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

Eighty-Second Session
March 3, 2023

The Committee on Health and Human Services was called to order by Chair Sarah Peters at 1:33 p.m. on Friday, March 3, 2023, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 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/82nd2023.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Sarah Peters, Chair
Assemblyman David Orentlicher, Vice Chair
Assemblywoman Cecelia González
Assemblywoman Michelle Gorelow
Assemblyman Ken Gray
Assemblyman Brian Hibbetts
Assemblyman Gregory Koenig
Assemblywoman Sabra Newby
Assemblyman Duy Nguyen
Assemblywoman Angie Taylor
Assemblywoman Clara Thomas

COMMITTEE MEMBERS ABSENT:

Assemblyman Gregory T. Hafen II (excused)

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Shuruk Ismail, Committee Manager
Terry Horgan, Committee Secretary
Ashley Torres, Committee Assistant

OTHERS PRESENT:

Mathilda Guerrero, representing Battle Born Progress
Patrick D. Kelly, President and Chief Executive Officer, Nevada Hospital Association
George Ross, representing HCA Healthcare
Izack Tenorio, representing Valley Health System
Wiz Rouzard, Deputy State Director, Americans for Prosperity, Nevada
Brian D. Kleven, Chief Financial Officer, Nevada Market, Dignity Health-St. Rose Dominican
Sara Watkins, Executive Director, Nevada State Medical Association
Lindsay Knox, representing Nevada Orthopaedic Society
Chris Bosse, Vice President, Government Relations, Renown Health
Helen Foley, representing Nevada Association of Health Plans
Kristina R. Kleist, representing Northeastern Nevada Regional Hospital
Emily Osterberg, Director, Government Affairs, Henderson Chamber of Commerce
Marcos Lopez, representing Nevada Policy Research Institute
Barry Cole, Private Citizen, Reno, Nevada
Jennifer M. Richards, Chief Elder and Disability Rights Attorney, Aging and Disability Services Division, Department of Health and Human Services
Jonathan Norman, representing Nevada Coalition of Legal Service Providers
Charlie Shepard, State President, AARP Nevada

Chair Peters:
[Roll was called. Committee rules and protocol were explained.] I will open the hearing for Assembly Bill 85 presented by Assemblyman Orentlicher.

Assembly Bill 85: Establishes procedures to fix rates for certain health care goods and services. (BDR 40-169)

Assemblyman David Orentlicher, Assembly District No. 20:
This bill is about fixing rates, and I guess you could think about that two ways—to separate and to correct rates—because they are too high in many situations. Assembly Bill 85 is about making our health care system fair. By making it fair, it will help countless residents of Nevada. This bill will help uninsured Nevadans who do not have health care coverage because it is too expensive. Maybe they worked for a small business that cannot afford to offer health care benefits because insurance premiums are too high. Or maybe they are self-employed and do not make enough money to buy health insurance. Or maybe they are poor, but not poor enough to qualify for Medicaid. We cannot afford to cover them under Medicaid because health care is just too expensive. This bill will also help Nevadans who have health care insurance but cannot afford the deductibles or other copayments they have to pay when they seek care. They delay seeking care and do not fill their prescriptions and get sick.

As I said, this is about fair prices [page 1, Exhibit C]. It only covers hospitals, surgical centers, and emergency care centers. These are facility fees, not doctor fees. It has nothing to do with physician rates.

As some background, especially for those who are new to the Committee, this was Assembly Bill 347 of the 81st Session from two years ago. It was a product of an ongoing working group with a large group of stakeholders. I think we had 75 stakeholders and got a lot of input. Since then, in response to that input, I made some changes. One is to narrow this to just hospitals, surgical centers, and free-standing emergency care centers. The bill does not address physician fees or other individual providers.

There were many changes. We are going to talk about how we get to fair fees and have a government commission to set them. Initially, I thought that should be created as part of the Department of Health and Human Services (DHHS). However, a lot of stakeholders said it would be better to have it independent, so in this iteration it is as the Independent Commission on Rates for Health Care Services, although relying on staff at DHHS.

As I said, this is going to help a lot of Nevadans. Another class of Nevadans it will help are workers who have insurance, but they do not see pay increases because their employers have to spend more and more money to pay employee health care benefits rather than salaries. They see their paychecks inching up, and their benefit packages go up, but a lot of it is going to health care. This bill will make health care more accessible and affordable for the many Nevadans who struggle to get the health care they need.

What is the secret sauce here? How are we going to make health care more affordable? The idea here is to do what every other country and some states do, and a lot more states used to do. The motivation is health care costs are too high [page 2]. Here are the latest numbers I have. In the United States we spend nearly $12,000 per person for health care. Switzerland is number two, but it is only 61 percent of what we spend, just over $7,000. Germany is 59 percent of what we spend; Canada is less than half of what we spend; Japan is 39 percent of what we spend, under $5,000 per person; and then New Zealand.

These are not countries where there is trouble getting good health care. They have very advanced, very accessible health care, but look how much less they spend than we do. Hospital charges are the main reason. We hear a lot about drug charges and pharmaceutical prices being too high in many cases, but if we look at the main contributor to our high health care costs, it is hospital charges. There is a RAND Corporation study [Nationwide Evaluation of Health Care Prices Paid by Private Health Plans] documenting that.

Why are hospital bills high [page 3]? We pay more than double what a lot of countries pay and hospital bills are higher. Why? It is not because we spend more time in the hospital. We actually do not. Other countries have more admissions, and patients spend more time in the hospital. That is not why we spend more. It is not because we are sicker. Sometimes we

are sicker, but that does not explain it. It is not because we are more litigious. We may be more litigious, but that is not why our hospital costs are high. It is because our prices are high. We would get the same service in any of these other countries as we get here and the same quality service, but we would pay a lot less. We just have higher prices.

Why do we have higher prices? Because we rely on insurance companies rather than the government to negotiate fees. The hospitals negotiate with insurance companies. I know insurance companies are not very popular in this country, but they are not the big, bad bullies they sometimes seem to be. Unfortunately, they do not have sufficient leverage with hospitals. Hospitals have a lot of market power, and that is why hospital fees are so much higher. No other country allows that kind of negotiation. The government participates. It does not always set the fees, but it can organize them. What those countries do is make sure the hospitals in their countries cannot use their market power.

Why do our hospitals have so much market power? Because we are not like we used to be—with the local community hospital that provided care. We now have lots of consolidation, lots of mergers, and lots of major national companies that own a lot of hospitals, and that gives them a lot more leverage. Even the local community hospital could have leverage if it were the only game in town, and that is true in some communities, but it is hospital market power.

You might be wondering about antitrust laws that are supposed to protect us, and they should. However, the antitrust enforcers have not done their jobs in health care, so we have this major consolidation that drives up our health care costs.

I know hospitals did struggle some during the pandemic, but their bottom lines did not, mostly because we had federal relief funds [page 4, Exhibit C]. I picked one company, partly because I found it easily and partly because they have a number of hospitals in southern Nevada. I have Hospital Corporation of America (HCA) to show you their profits. They took a little dip at the beginning of 2020—the beginning of the pandemic—but they quickly rebounded, and their operating margin exceeded their average right before the pandemic. Yes, there was some turmoil in the health care system from the pandemic, but it did not affect the bottom line for most hospitals. Some hospitals it did affect. This is national, and the HCA chief executive officer's compensation was over $20 million, so they are obviously doing quite well.

That was national data [page 4], but what about Nevada [page 5]? I picked five hospitals. I wanted to show some of the examples of where the problems are. There may be a little over 20 hospitals and I picked 5 just to give you a sense. The orange line shows you what the state average per hospital is—what they charge as a percentage of Medicare. That is a standard benchmark health economists use. How do hospital charges, or anyone's charges in health care, compare to Medicare? Medicare does the best job. It is not perfect, but it is the best we have. You may hear a lot of people tell you how Medicare underpays, but it pays about 90 percent of costs.

