LEGISLATIVE COMMITTEE ON HEALTH CARE

Bulletin No. 91-9

LEGISLATIVE COMMISSION
OF THE
LEGISLATIVE COUNSEL BUREAU
STATE OF NEVADA

JANUARY 1991

REPORT OF THE NEVADA LEGISLATURE'S COMMITTEE ON HEALTH CARE

BULLETIN NO. 91-9

LEGISLATIVE COUNSEL BUREAU

CARSON CITY, NEVADA

JANUARY 1991

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NEVADA REVISED STATUTES

439B.200 Creation; appointment of and restrictions on members; officers; terms of members; vacancies; annual reports.

1. There is hereby established a legislative committee on health care consisting of three members of the senate and three members of the assembly, appointed by the legislative commission. The members must be appointed with appropriate regard for their experience with and knowledge of matters relating to health care.

2. No member of the committee may:

(a) Have a financial interest in a health facility in this state;

(b) Be a member of a board of directors or trustees of a health facility in this state;

(c) Hold a position with a health facility in this state in which the legislator exercises control over any policies established for the health facility; or

(d) Receive a salary or other compensation from a health facility in this state.

This subsection does not prohibit a member of the committee from selling goods which are not unique to the provision of health care to a health facility if the member primarily sells such goods to persons who are not involved in the provision of health care.

3. The legislative commission shall select the chairman and vice chairman of the committee from among the members of the committee. Each such officer shall hold office for a term of 2 years commencing on July 1 of each odd-numbered year.

4. Any member of the committee who does not return to the legislature continues to serve until the next session of the legislature convenes.

5. Vacancies on the committee must be filled in the same manner as original appointments.

6. The committee shall report annually to the legislative commission concerning its activities and any recommendations.

(Added to NRS by 1987, 863; A 1989, 1841)

439B.210 Meetings; quorum; compensation.

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 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 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 provided for state officers and employees generally and the travel expenses provided pursuant to NRS 218.2207.

3. The salaries and expenses of the committee must be paid from the legislative fund.

(Added to NRS by 1987, 864; A 1987, 1629; 1989, 1221)

439B.220 Powers. 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. Review competitive mechanisms to aid in the reduction of the costs of medical care.

9. Examine the problem of providing and paying for medical care for indigent and medically indigent persons, including medical care provided by physicians.

10. 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 9, inclusive.

11. Determine whether regulation by the state will be necessary in the future by examining hospitals for evidence of:

(a) Degradation or discontinuation of services previously offered, including without limitation, neonatal care, pulmonary services and pathology services; or

(b) A change in the policy of the hospital concerning contracts,

as a result of any legislation enacted to accomplish the purpose of restraining the costs of health care while ensuring the quality of services.

12. Study the effect of the acuity of the care provided by a hospital upon the revenues of hospital and upon limitations upon that revenue.

13. Review the actions of the director in administering the provisions of this chapter and adopting regulations pursuant to those provisions. The director

shall report to the committee concerning any regulations proposed or adopted pursuant to this chapter.

14. Conduct investigations and hold hearings in connection with its review and analysis.

15. Apply for any available grants and accept any gifts, grants or donations to aid the committee in carrying out its duties pursuant to this chapter.

16. Direct the legislative counsel bureau to assist in its research, investigations, review and analysis.

17. Recommend to the legislature as a result of its review any appropriate legislation.

(Added to NRS by 1987, 864)

439B.230 Investigations and hearings: Depositions; subpenas.

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 chairman of the committee may issue subpenas 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 subpena, the 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 subpenaed 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 subpena before the committee which is named in the subpena, 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 subpena 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.

(Added to NRS by 1987, 866; A 1987, 1630)

439B.240 Investigations and hearings: Fees and mileage for witnesses. 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.

(Added to NRS by 1987, 866)

REPORT OF THE
NEVADA LEGISLATURE'S COMMITTEE ON HEALTH CARE

TO THE MEMBERS OF THE 66TH SESSION OF THE NEVADA LEGISLATURE:

This report is submitted in compliance with Nevada Revised Statutes 439B.200 which was added to the statutes by Assembly Bill 289 of the 1987 legislative session (Chapter 377, Statutes of Nevada 1987, pages 862-891). Assembly Bill 289 established the Nevada Legislature's Committee on Health Care and directed the committee to provide legislative oversight into the effects of the bill on the health care industry and to monitor health care activities in Nevada.

The Legislative Commission originally appointed the following members to the committee:

Senator Raymond D. Rawson, Chairman
Assemblyman Marvin M. Sedway, Vice Chairman
Senator Bob Coffin
Senator Randolph J. Townsend
Assemblyman Morse Arberry, Jr.
Assemblyman David E. Humke
Assemblywoman Vivian L. Freeman (alternate)

After the untimely death of Assemblyman Sedway, the Legislative Commission appointed Assemblyman Arberry to the Vice Chairmanship and Assemblywoman Freeman to full membership.

Legislative Counsel Bureau staff services for the committee were provided by Dana R. Bennett of the Research Division (principal staff), Lorne J. Malkiewich of the Legal Division (legal counsel), and Ellen R. Nelson of the Research Division (committee secretary).

The committee held eight regular meetings from October 1989 through December 1990. Two additional subcommittee meetings were called by the chairman to consider action regarding rural health care issues and Section 55 of Assembly Bill 289 (1987).

The committee considered over 100 proposed recommendations and approved a total of 45 of them. These approved proposals are categorized into the following sections:

Assembly Bill 289 (1987)
Division for the Review of Health Resources and Costs
Health Care Professionals
Health Insurance

Health Planning
Medicaid, Welfare and State Social Services
Rural Hospital Regulations

In compliance with Section 59 of Assembly Bill 289, the committee submitted a report to the Legislative Commission on November 30, 1990, concerning the effect of the bill and the need for continued controls over the costs of health care.

The committee's final report contains a review of the major health care topics considered by the committee, and a discussion is included for each recommendation. The report also contains material which may be used to supplement Legislative Counsel Bureau Bulletin No. 87-6 titled Study of Restraining Costs of Medical Care dated December 1986 and Legislative Counsel Bureau Bulletin No. 89-8 titled Report of the Nevada Legislature's Committee on Health Care dated January 1989. These earlier reports should be consulted for a review of the history of health care, industry trends and the background information surrounding major issue areas.

Respectfully submitted,

Nevada Legislature's Committee on Health Care

Carson City, Nevada
January 1991

SUMMARY OF RECOMMENDATIONS

This summary contains the recommendations to the 66th session of the Nevada Legislature by its Committee on Health Care.

Although this summary lists the bill draft request (BDR) numbers that correspond to the recommendations, the BDRs were not available for inclusion with this report at the time of printing.

I. ASSEMBLY BILL 289 (1987)

A. Amendments to Health Care Cost Containment Provisions

The committee recommends that the following amendments be made to certain sections of Assembly Bill 289 of the 1987 legislative session (Chapter 377, Statutes of Nevada 1987, pages 862-891), a measure relating to restraining the costs of health care.

1. **Amend Section 4 to expand and personalize the definition of "Billed charge." (BDR 40-1025)**

2. **Amend Section 27 to allow private hospitals to pay within the first quarter of the year the amount of assessed uncompensated care in lieu of the indigency case by case determination process. At any time during the year, the hospital could pursue fund return through the normal case by case application process. (BDR 40-1025)**

3. **Amend Section 29 to give the Department of Human Resources the authority to include in the counting of a hospital's indigent care credits the care provided to a person denied indigent status for lack of additional information. (BDR 40-1025)**

4. **Amend Section 30 to include physicians in the prohibitions against improper inducements. (BDR 40-1025)**

5. **Amend Section 33 to require the Legislature's Committee on Health Care to review regulations related to the provisions of health care cost containment legislation before submission to the Legislative Commission. (BDR 40-1025)**

6. Amend Section 54 to allow the regulation of holding companies for health maintenance organizations. (BDR 40-1025)

7. Amend Section 55 to continue the limitations on increases in hospital billed charges for inpatient services by restricting such increases to 60 percent of the Consumer Price Index (All Items). Exempt hospitals whose profit margins are less than 2 percent. Require hospitals to bill patients covered by negotiated contracts an average negotiated rate. Freeze hospital billed charges for outpatient services at current rates for 2 years. (BDR 40-1127)

B. Additional Provision

8. Allow receivership of hospitals with certain licensure violations and other problems. (BDR 40-1025)

II. DIVISION FOR THE REVIEW OF HEALTH RESOURCES AND COSTS DEPARTMENT OF HUMAN RESOURCES

A. Data Collection

9. Conduct a study to design a good survey vehicle to include the monitoring of the costs of outpatient services. (BDR 40-1017)

10. Require the Division to obtain a breakdown of each hospital's billed charges to determine how much supports patient services, how much goes to the hospitals' debt burdens and how much is profit. (BDR 40-1017)

11. Provide funding for the collection of appropriate information, particularly on outpatient services, epidemiology, the health status of Nevadans and the factors driving health care costs in Nevada. (BDR 40-1017)

12. Authorize the Division to keep certain information confidential. (BDR 40-1017)

13. Require the Division to examine the case mix and severity of illness information in other states' hospital data to compare with Nevada hospital data. Provide the needed additional funding and staff to complete this project. (BDR 40-1017)

B. Data Dissemination

14. Require the Division to publish a two-page summary of Personal Health Choices. (BDR 40-1017)

15. Require the Division to provide the Committee on Health Care with the hospital compliance reports prior to the meeting at which they are scheduled to be presented. Restrict the Division from publicly releasing the reports until they have been presented to the committee. (BDR 40-1017)

III. HEALTH CARE PROFESSIONALS

A. Educational Programs

16. Clarify the definition of the nursing assistant training program administration. (BDR 54-1035)

17. Urge the University of Nevada System (UNS) to develop a high school honors program as a means of recruiting nursing and allied health students. Encourage health care as a career at the high school level through vocational and educational programs which begin in the senior year and interface with UNS. (BDR 34-1018)

18. Support the current UNS budget proposals to increase faculty and programs to graduate more health care professionals from existing programs.

19. Fund program development and faculty recruitment to provide programs for advanced practitioners of nursing, certified registered nurse anesthetists and clinical nurse specialists. (BDR 34-1027)

20. Expand training programs at the community colleges to allow for the cross-training of health care technicians. (BDR 34-1018)

21. Create and fund a loan program for health care students who agree to work in rural or underserved areas. (BDR 34-1018)

B. Nurses

22. Require Nevada public school districts to progress toward a goal of 1,000 school children per nurse within 5 years and to establish a plan to reach this goal. (BDR 34-1033)

23. Allow nurses in Nevada communities of less than 30,000 population and within 25 miles of the state's border to take orders from physicians in neighboring states. (BDR 54-1034)

C. Physicians

24. Subsidize malpractice insurance premiums for the obstetrical practices of rural physicians who agree to certain conditions regarding the provision of care. (BDR 3-1023)

25. Extend the Good Samaritan Act to prenatal care and drop-in deliveries. (BDR 3-1023)

26. Develop no-fault liability coverage for certain conditions in newborn babies. (BDR 57-1024)

27. Provide funding to add a cytogeneticist and a medical geneticist to the University of Nevada School of Medicine Genetics Program. (BDR 34-1032)

IV. HEALTH INSURANCE

A. Assistance for the Uninsured

28. Require a study to be conducted by UNS to determine the number of uninsured in Nevada, their ages, employment status, income levels and so on. (BDR S-1019)

29. Create a risk pool for the medically uninsurable. Set premiums at 25 to 50 percent over the market average with flexible deductibles. Include reciprocity. (BDR 57-1038)

30. Develop a program to provide health care insurance coverage for the working uninsured. (BDR 57-1126)

B. Benefits

31. Support the recommendations submitted by the Legislative Commission's Subcommittee to Study Health Insurance Benefits (S.C.R. 58).

C. Insurance Companies

32. Allow the Commissioner of Insurance to contract for experts to investigate alleged violations of antitrust restrictions on insurance companies. (BDR 57-1026)

D. Utilization Review

33. Require the State Board of Health (in the Health Division of DHR) to license and regulate utilization review organizations operating in Nevada. (BDR 40-1037)

V. HEALTH PLANNING

A. Studies

34. Fund a comprehensive study of Nevada's health planning system and the organization of the state's health regulatory agencies. (BDR S-1020)

35. Establish a task force to develop a feasibility plan for trauma and perinatal networks, including transportation and facility improvements. (BDR S-1021)

VI. MEDICAID, WELFARE AND OTHER STATE SOCIAL SERVICES

A. Eligibility

36. Implement a process for presumptive eligibility for pregnant women who may be eligible for the Aid to Dependent Children or Child Health Assurance programs. (BDR 38-1028)

37. Support the plan presented by the Nevada Association of Counties to transfer the funds for the allowable federal match of long-term care to Nevada Medicaid from the county welfare systems.

