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

Eighty-Second Session
March 29, 2023

The Committee on Health and Human Services was called to order by Chair Sarah Peters at 1:36 p.m. on Wednesday, March 29, 2023, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda [Exhibit A], the Attendance Roster [Exhibit B], and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/82nd2023.

COMMITTEE MEMBERS PRESENT:

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

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Eric Robbins, Committee Counsel
David Nauss, Committee Counsel
Terry Horgan, Committee Secretary
Ashley Torres, Committee Assistant

OTHERS PRESENT:

Maggie Carlton, Executive Director, United Labor Agency of Nevada
Bobbette Bond, Vice President, Health Policy, Culinary Health Fund
Mason Van Houweling, Chief Executive Officer, University Medical Center
Susie Martinez, Executive Secretary-Treasurer, Nevada State AFL-CIO
Marc Ellis, President, Communication Workers of America, Local 9413
Randy Soltero, representing International Alliance of Theatrical Stage Employees
Paula Luna, Operations Manager, Battle Born Progress
Paul Catha, representing Culinary Workers Union, Local 226
Maya Holmes, representing Culinary Health Fund
John Abel, Director of Government Affairs, Las Vegas Police Protective Association Metro, Inc.; Co-chair, Las Vegas Metro Police Health Trust
Linda Hunt, Member, Culinary Union
Stacie Sasso, Executive Director, Health Services Coalition
Russ James, President, Building and Construction Trades Department, Nevada State AFL-CIO
Renee Ruiz, Legislative Advocate, National Nurses United; National Nurses Organizing Committee of Nevada
Todd Inglesbee, President, Professional Fire Fighters of Nevada
Gary Watson, President, Teamsters Union, Local 533
Robert Sumlin, International Association of Machinists and Aerospace Workers, Local 711
Michael Gittings, President, United Food and Commercial Workers Union, Local 711
Sue Bird, Private Citizen, Fernley, Nevada
Liz Sorenson, President, Nevada State AFL-CIO
Sarah Watkins, representing Nevada State Medical Association
Irene Gutierrez, M.D., Program Director, Family Medicine, Dignity Health-St. Rose Dominican
Connor Cain, representing HCA Health Care; Sunrise Hospital; and Sunrise Children's Hospital
Dan Musgrove, representing Valley Health System of Hospitals
Patrick D. Kelly, President and CEO, Nevada Hospital Association
Paul J. Moradkhan, Senior Vice President, Government Affairs, Vegas Chamber
Kerrie Kramer, representing Aetna CVS Health
Barry Cole, Private Citizen, Reno, Nevada
Sara Ralston, Patient Advocate, Patient Protection Commission

Maria-Teresa Liebermann-Parranga, Deputy Director, Battle Born Progress
Leann McAllister, Private Citizen, Las Vegas, Nevada
Dionne Klug, Private Citizen
Alma Lozoya, Private Citizen, Las Vegas, Nevada
Linda Ward Smith, Private Citizen
Helen Foley, representing Nevada Association of Health Plans
Brian Kleven, Nevada Market Chief Financial Officer, Dignity Health-St. Rose Dominican
Chris Bosse, Chief Government Relations Officer, Renown Health
Deanna Latus, United Food and Commercial Workers Union, Local 711
Rawanda Rogers, Private Citizen, Las Vegas, Nevada
Ann Deconge, Private Citizen
Jim Wadhams, representing Nevada Hospital Association
Nancy Jones, Board Member, Health Freedom Nevada
Kathleen Palmer, Private Citizen, Carson City, Nevada
Janine Hansen, State President, Nevada Families for Freedom
Joy Trushenski, Private Citizen, Carson City, Nevada
John Eppolito, Private Citizen
Alida Benson, Executive Director, Nevada Republican Party
Lynn Chapman, State Treasurer, Independent American Party
Lisa Partee, Private Citizen
Bob Russo, Private Citizen, Gardnerville, Nevada

Chair Peters:
[Roll was taken. Committee rules and protocol were reviewed.] We will move on to our agenda. These are Patient Protection Commission (PPC) bills that were developed during the interim. The PPC has quite a history, and we have an opportunity to hear from former Assemblywoman Maggie Carlton who helped facilitate the design of the Patient Protection Commission and has an immense amount of institutional knowledge around the development of that commission. I would like to invite Ms. Carlton to give us a brief history on the PPC, how these bills come to be, and why we are hearing them today.

Maggie Carlton, Executive Director, United Labor Agency of Nevada:
Thank you for scheduling these three bills for hearing. The Patient Protection Commission is near and dear to my heart. It is the last bill I did in this building, and that was for a reason. I believed it was important to have a body that would have constructive experts build consensus and talk about real public policy issues when it came to health care. I survived this building on the second floor, third floor, and fourth floor through all kinds of health care debates, arguments, and even the dental wars of 2003 and 2005, so I do not want any of you to have to go through all that.

When we originally started working on balance billing, or surprise billing, the Patient Protection Commission was always part two of that. It took over a decade to get balance billing through this building, and I thought, Why do we have to take so long? Why do so many legislators have to take so much of their valuable time to talk about these things and

work on these things when we could have another body sit down and work on real data, real issues, and come to consensus on items to bring to the Legislature to let lawmakers know where we think the state of health care is and what needs to be done. In Senate Bill 544 of the 80th Session, the Patient Protection Commission passed, and that was a budget bill. The former governor put it in his budget, and I worked very closely with him on that. The mission was "To systematically review issues related to health care needs of Nevada residents and the accessibility, affordability and quality of health care in this state"; to have a body of experts sit down and look at all these different issues. The PPC bill that was passed in 2019 was our first attempt at that, and we did pretty well. We had some great commissioners doing a lot of good work. In 2021 there was one more bill. Anytime you do something, there are always some tweaks the second time around. We changed the makeup of the Commission and moved it over to the Department of Health and Human Services (DHHS). That was a data thing. The nexus between the Commission, DHHS, and the data we wanted to get made perfect sense. That was a good home for the Commission. So, that is my experience in health care in this building over the last 24 years and why the Patient Protection Commission is an integral part of the health care conversation in the state moving forward.

Chair Peters:
Thank you so much for the introduction. I also have been in this building since 2019 and the inception of the PPC. It has been a journey to get here, but it is part of a larger process we saw around surprise billing and the idea we needed to stand up something that was protective of the patient at the policy level. I appreciate the history and your ability to run us through the timeline, history, and intent of the PPC.

We have three bills in front of us from this last interim cycle of policy, vetting, and development through the PPC and we will be starting with Assembly Bill 11. It is my understanding, Ms. Carlton, that you are willing to introduce the concept of this bill. We will open the hearing on Assembly Bill 11.

Assembly Bill 11: Prohibits certain hospitals from employing a physician. (BDR 40-382)

Maggie Carlton, Executive Director, United Labor Agency of Nevada:
With the changes that have happened in the PPC recently, there is not an executive director who could present. Without having that option, and since I care deeply about this, I was asked if I would help present the bills because I know the process.

Assembly Bill 11 is known as the "corporate practice of medicine" bill. Last interim, while I was still serving in the Assembly, I asked for some research on this bill because I needed to learn more about it. I had heard about it, but only anecdotally. I received that research, and it is available to you if you would like to have it. That is the document I am going to be working from. Before I worked with the Patient Protection Commission moving forward on this, I wanted to make sure I understood the process really well. The overarching theme of A.B. 11 is the fact that we have had multiple attorneys general opinions—going back to

Attorney General Laxalt in 1977—that the corporate practice of medicine is not to be done here in the state. There are exemptions to that because not every rule is absolute, and in health care you need to make exemptions. The exemptions in the bill strictly apply to health care facilities in psychiatric hospitals. Something I think about with corporate practice of medicine is that the employment of a physician by a corporation may interfere with the physician's independent medical decision making. Is he accountable to his boss or is he accountable to his patient? Keep in mind his boss has shareholders to whom he is accountable. That is one reason we should not have the corporate practice of medicine in this state. We have always said that, when it comes to health care, the relationship is between the patient and the doctor, or the health care provider, and it needs to stay that way. Nobody should get in the middle of that relationship. As I alluded to, we are not sure where the corporation's obligation to their shareholders would be and if it would align with good patient outcomes. Those two thoughts are what I have boiled it down to when it comes to the corporate practice of medicine. I will invite up the commissioners who serve on the PPC and who were involved in A.B. 11 to expand upon that.

Chair Peters:
Thank you so much for that bit of history and research that has been done previously on this issue. We know this is an important issue you oversaw over the interim. Welcome, presenters. Please state your names for the record.

Bobbette Bond, Vice President, Health Policy, Culinary Health Fund, Las Vegas, Nevada:
I represent the Health Services Coalition, serve on the PPC, but here I am representing the Culinary Health Fund.

Mason Van Houweling, Chief Executive Officer, University Medical Center:
I am the chief executive officer of University Medical Center.

Bobbette Bond:
[Bobbette Bond presented a PowerPoint, Exhibit C.] Thank you for having us. At this late date, I appreciate the opportunity talk to you about the Patient Protection Commission. I am an originator of the Commission and have been with it since its inception in 2019. I am going to go through our understanding of the history of the corporate practice of medicine. This came to the Commission because there is confusion in the law and there is misinterpretation. It seemed an easy way for us to nip that in the bud before the confusion got worse. That was my reason for supporting the Patient Protection Commission having this be one of its three bill draft requests they are able to do a year. There are a lot of bill draft options, and it was great that this one was selected. I am here today on behalf of the Health Services Coalition and the Culinary Health Fund because my understanding is the PPC commissioners were asked not to present.

We said there have been some attorney general opinions that are part of this history we want to go through, and Assembly Bill 11 is designed to close that confusion. Nevada has had a longstanding practice, like many states, of prohibiting private hospitals from directly

employing doctors. Instead, doctors are contracted at hospitals and also have privileges to work at hospitals. The exceptions Mason Van Houweling will talk about are laid out in statute. The exceptions to that are what was legislated in Nevada.

The corporate practice of medicine issue has been considered by three different attorneys general as Maggie Carlton said. The first one was in 1977 and Robert List was Attorney General [page 3, Exhibit C], and I am pulling out the piece I think is key, so you can focus on that instead of trying to dig through the other supporting documents [Exhibit D]. They decided to consider physicians and surgeons and the corporate practice of medicine as legal only under *Nevada Revised Statutes* (NRS) Chapter 89, but they state in the conclusion that the practice of medicine by a general corporation, which is a hospital, organized under Chapter 78 of the *Nevada Revised Statutes* is illegal. Nevada-licensed physicians who aid or abet a corporation to illegally practice medicine may be charged with unprofessional conduct and have their licenses suspended or revoked. From that time, in 1977, there was an understanding that private hospitals will not hire doctors; they will not employ doctors; they will contract with them.

Then the second opinion happened in 2002 [page 4, Exhibit C]. At that time, the Attorney General was Frankie Sue Del Papa. She was asked to see if the corporate practice of medicine usurped authority of the state. In her conclusion, she said something else about the state of corporate practice medicine. A review of the Nevada statutes and case law reflects that the law is generally unchanged from the opinion issued in 1977. The corporate practice of medicine is still prohibited unless in the form authorized by NRS Chapters 89, 695B, 695C, 695F, and 695G. If a corporation is engaged in the practice of medicine and does not come within one of these referenced statutes, it would be operating unlawfully. That is like a second bite of, "there is nothing in statute that allows private hospitals to hire doctors." In 2010, the Nevada Supreme Court determined that private hospitals licensed under Chapter 449 cannot employ a physician [page 5]. Catherine Cortez Masto, the Nevada Attorney General at that time, was asked to opine on this and said there has never been an express indication that the corporate practice of medicine pertains to employment of physicians by private hospitals.

To my earlier point, it is not in statute that they can or cannot. The statute has only listed who can. It has never listed who cannot because everybody else cannot. So, the Attorney General said, yes, there has been a longstanding practice in Nevada that physicians only work as contractors for private hospitals and not as employees. To depart from this practice would mark a significant change that would be tantamount to a change in the state public policy. Her advice was, "Ideally such a change should occur through the legislative process in order to ensure full deliberation of the affected policies and interests of the public, physicians and hospitals," which leads us to why we are here today. There are a couple of places where legislative minutes and notes suggest there was a clear understanding among many stakeholders that physicians are not hired at private hospitals.

A legislative commission in 2002 did a study about government and private enterprise. In that hearing, Allan Stipe, who was at that time president and chief executive officer of

Sunrise Hospital and Medical Center, referred to Nevada's Corporate Practice of Medicine Law and an unnamed federal statute, and said private sector hospitals cannot hire physicians [page 8, Exhibit C]. University Medical Center (UMC), however, can hire physicians. He explained that the private sector must demonstrate a different medical malpractice standard. He was trying to make the case that he was being treated differently than UMC and that has always been the case. We wanted to show you the CEO of Sunrise Hospital was saying that his hospitals were not able to hire private doctors.

The second testimony we were able to find was in 2007 [page 9]. Senate Bill 412 of the 74th Session was introduced on behalf of Touro University. The reason they were coming to the Legislature was to get permission to hire physicians for the nonprofit medical institute they were building as an institute for research and teaching. Touro University of Nevada Chief Executive Officer Michael Harter stated:

> In the State of Nevada there is a prohibition against the corporate practice of medicine if the corporation is not owned by physicians. The Attorney General has written legal opinions on two occasions on this subject, and the result is that private not for profit corporations such as Touro University . . .

I lost a little bit of the content there, but they cannot hire doctors. The fix in 2007 was to legislate, so S.B. 412 of the 74th Session was created and passed. In section 5, subsection 1, it allows a private nonprofit medical school or a nonprofit medical research institute to hire a physician and operate the clinics [page 10]. That was the solution Catherine Cortez Masto as Attorney General recommended for clarity, and that is the solution Touro University followed in 2007. It is stated in statute that these kinds of companies can hire doctors. That is the history and why we believe it is clear there should not have been a detour into private hospitals hiring doctors. I would like to turn it over to Mason Van Houweling.

Mason Van Houweling:
I have the honor of being the chief executive officer of University Medical Center, the state's largest public hospital with 2,000 students coming through our doors every year: The largest teaching hospital training the next generation of health care workers in our state. As mentioned earlier, the PPC delivered on improving access quality outcomes and looking at the rising costs of health care. I had the honor serving with our fellow commissioners for the last couple of years, and I think we have lived by that charter. As mentioned, the corporate practice of medicine applies to all corporations, not just hospital corporations, but specifically addressing it in this bill. It is an existing law. I want to remind everyone that we have existing laws meant to protect the sanctity of the physician-patient relationship, so decisions and clinical judgments are in the best interests of patients, not the corporate bottom lines. The corporate practice of medicine doctrine requires clarity in Nevada, as mentioned, and that is what the PPC addressed in this bill. There are clear exceptions found currently in *Nevada Revised Statutes* 450.180 and NRS 630.365. The actual prohibition has been discussed in many attorneys general opinions over the last several decades. The PPC felt it was time to give clear rules around the law that already exists. Except in limited situations set forth in clear NRS exceptions like the ones I just referenced, physicians form their

practices by utilizing professional corporations and professional limited liability companies. One reason for this is to ensure that the individual malpractice liability will pass through the physician owners. Most, if not all, health care professional license statutes already contain fee splitting prohibitions. There are professional fees, which is the physician, and technical fees, which are the facilities; therefore, in states that do not follow corporate practice of medicine, these professionals need to be extremely concerned when they are sharing their fees for their professional charges without clear exception under the law.

Your support and advocacy of A.B. 11 for patient protection of the patients in our state will not allow commercialization of medicine in the state of Nevada. It will prevent misalignment of physician obligations, particularly in the Medical Practice Act. It will help impact the overall delivery of care and access and not exacerbate the shortages you have heard of for years and months and probably hours before this meeting. It also ensures the growth of independent doctors in our state, working at multiple hospitals, clinics, and in urban and rural settings, and lastly not having patients directed to particular facilities which limits their options and choices.

Bobbette Bond:
The next slide on your screens is the American Medical Association (AMA) and its 2015 Advocacy Resource Center bulletin [page 11, Exhibit C]. It explains the background on corporate practice of medicine, which is such a bad title for what we are talking about. It is confusing, so we appreciate your patience. The idea that hospitals do not hire doctors in this case is to make sure there is a separation between the entity that is providing the care and the corporation that may have many things to juggle besides the patients' care. The AMA determined there are three reasons they should be separated. It arises from medical practices based on a number of public policy concerns. Allowing corporations to practice medicine or employ physicians can result in commercialization of the practice of medicine, which I think is code word for profit and figuring out service lines that are more of use to the hospital and not necessarily the patient or the doctor. Also, a corporation's obligation to its shareholders may not align with a physician's obligations to his patients, which I think is self-evident. In addition, employment of a physician by a corporation may interfere with the physician's independent medical judgment, which is duplicating what you just said.