Two years ago when I presented Assembly Bill 347 of the 81st Session, Nevada's costs were not as high. It is interesting. These numbers come from the RAND Corporation. Two years ago, we had 2018 data to use, and Nevada was actually at the lower end in terms of hospital costs. Since then, using 2020 data, we moved to the upper half. I am not sure why we moved up, but this is not a good thing to move up in. It was much better when we were forty-fifth, and now we are twenty-second in terms of hospital charges. These are facilities charges. I am focusing on facility charges, not doctor charges.

As you can see, on average we are at 285 percent of Medicare. Some hospitals, one in the north, is 493 percent of Medicare. There are some that are lower, but close to 300 percent or more of Medicare. Medicare may be 10 percent or 20 percent below where it should be, but it is not 100 percent below of where it should be.

The National Academy for State Health Policy (NASHP) is a not-for-profit, nonpartisan group that looks at hospitals. This is all based on public data. Hospitals submit their cost data to Medicare, so NASHP mines the data and figures out their break-even point [page 6, Exhibit C], or what they need to cover their costs. On average, Nevada hospitals need 111 percent of Medicare to cover their costs. As you can see, it varies from hospital to hospital. One hospital needs 229 percent of Medicare to cover its costs, and others are closer to average. Clearly, Medicare undercompensates hospitals. It is also Medicaid costs.

Finally, profit margins [page 7] using the same five hospitals: You can see their profit margins. One is at 28 percent. I do not know what the right amount is. I am sure it is a few percent—maybe 10 percent—but it is not going to be this high. Hospitals do not need these kinds of profit margins to stay in business.

These are the goals of A.B. 85 [page 8]. I want hospitals to be fairly paid; I want them to cover their costs. I just do not want them to use their market power to charge more. It is not a free market when they have market power they can use to charge excessive prices. I want them to be fairly paid. I want patients not to have to pay excessive charges because when they do, they cannot afford the care. I want to simplify things. How many billing clerks do hospitals have? Some hospitals have more billing clerks than health care providers because it is so complicated to deal with all these health insurances. If we just have the state set the rates in a fair way, it simplifies the system, and we will not have so much of our health care dollars sucked up in unnecessary administrative costs, and it decreases the administrative burdens.

Section 9 is the heart of the bill [page 9]. I will go over some of the other sections also. The idea is what we do with public utilities. As I mentioned before, we worry about the market power of NV Energy and Southwest Gas Corporation, so we do not let them set their own rates. We require them to justify their rates before the Public Utilities Commission of Nevada (PUCN). What the PUCN gives them is what they call just and reasonable, which is the same idea. We want them to cover their reasonable costs and we want them to earn a fair

and reasonable profit. If you are wondering, there is a lot of case law about that because we have public utilities. This is not a new concept. Section 9, subsection 1 of this bill is the basic principle for this commission—fair and reasonable fees, cover reasonable costs, fair and reasonable profit.

Facilities would be guaranteed to receive payment at least at Medicare rates, which is the minimum. There is no statutory maximum because I do not know what the right amount is. It will vary from year to year and from hospital to hospital. Some states do try to set at least 160 percent to 180 percent of Medicare. Who knows what the right amount is. That is why we need a commission. We cannot do that. The floor is Medicare, and it would never go below Medicare; there is no statutory maximum because, again, it depends on the hospital.

With the state setting fees, again we get simplicity. We want fairness and we want simplicity. We will not have this inefficient system of negotiation between hospitals and who knows how many insurers they have to deal with. It could be dozens.

The first few sections of the bill, as usual, are definitional. Sections 5 through 7 and 9 talk about the Independent Commission [page 10]: Who is going to be on the commission, how often they meet, nine members who represent a diverse range of expertise—some in finance, some in health care, some are consumers, and some are employers who have to find health insurance for their employees.

In section 9, it spells out the requirements to cover reasonable costs and have fair and reasonable profit. In section 10, what are the factors to ensure they are treated fairly? Payer mix is important. Some hospitals have more Medicaid patients and more uninsured, so they need more money on the private side to cover their costs. We want the high-quality providers to be rewarded—I should say hospitals and other facilities, not providers. If hospitals are taking care of sicker patients, that is more expensive, so we want to take that into account. We want to reward hospitals and other facilities that have a population health focus to keep their patients out of the hospital and keep them healthy. We should reward them because we do not always do that. Any financial hardship, if we are going to reduce rates, it may be necessary to phase them in. We cannot just change the system overnight. These are all ways to make sure we treat each facility fairly.

What will this mean for the private market [page 11, Exhibit C]? It is not a single payer system. We will still have the same insurers. We will actually have more insurers, I think. We are still going to have insurers competing but they would just have a common reimbursement structure. There will not be this crazy system where different insurers and different hospitals have dozens of different rates. That does not make economic sense. That is going to mean lower health insurance premiums. It will mean fair pricing to consumers and the state budget because we all pay for the health insurance for state employees, which will reduce the cost to the state for that. It will mean greater competition. It will not only lead to a free market of competition for health insurers, but there will also probably be more health insurers.

If you want to open a new health insurance plan in Nevada, you need to form a network of hospitals and doctors. If you promise them volume, you may make them part of your network or plan, and they will know they will get an increased flow of patients, and then they will be willing to offer discounts. You will not need to do that because there will be fair rates set by the state. It would be easier for new health companies to come in. The way we know that is if you look at Medicare Advantage. Go online to MedicareAdvantage.com, pretend you want to buy a plan, put in your ZIP code, and you will see dozens of options. Medicare Advantage is a system of private plans that the government implements where they have a common rate system for reimbursement, so you get more competition.

As I said, it replaces the complicated, difficult negotiations between providers and insurers. We still have to have a rate setting, but it is just one instead of dozens, so it will be simpler.

That covers what I wanted to say, and I look forward to your questions.

Chair Peters:
We have several questions from Committee members. Assemblywoman Gorelow, you may begin.

Assemblywoman Gorelow:
Thank you so much for your presentation. It was really enlightening. I do have a question, and I apologize if I missed it in your presentation. What other states are doing this, and is there any data available that shows costs did decrease?

Assemblyman Orentlicher:
In the 1970s, many states set up these commissions. At the time, hospitals supported them, and everyone understood this was a good policy. What happened was, as some of you may remember, we entered a deregulatory phase in this country where the view was that we should remove government from making rules and let the free market operate. A lot of these commissions were disbanded. We have been trying to rely on the free market since the 1970s in health care to keep costs down, but it just does not work. I do not know any health economist who thinks we can make things work under an unregulated market. We need government intervention. As I said, the reason for the government intervention is to counteract the market power of hospitals, to do what the antitrust enforcers have not done.

Maryland never abandoned its rate regulation but has gone beyond this model to setting global budgets. Maryland says to the hospitals, Here is your budget for the year. That is something to look toward. I would love to do that. I started the discussion. Maryland still does rate regulation and Massachusetts does some. Because of the deregulatory ethic that started in the 1970s and 1980s, most states abandoned it. Now, states are realizing something needs to be done and are coming back to do more regulation.

Assemblywoman González:
In section 6, subsection 3, paragraph (a) of the bill, under the requirements of the Independent Commission on Rates for Health Care Services, it says that a person, in order to be on the board, has to be a citizen and a resident. I am curious as to why the citizen requirement is in there and what the background was on that.

Assemblyman Orentlicher:
I will concede that I did not pay a lot of attention to some of these provisions, including that one. I will need to check with the Legal Division to see if there was a reason they had in mind.

Chair Peters:
Thank you for bringing that up. We do not have legal counsel in the Committee right now as they are dutifully drafting bills for our upcoming deadlines. We can document that as a question for them and follow up with you.

