MINUTES OF THE
SENATE COMMITTEE ON HUMAN RESOURCES AND EDUCATION

Seventy-third Session
May 16, 2005

The Senate Committee on Human Resources and Education was called to order by Chair Maurice E. Washington at 2:10 p.m. on Monday, May 16, 2005, in Room 2135 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file at the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Maurice E. Washington, Chair
Senator Barbara K. Cegavske, Vice Chair
Senator Dennis Nolan
Senator Joe Heck
Senator Bernice Mathews
Senator Valerie Wiener
Senator Steven Horsford

GUEST LEGISLATORS PRESENT:

Assemblywoman Ellen M. Koivisto, Assembly District No. 14
Assemblywoman Sheila Leslie, Assembly District No. 27
Assemblywoman Genie Ohrenschall, Assembly District No. 12
Assemblyman Richard D. Perkins, Assembly District No. 23

STAFF MEMBERS PRESENT:

Leslie K. Hamner, Committee Counsel
Marsheilah D. Lyons, Committee Policy Analyst
Patricia Vardakis, Committee Secretary

OTHERS PRESENT:

Paulette Gromniak, Quality Assurance Specialist, Office for Consumer Health Assistance, Office of the Governor
Cynthia Kiser Murphey, MGM Mirage

Andrew S. Brignone, Attorney, Health Services Coalition
James Wadhams, Nevada Hospital Association
Chris Campbell, MGM Mirage
Hal Cohen, President, Hal Cohen, Incorporated
Raymond McAllister, Professional Firefighters of Nevada
Gary E. Milliken, Associated General Contractors, Las Vegas Chapter
Mike Sloan, Health Services Coalition
Stan Olsen, Las Vegas Metropolitan Police Department
Greg Ferraro, Harrah's Entertainment
Bill Welch, Nevada Hospital Association
John Ellewton M.D., Chief of Staff, University Medical Center
Dan Musgrove, Clark County; University Medical Center
Gail Yedinak, Senior Management Analyst, University Medical Center
Ann Lynch, Hospital Corporation of America

CHAIR WASHINGTON:
We will hear testimony on Assembly Bill (A.B.) 322, A.B. 342 and A.B. 353.

ASSEMBLY BILL 322 (1st Reprint): Requires major hospitals to adopt and carry out plans to provide community benefits and charity care. (BDR 40-1074)

ASSEMBLY BILL 342 (1st Reprint): Makes various changes concerning analysis, reporting and provision of health care services. (BDR 40-1163)

ASSEMBLY BILL 353 (1st Reprint): Makes various changes concerning hospital charges. (BDR 40-1164)

ASSEMBLYWOMAN SHEILA LESLIE (Assembly District No. 27):
I am here to present the consensus bill titled, "Proposed Amendment to Assembly Bill No. 342, First Reprint" (Exhibit C). This will remove A.B. 353 and A.B. 322 from your agenda. The affordability and access to quality health care is important to our constituents. There have been a number of bills relating to hospital costs and reporting introduced this Session which was a reaction to situations that the Senate Committee on Human Resources and Education has confronted as well. We have had repeated reports from businesses and consumers about the problem of rising health-care costs and the challenges that Nevada faces as its population grows. There are many interpretations of the bills before you and it has created a dialog about health-care costs. It is clear that we need more information before we can make policy decisions.

The new compromise of A.B. 342 is a bill that has evolved after much discussion and input from the Nevada Hospital Association and other interested parties. Since we have removed two of the three bills that had to do with hospital reporting, the new mock-up of A.B. 342 represents a sincere effort to shed light on hospital costs and profits so that we can begin to craft policy that addresses the health-care issues in our State. It is important to note that the new proposed A.B. 342 does not include any mandates or penalties. It does not ask the hospitals to create a burdensome level of reporting that would increase administrative costs. It asks that the hospitals provide information that will be new to our State but are documents or information that the hospitals have and hospitals in other states provide. The bill asks to begin to develop a comprehensive plan for health-care services in our State. We have heard this is necessary from the hospital industry and the health-care consumers.

The new A.B. 342 asks the Division of Health Care Financing and Policy to include a review of some of the new reports that the hospitals will be providing into the Division's annual report to the State. It also asks us to consider long-term health-care planning when we meet in the interim as the Legislative Committee on Health Care. This will be a return to the original intent of this committee to understand health-care trends whether they be cost, access or growth.

PAULETTE GROMNIAK (Quality Assurance Specialist, Office for Consumer Health Assistance, Office of the Governor):
On behalf of the Bureau for Hospital Patients, the Office for Consumer Health Assistance has submitted to the Committee our testimony on A.B. 353 (Exhibit D).

CHAIR WASHINGTON:
We will hear testimony on A.B. 296.

ASSEMBLY BILL 296 (1st Reprint): Requires certain major hospitals to accept certain payments for provision of emergency services and care to certain patients as payment in full. (BDR 40-790)

CYNTHIA KISER MURPHEY (MGM Mirage):
In the capacity of Senior Vice President of Human Resources for the MGM Mirage, I oversee a wide range of programs and benefits for our 70,000 employees. There is no MGM Mirage program that is more important to

our employees and our company than our health-benefits program. Last year, our 20 properties spent more than $128 million on health care for our southern Nevada employees. We have provided over $148 million in contributions to Taft-Hartley welfare funds on behalf of our employees who are represented by collective-bargaining agreements. In total, we have spent over $275 million in health care for our employees which is more than any other private employer in Nevada.

I serve as a management trustee for the health and welfare fund which is supported by the hourly contributions for the 50,000 culinary employees in Las Vegas. A significant portion of the funding is spent on inpatient and outpatient care. Last year the culinary-fund numbers paid $41.5 million to the local hospitals for inpatient care and $17.7 million for outpatient procedures. Those amounts do not include the payments for doctors, medicine and other costs. The double-digit rate increases for the health-care factor have been a major factor in the health-care costs in recent years. Health-care costs for our company and other employers have been increasing faster than in any other area of expense.

The task in negotiating hospital rates is challenging and difficult. The purchase of health-care services is generally not subject to the rules of free market where prices are set by bargaining between buyers and sellers. The role of the hospital in our local economy is like a public utility. As a large employer, the MGM Mirage is forced to contract with multiple hospitals to ensure care for all of our employees. We have limited choices. We recognize that for-profit hospitals are in the business to make money and experience cost increases. Health insurance is a major aspect of the employee compensation package. Because this benefit is critical to our employees, it is threatened by the escalation of costs. In Nevada, 24 percent of adults are without insurance and most are working. This threatens the ability of large companies to sustain adequate, affordable health care.

If the MGM Mirage is put in the position of not being able to afford quality health care, smaller companies will not be able to do so. This is a community crisis. I spend a large portion of my time understanding health-care financing. One reason is to allow companies like ours to continue to afford providing health coverage for our employees. If we cannot sustain an affordable contract with a hospital, the inability to control access at the emergency room will put our patients and our plans at risk when bill charges are incurred.

Assembly Bill 296 addresses a small piece of the health-care situation and only addresses those patients who are admitted to the hospital after an emergency transport. It is difficult for patients to determine where they wish to be transported. We see this bill as a moderate step towards stabilizing the hospital situation and the costs for our people. The bill will help us protect health-care coverage for our employees and families. We look forward to working on this issue in the next two years with those attempting to control the health-care costs and protect benefits. We believe it is essential to have state support to ensure affordable care for companies and individuals, particularly those transported to a facility during an emergency crisis where it is not possible to designate or request which hospital to utilize. We urge your support of A.B. 296.

