

STUDY OF RESTRAINING COSTS OF MEDICAL CARE



Bulletin No. 87-6

**LEGISLATIVE COMMISSION
OF THE
LEGISLATIVE COUNSEL BUREAU
STATE OF NEVADA**

August 1986

RESTRAINING COSTS OF MEDICAL CARE IN NEVADA

BULLETIN NO. 87-6

LEGISLATIVE COMMISSION
OF THE
LEGISLATIVE COUNSEL BUREAU
STATE OF NEVADA

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SENATE BILL 460 (CHAPTER 645, STATUTES OF NEVADA, 1985)

Senate Bill No. 460—Senators Rawson, Foley, Mello, Neal, Raggio, Ryan and
Townsend

CHAPTER ~~644~~ 645

AN ACT relating to an interim study on restraining the cost of medical services; making an appropriation; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. 1. The legislative commission shall conduct an interim study into ways of restraining the costs of health care in this state while ensuring the quality of those services.

2. The study must include:

(a) An examination of the effectiveness of the legislation enacted by the 63rd session in accomplishing this purpose and its effects upon the subjects of inquiry listed in paragraphs (b) to (j), inclusive, of this subsection;

(b) A review and evaluation of the quality and effectiveness of programs for the prevention of illness;

(c) A comparison of the costs of medical care among communities in Nevada and with similar communities in other states;

(d) An analysis of the overall system of medical care to determine ways to coordinate the providing of services to all members of society, avoid the duplication of services and achieve the most efficient use of all available resources;

(e) An examination of the business of providing insurance, including the development of cooperation with health maintenance organizations and organizations which restrict the performance of medical services to certain physicians and hospitals, and procedures to contain the costs of those services;

(f) An examination of hospitals to:

(1) Increase cooperation among hospitals;

(2) Increase the use of regional medical centers;

(3) Encourage them to use medical procedures which do not require the patient to be admitted to the hospital and to use the resulting extra space in alternative ways; and

(4) Encourage their participation with health maintenance organizations and organizations which restrict the performance of medical services to certain physicians and hospitals;

(g) An examination of medical malpractice;

(h) An examination of the system of education to coordinate:

(1) Programs in education about health, including those for the prevention of illness and those which teach the best use of available medical services; and

(2) The education of those who provide medical care;

(i) An evaluation of the need for a commission to regulate the rates charged by persons who provide medical care; and

(j) Any other matter which is determined by the legislative commission to be relevant.

3. The legislative commission shall submit its report and any recommended legislation to the 64th session of the legislature.

Sec. 2. There is hereby appropriated from the state general fund to the legislative fund the sum of \$113,360 for the support of the interim study conducted pursuant to section 1 of this act.

Sec. 3. Any remaining balance of the appropriation made by section 2 of this act must not be committed for expenditure after June 30, 1987, and reverts to the state general fund as soon as all payments of money committed have been made.

Sec. 4. This act becomes effective upon passage and approval.

19  25

REPORT OF THE LEGISLATIVE COMMISSION

TO THE MEMBERS OF THE 64TH SESSION OF THE NEVADA LEGISLATURE:

This report is submitted in compliance with Senate Bill 460 (chapter 645, Statutes of Nevada, 1985). Senate Bill 460 directed the legislative commission, under the auspices of the joint committee on human resources, to conduct a study into:

1. Ways of restraining the costs of health care in Nevada; while
2. Ensuring a high quality of services.

The measure appropriated \$113,360 to support the activities associated with the study.

The legislative commission appointed a subcommittee consisting of the following members to conduct the study:

Senator Raymond D. Rawson, Chairman
Assemblyman Steven C. Francis, Vice Chairman
Senator Helen A. Foley
Senator Joe Neal
Senator Randolph J. Townsend
Assemblyman David E. Humke
Assemblyman David D. Nicholas
Assemblyman Marvin M. Sedway

The subcommittee which conducted the study held 13 meetings, five of which were 2-day sessions. Hearings were held in Las Vegas, North Las Vegas, Reno, Carson City, Elko and Ely, Nevada.

Special speakers were brought into the state from the National Conference of State Legislatures' "Health Care Cost Containment Project," the American College of Healthcare Executives which had conducted a major national study, four other nationally recognized organizations, and three states which have implemented measures designed to address the rising costs of health care. Part of the study's appropriation was also invested in employment of in-house staff, support of a major survey and data gathering effort through the University of Nevada-Reno, and a health needs assessment of Nevada state government employees.

The subcommittee members considered over 250 proposed recommendations. A total of 51 recommendations were approved for submittal to the legislative commission. This package of recommendations was designed to address the issue of health

care cost containment in a comprehensive manner. The package contains recommendations in the general categories of regulatory authority, prevention/wellness/education, funding of health care, quality of care, health care for senior citizens, and medical malpractice.

The subcommittee's final report contains descriptions of the history of health care and trends in health care costs, a review of major topics associated with health care cost containment and a discussion of each recommendation. The associated drafts of bills are also included in the report.

Respectfully submitted,

Legislative Commission
Legislative Counsel Bureau
State of Nevada

Carson City, Nevada
December 1986

LEGISLATIVE COMMISSION

Assemblyman Louis W. Bergevin, Chairman
Assemblyman Bob L. Kerns, Vice Chairman

Senator James H. Bilbray	Assemblyman Robert M. Sader
Senator Helen A. Foley	Assemblyman James W. Schofie
Senator Lawrence E. Jacobsen	Assemblyman Danny L. Thompsc
Senator Kenneth K. Redelsperger	Assemblyman Barbara A. Zimme
Senator Sue Wagner	

SUMMARY OF RECOMMENDATIONS

Following is a summary of the recommendations approved by the legislative commission's subcommittee to study restraining the costs of medical care in Nevada:

I. REGULATORY AUTHORITY

A. DATA COLLECTION/DISSEMINATION

- 1: Direct the division for review of health resources and costs, department of human resources (DHR), to compile and distribute to the general public a document (brochure or pamphlet) which lists the hospitals in Nevada and their charges for representative services and procedures. (BDR 40-117)
- 2: Direct the division for review of health resources and costs to establish a toll-free telephone number to provide consumers with information relative to costs of services at medical facilities within the state. (BDR 40-117)
- 3: Transfer the health care library collection initiated by the legislative counsel bureau to the library of the medical school at the University of Nevada-Reno. Indicate that the library is to keep the collection current, disseminate information about the existence and contents of the collection, and provide information to people who request assistance.
- 4: Require that hospitals provide to the state copies of all contracts for provision of medical services. Ensure that the names of the contractors will remain confidential. (BDR 40-1002)

B. PROVIDERS OF HEALTH CARE

- 5: Require that Nevada hospitals offer all residents (who are not already covered by third party benefits) a rate which is no higher than the average daily rate that is allowed members of large groups contracting with each hospital. Specific items associated with this recommendation include:
 - a. Exempting rural hospitals;
 - b. Providing that the special rate must be offered to all Nevada residents who are uninsured and who make arrangements within 90 days for the manner in which their bills will be paid;

- c. Requiring that a patient be offered the special rate or billed charges, whichever is less;
 - d. Establishing the rate for each hospital through an independent audit of each hospital's contracts;
 - e. Requiring that hospitals post and publish their special rates;
 - f. Providing for a random examination of hospital records to ensure compliance (require that hospitals refund the amount of any errors in its favor with an additional 10 percent penalty);
 - g. Providing oversight of the process through the executive branch and a permanent legislative committee on health care; and
 - h. Establishing an office of consumer health advocacy to hear complaints; provide information and facilitate resolution of concerns through referral to proper agencies; boards and committees. (BDR 40-117)
- 6. Do not advocate a ratesetting commission for the State of Nevada; but include a minority report describing the activities of ratesetting commissions as an appendix to the final report.
 - 7. Amend the state statutes to allow county hospitals to engage in health-related enterprise activities. Eliminate statutory constraints on county hospitals generally (BDR 40-204)
 - 8. Allow hospitals to engage in "pooling" or "semi-blind pooling" of bond issues to obtain needed capital at reasonable interest rates. (BDR 40-205)
 - 9. Include in the final report an explanation of the nation ranking of Nevada's nursing homes and a description of methods used in some national surveys which tend to rate the state's nursing homes unreasonably low.

C. CERTIFICATE OF NEED (CON)

- 10. Express the subcommittee's support for the following recommendations to the subcommittee to study statutes requiring approval by the department of human resources of certain medical projects--CON (Assembly Concurrent Resolution No. 41; File No. 103; Statutes of Nevada, 1985):
 - a. Retain the present "bed/need methodology" as it is, except as proposed in the "State Health Plan."

- b. Raise the threshold above which new technological equipment must be approved before it is purchased from \$400,000 to \$1 million.
- c. Exempt from the CON process replacement of outdated equipment by similar new equipment.
- d. Exempt from the CON process nonmedical capital improvements to an existing facility or institution.

D. LEGISLATIVE OVERSIGHT

- 11. Establish, by statute, a permanent legislative committee on health care. (BDR 40-117)
- 12. Establish an interim study of mandatory coverage in health insurance policies of mental health and alcohol and substance abuse. (BDR R-478)

II. PREVENTION/WELLNESS/EDUCATION

A. HEALTH EDUCATION AND PHYSICAL-FITNESS IN SCHOOLS (K-12)

- 13. Prohibit the use of tobacco products by students in the public schools, grades kindergarten through 12th (K-12), in Nevada. (BDR 34-73)
- 14. Express support for the recommendations of the United Community Task Force on Confronting Youth Chemical Dependency concerning abuse of substances by adolescents. (BDR R-119)
- 15. Include in the final report a statement encouraging the appropriate officials to work toward developing nursing services in the schools (K-12) which meet national and professional standards.
- 16. Send a letter to the state department of education suggesting that a position to coordinate nursing services/programs in the state's school districts be included in the department's future budget requests.
- 17. Express support for a program through which the state department of education will provide inservice training in physical fitness for all elementary school teachers.
- 18. Express support for a program through which the state board of education will sponsor annual statewide curriculum conferences concerning prevention and wellness education.

19. Include in the final report a summary of the presentation and proposal of the Nevada Dental Hygienists Association concerning early detection of dental/oral disease and the use of fluoride.

B. EDUCATION OF HEALTH CARE PROFESSIONALS

20. Direct the appropriate professional organizations to include in at least 10 percent of their continuing education courses for health care professionals the concepts associated with prevention/wellness as tools for health care cost containment. (BDR 54-207)
21. Include in the final report a statement of support for the concepts associated with Area Health Education Centers (AHEC's) for the training/education of health care professionals in Nevada.
22. Appropriate \$1.25 million for construction of the initial phase of a health science center on the Torrey Pines/West Charleston Boulevard property in Clark County. (BDR S-479)
23. Establish a committee to study education of nurses in Nevada. (BDR S-88)

C. STATE EMPLOYEE HEALTH PROGRAMS

24. Fund a health needs assessment of state employees to determine the types of prevention/wellness/education programs which would be most appropriate for this population. (Financed through the study.)
25. Include in the final report a statement expressing support for conducting a prevention/wellness/education program for state employees; if the results of the health needs assessment indicate that such a program would be valuable. Indicate that this program would serve as a model for possible application for other groups in the state. Include a bill draft request which would establish a policy committee to direct a comprehensive wellness program for state employees and make the necessary appropriation. (BDR 23-537)

D. GENERAL PREVENTION/WELLNESS/EDUCATION

26. Require utilization of seatbelts in automobiles. (BDR 43-210)

III. FUNDING OF HEALTH CARE

A. THIRD PARTY PAYERS

27. Require that all group medical insurance policies include provisions whereby spouses of deceased members continue to be eligible for the group program (coordinate with federal law). (BDR 57-206)
28. Require that an employee who is covered by a group health insurance plan and subsequently becomes unemployed must have the option to continue the insurance coverage for up to 180 days (coordinate with federal law). (BDR 57-206)
29. Express support for federal tax credits designed to encourage small businesses to initiate or improve group health insurance programs for their employees. (BDR R-71)
30. Grant the insurance division, department of commerce, the authority to regulate holding companies that own health maintenance organizations (HMO's) in the same manner in which holding companies of insurance companies are regulated. (BDR 57-65)
31. Enact legislation concerning regulation of Preferred Provider Organizations (PPO's) which is similar to model legislation. (BDR 57-72)

B. MEDICAID

32. Expand the joint Medicaid/University of Nevada school of medical sciences project for capitated delivery of care to Medicaid-eligible people. Establish a goal that the school expand the delivery to 10,000 people by July 1, 1991. (BDR S-116)
33. Direct the Nevada Medicaid office (state welfare division, department of human resources) to establish a utilization review program which is independent of the state office and is designed to review hospital activities and charges associated with the Medicaid program. (BDR 38-86)
34. Establish a reserve fund of 4 percent of the total Medicaid budget for each fiscal year, requiring approval of the legislature's interim finance committee before a withdrawal may be made from the fund. (BDR 38-121)
35. Amend the state Medicaid program in order to provide reimbursement for home- and community-based hospice services. (BDR 38-203)

36. Place in the statutes a procedure and formula for determining Medicaid reimbursement rates based primarily upon the audited costs of services provided by the most efficient hospitals within similar classifications. (BDR 38-86)
37. Change the state eligibility requirements associated with Medicaid and aid to dependent children to include coverage for two-parent, unemployed families in an attempt to reduce "cost-shifting." (BDR 38-115)
38. Establish the criterion that any person whose monthly income is less than three times the income allowable to receive benefits pursuant to 42 United States Code §§ 1382 through 1383c is eligible to receive assistance to the medically indigent for the purpose of long-term medical care. (BDR 38-123)

C. UNCOMPENSATED CARE AND THE MEDICALLY INDIGENT

39. Recommend continuation of the 3-cent ad valorem tax to support medical services for indigents. Place this recommendation in a letter to the subcommittee to study operation of the program for state aid to the medically indigent (created by Senate Concurrent Resolution No. 34, File No. 120, Statutes of Nevada, 1985).
40. Require acute care hospitals which do not treat their "fair share" of indigents to pay assessments into a "pool" to finance indigent care. (BDR 38-1001)
41. Establish procedures to determine medical indigence and specify minimum standards to apply statewide. (BDR 38-110)
42. Provide that all punitive damages awarded (excluding attorney's fees) in civil liabilities cases be used to assist in financing medical services for indigents. (BDR 3-122)
43. Increase lower limits from \$15,000 to \$25,000 on required automobile insurance and increase administrative penalties for noncompliance. In addition, require that individuals must provide proof of insurance for renewal of automobile registration. (BDR 43-113)
44. Direct the director of the department of human resources to establish a program through which private companies "sponsor" health insurance coverage for needy children, similar to the Blue Cross program in Pennsylvania. (BDR 38-76)

45. Approve a skeleton bill to appropriate \$1 million in fiscal year 1987-1988 and \$1 million in fiscal year 1988-1989 to create a new program for "catastrophic" medical assistance for Nevada citizens who do not qualify for existing programs but have large medical bills which will destroy the family solvency. (BDR 38-120)

IV. QUALITY OF CARE

A. GENERAL

46. Establish an "ethics institute" at the University of Nevada school of medical sciences. (BDR 34-74)
47. Provide that the position of state health officer must be filled with a medical doctor who also has a background in public health care within 6 months of the time that the position becomes vacant. (BDR 40-118)

B. TRAUMA CARE

48. Direct the health division in the department of human resources to develop by January 1, 1988, the system through which a trauma network may be established throughout the state. The system should include the following provisions or elements:
- a. Use of the criteria of the American College of Surgeons for designation of hospitals as trauma centers.
 - b. Indication that designation as a trauma center does not, in itself, require approval through the certificate of need process.
 - c. Provision that a hospital, which is designated as a trauma center, must have an "open admission policy" with complete care until the patient is ready for discharge or until the patient requires transfer to a facility which has a higher level of care.
 - d. Requirement that physicians who work in trauma centers must be qualified and proficient in trauma care, and establishment of a goal that physicians in outlying areas who will be transferring patients into a trauma center have capabilities at least at the level of "Advanced Trauma Life Support."

- e. Provision by the state health division of "Prehospital Trauma Life Support" training and other necessary training to appropriate providers of trauma care.
- f. Compilation by the division for review of health resources and costs of a "trauma registry" within its system for gathering information and statistics concerning health care in Nevada.
- g. Compilation of information for the "trauma registry" through use of the "Cram scoring system" based upon "mechanism of injury" and use of "Champion scores," with physician evaluations taking precedence over evaluations made by ambulance attendants.
(BDR 40-85)

C. PERINATAL CARE

- 49. Direct the state board of health to develop statewide standards for perinatal care. (BDR 40-114)

V. HEALTH CARE FOR SENIOR CITIZENS

LONG-TERM CARE

- 50. Include a statement in the final report expressing support for the concepts contained in Governor Richard H. Bryan's proposed alternatives to traditional long-term care programs. These alternatives include adult day health care, adult day care, inhome attendant care, respite care, homemakers services and homebound meals. The programs are designed to reduce the institutionalization of Nevada's elderly population and improve its quality of life.* Include the following specific points:
 - a. Endorse a statewide case management program to coordinate community- and home-based services to seniors and their families.*
 - b. Support a program to train professional, paraprofessional and family caregivers in the unique needs of the elderly.*
 - c. Enter into discussions to develop a federal/state partnership in financing programs for the elderly.*

*Proposed in Governor Bryan's "Nevada Initiatives for Seniors - An Agenda for the Future."

- d. Promote specialized care units within existing and future long-term care facilities to meet the unique needs of the Alzheimer patient and similar groups.*
- e. Develop residential alternatives which offer varying levels of support services, such as supervised apartment living.*

VI. MEDICAL MALPRACTICE

- 51. Refer the following recommendations, which have been compiled from testimony presented to this subcommittee, to the subcommittee to study insurance against medical malpractice (A.C.R. 53, File No. 106; Statutes of Nevada, 1985) for its consideration:
 - a. Amend the state statutes to allow courts to award damage payments in excess of \$50,000 in installments rather than lump sums.
 - b. Modify the collateral source rule to permit a jury to know whether the plaintiff has been compensated from another source.
 - c. Establish a structure for attorney contingency fees which is based on a sliding scale and assure that the injured party is the primary beneficiary from the court award.
 - d. Limit the amount of noneconomic losses in court awards to no more than \$250,000.
 - e. Adopt a resolution supporting United States Senator Orrin G. Hatch's (Utah) Senate Bill 1804 which gives states eligibility to receive federal grants if the states adopt reforms and make them applicable to cases involving medical malpractice.
 - f. Modify Nevada's law relative to screening panels for medical malpractice lawsuits as follows:

If the panel determines that the claim is not viable and the case is pursued in court, the patient becomes responsible for the costs of the defense of the provider being sued unless the patient wins the case.

*Proposed in Governor Bryan's "Nevada Initiatives for Seniors - An Agenda for the Future."

- g. Provide state-supported malpractice insurance for physicians who work in state-supported facilities or programs.**
- h. Require that the judge's instructions to the jury in medical malpractice cases include a discussion of the general economic ramifications of the decision.**

REPORT TO THE 64TH SESSION OF THE NEVADA LEGISLATURE
BY THE LEGISLATIVE COMMISSION'S SUBCOMMITTEE
TO STUDY RESTRAINING COSTS OF MEDICAL CARE

I. INTRODUCTION - THE ISSUE OF HEALTH CARE
COST CONTAINMENT

Americans spend over \$1 billion on health care each day. Unless current trends change or present health care financing arrangements are modified, the national health expenditures are projected to reach approximately \$758 billion in 1990-- or about \$2 billion a day.

Although the growing costs of health care are a national phenomenon, nowhere have the increases been more dramatic than in Nevada. According to comparative national statistics, Nevada leads almost every other state in health care costs. For example, Nevada ranked:

- 5th among the 50 states in expenditures per capita for personal health care in 1982;
- 4th in average cost of a hospital stay in 1982;
- 3rd in average cost per hospital day in 1983;
- 1st in total gross charges per day in 1984; and
- 1st in net patient revenue per day in 1984.

A. RECENT HISTORY OF COST-CONTAINMENT LEGISLATION IN NEVADA

As the costs of health care were escalating in the late 1970's and into the 1980's, it became apparent that legislative action was necessary.

In 1980, Governor Robert List convened the first governor's conference on health care cost containment. In 1982, he formed the governor's committee on health care cost containment which reviewed cost-restraining issues and methods in Nevada. In 1983, a health care cost-containment team was created by Governor Richard H. Bryan to explore cost-containment measures. And, in January 1985, Lieutenant Governor Robert A. Cashell and Senator Randolph J. Townsend conducted major hearings on health care cost containment in Las Vegas and Reno.

As a result of these activities, the Nevada legislature responded to the issues in 1985 by adopting 14 measures relating to health care cost containment. Table No. 1 summarizes the health care cost-containment measures passed in the 1985 legislative session and shows their current status. While it is difficult to assess the impact of this legislation because of the short time that it has been in effect, most administrators of the programs are optimistic about the cost-containing potential of their respective programs.

TABLE NO. 1

1985 HEALTH CARE COST-CONTAINMENT LEGISLATION ENACTED IN NEVADA		
<u>Bill</u>	<u>Summary</u>	<u>Status of Implementation</u>
S.B. 136 (Chapter 454)	Creates the division for review of health resources and costs. Provides for the consolidation of the functions being performed by several divisions and departments into the new division. For example, consolidates statewide efforts for data collection, mandates an annual review of state regulations, provides for expanded coverage of certificate of need (CON) requirements, and raises the minimum threshold for requiring CON review and approval.	Division established July 1, 1985, and currently employs eight professional employees. Major duties include: CON review, data collection and information dissemination. On April 29, 1986, regulations for the implementation of a uniform health care cost information system became effective. In May 1986, a contract with the Center for Survey Research, University of Nevada-Las Vegas, was negotiated to receive and process the raw data from Nevada's community hospitals, and notices of reporting requirements were distributed.
S.B. 286 (Chapter 432)	Requires insurers to include provisions in health insurance policies to encourage the insured to use services and facilities that tend to control or reduce the cost of health care. Requires insurers to adopt and use three or more cost-containment measures in any health insurance policy.	Nevada's commissioner of insurance confirms general compliance with the directives of the bill.
S.B. 320 (Chapter 552)	Requires the department of human resources, under the state plan for the medically indigent, to provide for the reimbursement of services provided by registered nurses in advanced practice if the same services are reimbursed when provided by another health care provider.	Currently, there are few APN's registered with Medicaid for reimbursement under the state program.
S.B. 322 (Chapter 469)	Requires health insurance policies to provide for the reimbursement of services provided by registered nurses in advanced practice if those same services are reimbursed when provided by another health care provider.	Testimony before the subcommittee indicates that a number of APN's who are in practice in Las Vegas, Nevada, are directly billing third party payers.
S.B. 324 (Chapter 300)	Requires hospitals to itemize, on a daily basis, charges for services, equipment, supplies and medicines in terms that a patient can understand. Requires that hospitals prepare a summary of charges for services common to patients who are admitted to their facilities and make it available to the public. Also, requires that physicians furnish information relating to costs likely to be incurred for treatment and that each provider of health care must furnish an itemized bill for services, equipment, supplies and medicines provided.	There is no measure of impact at this time. The Nevada Hospital Association reports that the hospitals are complying but have had few inquiries regarding prices.

TABLE NO. 1 (continued)

<u>Bill</u>	<u>Summary</u>	<u>Status of Implementation</u>
S.B. 460 (Chapter 645)	Requires the legislative commission to conduct a comprehensive interim study on restraining the cost of medical services in Nevada. The bill appropriates \$113,360 from the state general fund to the legislative fund to support this study.	Study concluded. See Legislative Counsel Bureau Bulletin No. 87-6 (this report).
S.C.R. 34 (File No. 120)	Directs the legislative commission to study the operation of the state's program of aid to the medically indigent.	Study concluded. See Legislative Counsel Bureau Bulletin No. 87-20.
A.B. 183 (Chapter 568)	Allows health division to approve and license cost-effective health care alternatives (such as birthing centers).	Regulations are being developed by the state board of health.
A.B. 426 (Chapter 456)	Provides added authority to state welfare division to control Medicaid fraud by granting subpoena power, making illegal falsification of information to qualify for aid to dependent children (ADC), making illegal kickback and rebate systems, and granting authority to terminate provider agreements prior to fraud conviction.	Currently in operation. Medicaid officials feel that provider's knowledge of the extended authority will keep questionable charges to a minimum.
A.B. 533 (Chapter 677)	Creates attendant care program for disabled adults to prevent institutionalization of persons who can live independently with support services (\$250,000 annual appropriation).	Program implemented in October 1985. Administration of program contracted through the Northern Nevada Center for Independent Living in Reno, and Nevada Association for the Handicapped in Las Vegas. Projection of first 6 months' figures show annual savings of \$1,785,384.
A.B. 581 (Chapter 619)	Allows a pharmacist to substitute a less expensive equivalent of a drug ordered by a practitioner unless the practitioner specifically indicates that a substitution may not be made.	Law effective July 1, 1986. Information being collected relative to cost savings, but not yet available.
A.B. 696 (Chapter 620)	Establishes two screening panels to review all medical malpractice claims filed in Nevada to determine whether or not there is a reasonable probability that malpractice may have occurred.	Panels currently operating. As of November 1, 1986, have received 68 complaints, 11 of which went to panel review. Results: 1 sufficient grounds to proceed to litigation, 8 no malpractice, 1 no decision, and 1 currently being decided.
A.C.R. 41 (File No. 103)	Provides for an interim study on certificate of need requirements relative to capital expenditures in the health care field.	Study concluded. See Legislative Counsel Bureau Bulletin No. 87-10.
A.C.R. 93 (File No. 106)	Requires an interim study on medical malpractice insurance and its effect on health care costs.	Study concluded. See Legislative Counsel Bureau Bulletin No. 87-18.

B. CREATION OF COMPREHENSIVE INTERIM STUDY

Enactment of Senate Bill 460 (chapter 645, Statutes of Nevada, 1985) established a comprehensive interim legislative study into:

1. Ways of restraining the costs of health care in Nevada; while
2. Ensuring a high quality of service.

An eight-member legislative subcommittee was appointed to conduct the study. The members were directed to examine a number of items including cost-containment measures relating to education for recipients and providers of health care, hospitals, prevention and wellness programs, and the health insurance industry. To accomplish this mandate, the subcommittee held 13 meetings (18 days) throughout the interim.

The subcommittee received testimony from all segments of the health industry including hospitals, nurses, physicians, relevant executive agencies, scholars, the public, and third party payers.

Robert Pierce, senior staff member of the Health Care Cost Containment Project being conducted by the National Conference of State Legislatures (NCSL), apprised the subcommittee of national trends and activities in other states. The subcommittee also received a special presentation from Stuart Wesbury, Ph.D., president of the American College of Healthcare Executives. Mr. Wesbury explained the results of his organization's major study entitled "Health Care in the 1990's: Trends and Strategies." Additional expert testimony was received from a wide range of people including:

- Kenneth Osgood, M.D., member of New Mexico's Task Force to Study Health Care Cost-Containment;
- David Henninger, director of planning and analysis for the Maryland Department of Health (which administers the state's ratesetting function) and previously staff coordinator for the Maryland Governor's Task Force on Health Care Cost Containment;
- Representative Tom Hanlon, chairman of the Oregon House Human Resources Committee and cochairman of the Oregon Joint Committee on Health Care;
- James Simpson, director of the Legal Resources Program of the Western Consortium for the Health Professions, Inc.;
- Robert Rosen, Ph.D., consultant with the Washington Business Group on Health;

- Stephanie FallCreek, D.S.W., director of the Institute for Gerontological Research and Education at New Mexico State University; and
- Hervey Sweetwood, vice president of Affordable Health Care Concepts, located in California.

Primary staff support for the study was provided by the research division of the Nevada legislative counsel bureau. Legal assistance and bill drafting services were provided through the bureau's legal division.

C. RECOMMENDATIONS DEVELOPED THROUGH THE INTERIM STUDY

Based upon this extensive discussion, over 250 recommendations and concepts were offered for consideration. The subcommittee adopted 51 items which comprise the legislative package. This package of recommendations represents a comprehensive approach to health care cost containment in Nevada. It incorporates long-term and short-range actions, and it combines the elements of the competitive free market with necessary governmental regulation. Taken as a whole, the package of recommendations is designed to restrain the costs of medical care in Nevada while still ensuring a high quality of care.

While no single recommendation purports to be "The Answer" to Nevada's rising costs, it is the judgment of the legislative subcommittee that the overall package of recommendations will be effective in restraining the escalation of health care costs in the state.

The remainder of this report contains descriptions of the history of health care and trends in health care costs, a review of major topics associated with health care cost-containment, and a discussion of each recommendation. The associated drafts of bills are also included with the report.

II. HISTORY OF HEALTH CARE

Health care, as it is known today, has evolved from domestic or lay medicine prior to the mid-nineteenth century to the current high technology delivery system.

A. HEALTH CARE IN THE UNITED STATES

Organized medicine in the United States began in the 1850's with the establishment of large hospitals in the major urban areas. Prior to that time, services were scattered among various providers with little continuity of care. Hospitals were places that provided shelter and care for the sick poor and had little more to offer than the care one could receive at home if it could be afforded.

During the period between 1850 and 1900, medicine began to be professionalized. In the early 1860's, New York City enacted a law creating the Nation's first real municipal board of health. In 1869, Massachusetts created the first state board of health. The National Board of Health was created in 1879. The boards were composed of lay people and politicians. Often their decisions meant unpopular higher taxes for sewer construction and improvements. Consequently, public health really did not improve much during this period.

By 1900, medicine began to be thought of as an exact science rather than an informed "collection of unproven generalities and good intentions." With the establishment of a medical school at Johns Hopkins University in Baltimore, Maryland, medicine began to acquire a strong scientific base.

Between 1900 and 1935, public health agencies gravitated from recordkeeping and monitoring of water supplies, sewers, public markets and shipping to providing preventive health care. Public health officials began to implement neighborhood health centers in urban areas, offering maternal and child health care, examinations, treatment for social diseases and tuberculosis detection. The private medical profession also continued to expand its services in the areas of acute and curative care.

The Depression and World War II brought a period when few hospitals were built in the United States. Many existing facilities became obsolete. There was a shortage of hospital beds, and distribution of the existing beds was not equitable. In order to identify and meet some of these deficiencies, Congress passed the Hill-Burton Act in 1946.

The Hill-Burton Act required states to develop plans for funding hospital construction and public health centers and

established federal/state grants in aid for that purpose. The Hill-Burton Act was responsible for the building of thousands of hospitals nationwide. Many of these new hospitals were in rural areas that were greatly in need of health care facilities.

Along with the proliferation of hospitals came a philosophy biased toward inpatient care, justifying a need for more beds. This philosophy led to a dramatic increase in hospital utilization. Little emphasis was placed on costs of health care. Due to the emergence of health insurance, the consumer felt few financial constraints. Insurers paid whatever the hospitals charged.

In the 1960's and 1970's, federal involvement grew considerably with the creation of Medicare and Medicaid. During this same period, the Federal Government attempted to establish a national health planning policy with the implementation of the Regional Medical Program (RMP) and the Comprehensive Health Planning Act (CHPA). Both of these federal programs, however, maintained the voluntary nature of health planning. While eligibility for public grants was tied to the state or regional planning agencies, health care institutions themselves were not otherwise bound by the planning decisions.

These efforts were followed by passage of the National Health Planning and Resource Development Act of 1974. This act established the certificate of need program for review of capital expenditures. The program included mandatory health planning for all states, and it created a needs review process in order to help contain the rapidly rising costs of medical services.

Other attempts have been made at federal and state levels to gain a measure of control over the escalation of health care costs. These attempts have often been driven by the recognition that government's role in the financing of health care is increasing. Efforts to institute governmentally based control programs, such as the Carter administration's efforts in 1977 and 1979, were defeated. More recent efforts by the Reagan administration have been more successful.

As technology has expanded, however, the complexity and costs of medical services have continued to increase dramatically. Access to the newly developed procedures has also sparked a debate centered upon ethical, as well as economic, questions. The entire realm of medicine, including scientific, economic, social and ethical aspects, has experienced a tremendous expansion in recent years. In short, medicine and its allied fields have assumed positions of major significance in modern America.

B. HEALTH CARE IN NEVADA

The evolution of Nevada's health care system paralleled the national development. Nevada's economy in its early days revolved primarily around mining. There was an abundance of single men and little permanency of residence. People looked after themselves. Government was not expected to provide for their assistance.

The first hospitals in the state were built to serve the population areas. Saint Mary's Hospital in Virginia City, and Washoe County Hospital in Reno, Nevada, were built in 1876 to service the burgeoning population of the mining economy. Other hospitals were built by railroad or mining companies to provide care for their employees (i.e., Ely, Winnemucca, Yerington).

Clark County, Nevada's development was later, but it resembled the earlier growth in the northern portion of the state. By the 1920's, the county ran a poor farm and indigent hospital on the old Stewart Ranch, the site of the present University Medical Center in Las Vegas, Nevada. The county hired one doctor and one nurse to run the hospital. The Stewart Ranch caretaker and cook were kept on to serve the hospital. In the 1940's, the Work Project Administration helped to make improvements to the hospital. It became Clark County General Hospital and started admitting some private pay patients.

With the passage of the Hill-Burton Act in 1946, rural counties in Nevada were able to develop health care facilities within their own communities. However, shifting populations and unavailability of funds have placed the rural facilities under severe financial strains in recent years.

There are currently 28 acute care hospitals in Nevada. The largest concentrations of beds are found in Nevada's two urban centers--Las Vegas and Reno. Nevada is unique in that it has an unusually high percentage of investor-owned hospitals. Approximately, 42 percent of the beds in Nevada are proprietary, 42 percent are governmental, and 16 percent are classified as not-for-profit. These figures compare with national averages of 9 percent proprietary, 21 percent governmental, and 70 percent not-for-profit.

III. TRENDS IN THE COSTS OF HEALTH CARE

The costs of health care have been escalating dramatically in recent years--nationally and in the State of Nevada. Although the methods of data gathering may foster some questions concerning specific measures and rankings, two general points are clear:

1. Medical costs within the Nation and the State of Nevada have been increasing at a substantial rate; and
2. The costs of medical care in Nevada are among the highest in the United States.

A. NATIONAL TRENDS

Expenditures for health care have increased sevenfold nationally since 1965. These costs escalated dramatically from \$248 billion in 1980 to \$355 billion in 1983--an increase of over \$100 billion. Americans currently spend over \$1 billion a day on health care.

Unless basic changes are made within the system, this tremendous growth in national health expenditures is expected to continue in the future. If current trends continue, and if present health care financing arrangements remain basically unchanged, national health expenditures are projected to reach approximately \$758 billion in 1990. They will consume over 12 percent of the gross national product (GNP)--a rate of spending of over \$2 billion a day. National health expenditures are consuming an ever-increasing share of the GNP, rising from 6 percent of the GNP in 1965 to nearly 11 percent in 1984.

While the absolute expenditures for health care have been rising, the rate of increase has been decreasing during the recent past. The annual increase in the Consumer Price Index (CPI) for all medical care items, which averaged 11 percent from 1979 to 1982, dropped to 8.7 percent in 1983 and 6.2 percent in 1984. However, it should be noted that these rates of increase for medical care are still substantially greater than the rates of increase for the general American economy. The overall CPI registered 3.2 percent in 1983 and 4.3 percent in 1984. According to predictions made by Herman Saftlas, a health care analyst for Standard and Poor's Corporation, the increase in consumer health care costs is expected to be lower again in 1986, but it will still be greater than the general rate of inflation.

B. TRENDS IN COSTS OF HEALTH CARE IN NEVADA

According to statistics provided by the state division for review of health resources and costs, total spending on health care in Nevada increased more than 2 1/2 times between 1972 and 1978. Specifically, expenditures on health care have increased from \$213,500,000 in 1972 to \$595,200,000 in 1978 to \$1,209,000,000 in 1982.

Nevada has also exhibited higher per capita personal health expenditures than the national average. As seen in Table No. 2, Nevada ranked fourth among the states in personal health care expenditures per capita in 1982. The per capita expenditures for Nevada were \$1,380 as compared with the United States average of \$1,220.

TABLE NO. 2

PERSONAL HEALTH CARE EXPENDITURES, BY STATE: 1982										
[In millions of dollars, except as indicated. Distribution of expenditures by region, division, and state represents location of provider of service. Per capita figures cannot be interpreted directly as spending per resident, unless substantially all of the services provided in a state are consumed by residents of that state.]										
REGION, DIVISION, AND STATE	Total	Hospital care	Physicians' services	Nursing home care	Per capita expenditures (dol.)	DIVISION AND STATE	Total	Hospital care	Physicians' services	Nursing home care
U.S.	262,906	133,793	61,778	26,466	1,220	S.A.	43,728	20,888	10,040	2,938
Regions:						DE	682	331	151	51
Northeast	65,149	31,851	12,115	7,845	1,321	MO	5,262	2,588	1,117	438
Midwest	73,459	35,834	14,726	8,182	1,247	DC	1,777	1,268	280	35
South	85,618	40,808	19,882	6,579	1,082	VA	5,783	2,777	1,307	484
West	58,579	25,110	14,842	4,113	1,297	WV	2,073	1,107	430	122
N.E.	16,884	8,313	2,897	2,316	1,386	NC	5,802	2,575	1,215	452
ME	1,240	587	214	200	1,091	SC	2,787	1,282	565	247
NH	934	434	185	85	886	GA	5,820	2,781	1,430	444
VT	508	230	75	78	978	FL	12,848	5,952	3,578	686
MA	6,670	4,689	1,337	1,108	1,506	S.E.C.	16,336	7,827	3,291	1,281
RI	1,288	584	242	204	1,381	KY	3,538	1,588	757	383
CT	4,213	1,805	629	643	1,346	TN	5,326	2,680	1,207	358
M.A.	46,398	23,638	9,228	5,328	1,316	AL	4,072	2,132	840	311
NY	24,888	11,822	4,836	3,233	1,417	MS	2,304	1,108	487	230
NJ	8,281	3,888	1,834	718	1,118	W.S.C.	27,888	12,635	6,891	2,382
PA	18,121	8,020	2,758	1,377	1,273	AR	2,282	1,022	505	258
E.N.C.	51,927	26,574	10,573	6,188	1,348	LA	4,847	2,408	1,087	388
OH	13,431	6,467	2,871	1,537	1,247	OK	3,508	1,608	756	357
IN	8,088	2,808	1,188	708	1,101	TX	17,018	7,987	4,309	1,388
IL	14,988	8,027	2,808	1,281	1,308	Mt.	12,910	6,882	3,188	884
MI	11,578	6,725	2,428	978	1,281	MT	834	368	187	74
WI	5,784	2,588	1,288	713	1,218	ID	848	327	208	82
W.N.C.	21,881	10,388	4,184	2,888	1,341	WY	444	208	108	25
MN	5,079	2,238	878	572	1,228	CO	3,714	1,711	808	328
IA	3,418	1,567	687	488	1,178	NE	1,228	613	257	87
MO	6,383	3,383	1,170	688	1,288	AZ	3,217	1,441	878	154
ND	881	418	213	104	1,325	UT	1,407	627	338	100
SD	801	388	152	118	1,184	NV	1,208	562	314	72
NE	1,931	902	431	222	1,218	Pac.	45,888	18,378	11,842	3,218
KS	3,080	1,427	647	388	1,271	WA	4,881	1,888	1,145	588
						OR	3,107	1,250	744	301
						CA	35,828	15,480	8,458	2,258
						AK	527	248	121	11
						HI	1,224	478	378	63

Source: Statistical Abstract of the United States 1984.

Nevada Statistics for 1984

In 1984, Nevadans spent approximately \$1.6 billion for health care, an average of \$1,707 for each of Nevada's 937,317 residents. Health care costs comprised 10.6 percent of the Nevada Gross State Product and accounted for 12.8 percent of the state's total personal income. Table No. 3 shows how Nevada compared with the average for the U.S. in these and related figures in 1984.

TABLE NO. 3

EXPENDITURES FOR HEALTH CARE IN 1984		
	Nevada	United States
Population	937,317	245,189,873
Gross Product	\$15.127 ^b	\$3,662.8 ^b
Health Care:		
Total Costs	\$ 1.6 ^b	\$ 387.4 ^b
Per Capita	\$ 1,707	\$ 1,580
Percent Gross Product for Health Care	10.6%	11.8%
Personal Income:		
Total	\$12.485 ^b	\$3,135.7 ^b
Per Capita	\$13,320	\$12,789
Percent Personal Income for Health	12.8%	12.35%
(b = x 1 billion)		

Source: Division for review of health resources and costs, department of human resources.

By comparison, Nevadans spent \$127 more per capita for health care in 1984 than the average for all U.S. residents. The percentage of personal income allocated to health care was also slightly higher for Nevadans. However, the percentage of gross product allocated to health care in Nevada was lower than the corresponding national average.

Health Expenditures in Nevada by Types of Services

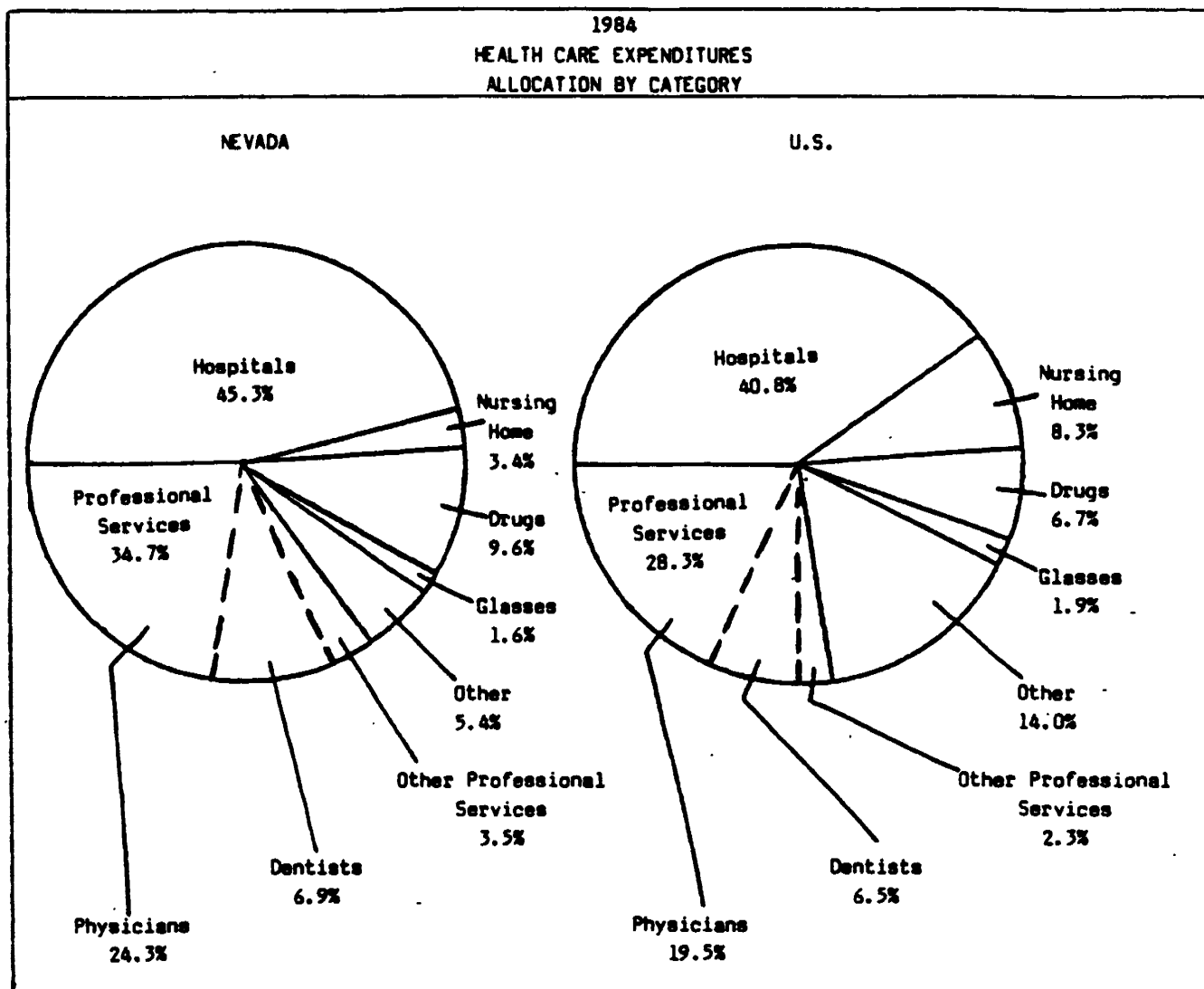
Tables Nos. 4 and 5 depict the percentages and per capita health care expenditures in 1984 by types of services for Nevada and the Nation.