Assemblyman Gray:
Did you consult with any of the hospitals in the area, and are any of them supporting you in this? I am just not seeing how the plan can actually work.

Assemblyman Orentlicher:
Two years ago, I had extensive discussions—not as much for this bill, but this tracks the other bill. Yes, I did talk with some hospitals at length. We have not reached agreement. I told them I am interested in continuing to work with them to see if we can bridge the divide. I understand hospitals have a duty to their shareholders to maximize profits, and this will limit their profits.

Assemblyman Gray:
The answer to that question is no. I am assuming that was in southern Nevada. Did you talk to any of the hospitals in the north?

Assemblyman Orentlicher:
Yes. Renown was part of the discussion. I invited the Nevada Hospital Association. As I said, when we had the stakeholder group, there were approximately 75 different stakeholders. I always welcome input. If you have things to add, please do.

Assemblyman Gray:
I should have been clearer. Outside the urban areas, have you talked to the rural hospitals, the ones that would suffer the most from this?

Assemblyman Orentlicher:
Indeed, I spoke with Joan Hall. As you will see, this bill does not apply to critical access rural hospitals.

Assemblywoman Taylor:
I hate that I missed the conversation last session, so it may seem repetitive because I know you have been through a lot of these questions before. If we look at the profit margins on slide 7 [page 7, Exhibit C], is there any national average information? I know you said we do not really know what the right number is. Where do hospitals who service their communities land?

Assemblyman Orentlicher:
There is that kind of data. When I said we do not know, I mean I do not know. There is extensive experience in the public utility rate-setting world about what it means to have a fair profit. That information is out there, I just do not know right now. It would not be hard to figure out what hospitals need. I am confident it will not be 23 percent or 28 percent.

Assemblywoman Taylor:
Is there any way we might be able to have that information?

Assemblyman Orentlicher:
I just talked to the PUCN. I will follow up with them to see if they could give me a sense of what their profit margin range is.

Assemblywoman Taylor:
If we could get that for hospitals, it would be helpful as we start looking at the numbers.

I also have a question on slide 10 [page 10, Exhibit C]. You mentioned some of the things the commission would be responsible for and some of the decisions and things they would set financially. I want to make sure I understand the scope of their work. I know they are going to set the rates for hospital services. Does that extend to setting rates for vendor contracts or employee contracts? Is there anything that really restricts the hospital?

Assemblyman Orentlicher:
The goal here, and the simplest thing, would be to say to a hospital, Thank you for showing us your costs daily and what your expenses are. We see just getting Medicare would not cover your costs. You need 20 percent more than Medicare. The numbers people use are 150 percent, 160 percent, sometimes 180 percent. It depends on the state. That is what they would say. We would leave it to them to work out everything else.

There is a provision in the bill to promote fair and adequate compensation for their workers. We want to make sure we give the hospitals enough money to pay fair wages. That is part of what the commission would take into consideration. Otherwise, it would be left to hospitals to make their own arrangements.

It is also important that they be reasonable costs. Hospitals have to explain why. We do not want them to just have a blank check like we used to do with health care reimbursement. Whatever the costs were would be reimbursed. That does not work either. We will hold them to justifying costs.

Assemblywoman Taylor:
It is really about those services and the cost to provide those services. I am trying to see if I can imagine a scenario where it could be an employee contract or a contract with a vendor that has to go before the commission. The commission could possibly not approve it because it is not enough or too much. Is that how you envision its scope, or did I just get way off?

Assemblyman Orentlicher:
They would not be passing on specific contracts. That would not be part of the presentation. What they would do is look at labor costs that need to be covered.

Assemblywoman Taylor:
It is for the commission to consider those costs. I understand.

Assemblywoman Newby:
On the data charts you were referencing on the rates hospitals are charging [page 5, Exhibit C], do you know if those are the negotiated rates or are those rates absent any negotiated rate from an insurer? My second question is, and please correct me if I am wrong, this contemplates a rate would be set individually for each facility. All of those factors you lay out in your bill would have to be considered for each separate entity. Is that correct? My third question is, given the hospitals and other facilities would need to provide this commission with all of their information on charges and costs, I think they would consider that information to be proprietary. Is there any protection in this process or commission to keep that information proprietary?

Assemblyman Orentlicher:
Yes, they would have to provide that data. That is already the same data they provide to Medicare. Medicare requires that kind of data so they can decide how much to reimburse. It is nothing new and certainly gives the same protections they already have. These would be facility-specific. Slide 6 [page 6] are the break-even points. While some of them are similar, you can see there are variations in their break-even points. The commission would have to tailor the rates to what the break-even points are.

These numbers are based on actual payments by private insurers, which were not always available. The RAND Corporation has done some good studies with health insurers and employers who were willing to share what they actually paid. Also, some states have these all-payor databases where the insurers and hospitals are required to report, so we have more and more data. This is based on actual negotiated rates, yes.

If I could follow up on Assemblywoman Gorelow's question, I mentioned a few states that do this across the board. I forgot to mention states like Montana, Colorado, and Washington that do this kind of rate setting for public option plans. In Montana, it is done for state employee plans. We are starting to see more states do it in limited parts of their health insurance, but this would do it across the board.

Assemblyman Koenig:
Excuse my ignorance, but I do not understand how you get such high numbers. In my clinic, I am contracted with Medicare and Medicaid. They tell me exactly what I have to charge and how much I am going to get reimbursed. I cannot charge a Medicare or Medicaid patient five times what is allowed because I cannot charge the extra to the patient. I am contracted with Medicare and Medicaid. The percentage in the hospitals has to be over 50 percent. Their patients have to be Medicare and Medicaid combined. I do not know how hospitals charge, but how are they able to charge 493 percent more than what Medicare pays? How do they bill? I do not understand their billing process. How do they get that high when they are only going to receive what Medicare and Medicaid are contracted to pay?

Assemblyman Orentlicher:
These are what they bill and get paid by private insurers. You are right. Medicare and Medicaid set rates, then they negotiate rates with the private insurers. These are the rates they negotiate with private insurers.

Assemblyman Koenig:
The private insurers are agreeing to 500 times Medicare's payment. I think I am negotiating incorrectly.

Assemblyman Orentlicher:
This is an example of the only hospital in town. If you are a health insurer, you have to deliver a hospital for your members. This is a good illustration of the market power that hospitals have. One of the reasons I am not including physicians in this bill is because there are a lot more physicians than there are hospitals. Another reason is, while hospitals drive a hard bargain in our state—285 percent of Medicare, the twenty-second highest in the country—physicians do not have that kind of market power in this state. There is not as great a need to regulate physician fees.

I was surprised at how low physicians are, maybe 107 percent of Medicare, in Las Vegas. In a lot of places, it would be much higher than that.

Chair Peters:
Are there any other questions at this time? [There were none.] This is an incredibly complex issue. It is very difficult to wrap my brain around one component of the cost of medicine when we have been talking about—at least for the three sessions I have been here—the varying areas where the cost of providing health care has been increasing and changing, and what the regulations look like in all of those cases. Assemblyman Orentlicher, I would like to ask you about how you think this particular commission would fit within some of the structures we have implemented, including the surprise billing bill from 2019; the Patient Protection Commission from 2019; the pharmaceutical cost transparency work that began in 2017; and the All Payers Claims Database, which is still trying to be fully implemented. Again, all that work has been in play for the last five years or so. Can you talk about how you envision this fitting into some of the other work we have done in this body?

Assemblyman Orentlicher:
We have done some important things. The surprise billing, for example, did address the problem where patients go out of network, they have a plan, and there are certain hospitals in the network that agreed to discounted prices. However, we see 285 percent of Medicare is not as discounted as it could be. If patients go out of network, they can be hit with a much higher bill. That is an important protection, but overall, it reaches a small percentage of hospital bills. For the people who get them, it is a big deal when they get a $100,000 bill if they were in network, and the copayment might be $2,000. It was an important, extreme example of unfair billing that, thankfully, we and the federal government closed.

