BACKGROUND PAPER 88-4

THE EFFECT OF ASSEMBLY BILL 289 IN CONTROLLING HEALTH CARE COSTS

H. Pepper Sturm, Research Analyst
Research Division
Legislative Counsel Bureau

TABLE OF CONTENTS

THE EFFECT OF ASSEMBLY BILL 289 IN CONTROLLING HEALTH CARE COSTS

I. INTRODUCTION

The 1987 legislature adopted, and the governor signed, Assembly Bill 289 (chapter 344) which established comprehensive programs for controlling health care costs in Nevada. The new law also established a legislative oversight committee to monitor health care activities in Nevada and to monitor certain provisions of the act. The committee members were appointed by the leadership of both the senate and the assembly. Its membership currently includes Senator Raymond D. Rawson, chairman; Assemblyman Morse Arberry, Jr., vice chairman; Senators Bob Coffin and Randolph J. Townsend; and Assemblymen Vivian L. Freeman and Bob L. Kerns.

The committee held nine regular meetings and three subcommittee meetings from October 1987 through November 1988. The committee considered a variety of topics and issued a number of recommendations (see the Legislative Counsel Bureau Bulletin No. 89-8, titled Report Of The Nevada Legislature's Committee On Health Care). Although the scope of the committee's investigations was wide, a compliance review of various A.B. 289 provisions was a central focus in each regular meeting. One of the subcommittee sessions dealt specifically with monitoring issues surrounding hospital compliance with the bill's provisions.

This background paper will review the history and scope of A.B. 289, and provide an analysis of the effect of those provisions which concern the control of health care costs.

A. HISTORICAL BACKGROUND OF A.B. 289

During the 1985 session of the Nevada legislature, Governor Richard H. Bryan introduced a legislative package that contained a hospital rate setting mechanism. Instead, the legislature passed Senate Bill 460 (chapter 645, Statutes of Nevada, 1985) which directed the legislative commission to conduct a study into ways of restraining the costs of health care in Nevada. A total of 51 recommendations, resulting in 32 bill drafts, were approved and submitted to the legislative commission. The Legislative Counsel Bureau's Bulletin No. 87-7, Study Of Restraining Costs Of Medical Care, should be consulted for a full discussion of the subcommittee's activities and cost-containment efforts previous to the 1987 session.

The 1987 legislature witnessed debate on a number of important bills related to health care costs. The most significant and controversial bills were Governor Bryan's ratesetting proposal and the S.B. 460 interim study recommendations. Both plans, while using different approaches, were designed to achieve equal access to quality medical care at an affordable price. A compromise bill emerged, Assembly Bill 289, which blended the primary concepts and components of both packages, excluding a ratesetting mechanism.

II. SCOPE AND ANALYSIS OF MAJOR COST-CONTAINMENT PROVISIONS

Asembly Bill 289 contains a comprehensive set of provisions designed to reduce health care costs. Major sections of the bill establish data collection procedures; require hospitals to treat and share the costs of the medically indigent; revise certificate of need (CON) requirements; mandate continued quality of care; and require that several Nevada hospitals reduce their billed charges to an established level, while also reducing their revenue per inpatient. Other hospitals are required to reduce their percentage of income to operating expenses. The measure requires that any savings be passed along to the consumer through reduced health care insurance premiums.

The bill also contains provisions prohibiting certain transactions between hospitals and their affiliates and between insurers and affiliated health facilities. Agreements between physicians and hospitals are also prohibited if such agreements contain financial inducements for physician referrals.

Each of the three major provisions relating to health care cost will be examined in this paper. Their principal features will be highlighted, and an estimate of their relative impact within the health care industry will be reviewed. An analysis of the effect of each provision will also be made. In addition, the data monitoring provisions of the bill will be discussed, along with the savings pass-along requirement for Nevada's health insurance premiums.

The provisions of A.B. 289 now may be found in chapters 439A, 439B and 679B of Nevada Revised Statutes (NRS); and in chapters 439A, 439B and 679B of the Nevada Administrative Code (NAC).

A. REQUIRED REDUCTIONS OF INPATIENT REVENUES

1. Description

Section 55 of A.B. 289 contains the provisions regarding mandatory reductions in billed charges and net revenues. Subsection 1 requires that hospitals whose profit rate exceeded 17 percent in 1986 must reduce billed charges by 25 percent and net inpatient revenues per inpatient for non-Medicaid and Medicare patients by 15 percent in fiscal year 1987-1988 and freeze their billed charges and net inpatient revenues at that level for fiscal year 1988-1989.