As indicated by these tables, hospitals consumed the largest portion of health care costs. The figure of 45.3 percent for Nevada was substantially higher than the 40.8 percent figure for the Nation as a whole. On a per capita basis, Nevadans paid \$128 more for hospital care than did their counterparts throughout the Nation. Multiplication of the per capita figure by the state's population indicates that approximately \$724.6 million was spent for hospital care in Nevada during 1984.

The health care dollars allocated for professional services include payments to chiropractors, dentists, freestanding home health agencies, nurse practitioners, optometrists, physicians, podiatrists, psychologists, therapists, and other similar professions. Of the health care dollar, a total of 34.7 percent was allocated for professional services in Nevada in 1984, compared to 28.3 percent nationally. A major difference was evident in the category of physician services where Nevada exhibited a percentage of 24.3 as compared to 19.5 percent in the U.S. A total of approximately \$555.8 million was spent in Nevada for professional services and Nevadans paid \$146 more in this category than their counterparts in the remainder of the United States.

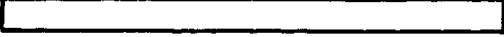
Several categories containing expenditures of lesser magnitude are also described in Tables Nos. 4 and 5. Of special interest are the figures which indicate that Nevada allocated a significantly lower portion (3.4 percent) of its health care dollars to nursing homes than the national average (8.3 percent). However, the state's expenditures for drugs and sundries were above the national figure, and the statistics for glasses and appliances were very near the national average.

TABLE NO. 4



Source: Division for Review of Health Resources and Costs, Nevada Department of Human Resources.

TABLE NO. 5

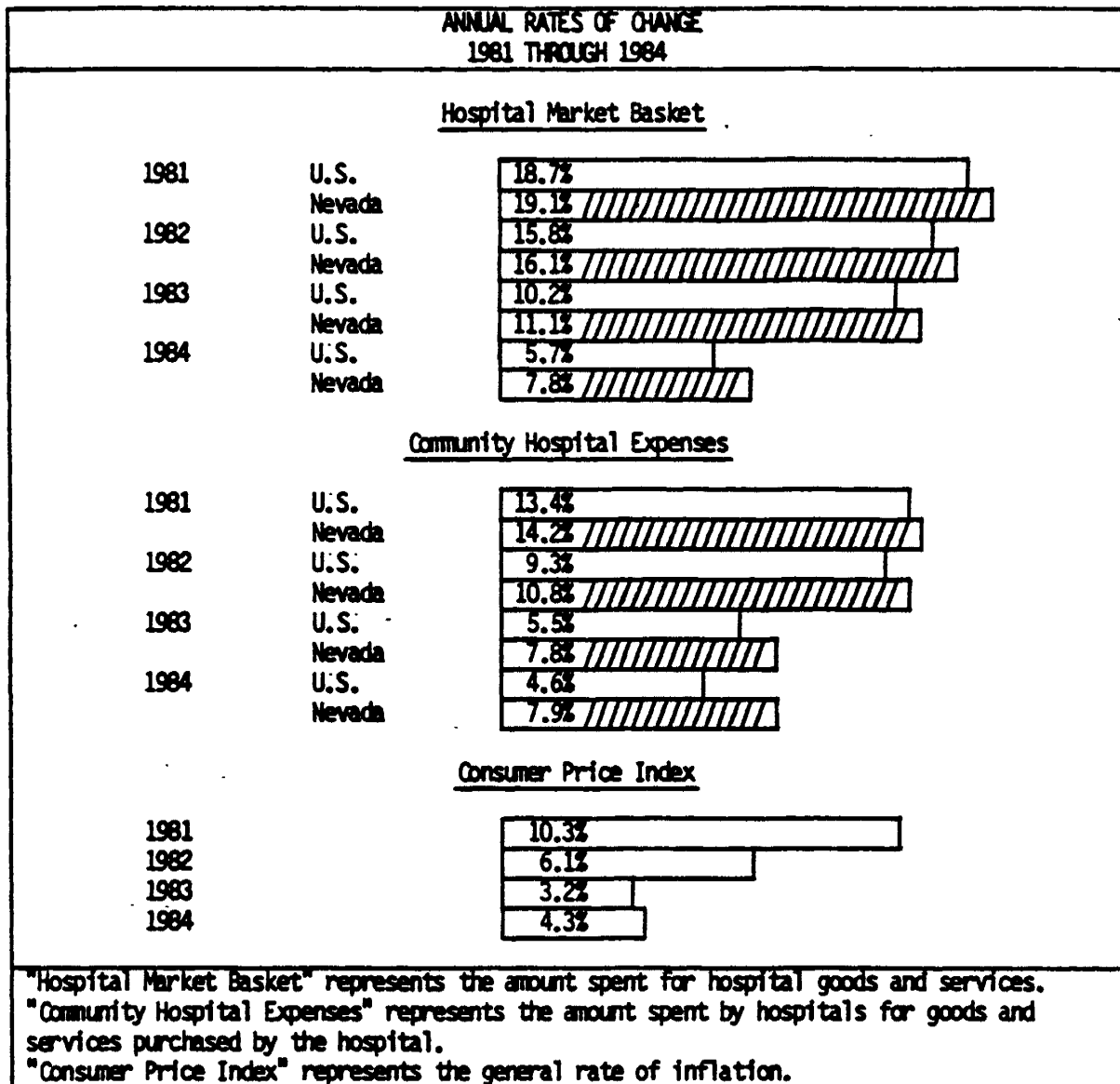
1984 HEALTH CARE EXPENDITURES PER CAPITA ALLOCATIONS				
Category		Percent	Per Capita Costs	
Total (double scale)	Nevada			\$1,707
	U.S.			\$1,580
Hospitals	Nevada	45.3%		\$773
	U.S.	40.8%		\$645
Professional Services	Nevada	34.7%		\$593
	U.S.	28.3%		\$447
Physicians	Nevada	24.3%		\$415
	U.S.	19.5%		\$308
Dentists	Nevada	6.9%		\$118
	U.S.	6.5%		\$103
Others	Nevada	3.5%		\$60
	U.S.	2.3%		\$36
Nursing Homes	Nevada	3.4%		\$58
	U.S.	8.3%		\$131
Drugs and Sundries	Nevada	9.6%		\$164
	U.S.	6.7%		\$106
Glasses and Appliances	Nevada	1.6%		\$27
	U.S.	1.9%		\$30
Other	Nevada	5.4%		\$92
	U.S.	14.0%		\$221

Source: Division for Review of Health Resources and Costs, Nevada Department of Human Resources.

Hospital Statistics for Nevada

Several types of statistics have been compiled in an effort to depict the situation associated with hospital costs in Nevada. Table No. 6 compares Nevada to the national averages for the amount spent on hospital services and the expenses incurred by hospitals. These statistics are based upon the rate of change. They indicate that the rate of increase in cost of hospital services and the rate of increase in hospitals' incurred expenses in Nevada are both greater than the national averages.

TABLE NO. 6



Sources: American Hospital Association (AHA); Division for Review of Health Resources and Costs, Nevada Department of Human Resources; United States Bureau of Labor Statistics; AHA "Hospital Week," (January 3, 1986).

It is, however, notable that the rate of increase in hospital costs has been declining in recent years. The annual percentage increase for hospital expenditures nationally has dropped from 18.7 percent in 1981 to 5.7 percent in 1984. Correspondingly, the rate of increase in Nevada hospital expenditures has decreased from 19.1 percent in 1981 to 7.8 percent in 1984. The Consumer Price Index dropped from 10.3 percent to 4.3 percent during this same period.

Tables Nos. 7, 8, 9 and 10 provide comparative statistics for hospitals nationally and in the region surrounding Nevada. Although ranking in the upper portion of the Nation, Nevada's statistics for average length of stay, beds per 1,000 population, occupancy rate, inpatient days per 1,000 population, admissions per 1,000 population, and surgical operations per 1,000 population do not appear to be inconsistent with the corresponding figures for other states in the region. The state's ranking in the financial statistics, however, is more conspicuous. Nevada's hospitals rank first in the Nation for charges per inpatient day and per admission. They also rank first in revenue generated and profits.

TABLE NO. 7

AVERAGE LENGTH OF STAY, BEDS PER 1,000, AND OCCUPANCY RATES NEVADA AND SELECTED WESTERN STATES						
State	Average Length of Stay		Beds Per		Occupancy	
	Days	Rank	1,000	Rank	Percentage	Rank
NEVADA	6.14	44	3.61	38	58.6%	48
Arizona	6.45	27	3.26	45	64.5%	31
California	6.31	40	3.28	44	64.1%	34
Idaho	6.38	38	3.58	40	59.5%	47
Oregon	5.56	49	3.33	43	60.0%	45
Utah	5.14	50	2.66	49	61.1%	44
Washington	5.67	48	3.05	46	64.2%	33
U.S. Total	7.30		4.34		69.0%	

Source: Division for Review of Health Resources and Costs, Nevada Department of Human Resources. (Statistics for 1984)

TABLE NO. 8

UTILIZATION CHARACTERISTICS PER 1,000 POPULATION NEVADA AND SELECTED WESTERN STATES								
State	Inpatient Days Per 1,000	Rank	Admissions Per 1,000	Rank	Outpatient Visits Per 1,000	Rank	Surgical Operations Per 1,000	Rank
NEVADA	774.9	43	126.2	42	688.4	38	75.1	37
Arizona	770.0	44	119.5	47	618.9	42	73.8	41
California	768.6	45	121.9	45	913.3	18	69.1	47
Idaho	781.7	42	122.5	44	772.4	29	64.9	49
Oregon	731.3	46	131.6	36	785.0	28	81.6	27
Utah	594.6	49	115.7	48	809.2	25	74.0	40
Washington	715.0	47	126.1	43	745.5	32	79.1	33
U.S. Total	1,094.5		150.0		904.1		84.9	

Source: Division for Review of Health Resources and Costs, Nevada Department of Human Resources. (Statistics for 1984)

TABLE NO. 9

PER INPATIENT DAY FINANCIAL INFORMATION NEVADA AND SELECTED WESTERN STATES								
State	Charge	Rank	Revenue	Rank	Expense	Rank	Profits	Rank
NEVADA	\$910	1	\$658	1	\$615	2	\$43	1
Arizona	\$655	4	\$528	4	\$525	4	\$2	22
California	\$801	2	\$600	3	\$603	3	(\$2)	33
Idaho	\$417	39	\$353	33	\$351	33	\$2	24
Oregon	\$591	8	\$488	7	\$481	7	\$7	7
Utah	\$592	7	\$518	5	\$500	5	\$19	2
Washington	\$567	12	\$488	6	\$484	6	\$4	13
U.S. Total	\$520		\$405		\$411		(\$6)	

Source: Division for Review of Health Resources and Costs, Nevada Department of Human Resources. (Statistics for 1984)

TABLE NO. 10

PER ADMISSION FINANCIAL INFORMATION NEVADA AND SELECTED WESTERN STATES								
State	Charge	Rank	Revenue	Rank	Expense	Rank	Profits	Rank
NEVADA	\$5,589	1	\$4,040	1	\$3,777	3	\$263	1
Arizona	\$4,218	9	\$3,401	6	\$3,370	8	\$31	17
California	\$5,049	2	\$3,783	2	\$3,787	2	(\$3)	30
Idaho	\$2,661	47	\$2,252	47	\$2,240	46	\$12	26
Oregon	\$3,285	24	\$2,713	24	\$2,665	28	\$48	11
Utah	\$3,044	35	\$2,663	18	\$2,554	32	\$108	2
Washington	\$3,211	27	\$2,770	21	\$2,734	23	\$36	14
U.S. Total	\$3,799		\$2,956		\$2,995		(\$39)	

Source: Division for Review of Health Resources and Costs, Nevada Department of Human Resources. (Statistics for 1984)

Table No. 11 contains statistics for Nevada hospitals having 100 or more beds. The trend for 1984 through 1985 was generally for declining occupancy rates and declining average lengths of stay. There was no clear trend for numbers of admissions. Although not conclusive, the statistics appear to suggest that the decline in occupancy rates is more attributable to shorter lengths of stay than to a reduction in the number of people being admitted to the hospitals. The data also indicate that the average length of stay in hospitals in the southern portion of the state is higher overall than in the north. However, additional data and analyses would be required to determine the reasons for these characteristics.

TABLE NO. 11

SELECTED HOSPITAL STATISTICS - NEVADA HOSPITALS WITH 100 OR MORE BEDS				
<u>Hospital</u>	<u>Year</u>	<u>Occupancy (Percent)</u>	<u>Number of Admissions</u>	<u>Average Length of Stay (Number of Days)</u>
Northern Nevada				
Carson-Tahoe	1984	48.8%	4,062	3.8
	1985	43.2%	3,757	3.6
Saint Mary's	1984	63.1%	11,389	5.3
	1985	62.3%	11,394	5.2
Sparks Family	1984	35.0%	2,766	4.8
	1985	36.2%	2,628	5.2
Washoe Medical Center	1984	54.8%	14,408	6.0
	1985	53.9%	14,443	5.5
Southern Nevada				
Desert Springs	1984	55.7%	4,835	7.1
	1985	49.4%	4,637	6.5
Southern Nevada Memorial	1984	73.3%	11,159	6.5
	1985	67.7%	11,115	6.3
Humana Sunrise	1984	55.0%	15,171	6.7
	1985	52.5%	15,283	6.4
Valley Medical Center	1984	65.7%	8,007	6.7
	1985	59.4%	7,926	6.3

Source: Division for Review of Health Resources and Costs, Nevada Department of Human Resources.

C. PROJECTIONS FOR THE FUTURE

It is anticipated that the rapid changes which have been experienced in the health care system will continue into the future. Many experts project that the changes will come even more rapidly than has been the case in the past.

Factors Expected To Shape the Future

The authors of the National Conference of State Legislatures' report entitled "Hospital Cost Containment - A Legislator's Guide" discuss the future of the health care system. They contend that three main factors will influence the shape of the health care system for the next 20 years. These factors are:

1. Changing demographics;
2. Medical and technological advances; and
3. Changing purchasing approaches.

The most striking demographic development is expected to be growth in the population of people over 65 years of age. Of special significance will be the increase in the number of people in the category of 75 years and older. This latter group is the leading consumer of health services on a per capita basis and accounts for a large percentage of state Medicaid expenditures.

Medical and technological advances are also expected to play a major role in shaping the medical future. Major advances are expected in the areas of diagnosis, noninvasive therapies, organ transplantation, and prevention during the next 20 years. The increased application of computer technology, lasers, and robotics to the medical field will stimulate much of this activity.

Purchasing practices have been changing rapidly in the most recent past. It is anticipated that this trend will continue and may accelerate. The experts believe that federal and state programs through Medicare and Medicaid will continue to develop cost-containment measures. The trend is clearly toward prospectively determined payment rates. Fee-for-service medicine is expected to decline. The popularity of health maintenance organizations, preferred provider organizations, and primary care networks suggests that pre-paid, capitated systems also will continue to increase over the next 20 years.

Future Trends in the Medical Industry

The authors of the NCSL report outline the following elements as probable developments in the future of the health care industry:

- A significant portion of medical care traditionally delivered in hospitals may be delivered in less intensive settings.
- The number of hospital beds may decline by 25 to 50 percent by the 21st century. Hospitals will close at an unprecedented rate.
- Hospital personnel layoffs may be extensive if the number of hospital beds declines.
- The industry may see greater horizontal and vertical integration as corporations play a larger role in the health care sector.
- Enrollment in prepaid, capitated plans may grow significantly, and enrollees in these plans may be able to choose among participating providers and sites of care around the country.
- Price competition among competing health care plans may continue to increase.
- Competition among physicians for hospital contracts, patients, and jobs in clinics and surgicenters may grow, at least in the near term, as a result of the current physician surplus in many specialties.
- More and more, hospitals may contract with health professionals for their services.

In a major study and report entitled "Health Care in the 1990's: Trends and Strategies" prepared in 1984 by the firm of Arthur Andersen and Company in conjunction with the American College of Health Care Executives, the authors contend that a high level of consensus exists among experts from all sectors of the health care field concerning trends for the future. The authors provide the following general observations concerning the future:

For hospitals, the experts agree that:

1. Multihospital systems will continue to grow and will be positioned best to implement and take advantage of the strategies of choice in the new competitive market.

2. Investor-owned hospitals will substantially increase in numbers and will be more profitable.
3. The amount of money spent nationally on health care services will continue to grow.
4. New types of providers will erode the acute care inpatient hospitals' share of health care expenditures.
5. Emphasis in health care will shift to ambulatory services and new alternative delivery systems.
6. Hospitals may be at a disadvantage in attracting capital financing and many will have to create new corporate structures and business ventures to compete in the capital market.

For physicians, the experts predict that:

1. Prospective payment systems will be extended to include physician payments and this action will result in a drop in their relative income levels.
2. The anticipated oversupply of physicians and the continued trend toward practicing in hospital-based positions and alternative delivery systems will mean a decline in influence. These factors also mean a decline in the fee-for-service payment method.
3. Increased fiscal restraints and greater use of prescribed patient care protocols portend less autonomy for tomorrow's physicians, more frequent conflict with their hospitals and an anticipated decline in the professional satisfaction they will derive from their practice.
4. Hospitals and their medical staffs will collaborate and advocate together on behalf of the patients they serve. This collaboration will lead to the development of new relationships and new organizational designs for working together.

For other providers, such as ambulatory care facilities, extended care facilities, nursing homes, and specialty care institutions, the experts foresee that:

1. Greater utilization and growth of less expensive alternatives to acute inpatient hospital care will occur.

2. More providers, both institutional and individual, will compete in the markets represented by these alternative levels of care.

For the patient, the experts forecast that:

1. The level of patient financial participation will increase and the patient's expectations of the health care system will have to be adjusted.
2. Persons covered under governmental programs can anticipate the greatest changes as the benefits and eligibility standards of these programs undergo the most significant changes.
3. Patients with private coverage will experience restrictions as well, but additional levels of service will be available to those willing to pay for them.

All of the people associated with health care agree upon one general point--change will continue, and at an accelerated rate.

IV. INFORMATION SYSTEMS ASSOCIATED WITH HEALTH CARE COST CONTAINMENT

It is generally accepted that good decisions are based upon good information. Information in the field of health care traditionally has been voluminous but uncoordinated, incomplete, sometimes biased, and often not extremely useful.

A. STATE INFORMATION PROGRAMS

Most states have some type of health data gathering system. The recent trends have been toward developing systems which present information in more useful formats and systems which provide comparative information for broad distribution.

States have taken two main approaches to promote publication of data associated with hospital costs.

1. Requiring that hospitals furnish upon request or post the information; and
2. Requiring that hospitals report data to a state agency which publishes the information.

According to the National Conference of State Legislatures, "What Legislators Need to Know About Health Data/Cost Information Programs," 17 states (including Nevada) have health data programs which include an information dissemination component. They indicate that a typical program includes a planning or advisory body to adopt rules and administer the program, a central data collection function, a capacity to analyze the data, and a mechanism to provide information relative to cost comparisons.

Programs vary widely in scope and size. For example, Florida's Hospital Cost Containment Board publishes consumer pamphlets showing average charges for each hospital for various illnesses and average physician charges for numerous services. The state also plans to publish comparative nursing home charges. In contrast, Nebraska does not have a central collection program but requires individual hospitals to make specified charge information available to the public. Vermont's program covers only 16 hospitals, while California publishes information about almost 600 hospitals and 1,200 long-term care facilities.

Descriptions of Programs for Data Gathering and Dissemination

For the 17 states which have data gathering/dissemination programs, Table No. 12 outlines the relevant statutory references, names of administrative bodies and funding information. Table No. 13 specifies the entities which are required to report information in each state.

State programs may be relatively independent, or they may be made part of a health planning or regulatory function. Some programs are broad in scope, while others have a limited function, and still others are at least partially voluntary.

TABLE NO. 12

STATE PROGRAMS FOR DATA GATHERING AND DISSEMINATION - STATUTORY AND BUDGET INFORMATION							
State	Program/Citation	Administrative Agency	Funding	State	Program/Citation	Administrative Agency	Funding
AZ	Ariz.Rev.Stat. §36-125.05 et seq. (1983)	Dept. of Health Services	General Fund: \$487,700 (FY 1986 - includes the rate review budget)	NE	Nebr.Rev.Stat. §71-2082 et seq. (1985)	Public Health and Welfare Committee	None
CA	Cal. Health & Safety Code §443 et seq. (1984, as amended by AB 2011, 1985)	Office of Statewide Health Planning and Development	Fee on health facilities (hospitals and nursing homes) of up to 0.0385 gross operating costs: \$4.084 (FY 1985)	NV	Nev.Rev.Stat. 438A (1985)	Division of Health Resources and Cost Review	General Fund: \$99,000 (FY 1985) (excludes personnel expenses for 2.5 employees)
CO	Colo.Rev.Stat. §25-28-101 et seq. (1985)	Health Data Commission	General Fund: \$200,000 (FY 1985)	NH	N.H.Rev.Stat.Ann. §126.25 et seq. (1985)	Division of Health Services	General Fund: \$250,000 (FY 1985, est.)
FL	Fla.Stat. §385.902 et seq. (1984) and §400.361 et seq. (1985)	The Hospital Cost Containment Board	Hospital and nursing home assessments: \$250,000 (FY 1985) Copy fees: \$35,000	NC	N.C.Gen.Stat. §131E-210 et seq. (1985)	Medical Database - Department of Insurance	General Fund: \$100,000 (FY 1985); \$135,000 (FY 1986) (Note: providers are to be paid the reasonable cost for providing data)
IL	Ill.Rev.Stat. Ch.III 1/2, §6501 et seq. (1984, amended by SB 103, 1985)	Health Care Cost Containment Council	General Fund: \$2.34 (FY 1985) (Note: \$268,000 is earmarked to pay hospitals for submitting data)	OR	Or.Rev.Stat. §442.025 et seq. (1985)	State Health Planning and Development Agency	General Fund: \$114,175 (FY 1985)
IA	Iowa Code §145.1 et seq. (1983, as amended by SF 113, 1985)	Health Data Commission	No direct appropriation. Three part-time staff from state agencies; two part-time staff from federal health planning money.	SC	S.C.Code Ann. §44-6-170 et seq. (Law.Co-op 1985)	Joint Legislative Health Care Committee	General Fund: \$42,500 (FY 1985); Masticald: \$42,500
MD	Md.Ann.Code Art. Health-General §19-201, et seq. (1971, as amended)	Health Services Cost Review Commission	General Fund: \$110,500; Hospital user fees: \$224,500 (FY 1985, est.)	TX	Tenn.Code Ann. §681-108 et seq. (1985)	Center for Health Statistics	General Fund: \$283,600 (FY 1985)
MT	Mont.Stat. §144.085 et seq.	Health Care Cost Information System	General Fund: \$50,000; Hospital fees: \$250,000 (FY 1985)	VT	Vt.Stat.Ann. Title 18, §1951 et seq. (1983)	Division of Public Health Statistics	General Fund: \$125,950 (FY 1985) hospitals and non-profit hospital service corporations contribute a match (\$67,900 est. from each group in FY 1985)
WV	Wyo.Stat. §35-2-801 et seq. (1985)			WV	Wyo.Stat. §35-2-801 et seq. (1985)	Health and Medical Services	General Fund: \$24,000; Federal Fund: \$68,000 (FY 1985)

Source: National Conference of State Legislatures, "What Legislators Need to Know About Health Data/Cost Information Programs," 1985.

TABLE NO. 13

STATE PROGRAMS FOR DATA GATHERING AND DISSEMINATION - ENTITIES REQUIRED TO REPORT																	
REPORTING ENTITIES	AZ	CA	CO	FL	IL	IA	MD	MN	NE	NV	NH	NC	OR	SC	TN	VT	WY
Hospitals	X	X	.	X	X	.	X	V	X	X	X	X	X	X	X	X	X
Third-Party Payers			.			X						X	.		X		X
Nursing Homes		X	.	X		.				X	X						X
Doctors			.					V			.	.	.				
Others			.		X			V	X	X	.	.	.				
Reporting Entities May Verify Information Before Distribution			X	X	X	X				R		X		V	V		X
Noncompliance Penalties	.	X		X	X		R	.	X	.	X	R					X
Protection of Confidential Information	X	X	X	X	X	X	X	X		X	X	X		X	X	X	X
KEY: X = Mandated by statute . = Enabling legislation R = Rule/regulation V = Voluntary NOTE: Additional information about many of these items is contained in the footnotes accompanying the corresponding chart on pages 14-15 of the referenced source.																	

Source: National Conference of State Legislatures, "What Legislators Need to Know About Health Data/Cost Information Programs," 1986.

Legislatures in Colorado, Illinois, Iowa, New Hampshire, North Carolina, and Vermont established separate health data commissions or created new program units within existing offices to perform health data functions. Arizona, Florida, and Maryland include health data/cost information functions in their hospital budget review or ratesetting programs. California, Nevada, Oregon, Tennessee, and Wyoming incorporate their data programs within health planning programs. In addition to acting as a health data clearinghouse, the Oregon Health Council, for example, is charged with preparing an annual state health plan, identifying health care issues affecting the state, and performing several other functions.

Nebraska and South Carolina have programs with a narrowly defined purpose or limited cost disclosure responsibilities. The South Carolina Medically Indigent Assistance Act focuses on uncompensated care statistics, but it also contains a data collection and dissemination program that encompasses health cost information from all payer sources. On the other hand, Nebraska's program has no central data collection. Instead, it requires hospitals to make available to consumers a list of average charges and lengths of stay for their 20 most common diagnosis-related groups (DRG's).

Minnesota is the only state with a voluntary price disclosure statute, although Oregon's law requests physicians and insurers to report data on a voluntary basis to supplement the hospital data collected. To publish its cost comparison report for Minneapolis-St. Paul hospitals, the Minnesota Department of Health relies on data collected and reported by the Council of Community Hospitals, a private organization

Publication or Dissemination of Data

Most of the state programs compile and publish information for distribution to interested people, sometimes for a nominal fee. Some programs also provide other consumer services, such as a telephone information center or a consumer affairs adviser.

Almost as many types of data comparisons and formats exist as state programs. Published information ranges from statewide average charges for various services or illness categories to specific charges for specific services by individual facilities. Most publications that compare charges for illnesses are based on the most common statewide DRG's treated or procedures performed at hospitals.

Publication formats range from one-page brochures (Florida's "The Patient's Guide to Hospital Charges by Illness Category") to comprehensive books up to 200 pages long

(California's West Bay Area publication). Maryland's guide and an Ohio Blue Cross publication offer numerous consumer tips in addition to comparative data. Iowa's booklets explain average charges, variations among hospitals, differences in illness severity, and other variables readers should consider. Illinois' booklet begins with "how to use this report," which addresses variations in hospital prices.

Following are examples of the different types of information published for consumer use. (More detailed information may be found in Appendix III of the NCSL's "What Legislators Need to Know About Health Data/Cost Information Programs.")

- Average charges per admission for each hospital for various illness categories (Arizona, California, Florida, Iowa, Maryland and Vermont).
- Average length of stay for various illness categories by hospital (Arizona, California, Iowa, Maryland and Vermont).
- Number of cases of various illness categories treated by each hospital (Arizona, California, Iowa, Maryland and Vermont).
- Specific prices for common services for each hospital (Illinois, Iowa and Maryland).
- Average prices for each hospital for illnesses based on payer source (California).
- Utilization rates for each hospital service area - number of admissions and days of hospitalization per 1,000 population (Vermont).
- Average prices for each hospital for illness categories based on a "case severity controlled index" (Minnesota).
- A ranking of hospitals from least expensive to most expensive both by rate review average price and by case severity controlled price index (Minnesota).
- Statewide averages for charges or length of stay per case for various illness categories (Arizona, California, Iowa and Maryland).
- Statewide total number of cases by year for various illnesses (California and Maryland).
- The range of average charges and lengths of stay per case for various illnesses for large and small hospitals (Iowa).

- Average charges for selected physician services by geographic region (Florida).
- Specific financial data by hospital (Florida, Illinois and Vermont).
- Overall price increases from one year to the next for each hospital (Illinois and Vermont).
- Consumer tips about containing costs, patients' rights, and other matters (Maryland and Oregon's private sector publication).
- Comments by providers explaining their services, prices, and unique situations (Minnesota's private sector publication).
- A comparison of average charges for the same procedures done on inpatient and outpatient bases (Ohio's private sector publication).

Areas in Which Information Programs May Not Meet Expectations

Data gathering/dissemination programs have been shown to be effective in several areas, such as providing information for selective contracting by public and private groups, alteration of physicians' practices, and public utilization of services. However, in some instances, the expectations about the ability of the data gathering/dissemination program to affect (on its own) the costs of health care have been overly optimistic.

In addition to pointing out several positive aspects of the program, a review of initial efforts in Iowa outlined the following four areas in which expectations for the program may have been too great:

- Unexpected problems were encountered because of failure to appreciate the complexity and size of the task of collecting uniform data from so many sources and the time required to accomplish it.
- Purchasers do not yet feel confident of their ability to exercise the kind of discretion in the marketplace which they felt would be at their disposal. Without physician cost information, the identification of candidates for selective contracting is difficult.
- The Health Data Commission has not found a way to deal effectively with the issue of "quality of care."

- Existing referral practices reduce consumer participation in selecting hospitals because physicians generally select hospitals for their patients. Unless physicians use comparative data to shop selectively on behalf of their patients, consumers do not benefit greatly from comparative hospital price information.

B. GENERAL RECOMMENDATIONS FOR ESTABLISHING A DATA GATHERING/DISSEMINATION PROGRAM

In its report of March 1985, the National Advisory Committee for State Data Commissions (through the Washington Business Group on Health) reviewed the topic of developing a state data base of health care information. The research was initially limited to creating a system for recording each hospital inpatient episode. The goal was to develop recommendations for creating a data base which would facilitate examination of cost and utilization of medical and health care services.

Following is a summary of the recommendations:

1. Create a state health data commission, or entrust an existing state agency with the data collection duties.
2. Provide the commission or agency with authority to extend data collection to other inpatient and non-hospital settings, i.e., rehabilitation, psychiatric, hospital outpatient, emergency room, ambulatory surgery and urgent centers.
3. Data collection - the commission or agency should:
 - a. Mandate the adoption of a uniform hospital billing system, UB-82, as the data source for all payers.
 - b. Mandate the submission of the UB-82 data by major carriers and/or hospitals to the commission or agency as appropriate.
 - c. Select only necessary standard data elements from the UB-82 to include in the data base.
 - d. Mandate five-digit diagnostic and four-digit procedural codes.*

*Note: The Health Insurance Association of America recommends a five-digit procedural code as well, since outpatient data is coded on a five-digit basis.

- e. Require additional aggregated, hospital-specific financial and utilization information apart from the patient-specific data base, as needed for public policy purposes.
 - f. Establish a system to allow use of unique physician identifiers in multiepisode analysis.
 - g. To the extent possible, include payer identification from the UB-82 for disaggregating information.
4. Reporting requirements and exemptions:
- a. The data base should be updated no less frequently than on a quarterly basis.
 - b. Hospitals and other designated providers should be permitted to review data they submit, and be required to do so within a month after receipt of draft reports.
 - c. Public reports from the data should be no less frequent than semiannual.
 - d. Speciality institutions should be included in the data base as soon as technologically feasible.
5. Focus of state data administration:
- a. Select one identifiable entity, either existing or new.
 - b. Provide interested parties some form of representation, involvement, or consultation role in the development of the data base and provisions for its use.
 - c. Promote full disclosure of nonpatient-specific data.
 - d. Develop guidelines for responsible release of data with clarifying interpretation.
 - e. Within the statutory bounds, place access restrictions to prevent anticompetitive uses of the data.
6. Competitive health benefit plan:
- Examine the feasibility of requiring benefit plan options to be submitted in a uniform format for purposes of encouraging consumers to assess comparability of plan

C. NEVADA'S INFORMATION PROGRAM

As outlined in Tables Nos. 12 and 13, Nevada is one of 17 states which have data programs that are designed to gather and disseminate information.

Data Collection by Nevada's Division for Review of Health Resources and Costs

One of the functions of Nevada's division for review of health resources and costs (established in 1985 through Senate Bill 136, chapter 454, Statutes of Nevada, 1985) is data collection and distribution.

Following its creation, the division began design of the information system for the state. On April 29, 1986, regulations for implementation of the system became effective. A contract has been negotiated with the Center for Survey Research at the University of Nevada-Las Vegas to receive and process the raw data.

Nevada's primary data system will be based upon information taken from the UB-82, the uniform hospital billing form. As recommended for adoption by the National Advisory Committee for State Data Commissions and many others, the UB-82 allows standardized comparisons of hospital information. Table No. 14 depicts the selected UB-82 categories from which Nevada will collect data and compares these categories with corresponding elements in other states' data programs. It is projected that the system, based upon the UB-82, will supplement and eventually replace most of the elements of the state's previous hospital information.

One of the major uses of information from the UB-82 will be "Small Area Analysis." Small Area Analysis is a method of examining the patterns of use and variations in rates of consumption of medical services by the populations residing within specific geographic areas. Different hospital service areas typically exhibit varying patterns of utilization on an aggregate and diagnosis-specific basis. Statistics calculated through Small Area Analysis for each diagnosis in each hospital service area can guide the efforts to reduce the number of inappropriate or unnecessary admissions and major procedures. It has been shown that provision of this information to local physicians and hospitals has been effective in promoting desired changes in practice patterns. Utilization of Small Area Analysis also should reduce the need for case-by-case monitoring of hospital admissions. Testimony before the legislative subcommittee indicated that approximately \$50,000 annually will be required to implement the Small Area Analysis program for the state.

TABLE NO. 14

<u>CATEGORIES OF DATA GATHERED FROM UB-82 FOR NEVADA AND SELECTED OTHER STATES</u>				
Information Category	STATES			
	NV	OR	CA	IA
Patient identification	X			
Birth date	X	X	X	X
Sex	X	X	X	X
Zip code	X	X	X	X
Admission date	X	X	X	X
Discharge date	X	X	X	X
Discharge hour	X			X
Source of admission		X	X	
Type of admission		X	X	
Principal diagnosis	X	X	X	X
Principal procedures	X	X	X	X
Principal pay source	X	X	X	X
Hospital identification	X	X	X	X
Other diagnosis	X		X	X
Other procedures	X		X	X
Total charges	X		X	X
Attending physicians	X			X
Patient disposition	X		X	X

Source: Nevada Division for Review of Health Resources
and Costs, "Healthcost Review," May 30, 1986.

One significant problem with utilization of the UB-82 in Nevada is the fact that the form is based on hospitals' billed charges. A substantial portion of the patients entering Nevada's hospitals are subject to contracted group rates which are less than the usual billed charges. For this reason, although a patient's billed charges are listed on the UB-82, the actual payment to the hospital may be substantially less.

Based upon this fact, many people contend that the statistics derived from the UB-82 are artificially high and do not represent a true picture of hospital charges in Nevada. Other people continue to support utilization of the UB-82 because it is the only widely accepted hospital billing form from which comparative statistics may be derived. It has been suggested that review of data derived from the actual contracts could supplement the UB-82 in providing a more accurate understanding of the hospital costs in Nevada.

University Contract for Information System Study

In order to determine the health care information which would be most useful to their organization, the Northern Nevada Employers' Health Cost Coalition contracted with the University of Nevada bureau of business and economic research and the school of medical sciences. The first phase of the study was designed as a market survey to identify issues which are most relevant to the area. Based upon these issues, it was projected that the most pertinent types of data can be determined.

The legislative subcommittee conducting the present study allocated funds for expansion of the market survey to include rural and southern Nevada. The researchers based this survey upon responses to questionnaires and personal interviews with consumers, employers, insurers, regulators, physicians, and administrators of hospitals and clinics. The health care issues most frequently cited in the survey in order of significance to the respondents were:

1. Competition;
2. Costs of health care;
3. Quality of care;
4. Preventative care programs;
5. Regulations;
6. Uncompensated care and services;
7. Health maintenance organizations, preferred provider organizations, and other insurer innovations;
8. Health care data base;
9. Medical malpractice; and
10. Needs for geriatric care.

The summary of issues proved valuable as the legislators were developing priorities among the recommendations which were submitted for consideration. The conclusions drawn from later phases of the study will be incorporated into the state's overall program of information gathering and dissemination.

V. OVERVIEW OF THE HEALTH INSURANCE INDUSTRY AND THIRD PARTY PAYERS

The insurance industry has exerted a significant influence upon the field of health care since the mid-20th century.

A. HISTORY OF DEVELOPMENT OF HEALTH INSURANCE

The concept of health insurance emerged in the 1920's when a plan for prepayment of hospital expenses was established for schoolteachers in Dallas, Texas, by Blue Cross. Following the success of the Blue Cross plan, several private companies began to offer similar types of health insurance programs as technology and its high cost brought a greater need for financial protection.

During World War II, medical technology progressed at a rapid rate. At the same time, the medical service delivery system was changing. The Veterans Administration and other military programs offered free care for soldiers. With the development of a large peacetime army after World War II, it became necessary to expand military medical benefits for military families. As these soldiers returned to civilian life, they took their expectations for medical protection with them.

During the 1950's, union contract negotiations began to include health care coverage as a benefit, either in place of or in addition to wage increases. Expanding companies began to compete for executive talent using broader health care plans as incentives. Private plans became available to those families or individuals who did not have benefit coverage through their employment.

Prior to World War II, health insurance coverage was not extensive with only 19 percent of the personal health costs being paid by third parties (insurance companies or government). By 1950, this figure rose to 34 percent, and by 1980, it had risen to 69 percent. As outlined in Table No. 15, the percentage of the population subject to some type of insurance coverage also increased steadily.

From 1965 to the present, the entire structure of health care financing and insurance was altered in a short time. As health insurance coverage increased for the consumer, the concept of retrospective payment was reinforced. Consequently, few cost-restraining incentives were considered or implemented by private or governmental entities during the developmental phases of the health insurance industry. In recent years, however, the rapidly escalating costs of health

TABLE NO. 15

TRENDS IN HOSPITAL INSURANCE AND THIRD PARTY REIMBURSEMENT 1940-1990					
	1940	1950	1960	1970	1980
U.S. Population (000 Omitted)	132,165	151,326	179,323	203,302	226,546
Number of Persons with Hospital Insurance Protec- tion in the U.S. - All Insurers - 000 Omitted	11,962	76,639	122,500	158,847	189,000
Percent of Total Population with Hospital Insurance	9%	50%	68%	78%	83%
Percent of Total Per- sonal Health Costs* Paid by Third Parties**	19%	34%	45%	60%	69%
*Personal health expenditures include all outlays for health care excep for administrative costs, additions to reserves and profits for insuri organizations, medical research, construction of medical facilities an government public health activities. **Third parties include insurance and government. All remaining costs a paid directly out-of-pocket by consumers.					
Sources: 1. U.S. Bureau of Census; 2. Source Book of Health Insurance Data, 1984-1985; 3. Mark S. Freeland and Carol Ellen Schnendler, "National Hea Expenditures: Short Term Outlook and Long Term Projection Health Care Financing Review, Winter 1981, pp. 97-138; and 4. Robert M. Gibson and Daniel R. Waldo, "National Health Expenditures, 1980," <u>Health Care</u>.					

care have brought about dramatic changes within health insurance programs as efforts to restrain the costs have been initiated on a broad scale.

B. THIRD PARTY PAYERS

The concept of insurance generally includes the premise that a "third party" actually makes the major payments when services are provided to consumers. While the field is changing so rapidly that categorization is difficult and somewhat arbitrary, third party payers may be described in four general categories. Although the distinctions may sometimes be hazy, these categories are:

1. Governmental programs which generally cover the aged and the poor;
2. "Traditional" insurers such as commercial insurance companies and fraternal benefit societies which usually establish a specific set of benefits and reimburse the provider on a fee-for-service basis, and which allow the consumer to select the provider of his or her choice;
3. Prepaid health services plans which are characterized by programs that provide services to the consumer directly through a specified set of providers (health maintenance organizations) or provide incentives to the consumer to select an approved or participating provider (preferred provider organizations); and
4. Self-insurers who (as an individual employer, group of employers, or group of employees) choose to assume the risk directly and insure themselves, thus becoming the insurer and grantor of benefits.

Governmental Programs

By the mid-1960's, it became apparent that, although over 70 percent of the American population was covered by some form of health care cost protection, certain major segments were not yet covered--the poor and the aged. In 1965, Congress passed legislation, Public Law (P.L.) 89-97, which amended the Social Security Act to establish the Medicare and Medicaid programs. Medicare provided persons age 65 and older with insurance to cover most medical costs. It was financed by the Social Security Trust Fund to which employers and employees were required to contribute. The Medicaid section provided federal matching grants to states in order to make medical services available to welfare recipients and the medically indigent.

For the first time, the Federal Government began to make direct payments to medical providers. At the same time, the federal Office of Economic Opportunity established comprehensive health centers in high poverty, medically underserved areas to help assure a more even geographic distribution of quality health care.

As federal programs became more and more costly, attempts were made to slow down the rapid growth of expenditures. In 1981, the Omnibus Budget Reconciliation Act set limits on total Medicare and Medicaid payments; and, in 1982, the Tax Equity and Fiscal Responsibility Act (TEFRA) set limits on Medicare hospital reimbursements. In addition, TEFRA allowed for the expansion of alternative plans, such as health maintenance organizations (HMO's), for Medicare. In 1983, Congress enacted legislation establishing a prospective reimbursement system based upon diagnostic related groups for which reimbursements are fixed in advance.

The history and development of Nevada's Medicaid program are discussed in chapter VII of this report under the heading of "State Programs for Care of the Needy."

Traditional Insurers

For over five decades, the major portion of health insurance was provided by "traditional" commercial insurance carriers. This type of service was characterized by a fee-for-services method of reimbursement. The types of benefits were specified in advance, and the consumer had great latitude in selection of providers.

Rapid increases in the costs of health care provided an incentive to modify the traditional approaches to health insurance. Even the "traditional" insurers began to evaluate alternative methods of planning and paying for services.

Prepaid Health Services Plans

A variety of new programs for handling health insurance services has been developed in recent years. Often cumulatively categorized as "prepaid health services plans," the most common of these approaches are HMO's and preferred provider organizations (PPO's).

Health maintenance organizations combine the provision of health care services with an insurance function. Basically, an HMO provides comprehensive health care for a set premium paid to the plan. Thus, the plan's revenue or income is fixed regardless of utilization, and the HMO is the risk carrier. The HMO concept was first developed in 1929, when the Ross-Loos Health Plan was started to provide health insurance

coverage for the employees of the Los Angeles, California, Water Department. Other plans followed during the 1930's and 1940's--most notably Kaiser Permanente, Group Health Cooperative of Puget Sound, Group Health Association of Washington and the Health Insurance Plan of Greater New York.