The public option is another good example of an important benefit, but unfortunately, it reaches a small slice of the health care market—the people who buy their own plans. Most of us are either on a government plan or an employer plan. We hit certain important areas of concern of especially high prices, but this bill is designed to reach across the board. For those of us who stay in network or are on an employer plan, what we have done so far does not help us with our hospital costs.

Chair Peters:
I want to make sure everyone knows how much work has gone into this particular issue area. As we have seen in some of this presentation, the cost of health care has not gone down. It is complex and there are many players. I want to ask about the benchmarks that exist today. You mentioned one, Medicare, and then we have Medicaid, but we have not, as a body here today, talked about the quantity of folks who are on those plans and who are able to negotiate those rates. In addition, the complexity of many folks, the majority of Medicaid recipients, those who are on NGO [nongovernmental organization] plans—we do not have transparency of what those reimbursement rates look like. Could you talk more about what benchmarks exist and how frequently they are used to drive the reimbursement rates we are seeing and how that might interplay with some of the costs that the RAND Corporation is seeing?

Assemblyman Orentlicher:
I would love to see Medicaid reimbursement rates go up. That is why you will, hopefully, see Assembly Bill 197, which is designed to do that. Medicare really is the standard benchmark in this country. Every state that proposes rate regulations of some kind, whether it is surprise billing, across the board, or public option, all start with Medicare. When you look at academic proposals, they will commonly say 125 percent or 150 percent. Medicare is universally viewed as the best benchmark. It is certainly not perfect, and I am sure some of the testimony will be about the imperfections of it.

Right now, Medicare's estimate is about 90 percent of cost. It is not perfect and misses some things. That is why this commission is not bound by Medicare. That is the minimum, and then it moves up as needed with no statutory cap. I thought it inappropriate to say 160 percent or whatever because that will change over time. We cannot come back and redo

the statute every two years as Medicare rates evolve and health care costs change. Anyone who writes legislation in this area or writes in this area as an academic uses Medicare as the benchmark.

Chair Peters:
I think it is important to note when we are talking about the analysis of Medicare reimbursement rates against the cost of providing health care, it is generalized rather than specific to the state, or am I incorrect in that—meaning that Medicare covering 90 percent is generalized across the country, not specifically Nevada. When we look at the cost of doing business in Nevada, we are just seeing that increase at a higher rate than other states at this point. I want to add that complexity to the mix as well.

Assemblyman Orentlicher:
That is important. Medicare does vary rates and does look at regional costs. Hot regions where there are higher labor costs or other costs will get higher rates, absolutely.

Chair Peters:
That is good to note. My last question today is whether you considered limiting the independent commission to looking at benchmarks for our state plans, including the potential public option plan that is being developed as we speak. Can you talk about whether you considered limiting it to just those and some of the factors that went into your thoughts on how broad this is?

Assemblyman Orentlicher:
Two years ago during the discussions, I did approach the Public Employees' Benefits Program (PEBP) and asked if we could do this. That is what Montana did, and it has been successful. The PEBP was not ready to do it, but it would make a lot of sense to start there and demonstrate its value and then expand. Montana is a good example because it has a lot of rural hospitals, and they have been able to implement it successfully across the state. Thank you for reminding me to reconnect with PEBP and see where they are on this.

Chair Peters:
Thank you for your responses today. Are there any other questions from the Committee before we move into testimony? [There were none.] We will move to support testimony on Assembly Bill 85. If you are in Carson City or Las Vegas, please approach the table for testimony in support. [There was no one.] Is there anyone on the public line who would like to provide support testimony?

Mathilda Guerrero, representing Battle Born Progress:
We are in unwavering support of A.B. 85, and we thank Assemblyman Orentlicher for sponsoring this critical measure. My husband is a first responder and has worked in the hospital setting for several years now. I cannot begin to tell you how many times he has

come home and told me about the number of patients he has come across who do not want to seek health care because of the high cost of hospital bills. Hospital rates must be reined in with more transparency and oversight over the hospital industry. We hope this Committee believes so too.

Thank you again, Assemblyman, for sponsoring this critical measure. I hope this Committee supports it too.

Chair Peters:
Is there anyone else on the public line who would like to provide testimony in support of A.B. 85? [There was no one.] I did forget to mention that because of time limitations, we are limiting support, opposition, and neutral testimony to 20 minutes. Last week, I was a little flexible on this because we had a number of people wanting to testify in those areas. However, we do have limitations, so I am going to start with a 20-minute timer and we will see where we are for opposition testimony. I will open opposition testimony. Anyone in opposition may approach the table. You have two minutes to speak. Please state your name for the record and spell your name for us. I will start in Carson City.

Patrick D. Kelly, President and Chief Executive Officer, Nevada Hospital Association:
We oppose A.B. 85. More than half of the acute care hospitals had a negative operating margin in the first three quarters of 2013 [2023]. Hospitals are having difficulty operating under the current system. Assembly Bill 85 starts hospitals at a Medicare rate. Changing the reimbursement system to a Medicare system would cause financial havoc for hospitals.

Nationally, Medicare pays only 87 percent of a hospital's cost to provide a service. I am not talking about hospital charges; I am talking about 87 percent of the cost to provide the service. Hospitals must be able to shift underpayments by Medicare and Medicaid to other payers. This bill would eliminate that cost shift and place hospitals in financial jeopardy.

We question the need for a rate-setting system. Nevada's health care expenditures are among the lowest in the country. The Kaiser Family Foundation ranks Nevada third in the nation for the lowest health care expenditures per capita. Forbes ranks Nevada among the top five states in the nation where health care is least expensive. Forbes also found that Nevada was in the top five states where overall health care spending grew the least over a recent five-year period. Nevada ranks positively on another national benchmark: the Affordable Care Act's average benchmark premium. The Kaiser Family Foundation ranked Nevada as having the eighth-lowest average benchmark premium in 2023 in the nation.

Rate setting is often used when competition does not exist. You see it when companies are granted exclusive rights to provide services such as power, water, or sewage. Rate setting is established so companies do not overcharge customers. In our case, hospital competition is alive and well. In the Las Vegas market, we have numerous hospitals competing with one another on price. University Medical Center of Southern Nevada, Universal Health Services,

Health Corporation of America, Prime Healthcare Services, and Dignity Health are all active in the market and compete with one another.

Chair Peters:
We are at two minutes, Mr. Kelly. I realize people speak at different rates. If you have written comments, you can provide them to staff, and we will make sure all your comments get into the record and distributed to the entire Committee [Exhibit D].

George Ross, representing HCA Healthcare:
First of all, the data that was presented about my client we believe to be inaccurate and misinterpreted. We wish the sponsor had taken the opportunity to run that by us beforehand so we could discuss it and correct it. Let me make these points. First of all, this is a very political board. It serves at the whim of the Governor. A lot of the policies that this would present—you could see it with the Patient Protection Commission—because it can change so radically, you may get one set of policies and one set of interpretations every four years or every eight years. It would provide regulatory uncertainty. Nothing is worse for private sector investors. Like it or not, southern Nevada is almost completely dependent upon private hospital investment for the growth of access to care and improvement of access to care in Nevada. The last thing a private sector company needs to confront is regulatory uncertainty. You cannot be certain that whatever you make your decisions on, whatever the basis, is going to be there in a few years.

Second, this is going to lead to a major increase in the bureaucracy of the state for a department that is currently, according to yesterday's testimony by the director, 20 percent understaffed in finance. I will put it this way: Every single service in a hospital is going to have to go to appeal. Medicare covers the cost nowhere. Sunrise Hospital and Medical Center has at least 30 lines of service overall. If you break that down, you have hundreds. Every single one of those services is going to come in and appeal to get a reasonable rate. You are going to need a very large staff of highly skilled, MBA [master of business administration]-type analysts with health care backgrounds to even remotely get the right decisions. Even then, as soon as the board changes, those could change. Yes, I understand that you might not have to take every collective bargaining agreement to these folks, but very clearly in the law, it says fair and reasonable labor costs.