In Nevada, we have two additional reasons to want to bring this bill before you—physician shortages. You will hear from the hospital association about shortages. They talk a lot about physician shortages, and we have severe physician shortages. In some cases, we do not have a shortage of facilities, we do not have a shortage of hospitals, but we have a severe shortage of physicians. We are all agreed about that. Private hospitals in Nevada are focused on building market share, which results in their ability to buy a bigger piece of the business in the health care space in Nevada. Part of that has made hiring physicians attractive, and then those physicians will send the care of their patients to the company they work for through the hospital they work for. That is a problem because patients are not able to go to the hospital they might prefer. If patients go to the hospital they might like most, they might not be able to see their doctor if the physician is owned by another hospital. That is one of the things that triggered our involvement in this.

Secondly, because of the shortage, there is not any way for this bill to move forward without completion. If we leave this unfinished and the interpretation by the hospitals is that they are allowed to hire private physicians, then we are never going to have enough doctors in this state for patients in every hospital to be seen by doctors. There are not enough doctors to go around. I was told of an experience at UMC where it was not possible to take a patient to surgery because the only doctor available had gone to work for one specific hospital, so it has happened.

Most states prohibit the corporate practice of medicine in some way, which includes physicians being hired by private hospitals [page 12, Exhibit C]. There are 17 states out of the 50 states that do not do anything with corporate practice of medicine. There are 12 states that have a corporate practice of medicine doctrine and exceptions for nonprofits very similar to what you just heard from Mason Van Houweling about UMC and the other public hospitals in the state of Nevada. There are 11 states that have an exception for specific types of nonprofits such as what we just talked about with medical institutions and research entities. Eleven more states have no nonprofit exceptions. They do not allow any facilities to hire physicians.

Here are our key points [page 13]: There have been statutory and legal opinions on this for the last 45 years. There have been three separate opinions we just went through. There is no law stating that a hospital can employ physicians on the books in Nevada, and there is repeated evidence that they cannot if it is a private facility. The statute offers exceptions to the general prohibition, and those are laid out in NRS Chapter 450 and NRS Chapter 630. That is our perspective on the bill. I want to add a slide here about where I think some of this is coming from [page 14]. The hospitals are going to talk about how they need to grow and how they need to spend more. I have heard them say that and how there is a doctor shortage that will get worse if they are not able to hire doctors. I do not even know how many hospitals are hiring doctors. I just know this became an issue because there is this conflict you are going to hear about. It would be nice to know that. But the flipside of a hospital hiring a doctor is the doctor is then held to specific requirements that they not disclose things about their occupation and they cannot compete. They have to sign a non-compete clause. If a doctor goes to work for one hospital and then changes his mind and wants to go to another hospital, he is not able to do that in many cases, having signed these documents. That is exacerbating what could be a potential shortage; it is not solving it. I want to make sure you see that perspective when you hear from the hospitals about why their hiring doctors is a net benefit to the state.

This slide [page 14] shows that four hospital companies in Nevada control 70 percent of the hospitals, and those are four huge companies. There are 37 acute care hospitals in Nevada. There are 14 in the rural areas, and there is one county hospital. They generated $35.8 billion in revenue. They had $1.8 billion in net income, and they own 22 of the 37 hospitals. This is a growing trend the state of Nevada is going to see, as in many states, where they are generating more and more concentrated care and wanting to own the whole care system. That consolidation is leading to some other issues we are concerned about, and corporate practice of medicine was our first stop because we feel it should be an easy solution since it

is already the law. This next slide shows how the profit margins have been going for the hospitals, and this is where I will leave off [page 15, Exhibit C]. This is the profit margins for the hospitals. This is from a tool that is now accessible through NASHP [National Academy for State Health Policy]. It was accessed March 8, 2023. That is the last time it was updated. Hospitals are not under immediate or imminent duress. They are making profits, they are building, they are growing, they are buying new properties. What we have to worry about is the doctors. What we all agree on is the need to do better with our physicians. We need to have more physicians in Nevada, and we do not think that gets better the way the corporate practice of medicine is set up.

Here is what we are trying to do [page 16]. The bill confirms the longstanding practice we have been talking about not to hire physicians at private hospitals and keeps the exception stated in statute. It allows hospitals that have a graduate medical education (GME) physician or GME program to hire those physicians. We want to ensure patients can get care at hospitals with doctors having contracts and privileges as always and that they can get to a doctor they want at a hospital they want. That is what we want to do. As late as the last legislative session, the Nevada hospitals' position was that physicians are not hired by private hospitals, so I was surprised when in one of the Patient Protection Commission meetings, the public comment that came in about this bill from the Hospital Association, was that, in fact, there is no corporate practice medicine in Nevada. If nothing else, we need to clarify this now because we cannot have the hospitals leave here and decide that every private hospital should be able to hire private physicians because the state cannot support it.

Chair Peters:
Thank you for the presentation and for outlining the PPC's process for determining that this was what you were going to bring this legislative session. I have a few questions from our Committee members.

Assemblywoman Taylor:
It sounds as though this has been in statute and has been reinforced, backed up, and confirmed by several attorney general opinions and even from the Nevada Supreme Court, but we are here to say it should be codified in a different way. I am assuming it is because there is a problem. Can you talk a little bit about that

Mason Van Houweling:
Correct. The laws exist currently, and we are trying to bring clarity to the state. We also want to make sure we are not exacerbating the physician shortage, which we believe it would, I believe it would, and the PPC does unanimously. We also want to make sure we are having access to all of the physicians and growing our independent physicians for all of our communities—in the north, south, urban, and rural. The Commission took this up to bring clarity and certainty to the corporate practice of medicine in the state of Nevada.

Maggie Carlton:
It is one of the things that happens in statute. When you give exemptions to folks, you are listing an amount, but you are not saying who can or cannot do it. So, you get three or four

lawyers around the table trying to figure out what they can and cannot do, and they are going to say, "Well, it does not say I cannot do it; it does not say I can. Let us see what we might be able to do."

This is not about good hospitals or bad hospitals. It is about making sure that everybody plays by the same rules. If you are left out of the statute, there is always that conversation of does it really apply to you, especially when there are exemptions in the statute. In my interpretation of it, I am not a lawyer, I have always deferred to legal, but because it is silent, it is best that we make sure for public policy reasons it is explicitly clear that we do not want this to happen in our state.

Bobbette Bond:
We have had at least one situation we are aware of where a patient was unable to get the care they needed in a hospital because the only physician available to help that patient was no longer available as a community doctor. That is part of it. It is a problem if a provider is hired by a private hospital and signs a non-compete clause and nondisclosure agreement then wants to go to a health center or clinic, that provider is unable to stay a doctor in their community and unable to keep their patients because they were under an employment agreement. They have signed a corporate non-compete clause. We do not want that to get out of control. We have heard doctors are starting to be hired by hospitals is why we are here. Those doctors have to leave.

Assemblywoman Taylor:
On one of the slides, you show the profit margins of the largest systems in our state [page 15, Exhibit C]. What is an average profit margin? What should a hospital board expect?

Mason Van Houweling:
It varies by type of hospital corporation. You have public hospitals like UMC, and many of our rural hospitals are public. You have for-profit, not-for-profit, faith-based, and others in the industry. As you heard, the state of Nevada is often at the bottom of the list ranking providers, outcomes, and other things. We are all trying to fix that. We truly are. The one thing Nevada ranks highest in is the number of for-profit hospitals in the state. We are at the top of the list on that one. Often, they are not based in Nevada; most of the revenue and profit leave the state. Those ranges you are seeing move year to year. During the pandemic year, those were all upside down, so there has been a lot of recovery in those numbers coming off 2021. Typically, 0 to 10 percent or somewhere in that range is a typical number on an annual basis.

Assemblyman Gray:
I have been following this for a while with some interest. One thing being left out is the changing nature of our workforce. Even doctors coming out of medical school these days want a nine-to-five career, especially in the state of Nevada—we are a playground. They are leaving that out. They can work four days, be off for three days, and not have to worry about running a business or a contract or anything. Would this prohibition apply to other corporate entities like health insurers or new market entrants like CVS Health?

Mason Van Houweling:
Yes, this bill applies to health care corporations, but we believe that the corporate practice of medicine applies for all corporations, so you are going to hear a lot about Walmart, CVS, and Walgreens. Back to Ms. Bond's point, often they are signing non-compete agreements that would limit them to move throughout the state. I have seen a lot of doctors unfortunately have to leave the state because they are so restrictive, so enforced, and so threatened. This would make sure we have our independent contractors. Back to your earlier point, there are a lot of doctors who do not have to hang out that shingle. There are a lot of businesses they can join where they do not have to worry about billing, collections, and staffing; the infrastructure is there. I want to make sure this body knows that the infrastructure is there. It is working well today. We do not want to do anything that impedes, limits, or hurts that, and that is what this Patient Protection Commission set out to do.

Chair Peters:
Thank you for the question. The answer was yes, this would apply to all health care corporations, but I would like to confirm with legal that is the case.

Eric Robbins, Committee Counsel:
That is not, in fact, the case. This bill only applies to hospitals and psychiatric hospitals. I believe the testimony was referring to the doctrine developed through the attorneys general opinions and not what this bill does.

Chair Peters:
Thank you for clarifying; I am glad I asked.

Assemblyman Hibbetts:
How does restricting avenues of employment for our medical students and providers who are currently out of state bring anybody here?

Maggie Carlton:
It is a good point to bring up. As has been stated over and over again, we need doctors in this state. As Mr. Van Houweling mentioned earlier, there are FQHCs [federally qualified health centers], there are HMOs [health maintenance organizations], and there is UMC—the public hospital. There are a lot of different options for doctors to come to the state. We want doctors to come to the state and we want to support them as much as possible. We also want to grow our own doctors, too, and that is why we have the medical schools. The State has stepped up and funded those medical schools because we do want to grow our own docs and keep them here in the state. We know wherever a medical school student does his or her residency, the likelihood of that student staying in that state is very high. There are other options out there, but ultimately, the public policy this body sets is about protecting patients and making sure patients can get the access and quality care they need. We want to make sure the doctors are not put in the awkward position of having to choose between patient care and what the hospital tells them. This is about the patient and the doctor and their relationship and making sure that stays a clean relationship. Any doctors coming to this state

would appreciate we are protecting them and giving them all the rights they need to treat their patients without any outside interference.

Assemblyman Hibbetts:
So, it is perfectly okay for the county to employ doctors at their hospital, but not for the private competitors?

Maggie Carlton:
In reference to the county, you mean UMC I am assuming?

Assemblyman Hibbetts:
That is the only county hospital I am aware of.

Maggie Carlton:
I want to make sure you were not talking about another clinic or something like that, so we are on the same page. Because they are a nonprofit hospital, they have an exemption in this bill, and because they are the public hospital, the only one in the state where anyone who walks through the door is guaranteed to be taken care of. So, yes, they do have an exemption for that. It was a public policy decision that this body made and made it through the attorneys general opinions as being sufficient.

Mason Van Houweling:
We have exemptions to corporate practice of medicine, and I refer to back to NRS 450.180 and NRS 630.365. University Medical Center is different because we are back to the 2,000 students coming through our doors—the medical students. We are partnered with UNLV, the residents to fellowships, the employment around those doctors are for teaching purposes. That is why we are exempt, and UNLV is our partner. Again, I point out the exemptions to the practice we have had in the opinions from the attorneys general over the decades.

Bobbette Bond:
I would like to weigh in here after doing this research. CVS or Walgreens are not considered our community partners or the network underpinning our foundation of health care for our community. Our patients are going to need to go to a hospital, and they do not get to choose which one. If we have built laws, federal and state laws, around the assumption that the hospitals in the state have a special mission, they are different than CVS. That is one reason they are treated different legally. What hiring opportunities are we shutting down? There are plenty of ways for any physician to work at a hospital through contracts, privileges, and consulting agreements. No one is saying a physician should not be tied to a hospital in some way, but there does need to be a separation where the doctors care about the patient in the community and the hospital should not be in charge of the doctor's decisions about that care.

Assemblywoman Newby:
Everybody agrees we have a doctor shortage. There are very few people who practice in some specialties, so I understand the concern about specialty doctors being locked up by a particular hospital. What if there was a way for them not to be exclusively with that

hospital? What if we said there shall be no exclusive agreements and that every doctor could be accessible by plans—primarily in the hospital in which they would be employed—but also in other hospitals, or even outside?

Bobbette Bond:
What is the right solution for hiring doctors? What are the settings and ways doctors should be hired? Those are all great policy issues. The policy in place right now in Nevada is that a private hospital cannot hire a physician. If that is going to change after 45 years, it should be legislated. Hospitals and other entities should not make their own decisions about what they think they should do or could do. That is why we are here and why the bill came. We need the Legislature to make these things clearer and not left up to each entity to decide who they are going to hire. This should be a slam dunk because it has been the way it is for my whole life. If you look through somebody else's eyes, they might say, well there is no corporate practice of medicine so I can just go hire ten new doctors at my hospital. And then what? How many doctors will we need for all those hospitals if every hospital does that, and we are not structured for that. The legislation is designed to help control that.

Assemblyman Koenig:
I was going to ask how this bill addresses the physician shortage we have in the state, but I think you have already covered that, so I am going to withdraw my question.

Assemblyman Hafen:
I want to recap some of what I heard today, and then ask a couple of questions. We are talking about corporate practice of medicine already being illegal. That is what you stated in your presentations today, and that we do not want hospitals to own the doctors. In reading the bill, we are providing exemptions that would allow both UMC and the Culinary Health Fund to hire doctors directly and give you an unfair competitive advantage. You could hire when nobody else could. Could you please explain why those exemptions are being placed into this bill?

Bobbette Bond:
The exemptions are the public hospitals, and they have been in statute along with medical training facilities and medical schools. They have been in statute since 2007 when Touro University got the law changed to support them. The private hospitals have never been in statute. This is a longstanding protection of the public health system. The county hospitals and public hospitals, particularly in the rural areas, have always gotten some benefit from the Legislature to keep the lights on. So, yes, they are treated a little differently. They always have been. I do not know that you would say they are unnecessarily competing because they are also fundamentally teaching facilities. Regarding Culinary—I am not sure what you are saying. Culinary does not hire doctors; we contract with them, so I am not sure what you are asking there.

Assemblyman Hafen:
My mistake: I was misled on that. I was under the impression you were trying to hire doctors. Mr. Van Houweling, did you want to add to that?

Mason Van Houweling:
This is specific to hospitals, and Culinary is not in the hospital business that I am aware of. I refer back to the exemptions set out long ago to address this—singling out UMC—the charity, uncompensated care, and the safety net of the hospital; today and starting back in 1931, the care we have been providing in southern Nevada and also the services needed in our communities that others have chosen not to get in the business of doing, such as transplants and trauma centers. Long ago, nobody wanted to do that. University Medical Center is Nevada's only Level I trauma center and provides services other hospitals do not find creative to their margins or part of their strategic plans. That is where UMC has stepped in for close to 95 years.

That is part of UMC's importance, but also the physicians who are hired reference back to our teaching mission. We take very seriously our training of medical students. At UMC, 2,000 students come through. The need to hire those doctors to teach is very important. That takes away some from the operating rooms there. Working in classrooms or in teaching mode versus revenue-generating or procedures mode helps explain why these exemptions were set long ago and why they exist today—to be able to carry out the mission of a public hospital only UMC does in the community. Many states recognize the need to care for the community that no other hospital takes care of.

Assemblyman Hafen:
Thank you for that. Maybe legal counsel can help with a clarification. An emergency room in a hospital cannot turn away a patient if they walk in their front doors. Is that correct?

Eric Robbins:
Yes, that is correct. That is under federal law called EMTALA [Emergency Medical Treatment and Labor Act].

Assemblyman Hafen:
I do have concerns with a hospital owning the doctors, as was stated. It is my understanding that UMC is now paying some doctors two to three times the market rate, and basically saying, "Hey, come work for us. We will give you half the year off and pay you double what you are making now." Is that not the intent of this bill; to prevent that from happening at other facilities but not at UMC?

Mason Van Houweling:
That is illegal. That is not true. We are held to the same standards via the Centers for Medicare and Medicaid Services (CMS) and the federal laws. You are talking about Stark [Stark Law] and anti-kickback. That does not exist. I have a very extensive legal team at UMC. We make sure that everything is within fair market value. I am not sure where that information came from, but I would like you to come to UMC and I will be glad to show you what we do there. Everything we do is at fair market value. We get valuations; they are reviewed between our compliance department and our internal audit, legal, so that is just not the case. We are fiscally not allowed to do that. I would not put the organization at risk to do that. I follow the same rules and regulations as every other hospital in the state.

Assemblyman Hafen:
So, if I had a contract in my office that said you are paying double what the average market is, I should show it to you so you will be aware of it?

