The subcommittee of the Senate Committee on Health and Education was called to order by Chair Steven A. Horsford at 3:57 p.m. on Tuesday, April 7, 2009, in Room 2149 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 in the Research Library of the Legislative Counsel Bureau.

**SUBCOMMITTEE MEMBERS PRESENT:**

Senator Steven A. Horsford, Chair
Senator Joyce Woodhouse

**SUBCOMMITTEE MEMBERS ABSENT:**

Senator Maurice E. Washington (Excused)

**STAFF MEMBERS PRESENT:**

Marsheilah D. Lyons, Committee Policy Analyst
Sara Partida, Committee Counsel
Betty Ihfe, Committee Secretary

**OTHERS PRESENT:**

Bill M. Welch, President/CEO, Nevada Hospital Association
Scott Craigie, Nevada State Medical Association; American College of Emergency Physicians
Bret Frey, M.D., Northern Nevada Emergency Physicians
Karen Massey, CPMSM, Executive Director, Northern Nevada Emergency Physicians
Heather Vance-Nelson, Member, Ironworkers Union Local No. 433 and Local No. 416
Darrell Fagg, Organizer, Ironworkers Union Local No. 433
Valerie M. Rosalin, R.N., Director, Office for Consumer Health Assistance, Office of the Governor
Chair Horsford:
Based on the concept paper I presented on Friday, April 3, 2009, at the subcommittee meeting concerning Senate Bill (S.B.) 157, we will take suggestions and comments on those concepts (Exhibit C). This subcommittee will meet again on Thursday, April 9, 2009.

Senate Bill 157: Limits the amount that certain hospitals and physicians may charge for the provision of certain services and care. (BDR 40-808)

Bill M. Welch (President/CEO, Nevada Hospital Association):
I have provided a summary of my comments from the April 3 subcommittee meeting (Exhibit D). My understanding of where we want to go with this legislation is how do we deal with the patients who ultimately require emergent medical care, and what do we do if they fall outside their insurance plan due to circumstances out of their control. I am soliciting input from our broad membership of hospitals, but it takes some time to get a consensus.

I suggest that usual and customary could be one of the vehicles used for a basis to determine whatever schedule we end up with. There are provisions in our law, and it is my understanding that they do not cover all payers nor do they cover all plan designs. There would have to be some tweaking of the laws under usual and customary. At the last meeting, I suggested determining the barriers between providers and payers, and I repeat that today.

There are standard protocols for emergent care for ambulances. You have the Emergency Medical and Treatment and Active Labor Act of 1986 (EMTALA) law which has a slightly different interpretation of emergent care. You have the payers who have their benefit designs on emergent care. If this is the focus, it is important to figure out a common definition of emergent care and how it would apply across the board, so we are in compliance with EMTALA. A common definition should not put the ambulance drivers or emergency-response vehicles out of compliance, and it should integrate with what the insurance plans look like.
MR. WELCH:
There is precedent for hospitals about charity care or hardship cases. There are definitions on how we define and how we apply charity care. We have specific guidelines for hospitals, and we have to submit an annual report to the State. That may be something we would look at for everyone. It would be interesting to have similar information from the insurance industry as to whether or not they have policies for charity care. It would be interesting to know if they supplant or help individuals who are having hardship in paying their insurance premiums or their medical bills.

The authority is quite clear on how the Office for Consumer Health Assistance (OCHA) handles hospitals. It has been tightened up somewhat with respect to physicians, but it does not really get into what OCHA’s role and authority is over insurance companies. I have had a chance to reflect on Paulette Gromniak’s testimony from the last subcommittee meeting. She indicated patients present themselves for assistance when they are out of plan. She talks with the provider and asks if they would be willing to accept 30 percent off their billed charges. This is similar to the law we have in place when the self-funded, uninsured present themselves to our hospitals. We have to give them a 30-percent discount if they make arrangements to pay their bills within 30 days of their hospitalization. Ms. Gromniak usually initiates the negotiations, but what she did not say is that if the insurance companies do not agree, they begin to negotiate down from that point. It would be important to look at how that law would apply to the payer.