B. Medicaid Buy-Out

38. Allow the state to pay an employee's contribution towards the premium for group coverage when Medicaid eligibles are working or returning to work for employers with group health insurance coverage. (BDR 38-1029)

C. Reimbursement

39. Support increased reimbursements to long-term care facilities for Medicaid patients.

D. State Social Services

40. Create a 24-hour statewide hotline that would be answered by a person who would connect or direct a caller to the correct social service agency for assistance with a particular problem. (BDR 18-1031)

E. Welfare Division

41. Amend NRS 233B.039, "Applicability," to require the Welfare Division to adhere to the provisions of the Nevada Administrative Procedure Act. (BDR 18-1030)

VII. RURAL HOSPITAL REGULATIONS

A. Recommendations from the Nevada Rural Hospital Study

42. Urge the State Board of Health to eliminate duplicative surveys and licenses by implementing a policy which allows one license to cover all aspects of a health care operation, which are governed by the same board and located in the same county. (BDR 40-1022)

43. Mandate the Welfare Division, the Bureau of Regulatory Health Facilities and the State Board of Pharmacy and all future surveying agencies to combine licensure and certification surveys. (BDR 40-1022)

44. Require all agencies and boards to do cost/benefit analyses and impact statements for all proposed health care legislation and regulations. Include a requirement that the feasibility of waivers for

rural facilities be evaluated. Cost/benefit analysis would include all costs associated with regulation to the state and to the provider (and, therefore, the patient) on an ongoing basis. Include a requirement that conflicts (in terms of regulation) be resolved by agencies and boards before regulations are adopted. (BDR 40-1022)

45. Require that the Bureau of Regulatory Health Facilities annually present a seminar designed to provide a comprehensive review of current licensure regulations and current interpretations of regulations and Medicare Conditions of Participation being used by surveyors. Reasonable registration fees may be charged to cover the cost of the seminar. Appropriate $60,000 to fund a position in the bureau to coordinate educational programs on health facility regulations. Also, allocate $75,000 to establish a grant pool for technical administrative assistance to rural hospitals. Allow the Department of Human Resources to grant waivers from regulation requirements to rural hospitals where appropriate. (BDR 40-1036)

REPORT TO THE 66TH SESSION OF THE NEVADA LEGISLATURE
BY THE NEVADA LEGISLATURE'S COMMITTEE ON HEALTH CARE

I. INTRODUCTION - COST AND ACCESS ISSUES

Since the 1940s, expenditures for health care in the United States have grown 2.5 percent per annum faster than expenditures for other goods and services. The health sector's share of the gross national product (GNP) rose from well under 5 percent in the late 1940s to more than 11 percent currently.

FIGURE 1

RATES OF GROWTH OF THE HEALTH SECTOR

Rates of growth of the health sector and the rest of the economy, selected periods, 1947-1987 (percent per annum) (22-25). Rates are calculated from 3-year averages centered on the year indicated (except for 1947 and 1987).

Factor	1947-1987	1947-1967	1967-1987	1947-1957	1957-1967	1967-1977	1977-1987
Expenditures							
1. Health care	9.7	8.2	11.3	7.6	8.7	11.8	10.8
2. Rest of the economy	7.2	6.2	8.2	6.4	6.0	8.6	7.8
Prices							
3. Health care	5.7	3.7	7.6	3.7	3.6	7.1	8.3
4. Rest of the economy	4.1	2.4	5.8	2.7	2.0	6.2	5.3
Quantities*							
5. Health care	4.1	4.5	3.7	3.8	5.2	4.8	2.5
6. Rest of the economy	3.2	3.8	2.5	3.6	4.0	2.4	2.5
The gap (g)*							
1 minus 2	2.5	2.0	3.1	1.2	2.7	3.2	2.9
Relative prices*							
3 minus 4	1.6	1.3	1.9	1.0	1.6	0.8	3.0
Relative quantities*							
5 minus 6	0.9	0.7	1.2	0.2	1.2	2.4	0.0

*Calculated from unrounded data.

Source: "The Health Sector's Share of the Gross National Product." Victor R. Fuchs. Science, Vol. 247. 2 Feb 1990.

By the year 2000, these expenditures are expected to reach between 13 and 15 percent of GNP.

FIGURE 2

HEALTH SECTOR'S PERCENTAGE OF GNP IN FUTURE YEARS

The health sector's percentage of GNP in future years for selected values of g (initial share = 11.5%); g is the difference between the rate of growth of the health sector and the rate for the rest of the economy.

g (% per annum)	Years in Future 10	15	20	25
1.5	13.1	14.0	14.9	15.9
2.0	13.7	14.9	16.2	17.6
2.5	14.3	15.9	17.6	19.5
3.0	14.9	16.9	19.1	21.6

Source: "The Health Sector's Share of the Gross National Product." Victor R. Fuchs. Science, Vol. 247. 2 Feb 1990.

Consequently, concerns about the cost of health care have dominated national and state policy discussions for the past 15 years. Compounding the problem are the indications that approximately 30 million persons in this country are without any health insurance coverage.

A growing and dominant concern relative to the uninsured are the number of pregnant women and their babies who lack health insurance and are accordingly denied full access to health care services, especially prenatal care. This factor contributes to the nation's infant mortality rate which, in international comparisons, is quite high. The infant mortality in the U.S. places our country 20th among other nations.

Historically, Nevada has experienced some of the highest health care costs in the country. In 1987, the year the state's cost-containment legislation was enacted, Nevada ranked first in net revenue per inpatient admission, 32.2 percent above the Western States' average in this category. The 1989 data from the American Hospital Association indicates that Nevada has dropped only one place to second for net revenue per inpatient admission among all the states. Nevada's net revenue per admission still exceeds the Western States' average in this area by 24.3 percent.

FIGURE 3

WESTERN UNITED STATES
NET REVENUE PER ADMISSION
1987 AND 1989

	1987 (DOLLARS)	1989 (DOLLARS)
ALASKA	4,832	5,591
ARIZONA	4,086	4,430
CALIFORNIA	4,640	5,326
COLORADO	3,858	4,547
HAWAII	3,722	4,770
IDAHO	2,979	3,618
MONTANA	3,211	3,845
NEVADA	4,972	5,470
NEW MEXICO	3,175	3,676
OREGON	3,475	4,155
UTAH	3,595	4,264
WASHINGTON	3,661	4,250
WYOMING	2,681	3,271
AVERAGE	3,761	4,401

Data Source: American Hospital Association Annual Surveys.

In addition, it appears that a large percentage of Nevada's population lacks health insurance coverage. Estimates indicate that as many as 17 percent of the population, or over 200,000 people, are uninsured in this state.

A. NEVADA'S COST CONTAINMENT LAW

In 1987, the Nevada Legislature passed, and Governor Richard H. Bryan signed, Assembly Bill 289 (Chapter 377, Statutes of Nevada 1987, pages 862-891). A copy of A.B. 289, including notes on amendments made by the 1989 Legislature, is attached as Appendix A.

Assembly Bill 289 contains comprehensive provisions designed to reduce hospital costs. Some of these terms were limited to a specific amount of time. For example, the bill required several Nevada hospitals to reduce their billed charges to an established level, while also reducing their revenue per inpatient. Three Las Vegas hospitals were primarily impacted by A.B. 289: (1) Desert Springs Hospital; (2) Humana Hospital Sunrise; and (3) Valley Hospital. Other hospitals, such as St. Mary's Hospital in Reno, were required to reduce their percentage of income-to-operating expenses.

Other provisions of A.B. 289 are continuous. For instance, the measure prohibits specified transactions between insurers and affiliated health facilities and between hospitals and their affiliates.

The bill also contains sections devised to distribute the care of indigent patients more evenly in counties with more than one hospital. Additional provisions establish methods to monitor hospital financial data in an organized manner, to ensure continued quality of care, and to require that any savings be passed along to the consumer through reduced health care insurance premiums. The measure also created a legislative oversight committee to monitor the effectiveness of its provisions.

Although most of A.B. 289's sections have been codified in the Nevada Revised Statutes (NRS), the provisions concerning the limitations on rate increases in charges are only contained in the Statutes of Nevada 1987 and will expire by limitation on July 1, 1991.

B. LEGISLATIVE ACTION IN 1989

The 1989 Legislature passed many health care bills that originated in the Nevada Legislature's Committee on Health Care (NRS 439B.200). Some of the more significant measures include:

- Senate Bill 35 (Chapter 709, Statutes of Nevada 1989, pages 1632-1633), which requires the University of Nevada School of Medicine to conduct a study of chronic fatigue syndrome;

- Senate Bill 73 (Chapter 138, Statutes of Nevada 1989, pages 294-302), which provides a comprehensive reform of the laws governing the treatment and control of communicable diseases;

- Senate Bill 83 (Chapter 193, Statutes of Nevada 1989, pages 418-425), which makes various changes to the proceedings before the medical malpractice screening panels; and

- Senate Bill 85 (Chapter 840, Statutes of Nevada 1989, pages 2007-2019), which requires the certification of nursing assistants by the State Board of Nursing.

In addition, provisions of A.B. 289 were "fine-tuned" by several measures, including the following:

- Assembly Bill 858 (Chapter 717, Statutes of Nevada 1989, pages 1660-1664), which revises the provisions governing prohibitions on the transfer or refusal of patients by hospitals and physicians;

- Senate Bill 40 (Chapter 762, Statutes of Nevada 1989, pages 1800-1803), which increases the amount counties pay hospitals for the costs of treating indigent patients, revises the procedure for determining whether certain hospitals have met their obligations to provide such treatment and provides for the appeal of a determination by a county regarding the indigent status of a patient; and

- Senate Bill 76 (Chapter 761, Statutes of Nevada 1989, pages 1799-1800), which repeals Section 39 of A.B. 289 and requires hospitals to establish committees to ensure the quality of care provided by the hospitals.

C. PURPOSE OF THE HEALTH CARE COMMITTEE

Nevada Legislature's Committee on Health Care was established in 1987 by A.B. 289. The committee is charged with reviewing health care activities in Nevada and monitoring certain provisions of the bill. The committee held eight regular meetings from October 1989 through December 1990. Two additional subcommittee meetings were called by the chairman to consider action regarding rural health care issues and Section 55 of Assembly Bill 289 (1987).

The committee received testimony on a wide variety of topics from all segments of the health care industry including educators, hospitals, nurses, physical therapists, physicians, third party payers, various state agencies and the public. On a quarterly basis, the Division for the Review of Health Resources and Costs in Nevada's Department of Human Resources (DHR) presented data concerning the compliance of the hospitals with A.B. 289.

Expert testimony from out of state included David S. Bailey, Counsel for the Health Insurance Association of America (HIAA), and Aaron K. Trippler, Vice President with Communicating for Agriculture. Mr. Bailey presented the HIAA's proposal for providing health insurance coverage for the uninsured, noting areas of the proposal that are dependent on state legislative action.

Mister Trippler provided the committee with detailed information on the creation and operation of state risk pools. He reviewed the experiences of other states with risk pools and discussed with the health care committee the problems and advantages of different types of pools.

A number of health care issues were considered by the committee. Major areas of discussion included long-term care, Medicaid, the nursing shortage, rural health care, the uninsured, and the future of state control over health care cost containment.

II. DISCUSSION OF ISSUES AND RECOMMENDATIONS

Based upon these extensive discussions, the committee considered over 100 concepts and recommendations. After careful consideration, the committee approved a total of 45 of them (resulting in 24 bill draft requests) for the consideration of the 1991 Legislature.

These approved proposals are categorized into the following areas:

A. Assembly Bill 289 (1987)

B. Division for the Review of Health Resources and Costs

C. Health Care Professionals

D. Health Insurance

E. Health Planning

F. Medicaid, Welfare and State Social Services

G. Rural Hospital Regulations

This bulletin also contains material which may be used to supplement Legislative Counsel Bureau Bulletin No. 87-6 titled Study of Restraining Costs of Medical Care, dated December 1986, and Legislative Counsel Bureau Bulletin No. 89-8 titled Report of the Nevada Legislature's Committee on Health Care, dated January 1989. These earlier reports should be consulted for a review of the history of health care, industry trends and the background information surrounding major issue areas.