Mason Van Houweling:
I would ask you to turn it over to my general counsel, but I do not think that exists. We have the fair market value to back that up. We spend a lot of money to be able to make sure that there is a third party that does that—looks at the state of Nevada, the Southwest, looks at everything—BEP [break-even point] demand, uninsured patients, demand on the physicians. We contract with a lot of providers. We do not employ every doctor at UMC; in fact, most are not employees. They are independent contractors of UMC. Those providers of service agreements meet the full intent of federal guidelines in the law. So, I would be glad to see that and work with you on that.

Chair Peters:
Thank you. I appreciate your taking that offline.

Assemblywoman Newby:
Mr. Van Houweling, back to the teaching hospital aspect of UMC. It is my understanding that the residents doing their graduate medical education (GME), their residencies in particular specialties at UMC, are technically employees of UMC during those years of their education.

Mason Van Houweling:
Correct. They are there via what is called graduate medical education. University Medical Center is much like many teaching hospitals throughout the country that receive federal dollars. There are residents. It is called direct medical education and indirect because of cost of teaching and length of stay and more workups, but that falls into direct medical education. Because we qualify for that program, CMS pays us to pay the residents' salary. It is a pass through from the Feds. We pay UNLV to pay the residents, but ultimately, yes, those are employees at certain points. They are employees but are funded through federal funding.

Assemblyman Hibbetts:
Is a doctor employed by UMC allowed to have privileges at other hospitals, or is there something in their contract that says they are not allowed to go to another hospital and do work that is not for UMC?

Mason Van Houweling:
We do not put any restrictions on physicians who work at UMC as far as non-compete clauses. Because we are self-funded by the county, our medical malpractice does not extend to other facilities, so we cannot go to surgery centers or other hospitals because of the protections of being a county employee. We are limited. We cannot buy insurance to insure at other hospitals. One of the biggest concerns is that the individual malpractice liability with professional organizations that doctors set up in Nevada go directly to the doctor and

coverage. We limit doctors working outside of UMC because of malpractice. We are not allowed to do that.

Assemblyman Hibbetts:
So, the answer to my question is?

Mason Van Houweling:
Correct. They can only work at UMC.

Assemblyman Hibbetts:
So, they cannot work outside of your employment.

Mason Van Houweling:
Correct. They are not restricted if they do leave, which many are.

Chair Peters:
To clarify, as long as they are employed there. But there is no non-compete that extends beyond employment with the UMC institution.

Mason Van Houweling:
That is correct, Madam Chair. Thank you for summarizing that.

Assemblyman Nguyen:
I am related to a number of young doctors. Over a conversation about this bill, I asked if young doctors only want to work Monday to Friday, nine to five, with nights and weekends off. Their response was, "Well, if you only get sick Monday to Friday, nine to five, you let me know; and I want that schedule, too." It is interesting how folks are saying doctors want to work bankers' hours. I do not think that is realistic.

In terms of hiring physicians, I had discussions with folks who visited my office. The employment piece—whether you are a W-2 [wage form] employee versus being a 1099 [independent] contract employee—you can put non-compete clauses in both situations. Is that correct?

Mason Van Houweling:
At UMC, we contract with several physicians in the community who work at other hospitals. We know that going into it, but we want to make sure they are available in a timely fashion, especially when it comes to the Level I trauma center. As long as they are not employed with UMC, we do not limit where they go. We would love for you to look at some of the employment agreements. They are very strictly held, and a lot of physicians are intimidated by that. They cannot go anywhere else, or they have to leave the state. They are forced to leave the state should they choose to leave and maybe go into private practice or work in another venue, whether it is telemedicine or for a school, or that type of thing.

Assemblyman Nguyen:
It is my understanding as an employer—whether it is a 1099 or a W-2—you can have those non-compete clauses. It is something that the employer and the contractor has to agree to. It is their choice to engage with that company either as an employee or as a contractor. Is it consistent in the medical world as well?

Mason Van Houweling:
The radiology group that takes care of UMC is also contracted with another health system in the valley. We do not put limitations on them. They have been our partner for 50 years, but I am aware that the other hospital system does not allow them to work at other hospitals. They want exclusivity. We do not require exclusivity. Coverage for our patients who walk through our doors every day is our goal.

Chair Peters:
I want to make a point of clarification. Nothing in this bill has to do with non-compete or nondisclosure clauses. That is another issue area that has caused problems within the industry.

Assemblyman Nguyen:
The reason this bill is in front of us is patient protection. In terms of hiring a physician, you mentioned it would impact patient care negatively. I want to go back to that point. The reason we are here is the patient. Could you give us the expanded version of that thought process in terms of how hiring will negatively impact patient care?

Mason Van Houweling:
A clear example that happened in our community, Las Vegas, concerned cardiovascular/thoracic surgery (CVT)—the surgeons who do open heart surgeries, aortic valve replacements, bypasses. Cardiologists identify the issue and refer to a CVT surgeon. Within the last 12 months, the main CVT group in Las Vegas was hired by local hospitals. There were not 20 members in this group, there were about 5, and they were all employed. We were looking at not having CVT access for that side of town. Imagine needing some type of heart procedure—a heart catheter, open heart surgery, or some other pending medical issue. That pool was taken out of the market, and UMC had to quickly respond. We came very close. For perspective, UMC is a Level I trauma center that takes patients throughout the entire state—10,000 square miles—as well as patients from Arizona, California, and Utah. We were looking at not having that service available, and it is a Level I trauma center requirement. It really limits us. That hospital is not going to share that resource. They have invested in that professional expertise. Imagine, we were looking at having to send patients out of the state, and we are all trying to prevent that. That is a good example of a resource getting gobbled up and locked in with other restrictions—not being able to participate or even contract with that service. That is a good example of something that could have been very tragic for our community.

Chair Peters:
Are there other questions from the Committee? [There were none.] We will move into support testimony in our physical locations. I am limiting support, opposition, and neutral testimony to 20 minutes apiece. I have asked the opposition to coordinate so we have a limited redundancy in testimony.

Susie Martinez, Executive Secretary-Treasurer, Nevada State AFL-CIO:
On behalf of over 150,000 members and 120 unions, the Nevada AFL-CIO supports Assembly Bill 11. It is no secret Nevada is facing a dire health-care provider shortage. It is already difficult for a patient to find a doctor they can trust to provide them with care. If a doctor obtains employment at a different facility, it is a very real possibility their patients will be forced to go through the long process of finding another provider. That is why hospitals should contract with doctors and allow them to serve at as many facilities as they wish to. This bill will ensure that no Nevadan is left in the lurch when they need to receive vital health care services and expand health care accessibility across the state. I would like to thank the Patient Protection Commission for its work on this bill, and I urge the Committee to support Assembly Bill 11.

Marc Ellis, President, Communication Workers of America, Local 9413:
We are in strong support of this bill.

Randy Soltero, representing International Alliance of Theatrical Stage Employees:
We represent thousands of workers who work in the entertainment industry, and we are in strong support of A.B. 11.

Paula Luna, Operations Manager, Battle Born Progress:
We want to thank the Patient Protection Committee for bringing this bill. We believe medicine should be between the doctor and the patient and not corporate interest or shareholders. We believe A.B. 11 would help ensure that.

Paul Catha, representing Culinary Workers Union, Local 226:
The Culinary Union supports Assembly Bill 11. Through the Culinary Health Fund, the Culinary Union is one of the largest actors in health care in Nevada. As members of the Committee know, Nevada is experiencing a severe physician shortage. Despite the fact Culinary Union members have one of the best health care plans in the nation, when providers are not present, Culinary Union members cannot receive the care they deserve. Assembly Bill 11 will ensure doctors have the freedom to see patients at whichever hospital they choose, and guarantee doctors are able to make medical decisions free from the profit motive of corporate hospitals. Guaranteeing doctor independence from out-of-state hospital corporations will benefit all Nevadans, not just Culinary Union members. The Culinary Union supports Assembly Bill 11 and encourages the Committee to support and pass the bill.

Maya Holmes, representing Culinary Health Fund:
The Culinary Health Fund is a nonprofit labor-management trust that provides health benefits for members of the Culinary and Bartenders Unions—approximately 130,000 lives in

Nevada. We also want to thank the PPC for bringing the bill forward. It is a patient-centered bill that will ensure doctors are available to patients throughout our community. It has been longstanding practice in Nevada, as was laid out in the testimony. We are very concerned about the physician shortage and increasing restrictive employment of physicians in our community will only exacerbate that shortage. Research studies also show it increases costs. Also, it is consistent with longstanding practice in the state, so we urge the Committee to support the bill.

John Abel, Government Affairs Director, Las Vegas Police Protective Association Metro, Inc.; Co-chair, Las Vegas Metro Police Health Trust:
We support this bill.

Linda Hunt, Private Citizen, Las Vegas, Nevada:
I am a proud member of the Culinary Union. I have been a member for 45 years. As I have gotten older, I started needing more medical care. Since I am a Culinary Union member, I have access to great health insurance. I decided to become a more empowered patient. I discovered more doctors are now working directly for hospitals, and/or their practices are being sold to corporations that own hospitals, so there are fewer doctors available for patients like me. I saw in the news that there is a shortage of doctors in Nevada, and I learned recently that if one hospital or system employs a doctor or specialist, then that doctor cannot see patients in other hospitals. That does not make sense. Patients should be able to see their doctors at any hospital they choose. Right now, it is hard for patients. We have to find a doctor who is taking new patients, get on the schedule, go all the way across town, and then hope their practice is not sold to a corporation. If I lose my doctor, I will have to start the process all over again. Patients want to be able to stay with the doctors they know and trust. I am worried that this doctor shortage may impact me in the future, especially if doctors are only available at hospitals in wealthier parts of Las Vegas and not in my community. I urge the Nevada Legislature to support and pass A.B. 11 and ensure my doctor can treat me at any hospital I choose.

Stacy Sasso, Executive Director, Health Services Coalition:
The coalition represents 25 employer- and union-sponsored, self-funded health plans in southern Nevada covering an estimated 280,000 lives. Our groups range in diversity from union health plans such as culinary, plumbers and pipefitters, teamsters, and electricians to Clark County, the City of Henderson, and groups like Switch, the data warehouse, and NV Energy. The coalition's focus is achieving quality, affordable health care for our member participants. It is no secret. The cost of health care has continued to rise year-over-year with hospitals making significant profits from patients and health plans. Great effort has been made to try to control the rise of health care costs; however, hospitals continue to say they need higher reimbursement while still having a significant home office allocation. The coalition works hard to negotiate reasonable reimbursement for our participants and is proud of the work we have done controlling the cost of care our groups are paying. Now, hospitals want to directly hire physicians and will control what the physician can charge as well. You will hear it said that facilities directly hiring physicians will help bring more doctors to the state and help alleviate the current physician shortage. How can directly hiring physicians

and requiring them to sign non-compete clauses where they can no longer service other facilities be good for the physician shortage? The physician will be locked into the one facility and no longer be able to treat patients at other hospitals. They will no longer be able to take calls at another hospital, which will continue to impact patient access. The physician can no longer control where he provides care. In addition to limiting where a physician can practice, he will no longer be in control of the charge for care. This will lead to higher physician charges, increasing the profits hospitals are making from the patient. The coalition is in support of A.B. 11. This bill will ensure doctors will remain independent and their medical decisions remain free from corporate hospital pressure for more profit.

Chair Peters:
Thank you for your testimony. Are there other folks in Las Vegas who would like to testify in support on A.B. 11? [There were none.] Please check the public line for support testimony on Assembly Bill 11.

Russ James, President, Building and Construction Trades Department, Nevada State AFL-CIO:
I am here in full support of Assembly Bill 11, and I urge the Committee to support it as well.

Renee Ruiz, Legislative Advocate, National Nurses United; National Nurses Organizing Committee of Nevada:
I am the legislative advocate for National Nurses United and the National Nurses Organizing Committee of Nevada. We represent the interests of 3,000-plus nurses around the state. We are standing in full support of A.B. 11, and we encourage this Committee to also support it.

Todd Inglesbee, President, Professional Fire Fighters of Nevada:
I am here in support of A.B. 11. Not only am I here supporting this for our members but also with the lens of public safety for all Nevadans. What happens to our health care system if our patients can no longer see a physician because the physician is now employed by a particular hospital. I strongly support A.B. 11 and thank you for your consideration supporting this as well.

Gary Watson, President, Teamsters Union, Local 533.
I am here in support of A.B. 11 and urge the Committee to support it as well.

Robert Sumlin, International Association of Machinists and Aerospace Workers, Local 711:
I am with the International Association of Machinists and Aerospace Workers, Local 711 here in Las Vegas, Nevada. This legislation is important because there is a shortage of health-care providers across our state. It is critical that this Committee votes for this bill so doctors do not have to be tethered to just one hospital and can see all their patients. I am here in full support of Assembly Bill 11, and I urge the Committee to support it as well.

Michael Gittings, President, United Food and Commercial Workers Union, Local 711:
We represent 7,000 workers in Nevada, and I am here in full support of Assembly Bill 11. I urge the Committee to support it as well. Going to the hospital is stressful enough. Patients should not be cut off from their doctors by these unfair hiring practices.

Sue Bird, Private Citizen, Fernley, Nevada:
We have great difficulty finding doctors. In fact, my doctor canceled for a couple of months, and I was running out of my prescription. Luckily, someone gave me a 30-day supply and I was able to get an appointment. Please, I urge you to support A.B. 11.

Liz Sorenson, President, Nevada State AFL-CIO:
I am here today in support of A.B. 11, and I urge this Committee to support the bill as well.

Chair Peters:
Are there other callers? [There were none.] We will begin opposition testimony.

Sarah Watkins, representing Nevada State Medical Association:
We are here in opposition to A.B. 11. The Nevada State Medical Association is the largest physician-led advocacy organization in the state. We advocate and share this Committee's goal to attract and retain physicians in the state of Nevada. Because A.B. 11 does not improve access to care and does not support our shared goal of improving access to care, we are opposed. Assembly Bill 11 runs counter to national trends in health care. More than half of the patient care physicians in the U.S. are employed, and in 2020, almost 30 percent of physicians worked directly for a hospital. This trend is due in large part to the increase in regulatory and administrative burdens like prior authorization, electronic health records, and managing front office staff, to name a few. Doctors want to be doctors. We as a medical association, and Nevada as a state, should do everything we can to maximize the ability of physicians to provide clinical care, especially when you consider where we sit with our physician shortages. As this Committee knows very well, Nevada ranks near the bottom at forty-fifth in the country for active physicians. Nevada is below the national average in 33 of 39 physician specialties statewide. Nevada must be able to compete with other states to recruit and retain physicians. Hospitals in many other states employ physicians. Our hospitals should be able to do the same. This bill harms the development of the health care workforce in this state, and we are opposed.

Irene Gutierrez, M.D., Program Director, Family Medicine, Dignity Health-St. Rose Dominican:
I have spent my career training physicians and working to bring additional physicians to areas with shortages like southern Nevada. Dignity Health-St Rose Dominican is the only not-for-profit, faith-based health system in southern Nevada, and we will be adversely affected by this bill. The ramifications of this bill are significant. First, A.B. 11 will decrease access to care for Nevadans. Hospitals are one of the primary recruiters and employers of physicians, especially physicians who are specialists. We will begin to lose services and will be unable to expand access to services. Second, passage of A.B. 11 will hinder our physician recruitment efforts because nearly three-quarters of all physicians want

employment options. Many new medical school graduates prefer employment because they want to practice medicine, not run a business. The Nevada State Legislature has introduced several great bills this session incentivizing medical students and other physicians to come to Nevada. Assembly Bill 11 would reverse all the good work being done in this area. If A.B. 11 passes, we may lose the physicians we currently employ. Finally, if A.B. 11 passes, it would also prohibit physicians who would have been employed at a nonprofit like us from qualifying for the federal student loan repayment program through public service loan forgiveness, which requires employment by a nonprofit.

All of the high-quality health systems in the United States employ their physicians. Health systems like Mayo, Cleveland Clinic, and Cedars Sinai would not be where they are today without the ability to better manage their clinical workforce. Other states that have laws like A.B. 11 have either removed the law or passed significant workarounds like California's foundation model. Assembly Bill 11 is a bill in search of a problem. We do not need it, and it will make a bad situation in Nevada even worse. Please oppose A.B. 11. Thank you.