We asked for a lot of data from OCHA which would help all of us understand the complexity and degree of the issue. One of the additional pieces of information I would like the Committee to solicit from OCHA is to see if there is a pattern of enrollees who are asking for assistance because they have fallen out of plan, and is there a consistent trend with a few payers whose enrollees are consistently having that challenge? We do not seem to have that difficulty with most payers, yet recently we have been working more with OCHA. A couple of different payers have not been able to successfully negotiate contracts with hospitals, so they are paying the benefits as “out of plan.” They send a letter to the enrollee encouraging the enrollee to contact OCHA and ask that office for assistance on further discounting their bill. This seems to suggest the insurers are using OCHA as an extension of their benefit plan. There needs to be some accountability to tighten that up. Perhaps there is some middle ground where we could meet for a fall-back position for these patients.
Whatever moves forward, I would like to suggest that it be in writing so that all participants would go along with the theme of the concept paper you presented at the last subcommittee meeting, Exhibit C. The theme is that there will be responsibility by all parties. I encourage that and suggest it be followed by an accountability statement. All parties need to be responsible and accountable in meeting the standards. There are some insurers who do not have to meet the laws of the Nevada Division of Insurance and some who are not covered by OCHA. In order to benefit from any type of resolution that comes out of the Legislature, all the participants have to concur and agree to follow the standards.

CHAIR HORSFORD:
On the issue of negotiating with a patient who is not covered by a contracted insurance provider, is there something in regulation or in law that requires good-faith negotiation to assist that patient?

MR. WELCH:
I do not have the specific Nevada Revised Statutes (NRS) to which I am about to refer, but I will get that to you. We do have laws that require all hospitals to have a charity care and a discount policy. We are required to make that information available to every patient whether they are insured or uninsured. We also have a law that requires us to notify every patient about OCHA, so if they have a difficulty with their bill, they can go there directly. There are laws that govern how we notify the patient, and we are required to report on how we meet those standards.

There was legislation just proposed today that before a 100-bed or greater hospital could receive an indigent-care payment, they must meet a certain level of indigent pre-care. They must first meet a 0.6 percent of their revenues as free indigent care before they can bill for a payment on indigent care and be reimbursed at a Medicaid rate. There are a multitude of regulations and laws for hospitals that speak to that.

CHAIR HORSFORD:
In your estimation, are those policies administered on a consistent basis, meaning is every patient handled in the same way, and are they informed of the charity hardship provision?
MR. WELCH:
Yes, they are. By law, every patient has to be notified of the hospital’s charity-care policies. I think all our hospitals provide that information on the admission forms as to who they could contact.

By federal law, we have to charge every patient the same; we cannot charge them differently. We may be paid differently by payers as a result of contracts, but every patient has to be charged the same. Every patient has to be handled in the same manner and given the same opportunities as far as charity-care discounts. Based on the patient’s fiscal hardship, we have a sliding scale and discounted policies for charity care.

CHAIR HORSFORD:
Can you provide some information on that to our staff?

MR. WELCH:
Yes, and for the record, our hospitals have to submit that information to the State on an annual basis.

CHAIR HORSFORD:
Are those physicians who have privileges at a hospital part of the charity provisions or policies?

MR. WELCH:
If the physicians are hospitalists and employed by the hospital, they would be governed by the hospital’s policies. For the independent physicians who have privileges at the hospital, the hospitals have neither oversight nor regulatory authority over what physicians charge or what they do at their practices. Also, they are not required to meet our regulations.

CHAIR HORSFORD:
On this issue of independent contractors, if they are agents of your facility and if you represent yourself to a patient along with those independent contractors with whom you have a contract and to whom you have granted privileges, are you indicating they are not bound by any of the policies or practices that the hospital is required to have?
Mr. Welch:
The physicians are not contracted with the hospitals unless they are employed by the hospitals, but ... .

Chair Horsford:
They are independent contractors in that case, correct?

Mr. Welch:
Rather than independent contractors, they are independent practitioners. They are not contracted with the hospital, but they are “privileged” at our hospitals. They must submit an application. On it they must provide verification and documentation of their education and their qualifications to provide those medical services for which they are requesting medical privileges. They are not contracted; they request and apply for and receive privileges based upon their qualifications. As part of being granted medical staff privileges, they must agree to see the patients in the emergency room, and they have to agree to meet all the hospital’s standards of care and protocols as far as patient safety, quality of care and those types of functions. We do not interfere with their billing practices or their contractual relationships with third-party payers.