CHAIR WASHINGTON:
We will recess the hearing on A.B. 296 and reopen the hearing on A.B. 322, A.B. 342 and A.B. 353.

ASSEMBLYMAN RICHARD D. PERKINS (Assembly District No. 23):
I am here to discuss the evolution of the various hospital bills that the Assembly has heard this session. We are aware of the critical issue health-care costs are today. Health insurance has become more difficult to secure for many of Nevada's working families. We see cost increases and are constantly in danger of seeing coverage diminished or disappear. Hospital costs are a major driver in escalating health-care costs. Approximately 31 percent of total health-care spending goes to hospital care. Nevada has led the country in annual increases in health-care expenses at over 11 percent per year. Over 80 percent of the beds in southern Nevada are controlled by out-of-state companies.

Private businesses deserve profits but the hospital sector has seen major profitability even as costs have increased for consumers. We need to understand the reason this is happening, but currently the information we need is not available or difficult to decipher. During discussions with the parties concerned with this issue, the hospitals have shown a willingness to cooperate and share the information we need to create an effective policy that will make health care accessible to all Nevadans. For this reason, we are amending portions of A.B. 322 into A.B. 342. I have been assured that the 4-percent charity quick-care requirement by A.B. 322 has already been met. It is encouraging to hear this and A.B. 342 will allow hospitals to share this information with the State. The State will receive needed information in the

reports that A.B. 342 will require. Certain reports have been removed and others included. The reporting process under A.B. 342 will be streamlined and reduce the reporting burden hospitals currently face. We want what is best for Nevadans and want their health and safety to come first. Assembly Bill 342 as amended will help to get us to that point.

ASSEMBLYWOMAN LESLIE:
I draw the Committee's attention to Exhibit C. We wish the sponsorship to include Assemblyman Perkins. We have deleted section 1 of the bill. On page 2 of the mock-up, the new section 1 expands the current audit function to hospitals with 100 or more beds from the current *Nevada Revised Statute* (NRS) level of 200 or more beds. This recommendation came from the Division of Health Care Financing and Policy in order to give us more comprehensive comparison by including hospitals with 100 or more beds. The Nevada Hospital Association agrees that as we go forward not all hospitals should be included to increase the State's ability to plan for health-care services.

Section 2 expands the information submitted electronically to the State for hospitals with "100 or more beds" to change from the current NRS of "200 or more beds." This section does include an exemption if the hospital cannot afford this as a protection for the small single hospitals rather than small hospitals that are part of a large chain.

CHAIR WASHINGTON:
Does the small hospital need to file the waiver to the director?

ASSEMBLYWOMAN LESLIE:
Yes.

CHAIR WASHINGTON:
Would this be based upon a financial hardship?

ASSEMBLYWOMAN LESLIE:
Yes.

Section 3, on page 3 of the mock-up adds five new reports that should be filed by all hospitals in the State and allows consumers to review a hospital's billed charges. The first new report is replacing the current proposed operating budget with a capital-improvement report. The operating budget is being deleted,

because it has not proven to be useful. This will zero out any administrative costs. The report will facilitate the State's ability to understand what is happening with health-care-facility expansion and growth. This section will protect antitrust concerns by only requiring reporting on expansion where financial commitment has already begun.

CHAIR WASHINGTON:
Would this be for future expansion of a hospital?

ASSEMBLYWOMAN LESLIE:
These reports will be provided on an annual basis. This is an example of information we do not have presently. The language in the mock-up explains it. The capital-improvement report which includes without limitation any major service line that the institution has added or is in progress and any acquisition of a major piece of equipment that has occurred or is in progress.

On page 4 of the mock-up, is the new report we are asking for which is the corporate home-office allocation policy. Current hospital quarterly reports already have a line item with this aggregate amount reported, but the State does not have the ability to understand what this line item means and what costs an out-of-state corporation requires their Nevada hospitals to carry.

In a recent newspaper article, there was an explanation of what happens and how true costs are masked in the way that profits are reported. The article stated that the hospitals' corporate parent is often anxious to make it appear that they are not making large profits. They will often make their hospitals pay high prices for services that are system wide. The article states:

> If the corporate parent owns all the hospitals in the chain, it will often charge its hospitals high rent. It will do the same thing with the supplies that it buys for the entire chain. They negotiate a group discount, but when they sell them to their operating units they do not pass on the discounts. The same goes for legal fees. Any and all that they can, they do. It is called transfer pricing and it happens all the time. Unless you have an expert looking at the books, it is hard to tell the true performance.

CHAIR WASHINGTON:
Do other states have the same policy?

ASSEMBLYWOMAN LESLIE:
Yes.

CHAIR WASHINGTON:
Would this policy include hospitals that they are subsidizing in other states?

ASSEMBLYWOMAN LESLIE:
I have never seen a home-office allocation report; therefore, I cannot answer your question.

This is not an administrative burden to satisfy federal accounting principles but by having them filed in Nevada, we can understand why Nevada hospitals are being asked by their parent corporation to transfer so much out of state.

The next report came from A.B. 322. The bill had asked for a fixed amount to be dedicated to community reinvestment, but the industry said that in most cases in our State they already surpass the 4 percent. This report will help the state understand the level of investment that hospitals are making in Nevada, and will help us in planning our comprehensive health-service planning. This should have minimal or no administrative effect as the hospitals account for these services currently. We need a standard format in how it is reported to enable us to understand what they are doing and give them credit.

CHAIR WASHINGTON:
Would this go to the safety net that they are giving back to the community?

ASSEMBLYWOMAN LESLIE:
Yes. This bill asks the State to set regulations to ensure reports are in a consistent format across hospitals. This is information that we will receive in the Legislative Committee on Health Care so that we will see if they are providing 20 percent.

The next report we are seeking is their discount- or charity-care policy. Instead of mandating an increased discount for the uninsured, we are attempting to understand the new charity-care policies that many hospitals say they are currently offering or planning to institute. It appears the many hospitals are offering their own discount policies; however, we need to understand the policies and how they are applied.

I have provided the Committee with a document containing what other states are doing concerning discount- or charity-care policies (Exhibit E). What we are asking to be done is very moderate compared to other states. We need to know what our hospitals are doing. We are asking that these policies be submitted to the State and reviewed to allow us to make more informed policy decisions. This should have no administrative effect on the hospitals because they have the policy.

The next report is the debt-collection policy. There have been many stories of people's lives being ruined because of medical debt. Medical debt has become the primary reason for personal bankruptcy. We are not mandating a new policy. We are trying to understand the current practice so that we can make informed decisions. We do need to know what is happening statewide. If there are different charity-care policies, then there are different policies for qualifying for the discounts. There are different policies for when bills are written off and when they are given to collection. There are varied methods of collections. This should have no administrative-cost effect on hospitals as this should exist as part of their internal policy and would need to be filed and reviewed by the State.

The last area of change is on page 4 of the mock-up. The charge master is the document that shows how much an individual hospital charges for a service. They cannot be compared among hospitals. Major payers in our State as well as the Division of Health Care Financing and Policy would like to be able to review these charge masters. We are asking that they be made available for review at the hospital. This does not preclude filing a regulation of the document.

In section 4, on page 5 of the mock-up, the language would require the Division of Health Care Financing and Policy to include six new sections in its annual report concerning hospital costs and requires the Legislative Committee on Health Care to look at developing a comprehensive state health care plan. This is the most important part of the bill.