Connor Cain, representing HCA Health Care; Sunrise Hospital; and Sunrise Children's Hospital:

We are in strong opposition to Assembly Bill 11. University Medical Center and Sunrise Hospitals, in a lot of ways, complement each other. They are both important parts of the health care ecosystem in southern Nevada. We are all prone to casually throwing around the term "safety net hospital," often without unpacking what it means and why these facilities are so important to our communities. Safety net hospitals provide care to high levels of Medicaid and uninsured patients. Adult patients who are covered by Medicaid are, by definition, low-income, qualifying as households earning at or below 138 percent of the federal poverty level. These are folks who often have nowhere else to go for care given the lack of providers available to treat them due to the significant losses they must incur to do so. Collectively, all hospitals are essential to caring for the patients and communities they serve. Clark County has two primary safety net hospitals that provide the lion's share of Medicaid services. One in particular, Sunrise Hospital, provides the most Medicaid services by a wide margin. Of all Medicaid patients receiving inpatient hospital care in the state, Sunrise Hospital provides 19 percent of that care. The other safety net hospital in Clark County, UMC, provides just more than half of the Medicaid care that Sunrise Hospital does at 10 percent.

Looking specifically at Medicaid patients receiving care at any acute care hospital in Las Vegas, Sunrise Hospital now cares for over 25 percent of all Medicaid inpatients. The other safety net hospital is Number 2 at 13.8 percent. That is 25 percent compared to 13.8 percent. For the record, Sunrise Hospital, as a Level II trauma center, provides a number of critical services not offered anywhere else in the region. Sunrise Hospital only employs a handful of physicians, but they are vital to some of its most important and specialized hospital-based programs. For example, without directly employing certain doctors, Sunrise would not have a stroke center, and it would perform 50 percent fewer pediatric heart surgeries. Those children unable to receive heart surgery at Sunrise Children's

Hospital would have to go out of state, causing both a more costly service and heartbreaking realities for parents forced to decide between continuing to work or caring for their child.

For treatment of strokes, timing is of the essence. Each minute care is delayed can reduce the patient's future physical and mental capabilities. To put critical services like these at our state's largest safety net hospital at risk, especially considering how many vulnerable Nevadans rely upon them, is unacceptable. Moreover, to jeopardize lifesaving care at other hospitals across the state would be a disservice to all Nevadans. It will result in physicians leaving our state, higher health care costs, and, most importantly, reduced access to care for patients.

In the presentation you saw earlier, then-Attorney General Catherine Cortez Masto weighed in on this issue in an opinion in 2010, concluding that there is no provision of Nevada law prohibiting a hospital from employing a physician. I am the only attorney to testify so far, and I am not providing a legal opinion, but I would recommend you defer to your legislative counsel. On the first page of this bill, in the second sentence of the legislative digest, is exactly what I just told you. In closing, I would like to leave you with an excerpt from the opinion of then-Attorney General Cortez Masto. As part of the case law citation, it quotes the Supreme Court of Kansas: "Without physicians, nurses and medical technicians, a hospital cannot achieve that for which it is created and licensed—to treat the sick and injured. To conclude that the hospital must do so without employing physicians is not only illogical but ignores reality." We strongly urge your opposition of Assembly Bill 11.

Dan Musgrove, representing Valley Health System of Hospitals:
You heard the proponents of this bill talk about the fact that in Nevada we are unable to hire physicians. You have also heard we have an incredible lack of physicians. What I am asking, and the proponents are asking this Committee to weigh in on is the policy of hiring physicians. That is your job today, and that is what I am asking you to do as well, but I am going to take it from the other perspective, that Nevada needs to hire physicians. Everything we have been doing for the last 45 years has not grown our physician population. As you heard, we are last in just about every category, so what we are doing is not working. Why not add a new tool to the toolbox, which is allowing hospitals to hire physicians. We at the Valley Health System have a GME program. We have 160 doctors currently practicing and working in residency programs. Graduate medical education would cover them. We could hire them. But what if they want to stay at our hospital, continue working; maybe pay off that student loan, and not go into private practice with all its trials and tribulations—you have heard what it is like to be in private practice—but we could not hire those physicians because we would be precluded.

Why not keep them here in Nevada when we have already spent the dollars to train them rather than allow them to go to another state? Older doctors are beginning to retire; we are seeing that all over. Why? Because private practice is hard. It is tough being a businessperson. Why not allow hospitals to allow them to continue to do what they love, which is practice medicine. Why not give those new doctors a chance to come to Nevada because we offer an alternative that perhaps the 34 or 37 other states do not offer, which is

the hiring of physicians by hospitals. As Mr. Cain said, the hospital is the front door for most people, probably because we have so few primary care physicians—We are forty-seventh or forty-eighth. Unfortunately, most people seek hospital care, medical care, through a hospital. We need to have physicians on staff ready to help because we cannot refuse them. We need to take them, they come in in their desperate hour, and we want to help them. So please, I am asking you to put in statute that hospitals can hire physicians.

Patrick D. Kelly, President and CEO, Nevada Hospital Association:
[Patrick D. Kelly submitted a letter and additional information Exhibit E.] We oppose A.B. 11 and find its provisions a bit ironic. Hospitals are licensed and regulated by the state of Nevada. Most will be prohibited from employing physicians, but there is no prohibition on private equity firms and Wall Street venture capital funds from employing physicians in Nevada. That does not make sense. Large corporations like Walmart, Amazon, Walgreens, and CVS are purchasing physician practices like crazy. It is counterintuitive to allow large private equity firms to employ physicians in Nevada but prohibit Carson Tahoe Hospital, just down the street, from doing so. The policy decision you make on the employment of physicians will impact the entire state, not just a small section of Las Vegas. Let us work together to improve access for Nevadans and not limit it.

Paul J. Moradkhan, Senior Vice President, Government Affairs, Vegas Chamber:
The Chamber has concerns about A.B. 11. We believe this bill will have unintended consequences on health care services in southern Nevada. We are concerned about the direct prohibition of the vast majority of our hospital members not being able to employ doctors. This is found in section 1, subsection 1 of the bill. We believe this will hurt efforts to keep specialized doctors in Nevada and will hinder retention efforts to keep our doctors in our state. We believe patient access will directly be impacted in a negative way, especially those who need specialized care in the hospital setting.

Kerrie Kramer, representing Aetna CVS Health:
We support the positions of our partner area hospitals in their opposition as well as the concerns shared by other members.

Chair Peters:
Are there other folks in opposition in our physical locations before we go to the phones? [There was no one else.] Please check the public line for opposition testimony on Assembly Bill 11. [There was no one.]

We have a couple of questions from Committee members following opposition testimony. I would ask that we have representatives from Sunrise, Dignity, and Valley Hospitals come up to the desk.

Assemblywoman Taylor:
Mr. Cain, you mentioned there currently is no provision in law that prevents hospitals from hiring physicians. But part of the presentation is that we need to codify it. What is currently in statute?

Eric Robbins Committee Counsel:
That is correct. There is no provision in statute currently prohibiting hospitals from hiring physicians. However, there are provisions that say a physician cannot accept a position that would tend to create a conflict of interest between his or her duty to the patient. There are also provisions in existing law that create specific exemptions or specific cases in which a hospital can hire a physician. It is not clear under existing law how a court would interpret these. Generally, courts would say if something were not expressly prohibited, it is allowed. However, as I discussed, there are provisions of existing law that do tend to indicate that there might be some sort of unspoken prohibition; for instance, if it is allowed, why do you need the exemptions? That might be something a court would look at. As I said, the law around this is unclear right now.

Assemblywoman Tayler:
Thank you, clear as mud.

Connor Cain:
To build upon that a little bit, of the other examples cited, the attorney general's opinion is the most relevant and certainly the most recent, which means it would likely carry more legal weight, but I would be deferential to your legal counsel on that opinion.

Assemblywoman Newby:
I have two questions. Because each of your hospital organizations have hired physicians, was it your position that they were able to do that? It sounds like the answer is yes, but I would like to make sure. Also, in your employment agreements with those physicians, is it exclusive for only your hospitals or does it allow the physician to practice at a different hospital, a different system, or even in a doctor's office?

Dan Musgrove:
I would have to get back to you on the actual language of those agreements. We are a large system, so we have hospitals all over the Las Vegas valley. We believe that gives people access to physicians even though some of the proponents said we are limiting access to physicians. Obviously, if someone walks into one of our facilities, they are going to have access to every doctor we would have on staff. But, I will get that information as to whether we disallow them from working for other systems or other positions elsewhere.

Chair Peters:
Similar to the question to UMC, I would ask that we look at current employment and beyond that employment as well for the follow-up. Ms. Gutierrez, this may be out of the scope of your position in the institution, but do you have an answer for that?

Irene Gutierrez:
I do not have an answer for that. That is outside my scope as I am not involved in the contracts, but we can provide you with that information.

Chair Peters:
I appreciate that.

Connor Cain:
I am not sure what the answer is to the first question. The answer is "yes" to the second question. I would assume it is on a case-by-case basis. I was given an example of a pediatric neurologist. At one point, we had a pediatric neurologist who practiced at Sunrise Children's Hospital, UMC, and Dignity. That would be an example of one, but I would have to get more information to give you an answer with 100 percent certainty.

Chair Peters:
We appreciate that follow-up. Thank you so much, and we can have staff reach out with those specifics as well. Are there other questions from the Committee?

Assemblywoman Taylor:
Is anyone aware of what the national trends are? How does it look across the country? What are other states doing, and which way is it trending?

Sarah Watkins:
The question concerned trends as far as physicians being employed by hospitals. Since 2020, physicians are looking to be employed by hospitals. As I mentioned in my testimony, there are a lot of burdensome administrative duties, such as prior authorizations, that keep physicians from being doctors. What they really want to do is provide access to care for patients. By being employed by a hospital, a lot of our members find that role easier because burdens are taken from them.

Assemblywoman Taylor:
I was wondering what the states are doing. What the trends are.

Sarah Watkins:
I do not have a specific answer to that, but I can follow up on it.

Patrick Kelly:
If you look at the states that purport to have corporate practice of medicine bans, what happens is the states develop workarounds to figure out a way to hire and bring physicians in. It might not be the hospital, but it might be a foundation or something else. We need to stick with the trends and where things are going to be competitive. When we are looking for a neurosurgeon, we are not just competing with Elko and Pahrump. We are competing with other states that are offering incentives and other deals. That is where it becomes competitive in bringing physicians, especially specialists, into the state.

Chair Peters:
Are there other questions before we move on to neutral testimony? [There were none.] We will move to neutral testimony in the physical locations before moving to the phones.

Barry Cole, Private Citizen, Reno, Nevada:
I have the luxury of being a retired physician, so I can look at this from a lot of different perspectives. I have been a physician employed by a hospital. I have also been a "freelancer" and worked wherever I wanted. I have always found there were workarounds. Somebody brought that up. If you think about Kaiser, nobody works for Kaiser. They work for Permanente Medical Group. If you think about Renown, my understanding is they all work for something called Hometown Health, so there is always a way to hire physicians.

What about the nurse practitioners? There is a big trend now to move away from hiring physicians, and I can understand why. I gave a lecture last month to the Department of Psychiatry—the senior residents who were about to graduate—and they told me they are all looking for 28 to 32 clinical hours a week of work. One did say he could do up to 40 hours, but only if pushed, and nobody was going to take nights, weekends, or holidays. That should scare you. There is not a real commitment like there used to be. I always expected to work 80 to 100 hours a week; if I worked 40 hours, it was like a part-time job. We are seeing this trend nationally, but we are trying to bring people to Nevada. One of my colleagues at the state hospital system is very concerned if southern and northern Nevada adult mental health services are not specifically carved out of the legislation like the Veterans [Health] Administration was, he would not be able to hire psychiatrists to work at the two state hospitals. The good news is both are teaching facilities, so they may be grandfathered in technically, but that should be looked at. The reason I am neutral or agnostic is I do not think the bill is finalized yet. We need to think about federal issues as well as state issues. We are all competing in a large open market. It is not just happening in Nevada. It is everywhere.

Chair Peters:
Are there folks in Las Vegas who would like to provide neutral testimony? [There was no none.]. Please check the public line for neutral testimony on Assembly Bill 11. [There was no one.] I am going to ask the presenters for closing remarks on the bill.

Maggie Carlton:
Thank you very much for hearing the bills and taking into consideration what was forwarded to you by the Patient Protection Commission. This is not one person's bill. This bill was put together by consensus of a commission that this state established to address health care issues in this state. As you can tell, there is a difference of opinion on this bill. I feel, and the Patient Protection Commission feels, that the corporate practice of medicine is not allowed in this state, but you heard from entities sitting at this table that they feel it is. That is why the Commission brought this bill forward to you, knowing full well that this practice currently exists. Look at section 9, it says, "The provisions of section 1 of this act do not apply to any contract existing on the effective date of this act between a hospital or psychiatric hospital, as defined in NRS 449.2414, and a physician, but apply . . ." upon renewal. Those folks working in this space right now will still be allowed to work in this space until their contract comes up for renewal. It is up to the State Legislature to designate what the state policy on corporate practice of medicine truly is. I look forward to the follow-ups to find out what those contracts really look like. This bill clarifies the public policy this state has upheld for the last 45 years. Thank you very much, Madam Chair, for the opportunity to close out.

Chair Peters:
Thank you for your closing remarks. We will close the hearing on Assembly Bill 11. We want to take a two-minute recess before we move into the next bill [at 3:30 p.m.].

[The Committee reconvened at 3:37 p.m.] I will open the hearing on Assembly Bill 6.

Assembly Bill 6: Revises provisions relating to the cost of health care. (BDR 40-380)

Maggie Carlton, Executive Director, United Labor Agency of Nevada:
The chair of the Patient Protection Commission received a letter asking the Commission not to advance this legislation, but those who participated feel there was a lot of hard work done over the interim on these bills, and they wanted to bring these bills to this Legislature.

Assembly Bill 6 is the Health Care Cost Growth Benchmark bill. The Commission is proposing to commit to a long-term effort to address health care affordability for Nevadans in making the Nevada health care cost growth program permanent. In addition to augment the cost growth benchmark, the bill requires the Department of Health and Human Services (DHHS) to measure and report on primary care spending in the state and the percentage of total health care spending allocated in primary care. The members of this Committee know how to read a digest, and I am sure you have gone through the bill, so I am not going to do a section-by-section explanation. It is important to understand the issues around this and that the Commission had a partnership in order to fund it; however, that partnership no longer exists. The current administration has said they are no longer needed in this partnership, but it is important for us to talk about the cost of health care, what it does to everything else in this state, and what the drivers are.

For a long time, you have not had the data to make good decisions. Things have always been done by anecdote, and we have worked hard to get away from that and have professionals put data together they can present to you. In the previous bill, you asked questions about the data—give us the numbers. That is what this health care cost benchmark does. It will give you numbers on how to move forward and what you really need to look at. Is this affecting single moms? Is this affecting people who work paycheck to paycheck? Is there a racial and economic or socio-economic component to these health care drivers? With that, the previous director of the Patient Protection Commission, who worked extensively on this issue, will share her experience with it.

Sara Ralston, Patient Advocate, Patient Protection Commission:
I am the former Director of the Patient Protection Commission. I served as the inaugural executive director for the first Patient Protection Commission as well as the remake of the Commission in the 2019 legislation. I am also a former lobbyist. I have about nine years' experience representing a multitude of health care clients ranging from pharmaceutical companies, nonprofit hospitals, for-profit hospitals, as well as mental health care providers. So, I am uniquely positioned to be a resource to you, and I am grateful for the opportunity to talk about this important piece of legislation. I was also involved in the state's effort to go

after support from the Peterson Milbank Program for Sustainable Health Care Costs, and also served on the Commission, putting forth this piece of legislation.

I would like to be respectful of your time today, so, rather than walk you through the legislative digest, I would like to discuss what this measure does, why it is necessary, and what it does not do. In the last decade, the U.S. has taken measures to improve health care and consumer experience. However, a 2020 survey or study by Public Agenda and *USA TODAY* showed only 7 percent of Americans are satisfied with their current health care system. That is a statistic we want to keep in mind. There are a multitude of big problems with health care, and Nevada is not unique to the complexities of addressing solutions to these systemic issues. Lack of transparency and data are the major problems, and this bill addresses both. It also sets a necessary foundation for discussing health care affordability and accessibility.

For context, health care costs have risen faster than inflation for decades, and on its current path, it is unsustainable. For example, average premiums in Nevada for Nevada families have increased by 25 percent between 2016 and 2021. It has been increasing by 25 percent. That is far greater than any rate of inflation by any metrics. More than half of Nevadans have reported delaying or going without health care due to this cost. Health spending is expected to increase, and this measure helps address the unsustainability of this by establishing a cost growth benchmark which opens a window into what is driving cost growth in the state. To be clear, a cost growth target does not impose a cap on spending, provider prices, or workforce investments. Rather, it is one of the least hands-on cost containment approaches that focuses on driving the discussion by creating a target as a measurable goal that addresses excessive spending. Every dollar spent on health care in our state leaves a dollar less for other initiatives and other priorities. There is no downside to asking for this level of transparency and holding those accountable in this space to be forward facing with addressing the current unsustainable growth.

Chair Peters:
I have questions from the Committee.