Scott Craigie (Nevada State Medical Association; American College of Emergency Physicians):
These emergency-medicine people are here with the follow-up material you requested at the subcommittee meeting on April 3. We have been talking about the interactions of our physicians with patients, how those systems work and how we can move forward to improve the working relationship with patients. We want to develop plans for reforms and systems that better serve the insured and uninsured and those patients who have difficulty in paying their medical bills.

Emergency-room physicians and their personnel make a major contribution with their 24-hour care. They want to help improve what they are doing, and we hope that can be accomplished in this Legislative Session.

Bret Frey, M.D. (Northern Nevada Emergency Physicians):
I am an emergency physician at Renown Regional Medical Center (Renown) and have also practiced at Sunrise Hospital and Medical Center and at Mountain View Hospital in Las Vegas. In my prepared testimony, I intend to express my strong patient-advocacy position and mission with respect to
S.B. 157 (Exhibit E). If this bill were to pass too quickly, it may present some unintended consequences.

Emergency medical service is a difficult thing to wrap your arms around because it involves so many different subspecialties on a call list. The call list for our facility at the trauma center is a report on page 11 of (Exhibit F, original is on file in the Research Library). Given the verbiage of S.B. 157, this call list may erode exponentially with respect to physicians who would decide they simply want to spend more time with their families and take less risk than being on call for the community. We have struggled to maintain these call lists over the years especially given the difficulties with vascular cases, spine cases, ear, nose and throat cases, and ophthalmology cases. While our call list is fairly well bolstered today, in the past, these cases have had to be transferred out of the community.

DR. FREY: When a patient has faith that their community is going to provide the services they need and they get transferred out of the area because we do not have the call-list capability to provide that service, unintended consequences occur. For the patient, that could include much higher bills than if we would have been able to provide the service in this area. Fixed-wing transport and helicopter transport alone can exceed $15,000 for one transport. In addition, the medical bills from out of state are very high. It makes sense to care for the people in our community.

I am bound first by an oath to my patients—the Hippocratic Oath—and am bound second by EMTALA. I want patients to be treated fairly by physicians and their insurance companies. A reasonable concession should be made from both sides of the table. Patients should be able to count on doctors to effectively manage their emergent conditions without being transferred out of the area. Patients should be able to count on physicians billing their insurance companies for sums that are not egregious and that represent the true value of service. Patients should be able to count on their insurance companies to make good on their contract with the patients and pay their fair share. Patients should be responsible and adhere to their responsibility to pay their co-pays and their fair share.

I have concerns from my patient advocacy position, given the little time remaining before the Friday deadline, that these large and complex issues can
be given the necessary consideration. For my patients, I ask the members of this Committee to have patience in addressing these issues and relationships. This must be done in a clear and concise manner, so we do not fail our patient population by incurring the unintended consequences in the current verbiage. I offer my service to this subcommittee without reservation in seeking legislation that provides incentives to contract fairly for the services that are essential to our community.

CHAIR HORSFORD:
Generally, what percentage of your time do you and most physicians spend doing emergency care at the hospital?

DR. FREY:
As an emergency-medicine physician, I spend approximately 70 percent of my time within the hospital caring directly for patients. The rest of my time is spent on administrative duties, continuing medical education and a number of other factors.

CHAIR HORSFORD:
The majority of your practice is in the emergency room, correct?

DR. FREY:
Yes, it is.

CHAIR HORSFORD:
Generally, how many patients do you see who are not contracted with an insurance provider that may be covered by that hospital?

DR. FREY:
I am not sure I understand your question.

CHAIR HORSFORD:
How many patients do you see that you ultimately have to work with on their bill? The patients have insurance, but you are not contracted with that insurance provider. Do you end up having to work with them on the terms of their billed charges?
KAREN MASSEY, CPMSM, (Executive Director, Northern Nevada Emergency Physicians):
Generally, the way our reports are provided to us, they show us insured patients. I would need to do research to answer further.

CHAIR HORSFORD:
At the time of service, you do not know if the person is insured with a contracted company of that hospital or not; is that correct? Do the intake papers indicate “insured or not insured?”