Use of the HMO concept, however, did not really expand until the 1970's. In 1973, Congress passed the Health Maintenance Organization Act. This act required employers to offer local qualified HMO's as an insurance option. The act also provided grants and loans for implementation and initial operating costs. The funding was ended in 1981, but the federal encouragement of HMO's has continued. During the period from 1972 to 1985, HMO's increased from 39 plans serving 3.5 million enrollees to 393 plans serving 18.9 million enrollees. Enrollment exhibited a 25 percent increase in 1985 alone, and the number of HMO's expanded by 29 percent during the same year.

Preferred provider organizations also offer an alternative to traditional health insurance programs. While the structure of the concept is loosely defined, PPO's can be organizations, delivery systems, or arrangements between providers and third party payers. Generally, PPO's are a group of health care providers who contract with a group of consumers to provide agreed upon services on a discounted fee-for-service basis.

The PPO concept is relatively new, having just begun to proliferate in the past 4 years. In 1982, a census conducted by the American Hospital Association showed that there were 33 PPO's in existence nationally. By 1985, a PPO directory published by the American Medical Care and Review Association listed 334 PPO's in 35 states (Nevada was listed as having four). Statistics provided in the directory show hospitals owning 60 PPO's; physicians and hospitals jointly owning 59; physicians owning 31; insurance companies owning 23; third party claims administrators owning 12; HMO's owning 11; and investors owning nine; while the remaining are not specifically categorized.

Preferred provider organizations are the fastest growing health care delivery system in the country. In 1985, PPO's comprised only 1 percent of the health care delivery market. Some experts predict that by 1995 they will command 25 percent of the entire health care market.

Self-Insurance/Third Party Administrators

Many larger employers and employees' groups have chosen to self-insure. Lack of good data and inability to achieve realizable economies in a market which appears to be ideal

for competitive purchasing of health care services have encouraged employers to evaluate this alternative. Self-insurers have personal access to current information about health care costs, utilization and demographics and can respond directly to their own specific needs.

Among the advantages of self-insurance, proponents include:

1. No state insurance premium taxes;
2. Interest savings derived from not having to maintain the same reserves as the regulated insurance industry;
3. No commissions to pay; and
4. The ability to manage health benefits and contract directly for services.

Self-insurers often contract with third party administrators (either insurance carriers or other types of service organizations) for claims processing and/or utilization review. Typical mechanisms include contracts for administrative services only (ASO) and minimum premium plans (MPP's) for stop-loss coverage. Statistics provided by the Health Insurance Association of America show the rapid growth in these types of arrangements. Prior to 1975, ASO's and MPP's were utilized by only 5 percent of the private insurance market. By 1980, that share increased to 25 percent, and by 1984, they were associated with nearly 50 percent of the market. In addition, a Blue Cross and Blue Shield Association study reported that, in 1983, almost 60 percent of the business of the 10 largest commercial carriers came primarily through ASO's, MPP's and similar types of arrangements.

C. NEGOTIATED RATES/CONTRACTING FOR SERVICES

As previously noted, health insurance programs are shifting from structures which use fee-for-service payment plans to alternatives which incorporate prospective reimbursement mechanisms. Third party payers are negotiating special rates and contracting for services.

Negotiated Hospital Rates

Although the third party payers are contracting with a variety of types of providers, negotiated hospital rates are viewed as holding the greatest potential for reducing the escalation in health care costs.

Negotiated contracts may apply to an assortment of hospital payment schedules. Contracts may specify payments on the basis of per diem rates (including or excluding ancillary

services), percentage discounts in overall charges, percentage discounts for specified services, specific payments per service group (as in DRG's), or other related measures. These contracted rates are usually accompanied by aggressive utilization review and other program elements designed to reduce the overall hospital charges.

Contracting of Medical Services in Nevada

Nevada has been a forerunner in hospital contracting by the private sector. According to reports from the hospital and insurance industries, up to 80 percent of the people entering hospitals in Clark County are covered by negotiated per diem rates. Contracting in northern Nevada is characterized more frequently by discounted rates arrangements.

The largest single purchaser of health care in Nevada is the Culinary Workers Union (CWU) in Las Vegas, representing four unions (bartenders, culinary, musicians and stagehands) with contributions from about 30,000 people. In 1982, the CWU entered into a pilot study trust with the Nevada Resort Associations. They collected data and reviewed over 20,000 hospital bills. As a result of this study, the CWU negotiated contracts with hospitals and other providers for specified per diem rates. Their plan also incorporates a strong utilization review component and maintains a goal of providing coverage for a broad spectrum of necessary services.

Other purchasers of care, such as the Health Plan of Nevada (an HMO), use a combination of flat per diem, discounted and capitated rates. These rates are coupled with other cost-containing measures, such as utilization review and incentive programs which have lowered health care costs for the purchaser.

As the trend toward negotiated rates and contracting for services has been established in states like Nevada, it is anticipated that these types of approaches will continue to expand through the entire health insurance field.

D. TRENDS IN EMPLOYEE BENEFITS

As the administrative structures of health insurance programs have changed over the years, the benefit packages have also been modified.

Benefits Through Employee Group Insurance

The spiraling costs of providing medical benefits for employees has caused employers to reanalyze the ramifications of their group health insurance programs in terms of payroll costs. A large number of corporations have begun

collecting data related to utilization, employee motivation, incentive programs, wellness programs and other methods of reducing their costs. Companies have also initiated actions to increase the employees' share of the benefits, modify plans to encourage use of less costly health services and provide incentives for seeking second opinions. As previously discussed, some companies implemented self-funding health insurance programs in order to monitor the costs and utilization more closely.

As a result of this new employer awareness, for the first time, employer contributions for health benefits as a percent of the Gross National Product declined in 1984 (see Table No. 16). In addition, employers paid the same percentage of their payrolls for employee benefits in 1984 as they did in 1983, although the makeup of that payment changed.

According to a United States Chamber of Commerce survey of employee benefits, total benefits amounted to 36.6 percent of payroll in 1984, continuing to level off after years of explosive growth. However, insurance costs rose from 7 percent of payroll costs in 1983 to 7.4 percent in 1984. The survey estimates that 88 percent of employers' overall insurance costs went to health insurance. During this same period, the employees' portion of the health costs rose significantly, according to a U.S. Department of Labor report. While 12 percent of employees with only major medical coverage were required to pay higher deductibles in 1983, 21 percent of the employees in this category paid higher deductibles in 1984.

Mandated Insurance Benefits

In the past 6 years, more than 350 bills have been passed in state legislatures mandating that certain health care services be included in employee health insurance programs. While the benefits have greatly increased, the cost and/or cost-effectiveness of mandated benefits are currently under dispute. Proponents argue that mandated benefits save money in the long run because of the drop in absenteeism and the increase in production, as well as providing greater access to a broader range of providers and services. Opponents claim that mandated benefits increase costs overall and that they eliminate the ability to bargain and develop a targeted benefit package.

There is not enough data to evaluate accurately the impact of mandated benefits at the present time. A number of states and private organizations are, however, currently reviewing the trends in costs associated with mandated benefits and their impact on the overall cost of health care. While it

appears that states will continue to mandate benefits, there is a growing reluctance to do so without a thorough assessment of the related costs.

TABLE NO. 16

ESTIMATES OF EMPLOYER CONTRIBUTIONS FOR EMPLOYEE HEALTH INSURANCE		
Year	Employer Contributions (in millions)	Employer Contributions as a Percent of GNP
1973	\$ 18,311	1.35
1974	21,105	1.43
1975	25,500	1.60
1976	32,025	1.80
1977	38,754	1.95
1978	44,114	1.97
1979	51,293	2.05
1980	59,555	2.18
1981	68,790	2.25
1982	80,328	2.54
1983	89,370	2.63
1984	97,168	2.57
Note: These figures include short-term disability coverage.		

Source: Employee Benefit Research Institute (EBRI) tabulations based on U.S. Department of Commerce, Bureau of Economic Analysis, National Income Accounts, unpublished.

At the national level, Congress recently enacted legislation which mandates extension of group health insurance benefits to former employees and widowed/divorced spouses of members. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which became effective July 1, 1986, requires most employers with more than 20 employees to offer extended

health care coverage to employees and their dependents who might otherwise lose their health care coverage due to:

- Termination of employment or reduction of hours;
- Death of a covered employee;
- Divorce or legal separation;
- Eligibility for Medicare; or
- Loss of dependent status by a child.

Although the employers will still be able to charge the beneficiary up to 102 percent of the cost of the group premium, some analysts are predicting an increase in hidden costs including additional administrative and actuarial costs.

Members of Congress are also designing legislation which would expand the COBRA provisions to require employers to continue paying the employers' share of premiums for up to 4 months after dismissal and to require that employers participate in risk pools for uninsured persons. Although it appears that this approach might have a positive impact upon uncompensated and/or indigent care, the cost-effectiveness is a major question for debate.

E. FUTURE TRENDS IN THE HEALTH INSURANCE INDUSTRY

Although revolutionary changes have been experienced by the health insurance industry in the recent past, experts agree that the future will hold even more rapid transformation. Based upon surveys of experts in the field, Arthur Andersen and Company, in conjunction with the American College of Health Care Executives, included projections of the future in its report entitled "Health Care in the 1990's: Trends and Strategies." The following projections are contained in the chapter concerning payment systems:

- Prospective Payment/DRG's Will Prevail by 1990.
 - The DRG prospective payment system will continue to be utilized by Medicare over the next 5 years.
 - The use of a DRG system by other payers is expected as well.
 - Negotiated payment rates will be the primary method used by HMO's and PPO's through 1995.
 - By 1990 and through 1995, only self-pay patients will be paying full charges.

- Health Maintenance Organizations and PPO's Will Increase Market Share Five-Fold.
 - Health Maintenance Organizations and PPO's will account for approximately 10 percent of all hospital revenues by 1995, five times their 1982 percentage.
 - Blue Cross and commercial insurance will experience a decline to 27 percent of hospital patient revenues by 1995, down from 33 percent in 1982.
 - Although the government's share of total health care expenditures will increase, government payments to hospitals will remain relatively unchanged during the next decade.
 - Revenues paid directly by patients will decline from 12 percent in 1982 to 9 percent by 1995.
- Physicians Will Be Pressured to Control Costs.
 - Hospital management will exert significant pressure on medical staff members to reduce patient length-of-stay and the number of diagnostic tests performed for Medicare patients.
 - There will be a trend toward prescribed diagnostic and treatment standards or protocols in the future.
 - The DRG system will also result in increased consolidation of physicians' practices as they attempt to develop larger referral bases.
 - There will be an increase in the formation of joint ventures between hospitals and physicians.
- Cost Shifting Will Be Attacked.
 - Commercial payers will establish more of their own HMO's and PPO's as vehicles through which to negotiate lower rates and remain competitive.
 - Commercial payers are expected to push actively for state or federally mandated "all-payer" systems under which all insurers pay according to the same methodology but can negotiate their own rates or discounts.
 - Insurers will encourage or require their policyholders to use alternative delivery systems.

The report concludes that the rapid rate of change in payment systems will continue as payers react to the new environment and experiment with various combinations of financial incentives. Patients may see themselves as both winners and losers in the future as a result of these payment system changes.

On the one hand, reducing the rate of increase in health care costs is a primary objective. Conversely, however, there is concern over maintaining quality of care. Patients also may find it more difficult to get the full range of services and conveniences which many have come to expect as physicians and hospitals are forced to trim programs because of financial constraints.

VI. GOVERNMENTAL RATESETTING FOR HOSPITALS

During the past several years, governmental entities have attempted to influence the rates charged for hospital services in various ways. Some approaches to this "ratesetting" have been relatively indirect while others have been direct and comprehensive.

A. THE FEDERAL INFLUENCE ON RATESETTING

Federal activities since the early 1970's have influenced the overall perspective of hospital ratesetting.

The Economic Stabilization Program (1971-1974) was designed to freeze prices and wages on a broad scale, and thus control the aggregate growth nationally of prices, wages, capital investments and revenue. Because hospital revenues are based on reimbursement of costs and not prices charged, the model was difficult to apply to health care. Many hospitals were routinely granted exceptions to the program. Research on the impact of the program revealed ambiguous results. In some respects, hospital spending slowed. However, it could not be determined if this decrease was the result of the controls or of a preexisting trend. Other studies reported stabilized growth in wages, but no decrease in other hospital spending. The program also placed a freeze on physician fees and controls on the aggregate growth of their rates. However, a study revealed that while the growth of physician fees and per capita spending for physician services slowed, the volume of services increased at a rate which offset the decline in the real value of physician fees.

In the late 1970's, the Federal Government attempted to develop programs aimed at establishing prospective reimbursement payment systems for Medicare. Although the expenditures for Medicare were rising dramatically, the original attempts were unsuccessful.

In 1982, Congress adopted the Tax Equity and Fiscal Responsibility Act. Included in the act was an Interim Medicare cost-containment measure which established hospital-specific rates. This action was followed in 1983 by more comprehensive reform. A Medicare payment system based upon prospectively determined reimbursement rates for Diagnosis Related Groups (DRG's) was instituted.

Thus, the federal ratesetting activities were restricted to the Medicare program. The influence of this type of ratesetting, however, has produced ramifications throughout the field of health care.

B. RATESETTING MECHANISMS AT THE STATE LEVEL

Although it is clear that the Federal Government has influenced hospital ratesetting through the Medicare prospective payment system based upon DRG's, the major actions for direct regulation of hospital rates on a broad scale have been undertaken at the state level.

Among states which have hospital ratesetting programs, the procedures are generally characterized by examination of hospitals' budgets and/or rate structures. In most cases, the state's regulatory body makes a determination of the extent to which the budgets and rate structures are reasonable or within some prespecified limitation on allowable increases. A hospital then uses the approved budget or rate structure until a new one is authorized. In some instances, the state regulatory body carries the process one step further by approving specific rates (rather than rate structures) which hospitals are allowed to charge for a particular unit of service.

Examples of State Ratesetting Programs

The State of New York became the first state to initiate direct ratesetting for hospitals in 1970. There are presently 11 states which have ratesetting programs which include mandatory hospital participation. (See Table No. 17 for highlights of the programs.)

Recent Legislative Activity

A review of the information in Table No. 17 indicates that major activities relative to creation or modification of ratesetting programs have occurred in two time periods--1971 through 1973, and 1983 through 1984. Seven of the existing 11 ratesetting programs were created or modified significantly in the years 1971 through 1973. Two programs were established in 1983, and four others were altered significantly in 1983 or 1984.

The trend in 1985 and 1986, however, has been toward disapproval of ratesetting proposals. According to surveys of legislative activity printed in the Federation of American Hospitals' "Review" magazine, proposals to create ratesetting programs were rejected in 13 states during 1985 and two states during 1986. No new ratesetting programs were approved during this most recent 2 years.

TABLE NO. 17

SUMMARY OF STATE RATESETTING PROGRAMS WHICH INCLUDE MANDATORY HOSPITAL COMPLIANCE						
<u>State</u>	<u>Date of Law</u>	<u>Payers Covered</u>	<u>Administrative Body</u>	<u>Performance Indicator</u>	<u>Unit of Payment</u>	<u>Price-Setting Mechanism</u>
Connecticut	1973, 1984	All payers	Commission on Hospitals and Health Care	Budget Cost per case	Per service Per case	Formula
Florida	1976, 1979 1984	All payers	Hospital Cost Containment Board	Budget	N/A	Formula
Maine	1983	All charge-based payers	Health Care Finance Commission	Budget	Per diem	Formula
Maryland	1973	All payers	Health Services Cost Review Commission	Peer group averages Cost per case	Per service Per case	Formula, budget review
Massachusetts	1971, 1976 1982	All payers	Ratesetting Commission	Budget	Per diem	Formula, budget review
New Jersey	1971, 1978	All payers	State Dept. of Health	Costs per case	Per case	Formula
New York	1969, 1978	All payers	State Dept. of Health	Budget/peer group averages	Per diem	Formula
Rhode Island	1971	Medicaid and Blue Cross	State Budget Office and Blue Cross	Budget	Per service	Negotiation
Washington	1973, 1984	All payers	State Hospital Commission	Budget/peer group averages Costs per case	Per service Per case	Budget Measure of hospital efficiency
West Virginia	1983	All payers	Health Care Cost Review Authority	Budget/peer group averages	Per service Per case	Budget review, formula
Wisconsin	1972, 1983	All charge-based payers	Hospital Ratesetting Commission	Budget/peer group averages	Per service	Budget review

Source: National Conference of State Legislatures, "Hospital Cost Containment - A Legislator's Guide," 1985.

A summary of the state activities in 1985 and 1986 relative to ratesetting programs is as follows:

<u>Year/State</u>	<u>Comments</u>
<u>1985</u>	
Alabama	Ratesetting proposal not approved.
Alaska	Ratesetting proposal rejected; broad opposition including the gubernatorial administration.
Arizona	Voters rejected ratesetting proposal at 1984 general election; legislative proposals rejected in 1985.
Hawaii	Ratesetting proposals defeated.
Idaho	Legislation to establish rate review system failed.
Indiana	Mandatory ratesetting proposal not approved, as has been the case with similar legislation introduced each year in recent past.
Kansas	Rate control legislation not approved, as has been the case for similar legislation introduced annually for past 7 years.
Louisiana	Rate control legislation defeated.
Montana	Ratesetting proposal failed.
Nevada	Proposal for standby ratesetting commission not approved; interim study established.
New Mexico	Proposal for rate control defeated; state Health Care Cost and Access Commission studying rate review process.
Pennsylvania	Ratesetting proposal not approved.
Tennessee	Rate control proposal similar to Maryland law introduced, but deferred until 1986 session.
<u>1986</u>	
Illinois	No legislative activity; the Illinois Health Care Cost Containment Report for 1986 did not recommend rate regulation.
Kentucky	Ratesetting program for hospitals whose costs exceed 125 percent of the Consumer Price Index defeated.
Montana	Governor's Advisory Council on Health Care Cost Containment voted not to support mandatory ratesetting at this time.
Tennessee	Legislation deferred from 1985 not acted upon in 1986; other proposal for ratesetting program not brought to a vote.

Source: Federation of American Hospitals' "Review" magazine, September/October 1985 and September/October 1986.

Effectiveness of State Ratesetting Programs

According to the authors of the NCSL's "Hospital Cost Containment - A Legislator's Guide," evidence from a variety of studies of ratesetting programs provides conflicting results concerning their effectiveness. While some studies have shown that the programs have succeeded in restraining costs, other investigations have demonstrated that these results may be short-term and may, in fact, have adverse impacts.

The authors cite several examples of studies which provide somewhat conflicting conclusions. The first analyses of the effects of prospective payments upon hospitals in several states during the mid-1970's reported mixed findings. The Indiana and New York studies indicated success in controlling hospital costs, while studies of other states found little or no success. The early findings of a "National Hospital Rate Setting Study" found that eight rate review programs had successfully slowed the rate of increase in hospital expenditures by 2 percent or more per year. Several studies have concluded, however, that ratesetting programs may achieve their success at the expense of increased admissions, longer lengths of stay, reduced quality of care, and a limited capacity for capital formation. Other studies have indicated that ratesetting is not a "quick-fix solution" to the cost-containment problem. Rather, several years of startup activity and an ongoing effort may be required before cost-savings can be realized.

In combination, these studies highlight the difficulty of accurately assessing the effectiveness of ratesetting programs. The authors of the NCSL report suggest that supporters of rate regulation could argue the following as advantages for these programs:

- They can contain the costs of care by constraining the rise in price;
- They deal with market dysfunction by replacing prior reimbursement policy with a prospective mechanism that provides different incentives;
- They create a more orderly market, in some cases, by controlling cost-shifting and preventing overcharging of certain payers;
- They provide a way to finance the care of the medically indigent; and
- They attempt, through the external control of hospitals, also to control physicians, who act as the suppliers and orderers of patient care.

Conversely, the authors outline the following arguments which can be made against ratesetting programs:

- They are not cost-effective;
- They are intrusive and allow government to control private industry;
- They are too restrictive and prevent hospitals from making sufficient profit to accumulate capital for long-term investments and to assure their viability over extended periods;
- In some states, operating such programs may be impractical due to their complexity and the lack of local expertise readily available to implement and run them;
- They protect the hospital industry by guaranteeing as well as limiting hospital revenue and thereby preserving excess hospital capacity;
- They prohibit market entry of new providers, thereby limiting competition; and
- More effective alternatives exist to control costs.

C. REGULATION OF CAPITAL EXPENDITURES THROUGH CERTIFICATE OF NEED (CON)

Over the past several years, states have attempted to restrain the increases in costs of health care by regulating hospitals' capital expenditures. The Certificate of Need program has been the major vehicle designed to accomplish this purpose.

History of Certificate of Need

Certificate of Need is a capital expenditure review program administered by a state for the purpose of regulating expenditures for health care facilities, new institutional health services, and acquisition of major medical equipment. The concept grew out of the voluntary health planning movement following the passage of the Hill-Burton Act by the Congress of the United States in 1946. Health planners felt that there was a need for some sort of regulation to oversee the expenditure of public money and to set minimum standards of care for health facilities.

New York became the first state to move to compulsory planning and enacted the first CON law in 1964. Similar regulations were subsequently adopted by California, Connecticut,

Maryland and Rhode Island. Laws of this type generally provided that any new capital expenditures above a certain dollar threshold, and substantial changes in services being offered, were subject to review and approval by a designated state agency.

After a number of states enacted CON laws, Congress passed Public Law 93-641, the National Health Planning and Resource Development Act of 1974. Public Law 93-641 created a network of health service areas and health systems agencies (HSA's) to assist in directing allocation of health resources within the states. The HSA's reviewed local health capital and service needs and recommended approval or denial to the state agency that administered the CON program.

State CON programs were established through state legislation in a majority of states after 1974.

Over the past 3 years, Congress has indicated a desire to allow states more autonomy in health planning by prohibiting the imposition of sanctions upon states that are not in compliance with P.L. 93-641. In addition, Congress appears to want to allow states to return to a voluntary, rather than mandatory, participation in the federal legislation. Consequently, since 1983, a number of states have either modified CON laws, raised thresholds and/or exempted certain types of facilities or equipment, or have abolished CON altogether.

The Certificate of Need Program in Nevada

Nevada's CON law (chapter 439A of the Nevada Revised Statutes) was initially established in 1971 when Senate Bill 326 was passed by the legislature and approved by the governor. This measure provided for regulatory approval by a state agency of projects proposing additional beds, capital expenditures, or services by health facilities. The program is currently administered by the department of human resources (DHR). The director of DHR has ultimate authority for approval of any project covered under CON.

In 1977, the legislature amended chapter 439A of NRS to be in compliance with P.L. 93-641. Since that time, the CON statutes have been amended several times, most recently by the 1985 legislature.

As described in the 1985-1989 Nevada State Health Plan, the purpose and function of the Nevada CON program is as follows:

The CON program is intended to implement health planning by:

- (1) Reviewing proposals that would increase health facility bed capacity either by expansion of existing or construction of new facilities;
- (2) Reviewing proposals that would increase existing services or establish new services in health facilities; and
- (3) Reviewing proposals to acquire major medical equipment or initiate capital expenditure projects by health facilities.

The details of the review process are delineated in chapter 439A of the Nevada Administrative Code as follows:

The CON program, by means of its regulatory authority, exercises a degree of control over the growth of health facility bed capacity and services in the State. The principal function of the program is to avoid unnecessary and costly duplication of health facilities, services and equipment. This is accomplished by determining whether proposed projects address goals and meet criteria set forth in the State and/or local health plans. Recommendations of affected health planning agencies are considered in making determinations, in addition to evaluation of the financial aspects of the projects.

The 1985 Nevada legislature adopted Assembly Concurrent Resolution No. 41 (File No. 103, Statutes of Nevada, 1985). This measure established an interim study of the CON process in the state. The subcommittee for the present study met jointly with the legislators assigned to the A.C.R. 41 study to analyze the issues associated with the CON program in Nevada. The legislative counsel bureau's Bulletin No. 87-10 entitled "Study of Statutes Requiring Approval by Department of Human Resources of Certain Medical Projects" provides a more thorough discussion of the CON process nationally and within the State of Nevada.

VII. STATE PROGRAMS FOR CARE OF THE NEEDY

The provision of medical care for the needy has become a significant issue at the state level in recent years. For the purpose of this report, the discussion is divided into Medicaid programs and other forms of "indigent care."

A. MEDICAID

The Medicaid program is designed to ensure that the needy have access to medical care. The recession of the early 1980's and the 1981 reduction in federal matching rates for Medicaid prompted states to look closely at their activities. With Medicaid consuming a greater percentage of the state budgets each year, it became clear that more cost-effective ways of providing health care to the Medicaid population were necessary.

History of the Medicaid Program

The Medicaid concept was adopted by Congress in 1965. Each state that participates in Medicaid must authorize a program under state law and administer it according to federal guidelines. The programs are jointly funded by the federal and state governments on approximately a 50 percent matching basis.

The federal law requires that Medicaid programs cover categorically needy individuals. This group includes all persons receiving cash payment from either the Aid to Families with Dependent Children (AFDC) program or the Supplemental Security Income (SSI) program who meet certain income and assets tests required by the state. Other groups of individuals, such as those eligible for AFDC or SSI who are not receiving cash payments, may be included in the Medicaid program at the option of each state.

The federal law also requires that specified medical services be provided. These services include: inpatient and outpatient hospital care, laboratory, X-ray, skilled nursing facility, physician, and rural clinic services. States may also include certain optional care such as clinic and dental services, intermediate nursing, and optometry.

Prior to 1981, the approaches used by states to contain rising costs of Medicaid programs usually involved freezing eligibility standards, lowering reimbursement rates and/or reducing covered benefits. The Omnibus Budget Reconciliation Act of 1981 added new provisions to existing Medicaid law which allowed states greater flexibility in developing innovative reimbursement systems. By using waivers, states are

now free to pursue a number of alternative health care financing and delivery approaches with the goal of containing costs while continuing to improve access and quality of care. Options include:

- a. The establishment of primary care management systems;
- b. Greater use of health maintenance organizations and similar prepaid arrangements;
- c. Selective contracting with cost-effective providers; and
- d. Use of competitive bidding to choose providers.

Nevada Medicaid

Nevada's Medicaid program was adopted in 1967 after 2 years of intense debate. The state's program is entitled "State Aid to the Medically Indigent (SAMI)." Its original intent was to augment medical care for indigents enrolled in the state's categorical welfare programs.

The program has grown and changed dramatically through the years. Table No. 18 reflects the growth in the major Medicaid element--reimbursement for medical services. Implementation of cost-containment measures is evidenced by reductions in expenditures for fiscal years 1984 and 1985. The total expenditures for Nevada's Medicaid program were \$91,229,699 in fiscal year 1985-1986.

TABLE NO. 18

<u>NEVADA MEDICAID REIMBURSEMENTS FOR MEDICAL SERVICES</u> <u>1968 - 1986</u>		
Note: Reimbursement for medical services to providers is the largest single line item in the Medicaid budget. The figures presented here do not reflect total expenditures.		
<u>Fiscal Year</u>	<u>Medical Payments*</u>	<u>Change from Prior Year</u>
1968	\$ 5,117,412	N/A
1969	6,913,703	0.351
1970	6,892,733	-0.003
1971	7,405,962	0.074
1972	9,333,739	0.260
1973	11,697,835	0.253
1974	12,611,326	0.078
1975	16,267,962	0.290
1976	22,495,706	0.383
1977	19,500,969	-0.133
1978	23,610,553	0.211
1979	31,181,532	0.321
1980	40,392,438	0.295
1981	57,017,186	0.412
1982	65,273,420	0.145
1983	72,167,772	0.106
1984	68,058,727	-0.057
1985	66,229,387	-0.027
1986	74,838,834	0.130

*Excludes purchase of Medicare Part B coverage.

Source: Nevada Medicaid Report HLB0007
(Statistics based on fiscal years.)

TABLE NO. 19

NEVADA MEDICAID SERVICES AND CORRESPONDING EXPENDITURES

<u>PROV NO.</u>	<u>MANDATORY SERVICES</u>	<u>FISCAL YEAR 1985</u>	<u>FISCAL YEAR 1986</u>
11	Inpatient Acute Hospital	\$16,553,039	\$18,751,263
12	Outpatient Hospital	1,190,579	1,737,514
15	Rural Health Clinic	3,475	6,688
18	Skilled Nursing	2,060,605	2,162,288
20	Physician	5,989,433	7,852,527
27	Laboratory and X-ray	322,885	356,134
29	Home Health Agencies	150,895	295,624
31	EPSDT (Child Screening)	171,179	248,886
32	Ambulance	167,848	210,110
35	Transportation	408,725	601,535
*	Family Planning	*	*
	SUBTOTAL	<u>\$27,018,663</u>	<u>\$32,222,559</u>
	<u>OPTIONAL SERVICES</u>		
10	Ambulatory Surgery	\$ 331,253	\$ 658,867
13	Inpatient Mental Hospital	224,792	189,195
14	Outpatient Mental Hospital	421,145	504,568
16	Intermediate Care/Mental Retardation	8,534,990	8,976,177
17	Clinics	96,391	123,349
19	Intermediate Care	21,505,325	22,688,577
21	Podiatrist	18,190	22,227
22	Dental	1,079,887	1,352,818
23	Hearing Aids	9,428	16,662
24	Cert. Registered Nurse Practitioner	18,262	39,187
25	Ocular	161,653	197,077
26	Psychologist	0	2,597
28	Prescription Drugs	3,447,721	4,016,204
30	Home Care	450,219	866,040
33	Prosthetics/Supplies/DME	595,980	731,227
34	Therapy	84,227	71,895
36	Chiropractors	1,341	673
37	Home IV Supplies	29,996	40,744
38	Habilitation	1,756,548	1,406,860
40	Primary Care Case Management	443,376	711,319
	SUBTOTAL	<u>\$39,210,724</u>	<u>\$42,616,263</u>
	Medicare Part B Coverage	\$ 938,408	\$ 1,003,362
	TOTAL	<u>\$67,167,795</u>	<u>\$75,842,195</u>

*Family Planning expenditures are distributed among various providers.

Source: Nevada Medicaid Report WL80R07

In addition, the program has been expanded to include several optional services. Table No. 19 on the previous page lists the expenditures and services offered in fiscal years 1985 and 1986.

Capitated Delivery of Services in Nevada Medicaid Program

In 1983, Nevada developed a joint Medicaid/University of Nevada school of medicine project for delivery of care. Under this project, Medicaid-eligible people are provided incentives to obtain their medical services at clinics administered through the school of medicine. Enrollment in the program is voluntary so physician/patient relationships already established are not necessarily disrupted. To market the program, however, patients are not charged a copayment, and they are allowed unlimited necessary doctor visits and medications. A maximum of 5,000 Medicaid recipients are to be involved in the project at the present time. Table No. 20 reflects the most current enrollment statistics available.

TABLE NO. 20

PRIMARY CARE CASE MANAGEMENT NEVADA MEDICAID/SCHOOL OF MEDICINE PROJECT			
Per Capita Rates			
	1984 Rate	1985 Rate	1986 Rate
ADC Reno	\$27.30	\$26.99	\$29.95
ADC Las Vegas	22.77	25.66	23.61
Aged in Community	29.32	29.43	31.05
Aged in Nursing Homes	55.43	48.58	57.97

E N R O L L M E N T			
RENO			
Sept. 1985	Total Population	Enrollees	Percent Enrolled
ADC	1,113	367	33.0
Aged	962	78	8.1
Sept. 1986			
ADC	1,545	600	38.8
Aged	948	82	8.6

LAS VEGAS			
Sept. 1985	Total Population	Enrollees	Percent Enrolled
ADC	8,505	1,328	15.6
Aged	2,215	169	7.6
Sept. 1986			
ADC	9,695	1,618	16.7
Aged	2,329	264	11.3

RENO/LAS VEGAS COMBINED			
Sept. 1985	Total Population	Enrollees	Percent Enrolled
ADC	9,618	1,695	17.6
Aged	3,177	247	7.8
TOTAL	12,795	1,942	15.2
Sept. 1986			
ADC	11,240	2,218	19.7
Aged	3,277	346	10.6
TOTAL	14,517	2,564	17.7

Source: Nevada Medicaid Report WL00765

This type of program is called a capitated health care delivery system. As discussed in previous sections of the report, it exhibits several attractive features when compared to the traditional, cost-based reimbursement system. First, capitated delivery programs can reverse expensive financial incentives which are built into the fee-for-service system. Capitated programs profit more by using resources efficiently and keeping patients healthy than by delivering large amounts of expensive care, because they receive a set fee regardless of the amount or type of care delivered. Second, by enrolling patients in capitated programs, states can constrain patient misuse of the system. Enrollees cannot "doctor-shop" but must use participating providers. Third, capitated programs guarantee clients a point of access to health care. Finally, and perhaps most importantly, these programs have a history of lower hospital utilization among their enrollees than do fee-for-service systems.

B. INDIGENT CARE

For the purposes of this report, the medically indigent population includes those who are poor but who do not qualify for Medicaid and have either inadequate or no health insurance benefits.

The Medically Indigent Population

It is not clear exactly how large the medically indigent population is statewide or on a national level. The uninsured, however, who encompass many of the recipients of indigent (or uncompensated) care were analyzed in the 1977 National Medical Care Expenditure Survey. The study revealed that 18.4 million people in the United States are continuously uninsured, and another 16.1 million are temporarily uninsured at any given time. In addition, the study found that, among the uninsured:

- Over one-half were under 25 years of age;
- One-third were children aged 18 or younger;
- Almost one-half were from families with incomes above \$15,000;
- Almost three-fifths were white; and
- Over one-half were employed all or part of the year.

This information dispels some of the myths about the uninsured, particularly with respect to employment and poverty. Furthermore, it suggests that medically indigent patients represent a very diverse group.

In 1981, a hospital discharge survey from the National Center for Health Statistics discovered that:

- a. Uncompensated care patients were most likely to be maternity or accident-related;
- b. Problems relating to premature birth were common; and
- c. Patients were likely to have surgery on the day of admission.

Cost of Indigent Care

A national survey conducted by the Intergovernmental Health Policy Project (IHPP) indicated that in 1983, states and counties paid more than \$2.3 billion for indigent care above and beyond the \$16 billion they spent on Medicaid. The IHPP explained that this figure is low because not all county contributions were available and spending on programs for specific diseases or populations was not included. Moreover, counties often allocate money directly to hospitals to help offset the cost of uncompensated care, and this amount was also not reflected in the general figure.

In Nevada, county expenditures for medical indigents are estimated to be over \$22,000,000 in fiscal year 1985-1986 (see Table No. 21). These costs, in light of the budget constraints faced by the counties, have made it necessary for the state to seek alternative funding sources to assist in financing indigent care.

TABLE NO. 21

COUNTY EXPENDITURES FOR MEDICAL INDIGENTS IN NEVADA			
	Actual 1983-1984	Actual 1984-1985	Estimate 1985-1986
Group Care	\$ 255.9	\$ 322.7	\$ 150.6
Conv. Home Care	386.1	1,289.3	2,102.6
Ambulance	55.9	74.6	85.0
Burials	71.6	140.5	149.0
Hosp. In-Patient	3,286.3	6,961.4	7,869.8
Hosp. Out-Patient	3,480.6	1,872.7	1,938.4
Hospital Subsidy	9,838.0	3,004.1	2,609.0
Home Health Care	242.9	598.4	468.3
Mental Health	213.2	795.3	1,006.1
Pharmacy	29.2	27.7	34.0
Prisoner	79.4	79.0	208.6
Other	-	919.9	5,596.3
TOTAL	\$17,939.1	\$16,085.6	\$22,217.7

Source: Nevada Association of Counties.

Alternative Financing Mechanisms

A survey conducted by the Federation of American Hospitals revealed that funding of indigent care was the number one health issue discussed by state legislatures in 1985. A number of financing options have been considered and adopted by the various states. They include direct appropriation of state funds as in Colorado, earmarking highway user tax funds to finance the care of medically indigent accident victims as in Ohio, and placing an assessment on all or some hospitals to develop a revenue poll.

At least five states (Florida, New York, South Carolina, West Virginia and Wisconsin) fund a part of their indigent care through assessments placed upon hospitals. Typically, the assessments are put into a special fund and distributed to hospitals which are providing care for indigents. Table No. 22 describes the programs in the five referenced states.

A concept known as "fair share" assessments has also been considered by several states in recent years. Under this concept, each hospital is expected to provide its "fair share" of care for indigents. An assessment is placed upon hospitals which do not attain this requirement, and the proceeds are used to finance the necessary indigent care at other facilities. A variety of mechanisms for determining "fair share" may be derived. Likewise, the specific situation within a state would indicate the most effective method of fund disbursement.

Legislative Action in Nevada

In 1985, the Nevada legislature adopted an ad valorem tax of 3 cents per \$100 assessed valuation to establish county funds for medical assistance to indigent people. From this total amount, three-tenths of 1 cent per \$100 of assessed property is deposited in a statewide supplemental fund. When an indigent person incurs unpaid hospital costs of \$25,000 or more, and more than 90 percent of the money in the county fund has been spent, the county may apply for relief from the supplemental fund. However, the act contains a "sunset" provision whereby it expires in July 1987, unless the 1987 legislature rescinds the "sunset" clause and thus provides for continuation of the tax.

According to county officials, funds derived from the ad valorem levy have been utilized only when traditional county funding has been depleted. They contend that the program has served as a vital link in the delicate revenue structure which is designed to pay the costs of indigent medical care.

Table No. 23 reflects the amounts of revenue generated by the tax for fiscal year 1985-1986.

TABLE NO. 22

STATE PROGRAMS THAT ASSESS HOSPITALS TO FUND HEALTH CARE FOR THE MEDICALLY INDIGENT

State and Citation	Assessment Mechanism(s)	Estimated Revenue	State Gen. Fund Contribution	Eligible Patients	Estimated Number of Patients	Distribution of Funds	Providers / Covered Services
FLORIDA							
Fla. Stat. §395.101(2) (1984)	Assesses hospitals 1% of annual net operating revenues in first year and 1.5% in subsequent years for Public Medical Assistance Trust Fund. Federal Government matches state contribution at Medicaid matching rate.	\$75 million raised from hospital assessments. \$29 million from federal funds (FY 1985).	\$20 million (FY 1985)	Those newly eligible for medical assistance as a result of the state expanding its Medicaid services to include the medically needy program.	51,000 (FY 1985)	Same as for Medicaid (Note: a defeated 1986 bill, H.B. 1268, would have expanded the use of revenues to include funding for medically indigent persons. The state would have contributed excess revenues in the fund to county-run capitated programs for the medically indigent. Counties would have contributed 40% of the costs.)	Same as for Medicaid.
NEW YORK							
1985 N.Y. Laws, Chap. 807, N.Y. Public Health Law, §2807-a	For 1986 and 1987, maintains add-ons (4.5% statewide average) to the rates of each third party payer except Medicare. The add-ons are used to establish eight regional indigent care pools. In addition, a 4.5% assessment of Medicare revenue is used to form a statewide pool for the years 1986 and 1987. (Note: the assessment on Medicare revenues has been voided by the N.Y. Supreme Court.)	\$480 million (1986) \$485 million (1987)	None	Helps pay for charity patients and bad debts.	Unknown	Distribution based on type of hospital (whether public or not) and relative bad debt and charity care need. Hospitals must have adequate collection procedures. Approximately 0.08% is set aside for hospitals that, after the above distribution, are still considered "financially distressed."	Providers: Hospitals & bad debt and charity care Services: Inpatient & outpatient care.
1985 N.Y. Laws, Chap. 272	Assesses hospitals 1.5% of total inpatient revenues beginning July 1, 1986. (Note: intended to replace revenue collected from Medicare assessments under Chapter 807, which was voided by N.Y. Supreme Court.)	\$159 million (first calendar year).	Same as above.	Same as above.	Same as above.	Same as above.	Same as above.
SOUTH CAROLINA							
Medically Indigent Assistance Act, S.C. Code Ann. §44-6-5 et seq. (1985)	Assesses all general hospitals and counties at a rate determined by specified criteria. Requires the General Assembly to set an annual funding goal and requires hospitals to contribute 50% of the total. Requires eligible persons to pay fees on a sliding-scale formula.	\$3.75 million each from hospitals and counties (1986 - 6 months). \$7.5 million from each group (1987).	\$150,000 (1986 - 6 months)	Persons with income at or below 200% of federal Community Services Administration guidelines who meet other specified criteria.	5,790 (1986 - 6 months) 11,500 (1987)	Creates the South Carolina Medically Indigent Assistance Fund to be administered by the state Health and Human Finance Commission. Funds are distributed to general hospitals as compensation for medically indigent services to eligible persons. Payments are based on prospective payment system.	Providers: General and Services: General acute (inpatient), no, or limited psychiatric
WEST VIRGINIA							
W. Va. Code §16-29c	Assesses an annual fee on hospitals' net patient revenues to raise an amount equal to the state's contribution.	\$3 million (FY 1986)	\$3 million (FY 1986)	Medicaid recipients.	Unknown	Creates an indigent care fund to be used to finance the reinstatement of recent cuts in Medicaid hospital services.	Providers: Hospitals. Services: Same as Medi
WISCONSIN							
1985 Wisconsin Acts 29 (the budget document)	Assesses a fee on hospitals based on a percentage of private pay revenues.	\$1.6 million (1986) \$2 million (1987)	None	Those without the means to afford available insurance, including Medicaid recipients.	Unknown	Majority of dollars to fund final 2 years of Wisconsin Care program for 18 counties with high unemployment rates. Balance to fund two health care studies.	Providers: usually cover health insurance policies. F would encourage enrollment in prepaid program Services: usually cover health insurance policies.

Source: Alternative Funding Sources for Care of the Medically Indigent, National Conference of State Legislatures, July 1986.

TABLE NO. 23

STATISTICS ASSOCIATED WITH THE TAX TO SUPPORT THE MEDICALLY INDIGENT (MEDICAID) IN NEVADA FISCAL YEAR 1985-1986			
<u>County</u>	<u>Revenue Generated By 3-Cent Tax</u>	<u>Funds Available To County</u>	<u>Estimated County Expenditures</u>
Carson City	\$ 124,395	\$ 111,955	\$ 111,955
Churchill	42,234	38,011	0
Clark	2,255,450	2,029,905	2,029,905
Douglas	182,380	164,142	82,071
Elko	108,127	97,315	97,315
Esmeralda	10,965	9,868	0
Eureka	21,871	19,683	0
Humboldt	70,924	63,831	31,915
Lander	20,834	18,751	0
Lincoln	14,527	13,074	13,074
Lyon	63,630	57,267	0
Mineral	21,739	19,565	19,565
Nye	93,206	83,886	83,886
Pershing	24,364	21,928	0
Storey	12,886	11,597	0
Washoe	1,044,588	940,129	940,129
White Pine	<u>23,618</u>	<u>21,256</u>	<u>21,256</u>
Total	\$4,135,738	\$3,722,163	\$3,431,071

Sources: 1985-1986 Red Book (Department of Taxation);
County expenditures reported by county social
service department or county auditor are
estimates at this time.

VIII. WELLNESS PROGRAMS

Reducing the need for acute health care has been identified as one method of controlling health expenditures. Prevention, health promotion, and early intervention programs are all used to achieve this goal, and they have been proven to be effective, long-term cost-containment measures.

The purpose of prevention programs is to keep people from contracting a specific illness or disability. Examples of prevention include vaccinations for early childhood diseases and fluoridation to prevent tooth decay. Health education programs encourage people to take active steps to make and keep them healthy. Examples include smoking cessation classes, physical fitness programs and attention to diet and nutrition. Early intervention programs are designed to detect and treat or cure health problems before they become acute conditions requiring expensive care. Screening for breast cancer and prenatal care are examples of intervention programs. The term "wellness" relates to a combination of all of these approaches.