ASSEMBLYWOMAN LESLIE:
The new reports that we will be reviewing are: a summary of the trends that are noted in the State's audits; an analysis of the trends and the data that is currently collected regarding costs, expenses and profits; an analysis of the corporate home-office allocation policies; analysis and recommendations regarding the standardization of any data collected in the quarterly reports; a

review of charity-care policies and review of the debt-collection practices. This information will be given to the Legislative Committee on Health Care to enable us to develop a comprehensive health care plan that includes a review of health care needs in current health-care-facility expansion.

This new A.B. 342 is a first step. Other states have had a more extreme reaction to the rising costs of hospital care. In Nevada, we are not jumping to a regulatory framework. We are taking the time to understand the complexities of the problem. We understand that Nevada hospitals make a commitment to our State by being here. We all need to take a closer look at the problem to enable us to arrive at a solution to this crisis.

ASSEMBLYMAN PERKINS:
Assembly Bill 322 started as a community-reinvestment act for hospitals. Part of the reason was watching the evolution of health care, particularly in Las Vegas, and in the areas that were being addressed I felt there was no connection to the community. The reinvestment portion of the bill was to force the dialog between the companies that were providing health care, the community and the needs that were being requested by the community. We support businesses to make money. Health care is a right not a privilege. As it relates to this industry, there are extra steps that need to be taken. The reports requested by this bill pale in comparison to other states. Even though they have an administrative requirement, their hospital costs are lower. Without driving up administrative costs, we are trying to encourage information reporting that will allow the consumer of health care to choose their hospital and that would help the free market work. The information that is out there requires the different companies to compete and operate in one complete market.

CHAIR WASHINGTON:
As we develop this comprehensive plan that is in the bill, we must make certain that we do not begin to socialize our medical services. I would like to allow the free market to work and be oriented towards a free-enterprise system.

SENATOR HORSFORD:
The mock-up indicates the date that these various reports should be submitted will be done by regulation. Will that be accomplished in sufficient time for the interim committee to review and analyze the information and make recommendations?

ASSEMBLYWOMAN LESLIE:
We tried to streamline them into the annual report which the Division does by October 1. We will then have policy recommendations for the next Legislative Session.

ANDREW S. BRIGNONE (Attorney, Health Services Coalition):
On behalf of the Health Services Coalition, I am testifying in support of A.B. 342. The Coalition represents the hospital and health-care interests for over one-third of the insured population of southern Nevada. The Coalition supports this bill and any efforts to increase disclosure and transparency of information regarding hospital-financing costs and pricing. It is impossible to plan, budget or manage costs in this area of escalating costs without coherent and complete information. This compromise bill is a good first step in that direction and if passed by the Legislature, Nevada will join the leadership of at least a dozen other states which are promoting full disclosure and transparency of information. We appreciate the collaborative effort. We hope this leads to further collaboration with the hospital industry, Nevada and other interested parties to start a process of comprehensive health-care planning; this is a process that has not taken place to date. If we have any hope of maintaining the survival of an employer-based health-care system, we must plan ahead.

JAMES WADHAMS (Nevada Hospital Association):
The Nevada Hospital Association is in support of the new A.B. 342. The most important element of the bill is the commitment of the Legislature to begin to develop a comprehensive plan at the state level for health care in Nevada. We think that separates this from all other issues. It is not the number of reports or the detail, but it is an adequate number of reports and detail which will begin to develop a comprehensive state plan.

It was identified that 80 to 85 percent of our hospital beds are controlled by the private sector. This is an issue that needs to be considered. An increased percentage of public beds would require both state and local planning.

The news article that Assemblywoman Leslie referred to identified some clear statistics that the facility profitability in Nevada is relatively low. It also identified the reason for the tremendous growth and the response to that growth. We have had seven new hospitals built in less than seven years. States such as Pennsylvania, Texas and Ohio have not had that many hospitals built in the last 30 years. The investment by the private sector in new campuses itself

is a significant factor. The investment seems to be increasing. The dramatic shortage of nurses to serve the patients is an important element in this situation. It requires our average nursing salary to rise dramatically. The cost of labor is a critical component of the cost of health care. The elements of information that are requested by this bill and the comprehensive state plan make this legislation important to consider.

CHAIR WASHINGTON:
It may be beneficial to amend A.B. 342 by changing the October 1 date to "upon passage and approval."

We will reopen the hearing on A.B. 296.

ASSEMBLYWOMAN ELLEN M. KOIVISTO (Assembly District No. 14):
Assembly Bill 296 addresses bill charges. The intent of the bill is to address those individuals with insurance who end up paying bill charges through no fault of their own because of contracting issues. Since they cannot control where they are transported and bill charges are not regulated, patients are left with unexpected high costs even when they have insurance. The bill refers to major hospitals. On page 2, lines 28 through 33, "major hospital" is defined. The reimbursement has been set at 150 percent of Medicare to avoid problems with hospitals about disclosing confidential contracting information.

MR. BRIGNONE:
I support A.B. 296 on behalf of the Health Services Coalition. The coalition is a nonprofit organization formed many years ago to improve and advance the quality, affordability and accessibility of health care for our members and the entire community. We represent the hospital health-care interests of over 320,000 citizens of southern Nevada. The Coalition includes MGM Mirage, Harrah's Entertainment, the Boyd Group, Caesar's Entertainment, Sierra Pacific Power Company, the health plans of the City of Las Vegas and Clark County firefighters, Las Vegas Metropolitan Police Department and will soon include the cities of Las Vegas and Henderson.

It is important to remember that private health care including hospital care is provided directly or indirectly primarily by Nevada's private employers. The coalition supports A.B. 296, because it ensures hospitals make a profit while ensuring that Nevada's employers and their employees pay a reasonable price

for emergency care at hospitals where the employer or health plan does not have a contract for rates discounted off of billed or list charges.

Billed charges are a unique entity in the hospital world. A good analogy is the list price of a car which is the price you pay unless you can negotiate a lower price or discount. The reason that billed charges are important is because few individuals may pay the list price. It is the reference point for negotiations. If the list price escalates, so does the price a person ultimately pays for that health care regardless of negotiations.

The Coalition recently concluded negotiations with the three major chains which own 80 percent of the hospitals in Las Vegas. One hospital demanded rate across-the-board increases of 130 percent. They were candid in telling us that they can make more money without a contract. Without a discounted contract, the hospital can charge billed or list charges 300 to 600 percent higher than our contracted rates for emergency care where the employers, their health plan or employees had control of where they are transported. What this hospital was telling us was that even though the people are aware of where they can go, we will capture them through the emergency room and charge 300 to 600 percent of the contract rate. We can make more money by charging those rates over a limited population than if we had a contract rate with you. This example illustrates the importance of A.B. 296.

We had similar experiences with other hospitals. We came close to having no contracts with two major chains. In the end, it took the Governor to persuade those hospitals to be reasonable and sign the contracts to avert a hospital health-care crisis.

CHAIR WASHINGTON:
Do you have contracts with all the providers?

MR. BRIGNONE:
Yes. The same pattern happened in 2001.

CHAIR WASHINGTON:
When will the next contract negotiations take place?

MR. BRIGNONE:
The current contracts will expire in three years.