Chair Peters:
We have reached two minutes, Mr. Ross. Of course, you are more than welcome to submit written comments to the Committee. We will make sure those get distributed.

George Ross:
Can I have 30 more seconds?

Chair Peters:
If I allow you 30 more seconds, I have to allow Mr. Kelly 30 more seconds. I apologize, but I need to make sure we are able to allow everyone to testify in the time frames we have.

Izack Tenorio, representing Valley Health System:
I am here representing the Valley Health System of hospitals. In the interest of time, I will echo the comments of the previous testimonies.

Wiz Rouzard, Deputy State Director, Americans for Prosperity, Nevada:
On behalf of more than 100,000 activists with our organization, we urge you to vote no on A.B. 85, which creates another bureaucratic commission called the Independent Commission on Rates for Health Care Services to control and fix the rates charged by medical care facilities, surgical centers, ambulatory services, patients' goods and services. If our goal is to attract and have the best health care in the nation, a bill like this simply does the opposite. Price controls cause scarcity and are never helpful to consumers. Our state should work on empowering every person to attain success, contribute to his or her community, and live productive, meaningful lives. If passed, however, this bill would not create a health care system that delivers quality care at a cost Nevadans can afford.

Like any other market, competition has been more effective in driving down costs and creating better choices than price-fixing ever could. Although well-intentioned, price-fixing does more to limit available supply than to improve it. Doctors, nurses, and hospitals should be free to compete to offer the best health care at the best price that meets the needs of their patients.

For reasons we and others have shared, we urge you to vote no on this bill.

Brian D. Kleven, Chief Financial Officer, Nevada Market, Dignity Health-St. Rose Dominican:
St. Rose Dominican is the only not-for-profit, faith-based health system in all of southern Nevada. We do not have shareholders. We proudly serve, and in fact it is our privilege to serve, in the best interests of the communities that we operate in. I am here today in opposition to A.B. 85 and agree with my colleagues who have spoken before me.

There are so many unknowns related to this bill that it is extremely difficult for our team to model what kind of impact this would have on Dignity Health-St. Rose. Medicare rates, as stated before, do not cover costs. Medicaid rates are far worse, and there is no guarantee that the state or this rate commission would pay providers more than Medicaid rates.

Modeled at rates set at Medicare levels, that issue alone would result in a $233 million bottom-line reduction to Dignity Health-St. Rose, and the hospitals we operate, ambulatory surgery centers, medical groups, and micro hospitals we operate in the greater Las Vegas area. Because Dignity Health-St. Rose is a not-for-profit system, any operating model excess is redistributed and reinvested back into the community that we serve to pay for charity care and to support Nevada's already limited health structure. In 2022 alone, during financially challenging times due to the COVID-19 pandemic, Dignity Health-St. Rose contributed almost $112 million in community benefits in charity care as part of our operating model.

Dignity Health-St. Rose has been a part of southern Nevada since 1947. We have been there 76 years, living the mission of the Adrian Dominican Sisters, and we proudly do it. This bill would jeopardize our ability to adequately care for patients and provide care. A rate commission is the wrong thing for Nevada. Thank you for your time and thank you for serving as elected officials in the great state of Nevada.

Sara Watkins, Executive Director, Nevada State Medical Association:
Our members across all specialties of the Nevada State Medical Association oppose this bill, as it could negatively impact a provider's ability to negotiate rates and further practices to remain solvent and available to provide care to Nevada patients. It is not about the solvency of the physicians. It is about the ability of their practices to continue to provide care, which is dependent on the practice's solvency, not the physician's. This could also be a direct effect on the overall potential barriers to access to care for patients. Thank you for the opportunity to speak on this bill.

Lindsay Knox, representing Nevada Orthopaedic Society:
We currently believe that fixing rates would create a loss of service line. Health care entities would be exiting the market, and it would be even more difficult to provide adequate medical care to Nevada citizens. As a recent patient to the Reno Orthopedic Clinic's ambulatory surgery center, I expected quality care. I know the rate that I paid and the number I saw when I signed that piece of paper saying what I would be paying pays for the nurses, my physician, my anesthesiologist, and that facility, all of which, I believe, was the best care I could have asked for. I believe with this bill, that would be diminished.

Chris Bosse, Vice President, Government Relations, Renown Health:
Renown Health is the only private, not-for-profit hospital in the Reno and Sparks area. We are opposed to A.B. 85 and support the testimony of the folks before me opposing this bill.

I had a whole bunch of things written but I do not want to waste your time with a bunch of details. I do think that the intention of rate regulation if it were to work perfectly, my fear is that patients could end up paying more. As Mr. Kelly mentioned earlier, more than half of us are losing dollars from operations. If this rate commission were to actually take all the underfunding that happens from Medicare, Medicaid, and uninsured that we provide now as the safety net facility in northern Nevada, fold that into rates for commercial products in northern Nevada, add a fair rate of return—right now my organization is losing tens of millions of dollars—the rates I would have to be paid would be significantly higher than I receive today in order to make up for that shortfall.

I urge you to really pay attention to Nevada specifically. I think we have an unusual dynamic as it relates to Medicaid and just how underfunded we are in this state. Seventy-five percent of the population we serve are those programs. We are only talking about rate fixing about 25 percent of the population we serve. If we were actually going to do what the Assemblyman indicated, we could end up with much higher rates.

Helen Foley, representing Nevada Association of Health Plans:
The Nevada Association of Health Plans is a trade organization of ten member companies that provide commercial health insurance and government programs in Nevada. I do apologize to you. I just got our letter to the committee manager today. I will submit that for the record. [The letter was not received.] We agree with everything that has been said in opposition.

Kristina R. Kleist, representing Northeastern Nevada Regional Hospital:
We are also opposed to this bill and echo the concerns mentioned and submitted by the Nevada Hospital Association [Exhibit D] and support the testimony of others in opposition today.

Chair Peters:
Is there anyone else in Carson City who would like to provide opposition testimony? [There was no one.] Is there anyone in Las Vegas who would like to provide opposition testimony?

Emily Osterberg, Director, Government Affairs, Henderson Chamber of Commerce:
I am here representing the Henderson Chamber of Commerce and our over 1,800 members. Forcing fixed hospital rates based on Medicare costs would not cover the full cost of care, causing hospitals and services to close across the state. Because of these concerns, the Henderson Chamber opposes A.B. 85.

Chair Peters:
Is there anyone else in Las Vegas who would like to provide opposition testimony? [There was no one.] Is there anyone on the public line wishing to provide opposition testimony?

Marcos Lopez, representing Nevada Policy Research Institute:
Nevada Policy Research Institute opposes A.B. 85. More government price controls into the health care market are not the solution. There are very few economic questions that have as much agreement among economists than the failure of price controls. There is an extensive body of economic literature that has repeatedly shown that regardless of the goods and services, price controls always have negative consequences. This bill will certainly lead to further price-shifting and reduced health care options for Nevada.

This is the most fundamental lesson of economics. The interest action of supply and demand determines price. For too long, the government has been restricting price competition in the markets by artificially limiting supply, the restrictive licensing schemes that prevent health care professionals from operating across state lines, and certificate of need laws. There is a ton of work we need to do to help fix our economic system and our health care system, but this is not the solution. We should be looking at ways to reduce the distorted and destructive effects of existing interventions, not going to a full, commanding control of our health care sector. It is paramount to the efficiency of the Soviet Union, what we are going to see if we go down this path.

Chair Peters:
Are there any other callers on the public line to provide opposition testimony? [There were none.] We will move to neutral testimony. Is there anyone here in Carson City?