The members of the health care committee are aware that the budget limitations of the State of Nevada may preclude passage of several proposals. However, it is the intent of the committee to present a complete package of recommendations concerning health care in Nevada for the consideration of the full Legislature.

Background information for each of these recommendations is summarized in the following discussions.

A. ASSEMBLY BILL 289 (1987)

With certain provisions of A.B. 289 scheduled to expire in 1991, the health care committee focused on the effects of the bill on health care cost containment in Nevada and the need for continued controls.

Essentially, A.B. 289 required three major hospitals in Las Vegas to reduce their billed charges to a certain level. Moderate increases are then allowed according to a formula in the bill. Any savings realized from the implementation of this measure are to be passed onto the Nevada health care consumer in the form of reduced health care insurance premiums.

1. Hospital Cost Containment

According to information presented to the health care committee, all hospitals affected by this legislation complied with its provisions throughout the 4-year period of the bill's impact and met their respective targets. Analysis provided by the Division for the Review of Health Resources and Costs indicates that A.B. 289 had an initial, substantial impact on charges and revenues for the targeted hospitals.

FIGURE 4A

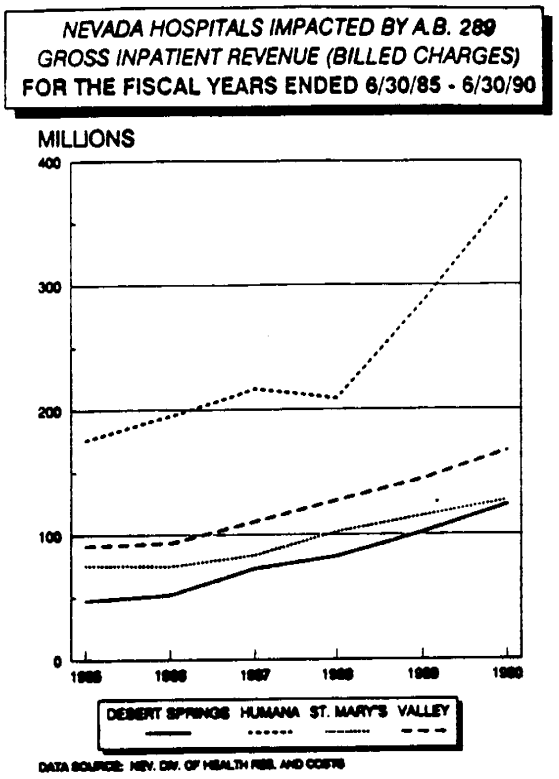
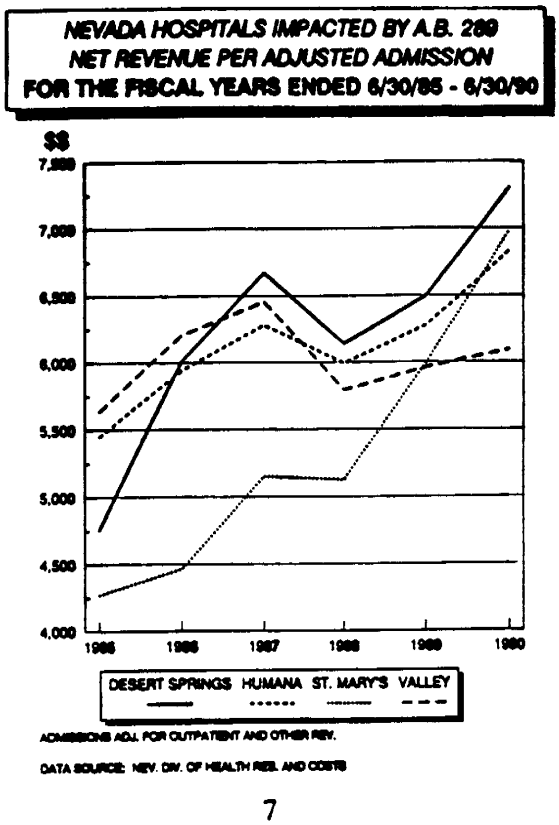


FIGURE 4B



However, Nevada's position among the other states in hospital cost comparisons has not changed much since A.B. 289 was introduced in 1987. Although Nevada's hospital costs rose more slowly than did other states' from 1987 through 1989, Nevada still ranked first in 1989 for billed charges per day. The state also moved into first from second for billed charges per admission. In addition, Nevada placed second in 1989 for highest net revenue and profit per day. The state ranked third in the country for net revenue per admission.

2. Insurance Savings

Nevada's Commissioner of Insurance reported to the Committee on Health Care that the inpatient component of the health care dollar was reduced by A.B. 289. However, outpatient costs and charges by other sectors of the health care industry (which were not affected by A.B. 289) increased.

Thus, savings in the inpatient component were offset by increases in other medical areas, and a reduction in the cost of health insurance as a result of A.B. 289 was not realized. Yet, it can be argued that the bill's impact on inpatient care costs held premium cost increases to a lower level than they might have been if A.B. 289 had not been passed.

See Appendix B for an analysis of the effect of A.B. 289 and further discussion of the need for continuing controls on health care cost containment.

3. Amendments to A.B. 289

Based on the information presented to the committee, the Committee on Health Care recognizes that controls on health care costs in Nevada must be maintained and should be expanded. Nevada still ranks among the top five states in the areas of hospital billed charges and net revenue. The health care insurance industry is not reducing premiums as a result of savings from A.B. 289 because costs in areas outside the purview of the measure continue to rise. In sum, the cost of health care in Nevada is still unacceptably high, despite 4 years of A.B. 289.

State controls on health care costs continue to be necessary and justified. As a result, the committee recommends that several amendments be made to certain sections of A.B. 289.

Recommendations:

Amend Section 4 to expand and personalize the definition of "Billed charge." (BDR 40-1025)

Amend Section 27 to allow private hospitals to pay within the first quarter of the year the amount of assessed uncompensated care in lieu of the indigency case by case determination process. At any time during the year, the hospital could pursue fund return through the normal case by case application process. (BDR 40-1025)

Amend Section 29 to give the Department of Human Resources the authority to include in the counting of a hospital's indigent care credits the care provided to a person denied indigent status for lack of additional information. (BDR 40-1025)

Amend Section 30 to include physicians in the prohibitions against improper inducements. (BDR 40-1025)

Amend Section 33 to require the Legislature's Committee on Health Care to review regulations related to the provisions of health care cost containment legislation before submission to the Legislative Commission. (BDR 40-1025)

Amend Section 54 to allow the regulation of holding companies for health maintenance organizations. (BDR 40-1025)

Amend Section 55 to continue the limitations on increases in hospital billed charges for inpatient services by restricting such increases to 60 percent of the Consumer Price Index (All Items). Exempt hospitals whose profit margins are less than 2 percent. Require hospitals to bill patients covered by negotiated contracts an average negotiated rate. Freeze hospital billed charges for outpatient services at current rates for 2 years. (BDR 40-1127)

4. Additional Provision

Although the committee recommends the placement of additional restraints on the operation of hospitals and the revenue collected, the committee recognized that the state cannot afford to lose any hospitals to closure.

Recommendation:

Allow receivership of hospitals with certain licensure violations and other problems. (BDR 40-1025)

B. DIVISION FOR THE REVIEW OF HEALTH RESOURCES AND COSTS

The Division for the Review of Health Resources and Costs is responsible for collecting certain data on health care facilities in Nevada and reporting that information to the Committee on Health Care and to the public.

1. Data Collection

Testimony to the Committee on Health Care indicated that inpatient hospital costs constitute only one component of the larger issue of health care costs. Trends seem to indicate that fewer people are being admitted into hospitals for inpatient procedures because more patients are opting for outpatient treatment. While A.B. 289 helped reduce the costs of inpatient care, the costs of outpatient care increased.

Recommendation:

Conduct a study to design a good survey vehicle to include the monitoring of the costs of outpatient services. (BDR 40-1017)

In addition to receiving information on outpatient services provided in Nevada, the health care committee indicated that additional information on several aspects of health care in the state would assist it in performing its duties.

Recommendations:

Require the Division to obtain a breakdown of each hospital's billed charges to determine how much supports patient services, how much goes to the hospitals' debt burdens and how much is profit. (BDR 40-1017)

Provide funding for the collection of appropriate information, particularly on outpatient services, epidemiology, the health status of Nevadans and the factors driving health care costs in Nevada. (BDR 40-1017)

The division indicated that some difficulty exists in obtaining certain information requested by the committee. Currently, the division is required to make public any information it receives. Thus, the division cannot request proprietary data from the hospitals for analysis without placing the hospitals in jeopardy of revealing trade secrets.

Recommendation:

Authorize the Division to keep certain information confidential. (BDR 40-1017)

The health care committee has found it helpful to compare Nevada health care data with other states' information and would like to expand this function of the division.

Require the Division to examine the case mix and severity of illness information in other states' hospital data to compare with Nevada hospital data. Provide the needed additional funding and staff to complete this project. (BDR 40-1017)

2. Data Dissemination

Nevada law requires the Division for the Review of Health Resources and Costs to publish, on a regular basis, certain data on health care costs and procedures to assist Nevadans in making their health care decisions. The division is also required to present reports on hospital compliance with A.B. 289 and other financial information to the committee on a routine basis. The committee believes that this information must be received in a timely and efficient manner.

Recommendations:

Require the Division to publish a two-page summary of Personal Health Choices. (BDR 40-1017)

Require the Division to provide the Committee on Health Care with the hospital compliance reports prior to the meeting at which they are scheduled to be presented. Restrict the Division from publicly releasing the reports until they have been presented to the committee. (BDR 40-1017)

C. HEALTH CARE PROFESSIONALS

Health care professionals are the backbone of Nevada's health care system. It is imperative that qualified nurses, physicians and allied health care providers practice throughout Nevada in sufficient numbers to ensure that all of the state's citizens have access to quality care.

1. Educational Programs

In 1989, the Nevada Legislature required the State Board of Nursing to certify nursing assistants. During the past interim, the board indicated to the committee that many of Nevada's existing nursing assistants are now certified and procedures are in place to certify future assistants. However, some confusion has persisted among the participating organizations over the definition of the administration of the nursing assistant training program.

Recommendation:

Clarify the definition of the nursing assistant training program administration. (BDR 54-1035)

The University of Nevada System (UNS) is primarily responsible for educating and training many types of health care professionals. However, the number of students entering many health care programs and subsequently graduating is not sufficient to meet Nevada's needs.

On April 26, 1990, the Committee on Health Care sent a letter to the chairman of the UNS Board of Regents requesting that UNS approach the 1991 Nevada Legislature with a bold plan to expand its nursing and other health occupational programs on all levels. The health care committee members expect such a plan to include innovative and progressive programs to recruit, maintain, and graduate an increased number of students qualified to fill positions ranging from technicians and auxiliaries to advanced nurse practitioners.

In the letter, the committee pledged its support to UNS throughout the budget process in order to obtain the increases needed for nursing education in Nevada to realize its full potential.

A copy of the letter is enclosed with this report as Appendix C.

Recommendations:

Urge the University of Nevada System to develop a high school honors program as a means of recruiting nursing and allied health students. Encourage health care as a career at the high school level through vocational and educational programs which begin in the senior year and interface with UNS. (BDR 34-1018)

Support the current UNS budget proposals to increase faculty and programs to graduate more health care professionals from existing programs.

Fund program development and faculty recruitment to provide programs for advanced practitioners of nursing, certified registered nurse anesthetists and clinical nurse specialists. (BDR 34-1027)

Nevada's rural areas suffer from not having a large pool of health care professionals from which to draw to fill all of the positions necessary in a community's health care system. This problem is particularly acute with allied health care positions. However, the responsibilities of some related occupations, such as laboratory and X-ray technologists, could be managed by one person trained in more than one discipline.

Recommendation:

Expand training programs at the community colleges to allow for the cross-training of health care technicians. (BDR 34-1018)

Testimony to the committee indicated that the shortage of health care professionals in rural and underserved areas of Nevada remains a critical problem. The committee determined that an incentive is needed for students to enter the health care field and practice in these areas.

Recommendation:

Create and fund a loan program for health care students who agree to work in rural or underserved areas. (BDR 34-1018)

2. Nurses

Many children in Nevada do not have access to a school nurse. In fact, there are currently 3,000 school children for every nurse in the state's public schools. The national average is 750 students per nurse.

Recommendation:

Require Nevada public school districts to progress toward a goal of 1,000 school children per nurse within 5 years and to establish a plan to reach this goal. (BDR 34-1033)

The responsibilities of nurses working in hospitals located near the Nevada state border often include providing care to patients whose physicians may be from states contiguous to Nevada.