One approach to discussing the broad topic of wellness is to review the subject matter by age category.

A. PRENATAL AND PEDIATRIC CARE

Prenatal care is cost-effective because it reduces the need for expensive neonatal and long-term nursing care. A major goal of such a program is to identify and prevent high-risk pregnancies by monitoring the baby's growth and the expectant mother's condition. Good prenatal care reduces the number of premature and low birth-weight babies. Because neonatal intensive care for babies with serious problems at birth is one of the most expensive forms of health care, prenatal care has been identified as one of the most effective methods of reducing overall health costs.

For example, Doctor William J. Lloyd, Jr., a Nevada physician, indicated that an average cost per infant requiring admission to a neonatal intensive care unit is \$50,000. About 800 babies require this service in Nevada each year. The doctor estimated that 25 percent of the costs--or about \$10 million per year--could be saved through good prenatal care.

A significant amount of medical costs can also be saved through efficient use of well-child visits to the doctor. The American Academy of Pediatrics developed guidelines for health supervision which recommend 20 periodic doctor visits from birth to age 20. An actuarial study found that even

assuming 100 percent utilization of all services by 100 percent of all eligible children, the cost was minimal--\$2.28 per family per month. Thus, the total costs for providing all child health supervision services from birth to age 20 are about the same as 1 day in the hospital. Another valuable aspect of the well-child visits is the opportunity for the physician to educate the parents about the proper care of the child.

B. PROGRAMS FOR SCHOOL AGE CHILDREN

Fitness programs for school age children have constituted a significant topic in recent years. Lifelong fitness and exercise attitudes often develop at an early age. Likewise, several health risk factors have been shown to arise at an early age and continue through adulthood.

According to pediatrician Patrick J. Colletti, 25 to 40 percent of Nevada's children are inactive and overfat. Ninety percent of these children will be obese by the time they reach adulthood.

Obesity is identified as a cause for concern because overfat individuals have a higher risk for a shorter life. For example, people who are moderately overfat have a 40 percent higher than normal risk of shortened life. More severe obesity results in 70 percent higher than normal death rate. Health care costs are also considerably higher for obese individuals because of increased health problems and risk for disease.

Physiologically, children are particularly susceptible to fat cells. Because it becomes increasingly more difficult to lose and keep weight off as an adult, it is considered important for children to retain their fat cells at a normal level.

Examples of physical fitness and health education programs exist nationally and within Nevada school districts. These programs, however, tend to be expensive because they are labor intensive. While some parents and teachers realize the value of these types of programs, others emphasize the role of schools in basic educational courses. Thus, the problems associated with fitness programs for school age children are economic, perceptual, and programatic within the specific school districts.

C. PROGRAMS FOR ADULTS IN THE WORKPLACE

The most effective location for implementation of adult wellness programs appears to be the workplace. The employer,

as well as the employee, experiences benefits from this cooperative approach.

Employee Programs in General

Because health promotion and wellness programs encourage people to adopt behaviors associated with good health and abandon behaviors associated with increased illness or mortality, the concept has attracted the attention of executives in the private sector who employ great numbers of people. For example, it has been estimated that out of every 1,000 employees, at least 100 will be found with two or more coronary risk factors, such as hypertension, smoking, obesity, or high levels of cholesterol. Moreover, according to testimony from Robert H. Rosen, a consultant with the Washington Business Group on Health, extremely high-risk individuals, representing 1 percent of the work force, can account for up to 50 percent of annual medical care spending on all employees.

Well-managed health promotion programs at the worksite have the potential of reducing employee health insurance costs, by creating a healthier workforce at lower risk of having expensive illnesses. A study conducted by Control Data Corporation (CDC) of Minneapolis, Minnesota, for example, revealed the annual range of costs to employers for specific risk factors to be as follows:

<u>Employee Risk Factor</u>	<u>Annual Cost to Employer</u>
Smoking	\$600 - \$900
Lack of exercise	\$250 - \$500
Overweight	\$100 - \$150
Not a regular user of seat belts	\$ 50 - \$100

In a 1980 report by the U.S. Surgeon General, it was concluded that well over 50 percent of premature deaths in America are related to lifestyle of the individual. In addition, individuals with poor health habits have 86 percent higher absenteeism than those exhibiting healthy lifestyles. Consequently, employers save with healthy employees--in terms of benefits and increased productivity. Employees also benefit from longer, healthier lives.

State Government Employee Programs

Several states have considered the possibility of initiating wellness programs for state government employees. In this type of program, Nevada has the advantages of a comparatively small employment force and a relatively nondispersed geographic pattern of employment.

In order to assess the potential savings associated with a wellness program for Nevada's 9,000+ employees, the legislative subcommittee commissioned a health needs assessment to be undertaken by Control Data Corporation. The study was based on a random sample of 1,316 State of Nevada employees who completed an "Employee Health Survey." The responses were compared to a norm group of 44,000 employees representing 23 national companies. The findings revealed that:

- Over 50 percent of State of Nevada employees have a significant health risk due to poor nutritional habits, lack of seat belt use, lack of exercise and stress.
- A larger number of state employees report being absent from work due to illness in the past year when compared to the norm group.
- State of Nevada employees with fewer health risks are much less likely to report being absent from work due to illness in the past year.
- More state employees report having chronic health problems than the norm group.
- One-fifth of the State of Nevada's employees report chronic anxiety/stress/tension and back pain/problems.
- The personal problem which concerns the most State of Nevada employees is "burnout." Other personal problems of concern to state employees include alcohol/drug dependency, depression and mental health.

The CDC also projected the percentages of employees at risk 5 years in the future based on risk reduction objectives for two levels of effectiveness for health promotion programs. Table No. 24 illustrates these projections.

TABLE NO. 24

PROJECTED PERCENTAGES OF STATE EMPLOYEES AT RISK BASED UPON EFFECTIVENESS OF HEALTH PROMOTION PROGRAMS			
	<u>Today</u>	<u>Five Years in Future</u>	
		<u>Moderate Effectiveness</u>	<u>High Effectiveness</u>
Smoking	30%	20%	15%
Hypertension	7%	5%	3%
Exercise	19%	10%	6%
Seat Belts	57%	42%	20%

Source: Control Data Corporation, "StayWell Impact Model: Report on Excess Costs of Lifestyle Risk Factors - State of Nevada," September 1986.

In addition, the company estimated the annual cost savings which could be achieved by the State of Nevada 10 years in the future. Table No. 25 contains these projections.

TABLE NO. 25

PROJECTED ANNUAL COSTS SAVINGS 10 YEARS IN THE FUTURE - HEALTH PROMOTION PROGRAMS FOR NEVADA STATE EMPLOYEES			
	Moderately Effective Programs	Highly Effective Programs	All Risks Within Category Reduced (Hypothetical)
Smoking	\$1,189,000	\$1,783,000	\$3,566,000
Hypertension	122,000	243,000	424,000
Exercise	377,000	544,000	794,000
Seat Belts	58,000	144,000	221,000

Source: Control Data Corporation, "Consulting Report on Health Status and Health Promotion," September 1986.

It is important to note that the savings depicted in Table No. 25 are per year. Once risk is reduced, the yearly pay-back continues as long as the employee continues employment and retains the healthier lifestyle. Of course, cost savings begin to accrue as individuals change their behaviors. It also should be noted, however, that the projected cost savings should not be totaled across the four risk factors. Employees may have multiple risks; for example, smoking and lack of exercise. The model used by CDC to calculate the projected savings automatically accounts for these overlaps of risks.

D. SENIOR CITIZENS AND GERIATRIC PROGRAMS

Nevada's senior population is growing at the fastest rate in the Nation. Because health care for older citizens comprises such a large portion of overall health expenditures, the status of the health of Nevada's older residents is especially significant.

Stephanie FallCreek, D.S.W., director of the Institute for Gerontological Research and Education at New Mexico State University, is an expert in the area of health promotion and disease prevention for older adults. She dispelled several myths commonly held about seniors and wellness programs. Some of her major points included:

1. It is a fallacy that older people are not interested in making health-promoting changes. This notion has been disproven repeatedly and most recently in a series of

focus groups held by the Public Health Service (PHS). Findings are included in PHS's report titled: "Aging and Health Promotion, an Executive Summary."

2. There is a misconception that even if seniors are interested, older people cannot and will not change. Empirical research has found that older citizens are interested and tend to make changes at perhaps an even more progressive and rapid rate than younger people.
3. A third misconception is that if senior citizens are interested, and if they do change, it will not make any difference because the change is too late in life. As an example, research is producing evidence that seniors who quit smoking will experience the same types of dramatic reduction in health risk that younger people might experience.
4. Another myth is that change in later life is dangerous. In the area of fitness, older people are afraid to undertake programs because the messages they have received are that exercise might be bad for their hearts. The exact opposite appears to be true.

Several states have taken the initiative to promote good health among their seniors. For example, North Carolina sponsors a statewide promotion program for all older adults called LIFE--Living Independently for Elders. The program encompasses nutrition, stress management, health and fitness, and community involvement. Ohio has a program which provides nursing clinics, a medication record card program and group teaching. A geriatric nursing consultant provides lesson plans to public health nurses statewide for group teaching of health issues to people over the age of 55. In addition, several states have developed a coalition approach to geriatric health promotion programs by establishing a task force or identifying an interdepartmental liaison between their agencies for aging services and health services. All of these types of programs for older citizens are predicted to increase in future years.

E. CONCLUDING COMMENTS

Wellness programs encourage people to take responsibility for their health. Healthier people generally require a lesser amount of and less expensive health care. They typically live longer, more productive lives. Although the benefits of wellness programs are sometimes not immediately evident, they are well documented and significant.

IX. SPECIAL ISSUES IN NEVADA - CARE FOR THE ELDERLY AND RURAL HEALTH CARE

The State of Nevada exhibits several somewhat unique characteristics. Included among these traits are a very rapidly increasing elderly population and an extremely sparse distribution of people in the rural portions of the state. The legislative subcommittee determined that these two "Nevada" topics deserve special attention.

A. LONG-TERM/NURSING HOME CARE FOR THE ELDERLY

Although long-term and nursing home care are not exclusively for senior citizens, a great majority of these types of services are directed toward the elderly. These programs include a broad range of health, social and personal care. Typically associated with long-term and nursing home care are services such as skilled nursing care, physical and occupational therapy, bathing, toileting, mobility, meal preparation, homemaker services, and other services necessary to help the elderly live functional lives.

National Population Trends for the Elderly

The population in the over-65 age category has grown rapidly in the United States since 1950. During that period, the aging population doubled in size while the total population grew by only 50 percent. Projections show that the aged population will grow from 25.5 million in 1980, to 35.0 million by 2000, and to 64.6 million by 2030. On an average, a 65-year-old man will live to almost 80 years old, and the average 65-year-old woman will live to almost 84 years of age.

The increase in the "old" old, who are most in need of nursing home services, is projected to grow at a similar rate. Experts project that the 75 to 84 age group will increase from 7.7 million in 1980, to 10.3 million in 1990, and to 12.2 million in 2000. The 85+ age group is expected to grow from 2.2 million in 1980, to 3.5 million in 1990, and 5.1 million in 2000. To illustrate the significance of these figures, the 1977 "National Nursing Home Survey" found that 22 percent of the people 85 years old and older were in nursing homes.

Expenditures for Health Care

The elderly are the major consumers of health care and medical services. In 1985, the aged (over age 65) accounted for 31 percent of health care expenditures nationally. Of that amount, the largest expense--\$54.2 billion--was for hospital care. The second largest expense was nursing home care.

On any given day, there are 1.5 million Americans who occupy beds in the Nation's 15,000 nursing homes. The annual cost for nursing home care is nearly \$30 billion or about one-half of the Medicare and Medicaid budgets.

For many of the elderly, confinement to a nursing home can be a catastrophic expense, since the average yearly cost exceeds \$20,000. A study for the Select Committee on Aging of the U.S. House of Representatives found that 66 percent of the single elderly and 33 percent of the married elderly will be impoverished within 13 weeks of entering a nursing home. Given this fact, many more elderly rely on Medicaid to help finance the cost of their care than is suggested by the fact that one-half of all care is paid for by the patients themselves.

When nursing home residents become eligible for Medicaid, due to a depletion of personal resources and insufficient income, the program requires that all income (with the exception of a small personal allowance) be devoted to paying for their care. The difference between their income and the cost of nursing home care is borne by Medicaid. Since nursing home care is expensive, few elderly have enough resources and income to bear the cost for very long.

Alternative Approaches to Long-Term Care

With the rise in both the cost of health care and increased utilization, Medicaid budgets are stretching to their limit and are greatly impacting overall state budgets. State governments are seeking ways to provide long-term care in a more cost-effective way. States are aggressively experimenting with alternative types of programs, such as home- and community-based services, while encouraging private sector involvement, such as long-term care insurance.

Examples of home- and community-based services include: home health care, monitoring services, homemaker services, nutrition programs, legal/protective services, senior centers, community medical services, community dental services, community mental health, adult day care, and hospice care.

Other alternatives being tried by some states include: targeting resources to those people most in need, encouraging informal family caregivers and providing the appropriate support services, and programs where seniors can volunteer their time to an in-home service or voluntary agency in return for credits which may be used by them or their families if they need respite services.

The prospect of a market for long-term care insurance has improved considerably in the past several years. Until

recently, it was felt that a market did not exist and policies could not be developed to provide adequate coverage at an affordable cost. Recently, insurance companies have taken another look at the expanding elderly population and are now seeing a "new and profitable market." In early 1986, as many as 20 insurance companies either offered or were proposing to offer long-term insurance coverage with an estimated 130,000 policies in effect on January 1, 1986.

Several states, such as West Virginia, have passed legislation requiring insurance carriers based in (or doing business in) the state to offer policies covering long-term care services.

Nevada's Long-Term/Nursing Home Care for the Elderly

While the growing senior population is a national phenomenon, Nevada is experiencing an even greater increase. Nevada leads all of the other states in growth experienced by the senior population between 1970 and 1980. During that period, Nevada's aged increased their numbers by 112 percent, almost four times the national average. Projections predict a growth of another 285 percent from 1980 to 2000. Nevada's explosive senior population growth means a greater demand for health care services for the elderly, particularly in long-term nursing care.

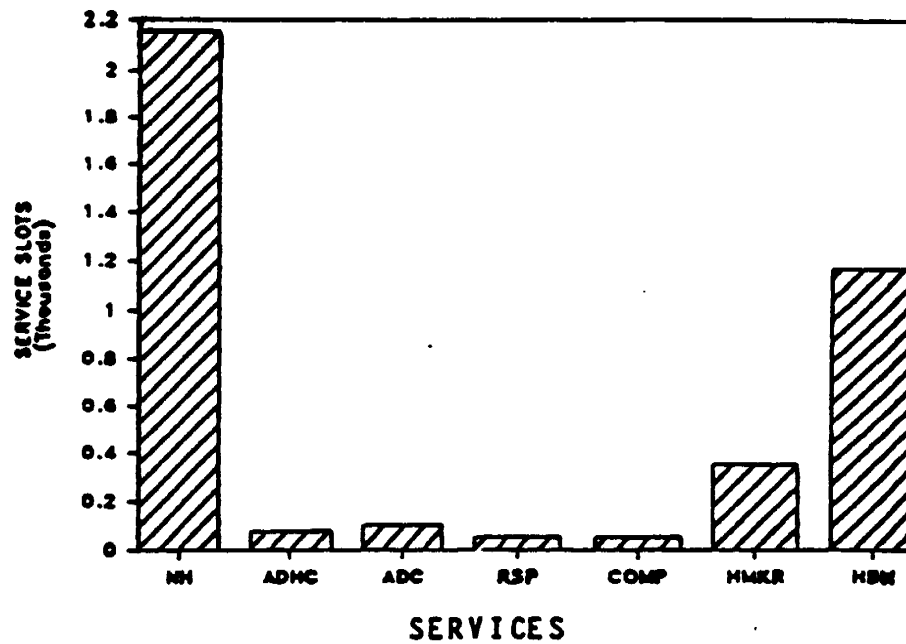
Presently, the existing range of services for long-term care in Nevada is heavily biased towards nursing home care (see Table No. 26). While this type of care is appropriate for those seniors who are the most chronically ill, it is not necessarily appropriate for all who need assistance. Nevada currently has 32 long-term care institutions which provide skilled nursing, intermediate care, and intermediate mental retardation care to 2,784 persons. By the year 2000, the state will require an additional 4,615 beds unless alternatives to institutional settings are developed (see Table No. 27).

In an effort to curb the escalating costs, as well as provide a continuum of care, Governor Bryan developed a broad proposal which was presented to the legislative subcommittee in late 1985. The proposal would provide:

1. A wide range of alternative programs designed to reduce the institutionalization of Nevada's elderly population and improve their quality of life.
2. A statewide case management program to coordinate community- and home-based services to seniors and their families.
3. Increased support programs to family care givers serving the elderly in their own homes.

TABLE NO. 26

**EXISTING HEALTH CARE SERVICES FOR
NEVADA'S SENIOR POPULATION
1985**



NH - Nursing Home
ADHC - Adult Day Health Care
ADC - Adult Day Care
RSP - Respite Care
COMP - Adult Companion
HMKR - Homemaker
HBM - Homebound Meals

Source: "Nevada's Initiatives for Seniors - An Agenda for the Future, Proposed Gubernatorial Program," 1986.

TABLE NO. 27

PROJECTION OF BED NEED FOR LONG-TERM CARE AND ANNUALIZED COST FOR NEVADA 1988 THROUGH 2000							
<u>Year</u>	<u>Total Beds</u>	<u>Cumulative Bed Growth</u>	<u>Bed Growth</u>	<u>Annual Cost</u>	<u>Cumulative Cost</u>	<u>Utilization Rate</u>	<u>Daily Rate +4% CPI</u>
1987	3,078			B A S E	Y E A R	95.00%	68.14
1988	3,273	195	195	4,791,666	4,791,555	95.00%	70.87
1989	3,493	220	415	10,605,554	15,397,220	95.00%	73.70
1990	3,738	245	660	17,541,331	32,938,552	95.00%	76.65
1991	4,013	275	935	25,844,228	58,782,780	95.00%	79.71
1992	4,313	300	1,235	35,501,954	94,284,734	95.00%	82.90
1993	4,643	330	1,565	46,787,838	141,072,572	95.00%	86.22
1994	4,998	355	1,920	59,697,096	200,769,667	95.00%	86.22
1995	5,378	380	2,300	74,372,632	275,142,299	95.00%	93.25
1996	5,788	410	2,710	91,135,576	366,277,875	95.00%	96.98
1997	6,223	435	3,145	109,994,923	476,272,799	95.00%	100.86
1998	6,688	465	3,610	131,308,407	607,581,206	95.00%	104.90
1999	7,178	490	4,100	155,096,689	762,677,895	95.00%	109.09
2000	7,693	515	4,615	181,561,480	944,239,375	95.00%	113.46

Source: "Nevada's Initiatives for Seniors - An Agenda for the Future, Proposed Gubernatorial Program," 1986.

4. A program to train professional, paraprofessional and family care givers in the unique needs of the elderly.
5. Development of a joint federal/state partnership in financing programs for the elderly.
6. Promotion of specialized care units within existing and future long-term care facilities to meet the unique needs of the Alzheimer patient and similar groups.

7. Development of a wide range of residential alternatives offering varying levels of support services, such as supervised apartment living.
8. Public hearings to be held by the commission on aging to refine the broad program.

Table No. 28 describes the components of the alternative programs which are being proposed by the governor for 1988 and 1989.

Response to U.S. Senate's Nursing Home Care Report

A report, entitled "Nursing Home Care: The Unfinished Agenda," was released by the U.S. Senate's Special Committee on Aging on May 21, 1986. The report contained the findings of that committee's 2-year investigation concerning the quality of care in the Nation's nursing homes. Specifically, the conclusions were based on states' compliance with federal standards.

A news article summarizing the study was brought to the attention of the legislative subcommittee because it stated that Nevada's nursing homes ranked last in the Nation in meeting federal standards for patient care, diet and building conditions. The director of the department of human resource was asked by the subcommittee to respond to the report and the ranking.

The director informed the subcommittee that the report contained a major disclaimer which stated that there are different enforcement procedures in each state. This disclaimer was overlooked in the news article. In addition, he said that the Federal Government sets the standards for nursing homes, but each state is expected to prepare regulations, conduct surveys, cite deficiencies and determine when the facilities need to make improvements.

Furthermore, many states consider themselves to be consultants, not enforcers. As consultants, they do not cite deficiencies but simply offer recommendations for improvement. Those recommendations are not listed as cited deficiencies and are never made a part of the federal statistics. Conversely, states with active enforcement programs will have a greater number of cited deficiencies, and thus, they may wrongly appear to have a lower quality of nursing home care.

In Nevada, the department of human resources not only cites deficiencies, it also requires written plans of corrective actions and conducts a followup survey to ensure that the corrections are made. It is contended that a better quality

TABLE NO. 28

COMPONENTS OF GOVERNOR'S PROPOSED ALTERNATIVES TO NURSING HOME CARE			
<u>Program Component</u>	<u>Description</u>		
Residential Alternatives Generally	As a condition for future nursing home approvals, private developers would be required to create noninstitutional residential options offering a range of support services aimed at maintaining maximum independence of seniors.		
Adult Day Health Care	Program of services provided under health leadership in an ambulatory care setting for adults who do not require 24-hour institutional care, yet due to physical, mental or social impairment, are not capable of full-time independent living.		
Adult Day Care	Program designed to meet the needs of functionally impaired seniors through an individual plan of care that provides a variety of health, social and related support services in a protective setting during any part of the day, but less than 24-hour care.		
In-Home Attendant Care	The provision of a personal attendant to assist the physically disabled senior with activities of daily living to maintain independent living.		
Respite Care	Temporary, short-term services in a senior's home or congregate setting to provide relief for the primary caregiver, usually family.		
Homemaker Services	The provision of a personal attendant to assist the physically disabled senior with activities of daily living in order to maintain independent living.		
Adult Companion Services	Program providing companion/supervision services to homebound seniors by low-income senior citizens, thus often providing temporary respite for primary caretaker.		
Homebound Meals	Provision of nutritious noon meal to homebound senior, also enhanced emergency service.		
Family Support Groups	Family caregivers support network facilitated by professional counselors.		
Case Management	Process of planning, arranging, coordinating and monitoring service delivery for functionally impaired seniors to ensure the delivery of appropriate, high quality services in a timely and cost-effective manner.		
Training/University	Enhancement of manpower development programs in geriatrics and gerontology to prepare professionals, paraprofessionals and family caregivers to meet better the needs of the senior population.		
<u>Total Approximate Costs:</u>		Fiscal Year 1987-1988	- \$1,443,941
		Fiscal Year 1988-1989	- \$2,928,354

Source: "Nevada's Initiatives for Seniors - An Agenda for the Future, Proposed Gubernatorial Program," 1986.

of care should be provided because of surveyors who continually monitor the activities of nursing home facilities and cite them for even minor infractions.

Nevada regulations also do not allow nursing home providers to "cut corners" in two critical areas--patient staffing patterns and food. Minimum staffs are established and must be maintained. In contrast, some states pay a set rate per day which allows for-profit nursing home facilities to reduce their staffs in order to increase their overall profit.

Based upon these factors, it was concluded that the varied data on which the Senate's nursing home care report was based could not be adequately or properly compared to produce rankings or comparisons among the states. Moreover, it was concluded that Nevada's stringent enforcement procedure probably indicate that the state's nursing home facilities are among the best in the Nation.

B. RURAL HEALTH CARE IN NEVADA

Rural areas pose a special health problem because of the time and distance factors which reduce the chances of delivering quality health care at a reasonable cost. To ensure that rural issues received suitable discussion and consideration, the subcommittee designated several of their meetings to address only rural concerns. One such meeting brought several speakers--including physicians, rural hospital administrators, public health professionals and educators--together to discuss health and medical problems that are unique to outlying portions of Nevada. The members also held public hearings in Nevada's smaller communities in order to learn of residents' concerns firsthand. The subcommittee also sponsored workshops related to perinatal care and trauma care which are of particular relevance to rural Nevada.

Input from all of these sources enabled the legislators to identify and prioritize the following health care concerns of rural Nevadans.

Background

As Table No. 29 indicates, rural counties comprise 15 percent of the state population yet only have 7 percent of the total hospital beds in Nevada. The facilities in rural Nevada are primarily small hospitals. Only Elko General Hospital has more than 50 beds.

TABLE NO. 29

HOSPITAL BEDS AND POPULATION BY COUNTY: 1985				
County	Hospital Beds	Percent of Total Beds	Population (estimated)	Percent of Total Population
Carson City	116	2.86	35,150	3.58
Churchill	40	0.99	15,147	1.55
Clark	2,156	53.17	567,150	57.84
Douglas	----	----	24,480	2.50
Elko	67	1.65	23,220	2.37
Esmeralda	----	----	1,000	0.10
Eureka	----	----	1,550	0.16
Humboldt	18	0.44	13,660	1.39
Lander	16	0.39	6,550	0.67
Lincoln	7	0.17	4,890	0.50
Lyon	26	0.64	17,320	1.77
Mineral	29	0.71	6,210	0.63
Nye	21	0.51	20,190	2.06
Pershing	24	0.59	4,020	0.41
Storey	----	----	1,890	0.19
Washoe	1,492	36.79	228,030	23.25
White Pine	43	1.06	10,140	1.03
Urban Counties*	3,764	92.82	830,330	84.68
Rural Counties	291	7.18	150,267	15.32
Statewide	4,055	100.00	980,597	100.00
*Carson City, Clark and Washoe.				

Sources: Greater Nevada Health Systems Agency (1985, February).
County Hospital and County Medical Indigency Finances in the
State of Nevada, pp. 8, 9, and Nevada Office of Community
 Services (1984, October). Nevada Statistical Abstract:
1983-1984, p. 26, Carson City, Nevada.

Expenses in county hospitals for 1983 are detailed in Table No. 30. While the three urban hospitals had expenses per patient day very close to the state average of \$643.22, the rural hospitals varied from a low of \$491.77 at William Bee Ririe in Ely, to a high of \$1,918.65 at Nye General Hospital in Tonopah, Nevada. The average expenses per patient day in rural county hospitals are almost \$100 more than in urban county hospitals.

TABLE NO. 30

EXPENSES PER ADMISSION AND PER PATIENT DAY - COUNTY HOSPITALS - 1983					
Rural Hospitals	Admissions	Patient Days	Expenses	Expenses Per Admission	Expenses Per Patient Day
Battle Mountain	284	810	\$ 631,715	\$2,224.34	\$ 779.89
Elko	2,462	9,859	5,323,340	2,162.20	539.94
Grover C. Dils	192	1,141	938,185	4,886.30	822.24
Humboldt	738	2,013	2,596,122	3,517.78	1,289.67
Lyon	651	4,085	2,044,057	3,139.87	500.38
Mt. Grant	243	1,675	1,813,628	7,463.48	1,082.76
Nye	737	2,425	4,652,747	6,313.08	1,918.65
Pershing	273	2,520	1,383,559	5,067.98	549.03
Wm. Bee Ririe	1,081	4,398	2,162,823	2,000.76	491.77
TOTAL	6,661	29,466	\$ 21,545,176	\$3,234.52	\$ 731.18
<u>Urban Hospitals</u>					
Carson-Tahoe	5,742	23,353	\$ 14,821,656	\$2,581.27	\$ 634.67
S. Nevada Memorial	14,875	99,771	61,123,065	4,109.11	612.63
Washoe Medical	19,636	129,258	83,737,918	4,264.50	647.83
TOTAL	40,253	252,382	\$159,682,639	\$3,966.97	\$ 632.70
STATEWIDE	46,914	281,848	\$181,227,815	\$3,682.97	\$ 643.22

Source: Greater Nevada Health Systems Agency (1985, February). County Hospital and County Medical Indigency Finances in the State of Nevada, p. 31.
Carson City, Nevada.

Revenues in rural hospitals, however, lagged behind those in urban hospitals. For example, according to the Greater Nevada Health Systems Agency, during the 7-year period, 1978-1984, revenues increased 139 percent for urban hospitals but only 63 percent for rural facilities. The average annual deficit for rural county hospitals during that period was 14.47 percent of income.

Financial Difficulties

Many of the county or public hospitals/clinics in rural Nevada are suffering from financial difficulties. Expert testimony

revealed that most rural facilities have been unable to meet their expenses for a combination of reasons, including:

1. Low utilization/occupancy of beds;
2. Bad debt;
3. Ineffective billings/collections system;
4. Changes in the reimbursement system;
5. Obsolete equipment;
6. Competition from urban institutions offering a complement of services;
7. High turnover among professionals;
8. Lack of opportunities for continuing education; and
9. Excessive government regulation and paperwork requiring additional staff.

These problems are compounded by the fact that less federal and state funding is available to modernize or repair present facilities. Unless structures can be upgraded, updates in equipment and technology are often impossible. Moreover, until its dissolution in 1980, the Fleischmann Foundation funded the majority of equipment purchases in rural facilities. Since then, improvements have been curtailed dramatically.

Liability Insurance and Perinatal Care

Liability insurance was identified as another area of concern. While the dramatic rise in liability insurance premiums is a national phenomenon, the increases have been more acutely felt by rural physicians. Statistics suggest that there are actually fewer medical malpractice suits filed in rural areas. However, premium rates for rural Nevada are based on the experience of all physicians within California, Nevada and Utah, and these uniquely rural factors are not taken into account.

Obstetrical practice is the most dramatically evident area of concern in the rural portions of the state. The lack of affordable malpractice coverage has resulted in a problem of crisis proportions.

More and more rural physicians have simply discontinued providing obstetrical services. According to the director of the office of rural health at the University of Nevada school of medical sciences, over half of the 41 rural doctors in Nevada who practiced obstetrics in 1984 have now discontinued the service.

Eighteen hundred to 2,000 babies are delivered in rural Nevada each year. It is clear that it is not feasible for all of these expectant mothers to be transferred to an urban center for delivery, nor is it desirable. Therefore, it was necessary to explore avenues which promote quality perinatal care in the rural areas at a reasonable cost.

Trauma Network

Despite Nevada's ranking of eighth in the Nation in the number of traffic deaths per million vehicle miles, the state has no established trauma network. Considerable discussion focused on how a coordinated statewide trauma network would improve stabilization and transportation capabilities in the rural portions of Nevada. For comparison, it was noted that the number of hospital days per year utilized for trauma care is greater than those utilized by all heart patients and four times the number used by all cancer patients. Thus, savings due to efficiency in a trauma network could be substantial in terms of human life and economic factors.

Indigent Care

Finally, the subcommittee members deemed indigent care to be a priority issue with regard to rural health. Because most of the rural facilities were built with federal Hill-Burton funds that were available from 1946 through 1977, the hospitals/clinics have been obligated to provide a certain percentage of free care as repayment for their loans. The counties are also responsible for providing finances to cover the costs of indigent care (see Table No. 31).

In many rural areas, however, the local economic base simply is not great enough to handle this financial burden. County support for the rural facilities ranges from almost 27 percent for Nye General Hospital to less than 1 percent for Grover C. Dils Hospital in Caliente, Nevada, and the Lyon Health Center in Yerington, Nevada.

For a more complete discussion of the general topic of indigent care, see Chapter VII, "State Programs for Care of the Needy."

TABLE NO. 31

COUNTY GOVERNMENT EXPENDITURES FOR COUNTY HOSPITALS						
Hospital	County	Income	County Support 1984			As a Percent of Total Income
			Care for Medically Indigent	Subsidy	Total	
Battle Mountain	Lander	\$ 389,855	\$ 75,000	\$ —	\$ 75,000	19.23
Elko	Elko	5,435,895	104,000	100,000	204,000	3.75
Grover C. Dils	Lincoln	903,891	2,000	—	2,000	.22
Humboldt	Humboldt	2,485,810	65,000	350,000	415,000	16.69
Lyon	Lyon	2,119,203	10,000	—	10,000	.47
Mt. Grant	Mineral	1,733,019	90,000	55,000	145,000	8.36
Nye	Nye	2,488,872	162,000	500,000	662,000	26.59
Pershing	Pershing	1,320,272	23,500	200,000	223,500	16.92
Wm. Bee Ririe	White Pine	<u>2,216,186</u>	<u>26,000</u>	<u>30,000</u>	<u>56,000</u>	<u>2.52</u>
TOTAL		\$19,093,003	\$557,500	\$1,235,000	\$1,792,500	9.38

Source: Greater Nevada Health Systems Agency (1985, February). County Hospital and County Medical Indigency Finances in the State of Nevada, p. 4. Carson City, Nevada.

X. DISCUSSION OF ISSUES AND RECOMMENDATIONS

After reviewing more than 250 proposals, the legislative subcommittee approved a total of 51 recommendations. These recommendations constitute an overall package which, in the judgment of the subcommittee, will be effective in restraining the escalation of health care costs, while still preserving a high quality of care.

Although a summary of the subcommittee's recommendations is included at the beginning of this report, it was determined that a concise discussion of each recommendation would also be valuable. As a package, the recommendations are designed to address the relevant topics in a comprehensive manner. However, each recommendation also focuses upon a discrete issue which merits individual consideration.

A. REGULATORY AUTHORITY

Recommendations under the heading of "Regulatory Authority" may be categorized in the subheadings of data collection/dissemination, providers of health care, certificate of need, and legislative oversight.

Data Collection/Dissemination

Topic:

Public Distribution of Information

Discussion:

The necessity of obtaining credible, comprehensive data relative to health care has been realized by most of the states in the Nation. Efforts to restrain the escalating costs of health care must be based upon a foundation of sound information.

Recent trends have been toward developing systems which present information in more useful formats and systems which provide comparative information for broad distribution. Nevada is one of 17 states which have implemented health data programs that include an information dissemination component.

See Chapter IV entitled "Information Systems Associated with Health Care Cost Containment" for a more thorough discussion of systems for data collection/dissemination and a description of Nevada's activities in this area.

Relative to the following specific recommendations, it should be noted that the States of Arizona, California,

Florida, Iowa, Maryland, and Vermont publish the average charges per admission for each hospital for various illness categories. Specific prices for common services for each hospital are published by the States of Illinois, Iowa and Maryland. At least two states, Florida and Illinois, operate toll-free consumer telephone lines.

Recommendations:

1. Direct the division for review of health resources and costs to compile and distribute to the general public a document (brochure or pamphlet) which lists the hospitals in Nevada and their charges for representative services and procedures. (BDR 40-117)
2. Direct the division for review of health resources and costs to establish a toll-free telephone number to provide consumers with information relative to costs of services at medical facilities within the state. (BDR 40-117)

Topic:

Library Compiled During Study

Discussion:

As part of the subcommittee's study, the legislative counsel bureau's research library compiled a significant amount of information concerning health care cost-containment. This specialty library contains between 500 and 1,000 items including books, periodicals and copies of articles.

The subcommittee determined that the specialty library should be transferred to a permanent location where it could be maintained after completion of the interim study. Locations within the state division for review of health resources and costs, the University of Nevada-Reno school of medical sciences, and the state library were considered. The members decided that \$1,900 from the subcommittee's budget should be given to the University of Nevada-Reno school of medical sciences to assist with transfer and maintenance of the library materials.

Recommendation:

3. Transfer the health care library collection initiated by the legislative counsel bureau to the library of the medical school at the University of Nevada-Reno. Indicate that the library is to keep the collection current, disseminate information about the existence and contents of the collection, and provide information to people who request assistance.

Topic:

Information Concerning Contracts for Provision of Hospital Services

Discussion:

Because a large proportion of the hospital services in Nevada are subject to contracted rates, it is important to know the statistics associated with these agreements. A simple record of usual billed charges creates a false impression of the actual costs to the patient/third party payer who is covered by a contracted rate. Thus, it is virtually impossible to study the costs of health care in the state without being familiar with the contract provisions being utilized.

A more thorough discussion of negotiated rates and contracting for services may be found in Chapter V, "Overview of the Health Insurance Industry and Third Party Payers." A concise explanation of Nevada's current data collection system is contained in the subsection entitled "Nevada's Information Program" within Chapter IV, "Information Systems Associated with Health Care Cost Containment."

Recommendation:

4. Require that hospitals provide to the state copies of all contracts for provision of medical services. Ensure that the names of the contractors will remain confidential.

Providers of Health Care

Several recommendations which apply specifically to regulation of the providers of health care in Nevada were approved by the subcommittee.

Topic:

Negotiated Hospital Rates for All Nevada Residents

Discussion:

Testimony indicated that a very high percentage of the hospital patients in Nevada are members of organizations which have contracted for preferred rates with hospitals in the state. In most cases, these negotiations have resulted in substantial discounts from the hospitals' "billed charges."

See Chapter V entitled "Overview of the Health Insurance Industry and Third Party Payers" for a more complete discussion of this topic.

The subcommittee concluded that implementation of similar types of measures for the general public should have the same effect in restraining the costs of health care. Thus, a method of combining the initiative of the emerging Nevada private market with a necessary degree of governmental regulation was devised. In effect, the privately "negotiated" marketplace is used as a mechanism for establishing hospital rates for Nevada residents who are not members of large organizations. Under the proposed program, the patient benefits from lower hospital rates, while the hospitals benefit by being assured that they will be paid for their services. Necessary "checks-and-balances" are also designed to ensure that the system works equitably.

Recommendation:

5. **Require that Nevada hospitals offer all residents (who are not already covered by third party benefits) a rate which is no higher than the average daily rate that is allowed members of large groups contracting with each hospital. Specific items associated with this recommendation include:**
 - a. **Exempting rural hospitals;**
 - b. **Providing that the special rate must be offered to all Nevada residents who are uninsured and who make arrangements within 90 days for the manner in which their bills will be paid;**
 - c. **Requiring that a patient be offered the special rate or billed charges, whichever is less;**

- d. Establishing the rate for each hospital through an independent audit of each hospital's contracts;
- e. Requiring that hospitals post and publish their special rates;
- f. Providing for a random examination of hospital records to ensure compliance (require that hospitals refund the amount of any errors in its favor with an additional 10 percent penalty);
- g. Providing oversight of the process through the executive branch and a permanent legislative committee on health care; and
- h. Establishing an office of consumer health advocacy to hear complaints, provide information and facilitate resolution of concerns through referral to proper agencies, boards and committees. (BDR 40-117)

Topic:

Governmental Ratesetting

Discussion:

The topic of governmental ratesetting for hospital charges was reviewed in some detail. A majority of the subcommittee determined that the traditional ratesetting approach of creating a government ratesetting body to establish hospital rates within a state would not be the most effective method of cost containment in Nevada. The members concluded that the comprehensive approach achieved through this report's package of recommendations, with special emphasis upon the program providing preferred rates to all Nevada citizens, constitutes a more productive and effective approach.

For additional discussion of governmental ratesetting, see Chapter VI, "Governmental Ratesetting for Hospitals." A minority report advocating establishment of a ratesetting commission is also included as Appendix A of this report.

Recommendation:

- 6. Do not advocate a ratesetting commission for the State of Nevada, but include a minority report describing the activities of ratesetting commissions as an appendix to the final report.

Topic:

Hospital Finances

Discussion:

In reviewing the topic of "quality of care," the subject of hospital finances was addressed by the subcommittee. Of special concern were the competitive disadvantages currently faced by public hospitals, the inability of small facilities to obtain financing for needed improvements, and the financial viability of rural hospitals and clinics. The members determined that the public facilities should not be constrained in ways that place them at a competitive disadvantage. Likewise, the subcommittee basically felt that the rural institutions were important components of the overall health care system for the state.

Additional information concerning the financial difficulties facing rural facilities is contained in Chapter IX, "Special Issues in Nevada - Care for the Elderly and Rural Health Care."

Recommendations:

7. Amend the state statutes to allow county hospitals to engage in health-related enterprise activities. Eliminate statutory constraints on county hospitals generally. (BDR 40-204)
8. Allow hospitals to engage in "pooling" or "semi-blind pooling" of bond issues to obtain needed capital at reasonable interest rates. (BDR 40-205)

Topic:

Ranking Nationally of Nevada's Nursing Homes

Discussion:

As part of its responsibility, the subcommittee reviewed the nursing home industry in Nevada. Quality of care and costs were the subjects of discussion. During the course of the study, a federal report was released which contained a national, state-by-state ranking of the quality of care in nursing homes within each state. Nevada's low ranking in this report provided the incentive for additional investigation of the subject.

Chapter IX entitled "Special Issues in Nevada - Care for the Elderly and Rural Health Care" contains a

discussion of the nursing home industry in Nevada. A significant portion of the chapter is devoted to an explanation of the national ranking of Nevada's nursing homes and a description of the problems associated with the national survey which rated the state's nursing homes unreasonably low.

Recommendation:

9. Include in the final report an explanation of the national ranking of Nevada's nursing homes and a description of methods used in some national surveys which tend to rate the state's nursing homes unreasonably low.

Certificate of Need (CON)

Topic:

The State's Program for Certificate of Need

Discussion:

A discussion of this topic is contained in section C, "Regulation of Capital Expenditures Through Certificate of Need" within Chapter VI, "Governmental Ratesetting for Hospitals."

The subcommittee responsible for conducting this comprehensive study met jointly on two occasions with the members of the subcommittee which was specifically directed to review the state's CON program. For a report of the latter subcommittee's findings, see Legislative Counsel Bureau Bulletin No. 87-10.

Recommendation:

10. Express the subcommittee's support for the following recommendations to the subcommittee to study statutes requiring approval by the department of human resources of certain medical projects--CON (A.C.R. 41, File No. 103, Statutes of Nevada, 1985).
 - a. Retain the present "bed/need methodology" as it is, except as proposed in the "State Health Plan."
 - b. Raise the threshold above which new technological equipment must be approved before it is purchased from \$400,000 to \$1 million.
 - c. Exempt from the CON process replacement of outdated equipment by similar new equipment.

- d. Exempt from the CON process nonmedical capital improvements to an existing facility or institution.

Legislative Oversight

Topic:

Future of Subcommittee

Discussion:

Testimony indicated that permanent legislative oversight of health care issues would be valuable in Nevada. Virtually all of the people who spoke before the members expressed a desire to retain the subcommittee forum for communication and policy debate. It was also evident that legislative oversight would be valuable in monitoring the implementation of recommended programs, such as the "negotiated" hospital rates for all Nevada citizens, as previously discussed.

For additional descriptions of the subcommittee's activities, see the portion of this report entitled "Report of the Legislative Commission to the Members of the 64th Session of the Nevada Legislature." Relevant information is also contained in the section entitled "Creation of Comprehensive Interim Study" within Chapter I, "Introduction - The Issue of Health Care Cost Containment."

Recommendation:

11. Establish, by statute, a permanent legislative committee on health care. (BDR 40-117)

Topic:

Interim Study of Mandatory Coverage in Health Insurance Policies

Discussion:

Mandated health insurance benefits are one aspect of health care costs which appear to warrant additional study. The cost and effectiveness associated with various mandated benefits are currently being debated.

The subcommittee received testimony which supported mandatory inclusion of mental health benefits in all health insurance policies. However, the costs of such a requirement versus the value of the action were not readily identifiable.

An NCSL report entitled "Mandated Mental Health Insurance: A Complex Case of Pros and Cons," Volume 11, No. 10, of State Legislative Report - Human Resources Series, dated July 1986, presents an overview of the topic. According to the report, 12 states require minimum benefits for mental health, 12 states require the availability of such benefits, and two states require coverage for certain services and the availability of coverage for others. The pros and cons of the subject are discussed in the report, as are the types of points which should be included in proposed state legislation.

Within the present report, Chapter V entitled "Overview of the Health Insurance Industry and Third Party Payers" contains a description of the concepts associated with mandated benefits in general.