Subsection 2 of section 55 is similar to subsection 1 for hospitals with profit rates of between 12 to 17 percent. Billed charges are to be reduced 12 percent and the net inpatient revenue reduction required being 7.5 percent.

The third subsection requires hospitals whose 1986 profit was between 7 and 12 percent to reduce their billed charges by an amount sufficient to ensure that their profit rate does not exceed 7 percent in any of the next fiscal years.

Subsequent subsections provide for adjustments in billed charges and net revenues; state the intent of the legislature to cap the required revenue reduction at a specified level; provide for penalties for failure to comply with the provisions; provide a credit for increasing the nurse to patient ratio; and authorize Nevada's department of human resources (DHR) to conduct any necessary analysis and adopt regulations pursuant to the section.

2. Scope

The legislature determined in A.B. 289 that the following hospitals were subject to the provisions outlined in section 55:

Percentage of Income to Operating Expense Exceeds 17 Percent

Desert Springs Hospital, Las Vegas, Nevada
Humana Hospital Sunrise, Las Vegas, Nevada
Valley Hospital Medical Center, Las Vegas, Nevada

Percentage of Income to Operating Expenses Greater than 12 Percent but Less than 17 Percent

No hospitals subject to this provision.

Percentage of Income to Operating Expenses Greater than 7 Percent but Less than 12 Percent

Saint Mary's Hospital, Reno, Nevada

Other hospitals would be affected by the legislation should their income to operating expenses reach 7 percent or more. Such a determination would be made by DHR upon examination of the quarterly financial information reports required of each hospital by regulation. In addition, the provisions of the law would affect only those charges made to non-Medicare, non-Medicaid patients, and those patients whose insurers had not negotiated a per diem rate.

3. Analysis

According to data presented to the committee by Jerome F. Griepentrog, director of the department of human resources, all hospitals affected by A.B. 289 met their targeted reductions of billed charges. Table 1 provides the established amount of reduction and the actual reduction for each hospital affected by the cost rollback provisions of A.B. 289:

TABLE 1

Average Net Revenue Per Admission
(July 1, 1987, through June 30, 1988)

	Desert Springs	Humana Sunrise	Valley	Total
Required Reduction	$3,494,151	$9,878,425	$5,103,931	$18,476,507
Actual	$4,685,200	$11,293,548	$9,278,821	$25,257,569
Percent of Goal	134%	114%	182%	137%