Barry Cole, Private Citizen, Reno, Nevada:
I am neutral for a variety of reasons. I am a psychiatrist, which means I am sort of left of center on those things, anyway. Until recently, psychiatrists actually earned less than pediatricians, which is hard to believe, but now we are doing much better. There is no profit in Medicare. I have learned that from working in what are called DRGs, diagnosis-related group-exempt geropsychiatric units. I have kept the hospital alive because of the ten-bed geropsychiatric unit I ran that got them the revenue they needed to underwrite the rest of the hospital. We need to get every willing Nevadan to actually get insurance. That was the intent of Obamacare until the Supreme Court of the United States gutted that element of it.

There is a caution to this. If we do not take care of sick people early in their illness when they could benefit from preventive care, we are going to get a sicker cohort of patients who will cost more to treat. The deinstitutionalization of the mentally ill has led to people now living on the streets, homeless, and eating out of dumpsters. Worse, they are not getting basic medical care, or they are getting inadequate care. We have actually heard from the commissioner of the prison system that not only are a majority of his inmates violent and sexual predators, but they are also mentally ill substance abusers. We are going to pay for these people somewhere. I think the idea that is coming forth in this legislation—and why I am neutral—that needs to be resolved is how we answer all of these societal questions because what is being debated is, fundamentally, a national health plan.

I just want to leave you with a chilling prediction of my grandfather in 1964. He was also a physician, and he said health care was over as a consequence of Medicare. I assure you, health care is not over, and I am still alive.

Chair Peters:
Seeing no one else in Carson City to provide neutral testimony, is there anyone in Las Vegas who would like to provide neutral testimony? [There was no one.] Is there anyone on the public line who would like to provide neutral testimony on A.B. 85? [There was no one.] Would the bill sponsor like to provide closing remarks?

Assemblyman Orentlicher:
I do have a few comments. Mr. Kelly gave some data points which seemed to make it look like things are rosy. I want to give you the most important data point and that is, where do we rank as a state and the percentage of our citizens and residents who are uninsured. We are the eighth worst in the country in terms of uninsured rate. To me, that tells us we need to do something now to make sure we reach people. We should not have that level of uninsurance.

We have heard that hospitals will not get enough money, or they will get too much money. It goes down; it goes up. However, the bill language is very clear. The hospitals will be fairly paid. That is the standard. It will cover their reasonable costs, and they will get a fair profit. No, they are not going to be underpaid by this bill. They are going to be fairly paid.

In terms of people's concerns about price-fixing, we already have price-fixing by insurance companies. The only question is who is going to do it. The reason I brought this bill is because the market is not working. Hospitals are exploiting their market power. It is not a level playing field. All of this is about making sure it is a fair setting of prices because we have an unfair system now.

Finally, we heard from a lot of doctor groups about how this bill will affect them. This bill will not affect them. It is about facilities, not physicians. I understand their concern that if we regulate facilities now, the next bill will be about physicians. That is not my intention. This bill is only for facilities.

I appreciate all the time today and your helpful questions. I look forward to further discussion.

Chair Peters:
Thank you, Assemblyman Orentlicher, for your comments. I will close the hearing on Assembly Bill 85.

Assembly Bill 119 came out of the Joint Interim Standing Committee on Judiciary but pertains to health and human services, which is why it came to our Committee. This will be the first time we have really heard about this issue, so please be prepared with questions. I will open the hearing for Assembly Bill 119.

Assembly Bill 119: Creates the Vulnerable Adult Fatality Review Committee. (BDR 38-311)

Assemblyman David Orentlicher, Assembly District No. 20:
I am honored to present Assembly Bill 119. This bill would create a committee to study vulnerable adult fatalities. When we have vulnerable adults who die and there are suspicions there may have been maltreatment, this committee would study those fatalities, so we better understand the causes of these deaths and how to reduce them. The proposal for this committee was initiated by Jennifer Richards from the Aging and Disability Services Division, Department of Health and Human Services in a July 8 letter to the Joint Interim Standing Committee on Judiciary. The letter outlines several recommendations for committee action, including the creation of this kind of committee.

As Ms. Richards observed, Nevada currently has fatality review teams for domestic violence, children, and maternal mortality. Nevada's older adult population is one of the fastest growing in the country and continues to grow. In addition, case data for Adult Protective Services, Aging and Disability Services Division, Department of Health and Human Services

continues to increase. The committee that she proposed and the committee in this bill, the Vulnerable Adult Fatality Review Committee, can address the opportunity in Nevada to develop an elder abuse fatality review team. This kind of team can review deaths resulting from or related to elder abuse to learn about and improve the response of Adult Protective Services, health care providers, law enforcement officers, prosecutors, victim assistance providers, and other stakeholders.

What the committee learns as they review these fatalities can be used to promote policy changes in both government and private agencies, identify gaps in services for victims prior to death, increase public awareness, and positively impact the safety and health of Nevada residents. The American Bar Association has also discussed the value of these kinds of review teams, and they have been successful in other states.

I will walk you through the bill and then will rely on Ms. Richards to help me answer questions. Sections 2 through 7 define key terms in the bill. Section 8 establishes the committee and defines its membership. Sections 9 and 10, starting on page 4, line 18, set out the responsibilities of the committee to review a death in the state that is suspected or known to be caused by maltreatment. The death is investigated to determine what happened and how the state can do better in the future.

Sections 11 and 12 describe the actions the committee can take and the public records it can access to carry out the review responsibilities.

We also have a conceptual amendment [Exhibit E] to ensure the committee's work will lead to the necessary changes. Number one provides that the reports they make every year will go to the Office of the Attorney General and the Joint Interim Standing Committee on Health and Human Services in an even-numbered year, or the next regular session of the Legislature in an odd-numbered year. Number two requires the Attorney General to develop a plan to address the findings. The committee will determine what can be done to reduce fatalities, and we want the Attorney General to develop a plan to address the findings, take corrective actions, recommend policies, and hold a public hearing concerning its plan in order to get follow-up and ensure the reports do not get lost. Number three, a representative of the committee or Ms. Richards' office will present the findings, corrective actions, and policy recommendations to the Joint Interim Standing Committee on Health and Human Services when it meets during the interim.

Ms. Richards, would you like to add anything before we take questions?

Jennifer M. Richards, Chief Elder and Disability Rights Attorney, Aging and Disability Services Division, Department of Health and Human Services:
I am open to any questions you may have regarding this legislation.

Chair Peters:
There are several questions from the Committee.

Assemblywoman González:
I have a couple of questions regarding the board. Forgive me, but this is my first time on the Committee on Health and Human Services, so a lot of these questions are about how this will function. Section 8, subsection 3, paragraph (b) states they will be "Without compensation but are entitled to receive the per diem allowance and travel expenses . . . ." In section 11, subsection 1, it talks about consulting with experts to ensure data is being collected, and then in section 11, subsection 4, it also talks about employing such persons as deemed necessary. Is this board looking to hire people? In section 8, subsection 3, paragraph (b), it says they are not getting paid but will get per diem, but then it says they can employ people. Also in section 11, subsection 1, consulting with experts, are the board members not the experts? I am just curious as to what that means.

Jennifer Richards:
The team is intended to be a multidisciplinary team of professionals from across the state, typically from coroner's offices and professionals from Adult Protective Services. The members of the team are not paid to be part of the team, but the Aging and Disability Services Division would reimburse expenses as necessary. That is the allowance you see in section 8, subsection 3, paragraph (b). They would then be tasked with reviewing and developing the scope and protocol through regulations of how the team will operate and what that review entails.

At this time, the Division has not placed any fiscal impact on the bill. That may be something that needs to be addressed in future budgets.

Assemblywoman González:
How is there no fiscal impact if we are reimbursing for per diem and travel expenses? That sounds expensive.