Recommendation:

12. Establish an interim study of mandatory coverage in health insurance policies of mental health and alcohol and substance abuse. (BDR R-478)

B. PREVENTION/WELLNESS/EDUCATION

There is little question that reducing the need for acute health care is a sound method of controlling health expenditures. A combination of the varied approaches to "wellness" has been proven to be an effective, long-term cost-containment measure. A general discussion of this broad subject may be found in this report in Chapter VIII entitled "Wellness Programs."

Health Education and Physical Fitness in Schools (K-12)

Topic:

Use of Tobacco Products

Discussion:

According to the federal Office of Disease Prevention and Health Promotion, cigarette smoking is the single largest preventable cause of illness and premature deaths in the United States. Testimony from the dental profession also indicates that recent increases in the use of tobacco products for chewing among youth have resulted in correspondingly higher incidences of cancer in the mouth area.

In a survey of some of the school districts in Nevada, it was found that the districts in Carson, Douglas, Mineral and Washoe Counties do not allow smoking on school grounds. The district in Humboldt County provides a special smoking area on campus. In Clark County, smoking is not prohibited. However, each school in that district may make its own policy regarding smoking on campus.

Recommendation:

- 13. Prohibit the use of tobacco products by students in the public schools (K-12) in Nevada.
(BDR 34-73)**

Topic:

Substance Abuse

Discussion:

The United Community Task Force on Confronting Youth Chemical Dependency in Clark County has compiled a series of recommendations concerning substance abuse by adolescents. The recommendations include:

- Promoting a "Senior Sober Week" to remind graduating high school pupils of the dangers of drinking and driving;
- Establishing a chapter of "Students Against Driving While Drunk";
- Making the community aware of the problem of abuse of alcohol and drugs by young people;
- Providing productive and entertaining activities for adolescents as alternatives to the use of addictive substances;
- Using presentations by drug-free adults, such as athletes and entertainers, as positive models for adolescents;
- Providing educators with the necessary resources to educate pupils about the abuse of drugs and alcohol, including the employment by school districts of a full-time specialist on such abuse;
- Establishing a 24-hour telephone hotline for adolescents who abuse alcohol or drugs;

- Providing treatment for these adolescents; and
- Establishing residential group homes for these adolescents that will provide individual and family counseling.

Recommendation:

14. Express support for the recommendations of the United Community Task Force on Confronting Youth Chemical Dependency concerning abuse of substances by adolescents. (BDR R-119)

Topic:

Nursing Services in Schools

Discussion:

Nursing services in the schools play a significant role within the overall prevention/wellness/education program. In addition to providing emergency care, the nurses contribute to the wellness aspects of health care through early detection of problems, basic prevention activities and general education relative to good health.

Recommendations:

15. Include in the final report a statement encouraging the appropriate officials to work toward developing nursing services in the schools (K-12) which meet national and professional standards.
16. Send a letter to the state department of education suggesting that a position to coordinate nursing services/programs in the state's school districts be included in the department's future budget requests.

Topic:

Training in Physical Fitness

Discussion:

Physical fitness and exercise have been shown to be effective elements within wellness programs, even for very young people. Children are susceptible to the same risk factors as adults--improper diet, stress, smoking, lack of exercise, and so forth. Testimony

indicated that 98 percent of today's youth (ages 7 to 12) exhibit at least one risk factor. A total of 60 percent have at least two risk factors.

Aerobic exercise is accepted as a method of reducing health problems. Although most people assume that children get enough exercise, research has shown that American children rarely elevate their heart rates to a training level sufficient to reduce risk factors. More than 25 percent of American children are overfat, a condition which usually continues into adult life and creates statistically verifiable health problems. Physical exercise for the youth is one of the few effective approaches to reducing overfatness.

The subcommittee discussed the topic of inservice training in physical fitness for all elementary school teachers. The subject was also discussed with the state board of education which endorsed the concept and agreed to include a request for necessary funding in its 1987-1988 and 1988-1989 budget request.

Recommendation:

- 17: Express support for a program through which the state department of education will provide inservice training in physical fitness for all elementary school teachers.

Topic:

Curriculum Conferences

Discussion:

Curriculum conferences may be used as a tool for developing better school programs in most areas of education. The conferences also have the secondary benefits of developing a sense of camaraderie among educators within a given discipline, embracing the enthusiasm for a subject of concern, and educating people about the values of a specific subject or discipline.

Curriculum conferences in the field of wellness would provide the focal point for designing and implementing better programs in Nevada's schools. They would also provide teachers with basic information about health and physical education. Conferences could include sessions on teaching of nutrition, drug and alcohol abuse, developing healthy lifestyles, immediate and long-term effects of personal health choices, the influence of peer pressure and many other topics.

The state board of education joined the subcommittee members in endorsing the recommendation of holding statewide curriculum conferences in wellness on an annual basis. The board is requesting the necessary funding as a part of its 1987-1988 and 1988-1989 biennial budget request.

Recommendation:

18. Express support for a program through which the state board of education will sponsor annual statewide curriculum conferences concerning prevention and wellness education.

Topic:

Dental Care

Discussion:

The Nevada Dental Hygienists' Association prepared a presentation concerning dental care for school children. They cited studies which show that early detection of dental/oral disease and the use of optimal fluoride greatly reduce the costs of health care. They presented statistics indicating that nearly 98 percent of all children experience some form of oral/dental disease while still in their school years; and yet, only approximately one-third of the children visit a dentist on a regular basis. According to the hygienists, Nevada is one of only seven states which do not have a coordinated public oral health program.

The hygienists' association recommendations for the consideration of the subcommittee were as follows:

- a. Establish a public health hygienist/consultant program with two hygienists serving Nevada's northern counties and two hygienists serving the southern counties. The responsibilities of the hygienists would include:
 - Assessment of school children in kindergarten and the sixth grade for early detection of oral/dental problems.
 - Referral and followup of potential oral problems to personal dentist or state dental clinic.

- Supervision of a voluntary fluoride rinse program in the schools. (This type of fluoride rinse program has been proven to be up to 50 to 70 percent effective in reducing dental decay.)
 - Placement of pit and fissure sealants for indigent children. (The National Institute of Health has found sealants to be cost-effective and underutilized in the prevention of dental decay.)
 - Presentation of preventive oral health seminars for health professionals, teachers, senior citizen center staff, and other interested people.
 - Screening for oral cancer and dental disease in senior citizen centers, nursing homes and retirement communities with referral to personal dentist or state dental clinic.
- b. Establish a state dental clinic, staffed by licensed dentists with outstanding loans from the Western Interstate Commission for Higher Education (WICHE) program, to provide care on whatever basis the legislature deems fair and equitable.
 - c. Optimal fluoridation of community water supplies.

Recommendation:

- 19. Include in the final report a summary of the presentation and proposal of the Nevada Dental Hygienists Association concerning early detection of dental/oral disease and the use of fluoride.

Education of Health Care Professionals

Topic:

Continuing Education

Discussion:

Many professions have requirements for continuing education. The subject of wellness is relevant to professionals in the full range of health fields.

Recommendation:

- 20: Direct the appropriate professional organizations to include in at least 10 percent of their continuing education courses for health care professionals the concepts associated with prevention/wellness as tools for health care cost containment. (BDR 54-207)**

Topic:

Multidisciplinary Education

Discussion:

The subcommittee received a considerable amount of testimony indicating that a multidisciplinary approach to education of health care professionals would reduce educational expenses and produce well-rounded, highly skilled professionals.

The concept of Area Health Education Centers (AHEC's) was proposed. Area Health Education Centers provide multidisciplinary education and training in a variety of ambulatory settings. Activities span the continuum of the educational process from students to residents and on through continuing education, including technical assistance for practitioners and service institutions. The AHEC is an independent, nonprofit regional corporate entity which is designed to link the university medical school with the local communities. Its goals are to improve the geographic distribution of health personnel and specialty services, as well as to enhance the retention level and quality of health care personnel.

Area Health Education Centers are generally funded primarily through federal "seed" grants. The Federal Government contributes 75 percent of the financing for the first 3 to 6 years of AHEC program development. After the fourth year, nonfederal funding must increasingly be supplied from local, state or private sources.

The University of Nevada school of medical sciences has received an AHEC grant approval for \$1,013,229 over a 3-year period from the Federal Government. The initial money will be used to create a program office within the school of medicine and to establish an initial center within the state. Supplemental grants are being requested in order to expand the system by establishing a second regional center.

Closely allied, though not necessarily related, to the AHEC concept, the subcommittee members reviewed the need for a well-rounded, multidisciplinary program for the education of health care professionals in southern Nevada.

In 1973, the University of Nevada's board of regents received approval for transfer of approximately 79 acres of land on the corner of Torrey Pines and West Charleston Boulevard in Clark County from the United States Bureau of Land Management (BLM) to the University of Nevada System. The approved "plan of development" for the property describes its future use as "a comprehensive community college" and "community college and related facilities." Because of financial constraints, construction has not been initiated on the property. However, the BLM has approved an extension of time until December 31, 1994. Construction on the property is listed as priority number 15 on the "Capital Improvement Request" which will be submitted by the board of regents to the legislature in 1987. If the priorities are considered in order of preference, it is not anticipated that enough money will be available in 1987 to finance the project.

After reviewing the situation, the subcommittee determined that the "Torrey Pines/West Charleston Property" could serve several important roles simultaneously. In the area of health education, the members concluded that a portion of the property should be developed to serve as a regional center for multidisciplinary health education while simultaneously serving as a clinic to provide care for Medicaid patients.

Recommendations:

21. Include in the final report a statement of support for the concepts associated with Area Health Education Centers (AHEC's) for the training/education of health care professionals in Nevada.
22. Appropriate \$1.25 million for construction of the initial phase of a health science center on the Torrey Pines/West Charleston Boulevard property in Clark County. (BDR S-479)

Topic:

Education of Nurses

Discussion:

Education for nurses in Nevada is provided primarily through the universities and the community colleges.

Traditionally, these programs have lacked effective coordination. It is contended that the result has been a more expensive educational program which does not offer maximum flexibility to the students.

Recommendation:

- 23: Establish a committee to study education of nurses in Nevada. (BDR S-88)**

State Employee Health Programs

Topic:

Wellness Programs for Nevada State Employees

Discussion:

In order to evaluate the potential savings associated with a wellness program for Nevada's 9,000+ employees, the subcommittee commissioned a health needs assessment. The study projected substantial savings through participation in a well-designed, comprehensive program. A more thorough discussion of the assessment and its conclusions is contained in section C, "Programs for Adults in the Workplace" within Chapter VIII, entitled "Wellness Programs."

Recommendations:

- 24: Fund a health needs assessment of state employees to determine the types of prevention/wellness/education programs which would be most appropriate for this population. (Financed through the study.)**
- 25: Include in the final report a statement expressing support for conducting a prevention/wellness/education program for state employees, if the results of the health needs assessment indicate that such a program would be valuable. Indicate that this program would serve as a model for possible application for other groups in the state. Include a bill draft request which would establish a policy committee to direct a comprehensive wellness program for state employees and make the necessary appropriation. (BDR 23-537)**

General Prevention/Wellness/Education

Topic:

Utilization of Seatbelts

Discussion:

Utilization of seatbelts in motor vehicles has been shown to be an effective means of saving lives and lowering the cost of health care. Since the State of New York enacted the first mandatory seatbelt law in 1985, many other states have passed similar statutes.

There are presently 24 states which have enacted mandatory seatbelt utilization laws. Table No. 32 identifies these states and includes estimated annual fatality reductions for each state. In the most recent actions, Florida and Kansas passed seatbelt laws, while similar laws in Massachusetts and Nebraska were repealed.

TABLE NO. 32

STATES HAVING MANDATORY SEATBELT UTILIZATION LAWS		
State	Effective Date	Estimated Annual Fatality Reduction*
California	1-86	840
Connecticut	1-86	80
Florida	N/A	N/A
Hawaii	11-85	20
Idaho	7-86	40
Illinois	7-85	260
Indiana	7-87	150
Iowa	7-86	70
Kansas	N/A	N/A
Louisiana	7-86	150
Maryland	7-86	110
Michigan	7-85	260
Minnesota	8-86	100
Missouri	9-85	160
New Jersey	3-85	150
New Mexico	1-86	80
New York	12-84	340
North Carolina	10-85	240
Ohio	5-86	280
Oklahoma	2-87	140
Tennessee	4-86	180
Texas	9-85	640
Utah	4-86	50
Washington	7-86	120
District of Columbia	12-85	10

*Estimates based on 1984 data and assuming that full enforcement will result in 80 percent usage by front seat occupants of passenger cars.

Source: Highway Users Federation, "At Issue," Spring 1986; and Sharon Lawrence, National Conference of State Legislatures.

The specific elements within the state laws vary. This diversity is due, at least in part, to a situation associated with federal regulations promulgated by the United States Department of Transportation. The regulations indicate that air bags will be required in all new automobiles beginning with model year 1990 unless states enact mandatory seatbelt utilization laws which cover at least two-thirds of the Nation's population. The regulations also specify elements which must be contained in the state laws. Most of the state statutes do not comply with all of the elements outlined in the regulations. In several instances, the laws were drafted purposefully to avoid compliance, clearly expressing the states' support for air bag requirements.

Under the California, Ohio and Washington statutes, all automobile occupants, in both front and back seats, must use belts. The laws in the remainder of the states apply only to occupants in the front seats. Iowa chose to issue only warnings to offenders during the first 6 months after its law's effective date. After that period, the fines will be \$10. The Washington law also contains a 6-month warning period, but the fine after that period is at least \$20. Minnesota's law is penalty-free. Fines for violations in Utah and Missouri are \$10, while the highest fines of \$50 apply in New Mexico, New York, Texas and, for a second offense, in California.

Several studies have been undertaken to evaluate the effectiveness of mandatory seatbelt use laws. A survey of emergency room reports for 159 automobile accident patients at LDS Hospital in Salt Lake City, Utah, indicated that the average charges per patient in the survey were 10 times higher for the victims who were not wearing seatbelts. In a month-long study of accident victims at 23 hospitals in Colorado, the average hospital cost for treating patients who had been using seatbelts was \$441, compared to an average of \$1,390 for treating nonusers of seatbelts--more than three times higher.

The results of a 9-month review of accident cases at a Massachusetts hospital revealed that the medical expenses for victims who were wearing seatbelts were half the costs associated with patients who were not using seatbelts. The Massachusetts study also noted that "49 percent of the unbelted accident victims needed an ambulance to bring them to the hospital while only 29 percent of the seatbelt users required an ambulance."

Although these statistics vary significantly, all of the data substantiates the value of wearing seatbelts.

Nevada ranks eighth in the Nation in the number of traffic deaths per 1 million vehicle miles. The subcommittee members concluded that a mandatory seatbelt utilization law would produce substantial benefits in fewer automobile fatalities and lower medical costs.

Recommendation:

**26: Require utilization of seatbelts in automobiles:
(BDR 43-210)**

C. FUNDING OF HEALTH CARE

Studies of health care cost containment must review the types of funding for health care in some depth. Recommendations associated with this topic are categorized under the subheadings of "third party payers," "Medicaid," and "uncompensated care and the medically indigent." Although these categories are admittedly arbitrary, they serve the purpose of providing a somewhat reasonable format for discussion of the issues and recommendations.

Third Party Payers

Topic:

Continuation of Health Insurance Coverage

Discussion:

As discussed in Chapter V of this report entitled "Overview of the Health Insurance Industry and Third Party Payers," Congress enacted the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This act requires employers with more than 20 employees to offer extended health care coverage to employees and their dependents who might otherwise lose their health care coverage due to:

- Termination of employment or reduction of hours;
- Death of a covered employee;
- Divorce or legal separation;
- Eligibility for Medicare; or
- Loss of dependent status by a child.

As further described in the previous chapter, additional provisions are being considered as possible inclusions in COBRA.

The legislative subcommittee reviewed COBRA and determined that supplemental provisions would make the requirements of the law more effective in Nevada. Most significantly, the members concluded that the provisions relative to terminated employees and surviving spouses of members who die should apply to all group health insurance policies in which the group consists of employees of one or more employers, rather than limiting the requirements to employers with more than 20 employees. Over 80 percent of the businesses in Nevada employ less than 20 people; and therefore, the federal law would not cover these employees.

Recommendations:

27. Require that all group medical insurance policies include provisions whereby spouses of deceased members continue to be eligible for the group program (coordinate with federal law). (BDR 57-206)
28. Require that an employee who is covered by a group health insurance plan and subsequently becomes unemployed must have the option to continue the insurance coverage for up to 180 days (coordinate with federal law). (BDR 57-206)

Topic:

Tax Credits to Encourage Insurance Coverage

Discussion:

Because over 80 percent of Nevada's businesses employ less than 20 people, group health insurance coverage associated with small companies became a significant topic. The Health Insurance Association of America expressed to the subcommittee its support, over the long-term, of federal tax credits designed to encourage small employers to add or improve group health insurance plans for their employees.

Recommendation:

29. Express support for federal tax credits designed to encourage small businesses to initiate or improve group health insurance programs for their employees. (BDR R-71)

Topic:

Regulation of HMO's and PPO's

Discussion:

Because of the rapid proliferation of HMO's and PPO's, the regulatory structures needed to ensure their viability and proper practice have not fully developed.

Nevada's insurance commissioner discussed this topic before the subcommittee on several occasions. He advocated modification of the laws concerning regulation of HMO's and PPO's. He expressed his support for several of the provisions relative to regulation of PPO's which were being drafted by the National Association of Insurance Commissioners through its state and federal health policy task force.

The subject of HMO's and PPO's is discussed within this report in Chapter V entitled "Overview of the Health Insurance Industry and Third Party Payers."

Recommendations:

- 30: Grant the insurance division, department of commerce, the authority to regulate holding companies that own health maintenance organizations (HMO's) in the same manner in which holding companies of insurance companies are regulated. (BDR 57-65)**
- 31: Enact legislation concerning regulation of Preferred Provider Organizations (PPO's) which is similar to model legislation. (BDR 57-72)**

Medicaid

Topic:

The Medicaid Program in Nevada

Discussion:

A discussion of the history of the Medicaid program nationally and in the State of Nevada is contained within this report in Chapter VII entitled "State Programs for Care of the Needy."

The legislative subcommittee received a large amount of testimony relative to the Medicaid program. Although the subject matter was diverse, the major topics included eligibility criteria, reimbursement rates, and

the effectiveness of the joint Medicaid/University of Nevada school of medicine project for capitated delivery of services.

The members recognized that complex relationships exist among the Medicaid eligibility criteria/reimbursement rates, levels of uncompensated care in the state, and "cost-shifting" within the hospital industry. Thus, some actions which might appear to reduce Medicaid expenditures could conceivably result in greater costs in other sectors. In general, the subcommittee concluded that a sound, efficient Medicaid program is valuable within its own parameters and as a means of lessening problems in the other sectors. The subcommittee's recommendations for Medicaid, therefore, should be viewed in the broader context of overall cost containment.

Recommendations:

Medicaid Program Structure --

32. Expand the joint Medicaid/University of Nevada school of medical sciences project for capitated delivery of care to Medicaid-eligible people. Establish a goal that the school expand the delivery to 10,000 people by July 1, 1991. (BDR S-116)
33. Direct the Nevada Medicaid office (state welfare division, department of human resources) to establish a utilization review program which is independent of the state office and is designed to review hospital activities and charges associated with the Medicaid program. (BDR 38-86)
34. Establish a reserve fund of 4 percent of the total Medicaid budget for each fiscal year, requiring approval of the legislature's interim finance committee before a withdrawal may be made from the fund. (BDR 38-121)
35. Amend the state Medicaid program in order to provide reimbursement for home- and community-based hospice services. (BDR 38-203)

Medicaid Reimbursement Rate --

36. Place in the statutes a procedure and formula for determining Medicaid reimbursement rates based primarily upon the audited costs of services provided by the most efficient hospitals within similar classifications. (BDR 38-86)

Medicaid Eligibility Criteria --

- 37: Change the state eligibility requirements associated with Medicaid and aid to dependent children to include coverage for two-parent, unemployed families in an attempt to reduce "cost-shifting." (BDR 38-
- 38: Establish the criterion that any person whose monthly income is less than three times the income allowable to receive benefits pursuant to 42 United States Code §§ 1382 through 1383c is eligible to receive assistance to the medically indigent for the purpose of long-term medical care.

Uncompensated Care and the Medically Indigent

The subcommittee conducting this comprehensive study coordinated efforts with another interim legislative subcommittee which was responsible for analyzing specifically the indigent care program in the state. The subcommittee evaluating indigent care was created through S.C.R. 34 (File No. 120, Statutes of Nevada, 1985). The conclusions of that subcommittee are compiled in the legislative counsel bureau's Bulletin No. 87-20 entitled "Study of the Operation of the Program for State Aid to Medically Indigent."

The general topic of indigent care, including discussion of Nevada programs, is contained in Chapter VII of the present report under the title "State Programs for Care of the Needy."

Topic:

Future of Three-Cent Tax Supported Fund

Discussion:

The 1985 session of the Nevada legislature adopted an ad valorem tax of 3 cents per \$100 assessed valuation to establish county funds for medical assistance to indigent people. The act contains a "sunset" provision whereby it expires in July 1987, unless the legislature rescinds the "sunset" clause and thus provides for continuation of

As evidenced in Table No. 23 in Chapter VII, "State Programs for Care of the Needy," the tax generated during fiscal year 1985-1986 a total of \$4,135,738. Of this total revenue, the sum of \$3,722,163 was made directly available to the counties, and \$3,431,071 was expended. Eight counties spent all that was available to them through this funding source. A more detailed discussion

of the 3-cent tax and its relationship to the overall issue of indigent care is contained in the previously referenced chapter VII of this report.

Recommendation:

39. Recommend continuation of the 3-cent ad valorem tax to support medical services for indigents. Place this recommendation in a letter to the subcommittee to study operation of the program for state aid to the medically indigent (created by S.C.R. 34, File No. 120, Statutes of Nevada, 1985).

(Note - The subcommittee created under S.C.R. 34 concurred with this recommendation and adopted it as part of that subcommittee's final report.)

Topic:

"Fair Share" Program

Discussion:

The concept of a "fair share" program through which hospitals are required to treat their "fair share" of indigents or pay an assessment into a "pool" to finance indigent care is outlined in section B, entitled "Indigent Care," within Chapter VII, "State Programs for Care of the Needy."

The subcommittee reviewed testimony concerning the proportion of Medicaid and indigent care which is being provided by various hospitals in the state. The members also considered the burden which financing of indigent care places upon the county governments. As a means of distributing the responsibility for providing indigent care more equitably among the hospitals and reducing the financial burden carried by the counties, the subcommittee determined that a "fair share" program should be established in Nevada.

Under the subcommittee's proposal, a hospital's "fair share" is based upon the number of Medicaid patient days which it provides. However, because of the limited number of Medicaid-eligible patients in some areas and the inability of smaller hospitals to provide full Medicaid services, the program is limited to hospitals which have 200 or more beds.

Hospitals which do not provide their "fair share" of care are required to pay an assessment. The members of

the subcommittee determined that the most efficient utilization of the assessment revenues would be to "infill" the state's Medicaid program in the following areas:

1. Increase the "standard of need" and payments for the Aid to Dependent Children (ADC) program. (As also proposed by the legislative subcommittee specifically studying this topic--see legislative counsel bureau Bulletin No. 87-31.)
2. Expand the ADC program to include coverage for two-parent, unemployed families. (See recommendation No. 37 in this report.)
3. Expand coverage under the Child Health Assurance Program to include children over the age of 5 years who are members of families with income below the ADC needs standard.
4. Raise the limit on monthly income associated with Medicaid eligibility for institutionalized persons (long-term care) to the maximum allowed by federal regulation. (See recommendation No. 38 in this report.)

Use of the assessment revenues in this manner provides at least the following benefits:

- It doubles the state funds by matching them with federal money.
- It alleviates a portion of the counties' burden of financing indigent care by placing more indigents within the state Medicaid program.
- It reduces the amount of "uncompensated care" within hospitals and, thus, tends to alleviate "cost-shifting".
- It unifies the legislative package by providing funds to implement two of the recommendations which receive approval based upon analyses of their independent merits.

In order to ensure a stable revenue source to support the increased Medicaid program, the subcommittee decided that shortfalls in the projected "fair share" assessments would be replaced through a direct assessment placed upon all hospitals based upon their overall proportion of statewide patient days. It was also determined that Nevada's welfare division should have the discretion to

use 15 percent of the assessment revenues to supplement other programs which tend to reduce the counties' levels of indigent care and/or reduce "cost-shifting" within hospitals.

For a more detailed description of the proposed "fair share" program and its projected effect upon relevant hospitals, see Appendix B of this report.

Recommendation:

40. Require acute care hospitals which do not treat their "fair share" of indigents to pay assessments into a "pool" to finance indigent care.

Topic:

Definition of "Indigent"

Discussion:

The State of Nevada currently does not have a uniform definition of "indigent" which applies statewide. For this reason, there appears to be a wide variation in the services which are available to citizens in the different counties.

In order to address the issue on a statewide basis, and because of the proposals for new, statewide programs to address indigent care, it was determined that a uniform definition is necessary.

Recommendation:

41. Establish procedures to determine medical indigence and specify minimum standards to apply statewide. (BDR 38-110)

Topic:

Awards for Punitive Damages

Discussion:

The subcommittee heard testimony which contended that awards for punitive damages in civil liabilities cases could logically be directed toward financing of indigent care. The witnesses argued that defendants in civil liabilities cases receive compensation through the nature of the judicial system. However, the punitive damage awards are designed to punish the offender

and thus should not be part of the defendant's award. As argued before the subcommittee, these punitive damages should be directed toward a general social benefit, such as assisting to finance medical care for indigents.

Recommendation:

42. Provide that all punitive damages awarded (excluding attorney's fees) in civil liabilities cases be used to assist in financing medical services for indigents. (BDR 3-122)

Topic:

Automobile Insurance

Discussion:

The subcommittee received testimony indicating that a large percentage of the costs of uncompensated care and indigent care are the result of motor vehicle accidents. Many of the drivers are uninsured or underinsured. The members of the subcommittee concluded that addressing this issue should constitute an element within the package of recommendations designed to reduce the costs associated with uncompensated and indigent care.

Recommendation:

43. Increase lower limits from \$15,000 to \$25,000 on required automobile insurance and increase administrative penalties for noncompliance. In addition, require that individuals must provide proof of insurance for renewal of automobile registration (BDR 43-113)

Topic:

Additional New Programs

Discussion:

The subcommittee considered several additional programs which might have positive impacts upon the uncompensated and indigent care situation in the state. Two of these programs appeared especially valuable.

A regional program called "The Caring Program for Children" was developed in 1985 by Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield. The effort is the Nation's first private health insurance package designed exclusively for needy children. It provides

access to primary health care for children of unemployed or marginally employed families which are ineligible for publicly funded programs and unable to afford private health insurance.

The Western Pennsylvania Caring Foundation, Inc., has been established as a nonprofit entity to which individuals, churches, corporations, foundations and other interested organizations may contribute. The money is pooled and used to purchase health care benefits for the eligible children at a cost of \$13 a month (\$156 a year) per child. Benefits include full coverage for emergency outpatient and medical care, minor surgery, and diagnostic tests such as X-rays. Also covered are physicians' charges for outpatient surgery, pediatric preventive health maintenance, and unlimited physician office visits and diagnostic tests. Evidence indicates that preventive and emergency care reduce future need for expensive hospitalization. Thus, overall health care costs are contained, and a portion of the problem of uncompensated and indigent care is addressed.

Taking a different approach, the subcommittee also reviewed problems created by major, or "catastrophic," accidents or illnesses. The state's existing program based on the 3-cent ad valorem tax was examined and, as previously mentioned, determined to be valuable. However, the members still found additional problems associated with the counties' inability to fund enough indigent care, increases in uncompensated care in cases of catastrophic accidents or illnesses, and social disruption within the family when major medical bills cannot be paid. Although the administrative details of a program to address these additional problems were not discussed in depth, the subcommittee members concluded that the issues should be brought before the full legislature in at least a "skeleton" form.

Recommendations:

44. Direct the director of the department of human resources to establish a program through which private companies "sponsor" health insurance coverage for needy children, similar to the Blue Cross program in Pennsylvania. (BDR 38-76)
45. Approve a skeleton bill to appropriate \$1 million in fiscal year 1987-1988 and \$1 million in fiscal year 1988-1989 to create a new program for "catastrophic" medical assistance for Nevada citizens who do not qualify for existing programs but have large medical bills which will destroy the family solvency. (BDR 38-120)

D. QUALITY OF CARE

Throughout the study, the need to reduce medical costs was reviewed against the potential for simultaneously decreasing the quality of care for Nevada's citizens. The original directive to the subcommittee was to study ways of restraining the costs of health care in the state, while ensuring a high quality of services.

Measuring quality of care is much more difficult than measuring prices or utilization of health care services. However, a number of states are attempting to initiate efforts to measure the quality of medical services. Illinois has outlined a 2-year study to identify useful indicators of quality care and sources of data to measure those indicators. The goal of the Illinois study is to develop and release to the public a series of guidelines for monitoring and evaluating quality of care. Colorado Health Data Commission is including "quality indicators" in its publication of hospital prices and utilization. A 1984 Rand Corporation publication entitled "Quality Assurance in Medicine: Experience in the Public Sector" focuses upon Peer Review Organizations which review hospital utilization and quality of care for Medicare patients under the prospective payment system. Similarly, the federal Health Care Financing Administration has funded seven studies of potential quality problems in Medicare's prospective payment pricing system.

From a different perspective, a private sector initiative in Milwaukee, Wisconsin, illustrates another approach to measuring quality of care--based upon consumer satisfaction. While this approach provides some guidance to potential purchasers, critics caution that most consumers are unable to evaluate adequately a hospital's or doctor's technical competence.

Quality of Care--General Issues

Topic:

Ethical Questions Associated with the Medical Field

Discussion:

Many of the issues related to quality of care are actually ethical questions. Controversies surround questions of whether publicly financed patients have a right to all of the new, high-technology medical services which are available to privately paying patients; who determines the point at which use of costly life support systems should be discontinued; to what degree medical professionals provide fewer services to patients whose bills are paid through a prospective payment system; and many other similar issues. The authors of

"Health Care in the 1990's: Trends and Strategies" (Arthur Andersen and Company in cooperation with the American College of Hospital Administrators) contend that society must deal with the moral dilemmas and ethical implications of modern medicine. They conclude that most health care providers would welcome guidelines in these matters.

The legislative subcommittee received testimony supporting creation of an "ethics institute" within the University of Nevada school of medical sciences. As proposed, the institute would:

- Plan and arrange educational activities to provide for practical applications of ethical consensus in medical practice.
- Act as a focal point for visible public groups to address issues of medical ethics.
- Coordinate informed communication between health and care deliverers and public policymakers in matters of medical ethics.
- Act as a clearinghouse of information for members of the medical profession, hospital administrators, policymakers and the public on matters of medical ethics.

Precedents for this type of ethics institute are illustrated by The Hastings Center in Hastings-on-Hudson, New York; the Kennedy Institute at Georgetown University in Washington, D.C.; the Rose Medical Center in Denver, Colorado; and the Baylor Medical Center in Houston, Texas. However, according to testimony, the proposal for Nevada would be the first such institute in the Southwestern United States.

It was also suggested that the ethics institute would be a natural companion to the proposed Area Health Education Centers and/or health science center in Clark County.

Recommendation:

46. Establish an "ethics institute" at the University of Nevada school of medical sciences. (BDR 34-74)

Topic:

State Health Officer

Discussion:

The position of state health officer performs a significant function in Nevada. It was concluded that the person holding this position should have a well-rounded perspective of the health field in order to perform his or her duties effectively.

Recommendation:

47. Provide that the position of state health officer must be filled with a medical doctor who also has a background in public health care within 6 months of the time that the position becomes vacant.
(BDR 40-118)

Trauma Care

Topic:

Trauma Care Network

Discussion:

According to information provided by the University of Nevada school of medical sciences, trauma is the principal cause of death for Americans between the ages of 1 and 38 years. On a national basis, there are two cases of permanent disability for every trauma-related death. For comparison, it is significant to note that the number of hospital days per year utilized for trauma care is greater than those utilized by all heart patients and four times the number used by all cancer patients.

The subcommittee and the University of Nevada school of medical sciences cosponsored a trauma care workshop in April of 1986. The participants identified 32 problems which restrict quality trauma care in Nevada. The group established priorities among the 32 problems and determined that the following five items represent the most significant barriers to providing quality trauma care:

1. Lack of an organized trauma network;
2. Absence of a political or public mandate;
3. Problem of special interests;

4. Lack of money for facilities, personnel and administration; and
5. Lack of standards for trauma practice.

Despite Nevada's ranking of eighth in the Nation in the number of traffic deaths per million vehicle miles, the state has no organized trauma network. Based upon the priority ranking of this issue by the workshop participants, a considerable amount of subcommittee discussion focused on how a coordinated statewide trauma network would improve stabilization, transportation capabilities, and the ultimate medical care of trauma victims in the state. It was concluded that savings due to efficiency in a trauma network would be substantial in terms of human life and economic factors.

Recommendation:

48. Direct the health division in the department of human resources to develop by January 1, 1988, the system through which a trauma network may be established throughout the state. The system should include the following provisions or elements:
 - a. Use of the criteria of the American College of Surgeons for designation of hospitals as trauma centers.
 - b. Indication that designation as a trauma center does not, in itself, require approval through the certificate of need process.
 - c. Provision that a hospital which is designated as a trauma center must have an "open admission policy" with complete care until the patient is ready for discharge or until the patient requires transfer to a facility which has a higher level of care.
 - d. Requirement that physicians who work in trauma centers must be qualified and proficient in trauma care, and establishment of a goal that physicians in outlying areas who will be transferring patients into a trauma center have capabilities at least at the level of "Advanced Trauma Life Support."
 - e. Provision by the state health division of "Prehospital Trauma Life Support" training and other necessary training to appropriate providers of trauma care.

- f. Compilation by the division for review of health resources and costs of a "trauma registry" within its system for gathering information and statistics concerning health care in Nevada.
- g. Compilation of information for the "trauma registry" through use of the "Cram scoring system" based upon "mechanism of injury" and use of "Champion scores," with physician evaluations taking precedence over evaluations made by ambulance attendants. (BDR 40-85)

Perinatal Care

Topic:

Standards for Perinatal Care

Discussion:

Perinatal care refers to medical care provided to mothers and children from a time beginning before a child is born and lasting until several weeks after the child's birth. The subcommittee, in conjunction with the University of Nevada school of medical sciences, sponsored a workshop on the topic of perinatal care in April of 1986. The participants identified 75 problems which restrict the development of higher quality perinatal care in Nevada. The group's top-ranked recommendation was that statewide standards for perinatal care should be developed.

The subcommittee received additional testimony relative to the value of prenatal care--health care provided to expectant mothers prior to the time of birth. (Though potentially confusing in terminology, "prenatal" care is one aspect of "perinatal" care.) As described in greater detail in chapter VIII of this report under the title "Wellness Program," an estimated \$10 million could be saved annually in Nevada through good prenatal care.

Recommendation:

- 49. Direct the state board of health to develop statewide standards for perinatal care. (BDR 40-114)

E. HEALTH CARE FOR SENIOR CITIZENS

Topic:

Long-Term Care

Discussion:

Testimony revealed that Nevada is projected to experience a 285 percent growth in its senior population from 1980 to the year 2000. Consequently, programs designed to reduce the institutionalization of Nevada's elderly population, as well as to improve their quality of life, were important tenets in the subcommittee's deliberations. The adequacy and quality of care in the state's traditional nursing home facilities were also points of interest and review.

A more thorough discussion of the topic of health care for senior citizens is contained in chapter IX of this report under the title "Special Issues in Nevada - Care for the Elderly and Rural Health Care."

As part of his testimony before the subcommittee, the director of the department of human resources explained Governor Richard H. Bryan's proposal entitled "Nevada Initiatives for Seniors - An Agenda for the Future." The objective of this proposal is to restructure the long-term care system in Nevada by creating a broader range of community- and home-based options which can maintain the independence of the state's older citizens.

Recommendation:

- 50: Include a statement in the final report expressing support for the concepts contained in Governor Richard H. Bryan's proposed alternatives to traditional long-term care programs. These alternatives include adult day health care, adult day care, inhome attendant care, respite care, homemakers services and homebound meals. The programs are designed to reduce the institutionalization of Nevada's elderly population and improve their quality of life. Include the following specific points:
 - a. Endorse a statewide case management program to coordinate community- and home-based services to seniors and their families.

- b. Support a program to train professional; para-professional and family caregivers in the unique needs of the elderly.
- c. Enter into discussions to develop a federal/state partnership in financing programs for the elderly.
- d. Promote specialized care units within existing and future long-term care facilities to meet the unique needs of the Alzheimer patient and similar groups.
- e. Develop residential alternatives which offer varying levels of support services; such as supervised apartment living.

F. MEDICAL MALPRACTICE

Topic:

Medical Malpractice Insurance

Discussion:

According to the National Conference of State Legislatures' publication entitled "What Legislators Need to Know About Medical Malpractice" (July 1985), medical malpractice is defined as negligent care by a health care provider that causes injury to a patient. A bad treatment result, regardless of how severe, is not grounds for malpractice action unless the provider was at fault. Thus, medical malpractice actions are brought by injured people who believe that they are the victims of negligence.

Most providers of health care are insured in some manne against claims of medical malpractice. This type of insurance is offered by several national liability insurers and by provider-owned companies. Self-insurance is also an option in many instances for very large provide

In the mid-1970's, a "crisis" in the availability of malpractice insurance inspired reform legislation in almost every state. The 1975 and 1977 sessions of the Nevada legislature enacted several measures designed to address the malpractice problem.

Many people contend that the current "crisis" in malpractice insurance is not one of availability--but rather one of affordability. The number of malpractice claims the size of awards, and the cost of insurance have increased steadily during recent years. After a great

number of claims in the mid-1970's, their frequency declined briefly in the late 1970's. In 1979, however, the frequency of claims again began to rise rapidly. The size of malpractice awards and settlements has increased even more rapidly than the frequency. Likewise, the cost of malpractice insurance has risen dramatically, especially in the past couple of years.

In 1985, the Nevada legislature attempted to address the issue in several different ways. The following three bills were enacted:

- Senate Bill 38 (chapter 597, Statutes of Nevada, 1985) - Persons present solely to observe the rendering of care by a health care practitioner were exempted from liability.
- Senate Bill 64 (chapter 667, Statutes of Nevada, 1985) - The statutes governing the licensing and discipline of physicians were extensively revised.
- Assembly Bill 696 (chapter 620, Statutes of Nevada, 1985) - Medical malpractice screening panels were reinstituted.

The 1985 legislature also included the subject of medical malpractice in two interim studies. In addition to directing this legislative subcommittee to consider the effects of malpractice insurance upon the overall costs of health care, the legislature also adopted A.C.R. 53 which established a separate study of insurance for medical malpractice. The final report of the specific medical malpractice study is contained in the legislative counsel bureau's Bulletin No. 87-18 entitled "Study of Insurance Against Medical Malpractice."

In order to coordinate efforts, rather than duplicating activities, the members of the subcommittee reviewing the comprehensive issue of health care cost containment decided simply to forward their recommendations for consideration by the subcommittee studying the specific aspects of medical malpractice insurance.

Recommendation:

51. Refer the following recommendations, which have been compiled from testimony presented to this subcommittee, to the subcommittee to study insurance against medical malpractice (A.C.R. 53, File No. 106, Statutes of Nevada, 1985) for its consideration:

- a. Amend the state statutes to allow courts to award damage payments in excess of \$50,000 in installments rather than lump sums.
- b. Modify the collateral source rule to permit a jury to know whether the plaintiff has been compensated from another source.
- c. Establish a structure for attorney contingency fees which is based on a sliding scale and assure that the injured party is the primary beneficiary from the court award.
- d. Limit the amount of noneconomic losses in court awards to no more than \$250,000.
- e. Adopt a resolution supporting United States Senator Orrin G. Hatch's (Utah) Senate Bill 18 which gives states eligibility to receive federal grants if the states adopt reforms and make them applicable to cases involving medical malpractice.
- f. Modify the Nevada law relative to screening panels for medical malpractice lawsuits as follows:

If the panel determines that the claim is not viable and the case is pursued in court, the patient becomes responsible for the costs of the defense of the provider being sued unless the patient wins the case.
- g. Provide state-supported malpractice insurance for physicians who work in state-supported facilities or programs.
- h. Require that the judge's instructions to the jury in medical malpractice cases include a discussion of the general economic ramifications of the decision.

XI. CONCLUSION

The costs of health care in Nevada rank among the highest in the Nation. The legislative subcommittee charged with studying this topic invested a significant amount of time and effort in analyses of the issue. Thirteen meetings for a total of 18 days were held in several locations throughout the state. More than 250 proposals were considered, and a total of 51 recommendations were adopted.

As previously described, this package of recommendations represents a comprehensive approach to health care cost containment in Nevada. It incorporates long-term and short-range actions, and it combines the elements of the competitive free market with necessary governmental regulation. Taken as a whole, the package of recommendations is designed to restrain the costs of medical care in Nevada while still ensuring a high quality of care.

It should be reemphasized that no single recommendation purports to be "The Answer" to Nevada's rising costs. However, it is the judgment of the legislative subcommittee that the overall package of recommendations will be effective in restraining the escalation of health care costs in the state.

The members of the subcommittee wish to express their sincere appreciation to those who participated in the lengthy study. Of particular assistance have been the many special witnesses, in-state experts, state agency representatives, and other interested professionals who supported the effort with their valuable time and expertise. Also deserving of special mention are the representatives of the American Association of Retired Persons who monitored and participated in all of the meetings.

XII. APPENDICES

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APPENDIX A

**MINORITY REPORT TO THE LEGISLATIVE COMMISSION
FROM THE SUBCOMMITTEE TO STUDY RESTRAINING
COSTS OF MEDICAL CARE**

APPENDIX A

MINORITY REPORT TO THE LEGISLATIVE COMMISSION FROM THE SUBCOMMITTEE TO STUDY RESTRAINING COSTS OF MEDICAL CARE

It was determined that a minority report regarding the topic of ratesetting for hospitals should be included as an appendix to the final subcommittee report.

I, as the dissenting member of the subcommittee, feel that it is imperative that a commission to set and control hospital rates and profits be established in Nevada. This issue arose during the 1985 legislative session in Nevada and was defeated. The hospital industry, as an alternative, offered to voluntarily reduce hospital costs. According to statistics provided by the division for review of health resources and costs in the department of human resources, investor-owned hospitals increased their total charges in 1985 by almost \$30 million. They increased their profits over 1984 (which were already the highest in the Nation) by \$14.1 million, in spite of declining utilization. Had the ratesetting commission been in effect, even allowing a 20 percent profit margin, calculations indicate that over \$20 million would have been saved by the residents of the State of Nevada in 1985.

The for-profit, investor-owned hospital industry has grown at a rapid rate. At the same time, costs of health care rose at a similar rate. While hospital occupancy has decreased, profits have risen to an alltime high with for-profit hospital chains. Hospital Corporation of America, the largest of the investor-owned hospital chains, had 1984 revenues of \$4 billion. Humana Corporation had 1984 revenues of \$2.6 billion. In Nevada, according to data provided by the Health Care Financing Administration (HCFA), Humana Corporation showed profits of \$22 million in 1984 and \$31 million in 1985--from one hospital (Humana Sunrise in Las Vegas, Nevada).

An analysis of the 1984 hospital cost information from the American Hospital Association (as compiled by Nevada's division for review of health resources and costs) confirms that Nevada's hospital costs are extremely high. This analysis reveals that:

- The average charge per patient admitted to a Nevada hospital in 1984 was \$5,589. This figure compared to a national average for per admission charges of \$3,799. Nevada's average charge per day was \$910, while the national average was \$520.