The bill says that in an emergency case where the patient is transported by ambulance or other emergency vehicle and that person is then admitted to the hospital through the emergency room, the hospital is entitled to charge 175 percent of what Medicare would pay if that person's health plan does not have a contract with the admitting hospital but has a contract with another hospital. This prevents employers and employees from being held hostage to exorbitant bill charges by hospitals who will not contract for reasonable rates.

CHAIR WASHINGTON:
Am I correct that the 175 percent of Medicare does not apply if all the hospitals have contracted rates and a patient is transported to one of those hospitals?

MR. BRIGNONE:
Assembly Bill 296 only applies if there is no contract. The Medicare-cost reports tell us that Medicare pays between 94 and 96 percent of costs. At 175 percent of Medicare, we guarantee that hospitals get a healthy and respectable margin. We do not want to do anything to damage their ability to make a profit and deliver quality health care.

Assembly Bill 296 does not apply to small or rural hospitals. It does not apply to counties of less than 400,000 population. It does not apply unless the patient meets the three limiting criteria specified in the bill. Just because someone is transported to the emergency room does not mean they are admitted to the hospital. That is a separate and independent criterion. If a person is taken to the emergency room and it is determined that their condition is not acute or serious enough for admission, A.B. 296 does not apply. It does not apply to a patient who walks into an emergency room on their own volition. It does not apply to a patient who finds it more convenient to use an emergency room instead of a doctor's appointment.

CHAIR WASHINGTON:
If a person is brought into the emergency room either by a transport service or on their own and if they are not admitted to the hospital, then it does not apply. Is that correct?

MR. BRIGNONE:
Yes.

CHAIR WASHINGTON:
Is this based only on admission to the hospital?

MR. BRIGNONE:
Yes. Assembly Bill 296 focuses on that segment of hospital services, emergency care, which has the greatest financial impact that employers and their health plans cannot manage or control. Neither the employers nor the health plans would ever know in advance that the emergency services were rendered until after the charges were incurred. Emergency medical care is different because there is no advanced notice.

Assembly Bill 296 ensures that hospitals make money but enables the employers and their health plans to avoid astronomical charges that the individual never opted for or chose to bear.

CHAIR WASHINGTON:
Would you define acute care?

MR. BRIGNONE:
It is emergency care or services. It is defined in NRS 439B.410.

SENATOR CEGAVSKE:
To what percentage of patients using emergency care does this happen?

MR. BRIGNONE:
I cannot give you a specific answer. The percent will vary by hospital, plan and employer. It could be based on the coincidence of where the employers and employees live.

SENATOR CEGAVSKE:
What was the genesis of this bill?

MR. BRIGNONE:
The genesis comes from our experience in negotiations with the hospital. A hospital will say that they want a certain price increase and it is take it or leave it. We know it is extremely difficult to fund such a proposal but if you do not agree, then the costs will be so great that it will cause bankruptcy. It is an effort to promote good-faith negotiations with the hospitals at reasonable rates. When we entered negotiations, we did not ask the hospitals to reduce their

rates or remain the same. Based on our research, we knew what their costs were and we invited them to be transparent with us. Our research showed that their costs were in the moderate single digits and we were getting demands for healthy double-digit increases; in this case a 130-percent increase did not make sense. The goal of A.B. 296 is to take a first step in an effort to preserve an employer-based health-care system.

SENATOR CEGAVSKE:
By doing this, we are asking something of the hospitals but not justifying it with numbers, costs or how it will affect how the hospital does business.

MR. BRIGNONE:
One of the difficulties we have is the charge master of billed charges is not made public. Assembly Bill 342 addresses reporting a disclosure of additional financial information. Once that information is received from the hospitals, we will be in a better position to answer that question.

SENATOR CEGAVSKE:
The cost change is a concern. As a Legislator, I must view the issue from all sides.

MR. BRIGNONE:
What makes this bill fair to the hospitals is the charge of 175 percent of Medicare. It is a 70-percent margin over costs for the hospitals and we think it takes their interest into account.

CHRIS CAMPBELL (MGM Mirage):
I oversee our self-insured and fully-insured health plans for over 70,000 employees and their family members, and for the last six and a half years for two of the largest employers in Nevada. In addition, I have worked for a health-plan claims administrator and as a contracting director for the hospital coalition. I am also a director for two boards.

I want to discuss how our current environment affects patients who access noncontracted facilities as well as the health plans that cover them. In my different professional roles, I see how hundreds of millions of dollars are spent by health plans each year providing access to life-saving treatments and that are vital to the financial security of employees and their families. I have seen examples of patients receiving life-saving transplants, open-heart surgeries and

chemotherapy which are services that cost health plans hundreds of thousands of dollars, but the patient only pays a few thousand dollars. I see the financial devastation that can occur when a patient receives emergency services from a noncontracted health-care provider or hospital. This financial devastation is compounded by the fact that, due to their emergent state at the time, these patients had no say or choice in the hospital to which they were taken.

I have provided the Committee with information regarding patient-billed charges (Exhibit F). On page 6 of Exhibit F, is a sample of a patient's charges for a one-night stay in the hospital. The billed charges were $234,370. The majority of the charge was for a pacemaker which was charged at $203,052. On page 7 of Exhibit F, is an invoice cost for the pacemaker which was $20,675. There are a significant number of patients who are transported to emergency rooms for cardiac problems. If a person went to a noncontracted facility or did not have insurance and received a bill for $234,370 for one night in the hospital, there would be no way a person could pay that bill. Even if the health plan pays a portion of that bill, a health plan could not afford to long-term pay $234,000. This may not happen frequently but could increase over time and for small employers it would be compounded.

There are three main scenarios in which those bills are typically addressed. The first scenario is the health plan would use 100 percent of billed charges to process the claim. The disparity between billed charges and reasonable reimbursement can be substantial. For a health plan to pay based on 100 percent of billed charges is not a viable option for the long-term stability of those plans or its participants. Making these payments based on 100 percent of billed charges is particularly detrimental to small employers who will end up being experience-rated right out of affordable health care for their employees.

The health plan will pay what it normally would have paid if the patient had used a contracted hospital. Under this scenario, the health plan has provided its full benefit to the member, but this leaves a large portion of the hospital bill unpaid. With no contract in place, the hospital is free to balance-bill the patient for the remainder.

The less frequent scenario is that some health plans are set up to pay nothing for services provided by noncontracted providers. This leaves the patient with 100 percent of billed charges. Under scenarios two and three in which the patient is faced with astronomical bills from the hospital, what is the likelihood

the average working person will have the ability to pay those bills? The answer is, even with the patient's best efforts and intentions, the bills will go unpaid. In turn, the hospital spends significant resources and tactics on efforts to collect dollars from patients. Eventually, these patients end in collections and eventually file bankruptcy. This will affect not only the hospital's ability to be paid but other creditors as well.

Assembly Bill 296 is a solution to these scenarios. The bill establishes a system in which the patient and health plans are protected from unreasonable billed charges for certain emergency-related care. The bill also establishes a system in which hospitals are able to collect a reasonable amount of reimbursement that not only covers their costs but also provides a profit margin.

I draw the committee's attention to page 4 of Exhibit F. The total billed charges are $127,974.60 for a cardiac implant with cardiac cauterization. Based on the Medicare-cost ratios, the total cost for that treatment was $27,386.56. The Medicare payment would have been $33,887.04 and 175 percent of Medicare would be $59,302.32. That amount is more than double the cost of care in that situation.