Recommendation:

Allow nurses in Nevada communities of less than 30,000 population and within 25 miles of the state's border to take orders from physicians in neighboring states. (BDR 54-1034)

3. Physicians

The number of physicians providing obstetrical services in rural areas of Nevada has been dropping over the last few years. In recent years, one-half of Nevada's rural family doctors have ceased providing obstetrical services. In February 1990, the health care committee's Subcommittee on Rural Health was informed that only nine physicians are providing obstetrical services in rural Nevada.

One of the major reasons so few doctors provide these services is the high cost of medical malpractice insurance premiums. Although the problem is acute in rural communities, urban regions (particularly low-income areas) are not immune.

Recommendations:

Subsidize malpractice insurance premiums for the obstetrical practices of rural physicians who agree to certain conditions regarding the provision of care. (BDR 3-1023)

Extend the Good Samaritan Act to prenatal care and drop-in deliveries. (BDR 3-1023)

Develop no-fault liability coverage for certain conditions in newborn babies. (BDR 57-1024)

The Health Division and the University of Nevada School of Medicine Genetics Program propose to provide services in human genetics in order to ensure that all residents of the state who are, or are suspected of being, affected by a hereditary or chromosomal disorder have equal access to clinical genetic and diagnostic services. Such services would be provided by a cytogeneticist and a medical geneticist. The health care committee expects that this program will be a valuable addition to the state's health care system.

Recommendation:

Provide funding to add a cytogeneticist and a medical geneticist to the University of Nevada School of Medicine Genetics Program. (BDR 34-1032)

D. HEALTH INSURANCE

According to information presented to the committee by the Health Insurance Association of America, approximately 31 million Americans have no public or private health care coverage. Commentators indicate that the uninsured population has increased significantly in the past decade for several reasons, including the following:

- The economic downturn of the early 1980s and its effect on employment;
- Medicaid cutbacks;
- A decline in employer-based coverage of dependents in what may be a response to rising health care costs;

- An increase in state mandated benefits; and

- Increasing numbers of workers in industries less likely to offer health insurance.

In most cases, health insurance is a person's only means of obtaining health care. Without insurance, access to health care is limited and often denied. Consequently, the uninsured often forego necessary care or delay getting care until it is either too late or more costly.

For all of these reasons, the Committee on Health Care believes that it is incumbent on policy makers to devise ways to fill the gaps in the health financing system.

1. Assistance for the Uninsured

The most current information which identifies the extent of the medically uninsured problem in Nevada is a 1987 report from the U.S. Census Bureau. This report indicates that approximately 17.5 percent of Nevada's population is uninsured, about the same as the national average of 17.4 percent. Consequently, as many as 210,000 Nevadans may be currently without health insurance.

National studies indicate that the uninsured population consists essentially of the working poor, their dependents, and the unemployed. Most studies conclude that the working poor constitute the majority of the uninsured population.

This group includes those persons who work for small businesses which are unable to afford the premium costs of health insurance. Others in this group include the part-time employed and the self-employed. A significant portion of the unemployed are composed of students.

However, no study has produced detailed information on the uninsured in Nevada. The Committee on Health Care has found it difficult to respond to the uninsured situation in Nevada without sufficient data.

Recommendation:

> **Require a study to be conducted by UNS to determine the number of uninsured in Nevada, their ages, employment status, income levels and so on. (BDR S-1019)**

The committee received extensive testimony on state risk pools from Aaron K. Trippler, Vice President of a national, nonprofit, nonpartisan organization (Communicating for Agriculture). Mr. Trippler explained that a risk pool is a program intended to help any citizen within the state who

has been denied access to health care insurance due to a pre-existing health condition or individuals who have insurance but currently are paying rates so exorbitant that it would be cheaper for them to join a risk pool. He noted that 60 to 65 percent of the members of a risk pool are from rural areas because those people have less access to health care through employer-sponsored plans.

Mister Trippler provided detailed testimony on the funding of risk pools and the loss experience of existing pools. He indicated that some savings are provided by risk pools. For example, participation in a pool decreases the amount of uncompensated care.

The committee was intrigued by the information presented by Mr. Trippler. He explained that states have considerable flexibility in the structure and financing of state risk pool programs. He also discussed in detail the problems other states have experienced and ways to avoid those situations.

Recommendation:

> **Create a risk pool for the medically uninsurable. Set premiums at 25 to 50 percent over the market average with flexible deductibles. Include reciprocity. (BDR 57-1038)**

The committee also heard from representatives of Nevada's insurance industry who are designing an affordable policy to increase the health insurance options for Nevadans. This group is proposing the creation of a private sector program for providing health insurance to the working uninsured.

This program would include the following components:

- **Limited amount of benefits and policy limits;**
- **Elimination of state mandates;**
- **Preferred provider organization rates;**
- **Managed care features (such as utilization review and case management);**
- **No profit loss or gain for participating insurance companies;**
- **No premium tax;**
- **Voluntary participation by employees and employers;**
- **Standard medical underwriting;**

- Eligibility based on being uninsured for the previous 6 months;

- No subsidized premiums; and

- Guarantee of continued coverage.

The group anticipates that a health insurance program of this type would require relatively low premiums.

Although the proposal is for a private sector program, the group indicated that some legislative action may be necessary. The committee was encouraged by the support of the insurance industry for this program and urged its continued participation in discussions on providing for the uninsured.

Recommendation:

Develop a program to provide health care insurance coverage for the working uninsured. (BDR 57-1126)

2. Benefits

During this past interim, the Legislative Commission's Subcommittee to Study Health Insurance Benefits (Senate Concurrent Resolution No. 58) found that benefits mandated in state law greatly impact the cost of health care insurance. The subcommittee recommends several actions to reduce the number of current mandates and to prevent the proliferation of future mandates.

Recommendation:

Support the recommendations submitted by the Legislative Commission's Subcommittee to Study Health Insurance Benefits (S.C.R. 58).

3. Insurance Companies

It came to the committee's attention that the Insurance Division in Nevada's Department of Commerce may have difficulty investigating alleged violation of antitrust restrictions by insurance companies because of a lack of time and qualified personnel. The expectation of the health care committee is that alleged violations will be thoroughly investigated. The committee encourages the division to pursue these cases.

Recommendation:

Allow the Commissioner of Insurance to contract for experts to investigate alleged violations of antitrust restrictions on insurance companies. (BDR 57-1026)

4. Utilization Review

Utilization review (UR) is the management mechanism by which purchasers of health care seek to promote cost-effective medical decision making. Currently, a wide array of payers--insurers, health maintenance organizations, preferred provider organizations and many large employers--use UR in the administration of their benefit plans. The theory is that UR deters performance of inappropriate or unnecessary medical services.

According to information presented to the health care committee, as many as 3 out of 4 U.S. workers' medical care is subject to review by one of the 200 to 300 UR firms operating around the country. However, debate exists on the effectiveness of the program between organizations using UR and health care providers subject to UR and has not been settled.

States are beginning to notice the conflict. As of April 1990 Maryland, Arkansas, and South Carolina had passed legislation to regulate the UR industry. Six other states were considering similar measures.

Recently, the Nevada Hospital Association (NHA) created a task force which studied the relationship of UR organizations and the companies they represent with hospitals and other health care providers. The task force included representatives from private UR organizations, hospitals, the Nevada Medical Society, insurance companies, Nevada's Insurance Division, and peer review organizations.

The task force sought to assure that an effective and efficient method of conducting hospital UR would be in place across Nevada. Primarily, the task force was formed to respond to a lack of cooperation from some UR organizations to provide background information on decisions determining the medical necessity of hospital treatment. A lack of support for voluntary UR guidelines in other states led the task force to request legislation in this area.

The NHA presented the concerns and recommendation of the task force to the Committee on Health Care which agreed to request a bill draft on behalf of the association.

Recommendation:

Require the State Board of Health (in the Health Division of DHR) to license and regulate utilization review organizations operating in Nevada. (BDR 40-1037)

E. HEALTH PLANNING

Planning is a crucial component in any organization, particularly in one as complex and widespread as a state's health care system. As the provision and financing of health care changes, it is important that the entire health care system be updated and prepared for the future.

1. Studies

Health care is a rapidly changing field in Nevada. The committee questions whether the current health planning system and organization of health regulatory agencies are organized in the most efficient and effective manner.

Recommendation:

Fund a comprehensive study of Nevada's health planning system and the organization of the state's health regulatory agencies. (BDR S-1020)

The Committee on Health Care is also concerned about reducing unnecessary deaths among the citizens of Nevada, particularly those people in outlying or sparsely populated areas. One approach that shows promise, especially in holding down costs, is to regionalize expensive, specialized types of care.

Recommendation:

Establish a task force to develop a feasibility plan for trauma and perinatal networks, including transportation and facility improvements. (BDR S-1021)

F. MEDICAID, WELFARE AND OTHER STATE SOCIAL SERVICES

On a national level, the past few years have witnessed major changes in public policy approaches toward meeting the needs of the medically indigent. These changes are affecting the methods of financing indigent care as well as the criteria under which indigency is determined.

Although unique programs exist in several states, expanding state Medicaid eligibility criteria is by far the most common method other states have used to extend health care to a greater portion of the indigent population. Several optional features of the Medicaid program have not been implemented in Nevada and were considered by the committee.

1. Eligibility

About one-third of all infants delivered in the United States are born to mothers who do not receive adequate care, according to the Institute of Medicine (IOM). Adequate care begins in the first trimester and includes nine or more visits during a full-term pregnancy.

Babies who have no prenatal care have approximately 10 times the risk of dying in the first month of life. Of the infant deaths in Nevada during 1988, nearly 1 in 5 happened when prenatal care was absent. In addition, 11,000 low birthweight babies (defined as weighing 5 1/2 pounds or less) are born each year in the U.S. with long-term disabilities that result from their poor health condition at birth. In 1988, 1,520 low birthweight babies were born in Nevada. This number represents 8.2 percent of all of the births in the state.

The percent of low birthweight births in Nevada has increased from 6.6 percent in 1980 to 8.2 percent in 1988. Nationally, low birthweights have remained stable at 6.8 percent.

The National Commission to Prevent Infant Mortality indicates that at least half of the deaths are preventable, and many of the disabilities are avoidable, through proper and timely prenatal care.

Testimony indicated that, although Nevada's infant mortality rate is lower than the U.S. average (8.6 versus 9.9), it is due to the use of expensive newborn intensive care units, not to the provision of adequate prenatal care. Estimates are that a baby born at or below 5 1/2 pounds has a 50 percent risk of admission to an intensive care unit. A child delivered in a normal birthweight range has a 5 percent risk of admission to a newborn intensive care unit. Reducing the low birthweight rate would prevent many newborn intensive care admissions each year in Nevada. Those babies represent several million dollars worth of extra care.

Indications are that prenatal care is a bargain. A 1985 IOM report estimated that every dollar spent on prenatal care for low-income, poorly educated women saves about $3 in intensive care for infants born with birth defects. The infant mortality commission estimated in 1988 that every low birthweight baby that could be averted would save the U.S. health care system between $14,000 and $30,000.

The health care committee strongly supports the inclusion of programs in the state's health care system that will result in better prenatal care for more Nevada women.

Recommendation:

Implement a process for presumptive eligibility for pregnant women who may be eligible for the Aid to Dependent Children or Child Health Assurance programs. (BDR 38-1028)

In 1981, the monthly income level below which the state will supplement individuals in long-term care was frozen at $714, the maximum allowed by the federal program at that time. Since then, the federal maximum has risen to $1,158 per month (calculated at three times the federal Supplemental Security Income level), but Nevada's maximum has not changed. Currently, the state provides supplements to individuals whose income is less than $714 per month, and the counties pay supplements for those people whose income is over $714 but less than $1,158.

Information presented to the committee noted that, unless the state maximum is raised above $714, the state will eventually not supplement any long-term care patients. The federal Supplemental Security Income payment amount is currently $407. Each time the federal cost of living increases are applied to that minimum, approximately 60 people are dropped by Medicaid onto the county welfare system because their income exceeds $714. If the minimum keeps rising and the state maximum does not change, the minimum could conceivably exceed the maximum.

Indications are that the counties spend about $4 million supplementing low-income residents in long-term care facilities. It would cost Nevada $2 million for the same program because the state would be able to apply for matching funds from the Federal Government. Counties are not able to obtain matching Medicaid funds. Counties are paying for this program through ad valorem taxes which could be allocated to the state to pay the state's portion of the program.