These charges were the highest in the Nation.

- Nevada's hospitals were also the highest in the Nation in 1984 in revenues per day and per admission. Nevada's per diem revenues were \$658 compared to the national average of \$405, and the per admission revenues in Nevada were \$4,040, compared to the national average of \$2,956.
- In 1984, Nevada hospital profits for inpatient care were not only the highest in the Nation, they were more than double those of the second highest state. On the basis of daily charges, Nevada's hospitals made an average profit per patient of \$43, compared to \$19 for Utah, the second highest state. For each patient admitted to a Nevada hospital in 1984, the average profit was \$263, compared to \$108 for Utah, again the second highest state.

In response to increasing health care costs, several states established ratesetting commissions:

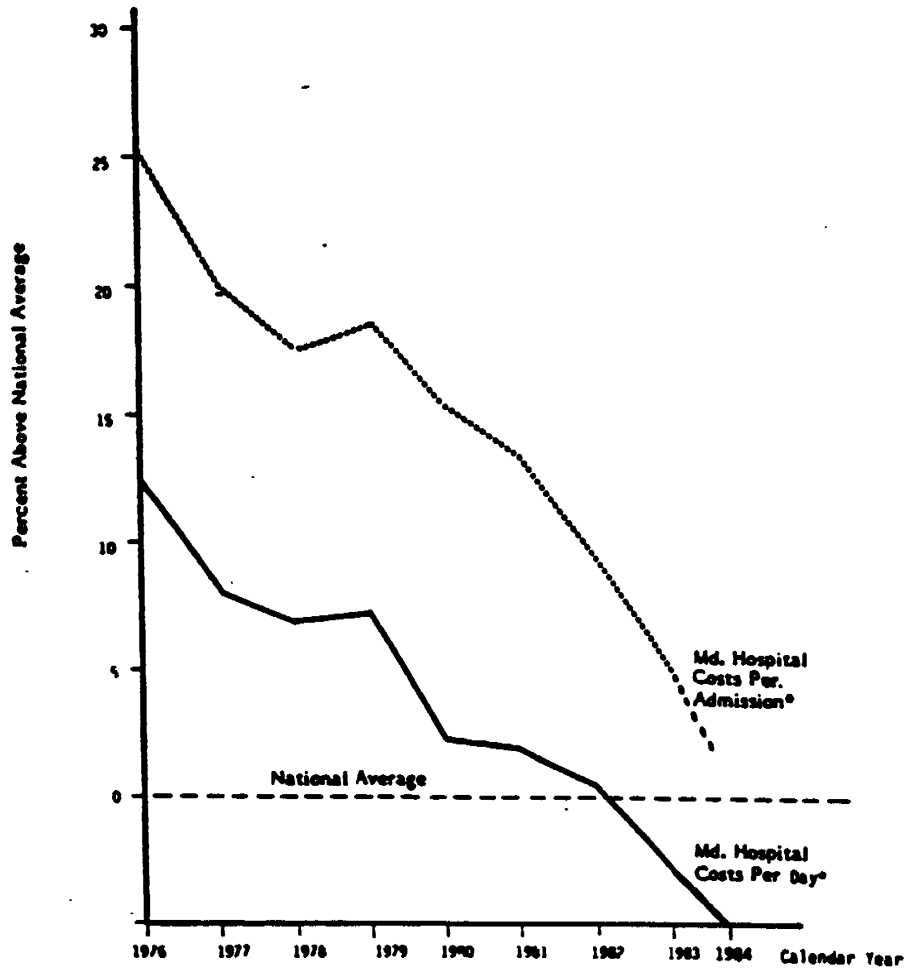
Maryland established hospital ratesetting in 1971 to contend with the dramatic increase in health care spending. With the support of the governor and the hospital association, the Health Services Review Commission was created as an independent agency. Ratesetting began in 1974.

Since the implementation of ratesetting in Maryland, officials report that the rate of inflation for hospital costs per day has gone from 25 percent above the national average to well below the national average (see Chart No. 1). Other statistics provided by the Health Services Cost Review Commission and presented to the subcommittee indicate that:

- If costs had risen at the national average since 1976, Marylanders would have paid over \$1.5 billion more in hospital charges.
- In 1984, costs per day in Maryland rose 10.5 percent, while nationally they rose almost 13 percent.
- In 1984, costs per admission in Maryland rose approximately 4.5 percent, while nationally they rose almost 8 percent.
- There were savings realized despite financing of uncompensated care within the established rates. In 1984, \$142 million, or 6.3 percent of total revenues, was included in rates for uncompensated care.
- In 1984, 45 hospitals showed a profit, while nine hospital incurred an operating loss.

CHART NO. 1

RATE OF INCREASE IN MARYLAND'S HOSPITAL COSTS AS COMPARED
TO NATIONAL AVERAGE



*Equivalent day and equivalent admission.

Source: Maryland Health Resources Cost Review Commission.
Presented to subcommittee October 11, 1985.

Similar statistics are available from other ratesetting states. The State of Wisconsin compiled a comparative study of ratesetting and nonratesetting states in its portion of the United States. The results of the study are contained in Chart No. 2. The statistics clearly indicate that the hospital costs for ratesetting states in that region are lower than the national average and lower than the corresponding figures for nonratesetting states.

CHART NO. 2

PERCENTAGE INCREASES IN HOSPITAL EXPENSES FOR THE
UNITED STATES, WISCONSIN AND OTHER STATES IN THAT
REGION - FROM 1973 TO 1982

	General Hospital Expenses	Hospital Expenses Per Admission	Hospital Expenses Per Inpatient Day	Hospital Expenses Per Capita
UNITED STATES	259.3%	214.1%	231.0%	227.7%
<u>RATESETTING STATES</u>				
Connecticut	197.4	184.5	195.7	194.0
Maryland	228.3	170.7	181.5	217.0
Massachusetts	203.8	201.6	199.5	206.8
New Jersey	225.9	176.6	184.7	222.2
New York	149.3	148.1	156.5	158.6
Rhode Island*	163.4	161.9	272.1	169.0
Washington*	259.8	196.5	247.8	193.5
TOTAL:	183.0%	203.9%	203.1%	192.0%
<u>NONRATESETTING STATES IN THAT REGION</u>				
Illinois	254.2	231.0	244.5	246.5
Indiana	270.1	234.6	240.2	258.5
Iowa	261.3	245.6	245.2	255.5
Michigan	237.7	206.0	230.5	236.0
Minnesota	217.0	211.6	205.5	198.5
Ohio	268.1	231.2	235.8	267.3
TOTAL:	252.5%	226.9%	237.0%	242.7%
WISCONSIN	231.0%	227.3%	270.2%	216.6%

*Rhode Island and Washington are considered to have "modified" ratesetting mechanisms.

Source: Wisconsin Hospital Association, Hospital Costs in Wisconsin - A Comparison, 1973-1982 (1984).

Another example of the effectiveness of ratesetting commissions is evident when comparing increases in per capita hospital costs. The national growth in average annual per capita hospital costs between 1976 and 1980 was 13.8 percent per year. In contrast, the seven states with mandatory ratesetting programs during that period had an average annual per capita increase of 10.5 percent--a 24 percent lower rate of increase.

For these reasons, I would recommend that the legislative commission review and support the following options as presented by Governor Richard H. Bryan:

1. Establish a ratesetting commission;
2. Establish an excess profits tax either in conjunction with or as an alternative to a hospital ratesetting commission;
3. Establish a state indigent care fund with revenues from hospitals (excess profits tax) and the state;
4. Expand the network for needed health services in rural Nevada to ensure access to care on a local level (this would include perinatal care and trauma care) and provide funding through an excess profit tax or assessment on hospital revenues;
5. Establish a strict uniform system of hospital financial reporting; and
6. Establish a state agency that would serve as the purchasing agent for patients currently paying top dollar for health care.

Respectfully submitted,

Nevada State Senator Joe Neal

APPENDIX B

EXPLANATION OF PROPOSED "FAIR SHARE" PROGRAM

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EXPLANATION OF PROPOSED "FAIR SHARE" PROGRAM

After reviewing relevant testimony and background information, the legislative subcommittee determined that a "fair share" program should be established in Nevada. Under this proposal, hospitals which do not treat their "fair share" of indigents are required to pay an assessment into a "pool" to finance indigent care.

CALCULATION OF "FAIR SHARE"

A hospital's "fair share" of indigent care is determined by reviewing the number of Medicaid patient days provided by the hospital. The hospital's proportion of Medicaid patient days to statewide Medicaid patient days should be equal to the proportion of its overall patient days to the total patient days for the state. Thus, the proportion is expressed as follows:

$$\frac{\text{Hospital's Medicaid Patient Days}}{\text{Statewide Medicaid Patient Days}} = \frac{\text{Hospital's Total Patient Days}}{\text{Statewide Total Patient Days}}$$

The hospital's "fair share" is, therefore, calculated as follows:

$$\begin{array}{l} \text{Hospital's Medicaid Patient Days} \\ \text{(Projected "Fair Share")} \end{array} = \frac{\text{Hospital's Total Patient Days}}{\text{Statewide Total Patient Days}} \times \begin{array}{l} \text{Statewide Medicaid} \\ \text{Patient Days} \end{array}$$

METHOD OF CALCULATING HOSPITAL ASSESSMENTS

Hospitals which do not provide their "fair share" of care must pay an assessment based upon the discrepancy between the amount of Medicaid service which they should have provided and the amount which they actually provided.

The subcommittee members noted, however, that geographic variables affect the distribution of Medicaid services. In some areas, Medicaid-eligible patients simply are not available to the hospitals. Likewise, many of the smaller hospitals do not have the capacity to provide all of the Medicaid-eligible services. For these reasons, it was concluded that the program should apply only to hospitals which have 200 or more beds.

Calculations of assessments are based upon the following general formula:

$$\text{Total Assessments} = \text{Constant} \times \text{Total Hospital Deficiencies}$$

In this formula, the "constant" is expressed in terms of dollars. In practice, the "constant" represents the amount of money assessed against a hospital for each Medicaid patient day which falls below its "fair share."

USE OF ASSESSMENT REVENUES

The subcommittee determined that the most efficient utilization of the assessment revenues would be to "infill" the state's Medicaid program. As proposed, 85 percent of the assessment revenues will finance Nevada's participation in the following "optional coverage groups" outlined in federal law relative to Medicaid:

1. Increase the "standard of need" and payments for the Aid to Dependent Children (ADC) program.
2. Expand the ADC program to include coverage for two-parent unemployed families (ADC-UP).
3. Expand coverage under the Child Health Assurance Program to include children over the age of 5 years who are members of families with incomes below the ADC needs standard.
4. Raise the limit on monthly income associated with Medicaid eligibility for institutionalized persons (long-term care) to the maximum allowed by federal regulation.

Increase "Standard of Need" and Payments

An interim legislative study created through S.C.R. 45 (File No. 131, Statutes of Nevada, 1985) was directed to review the adequacy of the state's "standard of need" for the ADC program. The subcommittee which conducted the study found that Nevada's needs standard has not been adjusted since 1975. The state's standard of need for a family of three ranks 49th among 54 states and other political subdivisions.

The subcommittee recommended that the standard of need be based upon the "Federal Poverty Guidelines" reduced by the amount of dollars allocated under the Thrifty Food Plan (Food Stamps). If the present needs standard is modified as proposed, the standard for a family of three will increase from an income of \$285 per month to approximately \$550 per month. This action would change Nevada's ranking for standard of need from 49th to 15th among the 54 states and political subdivisions.

The subcommittee studying the specific topic also recommended that payment levels be set at no less than 70 percent of the revised needs standard. According to data provided by the state welfare division, this change would mean that the average grant per ADC recipient would increase to approximately \$111 per month, and the estimated Medicaid costs would average between \$104 and \$108 per month for each recipient.

Increasing the standard of need makes more people eligible for ADC grants and Medicaid coverage. If the recommended modification is adopted, the number of recipients is expected to increase from approximately 17,000 to a level of 21,000 to 22,000 people. "Ballpark" projections prepared by the welfare division estimate that ADC grant costs would increase from the present \$15 million per year to \$28 million or \$29 million per year. Medicaid costs would likewise increase by perhaps \$11.7 million from a current level of \$15.6 million annually to an estimated \$26.2 million to \$28.5 million annually.

Half of the ADC and Medicaid costs would be federal money, and half would be state revenue. It also should be noted that the "ballpark" estimates do not include increases in administrative costs associated with the expanded programs.

Expand ADC Program To Include Coverage for Two-Parent, Unemployed Families (ADC-UP)

Nevada has historically provided ADC and Medicaid benefits only to single-parent households. Based upon studies of other states' programs, the ratio of ADC-UP cases to regular ADC cases may be expected to be 19 percent. Incorporating the new needs standard as previously discussed, the welfare division projects that Nevada's ADC-UP recipients would number approximately 4,085 per month.

Using the modified costs associated with the new standard of need, it may be estimated that the grant costs associated with the ADC-UP program would be approximately \$5.4 million per year, and the Medicaid costs related to this program would be in the range of \$5.1 million to \$5.3 million annually. Again, half of these costs would be borne by the Federal Government, and administrative costs are not included in the statistics.

The present study recommends approval of this option, regardless of whether the "fair share" program is established. (See recommendation No. 37 in this report.)

Expand Coverage Under the Child Health Assurance Program (CHAP)

Medicaid coverage (through CHAP) is offered for children in Nevada under the age of 5 years who were born after September 30, 1983, and who are members of two-parent, unemployed families with incomes below the ADC standard of need.

Although it is very difficult to project the costs associated with expansion of CHAP to include children over the age of 5 years, the welfare division anticipates that such an action would increase the Medicaid expenditures by something like \$1.5 million annually. It should be noted, however, that implementation of option 2 (expansion of the ADC program to include two-parent, unemployed families) would automatically expand the CHAP coverage to include children over the age of 5 years who are members of eligible families.

Raise Income Limit for Institutionalized Persons (Long-Term Care)

Federal regulation provides that states may set the maximum income level for institutionalized Medicaid recipients at an amount up to three times the income allowable to receive benefits pursuant to 42 United States Code §§ 1382 through 1383c. Thus, at the present time, the maximum income level may not exceed \$1,008 per month. Nevada's established income limit is \$714 per month.

Institutionalized individuals with incomes over \$714 per month who cannot afford private-pay rates often become part of a county's responsibility in terms of indigent care. In the past, Nevada's counties have not been able to agree upon a mechanism for jointly funding this Medicaid option and, thus, taking advantage of the federal matching dollars.

Raising the income limitation associated with this portion of the Medicaid program would increase the number of institutionalized people who are eligible for the program. Funding the increased benefits through the "fair share" program would, therefore, reduce the counties' burdens in the area of indigent care.

The welfare division projects that implementation of this option would increase Medicaid costs by approximately \$3.5 million to \$3.9 million, half of which would be borne by the Federal Government.

It should be noted that the subcommittee has also recommended approval of this option, regardless of whether the "fair share" program is established. (See recommendation No. 38 in this report.)

Summary of Cost Estimates

A summary of the estimates indicates that adoption of the four "optional coverage groups" would result in the following increases in the state's Medicaid costs:

- Option 1 - Increase of "standard of need" and payments.
Increase in overall Medicaid program =
approximately \$11.7 million.
Increase in state's share of Medicaid costs =
approximately \$5.85 million.
- Option 2 - Expand ADC program to include ADC-UP option.
Increase in overall Medicaid program =
approximately \$5.2 million.
Increase in state's share of Medicaid costs =
approximately \$2.6 million.
- Option 3 - Expand coverage of CHAP program.
Increase in overall Medicaid program =
approximately \$1.5 million.
Increase in state's share of Medicaid costs =
approximately \$0.8 million.
(These costs are automatically included in the previous estimates if option 2 is approved.)
- Option 4 - Raise income limit for institutionalized people.
Increase in overall Medicaid program =
approximately \$3.7 million.
Increase in state's share of Medicaid costs =
approximately \$1.85 million.

Thus, the cost to the State of Nevada for implementing the four options may be estimated as approximately \$10.3 million (\$5.85 million + \$2.6 million + \$1.85 million). It should be emphasized, however, that these projections are "ballpark" estimates and that increased administrative costs are not included. Detailed fiscal notes should be developed as legislation is being reviewed.

ADDITIONAL PROGRAM ELEMENTS

In order to ensure a stable revenue source to support the increased Medicaid program, the subcommittee decided that shortfalls in the projected "fair share" assessment would be replaced through a direct assessment placed upon all hospitals. This broader assessment would be based upon each hospital's overall proportion of statewide patient days.

It was also determined that the welfare division should retain a degree of flexibility in allocation of a portion of assessment revenues. Thus, the proposed program would give

the division the discretion to use 15 percent of the revenues to supplement other programs which will tend to reduce the levels of county indigent care and/or reduce "cost-shifting" within hospitals.

CALCULATION OF HOSPITAL ASSESSMENTS

There are 23 general acute care hospitals in Nevada. As previously noted, each hospital's "fair share" of Medicaid treatment may be calculated through the following formula:

$$\begin{array}{lcl} \text{Hospital's Medicaid} & & \text{Hospital's Total} \\ \text{Patient Days} & = & \text{Patient Days} \\ \text{(Projected "Fair} & & \text{Statewide Total} \\ \text{Share")} & & \text{Patient Days} \end{array} \quad \times \quad \begin{array}{l} \text{Statewide} \\ \text{Medicaid} \\ \text{Patient} \\ \text{Days} \end{array}$$

It is proposed that the hospital statistics for each calendar year be used to determine the assessments for the following fiscal year. For example, hospital statistics for calendar year 1985 will be used to calculate the assessments which will be collected for fiscal year 1986-1987. Thus, the hospitals and the program administrators will have a 6-month period in which to prepare their respective organizations for the assessments.

The most current statistics presently available cover calendar year 1985. Therefore, these figures are used to calculate the statistics for the example used in this report. It should be reemphasized, however, that the actual program will use data for calendar year 1986 to determine assessments to be levied in fiscal year 1987-1988 when the program is initiated.

Table No. 1 serves as an example with calculations of the hospitals' "fair share" based upon statistics for calendar year 1985. The Medicaid patient days include certified patient days as well as days of skilled nursing and intermediate care within the hospitals. The overall patient days are derived from the "Nevada Hospital Preliminary Utilization Reports, 1985" prepared by the division for review of health resources and costs.

Calculations of assessments are based upon the following general formula:

$$\text{Total Assessments} = \text{Constant} \times \text{Total Hospital Deficiencies.}$$

TABLE NO. 1

CALCULATION OF HOSPITALS' "FAIR SHARE" (Statistics for Calendar Year 1985)				
HOSPITAL	HOSPITAL TOTAL PATIENT DAYS STATEWIDE TOTAL PATIENT DAYS	QUOTIENT	STATEWIDE MEDICAID PATIENT DAYS	"FAIR SHARE" (MEDICAID PATIENT DAYS)
Battle Mountain	<u>594</u> 620,753	.00096	38,782	37.23
Boulder City	<u>4,803</u> 620,753	.00774	38,782	300.17
Carson-Tahoe	<u>18,244</u> 620,753	.02939	38,782	1139.80
Churchill	<u>5,304</u> 620,753	.00854	38,782	331.20
Desert Springs	<u>39,133</u> 620,753	.06304	38,782	2444.82
Grover C. Dils	<u>767</u> 620,753	.00124	38,782	48.09
Elko	<u>9,376</u> 620,753	.01510	38,782	585.61
Humboldt	<u>1,526*</u> 620,753	.00246	38,782	95.40
Lakeside	<u>2,084*</u> 620,753	.00336	38,782	130.31
Lyon	<u>1,809</u> 620,753	.00291	38,782	112.86
Mt. Grant	<u>1,092</u> 620,753	.00176	38,782	68.26
North Las Vegas	<u>19,517</u> 620,753	.03144	38,782	1219.31
Nye	<u>1,647</u> 620,753	.00265	38,782	102.77
Pershing	<u>2,699</u> 620,753	.00435	38,782	168.70
W. Bee Ririe	<u>2,923</u> 620,753	.00471	38,782	182.66
St. Mary's	<u>76,409</u> 620,753	.12309	38,782	4773.68
St. Rose de Lima	<u>11,746</u> 620,753	.01892	38,782	733.76
Sparks Family	<u>18,673</u> 620,753	.03008	38,782	1166.56
Sunrise	<u>128,470</u> 620,753	.20696	38,782	8026.32
University Medical	<u>93,827</u> 620,753	.15115	38,782	5861.90
Valley	<u>63,790</u> 620,753	.10398	38,782	4110.12
Washoe	<u>104,791</u> 620,753	.16881	38,782	6546.79
Women's	<u>9,529</u> 620,753	.01535	38,782	595.30

*Approximation based upon statistics for first three quarters of 1985.

Table No. 2 shows the discrepancies between each hospital's calculated "fair share" and the actual number of Medicaid patient days provided by the hospital. The deficiencies are shown as positive figures. Thus, the hospitals having positive figures in Table No. 2 served fewer than their "fair share" of Medicaid patients.

TABLE NO. 2

DISCREPANCIES BETWEEN "FAIR SHARE" AND ACTUAL MEDICAID PATIENT DAYS (Statistics for Calendar Year 1985)			
HOSPITAL	"FAIR SHARE" (NUMBER OF MEDICAID PATIENT DAYS THE HOSPITAL SHOULD HAVE PROVIDED)	NUMBER OF MEDICAID PATIENT DAYS PROVIDED BY THE HOSPITAL	DISCREPANCY
Battle Mountain	37	11	26
Boulder City	300	49	251
Carson-Tahoe	1,140	561	579
Churchill	331	282	49
Desert Springs	2,445	397	2,048
Grover C. Dils	48	18	30
Elko	586	377	209
Humboldt	95	96	-1
Lakeside	130	1	129
Lyon	113	0	113
Mt. Grant	68	29	39
North Las Vegas	1,219	247	972
Nye General	103	9	94
Pershing	169	101	68
W. Bee Ririe	183	264	-81
St. Mary's	4,774	3,367	1,407
St. Rose de Lima	734	335	399
Sparks Family	1,167	207	960
Sunrise	8,026	5,657	2,369
University Medical	5,862	14,078	-8,216
Valley	4,110	1,895	2,215
Washoe	6,547	8,968	-2,421
Women's	595	1,833	-1,238
TOTALS	38,782	38,782	- 0 -

As previously discussed, Medicaid-eligible patients are not available to all hospitals, and many of the smaller hospitals do not have the capacity to provide all of the Medicaid-eligible services. Thus, the "fair share" assessments are only applied to hospitals which have 200 or more beds.

The goal for total assessments must be determined in order to calculate the "constant" in the general equation. As previously outlined, "infill" of the Medicaid program would cost in the "ballpark" of \$10.3 million (state money). Assuming additional expenses for administrative costs and an additional 15 percent for supplemental programs, the total assessments should be in the range of \$15 million.

Table No. 3 provides figures depicting the assessment placed upon each relevant hospital if the total needed assessments are \$20 million, \$15 million and \$10 million. The calculations assume that the total assessments are allocated among hospitals having 200 or more beds which did not serve their "fair share" of Medicaid patients in calendar year 1985.

TABLE NO. 3

ESTIMATED ASSESSMENTS PER HOSPITAL FOR "FAIR SHARE" PROGRAM (Statistics for Calendar Year 1985)				
HOSPITAL	TOTAL ASSESSMENTS (PROGRAM NEEDS)	CONSTANT	DISCREPANCIES	ASSESSMENTS* PER HOSPITAL
Desert Springs	\$ 20 million	2488	2048	\$ 5,095,424
	15 million	1866		3,821,568
	10 million	1244		2,547,712
St. Mary's	\$ 20 million	2488	1407	\$ 3,500,616
	15 million	1866		2,625,462
	10 million	1244		1,750,308
Sunrise	\$ 20 million	2488	2369	\$ 5,894,072
	15 million	1866		4,420,554
	10 million	1244		2,947,036
University Medical	\$ 20 million	2488	-8216	0
	15 million	1866		0
	10 million	1244		0
Valley	\$ 20 million	2488	2215	\$ 5,510,920
	15 million	1866		4,133,190
	10 million	1244		2,755,460
Washoe Medical	\$ 20 million	2488	-2421	0
	15 million	1866		0
	10 million	1244		0
*Assessments only apply to hospitals having 200 or more beds which served less than their "fair share" of Medicaid patients.				

As derived from Table No. 3, the assessments placed upon each relevant hospital to fund the \$15 million program cost would be as follows:

- Desert Springs Hospital - approximately \$3.8 million
- St. Mary's Hospital - approximately \$2.6 million
- Sunrise Hospital - approximately \$4.4 million
- Valley Hospital - approximately \$4.1 million

CONCLUSION

The legislative subcommittee proposes the "fair share" program as an integral element within its package of legislative recommendations. The proposal addresses the problems of inequities in distribution of Medicaid patients among the hospitals. It also alleviates a portion of the counties' burden of financing indigent care, provides a mechanism for doubling the state's program dollars through matches with federal money, reduces the amount of "uncompensated care" within hospitals, and solidifies the overall package by providing funds to finance two additional recommendations and third recommendation approved through a different legislative study.

APPENDIX C

Suggested Legislation

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SUMMARY--Expands regulation of holding companies for health maintenance organizations. (BDR 57-65)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to holding companies; including health maintenance organizations which are combined with holding companies within the provisions which regulate insurance holding companies; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. Chapter 692C of NRS is hereby amended by adding thereto a new section to read as follows:

For the purposes of this chapter:

- 1. A health maintenance organization shall be deemed an insurer; and*
- 2. A combination of two or more affiliated persons, one or more of which is a health maintenance organization, shall be deemed an insurance holding company system.*

Sec. 2. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

A health maintenance organization which is combined in any manner with a holding company is subject to the provisions of NRS 680A.320. For the purposes of that section, a health maintenance organization shall be deemed an insurer.

Sec. 3. 1. The provisions of this act do not apply to any transaction between a holding company and a health maintenance organization which was entered into before July 1, 1987.

2. A holding company which is required to register with the commissioner pursuant to NRS 692C.260 must register on or before January 1, 1988.

SUMMARY--Urges Congress of United States to authorize tax credit to encourage small businesses to provide group health insurance for employees.
(BDR R-71)

FISCAL NOTE: Effect on Local Government: No.
 Effect on the State or on Industrial Insurance: No.

JOINT RESOLUTION--Urging the Congress of the United States to authorize tax credits to encourage small businesses to provide group health insurance for their employees.

WHEREAS. The cost of insurance for medical care is rising at an alarming rate; and

WHEREAS. Many small businesses cannot afford to provide group health insurance for their employees; and

WHEREAS. The employees of these small businesses are left without adequate health insurance and must rely on public sources; now, therefore, be it

RESOLVED BY THE AND OF THE STATE OF NEVADA, JOINTLY. That the legislature of the State of Nevada urges the Congress of the United States to authorize a tax credit for small businesses which would encourage these businesses to provide group health insurance for their employees; and be it further

RESOLVED. That copies of this resolution be prepared and transmitted forthwith by the _____ to the Vice President of the United States as presiding officer of the Senate. the Speaker of the House of

Representatives and the members of Nevada's congressional delegation;
and be it further

RESOLVED, That this resolution becomes effective upon passage and
approval.

SUMMARY--Authorizes agreements between insurers and providers of health care for preferential provision of health care. (BDR 57-72)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to health care; authorizing agreements between insurers and providers of health care for the preferential provision of health care; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. Title 57 of NRS is hereby amended by adding thereto a new chapter to consist of the provisions set forth as sections 2 to 12, inclusive, of this act.

Sec. 2. As used in this chapter, unless the context otherwise requires:

1. "Health care" means any service included in the furnishing to any natural person of medical or dental care or hospitalization or incident to the furnishing of such care or hospitalization, including the furnishing to any person of any other services to prevent, alleviate, cure or heal human illness or injury.

2. "Insurer" includes a person who is self-insured.

3. "Provider of health care" means any physician, hospital or other person who is licensed or otherwise authorized in this state to furnish health care.

4. "Subscriber" means any person on whose behalf an insurer is paying for or providing health care.

Sec. 3. 1. An insurer of health care may enter into a written agreement for the preferential provision of health care with a provider of health care or a group of providers of health care to control or reduce the cost of the health care by establishing a preferential business relationship between the contracting parties.

2. The agreement may include:

(a) The amount and manner of payment to the provider of health care;

(b) A requirement for a review of the use of services by subscribers;

(c) A limitation of the number of providers of health care with whom agreements may be made; and

(d) Any other provision approved by the commissioner.

3. The payment of a provider of health care for care provided pursuant to the agreement must not be based solely upon the number of subscribers covered by the agreement. Payment must be based upon the particular service provided to each subscriber. This subsection does not prohibit charges for payment of administrative expenses.

Sec. 4. A policy of health insurance which provides benefits based on an agreement for the preferential provision of health care:

1. Must allow the selection of a provider of health care other than one who is a party to the agreement;

2. Must provide for reimbursement for emergency health care received from a provider of health care who is not a party to the agreement if the subscriber cannot reasonably receive care from a provider of health care who is a party to the agreement;

3. Must disclose to the subscriber the incentive, if any, to use the services of a provider of the health care who is a party to the agreement or the disincentive, if any, against using the services of providers who are not parties to the agreement;

4. May provide that the benefits for services received from a provider of health care who is not a party to the agreement are limited to the amounts payable pursuant to the agreement; and

5. Except as otherwise provided in section 5 of this act, may provide an incentive to the subscriber to use the services of a provider of health care who is a party to the agreement or a disincentive against using the services of providers who are not parties to the agreement.

Sec. 5. The difference between payments made by an insurer of health care to:

1. A provider of health care who is a party to an agreement for the preferred provision of health care; and

2. A provider of health care who is not a party to such an agreement, must not be more than 30 percent, including any copayment and deductible amount. All agreements for the preferred provision of health care must be approved by the commissioner to ensure compliance with this limitation.

Sec. 6. A review of the use of services must not result in the imposition of costs on a subscriber or the holder of the policy of insurance because of a denial of payment after the care has been provided unless the care:

1. Was not approved before it was provided; and

2. Was not medically necessary.

Sec. 7. 1. Any person may enter into an agreement with a provider of health care or a group of providers of health care for the preferential provision of health care if he:

(a) Does so to offer participation in the agreement to insurers;

(b) Does not accept any risk of financial loss;

(c) Is paid by insurers or providers of health care for entering into and administering the agreement; and

(d) Clearly discloses his role and limited responsibility to an insurer when offering participation in the agreement to him.

2. A person who enters into an agreement described in subsection 1 shall file with the commissioner within 30 days after entering into the agreement, a statement executed under penalty of perjury:

(a) Affirming that he has complied with subsection 1; and

(b) Providing a description of his business.

Sec. 8. This chapter does not apply to an agreement for the preferential provision of health care between an employer and a provider of health care if the agreement is for the exclusive benefit of employees and their dependents.

Sec. 9. The commissioner may adopt regulations necessary to carry out the provisions of this chapter, including standards for agreements for the preferential provision of health care. The standards may include, without limitation:

1. The establishment of panels of preferred providers of health care;

2. The method to be used for making the services of a panel available to insurers or to organizations of potential patients;

3. The establishment of procedures for review of the use of services; and

4. The establishment of economic incentives for patients to use providers participating in the preferential agreement, other than the difference in payment authorized by a regulation adopted pursuant to section 5 of this act.

Sec. 10. The charging of an amount less than a provider of health care charges other patients, pursuant to an agreement for the preferential provision of health care, does not constitute:

1. The division of fees with an unlicensed person; or
 2. Compensation for referring a person to a provider of health care or otherwise inducing communication with a provider,
- for the purposes of statutes which provide for the licensing and regulation of providers of health care.

Sec. 11. 1. The state board of health may adopt regulations concerning the accessibility, adequacy and continuity of health care provided pursuant to an agreement for the preferential provision of health care. An agreement which does not comply with the regulations is unenforceable.

2. The health division may inspect the records and files of insurers and providers of health care at any reasonable time to determine whether an agreement for the preferential provision of health care complies with any regulations adopted pursuant to subsection 1.

Sec. 12. 1. Except as provided in subsection 2, a person who violates any provision of this chapter is guilty of a misdemeanor.

2. A person who knowingly fails to file the statement required pursuant to section 7 of this act is guilty of a gross misdemeanor.

Sec. 13. NRS 686A.100 is hereby amended to read as follows:

686A.100 1. No person may make or permit any unfair discrimination between persons of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such a contract.

2. No person may make or permit any unfair discrimination between persons of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy or contract of health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such a contract, or in any other manner whatever.

3. [No] *Except as provided in sections 2 to 12, inclusive, of this act, no person may make or permit any unfair discrimination between persons legally qualified to provide a particular service, in the amount of the fee or charge for that service payable as a benefit under any policy or contract of health insurance.*

Sec. 14. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

No policy of health insurance may provide that the insured does not have the option of selecting any licensee provided for in subsection 3 of NRS 689A.380 to perform any medical or surgical services covered by the policy if the service is within the scope of his license. This section does not prohibit agreements for the preferential provision of health care which comply with the provisions of sections 2 to 12, inclusive, of this act.

Sec. 15. NRS 689A.380 is hereby amended to read as follows:

689A.380 As used in any policy of health insurance delivered, issued for delivery or used in this state, unless otherwise provided in the policy or in an endorsement thereon or in a rider attached thereto:

1. "Accidental death" means death by accident exclusively and independently of all other causes.

2. "Confinement to house" or "house confinement" includes the activities of a convalescent not able to be gainfully employed.

3. "Medical or surgical services" includes also services within the scope of his license rendered by any person while [duly] licensed by the State of Nevada under [any of the following chapters of NRS: 631 (dentistry); 633 (osteopathic medicine); 634 (chiropractic); 634A (Oriental medicine); 635 (podiatry); or 636 (optometry). No policy of health insurance may provide that the insured does not have the option of selecting any licensee provided for in this subsection to perform any medical or surgical services covered by a policy of insurance if the service is within the scope of his license.] *chapter 631, 633, 634, 634A, 635 or 636 of NRS.*

4. "Total disability" means inability to perform the duties of any gainful occupation for which the insured is reasonably fitted by training, experience and accomplishment.

Sec. 16. NRS 631.347 is hereby amended to read as follows:

631.347 1. Participating in any plan or practice in which patients are required to select a dentist from a preselected group constitutes unprofessional conduct unless [those] :

(a) *Those patients are also offered a plan which provides them with a reasonable opportunity to select a dentist of their own choice [.] ; or*

(b) *The plan or practice is based on an agreement for the preferential provision of health care.*

2. The board may not revoke the license of a person who participates in [such] a *prohibited* plan or practice but may take any other action authorized in this chapter regarding unprofessional conduct.

Sec. 17. Any person who has entered into an agreement for the preferred provision of health care before July 1, 1987, shall, on or before September 1, 1987:

1. Notify the commissioner of the terms of the agreement:

2. Provide the commissioner with any information he considers necessary; and

3. If section 7 of this act applies to the person, file the statement required by that section.

SUMMARY--Requires adoption of disciplinary measures for pupil who uses tobacco. (BDR 34-73)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to public schools; requiring the adoption of disciplinary measures for a pupil who uses tobacco on school premises; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. NRS 392.464 is hereby amended to read as follows:

392.464 1. The board of trustees of each school district shall adopt and enforce measures for disciplining any pupil who [is] :

(a) *Is found in possession of an intoxicating liquor or a controlled substance [.] ; or*

(b) *Uses tobacco in any form.*

while on the premises of any public school in its district.

2. As used in this section:

(a) "Controlled substance" has the meaning ascribed to it in NRS 453.041.

(b) "Intoxicating liquor" has the meaning ascribed to it in NRS 202.055.

SUMMARY--Requires establishment of ethics institute within University of Nevada System. (BDR 34-74)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to the University of Nevada System; requiring the board of regents to establish an ethics institute to study issues relating to standards of medical care and to medical ethics; prescribing the powers and duties of the board of regents on behalf of the institute; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. Chapter 396 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 8. inclusive, of this act.

Sec. 2. *The board of regents shall establish for educational research an ethics institute as an institution of the University of Nevada System to study questions and define standards regarding medical ethics.*

Sec. 3. *The primary purposes of the ethics institute are:*

- 1. To study the current standard of medical care and to determine whether it is adequate;*
- 2. To determine what the standard of care should be; and*
- 3. To determine which medical procedures or actions are ethical and which are not ethical.*

Sec. 4. *The ethics institute may:*

1. Plan and arrange educational activities to provide for practical applications of ethical consensus in medical practice.

2. Act as a forum for persons to address issues of medical ethics.

3. Coordinate informed communication between providers of health care and persons who make public policy in matters of medical ethics.

4. Act as a clearinghouse of information for members of the medical profession, hospital administrators, persons who make public policy and the public on matters of medical ethics.

Sec. 5. *The board of regents, on behalf of the ethics institute, may:*

1. Enter into contracts with persons or governmental agencies who wish to use the services or facilities of the ethics institute.

2. Receive and hold any real or personal property, including patents, copyrights, royalties and contracts.

3. Manage, invest, use and dispose of any property received, either as specified by the donor or for the furtherance of the objectives of the ethics institute.

Sec. 6. *1. The board of regents may establish policies and procedures for personnel in connection with the operation of contractual or sponsored activities of the ethics institute, apart from those policies and procedures which are established for the professional personnel of other institutions of the university.*

2. In establishing such policies and procedures, the board of regents is not bound by any of the other provisions of this chapter or the provisions of Title 23 of NRS, and none of those provisions are applicable to any person employed in connection with the operation of contractual or sponsored activities of the institute except as may be prescribed by the board of regents.

Sec. 7. *Any money received by the board of regents on behalf of the ethics institute pursuant to section 5 of this act, may be deposited by the board of regents to the credit of the ethics institute in any federally insured financial institution in the State of Nevada. The*

board of regents may act through any authorized agent in depositing or withdrawing any money in such an account.

Sec. 8. *1. The board of regents shall establish fiscal policies and procedures in connection with the operation of contractual or sponsored activities of the ethics institute, apart from those fiscal policies and procedures which are applicable to other institutions of the university.*

2. None of the other provisions of this chapter or the provisions of Title 23 or 31 of NRS or any other statute relating to public officers and employees or public financial administration applies to the receipt, investment, management, disbursement, use, expenditure or accounting for any money or property received by the board of regents pursuant to section 5 of this act.

3. Any money received by or made available to the board of regents for the ethics institute by the State of Nevada, whether pursuant to direct legislative appropriation or otherwise, is subject to all laws relating to public money and expenditures.

SUMMARY--Requires establishment of program to provide health insurance for certain children. (BDR 38-76)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to health insurance; requiring the establishment of a program to provide health insurance for certain children; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. Chapter 432A of NRS is hereby amended by adding thereto a new section to read as follows:

1. The director shall establish and administer a program through which a person may donate money to provide health insurance for a child whose parents or guardians are not able to provide such insurance.

2. The director shall, by regulation:

(a) Establish a standard of eligibility for the enrollment of children in the program;

and

(b) Specify the benefits which must be provided in the policy of health insurance.

3. The director may adopt regulations which are otherwise necessary to the administration of the program.

SUMMARY--Requires health division of department of human resources to establish program for treatment of physical trauma. (BDR 40-85)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to emergency medical care; requiring the health division of the department of human resources to establish certain programs concerning the treatment of physical trauma; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY. DO ENACT AS FOLLOWS:**

Section 1. Chapter 450B of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 5, inclusive, of this act.

Sec. 2. *A person shall not operate a center for emergency medical care without first applying for and obtaining the written approval of the administrator of the health division.*

Sec. 3. *1. The health division shall establish a program for treating persons who require emergency medical care and for transporting and admitting such persons to centers for emergency medical care or other appropriate hospitals.*

2. The administrator of the health division shall adopt regulations which establish the standards for the designation of a hospital as a center for emergency medical care. The administrator shall consider the standards adopted by the American College of Surgeons for a center for the treatment of trauma as a guide for such regulations. The administrator of the health division shall not approve a proposal to designate a hospital as a center for emergency care unless the hospital meets the standards.

3. Upon approval by the administrator of the health division of a proposal to designate a hospital as a center for emergency care, the health division shall issue a license which designates the hospital as such a center. As a condition of continuing designation the hospital must comply with the following requirements:

(a) The hospital must admit any person who requires emergency medical care.

(b) Any physician who provides emergency medical care must be qualified to provide that care.

(c) The hospital must maintain the standards specified in the regulations adopted pursuant to subsection 2.

Sec. 4. The administrator of the health division shall adopt regulations which require each hospital to record and maintain information concerning emergency medical care in the hospital. The administrator shall consider the guidelines adopted by the American College of Surgeons which concern the information which must be recorded.

Sec. 5. In addition to the education and training required by this chapter, the health division shall cooperate with the American College of Surgeons to provide training in emergency medical care.

Sec. 6. A hospital may apply to the health division of the department of human resources before January 1, 1988, for designation as a center for emergency care. If the hospital meets the standards of the American College of Surgeons for a "Level II Trauma Center" which are in effect on the effective date of this act, the administrator of the division shall issue a license which designates the hospital as a center for emergency care. A hospital which is designated pursuant to this section is not required to obtain approval pursuant to section 2 of this act, but is required to comply with all regulations and conditions applicable to other such centers to maintain its designation.

Sec. 7. This act becomes effective upon passage and approval.

SUMMARY--Establishes formula to determine amount paid as assistance to medically indigent and requires review of persons who receive assistance. (BDR 38-86)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to assistance to the medically indigent; establishing a formula to determine the amount of payments; requiring review of persons who receive assistance; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. *1. The state plan for assistance to the medically indigent must require the welfare division to pay to a hospital in Nevada as assistance to the medically indigent a prospective payment for the care of each person who is certified for admission pursuant to section 3 of this act and who is eligible for such assistance. The payment is the entire amount to which the hospital is entitled for the care of the indigent person. The payment must be based upon the costs of medical care at the most efficient and economical hospital in its category and the average length of stay of a person admitted to such a hospital for the type of care for which he is admitted.*

2. The administrator shall, by regulation:

(a) Place each hospital in a category based on its size and location and the medical conditions of the persons it admits;

(b) Specify the different types of care for which prospective payment will be made; and

(c) Specify, for each category of hospital and each type of care:

(1) The elements included by the administrator in determining the costs of medical care;

(2) The costs of medical care;

(3) The most efficient and economical hospital; and

(4) The average length of stay of a person admitted to a hospital.

3. The prospective payment must be adjusted semiannually for inflation based upon the percentage increase in the Consumer Price Index (Medical Care Component for all Urban Consumers).

Sec. 3. *The welfare division shall cause an independent professional review to be made of each person who receives assistance to the medically indigent for care provided in a hospital. The purposes of the review are to certify that each person admitted meets the welfare division's criteria for admission and to ensure that hospitals are paid only the amounts to which they are entitled.*

SUMMARY--Requires study of system of articulation and transfer of credits for education of nurses. (BDR S-88)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to nurses; creating a committee to study the system of articulation and transfer of credits for education; prescribing the committee's duties; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. 1. There is hereby created the committee to study education of nurses. The committee consists of nine members appointed by the governor. The governor shall appoint:

(a) One member who is a representative of the state board of nursing;

(b) Two members who are educators of nurses who teach at universities;

(c) Two members who are educators of nurses who teach at community colleges;

(d) Two members who are providers of health care or their representatives; and

(e) Two members who are representatives of the general public.

The governor shall appoint one member from Nye, Clark, Lincoln or Esmeralda county and one member from any other county for each appointment made pursuant to paragraphs (b) to (e), inclusive.