Assemblyman Hafen:
I have questions about how the process would work. I have looked at some of the other states, and there are about half a dozen or a dozen that are doing something similar. I believe most of them have large employee bases of about 100 employees, like in Massachusetts, which are solely focused on evaluating this cost growth benchmark and extracting the data. How do you and the PPC envision that working in Nevada? Would we also need roughly 100 employees to gather all the data and prepare the cost growth benchmark?

Sara Ralston:
I understand what your question is, you want to know how this is going to work. We establish a benchmark as a target to say we want to make sure we invest in a cost containment strategy. We set a benchmark that is vetted through a public process already discussed in the Commission. Our former governor issued an executive order that

established a benchmark and decided on a certain percentage. So, we start there, saying this is the best market we want to establish, that health care should not exceed this benchmark. Then, we ask the providers and insurers to report against it in the following year. When they report on it, that report is given to the Commission. The Commission goes through it and makes recommendations. There are other provisions—I think in section 18 of the bill—that allows the state agencies to further that discussion and have recommendations on how the industry or the state can address meeting those targets. It is not a benchmark that creates a cap on spending. It is a benchmark that anchors the conversation to allow for a starting point to say this is where we would like to be, this is a goal, and let us see how you are performing against it. That opens up discussions for recommendations on data-driven policy solutions that address affordability, accessibility, and quality, because it opens a window and shines a light on the spending patterns; what is being spent in health care.

Assemblyman Hafen:
I apologize. I was not clear enough on my question. We have a 20-something percent vacancy rate across the state in most of our agencies. I am concerned. If these other states require such labor-intensive workforces to do this, what are we going to be able to do? Would our process be simpler than what other states are doing?

Sara Ralston:
You are asking whether this might be a resource issue. Do we have the capacity to analyze the data? What are the analytics? What are the investments? That is where additional support and investment need to be talked about. How do we parse out that information; how do we collect that information. There will be a regulatory process, and how that is determined. Nonetheless, I do think that it makes a lot of sense to collect that data and to have it. The state has talked constantly about having good data to drive the discussions with you as legislators, policymakers, and even patient advocates. We want to be able to see the information. We might not have it eloquently explained to us, and there might not be an executive summary because of lack of resources; nonetheless, that data does exist. When there is an opportunity to have resources at the table—state level, private level, nonprofit, public sector level—that the data is made available to us.

Maggie Carlton:
Assemblyman Hafen, I understand where you are coming from. You know me well enough. I would not be comfortable with the bill if it needs 100 FTEs [full-time equivalents] on it. I thought the partnership with the foundation that helped the Patient Protection Commission move this forward was important. One of the reasons the Patient Protection Commission was moved from the original standalone over to DHHS was because DHHS has the data and analytics and that is where our health care information should be going. Knowing full well they are probably at the same 25 percent vacancy rate everybody else is, they are the warehouse of data for health care. That is where it would be housed. I would not see this causing an impact on that level of FTEs for a long time. This is the first step. This is setting a target and moving forward to get the data to figure out what our next steps are. You are probably two or three steps ahead of us, but I cannot imagine the state putting that type of

FTE resources behind something along this line. It is really more of a "Commission-driven" mission.

Sara Ralston:
That is one of the reasons the Patient Protection Commission exists. This is a group of diverse perspectives from the health care industry put into place with everybody coming together for the common goal of discussing complex health care issues. When you have the data, you want that data to be presented in a public forum made available for everyone and then have an open discussion. Prior to the Commission existing, a lot of those conversations happened in the background. It was not public. It was not until this body met that we would shine a light on health care policy. So, the Patient Protection Commission is a resource that is theoretically a very low cost to the state. And I would be remiss if I did not also mention the Commission's ability to digest the information.

Assemblyman Orentlicher:
Could you elaborate on the relationship between this initiative and [Syntellis's] All-Payer Claims Data (APCD) tracking? How do they fit together in the overall puzzle of health care cost containment?

Sara Ralston:
Let me give you my perspective and why it is different. The All-Payer Claims Data databases are claims data. This is spending data. However, APCD is available to the state as a repository of data collection, and I believe it would complement the efforts of this data collection.

Assemblyman Koenig:
In section 8, under the definition of what a "third party" means, I read that self-insured plans and ERISA [Employee Retirement Income Security Act] plans would be included in this. Is that correct?

Sara Ralston:
I would defer to your legal counsel on that.

Eric Robbins, Committee Counsel:
Employee Retirement Income Security Act plans would not be included in this. There is a U.S. Supreme Court case from 2016 that says the state cannot require ERISA plans to report information.

Sara Ralston:
I would like to follow up. That does not mean that ERISA plans cannot voluntarily participate. There is no restriction in this legislation that says they are not allowed to voluntarily participate.

Maggie Carlton:
There are ERISA plan representatives currently sitting on the Commission and participating on a high level, so they are involved in the discussions. They have not shied away from the discussions.

Chair Peters:
I would like to be clear that the state cannot obligate them to share, but they could voluntarily share that information.

Eric Robbins:
That is correct.

Assemblyman Gray:
Do you know how many ERISA plans and self-insured responded to your data call in April and May of 2022?

Sara Ralston:
I do not recall.

Assemblyman Gray:
It is not clear in the legislation, which is why it needs to be asked. How is inflation going to be factored into the benchmarks? I am concerned that it is not going to keep pace with inflation; and then, down the road, we are going to start having discussions about penalties and everything else, so that needs to be addressed.

Sara Ralston:
The Commission was a part of the recommendations to the Executive Branch on what that benchmark number should be. There were robust discussions on the methodology in which you get there. Nevada is not unique to that discussion. The Commission is made up of a diverse representation of health care folks, and the public is invited to participate. So, it is a robust open discussion recommendation process that is sent to the Executive Branch which establishes the benchmark. There is a provision in this bill that allows for the readjustment on further recommendations from the Commission. If there was a concern about inflation, maybe a global pandemic, that says we need to adjust this for various reasons, there is a process for a recommendation to revisit that number. That number in our state is meant to anchor the conversation. There is not a mandate that requires anyone to meet the benchmark. It is a target goal.

Assemblywoman Taylor:
You spoke about ERISA plans being involved in the Commission and voluntarily participating. And other words that came up talked about the participation of the commissioners and the value it could be to the Commission. But you also mentioned that it was something the Commission prioritized at one point and then pulled back their support. Did I get that right? If so, will you share why?

Maggie Carlton:
A couple of letters went out from the current administration giving instruction to the Commission on how it should proceed. One of the letters said, "Do not work to advance the legislation." The other notified the partnering foundation that their assistance was no longer needed. I believe the foundation had been very important in giving this state good data. If you do not have the data, you cannot monitor it, you cannot measure it, you cannot fix the problems. This current administration has basically said, "Sorry, we do not want to partner with you anymore." I have concerns about that. Every administration has its own method moving forward, but those are the two messages that were sent to the Patient Protection Commission. I believe you cannot make good decisions, and I could never make a really good decision, if I did not have somebody to ask questions of. If we had not shown up, no one would have been here to talk to you about these three bills. I want to thank all these folks for doing this and trying to move these issues forward. These things were forwarded to the Legislature to be drafted before there was a change of administration. So, this work was done previous to all of that. This current administration is not looking at this Commission in the same light that the previous administration did.

Chair Peters:
I want to go back to our legal counsel on the participation of ERISA plans, or at least their placement in this bill.

Eric Robbins:
There is a provision of this bill that specifically deals with the participation of ERISA plans in the reporting. Section 11, subsection 2 of the bill states that a provider of health coverage for federal employees, a provider of health coverage that is subject to ERISA, or the administrator of a Taft-Hartley trust are not required to but may submit the data prescribed by the director pursuant to this section. The reason they cannot be required to report is because there is a U.S. Supreme Court case that says states cannot require plans to report; but, as we have discussed, they can voluntarily submit information.

Bobbette Bond:
I am one of the Commission members involved with an ERISA plan. The Culinary Health Fund is a Taft-Hartley ERISA plan, and we have had specific conversations about this because we have promoted 20 years of health care transparency. Many of the bills passed in this Legislature have been transparency bills we worked on. Do not bring new requirements if you are not going to join the party. We have a board of trustees that reviewed this request, and they wanted to see the first year of data to see what this looks like before they made a commitment that is a voluntary commitment, because they also have fiduciary responsibility. A lot of health plans do not have the same situation we have. Our trustees have direct fiduciary responsibility for anything that transpires, and they are careful about how we submit our data, but we are trying. They did not say no, and they want to see the first year. I think the Health Services Coalition was in the beginning stages of talking to some of those other health trusts about joining this, but I do not know what will happen now.

Sara Ralston:
For perspective, when this was being talked about within the Commission, a lot of discussion revolved around having everybody at the table. You wanted to have everyone at the table and the Commission was prohibited from requiring that ERISA plans participate because of the federal protections they have. This section was designed to put into law exactly the conversation Ms. Bond referenced, and this was the way you could go about it because you were not allowed to mandate it. You had to legally allow them to volunteer. However, you could not have absent language, so this language gives them the legal authority to volunteer to submit the information.

Bobbette Bond:
It is very similar to the 2019 surprise medical bill that was passed by this Legislature after five attempts. We are very excited that it worked because that has provisions for self-funded plans. In the first year there were not very many, but the third-year report just came out, and for 2022, there are over 40 plans now participating in the surprise bill law. Some things just take time, but we are working on it.

Chair Peters:
Thank you for the responses.

Assemblyman Hibbetts:
Does the benchmark help in alleviating the provider shortage?

Sara Ralston:
That is a complicated question. What it does do is shine a light into how health care spending is divided, so you can see what the driving factors of health care spending are. When it comes to worker shortage issues, I do not know how to answer that because we do not know the spending patterns. Are the providers' insurers spending 70 percent of their revenue trying to recruit and retain? We do not understand if that has been a problem. Do they need to spend 100 percent? I am not sure, so I do not know how to answer that question in the context of this measure.

Assemblyman Hibbetts:
From reading the bill, the third parties or the insurance companies are to submit their spending. The board, the Commission, whatever we are going to call it, sets a benchmark. They determine whether the spending met the benchmark, whatever it may be. Nowhere in the bill does it say anything about what happens if the insurance companies fail to provide the information. Let us say the benchmark is 5 of whatever the unit is, and they spend 10. Then the next time the benchmark is 8, and they spend 20. I do not see why we are doing this other than gathering data, which we have plenty of.

Sara Ralston:
This was designed not to have a penalty for noncompliance because it is a foundation to start the conversation about what we can do to address the systemic issues in our health care system. To further the discussion on affordability, access, and quality of health care we

provide to Nevadans. I would like to refrain from saying "benchmark" and say it is a "target." It is a target you want to reach, and you have to establish it because it is an anchoring point so you can measure performance against it. If you do not have something to start, and a common goal such as saying, "We would like to see our health care spending in the state not rise at a higher rate of inflation," or more than triple the amount of inflation—you need to start somewhere. This measure is a target goal to measure performance against the benchmark for the betterment of having a cost containment strategy for our state. In an ideal world, you would have an unlimited budget, but that is not the case, and you are accountable to the state budget. Every dollar you spend on health care is a dollar you could have spent somewhere else. This is a deeper conversation on having a cost containment strategy that is sustainable for our health care system.

Assemblyman Hibbetts:
I understand you do not want to use the word "benchmark," but that is what is in this bill—the word "benchmark," so I would suggest we use the language in the bill.

Sara Ralston:
Thank you for pointing that out. There was deep discussion about this, and we decided as a Commission to talk about this as a benchmark or as a target. Other states have referenced them, and they are interchangeable. On the first page it reads that this is "establishment of a health care cost growth benchmark for each year as a target for the maximum growth." I do not want it to be confused that a benchmark is a mandate or cap. It is not. It is a target and goal to anchor the conversation.

Chair Peters:
It makes you wonder what the origins of the term benchmark are.

Sara Ralston:
I would like to highlight the great state of Massachusetts, which established a cost growth benchmark that has provided a lot of value to that state in containing their costs and addressing health care issues. It came from the work that Massachusetts leads and others would like to model after.

Chair Peters:
I was thinking more existentially than that to the original origins of the use of the term "benchmark," but thank you for that history. Are there other questions from the Committee before we move into testimony? [There were none.] We will move into support testimony in our physical location.

Paul Catha, representing Culinary Workers Union, Local 226:
The Culinary Union supports Assembly Bill 6. The Culinary Union, through the Culinary Health Fund, is one of the largest health care consumers in the state. The Culinary Health Fund is sponsored by the Culinary Union and Las Vegas area employers. It provides health insurance coverage for over 145,000 Nevadans, Culinary Union members, and their dependents. Through vigorous engagement, the Culinary Union has maintained one of the

strongest health care plans in the nation with $0 monthly premiums, $0 deductibles for covered services, and free generic prescription drugs at multiple Culinary free pharmacies across southern Nevada. As health care prices continue to grow faster than wages and the cost of housing increases, it is more important than ever that the state of Nevada analyze the rate of this growth and cost and set a standard for health care cost growth. Passing this bill will not just benefit Culinary Union members but all Nevadans, and our union is proud of its decades' long history of advocating for and winning health care legislation that is not narrowly targeted at Culinary Union members but benefits the entire state and all Nevadans. The Culinary Union supports Assembly Bill 6 and encourages the Nevada Legislature to support and pass this bill.

Randy Soltero, representing International Alliance of Theatrical Stage Employees:
We have thousands of workers in the entertainment industry. We strongly support this legislation and hope it finds quick passage.

Susie Martinez, Executive Secretary-Treasurer, Nevada State AFL-CIO:
On behalf of over 150,000 members and 120 unions, the Nevada State AFL-CIO supports Assembly Bill 6. One of the biggest costs for working families every year is health care. No Nevadan should have to take on an extreme financial burden in order to keep themselves or their loved ones healthy. This bill will have a positive impact on Nevada families and ensure health care cost increases are kept to a minimum. I would like to thank the Patient Protection Commission for its hard work on this, and I urge the Committee to support Assembly Bill 6.

Marc Ellis, President, Communication Workers of America, Local 9413:
Ask, and you shall receive. The term "benchmark" originates from the chiseled or horizontal mark surveyors made in stone structures into which an angle iron could be placed to form a bench for a leveling rod, thus ensuring that a leveling rod could be accurately repositioned in the same place in the future. Also, we support this bill wholeheartedly.

Chair Peters:
I knew there was the right person in this room to answer that question.

Maya Holmes, representing Culinary Health Fund:
We are a nonprofit labor-management trust that provides health benefits for the participants of the Culinary Union and their dependents—about 280,000 lives. We want to thank the Patient Protection Commission for bringing this bill forward and the Committee for hearing the bill. It is important legislation to enact to address health care affordability and access in Nevada. A 2022 study found that 65 percent of Nevadans worry about whether they can afford the cost of health care, which is shocking, and 73 percent said they believe the health care system needs to change. Health care costs on average have grown much faster than wages or inflation in the overall state economy. It is straining family and governmental budgets; however, we cannot address what we cannot measure, and we need a benchmark to do that. Assembly Bill 6 will allow the state to track and analyze health care spending growth and compare it to a reasonable benchmark that takes into consideration wage growth in the state and the growth of the overall state economy as well as having the flexibility to

take into account abrupt and unforeseen changes in the economy. Assembly Bill 6 is a critical step for the state to understand health care spending and begin to address affordability by providing transparency into what is driving up costs and putting health care out of reach for so many Nevadans. Thank you, and we urge the Committee to support the bill.

Maria-Teresa Liebermann-Parranga, Deputy Director, Battle Born Progress:
We strongly support this bill and are appreciative that it is being brought forward even with the circumstances the Commission finds itself in, and that the members are still advocating for this important big step was just shared with us. I have an autoimmune disease, and for years have spent a lot of time in and out of doctors' appointments and hospital visits trying to stay healthy. Even with great insurance, I grew up with Culinary insurance, but now do not have it, unfortunately, because I am old. Even with my own insurance, the bills stack up. You can never have too much data to understand why we are having rising health costs and to use that data to save money for Nevada's families. We are struggling and need all the help, data, and benchmarks—or whatever word you want to use—so we can work on addressing those important things so Nevadans can stay healthy at an affordable price.

Chair Peters:
Seeing no one else coming up to the desk today, please check the public line for support testimony on Assembly Bill 6.

Leann McAllister, Private Citizen, Las Vegas, Nevada:
I am a resident of Assembly District 2. In 2012, when the state of Massachusetts established our nation's first health care cost growth benchmark, I was working as the administrator of a small pediatric practice in that state. From 2012 to 2018, I saw firsthand the role the health care cost growth benchmark had in increasing transparency to reduce asymmetric information providers faced when negotiating with insurers, pharmaceutical companies, and employers. In 2018, my family and I moved to Las Vegas to be near family living in southern Nevada. When a position on the Nevada Patient Protection Commission opened in the fall of 2021, I applied. Today, I give testimony only on behalf of myself, but for the record, I have been proud to serve as a patient advocate on the Nevada Patient Protection Commission for the past year and a half as we work to lower the cost of health care in Nevada. Thank you so much.