With America's population growing older and living longer, more attention is being focused by all levels of government on the provision of long-term health care for the elderly. Long-term care has been placed high on the agenda in many state legislatures. A growing elderly population, and increasing mandates at the federal level, will require Nevada to increase its expenditures for long-term care components of Medicaid.

Recommendation:

Support the plan presented by the Nevada Association of Counties to transfer the funds for the allowable federal match of long-term care to Nevada Medicaid from the county welfare systems.

2. Medicaid Buy-Out

Testimony to the committee indicated that many people continue to receive public aid when they are able to work because the termination of their public assistance funds results in the cessation of Medicaid benefits. It is important to encourage welfare recipients to become employed, so the committee supports a mechanism to ease the transition from Medicaid to an employer-sponsored health insurance plan.

The Health Insurance Association of America (HIAA) encourages state legislatures to take advantage of recent federal welfare reform legislation which allows Medicaid to pay low-income workers' share of employer-based premium contributions. This program assists such individuals in participating in available employer-based coverage for a transitional period when returning to work. HIAA recommends federal Medicaid matching funds when states elect to implement such a buy-out program.

Recommendation:

Allow the state to pay an employee's contribution towards the premium for group coverage when Medicaid eligibles are working or returning to work for employers with group health insurance coverage. (BDR 38-1029)

3. Reimbursement

At their March 1990 meeting, committee members were informed that the long-term care industry in Nevada has been subjected to lower reimbursements and freezes since 1987. Since that time, 11 facilities have gone out of business, comprising 44 percent of the industry in Nevada. In the last 2 years, there has been a serious upheaval in management and funding of nursing homes.

The United States spends $500 billion per year on health care with 60 percent of the overnight patients housed in long-term care facilities. Yet, the long-term care industry comprises only $35 billion or 7 percent of the total spent.

On October 22, 1990, the Second Judicial District Court of the State of Nevada determined that the state illegally withheld an inflation-based increase scheduled to be given to long-term care facilities on July 1, 1990. In response, Nevada's Welfare Division plans to include the increase in its budget for the next year.

Recommendation:

Support increased reimbursements to long-term care facilities for Medicaid patients.

4. State Social Services

As the number of telephone numbers that connect callers to the various social service agencies in Nevada increases, so does confusion for the average citizen. The health care committee acknowledges that the maintenance of these access numbers is important, but it also perceives a need to simplify the process.

Recommendation:

Create a 24-hour statewide hotline that would be answered by a person who would connect or direct a caller to the correct social service agency for assistance with a particular problem. (BDR 18-1031)

5. Welfare Division

According to the long-term care industry, Nevada's Welfare Division is the only such organization in the country specifically exempt from compliance with an administrative procedures act as a matter of law. The division, along with nine other units of Nevada government, currently are exempted from the state's Administrative Procedure Act which sets forth the regulation-making and adjudication procedure to be followed by agencies of the executive branch.

Recommendation:

Amend NRS 233B.039, "Applicability," to require the Welfare Division to adhere to the provisions of the Nevada Administrative Procedure Act. (BDR 18-1030)

G. RURAL HOSPITAL REGULATIONS

The Nevada Rural Hospital Project (NRHP) presented information to the Committee on Health Care that demonstrated the significance of the costs of regulatory compliance for Nevada's rural hospital. The average total costs are estimated at $398,333 per hospital per year, representing 12 percent of Nevada rural hospitals' average operating expenses.

The NRHP determined that regulatory compliance at Nevada rural hospitals increases the cost of health care by approximately $44 per patient day. In the judgement of hospital managers, this cost has uncertain benefits in terms of quality of patient outcomes.

1. Recommendations from the Nevada Rural Hospital Study

Assembly Bill 352 of the 1989 legislative session (Chapter 883, Statutes of Nevada 1989, pages 2155-2158) provided the Nevada Rural Hospital Project with funding to conduct a study of the impact of regulation on rural hospitals. The goal of the study was to find a way to ease the burden of regulation on rural hospitals.

The NRHP contracted with the Hay Management Consultant Group to assist in that part of the study relating to cost. This contract resulted in a report titled Cost and Effects of Regulatory Compliance in Nevada Rural Hospitals. Areas addressed were the qualitative effect, the estimated cost, and the economic implications of regulatory compliance.

The report determined that there is a significant impact on Nevada's rural hospitals. Based on this report and other aspects of the NRHP's investigation, several recommendations were presented to the health care committee to ameliorate the regulatory burden on rural hospitals. The committee voted to include all of the recommendations in this report.

Recommendations:

Urge the State Board of Health to eliminate duplicative surveys and licenses by implementing a policy which allows one license to cover all aspects of a health care operation, which are governed by the same board and located in the same county. (BDR 40-1022)

Mandate the Welfare Division, the Bureau of Regulatory Health Facilities and the State Board of Pharmacy and all future surveying agencies to combine licensure and certification surveys. (BDR 40-1022)

Require all agencies and boards to do cost/benefit analyses and impact statements for all proposed health care legislation and regulations. Include a requirement that the feasibility of waivers for rural facilities be evaluated. Cost/benefit analysis would include all costs associated with regulation to the state and to the provider (and, therefore, the patient) on an ongoing basis. Include a requirement that conflicts (in terms of regulation) be resolved by agencies and boards before regulations are adopted. (BDR 40-1022)

Require that the Bureau of Regulatory Health Facilities annually present a seminar designed to provide a comprehensive review of current licensure regulations and current interpretations of regulations and Medicare Conditions of Participation being used by surveyors. Reasonable registration fees may be charged to cover

the cost of the seminar. Appropriate $60,000 to fund a position in the bureau to coordinate educational programs on health facility regulations. Also, allocate $75,000 to establish a grant pool for technical administrative assistance to rural hospitals. Allow the Department of Human Resources to grant waivers from regulation requirements to rural hospitals where appropriate. (BDR 40-1036)

III. CONCLUSION

This report presents a comprehensive discussion of the major health care topics presented to the Nevada Legislature's Committee on Health Care during the past legislative interim. These subjects concern important health care issues that Nevada will be facing in the near future and, in some cases, in the long term as well. Many of the issues addressed in the report have been discussed by past Nevada Legislatures and will doubtless be part of many future debates. Since legislation governing these topics will affect a wide variety of Nevada private and public organizations as well as the state's citizens, it is expected that each issue will undergo intense scrutiny.

As noted earlier in the report, over 100 proposals covering a myriad of health care subjects were considered by the health care committee. A significant amount of time and effort was expended by the committee in reviewing and analyzing the issues confronting the health care consumer and the industry itself. This report is yet another step in the legislative effort to provide a comprehensive analysis of the regulation, financing, and operation of Nevada's health care system.

Despite major efforts by the 1987 and 1989 legislatures, health care costs in Nevada remain among the highest in the country. The committee continues to evaluate the many interrelated components driving health care costs. Action on one segment invarably leads to reaction in another. As the 4-year experiment in hospital cost containment provided by A.B. 289 ends, and a new direction begins, the committee pledges to continue its evaluation of the short-term and long-term effects of cost containment measures.

The shift of responsibility from the Federal Government to state and local governments for many health care programs continues. Although this shift provides the states with more control, it also demands that state governments expand their participation in and financing of numerous aspects of the health care field.

This report seeks to provide recommendations for responding to these new and continuing demands. The Nevada Legislature will undoubtedly debate these issues for some time as its concerns about the cost, availability and quality of health care for all Nevadans will not be easily resolved.

The members of the committee take this opportunity to thank all of those individuals and organizations who participated in committee meetings and discussions. A special note of appreciation goes to the many special witnesses, state agency representatives, and health care industry professionals. The committee's work would have been next to impossible without the valuable assistance of these talented people who willingly contributed their expertise in oral and written testimony.

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V. APPENDICES

APPENDIX A

ASSEMBLY BILL 289 OF THE 1987 LEGISLATIVE SESSION
(CHAPTER 377, STATUTES OF NEVADA 1987, PAGES 862-891),
INCLUDING NOTES ON AMENDMENTS MADE BY THE
1989 LEGISLATURE

ASSEMBLY BILL 239

AN ACT relating to health facilities; requiring certain hospitals to reduce charges and maintain those charges at the reduced level; requiring certain hospitals to reduce their revenue per inpatient; requiring certain hospitals to reduce their percentage of income to operating expenses; creating a legislative committee on health care; requiring certain hospitals to provide an established amount of treatment for indigent patients or to pay an assessment; prohibiting certain transactions between affiliated health facilities and insurers and between hospitals and their affiliates; requiring hospitals to provide emergency medical care; revising the criteria for determining whether certain projects require the approval of the director of the department of human resources; and providing other matters properly relating thereto.

WHEREAS, Limitations upon competition in the field of health care have artificially increased prices to a level which makes such care unaffordable for the average Nevadan; and

WHEREAS, The high price of health care has created a public health emergency requiring immediate and pervasive legislative action; and

WHEREAS, Legislative action to counteract the monopolistic advantage of providers of health care will allow the natural economic forces to surface and control future increases in the costs of health care; and

WHEREAS, If the reductions in prices and revenues required by this act sufficiently stimulate competition in the field of health care, future economic regulation of health care by the legislature will be unnecessary; now, therefore,

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 33, 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 16, inclusive, of this act, have the meanings ascribed to them in those sections.

Sec. 3. "Administrator" means the administrator of the division for review of health resources and costs of the department of human resources.

Sec. 4. "Billed charge" means the total amount charged by a hospital for medical care provided, regardless of the anticipated amount of net revenue to be received or the anticipated source of payment.

Sec. 5. "Committee" means the legislative committee on health care.

Sec. 6. "Department" means the department of human resources.

Sec. 7. "Director" means the director of the department of human resources.

Sec. 8. "Discharge form" means the form hospitals are required to use to report information concerning the discharge of patients.

Sec. 9. "Division" means the division for review of health resources and costs of the department of human resources.

Sec. 10. 1. Except as otherwise provided in subsection 2, "fiscal year" means a period beginning on July 1 and ending on June 30 of the following year.

2. A hospital's "fiscal year" is the period of 12 months used by a hospital for the purposes of accounting and the preparation of annual budgets and financial statements.

Sec. 11. "Health facility" has the meaning ascribed to it in NRS 439A.015.

Sec. 12. "Hospital" means any facility licensed as a medical, surgical or obstetrical hospital, or as any combination of medical, surgical or obstetrical hospital, by the health division of the department of human resources.

Sec. 13. "Medicaid" means the program established pursuant to Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.) to provide assistance for part or all of the cost of medical care rendered on behalf of indigent persons.

Sec. 14. "Medicare" means the program of health insurance for aged and disabled persons established pursuant to Title XVIII of the Social Security Act (42 U.S.C. §§ 1395 et seq.).

Sec. 15. "Net revenue" means all revenues earned from inpatient medical care provided to patients by a hospital.

Sec. 16. "Practitioner" has the meaning ascribed to it in NRS 439A.0195.

Sec. 17. The purposes of this chapter are to:

1. Promote equal access to quality medical care at an affordable cost for all residents of this state.

2. Reduce excessive billed charges and revenues generated by some hospitals in this state in order to provide relief from excessively high costs of medical care.

3. Provide the regulatory mechanisms necessary to ensure that the forces of a competitive market will be able to function effectively in the business of providing medical care in this state.

Sec. 18. 1. There is hereby established a legislative committee on health care consisting of three members of the senate and three members of the assembly appointed by legislative commission. The members must be appointed with appropriate regard for their experience with and knowledge of matters relating to health care. ~~The members must be appointed as follows~~:

(AB 194-1989)

~~(a) Two members must be appointed by the majority leader of the senate;~~

~~(b) One member must be appointed by the minority leader of the senate;~~

~~(c) Two members must be appointed by the speaker of the assembly; and~~

~~(d) One member must be appointed by the minority leader of the assembly~~.

2. No member of the committee may:

(a) Have a financial interest in a health facility in this state;

(b) Be a member of a board of directors or trustees of a health facility in this state;

(c) Hold a position with a health facility in this state in which the legislator exercises control over any policies established for the health facility; or

(d) Receive a salary or other compensation from a health facility in this state.

This subsection does not prohibit a member of the committee from selling goods which are not unique to the provision of health care to a health facility if the member primarily sells such goods to persons who are not involved in the provision of health care.

3. The ~~majority leader of the senate shall select the chairman of the committee and the speaker of the assembly shall select the vice chairman of the committee.~~ legislative commission shall select the chairman and vice chairman 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 majority leader of the senate or the speaker of the assembly, as appropriate, shall appoint a replacement for the remainder of the unexpired term.~~

4. Any member of the committee who does not return to the legislature continues to serve until the next session of the legislature convenes.