MS. MASSEY:
I will follow up on this and see if I can identify that for you. As part of their commitment to patient care and real time when they are providing that care, Dr. Frey and the physicians from our group do not know whether a patient is insured or uninsured.

CHAIR HORSFORD:
We have heard testimony that your billing offices often end up working with the patients. What is your charity-care policy? Is it similar to what Mr. Welch indicated?

MS. MASSEY:
Our group’s policy is whenever our billing department receives a complaint, it is reviewed by a physician in our group. There is some variation, but the commonality is that the policy is very generous. Typically, those bills are discounted 20 percent to 50 percent. In our group, our personal experience is that 30 percent of the patients we see are uninsured. Of that, 90 percent of what we receive from those bills is less than 10 percent. If the crux of the question is, “Are we stepping up to the plate to provide charity care, or are we stepping up to the plate to provide discounts,” I am confident we are. We do provide so much free service and give discounts on our bills and that is why, as emergency physicians, we want to be part of this conversation and help you craft the solution. We realize the health-care safety net is at risk without our involvement.

CHAIR HORSFORD:
On this bill-charge issue from the physician’s standpoint, give me the pros and cons you feel are happening with the billed charges. We tend to get testimony or complaints that the problem is with the billed charges. Are the bills too high,
so you have to discount them at 30 percent? Can you elaborate on that from your perspective?

Ms. Massey:
We recognize that a lot of folks who come to the emergency room are uninsured, but they are trying to pay their bills. Our charges are quite reasonable, and I was pleasantly surprised when I heard from Dr. David Strull of the Carson Tahoe Emergency Physicians group—whom I had not met before—that their Level III charge is only $4 different from ours. Our charge for Level III is $256. Level III is in the middle of the five levels of emergency medicine. It is the level you hope for if you go to the emergency room, rather than a Level V. I can appreciate that everyone puts a different value on things in all aspects of our lives. That is what the contracting process is about; it gets you the opportunity to agree on the value of services. I think our other charges are reasonable, too, and I am happy to share them with you.

Chair Horsford:
That would be helpful, and we appreciate the transparency. After a patient is assessed and stabilized in the emergency room, if additional services are recommended, do you try to find a physician or a provider who is contracted so that the insurance coverage can pay for the service? There are charges for those services. Are those charges also reasonable?

Dr. Frey:
This speaks to the situation of the gentleman who gave the testimony about his late wife. That was all a very difficult and unfortunate thing for us to hear. I am quite sure those charges did not come from the emergency department or from the physician who was on call in the emergency department; they came from the services provided on the medical floors in the hospital.

This proposed legislation does not address specific instances, for example, when an ear, nose and throat (ENT) physician or other subspecialist overbills a patient from the medical floor for providing consultation services. When a patient is so sick they need to be admitted to the hospital, oftentimes their hospitalists consult with various subspecialists such as an ENT physician for further care and stabilization. After the patient leaves the emergency room, a different mechanism takes over, and we have no control of that.
MS. MASSEY:
I know what our charges are. I do not know what the charges are of my colleagues. There certainly are a lot of competent individuals who are involved with other groups in northern Nevada. If that is part of the information you want, we would be happy to try to get it for you.

CHAIR HORSFORD:
Because we are here in Carson City, it is easier for you to participate. I would prefer to see a statewide comparison. I do not know if the procedures you are following are carried out everywhere. That is part of what we have to evaluate in making policy.

MS. MASSEY:
Your point is well taken. I can try to find those contacts; however, I am not aware of something that aggregates that in its present form.

HEATHER VANCE-NELSON (Member, Ironworkers Union Local No. 433 and No. 416):
I have worked in the medical field for approximately 20-plus years, and I live in Ward 6 in southern Nevada. I am here to shed some light on, and hopefully help resolve, what I feel are some undisclosed health-care practices in our emergency-room hospitals in Nevada.

I am proud to say my husband is an ironworker with Union Local No. 433. The 2,000 plus members, not including the wives and children, within the local unions who have had the unfortunate experience of having to go to an emergency room here in Las Vegas or in Henderson, have encountered problems with emergency physician groups, trauma surgeons and anesthesiologists, to name a few. Even though the members took great care to go to an in-network hospital for care, they were declared not “in network.” No one is being told that the emergency-room physicians, trauma surgeons and others are out of our insurance networks. Let us face it; most people, when they go to an in-network facility, think that everything is going to be covered within that network rate, and that is just the way we feel about that.