Liz Sorenson, President, Nevada State AFL-CIO:
I am here today in full support of A.B. 6. I urge the Committee to support the bill as well.

Sue Bird, Private Citizen, Fernley, Nevada:
I would like to urge you to support A.B. 6. As a retired chief financial officer of a nonprofit, if you do not measure, you cannot figure out what you are doing or where your funds are going.

Dionne Klug, Private Citizen:
I am in support of A.B. 6, and I urge the Committee to support it as well.

Alma Lozoya, Private Citizen, Las Vegas, Nevada:
I have been a Culinary member for two years. I am here today to testify in support of Assembly Bill 6. I am a single mother of three kids, and health care prices always going up impact my family and household budget. My daughter is diabetic, and my son has asthma. Before I had a good Culinary job with good health insurance, I worked for a nonunion casino and had to pay for my daughter's insulin and my son's inhaler. Both were expensive, and we were not fully covered by health insurance. My son needed care when he had an asthma attack, so we went to the hospital, but they did not take my nonunion casino insurance and I ended up with an expensive bill. Assembly Bill 6 would address health care affordability in Nevada by providing transparency into what is driving up costs and look for ways to address them. We need this law, and I am grateful to the Patient Protection Commission for working on this issue. I urge Nevada legislators to support and pass A.B. 6 and address health care cost growth in Nevada. Thank you.

Linda Ward Smith, Private Citizen:
I am in full support of Assembly Bill 6, and I urge the Committee to support it as well. I am with the American Federation of Government employees.

Chair Peters:
Other callers, please. [There were none.] We will move into opposition testimony.

Helen Foley, representing Nevada Association of Health Plans:
We oppose this bill. Assembly Bill 6 creates an unrealistic growth expectation that does not match current economic conditions. The proposed growth targets were mandated by executive order of Governor Sisolak, targets this legislation will gradually reduce from 3.19 percent to 2.47 percent, but within the last year, inflation hit a record 9.1 percent, almost three times the 2023 target rate. As of January 2023, the inflation rate sat at roughly 6.4 percent, which is twice the rate. Inflation rates that are higher than the growth target effectively result in cuts to health care and are nearly impossible to achieve. This is one of the major flaws of A.B. 6. The benchmark target rates are set five years in advance; now, a lot has happened in the last five years. The inflation rate in the past year is a prime example. Health care is dynamic and responds to macroeconomic forces outside its control, and five years is an eternity.

Another flaw in A.B. 6 relates to the indexes used to calculate the growth rates. The targets are a combination of Nevada's median per capita income and Nevada's gross state product. These indexes fail to reflect the reality in which health care insurers operate. Assembly Bill 6 does not consider all the factors that go into the cost of health care and health insurance, especially the cost of prescription drugs and medical equipment, which are completely outside the price controls advocated by A.B. 6. Setting a benchmark target based on one component will not result in lower overall health care costs or premiums. Assembly Bill 6 also creates unnecessary bureaucratic issues. Insurers will be required to report data in a manner that is inconsistent with how they collect data for themselves. That will force entities to rework their own data in a static template that will obfuscate the true cost drivers in health care. All these efforts will take resources away from meaningful activities that can

lower costs, improve care, promote interoperability, encourage data sharing, and increase the health care workforce in the state. We urge members to forgo the passage of A.B. 6 and refocus efforts on health care solutions that make sense and address our more pressing issues such as provider and other health care workforce shortages. Let us place our focus on resources where they are most needed.

Madam Chair, in listening to the testimony today, I heard repeatedly that they had robust discussion in a diverse group and that everything on this was commission-driven. Health plans used to have a seat at the table; they were kicked off last session. Hospitals had two seats, one for a nonprofit and one for a for-profit hospital. They were also kicked off. There is no mention of a doctor on the PPC, it is a "health care provider who operates a business," but we do have two pharmacists represented on the PPC. It does not seem fair; it does not seem diverse. As we listened to the PPC meetings, we often found that individuals, maybe they were from an FQHC or from other sectors of health care, were asking questions about insurance, and there was not a person on that PPC who could answer. When they talked about hospitals, it was only from the county hospital perspective. We need a balanced PPC, and we would like to start over and find something more practical than A.B. 6.

Sarah Watkins, representing Nevada State Medical Association:
We are here in opposition to A.B. 6. The Nevada State Medical Association is the largest physician-led patient advocacy association in the state. We believe passage of this bill will ensure Nevada remains at the bottom of the list of major health care indicators. Over the last decade, specifically with the Affordable Care Act expansion, Nevada began to meaningfully invest in its public health care structure. This bill would put a hard and fast stop to the investments this body has made and is considering. This bill would establish maximum growth limits for total health care spending. This approach limits adding additional eligible groups to Medicaid. It limits rate increases that help providers meet costs and would stifle the ability to bring in matchable needed federal dollars through the federal medical assistance percentages. We know Nevada has low Medicaid reimbursement rates, and we have not yet implemented all optional services for our most vulnerable populations. Many of you have cosponsored legislation that would expand eligibility to new groups. This body is moving in the right direction looking at expansion of populations and investing in provider rates across the board. We should be leveraging as many General Fund dollars to receive as much federal match as possible. That is the policy for all Nevadans, and this bill would stand in the way of achieving this goal.

Medicaid covers roughly one-third of Nevadans, but it is also a historically low payer in the state. Putting an artificial benchmark on increasing already low rates would be a detriment to those caring for Medicaid recipients and a deterrent to providers considering moving to Nevada. Today, there is a physician shortage here. Had this bill been in place, we would not have been able to opt into the Affordable Care Act. We would not be able to expand coverage for optional groups like eligibility presumption for pregnant women. These conflict with this proposal because the cost exceeds the proposed benchmarks. Putting an arbitrary cap set by an unelected board on an already underfunded health care system is the wrong policy for patients, providers, and everyday Nevadans.

Patrick D. Kelly, President and CEO, Nevada Hospital Association:
[Patrick Kelly supplied a letter and additional documents Exhibit F.] We oppose this bill as well. Health care cost growth benchmarks are nothing more than caps on the growth of all health care expenditures, not just expenditures for hospitals, but all health care expenditures. Nevada ranks last in the nation for access to health care. Why would we cap growth? Sixty-nine percent of Nevadans reside in a primary medical care health professional shortage area. Why would we cap growth? Eighty-six percent of Nevadans reside in a mental health professional shortage area. Why would we cap growth? Nevadans living in rural areas and urban areas lack access to specialty care services. Why would we cap growth? Proponents of the bill today suggested that the main purpose of this bill was to collect data. They can collect data without having to have this bill, or at least most of the provisions of the bill could be eliminated.

When inflation took off during the past year, the Nevada Hospital Association went to the PPC and asked them to readjust the benchmarks because inflation was at about 9 percent and the benchmark at 3.19 percent was not realistic. They refused to do so. If this bill passes, little if anything will improve for Nevadans living in rural Nevada, east Las Vegas, or other health professional shortage areas in the state. Nevada's position of last in the nation for access to health care will be cemented for decades.

Brian Kleven, Nevada Market Chief Financial Officer, Dignity Health-St. Rose Dominican:
We are the only not-for-profit, faith-based presence in southern Nevada. I am representing our hospitals, ambulatory surgery centers, medical group, acute rehabilitation hospital, and micro hospitals throughout the greater Las Vegas area. On behalf of Dignity Health-St. Rose Dominican, I would like to voice our opposition to A.B. 6. Cost growth benchmarks are not an effective decision for a state with poor access to health care and health systems that are doing everything they can to make a margin in the post-COVID-19 environment. I would like to address the difficult decisions health care providers will have to face if this bill passes. I will describe the thought process for a hospital, but the principles can apply to any health care setting. The hospital's chief financial officer will be asked to develop a plan to stay under a benchmark, which presents limited options for us given the very limited costs we control, which are few and far between. The things we could control are reducing personnel—the very people we called heroes during the COVID-19 pandemic—eliminating increases and merit increases to our staff, eliminating costly programs and service lines that serve our communities. We can also stop purchasing advanced equipment for medical care to advance procedures and move forward better health care for our communities. We could stop expanding buildings and services to meet the needs in our communities, especially the areas that lack those care sites. These are all grim choices that jeopardize health care that is needed in Nevada.

Labor costs have to be considered, as it represents roughly 50 percent of our cost line, and we have very limited control over them. We pay prevailing market rates to personnel in a competitive environment, and we already have a shortage of workers, especially nurses, in this post-COVID-19 environment. Reducing wages or eliminating personnel would only

worsen that problem. Hospitals would have to evaluate every service line we provide, especially the more costly ones. Not everything is weighted equally in costs, for example, labor and delivery and neonatal intensive care units. These are very costly services to provide because we have to staff them at all times regardless of volume when a mother presents to deliver a baby in an emergency. Medicaid mothers account for more than half of those babies born in Nevada; unfortunately, many of these mothers do not receive proper prenatal care in advance, so sometimes the baby will go to a neonatal intensive care unit. We all know Medicaid reimbursement is extremely low in this state and does not cover our costs.

We would also look at delaying purchasing of advanced medical equipment and advancing our services. The question would become, "How long can we delay that and make our loved ones suffer in the state?" Why is it in the best interest of the patient to delay purchasing needed medical equipment, and this also applies to growing services. The proposed growth target in A.B. 6 decreases every year. It goes from 3.19 percent to 2.47 percent. These declining targets do not align with the economic conditions we have experienced in the past few years with expense inflation soaring north of 8 and 9 percent consistently. If inflation worsens, like in past years, it will be a downward spiral that will only harm us even more. Building new facilities, expanding facilities, and renovating some of our older facilities should be a priority for Nevada. These are costly ventures, but they should be made in the best interest of the people of Nevada. In ten years, the public would see the same infrastructure we have today by holding to this benchmark. Is that really in the best interest of a fast-growing state? As Nevada's population grows, we should be focusing on growing services. Let us work for a better future. Please vote no on A.B.6.

Connor Cain, representing HCA Health Care:
We oppose A.B. 6 for many of the reasons brought forth already. We would like to ask this Committee to consider the following: Inflation is impacting everyone, including hospitals. In some cases, inflation hit our hospitals first because of the extreme increase in staff costs we experienced during COVID-19 as we tried to compete with other states to staff our hospitals and take care of our communities. As COVID-19 declined, we have ongoing needs to appropriately take care of our nursing staff and other employees. My understanding is that the proposed 3.19 percent benchmark for this year was chosen during the pandemic and has no connection to the actual experience of providing care for Nevada patients. Allow me to share some examples of the inflationary impact to necessary hospital supplies. We have seen a 48.8 percent year-over-year increase in polyester-based supplies like staff uniforms. A 16.6 percent year-over-year increase in neonatal internal feeding tubes. A 20.45 year-over-year increase in the cost of diapers for pediatric patients. A 27.42 percent year-over-year increase in the cost of exam gloves, and a 23.69 percent year-over-year increase in U.S. cotton-based supplies like bandages used for wound care. These are just a few examples of hundreds of important supplies. We need to take care of our patients.

Another major problem of selecting an arbitrary benchmark and placing it into statute is that it does not consider rising input costs caused by emergent world events. The situation between China and Taiwan is disruptive to semiconductors which impacts our surgical CV and IR [cardiovascular and interventional radiology] equipment lead times, and the Russia-

Ukraine War has impacted raw materials such as helium and neon, which has driven up costs and limited availability. Assembly Bill 6 does not allow for any flexibility to respond to these events. In closing, we appreciate this Committee for considering our experience and ask for your opposition to A.B. 6.

Chris Bosse, Chief Government Relations Officer, Renown Health:
Renown is the only private not-for-profit system in the Reno-Sparks area and serves as the community's health care safety net. By that, I mean it provides over 70 percent of the care provided to Medicaid and uninsured patients in our region. Renown also operates 3 hospitals, 19 primary care sites, 11 urgent care sites, 5 pediatric sites, and 28 specialty care locations in our region. Like others who have testified in opposition before me, Renown Health opposes codifying cost growth benchmark targets in Nevada and agrees with the comments of those who have testified in opposition before me. Given that Nevada already spends the third-lowest amount in the U.S. per capita on health care and more than 50 percent of Nevada hospitals have negative operating margins for the three quarters in 2021, applying an unrelated target on cost growth puts the industry in a position to control something it has no direct control over other than by putting pressure on providers and facilities to cut access and reduce services. With development of the All-Payer Claims database in Nevada going forward, we are going to have the opportunity to have data and be able to work together with actual data we have not had previously. It will be even better data to the extent that folks like the Culinary Union and others will also include their data. Over time, we will have complete robust data, which I think is going to be critical to identifying areas where we may not be spending enough. Those findings may cause us to identify areas that may result in workforce pipeline priorities or proposing policies that support our health care providers and/or recruitment and retention strategies we should be focused on. It may also identify areas where we may be spending too much, which might lead us to value-based strategies to get patients to lower levels of care in a timelier manner. As a health care industry, I would like to see us providing this body with proposed policies that will lead to outcomes we are looking for—improved access to quality, affordable health care—not policies that will lead to limiting access and services. Cost growth benchmark targets for health care spending should not be the priority for Nevada.

Paul J. Moradkhan, Senior Vice President, Government Affairs, Vegas Chamber:
The Chamber has concerns about A.B. 6. We believe the health care cost growth benchmark will inadvertently impact patient access in a negative way and will compound our existing challenges in our health care delivery system throughout our state. In southern Nevada, the reality is that inflation is impacting all sectors and industries, and health care is not exempt from the economic challenges. We believe those issues need to be addressed for all Nevadans.

Kerrie Kramer, representing CVS Health/Aetna:
We are in opposition to A.B. 6 and share the concerns of our trade partners and others who previously testified in opposition.

[Exhibit G, a letter in opposition to Assembly Bill 6, was submitted but not discussed and will become part of the record.]

Chair Peters:
Seeing no one else coming up to the desk, we will move to the phone lines. [There was no one.] I will open the hearing to neutral testimony. Is there anyone in Carson City 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 Assembly Bill 6? [There was no one.] I would like to invite the presenters back up for closing remarks.

Sara Ralston:
I am happy to follow up with any Committee members to talk about this and to gain a deeper understanding of what was happening during the opposition testimony. I want to reiterate there is no penalty for not meeting the target, and it was designed that way. It was designed that way because this initiative is a foundation for creating a cost containment strategy to help the state with the budget and to address the rising cost of health care, and to hold those in this space accountable for their spending patterns. At a rate of 25 percent, as I referenced before, or any other rate, even with inflation, I believe you, as policy leaders, and patients of the state have the right to ask why. We do not know what the "why" is without holding them to a target and having performance measured against that target. There was a reference to the benchmark index rate. I will go back and make sure I get the accurate methodology that was listed, but there was robust discussion—hours of testimony. There was a mix of both average median wage discussions and national GDP [gross domestic product] levels because we wanted to determine what was affordable for Nevadans. That is where the average median wage came in to play, but I will provide you with the exact methodology on that.

There is also a reference there is going to be a prevention of the federal match. There is no provision in this bill that prohibits or obstructs federal matching. There is no growth cap. Based on a lot of the testimony, I think one of the overarching pieces missing was, where is the pressure? Where is the pressure on establishing policies because you perceive growth will be limited. We do not have a bigger picture on what you are spending. How do you know where the money is going? Is it going to out-of-state expenditures? Is it going to for-profit entities that have to cater to shareholders? If you ask for the data, we can collect it. We tried; the state has tried for years. You have plenty of testimony, plenty of pieces of legislation where you have asked for that testimony. And if that testimony did not show you that if you ask for transparency, you are then threatened with arbitrary policy decisions that highlight that you are going to choose to put profits over patients. That transparency is necessary. It is a necessary part of the conversation to have a well-informed, robust discussion, not only for policymakers, but for patients. Patients have every right to ask where the health care spending is, why their pricing is the way it is, and what are any increases?

To the point about industry not being at the table and wanting to be a part of the Patient Protection Commission, it was a legislative decision by Ms. Carlton and this body last legislative session to make a change. Even today, industry is at the table, but who is

speaking for the patients? I have become a strong patient advocate, but you do not hear a lot of patient testimony. You hear a lot of industry testimony. They are familiar with the public process, and they are certainly at the table.

I cannot say how disappointed I am hearing such arbitrary policy decisions before you even answer why. Why would you make that decision to reduce services? Where is your spending going? Why are you saying you are not going to invest in expenditures? Is it cutting into your profits? Is it cutting into wages? We do not know, because we do not have the data, and that is what this measure is going to accomplish. It is going to help us understand the bigger picture. We will see the data and not have to take someone at face value. We all deserve to see that for ourselves.