5. Vacancies on the committee must be filled in the same manner as original appointments. 6. (Report annually to the legislative commission)

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 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 salaries and expenses of the committee must be paid from the legislative fund.

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. Review competitive mechanisms to aid in the reduction of the costs of medical care.

9. Examine the problem of providing and paying for medical care for indigent and medically indigent persons, including medical care provided by physicians.

10. 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 9, inclusive.

11. Determine whether regulation by the state will be necessary in the future by examining hospitals for evidence of:

(a) Degradation or discontinuation of services previously offered, including without limitation, neonatal care, pulmonary services and pathology services; or

(b) A change in the policy of the hospital concerning contracts,

as a result of any legislation enacted to accomplish the purpose of restraining the costs of health care while ensuring the quality of services.

12. Study the effect of the acuity of the care provided by a hospital upon the revenues of hospital and upon limitations upon that revenue.

13. Review the actions of the director in administering the provisions of this chapter and adopting regulations pursuant to those provisions. The director shall report to the committee concerning any regulations proposed or adopted pursuant to this chapter.

14. Conduct investigations and hold hearings in connection with its review and analysis.

15. Apply for any available grants and accept any gifts, grants or donations to aid the committee in carrying out its duties pursuant to this chapter.

16. Direct the legislative counsel bureau to assist in its research, investigations, review and analysis.

17. Recommend to the legislature as a result of its review any appropriate legislation.

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 subpenas to compel the attendance of witnesses and the production of books and papers.

(AB 615-1987

2. If any witness refuses to attend or testify or produce any books and papers as required by the subpena, 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 subpenaed 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 subpena before the committee which is named in the subpena, 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 subpena 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. Each hospital in this state shall maintain and use a uniform list of billed charges for that hospital for units of service or goods provided to all inpatients. A hospital may not use a billed charge for an inpatient that is different than the billed charge used for another inpatient for the same service

or goods provided. This section does not restrict the ability of a hospital or other person to negotiate a discounted rate from the hospital's billed charges or to contract for a different rate or mechanism for payment of the hospital.

Sec. 24. 1. Except as otherwise provided in subsection 4, each hospital in this state has an obligation to provide emergency ~~medical~~ services and care, including care provided by physicians and nurses, and to admit the patient where appropriate, regardless of the financial status of the patient.

Rear Hem (AB 359 1989)

2. Except as otherwise provided in subsection 4, it is unlawful for a hospital to refuse to accept a patient in need of emergency medical care or to transfer a patient to another hospital or health facility because of the financial status of the patient.

3. A hospital or other health facility which treats a patient as a result of a hospital's violation of subsection 2 is entitled to recover from that hospital an amount equal to three times the billed charges of the hospital which provided the treatment for the treatment provided, plus reasonable attorney's fees and costs.

4. This section does not prohibit the transfer of a patient from one hospital to another:

(a) When the patient is covered by an insurance policy or other contractual arrangement which provides for payment at the receiving hospital; or

(b) After the county responsible for payment for the care of an indigent patient has exhausted the money which may be appropriated for that purpose pursuant to NRS 428.050 and 428.285 and section 42 of this act.

No transfer may be made pursuant to this subsection until the patient's condition has been stabilized to a degree that allows the transfer without an additional risk to the patient.

Sec. 25. 1. The legislature finds and declares that:

(a) The practice of refusing to treat an indigent patient if another hospital can provide the treatment endangers the health and well-being of such patients.

(b) Counties in which more than one hospital is located may lack available resources to compensate for all indigent care provided at their hospitals. Refusal by a hospital to treat indigent patients in such counties results in a burden upon hospitals which treat large numbers of indigent patients.

(c) A requirement that hospitals in such counties provide a designated amount of uncompensated care for indigent patients would:

(1) Equalize the burden on such hospitals of treating indigent patients; and

(2) Aid the counties in meeting their obligation to compensate hospitals for such care.

(d) Hospitals with 100 or fewer beds have been meeting the needs of their communities with regard to care of indigents, and have a minimal effect on the provision of such care.

2. Except as otherwise provided in this subsection, the provisions of sections 25 to 29, inclusive, of this act, apply to each hospital in this state which is located in a county in which there are two or more licensed hospitals. The provisions of sections 25 to 29, inclusive, of this act, do not apply to a hospital which has 100 or fewer beds.

3. The provisions of sections 25 to 29, inclusive, of this act, do not prohibit a county from:

(a) Entering into an agreement for medical care or otherwise contracting with any hospital located within that county; or

(b) Using a definition of "indigent" which would include more persons than the definition in section 26 of this act.

Sec. 26. For the purposes of sections 25 to 29, inclusive, of this act, "indigent" means those persons:

1. Who are not covered by any policy of health insurance;

2. Who are ineligible for Medicare, Medicaid, the benefits provided pursuant to NRS 428.115 to 428.255, inclusive, or any other federal or state program of public assistance covering the provision of health care;

3. Who meet the limitations imposed by the county upon assets and other resources or potential resources; and

4. Whose income is 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 the 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.

Sec. 27. 1. A hospital shall provide, without charge, in each fiscal year, care for indigent inpatients in an amount which represents 0.6 percent of its net revenue for the hospital's preceding fiscal year.

2. The division shall compute the obligation of each hospital for care of indigent inpatients for each fiscal year based upon the net revenue of the hospital in its preceding fiscal year and shall provide this information to the board of county commissioners of the county in which the hospital is located.

3. The board of county commissioners shall maintain a record of discharge forms submitted by each hospital located within the county, together with the amount accruing to the hospital. The amount accruing to the hospital for the care, until the hospital has met its obligation pursuant to this section, is the highest amount the county is paying to any hospital in the county for that care. Except as otherwise provided in subsection 2 of section 28 of this act, no payment for indigent care may be made to the hospital until the total amount so accruing to the hospital exceeds the minimum obligation of the hospital for the fiscal year, and a hospital may only receive payment from the county for indigent care provided in excess of its obligation pursuant to this section. After a hospital has met its obligation pursuant to this section, the county may reimburse the hospital for care of indigent inpatients at any rate otherwise authorized by law.

Sec. 28. 1. **Except as otherwise provided in section 25 of this act and subsection 2 of this section, each county shall use the definition of "indigent" in section 26 of this act to determine a person's eligibility for medical assistance pursuant to chapter 428 of NRS, other than assistance provided pursuant to NRS 428.115 to 428.255, inclusive.**

2. A board of county commissioners may, if it determines that a hospital within the county is serving a disproportionately large share of low-income patients:

(a) Pay a higher rate to the hospital for treatment of indigent inpatients;

(b) Pay the hospital for treatment of indigent inpatients whom the hospital would otherwise be required to treat without receiving compensation from the county; or

(c) Both pay at a higher rate and pay for inpatients for whom the hospital would otherwise be uncompensated.

(AB45 1989)

3. Each hospital which treats an indigent inpatient shall submit to the board of county commissioners of the county ~~in which the patient resides~~ of residence of the patient a discharge form identifying the patient as a possible indigent and containing the

information required by the department and the county to be included in all such forms.

4. The county which receives a discharge form from a hospital for an indigent inpatient shall verify the status of the patient and the amount which the hospital is entitled to receive. (Aggrieved hospital may appeal) (SB 40-1989)

5. Except as otherwise provided in subsection 2 of this section and subsection 3 of section 27 of this act, if the ~~patient is a resident of the county~~ county is the county of residence of the patient a ~~and~~ the patient is indigent, the county shall pay to the hospital the amount required, within the limits of money which may lawfully be appropriated for this purpose pursuant to NRS 428.050 and 428.285 and section 42 of this act. (AB 45-1989) 3. (Residence determined per 428.020)

Sec. 29. 1. Before September 30 of each year, each county in which hospitals subject to the provisions of sections 25 to 29, inclusive, of this act, are located shall provide to the division a report showing: (Entire section revised... SB 40-1989)

(a) The total number of indigent inpatients treated by each such hospital;

(b) The number of such patients for whom no reimbursement was provided by the county because of the limitation imposed by subsection 3 of section 27 of this act;

(c) The total amount paid to each such hospital for treatment of such patients; and

(d) The amount the hospital would have received for patients for whom no reimbursement was provided.

2. The administrator shall verify the amount of treatment provided to indigent inpatients by each hospital to which no reimbursement was provided by:

(a) Multiplying the number of indigent inpatients who received each type of treatment by the highest amount paid by the county for that treatment; and

(b) Adding the products of the calculations made pursuant to paragraph (a) for all treatment provided.

If the total amount of treatment provided to indigent inpatients in the previous fiscal year by the hospital was less than its minimum obligation for the year, the director shall assess the hospital for the amount of the difference between the minimum obligation and the actual amount of treatment provided by the hospital to indigent inpatients.

3. If the administrator determines that a hospital which did not receive payment has met its obligation to provide treatment ~~to indigent inpatients but has not been compensated by the county for such treatment,~~ he shall notify the county of ~~the amount of~~ all (AB 614-1987)

by the hospital after it met its obligation

(AB6-1087) treatment provided ~~in excess of the hospital's obligation~~. The county shall pay the hospital for such treatment within 30 days after receipt of the notice[.] to the extent money available

4. The director shall determine the amount of the assessment which a hospital must pay pursuant to this section and shall notify the hospital in writing of that amount on or before November 1 of each year. Payment is due 30 days after receipt of the notice. If a hospital fails to pay the assessment when it is due the hospital shall pay, in addition to the assessment:

(a) Interest at a rate of 1 percent per month for each month after the assessment is due in which it remains unpaid; and

(b) Any court costs and fees required by the director to obtain payment of the assessment and interest from the hospital.

5. Any money collected pursuant to this section must be paid to the county in which the hospital paying the assessment is located for use in paying other hospitals in the county for the treatment of indigent inpatients by those hospitals. The money received by a county from assessments made pursuant to this section does not constitute revenue from taxes ad valorem for the purposes of NRS 428.050, 428.285, 354.59805, 354.59811 and 354.59816, and section 42 of this act, and must be excluded in determining the maximum rate of tax authorized by those sections.

Sec. 30. 1. A hospital or related entity shall not establish a rental agreement with a physician or entity that employs physicians that requires any portion of his medical practice to be referred to the hospital or related entity.

2. No rent required of a physician or entity which employs physicians by a hospital or related entity may be less than 75 percent of the rent for comparable office space leased to another physician or other lessee in the building, or in a comparable building owned by the hospital or entity.

3. A hospital or related entity shall not pay any portion of the rent of a physician or entity which employs physicians within facilities not owned or operated by the hospital or related entity, unless the resulting rent is no lower than the highest rent for which the hospital or related entity rents comparable office space to other physicians.

4. No health facility may offer any provider of medical care any financial inducement, excluding rental agreements subject to the provisions of subsection 2 or 3, whether in the form of immediate, delayed, direct or indirect payment to induce the referral of a patient or group of patients to the health facility. This subsection does not prohibit bona fide gifts under $100, or reasonable promotional food or entertainment.

(AB 873-1989) 5. The provisions of subsections 1 to 4, inclusive, do not apply to hospitals in a county whose population is less than ~~30,000.~~ 35,000

6. A hospital, if acting as a billing agent for a medical practitioner performing services in the hospital, shall not add any charges to the practitioner's bill for services other than a charge related to the cost of processing the billing.

7. No hospital or related entity may offer any financial inducement to an officer, employee or agent of an insurer, a person acting as an insurer or self-insurer or a related entity. A person shall not accept such offers. This subsection does not prohibit bona fide gifts of under $100 in value, or reasonable promotional food or entertainment.

8. A hospital or related entity shall not sell goods or services to a physician unless the costs for such goods and services are at least equal to the cost for which the hospital or related entity pays for the goods and services.

9. A practitioner or health facility shall not refer a patient to a health facility or service in which the referring party has a financial interest unless the practitioner or health facility first discloses the interest.

10. The director may, at reasonable intervals, require a hospital or related entity or other party to an agreement to submit copies of operative contracts subject to the provisions of this section after notification by registered mail. The contracts must be submitted within 30 days after receipt of the notice. Contracts submitted pursuant to this subsection are confidential, except in cases in which an action is brought pursuant to subsection 11.

11. A person who willfully violates any provision of this section is liable to the State of Nevada for:

(a) A civil penalty in an amount of not more than $5,000 per occurrence, or 100 percent of the value of the illegal transaction, whichever is greater.

(b) Any reasonable expenses incurred by the state in enforcing this section.