My personal issue in regard to these matters happened on November 13, 2007, when I had extensive gynecological surgery at Summerlin Hospital. On November 18, after being discharged, I had to go back through the emergency room as I was in extreme pain. I was diagnosed with ileus due
to anesthesia issues. I did not stay in the hospital overnight. The computed tomography (CT) scan bill in the emergency room was covered, and the hospital bill was covered. But, imagine my surprise finding out that the emergency-room physicians were not. On December 17, my son broke his arm at day care. We took him immediately to Summerlin emergency room as we did not know of the issues of my previous visit. They took X-rays and had to reset his arm. The X-ray bills were covered at the hospital. But, once again, the emergency-room physicians were not, nor were we told that they were not going to be. Obviously, not once during either visit was I told or given an option to have an emergency physician who might be in network. You are not given an option for an emergency-room physician. My son was also seen September 18 and 19 at Sunrise Children’s Hospital for some apnea testing and even though he had prior authorization for hospitalization, only one of the five physicians during his stay was in network. We were not told that the other four would be out of network.

If it were not for OCHA’s bureau for hospital patients, I would be drowning in debt. I had to pull my eye teeth to find out about that office. This was not something that was provided to me. I had to actually search it out. I had no idea of where to look. I can just imagine all the people, including the elderly patients that I have helped when I worked for the University of Nevada School of Medicine in Las Vegas, who have no idea of where to go for these things. In this recession, we need all the help we can get. I believe S.B. 157 should be passed so the people of Nevada will no longer be taken advantage of. It is a shame that what is going on here appears to be more the rule rather than the exception. In my testimony, I do not mean to be mean to doctors. I love them. I think they are wonderful. They do us a great service, but please know what I am saying is not just for my family, it is for yours as well.

Darrell Fagg (Organizer, Ironworkers Union Local No. 433):
I am the organizer for Ironworkers Union No. 433. I want to state that I have had numerous people from my area call me with the same problems that Ms. Vance-Nelson has explained. She is just one of the people who has come across this problem. Hers is not an isolated case. Other people have called me with the same problem.

Chair Horsford:
Have you been assisted or helped by OCHA?
Mr. Fagg:
Yes, I have. My wife was in an accident in 2003, and they did a great job helping out.

Valerie M. Rosalin, R.N. (Director, Office for Consumer Health Assistance, Office of the Governor):
I am the director of the OCHA. I will add whatever I can after my colleague provides the information you requested.

Paulette Gromniak, QAS (Bureau for Hospitals, Office for Consumer Health Assistance, Office of the Governor):
Last Friday, you asked for some additional information. One of your questions was, “What are the areas where OCHA has the greatest issues?” We do see problems with the following specialties: cardiovascular, orthopedics, general surgery, anesthesia, hospitalists and neonatologists. The numbers are difficult to pull from our system, but we do know we had a 26.5-percent increase in our cases last year. Of that, 70 percent were due to an out-of-network component. From the bureau of hospitals’ records, we are only able to identify those hospitals that are in network. In response to the hospital-and physician-bill issue, we do not have the capability to track that for each case.

Ms. Rosalin:
Our system identifies the main issue for which the consumer is coming to us. They come to us with their medical bills. Usually, one of them is the hospital bill, and the others are the provider bills for services rendered during their hospital stay. There might have been three physicians who assisted a patient while he or she was an inpatient, but we cannot separate the whole case as out of network. That is the number that messes up our numbers.

Of our over 3,000 cases since July, 570 of those cases were with hospital patients. Of those cases, 70 percent have an out-of-network component. I reinforce Ms. Gromniak’s statement about our positive communicating or negotiating with emergency-room physicians. Our fortune is not as good working with other specialists, and we are attesting to that.

Chair Horsford:
It would be helpful if you would provide that information to our staff, so we can review it.
MS. ROSALIN:
We will provide it in writing.

MS. MASSEY:
If it would be helpful to know, I am a Certified Professional Medical Staff Manager and was Medical Staff Manager at Renown from 1994-2000. I have been intimately involved in the credentialing process between physicians and hospitals that was discussed. The physicians on medical staffs are not independent contractors, and they are not agents of the hospitals. There are some semantics around this issue that I would be pleased to clarify if need be.