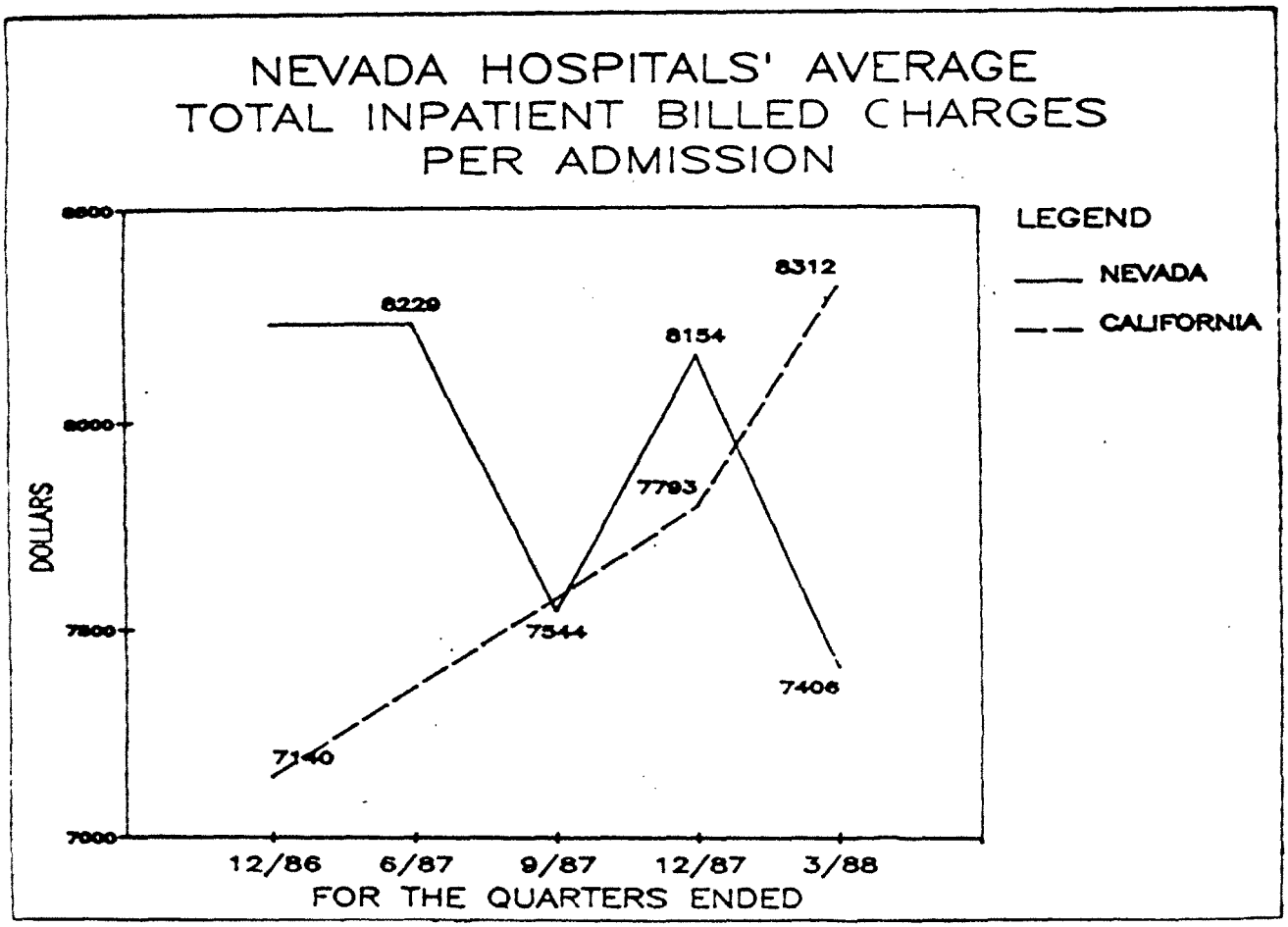
Source: Division for Review of Health Resources and Costs (DRHRC), Nevada's Department of Human Resources (August 1988, unaudited data).

The targeted amount totaled nearly $18.5 million, and the actual savings came in at over $25 million. The 25 percent reduction in billed charges was not required to meet the targeted reduction in net revenue per inpatient. According

to DRHRC, since patient acuities have changed over the last few years (hospitals are admitting more acutely ill persons), and since this type historical "case mix" data is not available, the billed charge reduction targets were not subject to accurate evaluation. The revenue reduction amounts set in section 55, subsection 8, effectively nullified the billed charge targets.

Based upon this data, California now exceeds Nevada in costs as measured by inpatient billed charges per admission. (See Figure 1.)

FIGURE 1



Source: Division for Review of Health Resources and Costs, Department of Human Resources (Nevada). August 1988.

The $25 million savings to consumers realized by A.B. 289 should be compared to the dollar increase in hospital inpatient revenue seen over the calendar years--$26 million from 1985 to 1986, and $21 million from 1986 to 1987. (See Table 2.) If the trend would have continued and the increase in net inpatient revenues for 1988 had been the average ($23.5 million), it could be argued that the law saved the actual $25 million, plus a significant percentage of the overall increase seen each year. Based upon this data, it could be said that the net inpatient revenue for hospitals would have been significantly higher without A.B. 289.

TABLE 2

Total Hospital Inpatient Net Revenue
Nevada 1985 - 1987

Calendar Year	Net Inpatient Revenue
1985	$493 million
1986	$519 million
1987	$540 million

Source: Division for Review of Health Resources and Costs, Department of Human Resources (Nevada). December 1988.

According to data provided by the insurance division of the department of commerce, quarterly reports from insurers have revealed the following figures. Only 43 percent of the claims dollar spent within the state goes toward inpatient hospital care. Of that number only 28 percent of the claims dollar is paid to hospitals targeted by A.B. 289. Since the largest insurance companies making these payments use per diem rates (not affected by A.B. 289), the percentage of claims dollars actually affected amounts to only 8.2 of the total, based upon the average of three quarters of data.

In addition, the national trend toward outpatient services is also reflected in the Nevada data. Figures from the insurance commissioner indicate that 9 percent of the claims dollar goes toward hospital outpatient costs, and the

remaining 48 percent for pharmaceuticals, physicians and other services. The division is beginning to track volume and costs of selected outpatient services though the utilization of the California Relative Value Scale.