Any money recovered pursuant to this subsection as a civil penalty must be deposited in a separate account in the state general fund and used for projects intended to benefit the residents of this state with regard to health care. Money in the account may only be withdrawn by act of the legislature.

12. As used in this section, "related entity" means an affiliated person or subsidiary as those terms are defined in section 31 of this act.

Sec. 31. 1. For the purposes of this section:

(a) An "affiliated person" is a person controlled by any combination of the hospital, the parent corporation, a subsidiary or the principal stockholders or officers or directors of any of the foregoing.

(b) A "subsidiary" is a person of which either the hospital and the parent corporation or the hospital or the parent corporation holds practical control.

2. No hospital may engage in any transaction or agreement with its parent corporation, or with any subsidiary or affiliated person which will result or has resulted in:

(a) Substitution contrary to the interest of the hospital and through any method of any asset of the hospital with an asset or assets of inferior quality or lower fair market value;

(b) Deception as to the true operating results of the hospital;

(c) Deception as to the true financial condition of the hospital;

(d) Allocation to the hospital of a proportion of the expense of combined facilities or operations which is unfavorable to the hospital;

(e) Unfair or excessive charges against the hospital for services, facilities or supplies;

(f) Unfair and inadequate charges by the hospital for services, facilities or supplies furnished by the hospital to others; or

(g) Payment by the hospital for services, facilities or supplies not reasonably needed by the hospital.

3. If the director has reasonable cause to believe that a violation of subsection 2 has occurred, he may conduct an examination of any books and records of the hospital, parent corporation, subsidiary or affiliated person which he deems pertinent to the examination. The director has the same authority to examine the parent corporation, subsidiary or affiliated person and recover the cost of the examination as he has with regard to the hospital. A parent corporation, subsidiary or affiliated person which refuses to permit the examination of its books and records is subject to the fine provided for in subsection 4 for each day that access to the books or records is restricted.

4. If a hospital, parent corporation, subsidiary or affiliated person is found, after notice and a hearing, to have violated the provisions of this section, the director may impose an administrative fine of not more than $20,000 for each violation or the actual amount of damage caused by the violation, whichever is greater.

5. Upon a second or subsequent violation of the provisions of this section, the director may commence a legal action in the district court of any county to secure an injunction against further violations of this section.

Sec. 32. 1. The director may by regulation require hospitals, other health facilities and providers of health services to submit such information as is reasonably necessary for the director and the division to carry out the provisions of this chapter.

2. Except as otherwise provided in subsection 3, the director shall by regulation require an examination of a hospital by an independent auditor appointed by the director to ensure compliance with this chapter. The audits must be scheduled on a regular basis but not more often than once each year. The hospital shall pay the costs of the audit. A hospital may contract with the auditor to conduct other work for the hospital in connection with the audit.

3. The director shall not require an audit of a hospital which has less than 200 beds or is subject to the provisions of chapter 450 of NRS. The director shall by regulation require such a hospital to submit audits of the hospital on a regular basis but not more often than once each year.

4. If a hospital fails to comply with any regulation adopted pursuant to this section or the director has reason to believe the hospital has violated any provision of this chapter, the director may conduct an examination or contract for an independent examination of the hospital to determine whether it is in compliance with those provisions. The hospital which is the subject of such an examination is responsible for payment of the costs of the examination if the director determines that the hospital did violate a provision of this chapter.

5. Any person who fails to submit information as required by any regulation adopted pursuant to this chapter to the department or the division or fails to submit to an audit or examination pursuant to this section is subject to an administrative fine of not more than $1,000 per violation per day until the required information is submitted or the person submits to the audit or examination.

Sec. 33. 1. The director:

(a) May adopt such regulations as are necessary to carry out the provisions of this chapter.

(b) Shall ensure that the administration of this chapter does not cause the state to fail to comply with the requirements of the Federal Government concerning Medicare and Medicaid.

2. In addition to any civil or administrative penalty specifically provided in this chapter, any person who violates a provision of this chapter shall be punished by a fine of not more than $5,000 for each violation.

Sec. 34. Chapter 439A of NRS is hereby amended by adding thereto a new section to read as follows:

The division shall prepare quarterly and release for publication or other dissemination a listing of every hospital in the state and its charges for representative services. The division shall report annually to the legislative committee on health care on or before December 1 regarding the effects of legislation on the costs of health care and on the manner of its provision.

Sec. 35. NRS 439A.100 is hereby amended to read as follows:

439A.100 1. Except as provided in NRS 439A.103, no person may undertake any project described in subsection 2 without first applying for and obtaining the written approval of the director. The health division of the department of human resources shall not issue a new license or alter an existing license for any project described in subsection 2 unless the director has issued such an approval.

2. The projects for which this approval is required are [as follows:

(a) Any] *:*

(a) Except as otherwise provided in subsection 3, any proposed expenditure by or on behalf of a [health facility] ~~*hospital* in excess of the greater of [$714,000] *$1,500,000 or such an amount as the department may specify by regulation, or by or on behalf of any other*~~ *health facility in excess of the greater of* ~~*$1,000,000*~~ *or such an amount as the department may specify by regulation,* which under generally accepted accounting principles consistently applied is a capital expenditure;

$2,000,000 (AB 615-1987) [$2,000,000] $4,000,000 (AB 949-1989)

(b) A proposal which increases the number of licensed or approved beds in a health facility *other than a hospital above the total of the number of licensed beds and the number of additional beds which have been approved pursuant to this subsection;*

(c) A proposal which increases the number of licensed and approved beds in a hospital through the addition of 10 or more beds or a number of beds equal to 10 percent of the licensed or approved capacity of that facility, whichever is less, over a period of 2 years;

[(c) The proposed addition, expansion or consolidation of any health service to be offered in or through a health facility which was not offered on a regular basis in the previous 12 months if the addition, expansion or consolidation:

(1) Involves a capital expenditure in excess of $100,000, or such an amount as the department may specify by regulation; or

(2) Would entail an annual operating expense for providing the service in excess of $297,500, or such an amount as the department may specify by regulation, whichever is greater;

(d) The]

(d) Except as otherwise provided in subsection 4, the proposed acquisition ~~*by or on behalf of a hospital*~~ of any *new or used* medical equipment which [would cost] *has a market value of* more than [$400,000.] ~~*$1,500,000*~~ [or such an amount as the department may specify by regulation, whichever is greater;] [;] ~~*or the proposed acquisition by any other person of any new or used medical equipment which has a market value of more than $1,000,000 or such an amount as the department may specify by regulation, whichever is greater;*~~ $2,000,000 (AB 615-1987) $2,000,000 $1,000,000 (AB 3-19-1989)

(e) The acquisition of an existing health facility if:

(1) The purchaser does not, within a period specified by a regulation of the department, notify it of his intention to acquire the facility; or

(2) The department finds, within 30 days after it receives the notice, that in acquiring the facility the purchaser will change the number of beds ; [or the health services offered;] and [The construction of a new health facility; and (g) (AB 615-198

(f) [The conversion of an existing office of a practitioner to a health facility, regardless of the cost of the conversion, if the establishment of the office would have met the threshold for review of costs pursuant to paragraph [(c).] *(a) or (d).* (Add NNIC, burns, open-heart, trauma) (AB 849-1989)

3. The provisions of paragraph (a) of subsection 2 do not include any capital expenditure for:

(Exempt addition of 60 beds over 3 years if approved by hospital less, only 60 or more.. AB 875 1989)

(a) The acquisition of land;

(b) The construction of a facility for parking;

(c) The maintenance of a health facility;

(d) The renovation of a health facility to comply with standards for safety, licensure, certification or accreditation;

(e) The installation of a system to conserve energy;

(f) The installation of a system for data processing or communication; or

(g) Any other project which, in the opinion of the director, does not relate directly to the provision of any health service.

4. The provisions of paragraph (d) of subsection 2 do not include acquisitions of medical equipment proposed primarily to replace existing equipment. [The department shall by regulation develop standards to determine [The person acquiring ... shall notify [the department] of his intention (AB 615-1987

whether the primary purpose of a proposed acquisition is to replace existing equipment.

5. In reviewing an application for approval, the director shall:

(a) Comparatively assess applications for similar projects affecting the same geographic area; *and*

(b) [Consider any recommendation of a health systems agency; and

(c)] Base his decision on criteria established by the director by regulation. The criteria must include:

(1) The need for and the appropriateness of the project in the area to be served;

(2) The extent to which the project is consistent with the state health plan;

(3) The financial feasibility of the project;

(4) The effect of the project on the cost of health care; and

(5) The extent to which the project is consistent with the purposes set forth in NRS 439A.020 and the priorities set forth in NRS 439A.081.

[4.] *6.* The department may by regulation require additional approval for a proposed change to a project which has previously been approved if the proposal would result in a change in the number of existing beds or a change in the health services which are to be provided, a change in the location of the project or a substantial increase in the cost of the project.

[5.] *7.* The decision of the director is a final decision for the purposes of judicial review.

Sec. 36. Chapter 449 of NRS is hereby amended by adding thereto the provisions set forth as sections 37, 38 and 39 of this act.

Sec. 37. 1. Each hospital in this state shall use for all patients discharged the form commonly referred to as the "UB-82," or a different form prescribed by the director with the approval of a majority of the hospitals licensed in this state, and shall include in the form all information required by the department.

2. The department shall by regulation:

(a) Specify the information required to be included in the form for each patient; and

(b) Require each hospital to provide specified information from the form to the department.

3. Each insurance company or other payer shall accept the form as the bill for services provided by hospitals in this state.

4. Each hospital with more than 200 beds shall provide the information required pursuant to paragraph (b) of subsection 2 on magnetic tape or by other means specified by the department, or shall provide copies of the forms and pay the costs of entering the information manually from the copies.

Sec. 38. *1. A licensee must obtain the approval of the health division before the addition of any of the following services:*

(a) The intensive care of newborn babies.

(b) The treatment of burns.

(c) The transplant of organs.

(d) The performance of open-heart surgery.

(e) A center for the treatment of trauma.

2. The health division shall approve an application to provide any of the services described in subsection 1 ~~unless it determines that the licensee has inadequate personnel or equipment for the provision of the services.~~ The health division may ~~deny approval or~~ revoke its approval if the licensee fails to ~~comply~~ with standards approved by the board for the provision of such services.

3. The board shall consider standards adopted by appropriate national organizations as a guide for adopting standards for the approval of the provision of services pursuant to this section.

~~**Sec. 39.** *1. The director shall by regulation create in each county whose*~~ ***population is 100,000 or more a commission for the advocacy of maintaining the quality of care provided by hospitals. Each hospital in such a county with more than 200 beds shall create a committee for the advocacy of maintaining the quality of care provided by the hospital. The director shall prescribe the powers and duties of such commissions and committees.***

2. Each committee must be composed of at least five physicians on the medical staff of the hospital who do not have a pecuniary interest in the hospital, who must be elected by a vote of all such physicians at the hospital.

3. The state health officer is ex officio a voting member of each commission. Except as otherwise provided in this subsection, each hospital in such a county shall have one representative on the commission. The representative must be elected by the physicians on the medical staff of the hospital who do not have a pecuniary interest in the hospital. If there are an odd number of hospitals in the county, the largest hospital, based upon the number of licensed beds, shall elect two representatives in accordance with the provisions of this subsection.

4. Each committee and commission shall represent the interests of patients of ~~hospitals in the county to ensure that the quality of care provided by hospitals~~ is

~~*not compromised in the interest of economic considerations. A commission may*~~ *require hospitals in the county to submit information concerning the patterns of staffing at the hospitals, and may compile that information for publication with similar information from other states. A committee may require such information from its hospital.*

5. If a committee determines that its hospital's quality of care is being compromised in the interest of economic considerations, it shall inform the commission for its county. If a commission determines, either on its own or as the result of information provided by a committee, that a hospital is so compromising its quality of care, the commission shall inform the director of the department of human resources of its determination in writing. Upon receipt of such a determination, the director may require the hospital to submit to an evaluation conducted by the health division or by another appropriate accrediting body. The hospital which is subject to such an evaluation shall pay the costs of the evaluation.

6. The committees, the commissions, the legislative committee on health care and the director of the department of human resources may exchange the ~~*information each acquires.*~~

Sec. 40. NRS 449.465 is hereby amended to read as follows:

449.465 *1.* The director may, by regulation, impose fees upon admitted health insurers to cover the costs of carrying out the provisions of NRS 449.450 to 449.530, inclusive **[.]** *, and section 37 of this act.* The maximum amount of fees collected must not exceed the amount authorized by the legislature in each biennial budget.