2. The committee shall:

- (a) Study the system of education of nurses in Nevada;
 - (b) Study the system of articulation and transfer of credits;
 - (c) Study other matters related to qualifications of nurses;
 - (d) Make recommendations for changes in laws related to education of nurses, articulation and transfer of credits, and other matters studied by the committee; and
 - (e) Report the results of the study and any recommendations to the governor and the 65th session of the legislature.
3. The state board of nursing shall provide staff and other assistance necessary to the committee for the completion of its study and report.

SUMMARY--Requires counties to establish standards to determine indigence and specifies minimum standard. (BDR 38-110)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to indigent persons; requiring counties to adopt standards of eligibility for financial and medical assistance; establishing a minimum standard for eligibility for medical assistance; authorizing an appeal of a denial of benefits; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. Chapter 428 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. 1. *The board of county commissioners shall, on or before July 1 of each odd-numbered year, adopt an ordinance and any related policies which establish the standards of eligibility for medical and financial assistance to indigent persons. The ordinance and policies must specify the allowable income, assets and other resources or potential resources of persons eligible for assistance. The board of county commissioners shall file the ordinance and policies and any amendment to the ordinance or policies with the secretary of state within 30 days after adoption.*

2. *A county's standards of eligibility for medical assistance must not deny eligibility to a person living in a household which has a total monthly income of less than:*

(a) For one person living without another member of a household, \$438.

(b) For two persons, \$588.

(c) For three or more persons, \$588 plus \$150 for each person in the family in excess of two.

For the purposes of this subsection, "income" includes the entire income of a household and the amount which a county projects a person or household is able to earn. "Household" is limited to a person and his spouse, parents, children, brothers and sisters residing with him.

3. A county's program of medical assistance to indigent persons must provide payment for:

(a) Emergency medical care; and

(b) Care in a medical facility, whether or not the person is admitted to the facility.

Sec. 3. *1. A person who is denied by a county financial or medical assistance pursuant to this chapter may appeal the decision to the board of county commissioners. If application is made directly to the board of county commissioners or if the board denies an appeal, the person who is denied assistance may appeal to the district court.*

2. If a board of county commissioners determines that a person to whom medical care has been provided is indigent and is a resident of another county in this state, the other county may appeal the determination to the district court for the county in which the care was provided. The district court shall determine:

(a) Whether the person is indigent according to the ordinance and policies in effect in the county in which care was provided; and

(b) Which of the two counties is the legal residence of the person, if the person is determined pursuant to paragraph (a) to be indigent and his residence is disputed.

Sec. 4. *NRS 428:010 is hereby amended to read as follows:*

428.010 *1. To the extent that [moneys] money may be lawfully appropriated by the board of county commissioners for this purpose pursuant to NRS 428.050, every county shall provide care, support and relief to the poor, indigent, incompetent and those incapacitated by age.*

disease or accident, lawfully resident therein, when such persons are not supported or relieved by their relatives or guardians, by their own means, or by state hospitals, or other state, federal or private institutions or agencies.

2. The boards of county commissioners of the several counties [are vested with the authority to] *shall* establish and approve policies and standards, prescribe a uniform standard of eligibility, appropriate [funds] *money* for this purpose and appoint agents who will develop [rules and] regulations and administer these programs [for the purpose of providing] *to provide* care, support and relief to the poor, indigent, incompetent and those incapacitated by age, disease or accident.

Sec. 5. NRS 428.030 is hereby amended to read as follows:

428.030 1. When any [poor] person meets the uniform standards of eligibility established by the board of county commissioners [and does not have relatives of sufficient ability to care for and maintain such poor person, or when such relatives refuse or neglect to care for and maintain such person, then such poor person shall] , *then he is entitled to* receive such relief as is in accordance with the policies and standards established and approved by the board of county commissioners and within the limits of the [funds] *money* which may be lawfully appropriated pursuant to NRS 428.050 for this purpose.

2. The board of county commissioners may:

- (a) Make contracts for the necessary maintenance of poor persons;
- (b) Appoint such agents as the board may deem necessary to oversee and provide the necessary maintenance of poor persons;
- (c) Authorize the payment of cash grants direct to poor persons for their necessary maintenance; or

(d) Provide for the necessary maintenance of poor persons by the exercise of the combination of one or more of the powers specified in paragraphs (a), (b) and (c) of this subsection.

SUMMARY--Requires proof of financial responsibility at time of renewal of registration and increases amount of required insurance on motor vehicles. (BDR 43-113)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to motor vehicles; requiring proof of financial responsibility at the time of renewal of registration; increasing the amount of security required as proof of financial responsibility; providing an additional administrative penalty for failure to provide proof of financial responsibility; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. NRS 482.280 is hereby amended to read as follows:

482.280 1. The registration of every vehicle expires at midnight on the day specified on the receipt of registration. The department shall mail to each holder of a valid certificate of registration an application for renewal of registration for the following period of registration. The applications must be mailed by the department in sufficient time to allow all applicants to mail the applications to the department and to receive new certificates of registration and license plates, stickers, tabs or other suitable devices by mail before the expiration of subsisting registrations. An applicant may present the application to any agent or office of the department.

2. An application mailed or presented to the department or to a county assessor under the provisions of this section must include:

(a) A signed declaration by the applicant that he has and will maintain, during the period of registration, security as required by NRS 485.185 covering the motor vehicle to be registered. *If the security is provided by a contract of insurance, the insurer shall provide evidence of that insurance to the department and the insured on a form approved by the commissioner of insurance which identifies the vehicle and indicates, at the time of renewal of registration, coverage which meets the requirements of NRS 485.185. The applicant must include his copy of the form with his application.*

(b) If required, evidence of compliance with standards for control of emissions.

3. The department shall insert in each application mailed as required by subsection 1 the amount of privilege tax to be collected for the county under the provisions of NRS 482.260.

4. An owner who has made proper application for renewal of registration before the expiration of the current registration but who has not received the license plate or plates or card of registration for the ensuing period of registration is entitled to operate or permit the operation of that vehicle upon the highways upon displaying thereon the license plate or plates issued for the preceding period of registration for such time as may be prescribed by the department as it may find necessary for the issuance of the new plate or plates or card of registration.

Sec. 2. NRS 482.295 is hereby amended to read as follows:

482.295 1. The department shall not register a vehicle intended to be leased by a short-term lessor until the owner [shall demonstrate]

demonstrates to the department his financial ability to respond to damages as follows:

(a) By carrying insurance in an insurance company or companies approved by the *commissioner of insurance* ; [commissioner of this state as provided in subsection 2 and NRS 482.305;]

(b) By filing with the department a surety bond in the principal sum of \$100,000 with an admitted insurer as surety for the protection of the lessee of the vehicle; or

(c) By making and thereafter continuously maintaining on deposit in this state through the director, cash or securities such as may be legally purchased by savings banks or for trust funds, of a fair market value of not less than \$100,000 for the protection of the lessee of the vehicle.

2. If the owner's demonstration of financial ability is pursuant to paragraph (a) of subsection 1, it [shall] *must* be as follows:

(a) If he [apply] *is applying* for the registration of one motor vehicle, insurance in the sum of at least [\$15,000] *\$25,000* for any person injured or killed [and in the sum of \$30,000] , *\$50,000* for any number more than one injured or killed in any one accident [.] *and \$20,000 for injury to or destruction of property.*

(b) If he [apply] *is applying* for the registration of more than one motor vehicle, then the insurance in the [foregoing] sums *required* for one motor vehicle and \$5,000 additional for each motor vehicle in excess of one.

3. [In any case, the] *The* owner's demonstration of financial ability is sufficient if he carries insurance or provides a surety bond or deposits cash or securities in the sum of \$100,000 for any number of motor vehicles.

Sec. 3. NRS 482.305 is hereby amended to read as follows:

482.305 1. The short-term lessor of a motor vehicle who permits the short-term lessee to operate the vehicle upon the highways [,] and who has not complied with NRS 482.295 [insuring or otherwise covering the short-term lessee against liability arising out of his negligence in the operation of such rented vehicle in limits of not less than \$15,000 for any one person injured or killed and \$30,000 for any number more than one injured or killed in any one accident, and against liability of the short-term lessee for property damage in the limit of not less than \$5,000 for one accident,] is jointly and severally liable with the short-term lessee for any damages caused by the negligence of the latter in operating the vehicle and for any damages caused by the negligence of any person operating the vehicle by or with the permission of the short-term lessee, except that the [foregoing] provisions *of this subsection* do not confer any right of action upon any passenger in any such rented vehicle against the short-term lessor. This section does not prevent the introduction as a defense of contributory negligence to the extent to which [such] *the* defense is allowed in other cases.

2. The policy of insurance, surety bond or deposit of cash or securities inures to the benefit of any person operating the vehicle by or with the permission of the short-term lessee in the same manner , [and] under the same conditions and to the same extent as to the short-term lessee.

3. The *policy of insurance* . [policy or policies,] surety bond or deposit of cash or securities need not cover any liability incurred by the short-term lessee of any vehicle to any passenger in [such vehicle; but the] *the vehicle. The* short-term lessor before delivering the vehicle shall give to the short-term lessee a written notice of the fact that [such policy or

policies,] *the policy* bond or deposit [do] *does* not cover the liability which the short-term lessee may incur on account of his negligence in the operation of [such] *the* vehicle to any passenger in [such] *the* vehicle.

4. When any suit or action is brought against the short-term lessor under this section, the [judge or court before whom the case is pending shall cause] *court shall hold* a preliminary hearing [to be had] in the absence of the jury for the purpose of determining whether the short-term lessor has provided insurance or a surety bond or deposit of cash or securities covering the short-term lessee in the [limits above mentioned.] *required amounts*. Whenever it appears that the short-term lessor has provided insurance or a surety bond or deposit of cash or securities covering the short-term lessee in the [sums above mentioned, the judge or] *required amounts, the* court shall dismiss as to the short-term lessor the action brought under this section.

Sec. 4. NRS 485.105 is hereby amended to read as follows:

485.105 "Proof of financial responsibility" means proof of ability to respond in damages for liability, on account of accidents occurring subsequent to the effective date of that proof, arising out of the ownership, maintenance or use of a motor vehicle, in the amount of [\$15,000] *\$25,000* because of bodily injury to or death of one person in any one accident, and, subject to the limit for one person, in the amount of [\$30,000] *\$50,000* because of bodily injury to or death of two or more persons in any one accident, and in the amount of [\$10,000] *\$20,000* because of injury to or destruction of property of others in any one accident.

Sec. 5. NRS 485.210 is hereby amended to read as follows:

485.210 1. No policy or bond is effective under NRS 485.190 unless issued by an insurance company or surety company authorized to do business in this state, except as provided in subsection 2 of this section, or unless the policy or bond is subject, if the accident has resulted in bodily injury or death, to a limit, exclusive of interest and costs, of not less than [~~\$15,000~~] *\$25,000* because of bodily injury to or death of one person in any one accident and, subject to the limit for one person, to a limit of not less than [~~\$30,000~~] *\$50,000* because of bodily injury to or death of two or more persons in any one accident and, if the accident has resulted in injury to or destruction of property, to a limit of not less than [~~\$10,000~~] *\$20,000* because of injury to or destruction of property of others in any one accident.

2. No policy or bond is effective under NRS 485.190 with respect to any vehicle which was not registered in this state or to any vehicle which was registered elsewhere than in this state at the effective date of the policy or bond or the most recent renewal thereof, unless the insurance company or surety company issuing that policy or bond is authorized to do business in this state or, if the company is not authorized to do business in this state, unless it executes a power of attorney authorizing the director to accept service on its behalf of notice or process in any action upon that policy or bond arising out of an accident.

Sec. 6. NRS 485.304 is hereby amended to read as follows:

485.304 Judgments [~~must~~] *shall* for the purpose of this chapter only. be deemed satisfied:

1. When [~~\$15,000~~] *\$25,000* has been credited upon any judgment or judgments rendered in excess of that amount because of bodily injury to or death of one person as the result of any one accident;

2. When, subject to the limit of [~~\$15,000~~] ~~\$25,000~~ because of bodily injury to or death of one person, the sum of [~~\$30,000~~] ~~\$50,000~~ has been credited upon any judgment or judgments rendered in excess of that amount because of bodily injury to or death of two or more persons as the result of any one accident; or

3. When [~~\$10,000~~] ~~\$20,000~~ has been credited upon any judgment or judgments rendered in excess of that amount because of injury to or destruction of property of others as a result of any one accident, but payments made in settlement of any claims because of bodily injury, death or property damage arising from a motor vehicle accident must be credited in reduction of the amounts provided for in this section.

Sec. 7. NRS 485.3091 is hereby amended to read as follows:

485.3091 1. A "motor vehicle liability policy" as the term is used in this chapter means an owner's or an operator's policy of liability insurance issued, except as otherwise provided in NRS 485.309, by an insurance carrier [duly] authorized to transact business in this state, to or for the benefit of the person named therein as insured.

2. [Such an] *An* owner's policy of liability insurance must:

(a) Designate by explicit description or by appropriate reference all motor vehicles with respect to which coverage is thereby to be granted; and

(b) Insure the person named therein and any other person, as insured, using any such motor vehicle or motor vehicles with the express or implied permission of the named insured, against loss from the liability imposed by law for damages arising out of the ownership, maintenance or use of [such] *the* motor vehicle or motor vehicles within [the United States of America or the Dominion of Canada,] *any state*, subject to limits

exclusive of interest and costs, with respect to each [such] motor vehicle, as follows: [\$15,000] \$25,000 because of bodily injury to or death of one person in any one accident, and, subject to the limit for one person, [\$30,000] \$50,000 because of bodily injury to or death of two or more persons in any one accident, and [\$10,000] \$20,000 because of injury to or destruction of property of others in any one accident.

3. [Such an] An operator's policy of liability insurance must insure the person named as insured therein against loss from the liability imposed upon him by law for damages arising out of the use by him of any motor vehicle not owned by him, within the same territorial limits and subject to the same limits of liability as are set forth [above] with respect to an owner's policy of liability insurance.

4. [Such a] A motor vehicle liability policy must state the name and address of the named insured, the coverage afforded by the policy, the premium charged therefor, the policy period and the limits of liability, and must contain an agreement or be endorsed that insurance is provided thereunder in accordance with the coverage defined in this chapter as respects bodily injury and death or property damage, or both, and is subject to all the provisions of this chapter.

5. [Such a] A motor vehicle liability policy need not insure any liability under any workmen's compensation law nor any liability on account of bodily injury to or death of an employee of the insured while engaged in the employment, other than domestic, of the insured, or while engaged in the operation, maintenance or repair of any [such] motor vehicle, nor any liability for damage to property owned by, rented to, in charge of or transported by the insured.

6. Every motor vehicle liability policy is subject to the following provisions which need not be contained therein:

(a) The liability of the insurance carrier with respect to the insurance required by this chapter becomes absolute whenever injury or damage covered by the motor vehicle liability policy occurs . [; the] *The* policy may not be canceled or annulled as to such liability by any agreement between the insurance carrier and the insured after the occurrence of the injury or damage . [; no] *No* statement made by the insured or on his behalf and no violation of the policy defeats or voids the policy.

(b) The satisfaction by the insured of a judgment for such injury or damage is not a condition precedent to the right or duty of the insurance carrier to make payment on account of the injury or damage.

(c) The insurance carrier may settle any claim covered by the policy, and if [such] a settlement is made in good faith, the amount thereof is deductible from the limits of liability specified in paragraph (b) of subsection 2 of this section.

(d) The policy, the written application therefor, if any, and any rider or endorsement which does not conflict with the provisions of this chapter constitute the entire contract between the parties.

7. Any policy which grants the coverage required for a motor vehicle liability policy may also grant any lawful coverage in excess of or in addition to the coverage specified for a motor vehicle liability policy, and the excess or additional coverage is not subject to the provisions of this chapter. With respect to a policy which grants such excess or additional coverage the term "motor vehicle liability policy" applies only to that part of the coverage which is required by this section.

8. Any motor vehicle liability policy may provide for the prorating of the insurance thereunder with other valid and collectible insurance.

9. The requirements for a motor vehicle liability policy may be fulfilled by the policies of one or more insurance carriers, which policies together meet those requirements.

10. Any binder issued pending the issuance of a motor vehicle liability policy shall be deemed to fulfill the requirements for such a policy.

Sec. 8. NRS 485.326 is hereby amended to read as follows:

485.326 The department shall suspend the license of any person convicted of violating NRS 485.185 and the registration of the vehicle described on the report of conviction. *The license must be suspended for not less than 6 months.* The license and registration must remain suspended until he shows proof of financial responsibility as set forth in NRS 485.307. He shall maintain proof of financial responsibility for 3 years after the reinstatement of his license and registration in accordance with the provisions of this chapter, and if he fails to do so, the division shall suspend his license and registration.

SUMMARY--Requires state board of health to establish standards for perinatal care.

(BDR 40-114)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to maternal and child health; requiring the state board of health to establish standards for perinatal care; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. Chapter 442 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The state board of health shall adopt regulations establishing standards for perinatal care provided by any provider of health care. The health division shall enforce the standards.

2. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

SUMMARY--Extends aid to dependent children to include children who live with both parents. (BDR 38-115)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to public assistance; extending aid to dependent children to include a child who lives with both parents; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 422.007 is hereby amended to read as follows:

422.007 As used in this chapter, "*aid to families with dependent children*" means the program established to provide assistance to needy dependent children pursuant to Title IV of the Social Security Act (42 U.S.C. §§ 601 et seq.) and other provisions of that act relating to assistance to dependent children.

Sec. 2. NRS 422.050 is hereby amended to read as follows:

422.050 For the purposes of this chapter, "public assistance" includes:

- 1. State supplementary assistance provided in connection with the supplemental security income program;**
- 2. Services to the aged, blind or disabled;**
- 3. Aid to *families with dependent children*; and**
- 4. Assistance to the medically indigent.**

Sec. 3. NRS 422.232 is hereby amended to read as follows:

422.232 1. The administrator shall establish a state plan for aid to *families with dependent children*. The state plan is subject to the approval of the board. The state plan must set forth the requirements for eligibility of a needy dependent child and the relative with whom he is living and must also set forth the nature and amounts of grants and other assistance which may be provided, the conditions imposed and such other provisions relating to the development and administration of the program for aid to *families with dependent children* as the administrator and the board deem necessary. *If a child is otherwise eligible, assistance must not be denied for the reason that he is living with both of his parents.*

2. In developing and revising the state plan, the administrator and the board shall consider, among other things, the amount of money available from the Federal Government for aid to *families with dependent children* and the conditions attached to the acceptance of such money, and the limitations of legislative appropriations for aid to *families with dependent children*.

Sec. 4. NRS 422.270 is hereby amended to read as follows:

422.270 1. The department shall:

(a) Administer all public welfare programs of this state, including:

(1) State supplementary assistance provided in connection with the supplemental security income program;

(2) Aid to *families with dependent children*;

(3) Child welfare services;

(4) Services to the aged, blind or disabled;

(5) Assistance to the medically indigent; and

(6) Such other welfare activities and services as now are or hereafter may be authorized or provided for by the laws of this state.

(b) Act as the single state agency of the State of Nevada and its political subdivisions in the administration of any federal money granted to the state to aid in the furtherance of any of the services and activities set forth in paragraph (a).

(c) Cooperate with the Federal Government in adopting state plans, in all matters of mutual concern, including adoption of such methods of administration as may be found by the Federal Government to be necessary for the efficient operation of welfare programs, and in increasing the efficiency of welfare programs by prompt and judicious utilization of new federal grants which will assist the department to fulfill the terms of this chapter.

2. The department through the welfare division shall:

(a) Make regulations, subject to the approval of the board, for the administration of this chapter which are binding upon all recipients and local units.

(b) Observe and study the changing nature and extent of welfare needs and develop through tests and demonstrations effective ways of meeting such needs, employing or contracting for such personnel and services as may be provided through legislative appropriations from the state general fund or may become available through legislatively authorized or new money from federal or other sources.

(c) Make all investigations required by a court in adoption proceedings as provided by law.

(d) Establish reasonable minimum standards and regulations for foster homes, and shall license foster homes as provided by law.

(e) Provide services and care to children, shall receive any child for placement, and shall provide for their care directly or through agents.

(f) Have the power to enter into reciprocal agreements with other states relative to public assistance, welfare services and institutional care.

(g) Make such agreements with the Federal Government as may be necessary to carry out the supplemental security income program.

Sec. 5. NRS 422.410 is hereby amended to read as follows:

422.410 1. Every person who knowingly and designedly, by any false pretense, false or misleading statement, impersonation or misrepresentation, obtains or attempts to obtain monetary or any other public assistance having a value of \$100 or more, whether by one act or a series of acts, with intent to cheat, defraud or defeat the purposes of this chapter shall be punished by imprisonment in the state prison for not less than 1 year nor more than 10 years, or by a fine of not more than \$10,000, or by both fine and imprisonment, and be required to make full restitution of the monetary loss or monetary value of services so fraudulently obtained, if it can be done.

2. For the purposes of subsection 1, whenever a recipient of aid to *families with dependent children* under the provisions of this chapter receives an overpayment of benefits for the third time and the overpayments have resulted from a false statement or representation by the recipient or from the failure of the recipient to notify the welfare division of a change in his circumstances which would affect the amount of assistance he receives, a rebuttable presumption arises that the payment was fraudulently received.

3. For the purposes of subsection 1, "public assistance" includes any money, property, medical or remedial care or any other service provided pursuant to a state plan.

Sec. 6. NRS 425.400 is hereby amended to read as follows:

425.400 1. The division may establish a central unit to serve as a registry for the receipt of information, for answering interstate inquiries concerning deserting responsible parents, to coordinate and supervise departmental activities in relation to deserting responsible parents and to [assure] *ensure* effective cooperation with law enforcement agencies.

2. To effectuate the purposes of this section, the administrator or a prosecuting attorney may request all information and assistance as authorized by NRS 425.260 to 425.440, inclusive, from the following persons and entities:

- (a)** State, county and local agencies;
- (b)** Employers, public and private;
- (c)** Employee organizations and trusts of every kind;
- (d)** Financial institutions and entities which are in the business of providing credit reports; and
- (e)** Public utilities.

All of these persons and entities, their officers and employees, shall cooperate in the location of a responsible parent who has abandoned or deserted, or is failing to support his child and shall on request supply the division and the prosecuting attorney with all information on hand relative to the location, income and property of such parent. A disclosure made in good faith pursuant to this subsection does not give rise to any action for damages for the disclosure.

3. Any record established pursuant to the provisions of this section is available only to:

- (a)** The attorney general;
- (b)** A district attorney;
- (c)** A court having jurisdiction in a paternity, support or abandonment proceeding or action;

(d) The resident parent, legal guardian, attorney or agent of a child who is not receiving aid to *families with dependent children* pursuant to Title IV of the Social Security Act (42 U.S.C. §§ 601 et seq.); or

(e) An agency in other states engaged in the establishment of paternity or in the enforcement of support of minor children as authorized by regulations of the division and by the provisions of the Social Security Act.

Sec. 7. NRS 274.270 is hereby amended to read as follows:

274.270 1. The governing body shall investigate the proposal made by a business pursuant to NRS 274.260, and if it finds that the business is qualified by financial responsibility and business experience to create and preserve employment opportunities in the specially benefited zone and improve the economic climate of the municipality and finds further that the business did not relocate from a depressed area in this state or reduce employment elsewhere in Nevada in order to expand in the specially benefited zone, the governing body may, on behalf of the municipality, enter into an agreement with the business, for a period of not more than 20 years, under which the business agrees in return for one or more of the benefits authorized in this chapter and NRS 374.643 for qualified businesses, as specified in the agreement, to establish, expand, renovate or occupy a place of business within the specially benefited zone and hire new employees at least 35 percent of whom at the time they are employed are at least one of the following:

(a) Unemployed persons who have resided at least 6 months in the municipality.

(b) Persons eligible for employment or job training under any federal program for employment and training who have resided at least 6 months in the municipality.

(c) Recipients of benefits under any state or county program of public assistance, including aid to *families with dependent children*, aid to the medically indigent and unemployment compensation who have resided at least 6 months in the municipality.

(d) Persons with a physical or mental handicap who have resided at least 6 months in the state.

(e) Residents for at least 1 year of the area comprising the specially benefited zone.

2. To determine whether a business is in compliance with an agreement, the governing body:

(a) Shall each year require the business to file proof satisfactory to the governing body of its compliance with the agreement.

(b) May conduct any necessary investigation into the affairs of the business and may inspect at any reasonable hour its place of business within the specially benefited zone.

If the governing body determines that the business is in compliance with the agreement, it shall issue a certificate to that effect to the business. The certificate expires 1 year after the date of its issuance.

3. The governing body shall file with the administrator, the department of taxation and the employment security department a copy of each agreement, the information submitted under paragraph (a) of subsection 2 and the current certificate issued to the business under that subsection. The governing body shall immediately notify the administrator, the department of taxation and the employment security department whenever the business is no longer certified.

SUMMARY--Requires expansion of project for capitated delivery of health care to recipients of Medicaid. (BDR S-116)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Contains Appropriation.

AN ACT relating to assistance to the medically indigent; requiring the welfare division of the department of human resources to expand its project for the capitated delivery of health care to recipients of Medicaid; making an appropriation to the University of Nevada System for the support of the clinic established to provide medical services to recipients of Medicaid; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. The welfare division of the department of human resources shall:

1. Expand its joint project with the School of Medicine of the University of Nevada for the capitated delivery of health care to recipients of Medicaid, with a goal of providing medical services to at least 10,000 persons by July 1, 1991;

2. Promote the use of the services provided by that project; and

3. Expand the project in a manner which is consistent with federal requirements concerning a recipient of Medicaid's freedom of choice regarding medical care.

Sec. 2. There is hereby appropriated from the state general fund to the University of Nevada System the sum of \$500,000 for the support of the clinic established to provide medical services to recipients of Medicaid.

Sec. 3. Any remaining balance of the appropriation made by section 2 of this act must not be committed for expenditure after June 30, 1989, and reverts to the state general fund as soon as all payments of money committed have been made.

SUMMARY--Makes various changes relating to health care. (BDR 40-117)

FISCAL NOTE: Effect on Local Government: Yes.

 Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to health care; requiring certain hospitals to offer preferred rates to certain patients; establishing a legislative committee to study issues relating to health care; creating the office of advocate for patients of hospitals within the office of the attorney general; creating the fund for the patient's advocate; providing a penalty; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. Title 40 of NRS is hereby amended by adding thereto a new chapter to consist of the provisions set forth as sections 2 to 14, inclusive, of this act.

Sec. 2. As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 3 to 6, inclusive, of this act, have the meanings ascribed to them in those sections.

Sec. 3. "Health services" has the meaning ascribed to it in NRS 439A.017.

Sec. 4. "Hospital" has the meaning ascribed to it in NRS 449.012.

Sec. 5. "Preferred rate" means the average rate per day or the average rate for a specific health service charged by a hospital pursuant to agreements negotiated between the hospital and a third party.

Sec. 6. "Uninsured patient" means a patient whose costs for health services are not required by law or contract to be paid in whole or in part by a third party, including an insurer or a governmental agency, but excluding the patient's parent or guardian.

Sec. 7. The provisions of sections 2 to 14, inclusive, of this act, apply only to hospitals in counties whose population is 30,000 or more.

Sec. 8. A hospital shall offer to every uninsured patient who is a resident of this state a rate per day or for a specific health service that is not higher than the preferred rate determined pursuant to section 9 of this act.

Sec. 9. 1. The legislative committee on health care shall employ an independent auditor to determine the average rates charged by each hospital pursuant to agreements negotiated between the hospital and a third party on behalf of the third party's members, subscribers or insureds.

2. The independent auditor shall, by July 1 of each year, conduct an audit of the rates charged by each hospital to determine the average negotiated rates for each hospital.

3. The costs of all audits and examinations conducted pursuant to this section and section 12 of this act must be paid by the hospital subject to the audit or examination.

Sec. 10. The independent auditor shall establish preferred rates each year for each hospital based upon the audit conducted pursuant to section 9 of this act for the preceding fiscal year. The preferred rates become effective on September 1 of each year.

Sec. 11. 1. A hospital shall:

(a) Post prominently in the area where patients are admitted its preferred rates for uninsured patients.

(b) Require each uninsured patient to sign a statement which discloses the hospital's preferred rates.

(c) Allow an uninsured patient who pays within 90 days after receiving a bill for health services to pay at the preferred rate.

2. If the billed charges for health services actually received are less than the preferred daily rate and the preferred rate for those services, the hospital shall charge the uninsured patient the billed charges.

Sec. 12. 1. The independent auditor shall conduct random examinations of the records of each hospital, not more than twice each year, to determine if the hospital is offering preferred rates to uninsured patients.

2. If the independent auditor's examination reveals any charges to an uninsured patient in excess of a preferred rate, the hospital shall refund to the patient an amount equal to the difference between the actual charges and the preferred rate plus 10 percent of the difference.

Sec. 13. Except for the preferred rates determined pursuant to section 10 of this act, all agreements, rates and other information furnished to the independent auditor by a hospital are confidential.

Sec. 14. Any hospital which fails to comply with the provisions of this chapter is guilty of a misdemeanor.

Sec. 15. Chapter 439A of NRS is hereby amended by adding thereto a new section to read as follows:

The division shall:

1. Annually prepare and distribute to the general public a publication listing every hospital in the state, its charges for representative health services and its preferred rates as determined pursuant to section 10 of this act. The division shall submit the publication to the advocate for patients of hospitals for review and comment.

2. *Establish a statewide, toll-free telephone number to provide purchasers of health care with information about the costs of services at health facilities in the state.*

Sec. 16. Chapter 218 of NRS is hereby amended by adding thereto the provisions set forth as sections 17 to 22, inclusive, of this act.

Sec. 17. *As used in sections 17 to 22, inclusive, of this act, "committee" means the legislative committee on health care.*

Sec. 18. 1. *There is hereby established a legislative committee on health care consisting of three members of the senate, three members of the assembly and one elected officer representing the governing body of a local political subdivision, appointed by the legislative commission with appropriate regard for their experience with and knowledge of matters relating to health care. The members who are state legislators must be appointed to provide representation from the various geographical regions of the state.*

2. *The members of the committee shall select a chairman from one house of the legislature and a vice chairman from the other. Each such officer shall hold office for a term of 2 years commencing on July 1 of each odd-numbered year. If a vacancy occurs in the chairmanship or vice chairmanship, the members of the committee shall select a replacement for the remainder of the unexpired term.*

3. *Any member of the committee who is not a candidate for reelection or who is defeated for reelection continues to serve until the next session of the legislature convenes.*

4. *Vacancies on the committee must be filled in the same manner as original appointments.*

Sec. 19. 1. *The members of the committee shall meet throughout each year at the times and places specified by a call of the chairman or a majority of the committee. The research director of the legislative counsel bureau or a person he has designated shall act as the nonvoting recording secretary. The committee shall prescribe regulations for its own management and government. Four members of the committee constitute a quorum, and a quorum may exercise all the powers conferred on the committee.*

2. *Except during a regular or special session of the legislature, members of the committee who are legislators are entitled to receive the compensation provided for a majority of the members of the legislature during the first 60 days of the preceding regular session for each day or portion of a day during which he attends a meeting of the committee or is otherwise engaged in the business of the committee plus the per diem allowance and travel expenses provided for state officers and employees generally.*

3. *The member of the committee who represents a local political subdivision is entitled to receive the subsistence allowances and travel expenses provided by law for his position for each day during which he attends a meeting of the committee or is otherwise engaged in the business of the committee, to be paid by his local political subdivision.*

Sec. 20. *The committee may:*

1. *Review and evaluate the quality and effectiveness of programs for the prevention of illness.*

2. *Review and compare the costs of medical care among communities in Nevada with similar communities in other states.*

3. *Analyze the overall system of medical care in the state to determine ways to coordinate the providing of services to all members of society, avoid the duplication of services and achieve the most efficient use of all available resources.*

4. *Examine the business of providing insurance, including the development of cooperation with health maintenance organizations and organizations which restrict the performance of medical services to certain physicians and hospitals, and procedures to contain the costs of these services.*

5. *Examine hospitals to:*

(a) *Increase cooperation among hospitals;*

(b) *Increase the use of regional medical centers; and*

(c) *Encourage hospitals to use medical procedures which do not require the patient to be admitted to the hospital and to use the resulting extra space in alternative ways.*

6. *Examine medical malpractice.*

7. *Examine the system of education to coordinate:*

(a) Programs in health education, including those for the prevention of illness and those which teach the best use of available medical services; and

(b) The education of those who provide medical care.

8. *Examine the effectiveness of any legislation enacted to accomplish the purpose of restraining the costs of health care while ensuring the quality of services, and its effect on the subjects listed in subsections 1 to 7, inclusive.*

9. *Conduct investigations and hold hearings in connection with its review and analysis.*

10. *Direct the legislative counsel bureau to assist in its research, investigations, review and analysis.*

11. *Recommend to the legislature as a result of its review any appropriate legislation.*

12. *Make recommendations concerning the performance of the office of advocate for patients of hospitals to the patient's advocate, the attorney general, the legislative commission, the interim finance committee and the legislature.*

Sec. 21. 1. *In conducting the investigations and hearings of the committee:*

(a) The secretary of the committee, or in his absence any member of the committee, may administer oaths.

(b) The secretary or chairman of the committee may cause the deposition of witnesses, residing either within or outside of the state, to be taken in the manner prescribed by rule of court for taking depositions in civil actions in the district courts.

(c) The secretary or chairman of the committee may issue subpoenas to compel the attendance of witnesses and the production of books and papers.

2. *If any witness refuses to attend or testify or produce any books and papers as required by the subpoena, the secretary or chairman of the committee may report to the district court by petition, setting forth that:*

(a) Due notice has been given of the time and place of attendance of the witness or the production of the books and papers;

(b) The witness has been subpoenaed by the committee pursuant to this section; and

(c) The witness has failed or refused to attend or produce the books and papers required by the subpoena before the committee which is named in the subpoena, or has refused to answer questions propounded to him,

and asking for an order of the court compelling the witness to attend and testify or produce the books and papers before the committee.

3. Upon such petition, the court shall enter an order directing the witness to appear before the court at a time and place to be fixed by the court in its order, the time to be not more than 10 days from the date of the order, and to show cause why he has not attended or testified or produced the books or papers before the committee. A certified copy of the order must be served upon the witness.

4. If it appears to the court that the subpoena was regularly issued by the committee, the court shall enter an order that the witness appear before the committee at the time and place fixed in the order and testify or produce the required books or papers. Failure to obey the order constitutes contempt of court.

Sec. 22. *Each witness who appears before the committee by its order, except a state officer or employee, is entitled to receive for his attendance the fees and mileage provided for witnesses in civil cases in the courts of record of this state. The fees and mileage must be audited and paid upon the presentation of proper claims sworn to by the witness and approved by the secretary and chairman of the committee.*

Sec. 23. Chapter 228 of NRS is hereby amended by adding thereto the provisions set forth as sections 24 to 32, inclusive, of this act.

Sec. 24. *As used in sections 24 to 32, inclusive, of this act, unless the context otherwise requires:*

- 1. "Hospital" has the meaning ascribed to it by NRS 449.012.*
- 2. "Patient's advocate" means the advocate for patients of hospitals.*

3. "Public interest" means the interests or rights of the State of Nevada and of the citizens of the state, or a broad class of those citizens, which arise from the constitutions, court decisions and statutes of this state and of the United States and from the common law, as those interests and rights relate to patients of hospitals.

Sec. 25. The office of advocate for patients of hospitals is hereby created within the office of the attorney general. The advocate for patients of hospitals may be known as the patient's advocate.

Sec. 26. 1. The attorney general shall appoint the patient's advocate for a term of 4 years. The patient's advocate is in the unclassified service of the state. The person appointed:

- (a) Must be knowledgeable in the various areas of the regulation of hospitals;
- (b) Must be independent of and have no pecuniary interest in any hospital or other medical facility or facility for the dependent;
- (c) Shall devote all of his time to the business of his office and shall not pursue any other business or vocation or hold any other office of profit; and
- (d) Must not be a member of any political convention or a member of any committee of any political party.

2. The attorney general may remove the patient's advocate from office for inefficiency, neglect of duty or malfeasance in office.

Sec. 27. The patient's advocate may:

1. Employ the staff necessary to carry out his duties and the functions of his office, in accordance with the personnel practices and procedures established within the attorney general's office.

2. Purchase necessary equipment.

3. Lease or make other suitable arrangements for office space, but any lease which extends beyond the term of 1 year must be reviewed and approved by a majority of the members of the state board of examiners.

4. *Apply for an order or subpoena for the appearance of witnesses or the production of books, papers and documents in any proceeding in which he is a party or intervener, in the same manner as any other party or intervener, and make arrangements for and pay the fees or costs of any witnesses and consultants necessary to the proceeding.*

5. *Perform such other functions and make such other arrangements as may be necessary to carry out his duties and the functions of his office.*

Sec. 28. 1. *The fund for the patient's advocate is hereby created as a special revenue fund. All money received for the use of the patient's advocate must be deposited in the state treasury for credit to the fund.*

2. *Money in the fund may be used only to defray the costs of maintaining the office of the patient's advocate and for carrying out the provisions of sections 24 to 32, inclusive, of this act.*

3. *All claims against the fund must be paid as other claims against the state are paid.*

Sec. 29. *All appropriations for the office of advocate for patients of hospitals and any gifts and grants of money which the patient's advocate is authorized to accept must be deposited with the state treasurer for credit to the fund for the patient's advocate.*

Sec. 30. *The patient's advocate may, with respect to all hospitals in this state:*

1. *Examine at any reasonable time the books, accounts, minutes, records or other papers or property of a hospital.*

2. *Petition for, request, initiate, appear or intervene in any proceeding which may affect rates charged by hospitals before any court, regulatory body, board, commission or agency having jurisdiction over the matter. The patient's advocate may represent the public interest or the interests of any particular class of patients of hospitals in any such proceeding, and he is a real party in interest in the proceeding.*

Sec. 31. 1. *The patient's advocate has sole discretion to represent or refrain from representing the public interest and any class of patients of hospitals in any proceeding.*

2. *In exercising his discretion, the patient's advocate shall consider the importance and extent of the public interest or the patients' interests involved and whether those interests would be adequately represented without his participation.*

3. *If the patient's advocate determines that there would be a conflict between the public interest and any particular class of patients of hospitals or any inconsistent interests among the classes of patients of hospitals involved in a particular matter, he may choose to represent one of the interests, to represent no interest, or to represent one interest through his office and another or others through outside counsel engaged on a case basis.*

Sec. 32. *The patient's advocate shall hear complaints from patients of hospitals and attempt to resolve the complaints through mediation or referral to the proper board, commission, agency or officer. The patient's advocate shall establish a statewide, toll-free telephone number to receive the complaints.*

Sec. 33. *The legislative committee on health care shall employ an auditor pursuant to section 9 of this act as soon as practicable. The auditor shall conduct the audits required by this act for fiscal year 1986-1987 and establish the preferred rates for each hospital. The rates become effective on January 1, 1988, or as soon thereafter as they are established by the auditor.*

SUMMARY--Restricts time for filling vacancy in position of state health officer.

(BDR 40-118)

FISCAL NOTE: Effect on Local Government: No.

 Effect on the State or on Industrial Insurance: No.

**AN ACT relating to the administration of public health; restricting the
time for filling a vacancy in the position of state health officer;
and providing other matters properly relating thereto.**

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. NRS 439.100 is hereby amended to read as follows:

439.100 [A vacancy in the office]

1. The director shall appoint a state health officer.

*2. The position of state health officer [shall] must be filled [by
appointment] by the director [.] within 6 months after it becomes vacant, except
that if a qualified applicant does not accept the position within that period, the director
shall continue his efforts to fill the position until a qualified person accepts the
appointment.*

SUMMARY--Supports recommendations of United Community Task Force on abuse of substances by adolescents. (BDR R-119)

CONCURRENT RESOLUTION--Supporting the recommendations of the United Community Task Force concerning the abuse of substances by adolescents.

WHEREAS, The abuse of alcohol and drugs by adolescents in this state threatens their lives and health and has contributed to the increase in the cost of medical care; and

WHEREAS, The United Community Task Force on Confronting Youth Chemical Dependency in Clark County has issued a series of recommendations addressing this problem; and

WHEREAS, Those recommendations offer an excellent basis for a statewide approach to the serious and complex issues related to adolescents and drugs; now, therefore, be it

RESOLVED BY THE OF THE STATE OF NEVADA, THE CONCURRING, That the Nevada Legislature support the recommendations of the United Community Task Force on Confronting Youth Chemical Dependency, which include:

- 1. Promoting a "Senior Sober Week" to remind graduating high school pupils of the dangers of drinking and driving;**
- 2. Establishing a chapter of Students Against Driving While Drunk;**
- 3. Making the community aware of the problem of abuse of alcohol and drugs by young people;**
- 4. Providing productive and entertaining activities for adolescents as alternatives to the use of addictive substances;**

5. Using presentations by drug-free adults such as athletes and entertainers as positive models for adolescents;

6. Providing educators with the necessary resources to educate pupils about the abuse of drugs and alcohol, including the employment by school districts of a full-time specialist on such abuse;

7. Establishing a 24-hour telephone hotline for adolescents who abuse alcohol or drugs;

8. Providing treatment for such adolescents; and

9. Establishing residential group homes for such adolescents that will provide individual and family counseling;

and be it further

RESOLVED, That the Nevada Legislature urge the school districts and teachers of this state to put those recommendations into effect; and be it further

RESOLVED, That the of the transmit a copy of this resolution to each school district in this state.

SUMMARY--Creates fund for catastrophic injuries and illnesses and provides for its administration. (BDR 38-120)

FISCAL NOTE: **Effect on Local Government: No.**
 Effect on the State or on Industrial Insurance: Contains
 Appropriation.

AN ACT relating to public welfare; creating the fund for catastrophic injuries and illnesses; providing for its administration; making an appropriation; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. Chapter 428 of NRS is hereby amended by adding thereto a new section to read as follows:

- 1. The fund for catastrophic injuries and illnesses is hereby created as a trust fund.*
- 2. The director of the department of human resources shall distribute the money in the fund to any person who:*
 - (a) Submits a written application for financial assistance from the fund;*
 - (b) Needs the financial assistance to cover costs incurred as a result of a catastrophic injury or illness;*
 - (c) Fails to qualify for financial assistance available from other sources; and*
 - (d) Meets any other applicable requirements adopted by the director.*
- 3. The director may, by regulation:*
 - (a) Set a limit on the total amount of money which may be distributed to an applicant;*
 - (b) Define "catastrophic injury or illness";*
 - (c) Adopt procedures for the verification of an applicant's needs; and*

(d) Establish other standards, requirements and forms necessary for the administration of the fund.

Sec. 2. 1. There is hereby appropriated from the state general fund to the fund for catastrophic injuries and illnesses created pursuant to section 1 of this act:

For the fiscal year 1987-88.....	\$1,000,000
For the fiscal year 1988-89.....	1,000,000

2. Any balance of the sums appropriated by subsection 1 remaining at the end of the respective fiscal years must not be committed for expenditure after June 30 and reverts to the state general fund as soon as all payments of money committed have been made.

**SUMMARY--Creates reserve fund for assistance to medically indigent.
(BDR 38-121)**

**FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: Contains
Appropriation.**

AN ACT relating to public welfare; creating the reserve fund for assistance to the medically indigent; making an appropriation; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The reserve fund for assistance to the medically indigent is hereby created as a trust fund. Money for the fund must be provided by direct legislative appropriation.

2. Money in the fund may be allocated and expended only if the interim finance committee finds that the allocation is necessary to supplement regular legislative appropriations in support of the state plan for assistance to the medically indigent which fail to cover unforeseen obligations created by:

(a) Changes in federal law; or

(b) Substantial increases in the number of persons eligible for assistance or in the amount of assistance provided.