It should be further noted that the most significant savings from A.B. 289 were realized during the first year of the new law (July 1987 through June 1988). The measure allows the hospitals affected to apply various credits and carryovers to their targets for fiscal year 1988-1989. Starting with the third year of the law, hospitals are allowed to adjust revenues based upon the medical component of the Consumer Price Index, historically around 7 percent per year. In short, the savings realized during the first year of the law will account for the largest share of the total savings realized across the 4-year lifetime of the law's provisions.

Using data derived from historical trends, the expected amount of increase for hospital net inpatient revenue is approximately what was saved by A.B. 289. At the very least, the law negated the increase for inpatient care effectively retarding the medical inflation rate in Nevada.

Based upon the information provided by the DRHRC and the insurance division, it would appear that A.B. 289 did achieve the targeted reduction in the hospital inpatient component of the health care industry. However, as with health care costs on the national scene, cost containment in a single area has not slowed the net increase in overall health care costs. While inpatient hospital costs have been moderated, the outpatient, pharmacy, provider, and other components have increased their market share of the health care dollar. The amount affected by the legislation represented 8.2 percent of the inpatient health care dollars spent in Nevada. The cost-containment effort worked on the area it targeted, although that area was a small but significant portion of Nevada's total health care dollar.

B. INDIGENCY PROVISIONS

1. Description

Nevada Revised Statutes 439B.300, et seq., embodies the indigent care provisions enumerated in A.B. 289. This section of NRS contains the findings of the legislature that the refusal of a hospital to treat an indigent patient endangers the health of the patient, and that a system is needed in counties with more than one hospital to equalize the burden of treating these patients. The statute also provides a uniform statewide definition of "indigent".

The measure also establishes the obligation of a hospital to provide emergency treatment, including admitting such emergency patients as are appropriate for admission. It makes "dumping" of patients because of financial status unlawful, and allows a hospital which is the victim of such "dumping" to collect a penalty equal to three times the billed charges for services provided to a patient who was "dumped" by another hospital.

The section of A.B. 289 now incorporated into NRS 439B.320, "Legislative findings and declarations; applicability," establishes a program in counties with more than one licensed hospital to distribute indigent care. Affected hospitals (those in Clark and Washoe counties with more than 100 beds) have a minimum obligation to indigent care of .6 percent of the hospital's net revenue from the preceding fiscal year. The law also sets forth the requirements for the county's administration of the indigent care program.

Section 439B.340 of NRS, "Report on indigent patients treated; verification by administrator; compensation for treatment provided in excess," requires counties to submit information regarding the program to the state, and specifies the duties of DHR and DRHRC with regard to the indigent care program, including the authority to collect assessments for a hospital's failure to meet its minimum obligations of free indigent care.

2. Scope

The prohibition against inappropriate transfers of patients affected every hospital in Nevada. In practical terms, the law had the greatest impact on those hospitals in Clark and Washoe counties which do not serve as county facilities. Historically, the county facilities in those two counties have received a large number of transfers of the medically indigent from the noncounty hospitals. University Medical Center (UMC) in Clark County and Washoe Medical Center in Washoe County serve as county facilities.

3. Analysis

Tables 3 and 4 summarize the impact of A.B. 289 on the level of indigent care, as reimbursed by county social services:

TABLE 3

NUMBER OF INDIGENT CASES BY FISCAL YEAR

Clark County, Nevada

Hospital	(1985/86)	(1986/87)	(1987/88)
Community	--	--	35
Desert Springs	--	6	24
Humana Sunrise	30	19	83
UMC	2,257	2,102	1,695
Valley	2	4	26

Source: Clark County Social Service Department.

TABLE 4

Washoe County, Nevada

Hospital	(1985/86)	(1986/87)	(1987/88)
Sparks	--	--	38
Saint Mary's	73*	36*	135
Washoe Medical Center	699	755	1,223**

*Estimates based upon average derived from total payments divided by total cases.
**Eligibility threshold changed resulting in increased cases.

Source: Washoe County Social Services Department.

The numbers for fiscal years 1985-1986 and 1986-1987 presented in Tables 3 and 4 represent the best information currently available. Some caution should be used since eligibility and payment levels were altered with the advent of A.B. 289, and since data was not kept in the same fashion in previous fiscal years. It can be assumed, however, that the measure did have an effect upon the number of indigent cases handled by the hospitals. The number of indigents seen by the county facilities seems to have declined slightly, while the number seen by the noncounty facilities has increased by approximately the same amount.