Maggie Carlton:
Thank you for hearing these bills. You can hear the passion in the room. Health care has always had passion and the reason the Patient Protection Commission was established was to have conversations with professionals in a dialogue through the interim so they could bring these issues back to you. As far as participation in the Commission, I sat in the same office for three sessions in a row. We established the membership of the Commission the first time around and there were conversations. Folks were not sure if they wanted to participate the first time around. The second time I realized there are new players here in the state. There is nothing that prohibits them from participating. The way the Commission is set up now, it does not have designated seats. If someone were that passionate about it, they could have asked for a bill draft to change some of that if they really wanted to be on the PPC.

I did check with some folks as I was working on this bill to find out what was going on, and I was under the impression that they were in a neutral position, but that changed. When I was in this building, I always had an open door, and I always answered the door. If someone had concerns, I would have been more than happy to have a conversation with them about their participation. The more the merrier. The more information we have, the more data we have, is better for the state of Nevada.

Sara Ralston:
There was a discussion about inflation and rising costs being a burden for providers. In particular, we heard testimony from HCA Health Care, the largest provider not only in our state, but in the nation. They are concerned about inflation, but it paints a different picture when in 2020, HCA returned $1.6 billion in CARES Act money. In addition to the $1.6 billion, they also returned $4.4 billion in Medicaid accelerated payments. If inflation were such a concern, why would you turn down that funding?

Chair Peters:
We will close the hearing on Assembly Bill 6.

I am going to open the hearing on Assembly Bill 7. I want to note all Committee members have a copy of a revised amendment [Exhibit H]. It is my understanding that the bill discussed at the Patient Protection Commission (PPC) that was Assembly Bill 7 was not

submitted properly. The original draft was miswritten with regard to the intent of the PPC, but I will let Ms. Bond and Ms. Carlton speak to that issue. What we are looking at today is the amendment to Assembly Bill 7.

Assembly Bill 7: Revises provisions relating to electronic health records. (BDR 40-381)

Maggie Carlton, Executive Director, United Labor Agency of Nevada:
I think the PPC commissioner who worked on this issue should walk the Committee through the different components of this bill. When I studied it, I was studying the wrong version.

Bobbette Bond, Vice President, Health Policy, Culinary Health Fund:
The bill was written completely wrong, and because the PPC does not meet all the time, by the time they saw it, it was too late to revise it. The suggestion was made that we bring an amendment instead, and this is the first hearing. The amended bill creates interoperability of electronic medical data between providers. It also provides that for patients. Patients need to have access to their records electronically. It is difficult to get your PET [positron emission technology] scans. It is difficult to get your prescription list. It is difficult to get your X-ray. It is difficult to get your diagnosis, but diagnostic results are particularly difficult to get because they are almost all electronic now. Physician offices are getting much better, as are hospitals, in creating interoperability with each other. The world is changing quickly now and allowing different health care records to be interoperable with other offices, but it is going to take a little time to do that. This bill is requiring providers to create interoperability for patient records so those records can be provided to the patient and for the patients to get those records to whichever doctor they want. That is the bill. In the meantime, it also gives the providers immunity if they end up using some patient record that was not their record in this interoperability and there is a problem. That was in the original bill, too. There is still a liability issue. Liability protection is still in there. Yes. I saw some testimony sent in with concerns about that, so that may be a future conversation we have to have. The final thing is we give until 2028 for this interoperability to be in place. Doing this with University Medical Center took us a week, so I think giving doctors and hospitals five years to do it is great. There was also a request for $3 million to go to small providers that might need help with technical support.

Chair Peters:
Are there questions from the Committee? We all need a minute to digest the amendment. It has been uploaded on the Nevada Electronic Legislative Information System (NELIS) and is also available on NELIS for the public to be able to review as well.

Bobbette Bond:
This was one of the pieces that was not completed with the transitions.

Assemblywoman Gorelow:
I would like to put this in a real-world situation, making sure I understand it, as I am just now seeing the amendment. It is going to make it easier for doctors to access patient records. Someone who has to go to multiple doctors for a variety of issues—and I will use my

daughter for an example who has to go to an orthopedic surgeon, plus her primary, plus a geneticist—it would allow them a case management-type of approach to read each other's records rather than me carrying things around.

Bobbette Bond:
Yes, Assemblywoman Gorelow. It would allow all that to become electronic. Some providers are doing a great job with that; some are not. We are trying to figure out a way to push it forward and also get some help to the small providers where it would be harder to do. Big providers have already done it, but we were trying to respond specifically to patient requests to be able to have access to their medical records.

Assemblyman Gray:
If I read this correctly, and correct me, if I am wrong, this is going to mandate that all providers and facilities, everybody moves to a health information exchange (HIE)-type system regardless of what the patient wants done with their records.

Bobbette Bond:
If the patient does not want their records released, they will not go anywhere. We are very big on opting out.

Assemblyman Gray:
No, ma'am. I am not saying released. I am saying added into an electronic system.

Bobbette Bond:
Oh, well, yes. There would be electronic entry of medical records, so patients could access them when they were transferred and so doctors could exchange them with each other. But all this is only upon patient request, and what they do with them is all in the patient's hands.

Chair Peters:
I am going to ask legal. We dealt with that a while back—the patient's electronic records. I have not thoroughly reviewed the amendment, but does this change what is in existence for the patients and how they want their records managed?

Eric Robbins, Committee Counsel:
No. Under existing law, electronic disclosure or maintaining electronic health records is opt out. The patient would have to say they do not want their records to be maintained electronically, and then they would not be maintained electronically. That is under existing law. For the HIEs, that is different. That is opt in, and that also would change under this bill.

Chair Peters:
Thank you.

Assemblyman Nguyen:
How about when the patient travels to other states in terms of interoperability? How does that work in terms of compatibility? Are they going to be able to? The second part of that is

language access—patients who have language challenges who go to a different country for treatment. Could that record be sent across states as well as across countries?

Bobbette Bond:
This is a state bill, so this would only require interoperability among providers in the state. The records go to the patients electronically, and those patients can do whatever they want with them. I do not believe the records are mandated to be presented in a language other than the language the provider is already using. If patients wanted to go to New Jersey or Korea, they could take their records with them electronically, and hand them over to an electronic provider.

Assemblyman Nguyen:
So, the record is like a file. Is that what you are saying? The record is an electronic file. It could be a PDF, it could be whatever, and they can take that with them if the patient is getting the information from the state.

Bobbette Bond:
I do not think how it looks is codified in this law, it is just to unify the records into a record set that can be sent to other providers. It is about interoperability. Instead of having to manually carry it or go through the health information exchange that currently exists, we are trying to create more of a spider web, so records can go from doctor to doctor and be in the patient's control, which is not something we have right now. I do not know if that looks like a PDF file or electronic file. I think the interoperability will work its way out in the next five years to make sure everybody has something that works. The industry has changed a lot since I tried to do this five years ago.

Assemblyman Nguyen:
This is for Nevada only. It does not matter where you are in Nevada, providers in Nevada and patient records in Nevada.

Bobbette Bond:
Yes, and those patients can send them anywhere they want out of state.

Chair Peters:
All of us have experience with our own health insurance provider and health care provider. Both have electronic forms from which I can access my data. They look like applications or websites. I have not tried to download my data to see what it would come out as, but I imagine a PDF. For language access, I do believe there are PDF readers that can do some translation services. I do not think they are great yet, but there is some work to be done in that space.

Assemblywoman Taylor:
How is this different than MyChart? I do not know if you are familiar with that, but MyChart is where all my records are. When I was going through cancer treatment, it was very handy to have all my stuff right there. I can pull it up now and look at images. How is

this different than that? I chose to do that. You have to sign up and opt in. How is it different, or is it?

Bobbette Bond:
If you can send those on to another provider, then that is the only way they are different. MyChart is a really good example. A lot of patients are getting these records now; a lot of patients are not. This bill is trying to move it along over the next five years. Your records are something you can put on a flash drive and take to another doctor or send to another doctor electronically; you can pull them down, MyChart does that. You can pull out your X-rays and send them to yourself, and you have that available electronically for your next doctor. It works on MyChart, but I do not know if it works on everything yet. A lot of places have not gotten that far and there are a lot of patients who would appreciate having this. We want the patients to be in control of their records, so we wanted support for the smaller medical practices that are going to take longer to be able to do this. We wanted to support them getting there.

Assemblywoman Taylor:
It is similar to MyChart. That is what you are working toward.

Bobbette Bond:
Exactly.

Assemblywoman Taylor:
I have full control over that. My second question is related. We believe it is in statute that patients can have this done. You opt in, but if you do not want your records electronically, you have to tell your provider that you do not want them electronically. Are patients informed of that? Do we know? Like for me, when MyChart came out, I had to sign up. That is how I was informed: if you want to be able to get your records electronically, this is how you sign up, this is how you log in. You create an account. At that point, I knew I could either do it or not.

Bobbette Bond:
That is exactly what happens. And if it is not in the statute, it is because it is required by other federal regulations about patient records.

Chair Peters:
This is a great nexus. I was going to go back to Mr. Robbins for a response to an earlier question, and maybe we can loop this one in.

Eric Robbins:
The relevant statute as far as opting out of patient records is NRS 439.538, subsection 2. That says that a covered entity—provider, insurer, or business associate of one of those entities that makes personally identifiable health information available electronically—shall allow any person to opt out of having his or her information disclosed electronically. There are a few exceptions. The one major exception is Medicaid and CHIP [Children's Health

Insurance Program] recipients are not allowed to opt out of having their information disclosed electronically. That is what existing law says on this matter.

Assemblywoman Taylor:
It says it "shall allow." But how will a patient know they can say they do not really want their data like that? I know it is "shall allow," but do we have to let them know, or what? If I am a patient and I do not want that? I know I have the option, but how do I know I have the option? Does that make sense?

Eric Robbins:
Yes, that makes sense. The statute is not specific about that. I would read "shall allow a person to." When it says that they shall allow them to opt out, I do not know that it is really allowing someone to opt out if you do not tell them they can do that. That might be implicit in the statute, but the statute does not explicitly say, and it certainly does not say how you have to let them know.

Assemblywoman Taylor:
They need to be informed somehow, some way, and figure it out.

Eric Robbins:
I would say, yes. I would say that by requiring them to allow a person to opt out, you are not really allowing the person to opt out if you do not tell them they can. I think that would be implicit in the statute.

Chair Peters:
We do not have a representative from the Department of Health and Human Services here today, but through quality control—the Bureau of Health Care Quality and Compliance—usually has regulations for things like this—how certain providers have to do those things, so there might be some regulations we can look into for you to follow up on that particular issue.

Assemblywoman Taylor:
I appreciate that. I think it was clear you are not allowing them to opt out if you do not let them know, and that is enough detail for me.

Assemblyman Hibbetts:
My question references the exemption from civil and criminal liability for a doctor who gets the records and there is some sort of erroneous entry in there, and a mistake is made based on that erroneous entry. They are exempt from liability. Let us say we are working under paper records, and I go to the doctor's office and they have a physical chart in front of them, not an iPad. Do we offer exemptions from liability if there is a mistake put into my paper record and another doctor looks at it and makes some sort of error based upon that mistake? Is that already exempted from liability?

Bobbette Bond:
That is a really good question. I have no idea. I think we are at the point where we need more help from the Nevada Legislature and the Nevada Executive Branch. We are going to need to answer your questions with a lot more expertise.

Assemblyman Hibbetts:
I appreciate that. And if you are not the right people to ask, maybe legal could answer.

Eric Robbins:
I am not aware of anything in statute providing specific immunity from liability like this for paper records. Malpractice cases are judged under the negligence standards. A provider of health care who takes reasonable care—and that is what the negligence standard is, did the provider take reasonable care—if what the provider did in terms of relying on a paper record was reasonable under the circumstances, the provider would not be held liable there. As I said, there is nothing explicit in statute, like there is with NRS 439.593 as amended by section 1, subsection 1 of this bill.

Assemblyman Hibbetts:
That was a whole lot of numbers, and I am going to trust you on that. Thank you very much.

Assemblyman Gray:
I am going to jump back in time. About 2011, the federal government had a big push going toward HIEs, EMRs, and EHRs [health information exchanges, electronic medical records, and electronic health records], whatever you want to call them. The reason I differentiate between the acronyms is there were all kinds of companies like Practice, Johnson and Johnson, and Epic. They were giving money to small practices, large practices, and hospitals to make this jump, but the big problem back then was that nobody could talk to each other. The systems they had in place could not import the data. It was garbage in and garbage out. Say I am a patient at Carson Tahoe Regional Medical Center, and I have to go to the emergency room in Gardnerville. Are they going to be able to access my record or do they have to have something sent over in a PDF? I do not think the systems are there yet where they are talking to each other on a one-to-one basis. How do you plan to protect the information and make sure it is good information? What is to stop my ex-wife, who works for a practice somewhere else that is on the HIE, or other nefarious actors, from looking at my information?

Bobbette Bond:
There are years of health information technology regulation coming out. There is a mountain of what has come out from CMS [Centers for Medicare and Medicaid Services] about interoperability rules. There is a lot of information that will be used to try to push this whole project forward should it happen. I know patient privacy is a paramount concern in Nevada. That is why the state statute is still an opt-in instead of an opt-out statute for records. These are all really good questions, but I do not feel qualified to weigh in on the exact answers. We should be keeping track, so we can go back and get the information for you.

Assemblyman Gray:
Thank you for the honesty. I have to say for the record, I do not have an ex-wife. As a matter of fact, my wife and I are going to have our twenty-eighth anniversary this Saturday.

Chair Peters:
So, I was questioning your judgment on this first, this nefarious first ex-wife. Does anyone else have questions before we move into testimony?

Maggie Carlton:
Chair Peters, if I could elaborate on one thing that has been glossed over—the fact this bill does have money in it to help folks get there. We have to start someplace. This is the first step towards my not having to go to two hospitals and three different doctors to get different CDs, X-rays, and all those other things, so when my husband sees that final cardiologist, I have everything all together for him. I would be able to compile it all. Hit a button, send it to the surgeon, and he would have everything. There have been times when we had a confirmed appointment and found out there was one more document they did not have. Guess who gets to go pick up whatever, take it to wherever and sit in the waiting room while they cut a CD, and then take it to the next physician.

It is important that we set aside dollars for the smaller practices so they can take care of this. They are very important. They are our primary care physicians. It starts there and works its way through the specialty fields. It is very important if we move forward with this, and we really want it to work right, that we give resources to those providers who need it, to make sure everybody is on the same page. It is not often I bring a bill that has $3 million in it, so I wanted to make sure it was on the record.

Bobbette Bond:
As a reminder, it also has a five-year window, so it would be 2028. The interoperability world is changing dramatically, now. It has changed dramatically since COVID-19 started. To your point, Assemblyman, there were a lot of problems with interoperability five and ten years ago. When the HIE world was created, it was impossible to get anybody talk to anybody, but it is changing rapidly. I cannot say it is perfect, but there are people who could help answer these questions about what the timeline and expectations are.

Chair Peters:
Thank you for that. In the environmental world, we are working on the same issue of sharing data and how we share it. Typically, we use something called a node which acts as a translator between different data sources. I think what this bill envisions is nodes that communicate data between several entities at different points in time, and that is not impossible to design. We are doing it in all areas, and this is just a health care design.

All right, we are going to move into support testimony on Assembly Bill 7. I would invite folks up to the table in our Carson City location, and then we will go to the phones.

Marc Ellis, President, Communication Workers of America, Local 9413:
As a labor leader, we support this.

Randy Soltero, representing International Alliance of Theatrical Stage Employees:
We are in full support of this bill. As a patient with diabetes and chronic kidney disease, I can show you that on MyChart. I have to have tests here regularly because I am here in Carson City for four-and-a-half months, and I have to communicate with my doctor. I go to Carson Tahoe Medical Center and have my blood drawn, have tests done, and I share that information with MyChart. I can do that with my app [smart phone application] and the information goes directly to my doctor in Las Vegas.

Paul Catha, representing Culinary Workers Union, Local 226:
The Culinary Union supports Assembly Bill 7. The Union, through the Culinary Health Fund, is one of the largest health care consumers in the state. The Culinary Health Fund is sponsored by the Culinary Union and Las Vegas area employers and provides health insurance coverage for over 145,000 Nevadans—Culinary Union members and their dependents. Nevadans should be able to access their health information electronically quickly and easily and have the freedom to do what they want with their personal medical information. Culinary Union members come from 178 countries and speak 40 different languages. The most health-impacted populations have the most difficulty navigating the health care system, and all people should have easy access to their own records. All Nevadans, not just Culinary Union members, will be healthier as a result of the free flow of medical information in this state. Our union understands there are ongoing conversations around an amendment, and we will engage in those discussions, which we view as necessary. Even so, the Culinary Union supports Assembly Bill 7 and urges the Nevada Legislature to support and pass the bill as well.