Jennifer Richards:
The Division's hope is to utilize technology as much as possible to facilitate the meetings and potentially use any other budgetary funds that are available as necessary. We currently have multidisciplinary teams authorized in statute, but they are on the micro- and mezzo-level addressing specific cases. Those meet virtually across the state through Adult Protective Services. Again, that may be a budgetary issue in the future, but at this time, there is no fiscal impact indicated.

Assemblywoman Thomas:
My question deals with section 8, subsection 2, regarding the director. Who appoints the director? How did you come up with the director? Is the director appointed by the Governor? I understand the director will select 6 and not more than 12 members. I want to know how the director gets to be the director.

Chair Peters:
It is not defined in this particular bill, but I think it is inherent in this section, we are looking at the Department of Health and Human Services, and then the director would be the director of the Department of Health and Human Services. If that is incorrect, please correct me. It is not specifically defined here, but it is a part of this particular statutory section.

Assemblywoman Thomas:
Should it be?

Chair Peters:
That is a good legal question. We can follow up with our Legal Division staff.

Assemblywoman González:
Section 12, subsection 4 states, "The Committee may use data collected concerning a death that is known or suspected . . ." to have occurred. Are you implementing a new data system for this or are you just working with other offices to get that data? My last question is regarding the conceptual amendment. Is the Office of the Attorney General okay with the responsibility to address the findings and develop a plan? I thought the intention was Adult Protective Services would be finding a plan and a solution. I am curious why we are giving that to the Office of the Attorney General.

Assemblyman Orentlicher:
I will start with the second question and defer to Ms. Richards on the first. I have not had a chance yet to talk with the Office of the Attorney General. I do know they already work with the Division in this area, and they already coordinate when there are concerns about mistreatment of vulnerable adults. I will touch base to make sure they are comfortable with this additional responsibility.

Jennifer Richards:
Before I answer your question, Assemblywoman, I would like to highlight that data in this area is very difficult to obtain. Adult maltreatment is subversive, and it is underreported. According to the National Center on Elder Abuse, 1 in 10 community dwelling adults experienced abuse in the prior year. If you look at individuals with intellectual or developmental disabilities, they are 4 to 10 times more likely to be abused than their nondisabled peers. According to a study, less than 1 in 14 cases actually makes it to the authorities to be reported. We have pieces of the puzzle at different agencies, but there is no central repository that addresses adult maltreatment. This team would fill that system's gap and collect those pieces across the spectrum, compile the data, and give us actionable items.

An example I have in my notes is, Adult Protective Services had 231 deaths in the state fiscal year 2022. We do not correlate those deaths with the coroner's office, for example. There is no communication with facility deaths due to neglect in one central space. It is not creating a new database; it is really taking the pieces of the puzzle that exist in different sectors and compiling them so we can get a clear picture of how we can help Nevadans. Every person, regardless of age or disability, has a right to live abuse-free in our state.

As our population grows, especially our individuals with cognitive disabilities such as dementia—we are the fastest-growing state for individuals with dementia who are more subject to abuse—we need to have that clear picture so we can improve our system to respond to those needs.

Assemblywoman González:
I look forward to continuing our conversation offline.

Chair Peters:
I want to direct the Committee's attention to two of the handouts that were given to us related to the research done on elder abuse [Exhibit F and Exhibit G]. I think it is easy to think that adults should be able to take care of themselves, but there are points in life where they need extra help. It is not necessarily a sexy or hot topic, but we are constantly trying to drive folks into the geriatric research space and geriatric care space because this is a growing population with a variety of issues we are looking at.

I appreciate the follow-up commentary. I was wondering about the research that has already been done in this area. We have a variety of state bodies that already look at elder abuse issues. I was wondering what this was going to do in relation to all of those. I think you clarified that for me very well.

We have a couple of other questions from the Committee.

Assemblyman Nguyen:
Along the lines of what Chair Peters just said, looking at the language of the bill, it is the intent for the Director of the Department of Health and Human Services (DHHS) to organize this body. Are there other bodies in this state currently, whether it is a Governor's commission or a different commission that exists, that are already looking at aging and issues dealing with the elderly community, or is this something that is unique and needs to be separated under DHHS?

Jennifer Richards:
There is not currently a fatality review team that addresses vulnerable adults. Other teams exist that have a different focus. Certainly, there are other bodies, boards, and commissions that address issues pertaining to older adults and people with disabilities, but there is not a team that has a focus specifically on system gap improvements for victim services and deaths that result from those instances.

Currently, there are 35 teams operating across the country, according to the American Bar Association. They have done studies to demonstrate the efficacy of these teams and have demonstrated how they improve systems in these states across the board. Where the teams are housed varies state by state. In some states, the team is housed within the office of the attorney general and in some states it is housed within the department of health and human services. The Assemblyman and I had that discussion candidly. Because Adult Protective Services already facilitates a multidisciplinary-type team, the team fit within DHHS at this

time in order to align with social services needs and address victim services aspects. It would bookend very well with the work of the Nevada Attorney General's Office. They have a special unit, and they are part of this legislation and specifically noted in the bill language.

Assemblyman Nguyen:
Before I ask my question, I would like to thank the Assemblyman for including "Represent the racial, ethnic, linguistic and geographic diversity of this State" in section 8, subsection 2, paragraph (b). That is an amazing line and usually my line of questioning in every single bill.

In terms of the previous paragraph, section 8, subsection 2, paragraph (a) regarding the makeup of the committee, I know it is very general in the bill in terms of giving the committee the ability to appoint a diverse group, but I want to make sure we specify some more things. This is just a suggestion, but if we could spell out law enforcement roles a bit more specifically because there are many layers of law enforcement. I want to make sure we specify the type of law enforcement that needs to be in there as well as social workers. Those are two things I see missing from the bill.

Jennifer Richards:
Our intent in leaving it a little broad was that the team would be developed by regulation so it could adapt to the changing needs in the state. I know California's fatality team, for example, reviewed COVID-19-related deaths in facilities that they identified were part of neglect, isolation, et cetera. They have the flexibility to pivot and determine what deaths they would focus on and what deaths they would not, and who may be necessary to be part of the team.

Our thought during the discussion of the bill was to leave that composition somewhat broad so the team makeup could reflect the needs of the state as it ebbs and flows. Certainly, local law enforcement, Adult Protective Services, social workers, and other health care entities may all be part of the makeup of the team. That would be spelled out through regulations once the legislation is adopted.

Assemblywoman Newby:
I have a question about section 12, subsections 3 and 5. It seems section 12 contemplates that there is investigation by law enforcement into a situation and the information coming out of that investigation then goes to this committee. What I am concerned about in those subsections is, it shields any additional information the committee gets from turning it over to any prosecution or criminal investigation because it says it must not be disclosed. Could you speak to that a little bit? It seems like whatever information this committee has should be made available to everyone. If I am wrong, please correct me.

Chair Peters:
This may be a situation in which we have to go back to our legal staff and ask about the connections there.

Jennifer Richards:
I do not interpret it that way. The goal of the committee is not prosecution or a blame-and-shame culture. It is truly to identify system gaps and improve the adult maltreatment response across the state on a large scale. However, I do believe the bill allows for referral "to the Unit for the Investigation and Prosecution of Crimes Against Older Persons or Vulnerable Persons of the Office of the Attorney General," if that should develop from the team. That was something we added at their request. That is in section 10, subsection 3, paragraph (b), indicating where the committee would refer a case to that special unit for further investigation and prosecution if appropriate.

Assemblywoman Newby:
In that case, I do believe section 12, subsection 5 may need to be changed where it says, "the records of, the Committee are confidential, are not public records, must not be disclosed and are not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding."

Jennifer Richards:
I will defer to the Legislative Counsel Bureau on that.