Table 5 illustrates the degree to which the hospitals in Clark and Washoe counties met their targeted amount of indigent care.

TABLE 5

STATUS OF INPATIENT INDIGENT CARE REQUIREMENT
OF HOSPITALS IN NEVADA AFFECTED BY A.B. 289

Clark County - July, 1987 through June, 1988

Hospital	No. of Claims	Approved/ Denied	0.6% Target	Credited	0.6% Remaining
Community	47	35/12	$ 71,431	$ 48,356	$ 23,075
Desert Springs	55	24/31	$232,118	$ 126,035	$106,083
Humana Sunrise	279	83/196	$651,444	$ 465,055	$186,389
UMC	2,764	1695/1069	$461,527	$ 461,527[1]	$ 0
Valley	57	26/31	$402,863	$ 123,687	$279,176
			$1,819,383	$1,224,660	$594,723

Washoe County - July, 1987 through June, 1988

Hospital	No. of Claims	Approved/ Denied	0.6% Target	Credited	0.6% Remaining
Sparks	219	38/181	$ 86,259	$ 86,259	$ 0
Saint Mary's	903	135/768	$376,698	$ 376,698	$ 0
WMC	5,813	1223/4590	$550,926	$ 550,926[1]	$ 0
			$1,013,883	$ 1,013,883	0

[1]Disproportionate share of payment authorized by County Commissioners.

Source: Clark and Washoe County Social Service Departments.

The data indicates that noncounty hospitals in Washoe County provided nearly $463,000 worth of indigent care for 173 cases, at an average cost of about $2,600 per case. In Clark County, the figure was $763,000 of care for 168 cases, or about $4,500 per case, on the average. Washoe County hospitals met their targets, while those in Clark County, other than UMC, failed to attain their targets. According to the provisions of NRS 439B.340, the $594,000 shortfall will be turned over to Clark County to pay for additional indigent care at UMC.

Some concern has been expressed on the part of the noncounty hospitals with regard to the mechanism by which claims are approved or denied. The Nevada legislature's committee on health care has heard arguments from the affected hospitals concerning a perceived conflict of interest on the part of county--the counties are responsible for approving claims that will ultimately reduce any assessment they might eventually receive. The committee did not take action on the perceived conflict. A recommendation was approved which, if enacted, would help to streamline the review of indigency claims. (See Legislative Counsel Bureau Bulletin No. 89-8, "Report Of The Nevada Legislature's Committee On Health Care)."

County government in the two counties affected have not had to expend as much public money for indigent care, directly or indirectly, as might have been the case without A.B. 289. It would appear from the information presented to the committee that additional action may be required with regard to indigent claims to achieve the goal of spreading the burden of indigent care more evenly within the hospital community.

C. CERTIFICATE OF NEED

1. Description

With regard to Nevada's CON statutes, some historical background is necessary. Certificate of need is a capital expenditure review program administered by the state for the purpose of regulating capital expenditures for health care facilities, new institutional health services, and the acquisition of major medical equipment. The concept grew out of voluntary health planning efforts which typically were led by local health planning councils made up of lay community leaders and hospital administrators. In 1974, and again in 1979, the United States Congress enacted legislation which formally established such health planning activities. However, by 1981, enthusiasm for federal regulation began to evaporate.

Changing philosophies about health care cost containment and lack of federal financial and legal support continue to erode state support for CON programs and their associated health planning organizations. Nearly every state, including Nevada, has modified its CON statutes within the last 5 years; some states have eliminated their programs altogether.

For a more detailed discussion of Nevada's CON laws, see Legislative Counsel Bureau Bulletin No.87-10, titled Study Of Statutes Requiring Approval By Department Of Human Resources Of Certain Medical Projects, dated August 1986.

Nevada's CON statute, NRS 439A.100, was amended by A.B. 289 to relax the requirements for review of most projects and to eliminate the review of additional services within an existing facility. Section 1 of Assembly Bill 615 (chapter 681, Statutes of Nevada, 1987) clarified several provisions from A.B. 289 and raised the capital and equipment thresholds to $2 million. Projects and equipment below the threshold are no longer subject to review.