On page 5 of Exhibit F, the total billed charges are $271,393, the cost of care was $58,892.28, the Medicare payment is $47,659.36 and the 175 percent of Medicare is $83,403.88.

CHAIR WASHINGTON:
On page 6 of Exhibit F, after the one-night stay in the hospital, was the patient transported to the provider of their contract?

MR. CAMPBELL:
In this instance, it was a contracted hospital. This patient was not transferred to another facility but was discharged or went to a rehabilitation facility.

CHAIR WASHINGTON:
Would this patient fall into the definition of acute care?

MR. CAMPBELL:
If this person had a cardiac situation and arrived by ambulance, they would fall under A.B. 296 and would have been afforded the protection.

CHAIR WASHINGTON:
Under the definition of acute care, was this patient conscious?

MR. CAMPBELL:
I do not know those details.

We believe that legislation to provide reasonable financial security to patients that require emergency health-care services while considering the business needs of hospitals is needed. The protections provided in A.B. 296 are the first of many steps toward creating a strong and sustainable health-care market for Nevadans.

SENATOR HORSFORD:
Based on your examples, could you give an overview on the actual cost for these scenarios?

MR. COHEN:
Medicare-cost reports give cost-to-charge ratios. You can calculate from the charges what would be the actual cost. On page 5 of Exhibit F, the amount of the billed charges is $271,393.28. The hospital's cost of $58,892.28 is derived from their Medicare-cost report. Medicare pays according to a prospective payment system which takes into account various factors. In this case, Medicare would have paid approximate $48,000. At 175 percent of Medicare, that would require a payment of $83,000 which is well above the cost to the hospital. To be fair to the hospital, the amount paid to the hospital needs to be above Medicare. The amount of 175 percent of Medicare provides a significant margin.

SENATOR HORSFORD:
Is there an industry-standard amount above the actual cost of care of what should be a profit margin?

MR. COHEN:
Hospitals claim that they need 4- to 5-percent operating profits. The American Hospital Association publishes annually by state, hospital cost, revenue and other data. Four to five percent is a typical margin. Hospitals can make this up by having the private sector pay 4 percent above costs. Another consideration is the uncompensated care. There is Medicaid which in many states does not come close to paying costs. According to the Medicare Payment Advisory

Commission, the private sector paid on average 118 percent of cost. The private sector needs to pay more than cost in order for hospitals to have a reasonable profit margin. The proposed amount of 175 percent above Medicare is far above the 120 percent of cost. The bill is trying to create an atmosphere in which there are reasoned negotiations between payers and hospitals. If you do not have a contract with the hospital, there must be an obligation that is more than with a contract. On average, the private sector negotiates rates that are 110 or 120 percent of Medicare; therefore, you do need to have an obligation if there is no contract. It cannot be unlimited as it is now if the obligation is to pay billed charges.

The U.S. Congress also addresses hospital charges. There are many social issues regarding hospital charges. This bill addresses the important issue generated by high charges which distorts the nature of negotiations. Many contracts call for some patients to pay on a percentage of charges. When charges escalate, payments do the same. There are many contracts which have unusual cases. When a contract states a reasonable amount for charges but also states that for any patient having charges above $80,000 the patient would pay 80 percent of charges. As charges have gone up dramatically, contracts call for unreasonable payments from patients.

RAYMOND MCALLISTER (Professional Firefighters of Nevada):
We have approximately 2,500 persons in our trust fund. The significance of this legislation to our trust fund can be substantial. The trust fund is a collectively bargained trust; therefore, we only negotiate for benefits during an opening of the contract. The amount of revenues received by this fund is fixed over a certain period of time. When we negotiate, we use an actuary to determine what the projected needs of the trust will be over the next three to four years. There has to be some level of stability to determine the amounts of future payments needed to pay for the benefits of the plan. We cannot return to the negotiation table to ask for more money. Assembly Bill 296 would help us develop that stability by knowing that in the future, we are not going to be subject to a situation where our trust may be responsible for huge payments of full-bill charges due to circumstances that may be out of our control.

Recently, one of our members was involved in an automobile accident. He was hit by a drunk driver and almost died. He spent an excessive amount of time in the hospital. The total billed charges for his hospital stay were $371,264. Fortunately, we did have a contract with the hospital. The charges the trust

fund paid were $78,000 which saved us $291,000. A few situations of this kind would deplete our fund.

Assembly Bill 296 would allow our members to be taken care of at a reasonable cost while at the same time pay 175 percent of Medicare payments and the hospital would still make a profit.

MR. MCALLISTER:
I have provided a document titled, Treatment Protocols (Exhibit G, original is on file at the research Library). This document contains some of the protocols used by emergency medical services (EMS) in southern Nevada. These protocols are guidelines for treatment established by the Medical Advisory Board of the Clark County Health District. They are essentially the rules by which we are permitted to operate. Based on these protocols, I will show you how the EMS system operates with regard to treatment and transport of some patients to the hospitals. You will see that many times patients do not have a choice as to where they are transported.

Pages 2 through 8 contain the general patient protocol. Every patient should have that general care. On page 2, in the second boxed paragraph, there is an exception if the patient has an inability to secure a patent airway, the patient must be transported to the nearest emergency department. The section on page 7 of Exhibit G describes the method for determining to which hospital the patient will be taken. Subsection 1a, describes stable patients and that they should be taken to the hospital of choice. We ask the patient if they have a preference as to which hospital they wish to be taken. If they do not have a preference, we check to see which is the closest facility and we can make suggestions to the patient. If the patient does not have a preference and is taken to the closest facility, any patient that can make a choice should be responsible enough to choose a hospital that their insurance covers or face full billed charges.

I wish to focus on those patients who have no choice of facility to which they are transported based on their medical condition. The information on page 7, Exhibit G, shows that many patients are transported to facilities based on their medical condition. If I were to pass up one emergency room to transport an unstable patient to an emergency room farther away because the patient had insurance coverage at that facility and the patient died or was severely injured due to the delay, I would be opening myself and my employer to huge liability,

because I have exceeded the standard of care or gone outside what protocol allows me to do.

MR. MCALLISTER:
The trauma protocol on page 9 of Exhibit G designates to which hospital a patient is transported is determined by their geographical location. Since the inception of the new trauma center at Sunrise Hospital, the guidelines have changed to create trauma-catchment areas. These are determined by geographical boundaries. A patient could have insurance, but based on what street he was on when he was injured and what trauma center he was required to be taken, he may face full-billed charges or contracted rates. Through no fault of his own, the patient may be facing a huge financial liability and bankruptcy. This trauma protocol will soon change when the new trauma center is opened and the geographical areas change.

The trauma protocol defines what types of injuries a person sustains to be taken to a trauma facility. There are many instances where a patient has no choice. In 2004, our department responded to 1,345 cardiac and respiratory arrests, 42 drowning incidents, 774 stabbings and gunshot wounds, over 1,400 falls and 16,984 motor vehicle accidents that met trauma criteria.

CHAIR WASHINGTON:
Is there a liability on the emergency medical technician (EMT) and their company if they do not transport the patient to the nearest hospital if the condition meets the criteria of acute care?

MR. MCALLISTER:
Yes. Although, we do not have a divert program in southern Nevada, we do have a trauma or emergency-room-closure protocol. This is where under certain circumstances the hospital can claim internal disaster and close the emergency room. These instances would be power outages, computer problems and other major disasters. On pages 17 through 21, Exhibit G, there is data on diversion status. There was 1 hospital that went on internal disaster 25 times. During that time an EMT cannot take patients to that hospital. We cannot take them even though it is a contract hospital to which a patient demands to be taken.