CHAIR HORSFORD:
To the extent you can, please put that in writing and bullet point those things. That would be helpful to us.

When a patient goes to the hospital to be cared for, he or she does not know whether the physicians are agents or independent contractors. I would like to understand that relationship better. This is not a commerce and labor committee, but from the health aspect, it is a matter of the consumer understanding with whom they are doing business.

MS. MASSEY:
I will put the information in writing. We do take great pains to put Northern Nevada Emergency Physicians on scrubs, on business cards and help patients understand who we are. There are some NRS requirements for posting notices in emergency-room waiting areas, but your point is well taken.

CHAIR HORSFORD:
Based on the information we are hearing from OCHA, it is not problems with the emergency-room physicians, it is with the other specialty-care physicians. I do not want the information you provide to reflect just what you do, but information on the broader group of physicians would be more helpful.

MS. MASSEY:
Since Friday, we have spent time looking at the concept paper you provided, Exhibit C. You have heard before and will hear again about the importance of the safety net. I repeat that emphasis in my written testimony (Exhibit G).
You framed your questions using the three legs of the stool—the patient, the providers and the insurers. My question is, “How do we find ourselves in this situation?” For at least part of the answer, we have to go back to the relationship that exists between the patient and the insurer and between the patient and the provider. The patient and the insurer have an elective relationship—often through an employer or an employer group. The patient’s relationship to the provider is an elective one as well, though it is not elective when you are having an emergency. That is the safety net.

When I go back to the beginning of that relationship and see how the patient ends up with insurance purchased by the employer, the problem we are having is that some of these networks are not complete networks. We are hearing there are gaps in coverage. The question is, “How does the patient know there is a gap in coverage?” I hear their frustration when they say, “No one told me they were not on my plan.” With emergency physicians providing care in real time and not knowing the insurance status of patients, this is not a bad thing. It is a great thing and that is why our system works.

When an insurance company is selling insurance to an employer, that employer is usually evaluating multiple plans. The question to ask at that juncture would be, “Is there an opportunity for the employer—who is about to buy insurance in good faith for the employees—to understand they might be purchasing a plan that has gaps in it?” I suggest that at the beginning of the process when an employer is considering buying the insurance, that there is full disclosure if the insurance company does not have a full complement of services. That does a service to the employer who is about to buy the insurance, and it creates a scenario that gets us all to the table to help them have complete networks.

CHAIR HORSFORD:
Can you submit those recommendations in writing?

MS. MASSEY:
Although I am on the back end of the process, there is something that mystifies me. It is this situation; the care has been provided, and there is a bill in existence. Either in our limited scenarios or in the scenarios you have heard, the insurer must know that patients occasionally come to the emergency room. The insurer must have actuarial studies that show patients are transferred because of trauma, availability of stroke centers or all kinds of legitimate patient-care reasons. I have no reason to doubt that the insurers are
sincere in their desire to contract with us. One of the frustrating things we find is even if we discount a bill, the patient is often viewed by their insurers as being out of network. Sometimes, depending on what their plan structure looks like, that creates more co-pays or co-insurance for the patient.

Another thing I will submit, which helps take the patient out of the middle, is patients who are within the defined set of emergency-care protocols be considered in network for those services. Again, emergency care is a tricky thing to define, but that would be is a valuable thing for us to spend some time on between now and Thursday’s subcommittee meeting.

My last recommendation is if a patient has been seen by us and our charge is reasonable and the insurance company has sold a plan to a patient through their employer that says they cover their health services, why it is acceptable for them not to pay the bill?

Right now on my desk, I have a contract that was submitted to us by a national insurer which is at 130 percent of Medicare. It is not a contract that we are going to be in a position to sign. It is unsustainable for us to contract at that rate. I am going to call that insurer in hopes of opening a dialog with them. If they choose not to have a dialog, I am not sure what incentive exists for them to come to the table. That is because if a patient comes to our hospital out of network, they will pay whatever they see as the appropriate fee. That is probably not what I see as the appropriate fee, and then to add insult to injury, they will tell the patient that they are out of network. That means the insurer will pay an even smaller portion of the fee. The challenge with this difficult issue is to create incentives in a manner that encourages us to contract with one another. I am not sure those incentives exist.