2. Scope

Until the revisions made by A.B. 289, most projects or technological purchases made by or on the behalf of a health facility were subject to the CON process. This included all capital expenditures in excess of $714,000, or would involve annual operating expenses in excess of $297,500. In addition, medical equipment purchases in excess of $400,000 were also subject to review.

Nevada Revised Statutes 439A.015, defines "health facility" and thereby sets the applicable boundaries of the the chapter. In effect, all but the typical office of a health practitioner (physician, dentist or licensed nurse) is subject to the provisions of the law. Even the practitioner's office is not exempt from the medical equipment provisions. According to a 1987 court case--Department of Human Resources v. UHS of the Colony, Inc., (103 Nev. 208, 735 P.2d 319 (1987)--mobile facilities, such as mobile diagnostic scanners, also are subject to the law.

In effect, all existing and proposed nonfederal hospitals, nursing facilities, and most other health facilities are subject to the law. In addition, the medical equipment provision affects those practitioners whose purchase exceeds the $2 million threshold.

Before A.B. 289, a significant number of equipment purchases and capital projects were subject to review. According to a

report submitted to the health care committee by the department of human services, provisions in A.B. 289 concerning CON effectively deregulated many, if not most of the types of projects formerly subject to review.

3. Analysis

According to information provided by DRHRC, the volume of new CON applications has been reduced about 60 percent due to the changes made by A.B. 289 and A.B. 615. The volume of review for medical equipment applications was reduced by about 70 percent. Total number of applications for fiscal year 1986-1987 was 63; for fiscal year 1987-1988, that number was 39. According to DRHRC, due to problems with litigation and due to requests to expand projects already reviewed, total workload has not decreased.

Administrative costs of performing CON reviews are set by DRHRC at $8,000. Estimates provided by the Nevada Hospital Association indicate that the cost to hospitals for CON review ranges anywhere from $5,000 to $20,000 depending upon the scope of the project and whether or not a consultant was hired to prepare the application.

With regard to the volume of requests, it should be noted that the effects of the changes made by A.B. 289 cannot be measured. Since applications are no longer required for projects under the $2 million limit, it is not possible to determine if the increased threshold resulted in increased volume. There may, in fact, be an increased number of projects underway in the state which may or may not have proceeded had the old CON law been in place.

One of the key concepts behind most CON programs was to reduce overbuilding (excess capacity) in certain segments of the health care industry and the attendant tendency to increase volume of services (perhaps unnecessarily) to offset investment expenses. Several states that have eliminated their CON laws have experienced excess capacity problems within several sectors of their health care industry. Utah experienced a phenomenal growth of private psychiatric facilities, while Arizona saw an explosion in the construction of nursing homes. Additional information concerning CON experience in other states may be found in a DRHRC report titled "CON - History, Status and Prospects: Nevada and Other States."

Another source of information concerning CON can be found in a memorandum submitted to the legislature on December 8, 1988, by Jerome F. Griepentrog, director of the department of human resources. The increase in the threshold for CON

review was expected to stimulate competition in an effort to stabilize and perhaps reduce health care costs. According to the memorandum:

> There is little evidence, to date, which supports this contention.

The report goes on to question whether duplicate technology has proliferated to the extent that investors are seeking to increase volume unnecessarily to recover investment costs.

In 1987, the division of health in the department of human resources was given the authority to regulate services such as cardiac bypass surgery, neonatal intensive care, and trauma care. According to the memorandum, the removal of these technology-intensive services from CON scrutiny, may have resulted in increased costs incurred by hospitals competing for services. Such costs are usually passed along to health care consumers.

For some services, such as bypass surgery, state regulations allow that any hospital meeting the required standards may proceed with such a program. For other services, such as trauma center designation, hospitals are required to compete on a request-for-proposal basis. In both instances, the costs incurred by the hospitals for additional equipment, facility modification, and appropriate staffing are significant.

With the provisions of A.B. 289 in place for a little over a year, it is not possible to validate any cost savings due to CON changes. Savings gained from competitive forces and fewer projects needing to have CON approval may be offset by the excess capacity theory, where volume for patient services may be increased unnecessarily to recoup investment costs. Neither theory can be validated at this time.

III. MEASURING COMPLIANCE

A. DATA MONITORING

1. Description

Section 439B.400 of NRS requires hospitals to maintain and use a uniform list of billed charges for inpatient goods and services provided. The provision was necessary to ensure that all information submitted by hospitals is in a comparable format. Section 439B.210 of NAC requires all hospitals to use the UB-82 report form for all inpatient transactions. It also requires all major hospitals to

provide the required UB-82 information to the state in magnetic tape format or pay the cost of manual input. The information gathered by this process is part of a data base maintained by DRHRC.