SENATOR NOLAN:
Were you implying that the hospital called illicit status?

MR. MCALLISTER:
On pages 17 through 21 of Exhibit G, there are various reasons for the diversion, but none were power outages.

SENATOR HECK:
I am an emergency-department physician who works with a third-party contract with University Medical Center (UMC). I am a contract consultant to the Nevada Hospital Association in the area of hospital preparedness, not hospital administration, and the emergency medical services medical director for Clark County.

The concept of A.B. 296 is interesting. Based on 175 percent of Medicare, you are assuming that Medicare provides a decent reimbursement. We have heard how Medicare determines how they reimburse charges. I have received my current issue of *Annals of Emergency Medicine* which contained four articles on costs of emergency-department care. In one article, the conclusion suggested that the marginal cost of the emergency-department outpatient visit is higher than is commonly believed. Large payers such as Medicare need to reexamine how they set prices for emergency-department services. The administered price properly compensates hospitals for their emergency-department services. While we are using Medicare as a guide, if the guide is low that does not necessarily meet the needs of the hospital.

Medicare pays $154 for an emergency visit. A level 5 emergency code is the highest code that Medicare pays. If a patient came to the emergency room suffering from a cardiac arrest and the physician spends many hours treating the patient, the physician reimbursement is $154. Medicare should not be taken as the end-all be-all as far as what is appropriate reimbursement.

We do approximately 120,000 emergency-medical-service calls per year. There are approximately 30 percent of those calls that are not transported to the hospital. After deducting 80 percent that are not emergent transports, the total is 16,000 lives. If you use 66 percent of those individuals as being covered by a third-party payer, the total amount would be 11,000 lives affected by this bill.

The next issue is how admission is defined. In most medical parlance, when someone is in the emergency department they are admitted to the hospital. If you mean inpatient admission, that would need to be defined in the bill.

SENATOR HECK:
The paramedics in Clark County are told that in their judgment if they think the patient too unstable to go to the hospital that the patient requested, they are to go to the closest hospital. All but trauma patients and unstable patients still have a choice. Even in the pediatric protocol, we try to send patients to certain pediatric receiving facilities. Here are protocols that try to steer patients to the right facility, and they are not all absolute.

If someone has an acute medical problem such as appendicitis, their appendix is removed within four hours and then they stay in the hospital for three or four days to recuperate, the emergency medical condition is over. Does that mean that on the second, third and fourth day the patient is back up to billable charges? Usually, emergency services are taken care of within the first 24-hour period. There are other issues that need to be addressed in A.B. 296 that may not have been considered in the initial drafting.

MR. COHEN:
It is my understanding that when the language states, "was admitted to the major hospital," that requires the patient to become an inpatient. Senator Heck is correct. The Medicare-payment system for inpatient hospital services is more generous than the Medicare-payment system for either outpatient hospital services or physician services. The 175 percent of Medicare is eminently reasonable if not too high for inpatient hospital services.

SENATOR NOLAN:
Have Nevada's health-care costs been increasing at the same rate as other states?

MR. COHEN:
First, we must differentiate between costs and charges. Over the last four years, hospital costs in Nevada have risen faster than any other state. Nevada hospital costs started at a low level. Nevada hospital costs per admission are adjusted for the outpatient business which is done at 5 percent higher than the national average. Hospital wages in Nevada are actually higher than the national average. When you wage adjust, Nevada hospitals have costs that are about 3.5 percent below the national average. While costs have been rising because of wage adjustments, our costs are still below the national average. Charges are another matter and are higher. The bill addresses the issue of charges.

SENATOR NOLAN:
Do we have a disparity in the uncompensated care in southern Nevada and other communities?

MR. COHEN:
My understanding is that the Nevada Hospital Association has suggested that there is 7 percent of uncompensated care compared to the national average which is 4 to 5 percent. That would explain that rather than paying the national average of 118 percent of cost, the private sector might pay 120 percent. Either way, it is below 175 percent of Medicare. There is a higher level of uninsured people in Nevada than the national average.

GARY E. MILLIKEN (Associated General Contractors, Las Vegas Chapter):
We feel A.B. 296 would bring savings to all our members both in their businesses and the individual members of our association. The passage of A.B. 296 would reduce health-care costs and create savings in the workers' compensation area as well.

MIKE SLOAN (Health Services Coalition):
A portion of this coalition represents some of the largest businesses in Nevada. We are mindful of the need and obligation to allow for-profit hospitals to remain profitable. It is in the best interest of the entities and the State. There is an increasing phenomenon of a decline in the number of businesses that are providing health care to their employees because of the increase in charges. The University of Nevada, Las Vegas did a study concerning the failure of payment. At UMC, the services are provided to working employees that were not covered by insurance which is an increasing factor in residential construction and retail. As health-care insurance increases, small businesses are being forced not to provide health care to their employees. The burden of this phenomenon of a patient being transported to a hospital without choice or the input of the employer provider poses a significant economic threat to the continued viability of an employer-provided health-care system. On behalf of the 300,000 people who are provided health care by the Health Services Coalition and the people who contribute, I ask the committee to give A.B. 296 serious consideration.

STAN OLSEN (Las Vegas Metropolitan Police Department):
The Las Vegas Metropolitan Police Department is one of the largest public employers in southern Nevada with 1,400 employees. As a major employer, we are continually concerned with the rising health care costs for ourselves as

employers and the cost to our employees. We have an obligation to provide the best health care we can to our employees. As first responders, we know the troubles facing the health-care system. We are faced with overcrowded emergency rooms and long waiting times to receive care in our hospitals, leaving some employees with no choices but to seek care from a noncontracted hospital. Our employees jeopardize their lives for the community. Is it fair that we jeopardize their financial future, because they were unfortunate enough to be cared for by a noncontracted hospital? We ask the Committee to give this some consideration.

GREG FERRARO (Harrah's Entertainment):
Harrah's Entertainment has approximately 3,500 employees in its health-insurance plan in Clark County. Once the acquisition of Caesar's Entertainment is complete, we expect to have over 7,000 insured employees and Harrah's Entertainment will be one of the largest gaming employers in Nevada. Assembly Bill 296 will ensure our employees' out-of-pocket costs are controlled for those situations over which they have no control. This bill addresses a narrow category of patients. Assembly Bill 296 will provide important protection for our members' physical and financial health. On behalf of Harrah's Entertainment, we urge the passage of A.B. 296.

MR. WADHAMS:
The Nevada Hospital Association is in opposition to A.B. 296. The bill is price fixing. There is a dramatic shift in the public policy of this state. If this is the policy we wish to adopt, then the Legislature should think long and hard about such a policy shift. It became clear with the first testimony. The predicate for the bill was clearly based upon a comment that was made in negotiations between a huge group of employers and employees and businesses that provide those services. Based on that occurrence, we have a bill which is reaction to a comment. We have heard various scenarios that are hypothetical. In those cases the individuals did not pay what was stated; it was paid by their employer. I do not support the tenor of that comment, theme or attitude it represents. In tense negotiations comments are made, but legislation should not be based upon those circumstances. Legislation should be base upon policy and thoughtful investigation. Assembly Bill 296 has problems.