3. If the interim finance committee finds such an allocation necessary, it shall by resolution establish the amount of the allocation and direct the state controller to transfer

that amount to the appropriate fund and account. The state controller shall thereupon make the transfer.

Sec. 2. 1. There is hereby appropriated from the state general fund to the reserve fund for assistance to the medically indigent created pursuant to section 1 of this act the sum of \$4,000,000.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 1989, and reverts to the state general fund as soon as all payments of money committed have been made.

SUMMARY--Requires use of money paid as exemplary and punitive damages for medical assistance to indigent persons. (BDR 3-122)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to medical care for indigent persons; requiring the payment of exemplary and punitive damages to the supplemental fund for medical assistance to indigent persons; distributing that money to the counties to provide medical care for indigents; making the program for medical care to the medically indigent permanent; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. NRS 42.010 is hereby amended to read as follows:

42.010 1. In an action for the breach of an obligation not arising from contract, where the defendant:

[1.] (a) Has been guilty of oppression, fraud or malice, express or implied; or

[2.] (b) Caused an injury by the operation of a motor vehicle in violation of NRS 484.379 or 484.3795 after willfully consuming or using alcohol or another substance, knowing that he would thereafter operate the motor vehicle,

[the plaintiff,] in addition to the actual damages. [may recover damages for the sake of example and by way of punishing] *exemplary and punitive damages may be assessed against* the defendant.

2. A plaintiff shall recover from an award of exemplary and punitive damages, for the payment of attorney's fees:

(a) Twenty-five percent of the amount of those damages, if he has not agreed to an arrangement for a contingent fee; or

(b) The amount agreed to in an arrangement for a contingent fee, not to exceed 35 percent of those damages, if he has agreed to an arrangement for a contingent fee.

3. The balance of an award of exemplary and punitive damages, after the payment required by subsection 2, must be deposited with the state treasurer for credit to the supplemental fund for medical assistance to indigent persons.

Sec. 2. Chapter 428 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The board of trustees of the fund for hospital care to indigent persons shall distribute to each county before May 1 from exemplary and punitive damages deposited in the supplemental fund an amount proportionate to the amount paid into the supplemental fund by the county in the previous fiscal year.

2. The money received by a county pursuant to subsection 1 must be deposited in the county's fund for medical assistance to indigent persons.

Sec. 3. NRS 428.265 is hereby amended to read as follows:

428.265 As used in NRS 428.275 to 428.345, inclusive[:], and section 2 of this act:

1. "Fund" means the fund for medical assistance to indigent persons.

2. "Supplemental fund" means the supplemental fund for assistance to indigent persons.

Sec. 4. NRS 428.275 is hereby amended to read as follows:

428.275 1. The board of county commissioners of a county shall before July 1, 1985, by ordinance, create in the county treasury a fund to be designated as the fund for medical assistance to indigent persons.

2. The money in the fund must be used for reimbursement, as provided in NRS 428.295 and 428.345, of any unpaid charges for medical care furnished to an indigent person who falls sick in the county other than care furnished on account of an injury suffered in a motor vehicle accident.

3. All money collected or recovered pursuant to this section or NRS 428.265 or 428.285, *or received pursuant to section 2 of this act*, and the interest earned on the money in the fund must be deposited for credit to the fund. Claims against the fund must be paid on claims approved by the board of county commissioners. Any money remaining in the fund at the end of any fiscal year does not revert to the county general fund.

Sec. 5. NRS 428.305 is hereby amended to read as follows:

428.305 1. The supplemental fund for medical assistance to indigent persons is created. Any money recovered pursuant to NRS 428.345 *or received pursuant to section 2 of this act*, and the interest earned on the money in the supplemental fund must be deposited for credit to the supplemental fund.

2. If the balance in the supplemental fund exceeds \$1,000,000 on May 1, the excess must be credited pro rata against the amounts due from the respective counties.

Sec. 6. Section 16 of chapter 629, Statutes of Nevada 1985, at page 2036, is hereby amended to read as follows:

Sec. 16. This act becomes effective upon passage and approval
[and expires by limitation on June 30, 1987.]

Sec. 7. The amendatory provisions of section 1 of this act do not apply to actions filed before July 1, 1987.

Sec. 8. 1. This section and sections 6 and 7 of this act become effective upon passage and approval.

2. Sections 1 to 5, inclusive, of this act, become effective on July 1, 1987.

SUMMARY--Establishes limit on monthly income for eligibility for benefits for long-term medical care. (BDR 38-123)

FISCAL NOTE: Effect on Local Government: No.

 Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to public welfare; establishing a limit on monthly income for eligibility for benefits for long-term medical care; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

Any person whose monthly income is less than three times the income allowable to receive benefits pursuant to 42 U.S.C. §§ 1382 to 1383c, inclusive, is eligible to receive assistance to the medically indigent for the purpose of long-term medical care.

SUMMARY--Provides for reimbursement to hospice for care provided to medically indigent person. (BDR 38-203)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to assistance to the medically indigent; requiring the department of human resources to reimburse a hospice for care provided to a person who is eligible for assistance; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

The department of human resources, through the welfare division, shall reimburse, under the state plan for assistance to the medically indigent, a hospice licensed pursuant to chapter 449 of NRS which provides the care described in NRS 449.0115 to a person who is eligible for assistance.

SUMMARY--Makes various changes in powers and duties of county hospitals.

(BDR 40-204)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to county hospitals; expanding the powers of county hospitals; modifying the duties of their boards of trustees; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. NRS 450.180 is hereby amended to read as follows:

450.180 The board of hospital trustees [shall have the power:

1. To appoint a suitable superintendent or matron, or both,] *may*:

1. *Appoint a chief executive officer and necessary assistants, and [to] fix their compensations.*

2. [To employ] *Employ* physicians and interns, either full time or part time, as the board determines necessary, and [to] fix their compensations.

3. [To remove] *Remove* those appointees and employees.

4. [To control] *Control* the admission of physicians and interns to the staff by promulgating appropriate rules, regulations and standards governing those appointments.

5. [To contract] *Contract* with individual physicians or private medical associations for the provision of certain medical services as may be

required by the hospital. The compensation provided for in the contract must not include compensation to the physician for services rendered to indigent patients.

Sec. 2. NRS 450.240 is hereby amended to read as follows:

450.240 1. In all counties where a tax for the establishment and maintenance of a public hospital has been authorized [, or is hereafter authorized,] by a majority of the voters voting for a bond issue in accordance with law, the supervision, management, government and control of the county hospital [shall vest] *vests* in and *must* be exercised by the board of hospital trustees for the county public hospital, and the institution [shall] *must* thereafter be operated by the board of hospital trustees.

2. [In all such counties, the supervision of the county isolation hospital, county home for the indigent sick, county workhouse for indigents, and the county poor farm, or any of them, may, at the discretion of the board of county commissioners, be vested in and exercised by the board of hospital trustees, and such institution or institutions may thereafter be operated by the board of hospital trustees.

3.] Annually, upon the request of the board of hospital trustees, the board of county commissioners may levy a tax for the maintenance and operation of the county public hospital . [or other institutions named in subsection 2.

4.] 3. The resolution adopted by the board of county commissioners imposing a tax levy for a county public hospital [shall] *must* state:

(a) The portion of the levy which is necessary to retire hospital bonds and any other outstanding hospital securities, and to pay interest thereon;

(b) The portion of the levy which is necessary to pay for the care of indigent patients; and

(c) The portion of the levy which is necessary to pay for the cost of new equipment, replacement of old equipment and other improvements to the hospital not covered by specific bond issues or other securities and not included in the cost of care of indigent patients as provided in paragraph (b). The cost [shall] *must* be prorated to the county in accordance with the number of patient days of care of county patients.

[5.] 4. The board of county commissioners may not levy a tax for the care of indigents in the county public hospital as a hospital expense unless the levy and its justification are included in the *budget for the* hospital fund [budget as] submitted to the department of taxation as provided by law.

Sec. 3. NRS 450.410 is hereby amended to read as follows:

450.410 1. Supervising boards of county hospitals [now or hereafter established in any of the counties of this state are authorized and directed to admit to such county hospital such] *may provide for treatment to* sick or injured persons [as such board may deem proper,] and require the payment of reasonable charges [and fees therefor; but the admission] *therefor. The treatment* of such persons [shall] *must* not be permitted to interfere with the [admission, care and] treatment of purely charitable cases.

2. Every person [admitted to] *treated by* a county hospital [. as provided in this section.] and required to pay charges [and fees] for hospitalization, shall pay the charges [and fees] fixed by the supervising board therefor, which charges . [and fees.] when paid, [shall] *must* be paid forthwith into the county treasury and deposited to the credit of the hospital fund.

3. Every person [admitted to] *treated* by a county hospital and required to pay charges [and fees thereto shall have] *to the hospital has* the right to the services of a physician or surgeon of his own choice, and [shall have] *has* the right to employ such special [nurse or] nurses as may be necessary , [:] but the cost of the physician, surgeon or nurses [shall never] *must not* become a claim against the county.

4. Supervising boards [are authorized and directed to] *shall* fix and determine [just and] reasonable charges [and fees] to be paid by sick and injured persons [admitted to] *treated by* county hospitals , [as provided in this section,] which charges [and fees shall] *must* include the board and lodging of the person and the customary use of hospital facilities by the person admitted.

Sec. 4. NRS 450.420 is hereby amended to read as follows:

450.420 1. The board of county commissioners of the county in which a public hospital is located may determine whether patients presented to the public hospital for treatment are subjects of charity. The board of county commissioners shall establish by ordinance criteria and procedures to be used in the determination of [patient] eligibility for medical care as medical indigents or subjects of charity.

2. The board of hospital trustees shall fix the charges for [occupancy, nursing, care, medicine and attendance, other than medical or surgical attendance.] *treatment* of those persons able to pay for the charges. as the board [may deem] *deems* just and proper. The board of hospital trustees may impose an interest charge of not more than 12 percent per annum on unpaid accounts. The receipts must be paid to the county treasurer and credited by him to the hospital fund. In fixing charges pursuant to this subsection the board of hospital trustees shall not include, or seek to

recover from paying patients. any portion of the expense of the hospital which is properly attributable to the care of indigent patients.

3. Except as provided in subsection 4, the county is chargeable with the entire cost of services rendered by the hospital and any salaried staff physician or employee to any person admitted for emergency treatment, including all reasonably necessary recovery, convalescent and follow-up inpatient care required for any such person as determined by the board of trustees of the hospital, but the hospital shall use reasonable diligence to collect the charges from the emergency patient or any other person responsible for his support. Any amount collected must be reimbursed or credited to the county.

4. The county is not chargeable with the cost of services rendered by the hospital or any attending staff physician or surgeon to the extent the hospital is reimbursed for those services pursuant to NRS 428.115 to 428.255, inclusive.

Sec. 5. NRS 450.630 is hereby amended to read as follows:

450.630 The board of trustees shall:

1. Carry out the spirit and intent of NRS 450.550 to 450.700, inclusive, in establishing and maintaining a hospital in each district created pursuant to NRS 450.550 to 450.700, inclusive.

2. Make and adopt bylaws, rules and regulations:

(a) For its own guidance and the government of any such hospital; and

(b) Fixing the charges for [occupancy, nursing, care, medicine and attendance] *treatment* of patients.

Sec. 6. NRS 450.640 is hereby amended to read as follows:

450.640 The board of trustees may:

1. Appoint a [suitable superintendent] *chief executive officer* and necessary assistants for each hospital, and fix the compensations of such persons.

2. Employ physicians, surgeons and interns, as the board determines necessary, and fix their compensation.

3. Remove such appointees and employees.

4. Control the admission of physicians, surgeons and interns to the staff by promulgating rules, regulations and standards governing such appointments.

Sec. 7. NRS 450.700 is hereby amended to read as follows:

450.700 1. The board of county commissioners of the county in which a district hospital is located [shall have power to] *may* determine whether [or not] patients presented to the district hospital for treatment are subjects of charity. The board of county commissioners shall establish by ordinance criteria and procedures to be used in the determination of [patient] eligibility for medical care as medical indigents or subjects of charity.

2. The board of trustees shall fix the charges for [occupancy, nursing, care, medicine and attendance, other than medical or surgical attendance.] *treatment* of those persons able to pay for [the same.] *it*, as the board [may deem] *deems* just and proper. The receipts therefor [shall] *must* be paid to the county treasurer and credited by him to the district fund.

Sec. 8. NRS 450.800 is hereby amended to read as follows:

450.800 In addition to having the powers conferred under chapter 277 of NRS, a county or district hospital may contract with a private hospital or other organization for emergency medical services, including

the transportation of patients, or any other services [required for] *performed in connection with or related to the operation of a hospital. The services may be performed by the parties to the contract or the parties may establish a separate organization for that purpose. A county or district hospital may enter into a contract to provide services for persons not admitted to the hospital if those services are performed in connection with or related to the operation of the hospital.*

SUMMARY--Expands permissible uses of money from bonds for county hospitals.

(BDR 40-205)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to county hospitals; authorizing a board of county commissioners to issue bonds for county hospitals without specifying the intended use of the money; authorizing the board to lend money from the issuance of the bonds to other counties and hospital districts; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. NRS 450.280 is hereby amended to read as follows:

450.280 1. Whenever the board of hospital trustees of any county deems it advisable that bonds be issued for the enlargement, maintenance, repair, improvement or reconstruction of a public hospital, including without limitation the construction, installation and other acquisition of additional fixtures, structures, and buildings for the public hospital, equipment and furnishings therefor, and additional sites therefor, [() or any combination thereof. (),] the board shall, by resolution, request the board of county commissioners of the county to issue general obligation bonds therefor and shall specify in the resolution the maximum amount of money proposed to be expended for any or all of such purposes.

2. [Thereupon] *The board of hospital trustees may, by resolution, request the board of county commissioners to issue general obligation bonds for the support of public hospitals, without specifying the intended use of the money. The resolution must specify the maximum amount of money proposed to be expended. The money may be used for the purposes provided in subsection 1 and in section 2 of this act.*

3. *Upon receipt of a resolution from the board of hospital trustees pursuant to subsection 1 or 2, the board of county commissioners shall:*

(a) *Comply with the provisions of NRS 350.001 to 350.006, inclusive; and*

(b) *Upon the receipt of the approval of the county general obligation bond commission of the proposal to issue the county hospital bonds, submit the question of issuing such bonds to the qualified electors of the county at an election called for that purpose, as provided in NRS 350.020 to 350.070, inclusive.*

Sec. 2. Chapter 277 of NRS is hereby amended by adding thereto a new section to read as follows:

The board of county commissioners may lend money from the issuance of bonds pursuant to subsection 2 of NRS 450.280 to another county or a hospital district for the enlargement, maintenance, repair, improvement or reconstruction of a public hospital in that county or district.

SUMMARY--Requires group health insurance to provide for continued coverage after termination of employment and for surviving spouse of deceased member. (BDR 57-206)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to group health insurance; requiring that a policy provide for continuing coverage for a certain period after the termination of a member's employment; requiring that a policy provide for continuing coverage for the surviving spouse of a deceased member; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. Chapter 689B of NRS is hereby amended by adding thereto the provisions set forth as sections 2, 3 and 4 of this act.

Sec. 2. 1. Every policy of group health insurance in which the group consists of employees of one or more employers must contain a provision which:

(a) Continues coverage under the policy for 18 months after a member's employment is terminated at the member's request.

(b) Permits the surviving spouse of a member who dies to elect to remain covered by the policy for 36 months under the same terms as if the deceased member were still a member of the group.

2. Every such employer shall:

(a) Give a written notice to each member, at the beginning of his employment, explaining his right to continued coverage pursuant to subsection 1.

(b) Notify the member or surviving spouse of his right to continued coverage pursuant to subsection 1 within 14 days after the termination of the member's employment or the death of the member.

(c) Notify the insurer within 30 days after the termination of a member's employment or death of a member.

3. A member or surviving spouse who elects to continue coverage shall notify the employer of that election within 60 days after being notified pursuant to paragraph (b) of subsection 2. If he chooses to continue coverage and pays the premium required by section 3 of this act, the coverage shall be deemed to have continued without interruption from the date of the termination of the member's employment or death of the member.

Sec. 3. *1. Any person who elects to continue coverage pursuant to section 2 of this act shall pay the premiums for such coverage, not to exceed 102 percent of the premium payable by the employer for an active member of the plan.*

2. If the employer is self-insured, he shall establish a premium based on actuarial methods for continued coverage.

3. The initial premium for continued coverage must be paid within 45 days after the election to continue coverage is made.

Sec. 4. *Continued coverage pursuant to section 2 of this act ceases before the end of the period provided in that section if:*

- 1. The employer discontinues group health insurance for his employees;*
- 2. The member or surviving spouse fails to pay the required premiums;*
- 3. The member or surviving spouse becomes covered under any other policy of group health insurance;*
- 4. The member or surviving spouse qualifies for Medicare; or*
- 5. The surviving spouse remarries and becomes eligible for coverage as a dependent under the new spouse's policy of group health insurance.*

SUMMARY--Requires that continuing education of certain providers of health care include instruction in preventative health care. (BDR 54-207)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to health care; requiring that the continuing education of licensed persons in health-related professions include instruction in preventative health care; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. NRS 630.253 is hereby amended to read as follows:

630.253 The board shall, as a prerequisite for the:

- 1. Renewal of a certificate as a physician's assistant; or**
- 2. Biennial registration of the holder of a license to practice medicine,**

require each holder to comply with the requirements for continuing education adopted by the board. *Not less than 10 percent of the required number of hours of continuing education must be devoted to preventative health care.*

Sec. 2. NRS 630A.325 is hereby amended to read as follows:

630A.325 1. To renew a license other than a temporary, special or limited license issued pursuant to this chapter, each person must, on or before January 1 of each year:

- (a) Apply to the board for renewal;**
- (b) Pay the annual fee for renewal set by the board; and**

(c) Submit evidence to the board of his completion of the requirements for continuing education.

2. The board shall, as a prerequisite for the renewal or restoration of a license other than a temporary, special or limited license, require each holder of a license to comply with the requirements for continuing education adopted by the board. *Not less than 10 percent of the required number of hours of continuing education must be devoted to preventative health care.*

3. Any holder failing to pay the annual fee for renewal after it becomes due must be given a period of 60 days in which to pay the fee, and, failing to do so, automatically forfeits his right to practice homeopathic medicine, and his license to practice homeopathic medicine in Nevada is automatically suspended. The holder may, within 2 years after the date his license is suspended, apply for the restoration of his license.

4. The board shall notify any holder whose license is automatically suspended for nonpayment of the annual fee for renewal and send a copy of the notice to the Drug Enforcement Administration of the United States Department of Justice or its successor agency.

Sec. 3. NRS 631.342 is hereby amended to read as follows:

631.342 1. The board shall adopt regulations concerning continuing education in dentistry and dental hygiene. The regulations must include:

[1.] (a) The number of hours of credit required annually;

[2.] (b) The criteria used to accredit each course; and

[3.] (c) The requirements for submission of proof of attendance at courses.

2. *Not less than 10 percent of the number of hours of credit must be devoted to preventative health care.*

Sec. 4. NRS 632.343 is hereby amended to read as follows:

632.343 1. The board shall not renew any license issued under this chapter until the licensee has submitted proof satisfactory to the board of completion, during the 2-year period before renewal of the license, of 30 hours in a program of continuing education approved by the board. The licensee is exempt from this provision for the first biennial period after graduation from an accredited school of professional nursing or practical nursing.

2. The board shall review all courses offered to nurses for the completion of the requirement set in subsection 1. The board may approve nursing and other courses which are directly related to the practice of nursing as well as others which bear a reasonable relationship to current developments in the field of nursing or any special area of practice in which a licensee engages. These may include academic studies, workshops, [extension studies, home study] *programs by extension, study at home* and other courses.

3. *Not less than 10 percent of the required number of hours of continuing education must be devoted to preventative health care.*

Sec. 5. NRS 633.471 is hereby amended to read as follows:

633.471 1. Except as provided in subsection 3 and in NRS 633.491, every holder of a license issued under this chapter, except a temporary or a special license, may renew his license on or before February 1 of each calendar year after its issuance by:

- (a) Applying for renewal on forms provided by the board;
- (b) Paying the annual license renewal fee specified in this chapter; and
- (c) Submitting verified evidence satisfactory to the board that in the year preceding the application for renewal he has attended *courses of* continuing education [courses] or programs approved by the board

totaling a number of hours established by the board which must not be less than 35 hours nor more than that set in the *requirements for continuing medical education [requirements]* of the American Osteopathic Association. *Not less than 10 percent of the required number of hours of continuing education must be devoted to preventative health care.*

2. The secretary of the board shall notify each licensee of the [renewal requirement] *requirements for renewal of a license* not less than 30 days before the date of renewal.

3. Members of the Armed Forces of the United States and the United States Public Health Service are exempt from payment of the annual [license renewal fee during their active duty status.] *fee for renewal while they are on active duty.*

Sec. 6. NRS 633A.290 is hereby amended to read as follows:

633A.290 1. Except as provided in NRS 633A.310, every holder of a license issued under this chapter may renew his license [.] on or before February 1 of each [calendar] year after its issuance by:

(a) Applying for renewal on forms provided by the board;

(b) Paying the annual [renewal] *fee for renewal* prescribed by the board;
and

(c) Furnishing proof of attendance at such *courses of continuing education [courses]* as are required by the board, not to exceed 12 hours since his last renewal or licensing. *Not less than 10 percent of the required number of hours of continuing education must be devoted to preventative health care.*

2. The secretary of the board shall notify each licensee of the [renewal requirement] *requirements for renewal of a license* not less than 60 days before the date of renewal.

Sec. 7. NRS 634.130 is hereby amended to read as follows:

634.130 1. Licenses and certificates must be renewed annually.

Each person licensed to practice chiropractic must, upon the payment of the fee provided for in this section, be granted a [renewal] certificate *of renewal* which authorizes him to continue to practice for 1 year.

2. Every person holding a valid license and actively practicing chiropractic in this state, whether on a full-time or part-time basis, must pay a [renewal] fee *for renewal* not to exceed \$200. Every person who holds a valid license in this state but does not actively practice chiropractic must pay a [renewal] fee *for renewal* not to exceed \$50. Every chiropractor's assistant must pay a [renewal] fee *for renewal* not to exceed \$100.

3. Each [renewal] fee *for renewal* must be paid to the board on or before January 1 of the year to which it applies.

4. A licensee in active or part-time practice within this state must submit satisfactory proof to the board that he has attended at least one 2-day educational seminar of at least 10 hours approved or endorsed by the board, with the exception of a licensee who has reached the age of 70 years. *Not less than 10 percent of the required number of hours of continuing education must be devoted to preventative health care.* The educational requirement of this section may be waived by the board if the licensee files with the board a statement of a chiropractic physician, osteopathic physician or doctor of medicine certifying that the licensee is suffering from serious or disabling illness or physical disability which prevented him from attending the required educational seminar during the 12 months immediately preceding the annual [licensing renewal date.] *date for renewal.*

5. If a licensee fails to pay his [renewal] fee *for renewal* by January 1 or fails to submit proof of continuing education pursuant to subsection 4.

his license is automatically suspended and may be reinstated only upon the payment of a [reinstatement] fee *for reinstatement* of \$100 in addition to the [renewal fee.] *fee for renewal*.

Sec. 8. NRS 634A.167 is hereby amended to read as follows:

634A.167 1. To renew a license issued pursuant to this chapter, each person must, on or before February 1 of each year:

- (a) Apply to the board for renewal;
- (b) Pay the annual fee for registration prescribed by the board; and
- (c) Submit evidence to the board of his completion of the requirements for continuing education.

2. The board shall, as a prerequisite for the renewal or reinstatement of a license, require each holder of a license to comply with the requirements for continuing education adopted by the board. *Not less than 10 percent of the required number of hours of continuing education must be devoted to preventative health care.*

Sec. 9. NRS 635.115 is hereby amended to read as follows:

635.115 1. After October 31, 1980, each podiatrist must, at the time of paying the annual fee for registration, present to the secretary-treasurer of the board satisfactory evidence that during the preceding 2 years he attended at least 50 hours of instruction in courses approved by the board for purposes of continuing professional education. *Not less than 10 percent of the required number of hours of instruction must be devoted to preventative health care.* The board may waive all or part of the requirement of continuing education in a particular year if the podiatrist was prevented from that attendance by circumstances beyond his control.

2. If a podiatrist fails to provide proof of his continuing education and does not obtain a waiver from the board, the secretary-treasurer shall not renew his license.

Sec. 10. NRS 636.260 is hereby amended to read as follows:

636.260 1. On or before the final day for renewal, each licensee shall pay a [renewal] fee *for renewal of his license* to the secretary in the amount specified in this chapter.

2. [Effective March 1, 1974.] *Except as provided in subsection 3, each licensee shall, at the time of paying [such renewal] the fee, present to the secretary satisfactory evidence that during the 12 months immediately preceding he attended an educational or postgraduate program approved by the board for the number of hours as may be set by the board [not exceeding 24, unless such licensee:] . not to exceed 24 hours. Not less than 10 percent of the required number of hours of continuing education must be devoted to preventative health care.*

3. *The provisions of subsection 2 do not apply to a licensee who:*

(a) Has been licensed to practice optometry in this state for 30 years or more on July 1, 1973;

(b) Is 65 years of age or older on July 1, 1973; or

(c) Is prevented from attending any such program because of illness or, in the discretion of the board, for other good cause.

Sec. 11. NRS 637.135 is hereby amended to read as follows:

637.135 1. Except as provided in subsection 2, all licensed dispensing opticians must complete a yearly program of continuing education in ophthalmic dispensing.

2. Licensed dispensing opticians on active military service are exempt from the requirement of this section.

3. The program of continuing education in ophthalmic dispensing must:

(a) Encompass such subjects as are established by regulations of the board.

(b) Consist of a minimum of 12 hours in each calendar year.

4. The board shall require persons who are certified to fit contact lenses to obtain additional continuing education related to that practice.

5. *Not less than 10 percent of the required number of hours of continuing education must be devoted to preventative health care.*

Sec. 12. Sections 1 to 11, inclusive, of this act, do not apply to hours of credit for continuing education earned before July 1, 1987.

SUMMARY--Requires driver and passengers in certain motor vehicles to wear safety belts. (BDR 43-210)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to traffic laws; requiring the driver and passengers in certain motor vehicles to wear safety belts; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. NRS 484.641 is hereby amended to read as follows:

484.641 1. It is unlawful to drive a passenger car manufactured after:

(a) January 1, 1968, on a highway unless it is equipped with at least two lap-type safety belt assemblies for use in the front seating positions.

(b) January 1, 1970, on a highway. unless it is equipped with a lap-type safety belt assembly for each permanent seating position for passengers. This requirement does not apply to the rear seats of vehicles operated by a police department or sheriff's office.

(c) January 1, 1970, unless it is equipped with at least two shoulder-harness-type safety belt assemblies for use in the front seating positions.

2. Any person driving and any passenger 5 years of age or older who rides in the front *or back* seat of any vehicle described in subsection 1, having an unladen weight of less than 6,000 pounds, on any highway.

road or street in this state shall wear a safety belt if one is available for his seating position.

3. A citation must be issued to any driver or to any adult passenger who fails to wear a safety belt as required by subsection 2. If the passenger is a child 5 years of age or older but under 18 years, a citation must be issued to the driver for his failure to require that child to wear the safety belt, but if both the driver and that child are not wearing safety belts, only one citation may be issued to the driver for both violations. A citation may be issued pursuant to this subsection only if the violation is discovered when the vehicle is halted or its driver arrested for another alleged violation or offense. Any person who violates the provisions of subsection 2 shall be punished by a fine of not more than \$25 or by a sentence to perform a certain number of hours of work for the community. A violation of subsection 2 is not a moving traffic violation under NRS 483.473 and may not be considered as negligence in any civil action or as negligent or reckless driving under NRS 484.377.

4. The department shall exempt those types of motor vehicles or seating positions from the requirements of subsection 1 when compliance would be impractical.

5. The provisions of subsections 2 and 3 do not apply:

(a) To a driver or passenger who possesses a written statement by a physician certifying that he is unable to wear a safety belt for medical or physical reasons;

(b) If the vehicle is not required by federal law to be equipped with safety belts;

(c) To an employee of the United States Postal Service while delivering mail in the rural areas of this state;

(d) If the vehicle is stopping frequently, the speed of that vehicle does not exceed 15 miles per hour between stops and the driver or passenger is frequently leaving the vehicle or delivering property from the vehicle; or

(e) To a passenger riding in a means of public transportation, including a taxi, school bus or emergency vehicle.

6. It is unlawful for any person to distribute, have for sale, offer for sale or sell any safety belt or shoulder harness assembly for use in a motor vehicle unless it meets current minimum standards and specifications of the United States Department of Transportation.

Sec. 2. Section 8 of chapter 678, Statutes of Nevada 1985, at page 2296, is hereby amended to read as follows:

Sec. 8. 1. Sections 1, 2 and 6 of this act become effective on July 1, 1986, but if, before that date, the Federal Government authorizes a maximum speed limit greater than 60 miles per hour, those sections become effective on the date that limit takes effect:

2. Section 3 of this act becomes effective on July 1, 1986, but if, before that date, the Federal Government authorizes a maximum speed limit greater than 60 miles per hour, that section becomes effective on the date that limit takes effect or at 12:01 a.m. on July 1, 1985, whichever is later.

3. If the Federal Government withholds money from this state that it would have received but for the provisions of this act, sections 1, 2, 3 and 6 of this act expire by limitation on the date that the money is actually withheld.

4. [If Nevada is authorized by the Federal Government to impose a maximum speed limit of or greater than 70 miles per

hour, section] *Section 5* of this act becomes effective on July 1, [1986, or on the date of that authorization, whichever is earlier. If that section takes effect, it expires by limitation on July 2, 1989.] 1987.

5. This section and sections 4 and 7 of this act become effective on July 1, 1985.

Sec. 3. 1. This section and section 2 of this act become effective on July 1, 1987.

2. Section 1 of this act becomes effective at 12:01 a.m. on July 1, 1987.

SUMMARY--Directs Legislative Commission to study mandatory coverage in policies of health insurance for mental illness and abuse of alcohol and drugs. (BDR R-478)

CONCURRENT RESOLUTION--Directing the Legislative Commission to study mandatory coverage in policies of health insurance for mental illness and abuse of alcohol and drugs.

WHEREAS, The rising cost of insurance is a burden upon the hard-working citizens of this state; and

WHEREAS, Provisions of state law that require all policies of health insurance to provide coverage for the treatment of the abuse of alcohol and drugs contribute to the already high cost of such insurance; and

WHEREAS, The inclusion of coverage for mental illness in policies of health insurance would help to reduce the demand for the provision of care for mental illness by the state; and

WHEREAS, Laws which mandate the provision of benefits in health insurance unfairly burden those persons who have the financial resources to purchase insurance while not providing coverage to those who need treatment but cannot afford insurance; now, therefore, be it

RESOLVED BY THE OF THE STATE OF NEVADA. THE CONCURRING. That the Legislative Commission is hereby directed to study mandatory coverage in policies of health insurance for the treatment of mental illness and the abuse of alcohol and drugs; and be it further

RESOLVED, That the study consider the cost of mandatory coverage in terms of premiums for insured persons and the effect of such federal laws as the Employee Retirement Income Security Act on state laws that require policies of insurance to cover specific illnesses and conditions; and be it further

RESOLVED, That the Legislative Commission report the results of the study and recommendations for any desirable statutory or regulatory changes to the 65th session of the Nevada Legislature.

SUMMARY--Makes appropriation to University of Nevada System for construction of building on certain land. (BDR S-479)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: Contains
Appropriation.

AN ACT making an appropriation to the University of Nevada for construction of a building on certain land in Clark County, Nevada; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. There is hereby appropriated from the state general fund to the University of Nevada System the sum of \$1,200,000 to begin construction of a building to be used by the Clark County Community College:

1. As a center of health science;
2. As an area center for multidisciplinary professional and paraprofessional health education; and
3. For the University of Nevada System's clinic to provide medical services for recipients of Medicaid.

on the following described land containing approximately 79.11 acres:

The western one-half of the northeastern one-quarter of Section 2, Township 21 South, Range 60 East, Mount Diablo Base and Meridian.

Sec. 2. Any remaining balance of the appropriation made by section 1 of this act must not be committed for expenditure after the project is completed and reverts to the state general fund as soon as all payments of money committed have been made.

Sec. 3. The University of Nevada System shall solicit and accept gifts and grants of money for the purpose of constructing the building authorized by section 1 of this act. The University of Nevada System shall not use any gift or grant of money in lieu of the money appropriated by section 1 of this act. The gift or grant must be used to supplement the appropriated money and permit the completion of the authorized building in a timely manner.

SUMMARY--Creates temporary program to improve health of state employees.

(BDR 23-537)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Contains
Appropriation.

AN ACT relating to programs for state employees; temporarily creating a committee to improve the health of state employees; prescribing its powers and duties; creating an account for the committee; making an appropriation for studies and programs conducted by the committee; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. Chapter 287 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 6, inclusive, of this act.

Sec. 2. *The committee to improve the health of state employees, consisting of three members appointed by the governor, is hereby created. Each member must be qualified by virtue of training or experience in a field related to health care.*

Sec. 3. *1. The committee to improve the health of state employees shall meet at least twice annually to review the programs established by the committee and assess the health of the employees of the State of Nevada.*

2. A majority of the members of the committee constitutes a quorum to transact all business.

3. Each member of the committee is entitled to receive a salary of \$60 per day while engaged in the business of the committee, and reimbursement for his actual and necessary expenses incurred in the performance of his duties.

Sec. 4. *1. Money received by the committee to improve the health of state employees from:*

(a) Appropriations made by the legislature to the committee; and

(b) Gifts and grants of money to the committee,

must be deposited with the state treasurer for credit to the account for the committee to improve the health of state employees, which is hereby created in the state general fund.

2. The interest and income earned on money in the account, after deducting any applicable charges, must be credited to the account.

3. Money in the account may only be used for:

(a) Studies and programs conducted or authorized by the committee to improve the health of state employees.

(b) The payment of the expenses of the committee and the salaries and expenses of the members of the committee and its employees.

Sec. 5. *The committee to improve the health of state employees shall:*

1. Conduct studies to assess the health of employees of the State of Nevada; and

2. Develop comprehensive programs to improve the health of state employees. The programs may include:

(a) Providing basic diagnostic tests for employees.

(b) Interpreting the results of those basic diagnostic tests.

(c) Conducting courses on nutrition, the management of stress, fitness and other subjects to improve an employee's health.

(d) Assisting employees to find economical providers of health care.

(e) Establishing programs to help employees maintain good health.

(f) Publishing a newsletter.

(g) Following the progress of employees who take part in the program.

Sec. 6. *The committee to improve the health of state employees may:*

- 1. Contract with any person to conduct the studies and programs required of the committee.*
- 2. Accept gifts and solicit grants of money.*
- 3. Hire administrative and clerical employees as it deems necessary to carry out its duties.*

Sec. 7. 1. The committee to improve the health of state employees shall establish a pilot program to study, assess and improve the health of a representative sample of employees of the State of Nevada for a period of 2 years. The program may include any of the matters set forth in subsection 2 of section 5 of this act.

2. The committee shall choose approximately 1,000 employees from southern Nevada and 1,000 employees from northern Nevada for the pilot program. The committee shall choose employees who work for agencies which are large enough to minimize the cost of the program.

3. The committee shall submit to the 65th session of the legislature a report of its findings and recommendations for legislation concerning the pilot program and its potential expansion.

Sec. 8. 1. There is hereby appropriated from the state general fund to the committee to improve the health of state employees for the studies and programs required by this act:

For the fiscal year 1987-1988..... \$100,000

For the fiscal year 1988-1989..... 100,000

2. The sums appropriated by subsection 1 are available for either fiscal year. Any balance of those sums must not be committed for expenditure after June 30, 1989, and reverts to the state general fund as soon as all payments of money committed have been made.

Sec. 9. Sections 1 to 6, inclusive, of this act expire by limitation on July 1, 1989.

SUMMARY--Requires certain hospitals to pay assessments based upon their size and number of medically indigent patients they admit. (BDR 38-1001)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to state assistance to the medically indigent; providing for the assessment of certain hospitals that do not admit a proportional share of persons who are eligible for such assistance; providing for additional assessments of all hospitals for such assistance; providing for the use of the money received from the assessments; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 5, inclusive, of this act.

Sec. 2. *As used in sections 3, 4 and 5 of this act, unless the context otherwise requires:*

1. *"Basic assessment" means an assessment made of hospitals which are licensed in this state for 200 or more beds and which do not admit their proportionate share of medically indigent patients.*

2. *"Hospital" has the meaning ascribed to it in NRS 449.012. The term does not include a psychiatric hospital, as that term is defined in NRS 449.0165, or any hospital operated and maintained by the Federal Government or an agency thereof.*

3. *"Medically indigent patient" means a natural person admitted to a hospital for observation, care, diagnosis or treatment, excluding care for newborns, who is certified by the welfare division as eligible to receive assistance to the medically indigent for the medical care provided that day, including such a patient who is admitted to the hospital and certified as eligible to receive such assistance for the lesser level of care normally provided by a facility for skilled nursing or a facility for intermediate care.*

4. *"Proportional share of medically indigent patients" means the number of medically indigent patients that a particular hospital is expected to admit in a calendar year.*

5. *"Residual assessment" means an assessment made of all hospitals if the basic assessment does not raise the required amount of money.*

Sec. 3. 1. *On or before July 1 of each year, the administrator shall calculate the proportional share of medically indigent patients for the preceding calendar year for each hospital licensed in this state for 200 or more beds, by:*

(a) *Dividing the total of the number of days in a calendar year that each patient is admitted to that hospital for observation, care, diagnosis or treatment, excluding care for newborns, by the total of the number of days in that year that each patient is admitted to all hospitals in this state for observation, care, diagnosis or treatment, excluding care for newborns; and*

(b) *Multiplying the result by the total of the number of days in that year that each medically indigent patient is admitted to all hospitals in this state for observation, care, diagnosis or treatment.*

2. *If the administrator finds that such a hospital has not admitted its proportional share of medically indigent patients in the preceding calendar year, he shall calculate the basic assessment for that hospital by multiplying \$1,866 by the difference between the proportional share of medically indigent patients calculated for that calendar year for that hospital and the total of the number of days in that year that each medically indigent patient is admitted to that hospital for observation, care, diagnosis or treatment.*

3. If the total amount of all of the basic assessments calculated for each calendar year pursuant to subsection 2 is less than \$15,000,000, the difference must be assessed proportionately by means of a residual assessment against each hospital licensed in this state. Each hospital shall pay the proportion of the assessment that the total of the number of days in a calendar year that each patient is admitted to that hospital for observation, care, diagnosis or treatment, excluding care for newborns, bears to the total of the number of days in that year that each patient is admitted to all hospitals in this state for observation, care, diagnosis or treatment, excluding care for newborns.

4. If, in addition to a basic assessment, a residual assessment is made for a hospital licensed in this state for 200 or more beds, the two assessments must be combined to determine the total amount assessed against that hospital.

5. The administrator shall, on or before July 1, notify each hospital assessed pursuant to this section of the amount of the assessment. Each hospital shall pay the assessment to the welfare division on or before September 1 of that year. If a hospital fails to pay the assessment when due, the hospital shall pay an additional amount equal to 10 percent of the amount of the assessment, plus interest on the assessment at the rate of 12 percent per annum from September 1 until the assessment is paid.

Sec. 4. 1. The money received each year pursuant to section 3 of this act must be deposited in the appropriate account of the welfare division in the state general fund.

2. The money in the account must be used, upon recommendation by the administrator and approval of the board, for assistance to the medically indigent in the manner provided in section 5 of this act.

3. Any balance remaining in the account at the end of each fiscal year does not revert to the state general fund and must be retained in the account for use in the following fiscal year pursuant to section 5 of this act.

Sec. 5. 1. At least 85 percent of the money in the account in each fiscal year must be used to provide the funding necessary to expand the benefits and coverage available

under the state plan for assistance to the medically indigent by one or more of the following methods:

(a) Increasing the standard of need and the level of assistance for recipients of aid to dependent children.

(b) Expanding the number of recipients eligible for aid to dependent children by including households with two parents in which the principal wage earner is unemployed.

(c) Expanding the number of recipients eligible for assistance under the state plan by including any child who is 5 years of age or older and who is a member of a family whose income is below the standard of need established for aid to dependent children.

(d) Increasing the limit on monthly income for eligibility under the state plan for persons receiving long-term care in a medical facility to the maximum allowed by 42 U.S.C. § 1396b(j)(4)(C).

2. The remaining money in the account in each fiscal year may be used to supplement any programs for assistance to the medically indigent which the administrator and the board consider appropriate.

3. In determining how to allocate the money in the account pursuant to this section, the administrator and the board shall consider whether the proposed allocations will:

(a) Provide the most assistance for medical and remedial care that would otherwise be uncompensated, including reducing the burden on local governments for the cost of medical care of indigents; and

(b) Minimize the shifting of medical costs among different groups of persons.

Sec. 6. NRS 422.234 is hereby amended to read as follows:

422.234 1. The administrator shall establish a state plan for assistance to the medically indigent. The state plan is subject to the approval of the board. The state plan must set forth the requirements for eligibility of indigent persons, the types of medical and remedial care for which assistance may be provided, the conditions imposed and such

other provisions relating to the development and administration of the program for assistance to the medically indigent as the administrator and the board deem necessary.

2. In developing and revising the plan, the administrator and the board shall consider, among other things [, the] :

(a) *The amount of money available from the Federal Government for assistance to the medically indigent and the conditions attached to the acceptance of such money [, and the] :*

(b) *The limitations of legislative appropriations for assistance to the medically indigent [.] ; and*

(c) *The amount of money available from assessments of hospitals and the conditions placed on the use of that money pursuant to sections 2 to 5, inclusive, of this act.*

Sec. 7. NRS 422.240 is hereby amended to read as follows:

422.240 1. [Funds] *Except as otherwise provided in sections 2 to 5, inclusive, of this act, money to carry out the provisions of this chapter [shall] must be provided by appropriation by the legislature from the state general fund.*

2. Disbursements for the purposes of this chapter [shall be made upon claims duly filed, audited and allowed in the same manner as other moneys in the state treasury are disbursed.] *must be paid out on claims as other claims against the state are paid.*

Sec. 8. The state welfare administrator shall collect and compile the statistics concerning admissions to hospitals in this state for the calendar year ending on December 31, 1986, which are necessary to calculate, pursuant to sections 2 to 5, inclusive, of this act, the proportional share of medically indigent patients for that year and the assessments which will be made against hospitals on July 1, 1987, based upon those statistics.

Sec. 9. 1. This section and section 8 of this act become effective upon passage and approval.

2. Sections 1 to 7, inclusive, of this act, become effective on July 1, 1987.

SUMMARY--Requires hospitals to submit certain contracts to division for review of health resources and costs of department of human resources.
(BDR 40-1002)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

AN ACT relating to health care; requiring hospitals to submit certain contracts to the division for review of health resources and costs of the department of human resources; authorizing the division to compile statistics derived from the contracts; and providing other matters properly relating thereto.

**THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:**

Section 1. Chapter 439A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. *"Hospital" has the meaning ascribed to it in NRS 449.012.*

Sec. 3. *1. A hospital shall submit annually to the division a copy of each contract or agreement to which the hospital was a party during the preceding year for the provision of health services to 20 or more natural persons.*

2. The division may compile and publish statistics derived from information contained in the contracts or agreements.

3. Each contract or agreement submitted to the division pursuant to this section is confidential.

Sec. 4. NRS 439A.010 is hereby amended to read as follows:

439A.010 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 439A.0105 to 439A.0195, inclusive, *and section 2 of this act*, have the meanings ascribed to them in those sections.