Susie Martinez, Executive Secretary-Treasurer, Nevada State AFL-CIO:
On behalf of over 150,000 members and 120 unions, we are in full support of A.B. 7. It is essential all Nevadans be in full control of their health decisions, and this requires transparency from their providers. Patients must be able to have free access to their electronic health care records so they can best determine the next steps and ensure their future providers can give them the high-quality care they deserve. The Nevada AFL-CIO endorses this bill.

Maya Holmes, representing Culinary Health Fund:
We thank the Patient Protection Commission for bringing forward this bill and the Committee for hearing it. We support interoperability for patients and providers to be able to seamlessly access, transfer, and receive their health and medical records. The federal government has been working for a while, and it has moved forward much more quickly on establishing a national framework that is voluntary providers can adopt. That is providing a base and that platform for interoperability, and A.B. 7 would do a lot to move that along in our state. That is why we are in support. Thank you.

[Assemblyman Orentlicher assumed the Chair.]

Maria-Teresa Liebermann-Parranga, Deputy Director, Battle Born Progress:
Battle Born Progress supports this bill.

Vice Chair Orentlicher:
Thank you. Is there anybody else here in support? [There was no one.] Do we have anybody on the phone to testify in support of Assembly Bill 7?

Liz Sorenson, President, Nevada State AFL-CIO:
I am here in complete support of A.B. 7 and urge this Committee to do the same.

Deanna Latus, United Food and Commercial Workers Union, Local 711:
We represent 7,000 members and are definitely in full support of Assembly Bill 7.

Rawanda Rogers, Private Citizen, Las Vegas, Nevada:
I am a guest room attendant and Culinary Union member for ten years. I am here today to testify in support of A.B. 7. My son has life-threatening asthma. He has an at-home care kit that includes a breathing machine and medicine. When Madison gets really sick, I have to take him to the doctor to get steroids to treat his asthma. Last night, my 13-year-old son got very sick. He could not breathe, he was throwing up, and was in a lot of pain. I made the doctor's appointment for today. When my son and I arrived for the appointment this morning, I was told they did not have the medical records and they would not be able to transfer them in time for him to be seen by the doctor. They said I needed to go somewhere else because they did not have the medical records, and that is not right. Patients need easier access to health care records. I texted my doctor and told her what was going on. The doctor came out in the front and told the front desk that my son was the patient and that he was going to be seen. If I did not have the doctor's personal number, I do not know what would have happened. My four kids and I have asthma. If it is happening to us, then it is happening to other families. Assembly Bill 7 would make it so patients like me could have fast and easy access to our medical records and ensure that my health records could be transferred to doctors. We need this law, and I am grateful to the Patient Protection Commission for working on the issue. I urge Nevada's Legislature to pass A.B. 7 to protect patients.

[Assemblywoman Peters reassumed the Chair.]

Ann Deconge, Private Citizen:
I support A.B. 7 for the electronic health records portion. However, I have some serious concerns about the liability and immunity portion of the bill, how it is written. So, I am looking forward to seeing what the final amendment may be. I urge the Committee to look at that portion as well as looking at creating a central system in northern and southern Nevada so things can be transferred in addition to the work that A.B. 7 has already written to provide. I do support it. I just have concerns about those two factors.

Chair Peters:
Thank you for your testimony. Typically, if you are not fully in support of the bill as written, and I realize that the amendment has just come out, I would reclassify your testimony in opposition, but today we will let it be what it is, based on our amendment issues.

Please add the next caller. [There was no one.] We will move into opposition testimony in the physical locations. If there are folks in Carson City who would like to provide opposition testimony on Assembly Bill 7, please come up to the table.

Jim Wadhams, representing Nevada Hospital Association:
We had not intended to either support or oppose the bill as it was originally written, but this amendment took a lot of people in the audience by surprise. We have not had an opportunity to review the amendment, particularly in the context of the federal law, whose final rules on interoperability just came out in December of last year, to see how all of this integrates. We support interoperability, and that is why we are going to be neither for nor against A.B. 7 in its original form. We were unaware the PPC had approved an amendment and would like an opportunity to review it. We will work with the Committee and the sponsors in that regard.

Nancy Jones, Board Member, Health Freedom Nevada:
I am a mother. I am a resident of Douglas County and a board member of Health Freedom Nevada, a nonpartisan, all-volunteer organization representing approximately 5,000 Nevada families. We are interested in protecting full, informed consent to all medical and pharmaceutical interventions, religious freedom, and parental rights in all personal health care decisions. We, like everyone else, are just reviewing the amendment and everything here, but we fundamentally oppose mandating the creation of electronic records. From the discussion here, I do not recall ever having been given the option of opting out. To Assemblywoman Taylor's question earlier, that is from a patient's experience. That is not something I am familiar with as far as, "Hey, we are going to make records. Do you want that to happen or do you not, and you have the right to say no to that." That would be essential language to put into any sort of system like that. Senate Bill 419, which was introduced and heard yesterday, creates a federal database for this kind of information to be stored and shared. In conjunction with that bill, this would create a sort of federal board all your data would get sucked up into, and you would not have control over it after that. These two bills would work in tandem to collect, store, and share our private information at the local, state, and federal levels, and this is in violation of the Fourth Amendment to the *U.S. Constitution*, which I am sure you are familiar with, that the people have a right to be secure in their persons; and, in this case, electronic papers.

I am also concerned that this bill does not address patient privacy or security of the records that are to be created. And it is very concerning to me that the records are not required to be accurate and there is absolutely no accountability for the accuracy of the records as they are going to be created because of that liability clause that is in there to make sure that no one is accountable for the contents of the records. It is a confusing bill to me that we are being required to create records, but no one is required to make sure they are accurate, and no one is accountable for when they are not accurate. We strongly oppose this.

Kathleen Palmer, Private Citizen, Carson City, Nevada:
Mandatory electronic records are a violation of my privacy. The system should be opt-in only, not opt-out. I oppose A.B. 7.

Janine Hansen, State President, Nevada Families for Freedom:
We received this amendment just now, and some of our concerns continue. We are concerned about patient privacy. We are concerned about being put in a state database. For instance, the amendment talks about the existing law that requires a health information exchange to be responsible for compiling the statewide master index of patients' health care providers. So, we are concerned not only about what is in this law, but in this amendment, and what may be in the current law right now that jeopardizes individual privacy. We also have the same concerns Assemblywoman Taylor had about opting in and opting out. Nobody knows that it is not readily available. We need something specific that would let people know there is a way they can decline to be involved in this. Once your information is in a database, it is not safe, it is not private, and it is not secure. That is a critical issue for all of us. As we watch other bills in this building moving forward, we continue to have concerns about not only a statewide database but moving into a federal database. That was addressed yesterday in S.B. 419, which is moving through this building. We appreciate the in-depth discussion; we appreciate the amendment, but we want to make sure it is clear that it is opt in, and that our private records are protected. Once they are in the database, they are not ours anymore.

Joy Trushenski, Private Citizen, Carson City, Nevada:
I agree with those who came before me who oppose this bill. I oppose this bill because computers are hacked all the time and information is stolen. My concern is a privacy matter. I am concerned that our information will go to people who will use it to abuse people. I do not agree with the fact that there is no liability for people who have put data into your health care information inaccurately. I want to read this amendment more closely, and then I will send you other comments, but thank you for the time.

John Eppolito, Private Citizen:
Personally, I need to hear more about notifying patients they can opt out before I would be in favor of this bill. It was really fuzzy, and we did not have the amendment in time as everybody else has said. There are data breaches daily in this country, so it is probably just a matter of time before these records are either breached or posted online as part of a ransomware attack. They ask for the ransom; it does not get paid, then the records are posted online. This already happened. In the Clark County School District, there was a ransomware attack. The school district did not pay the ransom, and student information was posted online. It was posted on the dark web. It just happened last month in the Los Angeles County School District. The psychiatric assessments of hundreds of previous students were placed on the dark web because the school district would not pay the ransomware. These people are now in their twenties and thirties, and we do not know how it is going to affect their futures. The statewide longitudinal data system throughout the United States when the federal government paid almost $1 billion to get all states' student data in the same place,

both the Tenth Amendment Center and the ACLU came out against that database. It did not matter; it was created anyway.

Nevada is especially bad. Experts have called Infinite Campus the most massive database ever created on children. This is the one all school districts in the state use and it includes things like medical, counseling, multi-tiered system of support, discipline, minor discipline, and psychiatric data on children. Currently, none of this data is ever deleted. A subset of the Infinite Campus data, the most incriminating part of Infinite Campus, is uploaded to the same database. That is the Nevada Department of Education's database. Currently, no student database in the same database is ever deleted. I spent four hours looking at what they have for my kids and there were tons of mistakes. How many parents do you think did that? The other 400,000 or whatever in the state? Most probably never have. Now, the Washoe County School District and the Nevada Department of Education are trying to figure out what student data can be deleted and when it could be deleted because they have already created this.

Chair Peters:
I am going to ask you to bring it back into the bill at hand today.

John Eppolito:
Thank you, I have it right here. No one really knows how this is going to affect the future of the kids. In addition, at least the Health Insurance Portability and Accountability Act (HIPAA) covers what these folks want to do, but HIPPA does not cover the SEIS [Special Education Information System] or Infinite Campus.

Chair Peters:
Thank you. I also want to mention this conversation is about two decades too late. We had initial conversations around HIPAA and electronic records in the 2007 Session. This is a conversation that has been well vetted over two decades and continues to be vetted. This bill at hand today does not modify what has historically happened around HIPAA and how electronic data is managed and stored. None of that would change based on this bill. This drives the process which is moving between bodies—which it currently is able to—and modernizes it a little bit. I want to bring us back around to the bill based on that opposition testimony. We still have neutral testimony to get through after the phone lines. I am going to go to the phone for further opposition testimony. Is there anyone on the public line who would like to provide opposition testimony?

Alida Benson, Executive Director, Nevada Republican Party:
I am testifying in opposition to A.B. 7 on behalf of the Nevada Republican Party. It has been stated often and loudly by our colleagues on the other side of the aisle, that the government does not belong in your doctor's office, and we agree. As they have stated so many times, including today, we look forward to seeing bipartisan opposition to this bill which would create even more government interference in health care. Assembly Bill 7 seeks more government intervention in health care by mandating electronic transmission of records and by giving inexplicable indemnity to doctors who use the system incorrectly. I would ask if

these are private, but the ACLU has already weighed in stating not only can the government use your medical records against you under HIPAA and the Patriot Act, but both of these uses likely are open violations of the Fourth Amendment barring unreasonable searches.

This bill would limit liability for doctors who use the information obtained from this giant database inappropriately. We are proud to be the party that sticks up for ordinary citizens against the government-medical complex. This bill disenfranchises ordinary people against the combined complexity of advocating for the medical care they deserve and holding bad actors accountable. On the right to be free from unreasonable government overreach into our medical records, we oppose this bill, and we hope you will too. Please vote no on Assembly Bill 7. Thank you.

Lynn Chapman, State Treasurer, Independent American Party:
We have not seen the amendment, so it is hard to speak to that right now, and I will just give you my testimony. We heard on a previous bill today that health care is between the doctor and the patient and no one else. Also, the people who support abortion say the same thing. It is between my doctor and me, but A.B. 7 would certainly change all that. There are a lot of questions and a lot of them have been asked over and over: Who is going to have access to our medical information.? How many people will be able to access the computers with all the medical information on them? Can computers be hacked? Well, of course, because companies' computers are being hacked all the time and our personal information is being compromised. We also heard that government computers have been hacked, so how safe can all the computers really be? Where is the accountability? We are really worried about the opt-out information that patients are not being given. Those are the most important things we are really worried about, so I thank you for letting me speak to that.

Lisa Partee, Private Citizen:
I would like to echo the sentiments of Janine Hansen and Miguel from Health Freedom, Nevada. I do not trust that this does not violate HIPAA. I just heard you talk about going back to 2007, but HIPAA is very private, but when it goes to a federal database, anybody can access that database who works for the federal government. I do not trust it. I want to know more about opt out. I have MyChart and another small one, but that is something I have between me and my doctor. I do not share it with everybody else. I implore you to vote no on A.B. 7. I do not trust it, and I hope you have a good day.

Bob Russo, Private Citizen, Gardnerville, Nevada:
I oppose A.B. 7. I understand the convenience of the electronic transfer of information between medical providers; yet, I have strong concerns about this bill violating our rights of privacy that are protected by the *U.S. Constitution*. Now, it appears from the discussion that a person's medical records could end up in a computer database without their knowledge. Therefore, this bill should include a requirement that all medical providers inform patients that they can opt out of having their medical records entered as part of a state health information exchange. This is so important. They need to know this. They need to know they can opt out. Each person's health care record should be a matter of confidentiality between patient and physician, yet this bill will set up a system where health records will be

available to the state, likely the federal government, and to the World Health Organization. Our health data would likely be unprotected in an electronic data system, and health information could be easily abused and used in a system of surveillance to monitor how well people comply with state and federal health mandates, with potentially dangerous repercussions for those who do not comply, as we saw during the COVID-19 debacle. I will say medical tyranny is the reality, and this bill will only enhance it, so I ask you to please vote no on it. Thank you very much.

Chair Peters:
Next caller, please. [There were no other callers.]

[Exhibit I in opposition to Assembly Bill 7 was submitted but not discussed and will become part of the record.]

We will move into neutral testimony in our physical location. Is there anyone in Carson City who would like to provide neutral testimony today? [There was no one.] Would you check the public line for neutral testimony? [There was no one.] At this time, I would invite the bill presenters up for closing remarks.

Maggie Carlton:
As I stated at the beginning of this meeting four and a half hours ago, you are real troopers. You have a hard job. The things you decide on in this room are so important to every working family. You heard a lot today on every bill from different unions and working families. Health care is a huge issue to families wanting to take care of their children, so thank you all very much for your hard work. These bills came to you today—there were ten different options—these are the three bills that got consensus from the Patient Protection Commission.

The concerns we heard about this bill, I want to assure everyone that it is my understanding the state is an opt-in state; that no one wants to take your records. This state has a libertarian bent that I have grown to love, and it is the right thing for the state. People should be able to choose how they want their records handled. I totally support that. This, I believe, is merely about making it easier when you have a family member that has a lot of different records to give you the opportunity to take them from one place to another. Just as you would pick up the paper documents, you would receive these electronic documents. I apologize for the lateness of the amendment. It got lost in transition. The fact that we did not have folks here who could answer your questions is a problem with the Legislature at times and gives me concerns. I believe anyone should be allowed to participate in the Legislature if they can answer your questions. That is part of the democratic process. And I am sorry, you did not have the opportunity to ask some of those people, some of your good questions. So, thank you all very much for all of your hard work today,

Bobbette Bond:
I just want to say thank you. It is a long afternoon and I really appreciate the time with you and hearing these bills. It was a long meeting today. I appreciate everyone's patience in

getting through them. We wanted to have a fair, balanced, and full hearing on these bills so we will have them on the record. I appreciate everyone's questions and time.

Chair Peters:
We are going to close the hearing on Assembly Bill 7 and move into our last item on the agenda today, public comment. We ask that public comment be kept to two minutes and please avoid repetition of comments made by previous speakers. Is there anyone in Carson City who would like to provide public comment today? [There was no one.] Would you check the public line for folks who may like to provide public comment today? [There was no one.]

We will close public comment and ask if there are additional discussion items from the Committee before I adjourn. [There were none.] Our next meeting will be on Friday. Thank you, this meeting is adjourned [at 5:47 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee 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 "Corporate Practice of Medicine," submitted and presented by Bobbette Bond, Vice President, Health Policy, Culinary Health Fund, in support of Assembly Bill 11.

Exhibit D is supplemental information submitted by Bobbette Bond, Vice President, Health Policy, Culinary Health Fund, in support of Assembly Bill 11.

Exhibit E is supplemental information including a letter to the Committee dated March 24, 2023, submitted by Patrick D. Kelly, President and CEO, Nevada Hospital Association, in opposition to Assembly Bill 11.

Exhibit F is supplemental information including a letter to the Committee dated March 24, 2023, submitted by Patrick D. Kelly, President and CEO, Nevada Hospital Association, in opposition to Assembly Bill 6.

Exhibit G is a letter to the Committee dated March 29, 2023, on behalf of the Nevada Association of Health Plans, the Nevada Hospital Association, and the Nevada State Medical Association, in opposition to Assembly Bill 6.

Exhibit H is a proposed mock-up amendment to Assembly Bill 7 presented by Bobbette Bond, Vice President, Health Policy, Culinary Health Fund.

Exhibit I is a copy of emails and letters in opposition to Assembly Bill 7.