Previous testimony stated that 2- to 4-percent profit for hospitals is reasonable. That was also the number that was mentioned in a newspaper report concerning the hospitals' profits in Nevada as being less than the 2 to 4

percent. We were given an analysis of a particular day or a couple of days in a hospital and an extrapolation from that about profitability. The two do not compute. The 2 to 4 percent is for a business activity for an entire enterprise. Then to isolate one element and place a 2- to 4-percent profit on it completely ignores the balance of the business activity.

Medicare-cost ratios are based upon an entire spectrum of those treatments of those protocols of codes whether they are by walk-ins, emergency people or otherwise. It covers a full range of circumstances. Senator Heck's observation about the physician's reimbursement is illustrative of what I am trying to bring to your attention. That procedure will be compensated under the Medicare reimbursement at a particular level predetermined regardless of the complexity of that activity. It is a gross average and used to suggest that a particular payment level would be profitable.

MR. WADHAMS:
I represent a variety of groups that are trying to address the availability and affordability of health insurance. That is not the problem addressed in this bill. According to prior testimony, every hospital has a contract with that major purchasing group and will for the next three years. This only applies to Clark County. The policy change that is represented by this bill is one that no hospital can support. If the policy is to start evaluating proper reimbursement levels and proper profitability in the 2- to 4-percent range, there are systems that you could adopt.

Senator Heck pointed out that this is for 11,000 people. The question is why and why so limited without a broader policy analysis of the profitability.

BILL WELCH (Nevada Hospital Association):
I am here to express opposition to A.B. 296. It is not clear as to how we are looking at the insurance industry to assure that there are appropriate applications of benefits to the enrollees. I was concerned to hear during testimony that an insurance plan had the right not to pay for medical services that were being provided in an emergency basis. I was not aware that was allowable under the insurance regulations in Nevada. If we need to look at this issue, we need to look at the issue from a global aspect and not from one component of the problem.

SENATOR NOLAN:
What is a reasonable profit? Most businesses would not think a 2- to 4-percent margin was profitable. We damage the hospital industry with a 2- to 4-percent profit margin. If we do not do something to improve the skyrocketing costs in hospital care, we will have more employers not insuring employees. There will be an increase in patients who cannot pay. Are the hospitals making a reasonable profit or are they overcharging? Is there a place were we can cut back so that more Nevadans can be insured?

MR. WADHAMS:
These are issues that the Legislature is facing. Everything that the Legislature is doing is in response to the requests of the people. Everything is being driven by growth. We have built more hospitals in the last year than most states have built in the last 20 years, but we still do not have an adequate ratio of hospital beds. Nursing salaries have been raised because of the shortage. We are making investments in this State. We have made a policy decision to not develop the public health-care system. Shifting policy in setting rates without regard to whether it is adequate is not a responsible approach to the problem. We would suggest this issue be integrated with the plan that comes out of the plan of the interim Legislative Committee on Health Care.

SENATOR HORSFORD:
We need a comprehensive solution to this problem in health care. What ideas does your organization have in resolving these complicated issues? If A.B. 296 is not the answer, then what is and when?

MR. WADHAMS:
The answer is A.B. 342. It is time the Legislature accepts the responsibility and looks at the data in a comprehensive way. We need to look at a plan for this State in which our growth outstrips our capacity. To focus on one particular service does not make sense. While all the hospitals are under contract, we should look at the data and then we will be able to address these issues in the 2007 Legislative Session.

SENATOR HORSFORD:
There have been bills this Session that we have been told we cannot do or support. There does not seem to be a willingness to come to an agreement other than to study the problem. The constituents that elected me or my colleagues do not want to wait for more studies on these issues.

Assembly Bill 296 is narrowly defined. Even though it will affect only 11,000 patients and 12 hospitals in Clark County, why would we not want to provide that type of assurance because we are not doing well in the insurance category?

MR. WADHAMS:
We have arrived at a policy that will allow Legislatures to be able to develop a basis of addressing the health-care costs. The predicate for this issue is based on a sense of profitability. There is acknowledgement that there is not profitability. Until the Legislature begins to look at how we deal with the policy question of whether we should set rates based upon a fair return, we should not single out one narrow area. A comprehensive approach is a better tool.

MR. WELCH:
There has been some proposed legislation that has been of concern to us. We talk about health-care costs and how it is out of control yet we continue to look at the private sector to fund the problem. We need to look at this issue from a comprehensive basis. All parties must be involved. In most states, the average is closer to 50-percent public and 50-percent private sector in health care. In Nevada, it is 80 to 85 percent private sector. We have become dependent on the private sector. The suggestions that we have proposed have not generated any momentum. This Legislature will have the opportunity to consider the Medicaid budget. Medicaid needs to be brought to an appropriate level of funding so that patients have the ability to receive primary care at an appropriate setting versus the hospital emergency room. Medicaid is behind in the mental health area as well. We need to have the appropriate health-care training programs so that we are not reliant on other states to train our workforce. We have a chance to address a limited part of the uninsured problem. Nevada ranks fourth in having the highest uninsured population. These issues need to be addressed in a comprehensive way. To look to the hospital community to underwrite this situation is difficult for us to accept.

SENATOR HORSFORD:
Is it appropriate for a hospital to charge $203,000 for a pacemaker? Is that hospital underwriting health care when the actual cost is $20,000? Can you explain how this occurs?

MR. WELCH:
I cannot speak on that specific hospital bill. The pacemaker is one piece of the supply utilized in the treatment of that patient. You would need to look at the entire continuum of the care that was delivered to that patient. The amount of that bill is extraordinarily high for a one-day stay in the hospital.

SENATOR HORSFORD:
The hospital charge for the pacemaker was ten times the price of the pacemaker.

MR. WADHAMS:
That individual could have been in an insured program and not paid that amount. It does illustrate the question of why the list price is as high as it is when the actual price for an insured person is substantially less. When you have a major component of our society that is able to negotiate for 380,000 people, the discounts will be significant. The individual who does not have that capacity will need to make up the difference. This is what is known as cost shifting.

CHAIR WASHINGTON:
We will address A.B. 296 in a subcommittee. We will address the narrow focus of the bill for the acute care as defined in statute. We will address the Medicare rate and whether 175 percent is sufficient. We will assure that the amendment does not allow one provider or employer to use the amendment as a way out. The subcommittee will address the patients who are admitted to the hospital. The contractual costs are only for emergency access and not for the patients who are admitted to the hospital.

SENATOR WIENER:
Are you referring to an admission based on an emergency-room entrance to the hospital?

CHAIR WASHINGTON:
We will be addressing patients being entered into the hospital through the emergency room.

We will close the hearing on A.B. 296. We will hear testimony on A.B. 59.

ASSEMBLY BILL 59 (1st Reprint): Makes certain changes to reporting requirements for sentinel events at medical facilities. (BDR 40-1025)

ASSEMBLYWOMAN GENIE OHRENSCHALL (Assembly District No. 12):
Hospital-acquired infections are a major health problem. We frequently hear about someone going to the hospital with a minor problem and contracting an infection which causes them to become sicker or die. These infections account for an estimated 2 million infections, 90,000 deaths and $4.5 billion in excess health-care costs annually. Common types of infections that are contracted in hospitals include the respiratory tract, bloodstream, urinary tract and surgical sites. Hospitals care for a high proportion of sick patients with compromised immune systems which makes the patient susceptible to infection. We have new strains of antibiotic-resistant bacteria that can make the risk of infection control much more difficult. There is much that can be done to make hospitals safer. It is estimated that more than half of hospital-acquired infections could be prevented by hand-washing practices, more careful adherence to antiseptic procedures for inserting catheters, attending to patients on ventilators and caring for surgical incisions could prevent additional infection. Better isolation techniques could prevent the spread of communicable diseases.