Chair Peters:
We will follow up with our legal staff on that and get back to you. I forgot to direct the Committee's attention to the conceptual amendment [Exhibit E] on this bill. Would you like to talk about the conceptual amendment? One of the things that came up for me in reading the bill initially as it came to our Committee was the actionable items from the newly set-up committee were unclear to me. I asked Assemblyman Orentlicher to talk about and work up what will now happen. Once we set up a committee, we like to see actionable things happening from the committee. The conceptual amendment includes some of those things, if you would like to go over a few of those.

Assemblyman Orentlicher:
Yes, we do want to make sure the work of this review committee does lead to action. There will be some annual reports to the Attorney General and the Joint Interim Standing Committee on Health and Human Services in the years it meets, and in other years it goes to the Legislature. We will hear about it, the Attorney General will hear about it, and then the Attorney General will develop a plan to address the findings. Not only will the Attorney General get the report, but will be required to act, develop a plan, and hold a public hearing for that plan. Also, the representative from Ms. Richards' office or the committee itself will present the findings and policy recommendations to the Joint Interim Standing Committee on Health and Human Services, so our interim analog will hear the report and have the opportunity to decide what action to take and come back to it.

Chair Peters:
Are there any questions from the Committee on the amendment or these additional items? [There were none.] Are there any other questions related to the bill? [There were none.] We will move into testimony. Is there anyone who would like to provide support testimony for A.B. 119 in Carson City?

Barry Cole, Private Citizen, Reno, Nevada:
I am a retired psychiatrist/neurologist. That has some relevance because in the last 24 hours of my mother's lucidity after she was hospitalized off and on for two years, she put her head on my shoulder and said, "I don't know what I would have done without you." What she really meant is, not very many people bring their own neurologist, psychiatrist, pain specialist, or master in public administration with a bad attitude when you screw with his mother. That changed a lot of the dynamics.

When she first came to Reno, having relocated from Roseville, California, I had to put her into a facility for memory care. That facility allowed her to fall repeatedly, allowed her to lie in bed for a week in her own excrement, did not feed her, did not provide her hydration. She then spent ten days in Saint Mary's Regional Medical Center recovering from that to go for four months to a rehabilitation facility to try to relearn and regain. She never did. She was downhill from that point on. The next memory care unit I admitted her to allowed a temporary employee to cut her wedding ring with two diamonds off her finger. A police report was filed, and the employee was terminated the next morning and disappeared from Nevada the next day.

Elder abuse is the norm; it is not the exception. I really want to make that point. We are an aging population. We have a lot of people in Nevada who are elderly. This idea of investigating bad things that happen to elderly, frail people is really important. I am soon to be one, and that scares me. What I saw with my mother, I do not want to happen to other people's mothers, and I do not want it to happen to my wife or me. I ask for your consideration of A.B. 119.

Chair Peters:
Thank you for your testimony. We feel for you in dealing with your mom's situation and are grateful you were there for her.

Jonathan Norman, representing Nevada Coalition of Legal Service Providers:
The Nevada Coalition of Legal Service Providers includes the Legal Aid Center of Southern Nevada and Northern Nevada Legal Aid. We represent protected persons and proposed protected persons. We have around 20 attorneys and are representing thousands of people who are in guardianship in care facilities. The story that was just shared, where persons are moving from facility to facility to facility, I think the power of this bill is following that thread to identify where the system has let down our elderly population. I think that is important for our attorneys because we are in those cases until the client passes away. Rarely is it the case where younger clients may come out of the guardianship. Typically for our

elderly, we are in it until they pass away. If there are questions about what happened, I think having this organization and this thread to say a step was missed where we could have protected someone is really important. I urge your support of this bill.

Chair Peters:
Seeing no one else in Carson City for testimony in support, we will move to Las Vegas. Is there anyone in Las Vegas who wishes to provide testimony in support of A.B. 119?

Charlie Shepard, State President, AARP Nevada:
Today, I testify on behalf of AARP Nevada's 347,000 members. AARP has a long history of fighting for protections for seniors and has been on the forefront of advocacy in support of federal and state laws and regulations that prevent elder abuse. Elder abuse, like many other forms of domestic abuse, is an often-hidden phenomenon that affects hundreds of thousands of older Americans.

Like other forms of abuse, it often occurs in hidden circumstances and is underreported. A study sponsored by the National Institutes of Health, U.S. Department of Health and Human Services, estimated that only 1 in 14 cases of abuse is reported. Older adults who experience elder abuse are likely to number in the hundreds of thousands.

Across the country, elder abuse fatality review teams, similar to the proposed Vulnerable Adult Fatality Review Committee in A.B. 119, examined the deaths of individuals that may have been caused by or related to elder or adult abuse with the goal of identifying system gaps and improving victim services.

It is AARP's belief that states should support the formation and ongoing operation of multidisciplinary teams like the Vulnerable Adult Fatality Review Committee to address elder abuse issues that cannot be effectively resolved by a single discipline and train professionals from a variety of disciplines, including prosecutors, police officers, sheriffs, lawyers, employees of financial institutions, and adult protective services agencies, to improve detection, investigation, and enforcement regarding cases of abuse, neglect, and exploitation. [Written testimony was also submitted Exhibit H.]

Chair Peters:
Is there anyone else in Las Vegas who would like to provide testimony in support of A.B. 119? [There was no one.] Are there any callers on the public line who would like to provide testimony in support? [There were none.] We will move to testimony in opposition. Is there anyone in Carson City or Las Vegas who would like to provide opposition testimony on A.B. 119? [There was no one.] Is there anyone on the public line who would like to provide opposition testimony? [There was no one.] We will move to neutral testimony. Is there anyone in Carson City or Las Vegas who would like to provide neutral testimony? [There was no one.] Is there anyone on the public line who would like to provide neutral testimony? [There was no one.] Would the bill sponsor like to provide any closing remarks? [He did not.]

[Exhibit I and Exhibit J were submitted in support of Assembly Bill 119.]

I will close the hearing on Assembly Bill 119.

That was the last bill on our agenda today. Are there any remarks from the Committee? [There were none.] Is there anyone in Carson City or Las Vegas who would like to provide public comment? [There was no one.] Is there anyone on the public line who would like to provide public comment? [There was no one.]

Our next meeting will be Monday, March 6, 2023, at 1:30 p.m.

The meeting is adjourned [at 3:23 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Recording Secretary

_____
Lori McCleary
Transcribing Secretary

APPROVED BY:

_____
Assemblywoman Sarah Peters, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a PowerPoint presentation, titled "AB 85: Fair fees for care at hospitals, surgical centers, and emergency care centers," presented by Assemblyman David Orentlicher, Assembly District No. 20.

Exhibit D is a letter dated March 2, 2023, signed by Patrick D. Kelly, President and Chief Executive Officer, Nevada Hospital Association, including various supporting documents in opposition to Assembly Bill 85.

Exhibit E is a conceptual amendment to Assembly Bill 119, submitted by Assemblyman David Orentlicher, Assembly District No. 20.

Exhibit F is a document titled "Abuse of Adults with a Disability," from the National Center on Elder Abuse, submitted by Jennifer M. Richards, Chief Elder and Disability Rights Attorney, Aging and Disability Services Division, Department of Health and Human Services, regarding Assembly Bill 119.

Exhibit G is a document titled "How at Risk for Abuse Are People with Dementia," from the National Center on Elder Abuse, submitted by Jennifer M. Richards, Chief Elder and Disability Rights Attorney, Aging and Disability Services Division, Department of Health and Human Services, regarding Assembly Bill 119.

Exhibit H is written testimony presented by Charlie Shepard, State President, AARP Nevada, in support of Assembly Bill 119.

Exhibit I is written testimony submitted by Charles Duarte, Nevada Public Policy and Advocacy Director, Alzheimer's Association, in support of Assembly Bill 119.

Exhibit J is a letter dated February 6, 2023, signed by Paul R. Greenwood, Deputy District Attorney, Retired, San Diego, California, in support of Assembly Bill 119.