	Bret W. Frey / American College of Emergency Physicians, Nevada Chapter	Written Testimony
A.B. 382	L	1	Physicians for Fair Coverage	Guidelines for Effective Policy Solutions to End the Surprise Insurance Gap

A.B. 382	M	2	Physicians for Fair Coverage	The Campaign to End the Surprise Insurance Gap Recommends FAIR Health
A.B. 382	N	2	Karen Massey / Nevada Medical Group Management Association; Northern Nevada Emergency Physicians	Written Testimony
A.B. 382	O	2	Chris Clifford	Written Testimony
A.B. 382	P	2	Kerry Novak	Letter
A.B. 382	Q	1	Amy Sue Hayes	Letter
A.B. 382	R	1	David Strull	Letter
A.B. 382	S	1	Aviva Gordon and Amber Stidham / Henderson Chamber of Commerce	Letter
A.B. 382	T	1	Eugene Bassett / Dignity Health-St. Rose Dominican	Letter
A.J.R. 14	U	1	Joan Hall / Nevada Rural Hospital Partners Foundation, Inc.	Rural Hospital Financials
A.J.R. 14	V	6	Joan Hall / Nevada Rural Hospital Partners Foundation, Inc.	OP Charts
A.J.R. 14	W	7	Joan Hall / Nevada Rural Hospital Partners Foundation, Inc.	Price Point Charts