CHAIR HORSFORD:
If you submit your recommendations in writing, we can figure out how they may fit into a solution or amendment to S.B. 157.

DAVID STRULL, M.D. (Director, Carson Tahoe Emergency Physicians):
Since last Friday, and between working shifts in the emergency room, I have spent some time looking at the points in your concept paper, Exhibit C. I have some specific suggestions to those points which are in my written testimony (Exhibit H).
This issue is complex and demands a well-crafted solution that is fair to all patients. We have not yet defined the scope of the problem we are solving. I have reviewed data from our practice. Out of 34,000 visits last year, we had 70 billing inquiries. These people were not necessarily out of network. Some of them are uninsured patients asking for a larger discount. We already have a charity policy in place, but sometimes patients ask for more. Sometimes patients simply want an explanation for why they were charged for an item or a procedure. In our practice when we look at out-of-network cases, we are truly looking at a handful. Since I am the “point guy,” I resolve these inquiries, and they were all resolved because I have a fall-back position. That position is if a patient is out of network, and they have a charge they cannot afford due to a financial hardship, I ask them to tell me what they can afford to pay, and we work it out with them. I ask you to consider if we truly do not know the scope of the problem—and we do hear some horrible stories of people falling through the cracks—do we need to hit this with a sledgehammer when maybe what we need are the tweezers?

I will skip to some salient points. If you are directing legislation toward emergency care and emergency physicians, they are going to take the brunt of it. Consider that emergency physicians already provide more uncompensated care than any other specialty. Our customary charges are reasonable. Bill Welch of the Nevada Hospital Association said, “We [the hospitals] do not control their charges as physicians are independent contractors.” While there is some truth to that, in our practice it is not quite true because we contract with the hospital as a group. We are not just members of the medical staff. If we have billing practices and charges that are unreasonable, it is simple for the hospital to just come to us and say, “Your charges are unreasonable. Change them or we will cancel your contract.” I submit to you that for our emergency-medicine specialty, our charges are reasonable. It really is the insurer’s responsibility to pay the bills.

CHAIR HORSFORD:
I must interrupt, because we are not getting the specifics I requested. Since our time is quite limited, we cannot have a philosophical discussion about this. I am sorry to be direct, but I have been clear in my request.

DR. STRULL:
On page 4 of Exhibit F, my suggestion there addresses the last point of your concept paper, Exhibit C. You stated, “If no resolution is reached through
negotiations, the provider is allowed to receive from the payer 200 percent of the Medicare allowable, minus the patient co-payment, deductible and coinsurance responsibilities.” The last phrase is the most problematic for our emergency-medicine specialty as it removes incentives for insurers to contract with us.

I would suggest two solutions to this. The first is if there is no resolution reached through negotiation, the providers will have to receive both charges, but the payer will have the right to challenge the charges which are not in line with other specialty physicians billed charges and submit those to an arbitration process. A second solution goes to the work done by OCHA. I have worked with Ms. Gromniak because there are people who fall through the cracks. It appears the problem that office has is it has “no teeth” to arbitrate a solution between the insurer and the payer. Hospitals and physicians already provide a charitable mission. I question how much insurers provide as a charitable mission. If an insured falls through the cracks, will their insurer ever step up and pay a little more than that plan provides?

The talking points as written in the bill where the Legislature actually sets a rate and circumvents a process where the physician can negotiate with the payer to cover the cost of the operation, really threatens the health-care safety net.

CHAIR HORSFORD:
We have received a letter in opposition to S.B. 157 from Patty Sredy, director of oncology services at Saint Mary’s Center for Cancer in Reno. It will be entered in the record (Exhibit I).

I ask the insurers to be prepared on Thursday to give their perspective on this issue. The subcommittee will take all the information that has been presented to it under advisement and decide the course on which we would like to proceed.
There being no further business to come before the subcommittee on the Senate Committee on Health and Education, the meeting is adjourned at 4:58 p.m.

RESPECTFULLY SUBMITTED:

Betty Ihfe,
Committee Secretary

APPROVED BY:

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Senator Steven A. Horsford, Chair

DATE:__________________________