Nevada Revised Statutes 439B.440 deals with information submission and dissemination and the authority of the director of DHR to adopt regulations and to examine hospitals as deemed necessary. Subsection 2 requires the director to adopt regulations requiring an independent audit of hospitals with more than 200 beds to ensure compliance with the bill. Section 439A.106 of NRS requires DRHRC to publish information on hospital charges on a quarterly basis and to provide information annually concerning the effects of the bill to the legislature's committee on health care.

Other data requirements related to the hospital revenue reduction provisions were discussed earlier in this paper in the section "Required Reductions of Inpatient Revenues."

2. Scope

The provisions of this portion of the bill affect all medical, surgical or obstetrical hospitals within Nevada, as defined in NRS 439B.110, "'Hospital' defined." Allowances are made for smaller hospitals (under 200 beds) to submit information in alternative formats. Currently all hospitals are reporting fiscal data either by hard copy or on floppy disc for computer. Standardized billing information is provided by all nonfederal hospitals in the state to the University of Nevada-Las Vegas computer services on contract with DRHRC.

3. Analysis

The impact of this segment of the bill upon health care costs cannot be analyzed. It should be noted, however, that any review of the effectiveness of the other provisions of the bill are wholly dependent upon the form and accuracy of the data collected. The requirement of standardized data is necessary to compare hospitals to one another and to track the effects of cost-containment efforts over time. The provisions covering this portion of the measure were designed to make use of existing standardized formats for the submission of data. The limitations of smaller facilities also were considered. According to information received by the committee, the quarterly fiscal information provided by the hospitals provides the best picture of activity within the hospitals. Monthly fluctuations tend to even out with the quarterly report, and annual totals provide the best information, since many hospitals see a

great deal of activity in the quarter closing their own internal fiscal year.

Having the ability to compare pertinent data with other states requires that each of the states concerned collects and reports the same data in exactly the same fashion. Since the collection of hospital financial information is relatively new for states, most do not have established systems with current data. The National Association of Health Data Organizations is attempting to establish standardized data collection and reporting among its members; however, not all states with such systems are members. The 20 or so states collecting information regarding health care costs are in varying stages of development with their systems. An added difficulty is that the information being reported may be out-of-date. Nevada's system has relatively current data available, usually within 60 days of the close of the quarter being measured. Many states have at least 6-month reporting backlogs, and others have a 1-year delay. National data, such as that gathered by the American Hospital Association and the Health Care Financing Administration, are several years out-of-date.

Another data factor warrants review. For example, the new law requires that DRHRC inform the public concerning hospital health care costs. The division issued the first such publication, Personal Health Choices, in November 1988. In addition to providing the consumer with important health-related advice, the brochure presents comparative data concerning hospital charges and average length of stay for selected diagnoses and procedures. The publication is scheduled to be revised periodically. The effect of such publications on health care costs is not easily measured. It can be assumed that such data is potentially helpful to both the consumer and insurers in making rough comparisons concerning cost and volume.

The data collection provisions of A.B. 289 are not subject to cost-based analyses. Their existence and effectiveness are based upon the need to collect accurate standardized data in order to track other provisions of the bill. Such information also is necessary for comparative purposes with health cost data produced by other states. Informing the health care consumer is another important function. Changes in consumer behavior on a large scale could translate to overall cost savings.

B. HEALTH INSURANCE PASS-ALONG

1. Description

Section 58 of A.B. 289 requires insurers and others who realize savings as a result of this bill to pass those savings along to their customers in the form of reduced premiums. In order to determine compliance, Nevada's insurance division, department of commerce, enacted several regulations (chapter 679B.501, et seq., Nevada Administrative Code). The division performs audits upon health insurance company claims to determine whether the dollar amount is being identified. Under the terms of A.B. 289, if the amount is less, the savings is supposed to be passed along by the insurer in the form of reduced premiums.

In addition, when an insurance company files a policy or other documentation with the division, the company must include an actuarial memorandum certifying that the savings are reflected in the rates and indicating the methodology used. The regulations also provide for standardized statistical reporting on a yearly basis.