I have received numerous calls from relatives of persons who have become ill while in the hospital due to infections. Assembly Bill 59 is intended to draw attention to this critical problem by establishing hospital-acquired infections as a separate category of sentinel events. Sentinel events are certain adverse events that hospitals, obstetric centers, surgical centers for ambulatory patients and independent centers for emergency care currently must report because of regulation to the Health Division and to the patient involved. Existing law requires facilities to establish patient-safety plans and processes. The law provides for data analysis and reporting of aggregate trend information. This is presently being done by regulation. We are trying to take what is being done by regulation and put it into statute.

Section 1 of A.B. 59 establishes the definition of hospital-acquired infection. Subsection 5 of section 1 authorizes the administrator of the Health Division to add new categories of infection by regulation. Section 3 adds facility-acquired infection to the definition of a sentinel event. Sections 2, 4, 5, 6 and 7 make conforming references to facility-acquired infections and other provisions governing the collection and reporting of sentinel-event data. This bill will make hospitals and medical facilities safer for all of us. We have no opposition to the bill.

SENATOR NOLAN:
How is it determined that the hospital was at fault?

MS. OHRENSCHALL:
The same regulations that are enforced are being carried out currently. I cannot tell you how the hospital can tell what illness a patient has when admitted. There are methods that are used and are accurate.

MR. WADHAMS:
The Nevada Hospital Association has worked with Assemblywoman Ohrenschall on this legislation. We feel it represents a codification of the existing regulation.

SENATOR WIENER:
Have you reviewed the amendment from the oral-health-program employees?

MR. WADHAMS:
We have been advised by the Legislative Counsel Bureau that it fails the germane test. The amendment was withdrawn and we are working to find another place for that amendment.

JOHN ELLEWTON M.D. (Chief of Staff, University Medical Center):
We treat approximately 100 new acute-leukemia patients per year. Each patient will get an infection in the course of their therapy. I caution the Committee to be careful that we are not creating another 100 sentinel events which are not sentinel events but, outcomes of the therapy. The figure is probably higher than that number because I just am highlighting the leukemia patients.

CHAIR WASHINGTON:
We will close the hearing on A.B. 59. We will hear testimony on A.B. 327.

ASSEMBLY BILL 327: Authorizes county hospitals to compensate physicians for provision of certain medical services to indigent patients. (BDR 40-928)

DAN MUSGROVE (Clark County; University Medical Center):
Assembly Bill 327 only affects the University Medical Center (UMC). The bill does not set a precedent, because it strictly relates to the NRS 450. We think this is important legislation. It does not face any opposition by Clark County. Clark County is the number-one payment source for indigent care.

This provision in law has been in effect since 1926. This law has put us in a position that we could not reimburse physicians for indigent care. This has been problematic for the UMC. We are to a point where this is costing the taxpayers more because we do not have the ability to negotiate a rate or fee-for-service for those indigents who are under the care of Clark County at the UMC. This bill did not face any opposition in the Assembly.

GAIL YEDINAK (Senior Management Analyst, University Medical Center):
I am here on behalf of the UMC in support of A.B. 327. This bill removes the restriction prohibiting county-owned hospitals to offer compensation to physicians who are asked to consult and/or treat indigent patients admitted to the hospital. With the tremendous growth we are experiencing and subsequent hospital admissions, the UMC has seen the continuous increase in the number of indigent patients who are admitted for inpatient care. Allowing the UMC the option to offer compensation to these physicians will realize a cost savings in the long run, because indigent patients will get more timely intervention and the patient's hospital stays will be shortened.

DR. ELLEWTON:
I am in support of this bill. This bill addresses an issue of fairness and how to provide the best quality care for all patients regardless of their ability to pay. Times have changed since this legislation was enacted. Besides the growth in Nevada, the legal climate has been difficult and medicine has become more complex. The law forbids paying physicians for indigent care. Removing this barrier does not mean that we are going to pay all the doctors who see indigent patients. It does not mean that doctors are not going to provide gratuitous care. In terms of fairness to the patient and doctor giving us all possible options to provide quality care to everyone, we need to remove this restriction. Assembly Bill 327 will give the UMC flexibility. I urge the Committee's support of A.B. 327.

SENATOR HECK:
How would these physicians be paid?

MR. MUSGROVE:
We have not begun to investigate pay sources, because the existing law is prohibitive. This bill would give us the enabling legislation to begin. There is no increased cost to taxpayers at this time.

SENATOR HECK:
Approximately 98 percent of the physicians at the UMC are in private practice. They are reimbursed based on that payer status. Currently, none are reimbursed or paid by the UMC.

DR. ELLEWTON:
Removing the prohibition will help us rationalize how we provide the care. It may be less expensive over the long term. We have on-call stipends for a variety of specialties for general and internal medicine. There is an increasing restriction in the amount of work that residents inside the university system can do. This is crippling hospitals like the UMC and presenting new challenges. There are on-call stipends for general medicine and general surgery, there are directorships and there are limited clinic reimbursements. This is the way it is cobbled together presently. Whatever will work best for that service and patients is what we are trying to provide.

SENATOR HECK:
Will this result in a greater physician's subsidy by tax dollars going to the UMC? If the physician is paid by stipend and they do not get their billable charges for indigent patients with this bill, they would get their billable charges but, not the stipend.

DR. ELLEWTON:
It will be based on a fee schedule not billable charges. Some of the stipends that are in place are as high as they are because we cannot provide a case-rate reimbursement for physicians who are on call.

SENATOR HECK:
Mr. Musgrove, will this result in a greater tax subsidy of services at UMC?

MR. MUSGROVE:
Yes. The cost-shifting would be less of a burden on taxpayers, because indigent patients would have less time in the hospital. We would be able to get the specialized care that the patients needed in a more timely manner.

ANN LYNCH (Hospital Corporation of America):
We have some concerns. When an emergency-room physician is called in to take care of a patient with an appendectomy and subsequently admitted, will that fee continue while they are in the hospital? Will they be paid for direct

care? Is this bill only for the emergency? This will drive up health-care costs. If a physician goes to the UMC and gets paid for taking care of indigent patients, then they will come to the rest of the hospitals for the same treatment. We do not have a cost-shifting capability. We cannot take it out of our social services or our clinics. It will come off the top of the profit from the provider hospitals.

Assembly Bill 327 will have a ripple effect throughout the industry, because there are few specialized physicians. There are many unanswered questions. How would the fee schedule work? If this bill only pertains to the UMC, then 80 to 85 percent of the beds in Clark County are provided by the proprietary area. A greater percentage of the indigents are being cared for by other hospitals. What will happen to the other physicians who are taking care of indigents?

SENATOR HECK:
Are you able to collect the funds out of the supplemental fund for indigent persons?

MS. LYNCH:
No.

SENATOR HECK:
Why are you not eligible for those funds?

MS. LYNCH:
We do not receive any monies from the county or the State.

CHAIR WASHINGTON:
We will close the hearing on A.B. 327.

There being no other issues before us today, the Senate Committee on Human Resources and Education will adjourn at 5:08 p.m.

RESPECTFULLY SUBMITTED:

_____
Patricia Vardakis,
Committee Secretary

APPROVED BY:

_____
Senator Maurice E. Washington, Chair

DATE:_____