2. Scope

According to Nevada's insurance division, audits of 15 to 20 of the insurance companies doing the largest share of business in Nevada would account for a majority of the insurance written in the state. According to information provided to the health care committee by the insurance commissioner, over 370 insurance companies write health insurance policies in Nevada. Claims-reporting regulations enacted by the division in 1987 require that companies report claims dollars spent in the state either annually or quarterly, depending upon how much business is written. If more than $1.5 million is written, the report is required quarterly; if less than that amount is written, the report is required annually. All of the 370 companies are required to make a report at least annually, and approximately 37 companies currently meet the criteria for quarterly reports.

3. Analysis

The effect of A.B. 289 is not easily measurable in this regard. As noted in the section concerning cost rollbacks, once those hospitals not affected by A.B. 289 are eliminated from the calculations, and once those companies that use a negotiated per diem rate also are eliminated, only a few companies are affected. Based upon information supplied by

the insurance commissioner in January of 1989, an average of 8.2 percent of the claims dollar paid in Nevada by insurers was actually affected by A.B. 289.

At the time this report is being written (January 1989), the insurance division is in the process documenting the results of certain examinations performed on selected insurance companies operating in the state. The examinations were conducted to document the savings pass-alongs as required in A.B. 289. The reports now are in the "comment" stage and are expected to be released during the first few months of 1989.

Preliminary reports from the insurance commissioner and others indicate that while the inpatient component of the health care dollar was affected by the bill, outpatient charges and charges by other sectors of the health care industry increased. Savings in the inpatient component probably were offset by increases in other components. This situation reflects the national trend where most insurers expect premiums to rise over the next year. Should this be the case in Nevada, the argument could be made that the increase would have been greater without the moderating effect of A.B. 289 on the hospital inpatient component.

IV. SUMMARY

Assembly Bill 289 of the 64th legislative session is a complex measure dealing with a complex industry. On one hand, it appears that savings realized by the provisions of the law may have been offset in other sectors not addressed. On the other hand, the reductions mandated by A.B. 289 have arguably moderated the inexorable increase in total health care costs.

The inpatient revenue reduction provisions of the bill exceeded the established targets. Hospital inpatient revenues decreased by $25 million, potentially offsetting the historical increase in this category. It should be noted, however, that the law only targeted about 8.2 percent of the total claims dollars paid in Nevada. Charges for outpatient services, pharmaceuticals, physicians, and so on, were not affected by the law, nor were inpatient charges by Medicaid, Medicare and insurers using contracted rates.

The indigent care provisions of the law appear to have saved the urban counties the cost of caring for a significant number of the medically indigent. Coupled with the

provisions in the federal law, the Nevada statute also has reduced the incidence of inappropriate transfers of indigent patients.

With regard to the changes in Nevada's certificate of need law, increased competition may be resulting in excess capacity for certain services. This situation may be balanced by competitive pricing and reduced administrative costs for the health facilities and DRHRC in the CON application process.

The data monitoring provisions of the law are vital to the accurate evaluation of the effects of other sections of the measure. The information collected also may have a long-term effect on consumer ulitization of health care services.

There were mixed results with regard to the requirement that any savings realized by insurers from this bill be passed along to consumers through reduced premiums. A report on the pass-along requirement is due to be issued by the insurance commissioner shortly. However, preliminary indications are that insurance premiums will not decrease. Other sectors not affected by A.B. 289 may offset the savings and cause increases in premiums.

As more data becomes available on the effects of A.B. 289, the legislature will be better able to measure the impact of the 1987 act. With regard to the revenue reduction portion, the data indicates that the bill was very effective. The savings realized should help to retard the rate of growth of hospital inpatient revenues in Nevada. The effects of other portions of the bill need further analyses as the required information becomes available. All portions of the bill will require continuing review over the lifetime of the law's inpatient revenue reduction provisions, which extend until 1991.

V. SELECTED REFERENCES

- "CON - History, Status and Prospects: Nevada and Other States" prepared by the Division for Review of Health Resources and Costs of Nevada's Department of Human Resources, dated September 1988.

- Report of the Nevada Legislature's Committee on Health Care. (1989). Bulletin No. 89-8. Carson City, Nevada: Legislative Counsel Bureau.

- Study of Statutes Requiring Approval by Department of Human Resources on Certain Medical Projects. (1986). Bulletin No. 87-10. Carson City, Nevada: Legislative Counsel Bureau.

- Study of Restraining Costs of Medical Care. (1986). Bulletin No. 87-7. Carson City, Nevada: Legislative Counsel Bureau.