2. The director shall impose a fee of $50 each year upon admitted health insurers for the support of the legislative committee on health care. The fee imposed pursuant to this subsection is in addition to any fee imposed pursuant to subsection 1. The fee collected for the support of the legislative committee on health care must be deposited in the legislative fund.

Sec. 41. NRS 449.490 is hereby amended to read as follows:

449.490 1. Every institution which is subject to the provisions of NRS 449.450 to 449.530, inclusive, *and section 37 of this act,* shall file with the department the following financial statements or reports in a form and at intervals specified by the director but at least annually:

(a) A balance sheet detailing the assets, liabilities and net worth of the institution for its fiscal year; and

(b) A statement of income and expenses for the fiscal year.

Each such institution shall file with the department a proposed operating budget for the following fiscal year at least 30 days before the start of that fiscal year.

2. The director shall require the certification of specified financial reports by [the institution's] *an independent* certified public accountant and may require attestations from responsible officers of the institution that the reports are, to the best of their knowledge and belief, accurate and complete.

3. The director shall require the filing of all reports by specified dates, and may adopt regulations which assess penalties for failure to file as required, but he shall not require the submission of a final annual report sooner than 6 months after the close of the fiscal year, and may grant extensions to institutions which can show that the required information is not available on the required reporting date.

4. All reports, except privileged medical information, filed under any provisions of NRS 449.450 to 449.530, inclusive, *and section 37 of this act,* are open to public inspection and must be available for examination at the office of the department during regular business hours.

Sec. 42. Chapter 450 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The board of county commissioners of a county in which a public hospital is located may, upon approval by a majority of the voters voting on the question in an election held throughout the county, levy an ad valorem tax of not more than 2.5 cents on each $100 of assessed valuation upon all taxable property in the county, to pay the cost of services rendered by the hospital pursuant to subsection 3 of NRS 450.420. The approval required by this subsection may be requested at any general or special election.

2. Any tax imposed pursuant to this section is in addition to the taxes imposed pursuant to NRS 428.050 and 428.285. The proceeds of any tax levied pursuant to this section are exempt from the limitations imposed by NRS 428.050, 428.285, 354.59805, 354.59811 and 354.59816, and must be excluded in determining the maximum rate of tax authorized by those sections.

Sec. 43. 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] *Except as otherwise provided in section 28 of this act, the* board of county commissioners shall establish by ordinance criteria and procedures to be used in the determination of eligibility for medical care as medical indigents or subjects of charity.

2. The board of hospital trustees shall fix the charges for treatment of those persons able to pay for the charges, as the board 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 [,] *of this section and subsection 3 of section 27 of this act,* 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. 44. NRS 450.490 is hereby amended to read as follows:

450.490 1. The board of county commissioners of any county for which a public hospital has been established or is administered pursuant to NRS 450.010 to 450.510, inclusive, and whose public hospital is the only hospital in the county, may convey the hospital for an amount not less than its appraised value or lease it for a term of not more than 50 years to any corporation if all of the following conditions are met:

(a) The corporation must provide in its articles of incorporation for an advisory board for the hospital. The advisory board must consist of persons who represent a broad section of the people to be served by the hospital.

(b) The corporation must contract to [care] :

(1) Care for indigent patients at a charge to the county which does not exceed the actual cost of providing that care, [and to receive] *or in accordance with sections 25 to 29, inclusive, of this act, if applicable; and*

(2) Receive any person falling sick or maimed within the county.

(c) The corporation must agree to accept all the current assets, including accounts receivable, to assume all the current liabilities, and to take over and maintain the records of the existing public hospital.

(d) The agreement must provide for the transfer of patients, staff and employees, and for the continuing administration of any trusts or bequests pertaining to the existing public hospital.

(e) The agreement must provide for the assumption by the corporation of all indebtedness of the county which is attributable to the hospital, and:

(1) If the hospital is conveyed, for payment to the county of an amount which is not less than the appraised value of the hospital, after deducting any indebtedness so assumed, immediately or by deferred installments over a period of not more than 30 years.

(2) If the hospital is leased, for a rental which will, over the term of the lease, reimburse the county for its actual capital investment in the hospital, after deducting depreciation and any indebtedness so assumed. The lease may provide a credit against the rental so required for the value of any capital improvements made by the corporation.

2. If any hospital which has been conveyed pursuant to this section ceases to be used as a hospital, unless the premises so conveyed are sold and the proceeds used to erect or enlarge another hospital for the county, the hospital so conveyed reverts to the ownership of the county. If any hospital which has been leased pursuant to this section ceases to be used as a hospital, the lease is terminated.

Sec. 45. NRS 450.500 is hereby amended to read as follows:

450.500 1. Except as otherwise provided in NRS 450.490, the board of county commissioners of any county for which a public hospital has been established pursuant to NRS 450.010 to 450.510, inclusive, or established otherwise but administered pursuant to NRS 450.010 to 450.510, inclusive, may convey the hospital, or lease it for a term of not more than 50 years, to a nonprofit corporation if all of the following conditions are met:

(a) The governing body of the nonprofit corporation must be composed initially of the incumbent members of the board of hospital trustees, as individuals. The articles of incorporation must provide for:

(1) A membership of the corporation which is broadly representative of the public and includes residents of each incorporated city in the county and of the unincorporated area of the county or a single member which is a nonprofit corporation whose articles of incorporation provide for a

membership which is broadly representative of the public and includes residents of each incorporated city in the county and of the unincorporated area of the county;

(2) The selection of the governing body by the membership of the corporation or, if the corporation has a single member, by the single member;

(3) The governing body to select its members only to fill a vacancy for an unexpired term; and

(4) The terms of office of members of the governing body, not to exceed 6 years.

(b) The nonprofit corporation [shall] *must* contract to [care] *:*

(1) Care for indigent patients at a charge to the county which does not exceed the actual cost of providing such care, [and to receive] *or in accordance with sections 25 to 29, inclusive, of this act, if applicable; and*

(2) Receive any person falling sick or maimed within the county.

(c) The nonprofit corporation [shall] *must* agree to accept all the current assets, including accounts receivable, to assume all the current liabilities, and to take over and maintain the records of the existing public hospital.

(d) The agreement must provide for the transfer of patients, staff and employees, and for the continuing administration of any trusts or bequests pertaining to the existing public hospital.

(e) The agreement must provide for the assumption by the corporation of all indebtedness of the county which is attributable to the hospital, and:

(1) If the hospital is conveyed, for payment to the county of its actual capital investment in the hospital, after deducting depreciation and any indebtedness so assumed, immediately or by deferred installments over a period of not more than 30 years.

(2) If the hospital is leased, for a rental which will over the term of the lease reimburse the county for its actual capital investment in the hospital, after deducting depreciation and any indebtedness so assumed. The lease may provide a credit against the rental so required for the value of any capital improvements made by the corporation.

2. Boards of county commissioners which have joint responsibility for a public hospital may jointly exercise the power conferred by subsection 1, and are subject jointly to the related duties.

3. If any hospital which has been conveyed pursuant to this section ceases to be used as a nonprofit hospital, unless the premises so conveyed are sold and the proceeds used to erect or enlarge another nonprofit hospital for the

county, the hospital so conveyed reverts to the ownership of the county. If any hospital which has been leased pursuant to this section ceases to be used as a nonprofit hospital, the lease is terminated.

Sec. 46. NRS 450.510 is hereby amended to read as follows:

450.510 1. The board of county commissioners of any county whose population is less than 100,000 may contract with any nonprofit corporation to which a public hospital has been conveyed or leased, for the care of indigent patients from the contracting county and the receiving of other persons falling sick or being maimed or injured within the contracting county. *The contract must be consistent with the provisions of sections 25 to 29, inclusive, of this act, if applicable.*

2. The contracting county may participate, from its county hospital construction fund or otherwise, in the enlargement or alteration of the hospital.

Sec. 47. 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 may determine whether patients presented to the district hospital for treatment are subjects of charity. [The] *Except as otherwise provided in section 28 of this act, the* board of county commissioners shall establish by ordinance criteria and procedures to be used in the determination of eligibility for medical care as medical indigents or subjects of charity.

2. The board of trustees shall fix the charges for treatment of those persons able to pay for it, as the board deems just and proper. The receipts therefor must be paid to the county treasurer and credited by him to the [district fund.] *fund for the district.*

Sec. 48. NRS 232.320 is hereby amended to read as follows:

232.320 1. [The] *Except as otherwise provided in subsection 2, the* director:

(a) Shall appoint, with the consent of the governor, chiefs of the divisions of the department, who are respectively designated as follows:

(1) The administrator of the aging services division;

(2) The administrator of the division for review of health resources and costs;

(3) The administrator of the health division;

(4) The administrator of the rehabilitation division;

(5) The state welfare administrator; and

(6) The administrator of the youth services division.

(b) Shall administer, through the divisions of the department, the provisions of chapters 210, 422 to 427A, inclusive, 431 to 436, inclusive, 439 to 443,

inclusive, 446, 447, 449, 450, 458 and 615 of NRS, NRS 444.003 to 444.430, inclusive, 445.015 to 445.038, inclusive, *sections 2 to 33, inclusive, of this act,* and all other provisions of law relating to the functions of the divisions of the department, but is not responsible for the clinical activities of the health division or the professional line activities of the other divisions.

(c) Has such other powers and duties as are provided by law.

2. The governor shall appoint the administrator of the mental hygiene and mental retardation division.

~~Sec. 49. 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. *The state plan must include a system of prospective payments to hospitals for treatment of eligible patients. The payments must equal the actual cost of treatment by the most efficient and economical hospital in its category. Costs must be determined in accordance with the annual reports filed by hospitals for the purposes of Medicare.*

(AB 615 1987)

2. In developing and revising the plan, the administrator and the board shall consider, among other things, 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 limitations of ~~legislative appropriations for assistance to the medically indigent~~.

Sec. 50. NRS 428.010 is hereby amended to read as follows:

428.010 1. To the extent that money may be lawfully appropriated by the board of county commissioners for this purpose pursuant to NRS 428.050 [, 428.265, 428.275] and 428.285, *and section 42 of this act,* 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] *Except as otherwise provided in section 28 of this act, the* boards of county commissioners of the several counties [are vested with the authority to]

may establish and approve policies and standards, prescribe a uniform standard of eligibility, appropriate money for this purpose and appoint agents who will develop 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. 51. 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 *or by section 26 of this act, if applicable,* and does not have relatives of sufficient ability to care for and maintain him, or when such relatives refuse or neglect to care for and maintain him, then he [must] *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 money which may be lawfully appropriated pursuant to NRS 428.050 [, 428.265, 428.275 or 428.285,] *and 428.285, and section 42 of this act,* for this purpose.

2. *The board of county commissioners shall pay hospitals for the costs of treating indigent inpatients who reside in the county an amount which is not less than 85 percent of the ~~prospective~~ payment required for providing the same treatment to patients pursuant to the state plan for assistance to the medically indigent, within the limits of money which may be lawfully appropriated pursuant to NRS 428.050 and 428.285, and section 42 of this act, for this purpose.*

3. 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] *deems* necessary to oversee and provide the necessary maintenance of poor persons;

(c) Authorize the payment of cash grants [direct] *directly* 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.]

Sec. 52. NRS 428.060 is hereby amended to read as follows:

428.060 1. If it appears to the satisfaction of the board of county commissioners that a pauper applying for relief has not established his residence and came to the county for some other purpose, but before coming to the county was a resident of some other county of this state, the board shall provide temporary relief for the pauper in accordance with the policies and

standards established and approved by the board of county commissioners and within the limits of money which may be lawfully appropriated thereby for this purpose pursuant to NRS 428.050 [, 428.265, 428.275 or 428.285.] *and 428.285, and section 42 of this act,* and shall notify immediately the board of county commissioners of the county where the pauper last had a residence.

2. The notice must be in writing, duly attested by the clerk of the board of county commissioners, and deposited in the post office, addressed to the board of county commissioners of the other county.

3. The board of county commissioners receiving the notice may cause the pauper to be removed immediately to that county, and shall pay a reasonable compensation for the temporary relief afforded. If the board of county commissioners chooses not to remove the pauper, the county affording relief has a legal claim against any money lawfully available in that county for the relief necessarily furnished, and may recover it in a suit at law.

Sec. 53. NRS 428.090 is hereby amended to read as follows:

428.090 1. When any nonresident or any other person who meets the uniform standards of eligibility prescribed by the board of county commissioners *or by section 26 of this act, if applicable,* falls sick in the county, not having money or property to pay his board, nursing or medical aid, the board of county commissioners of the proper county shall, on complaint being made, give or order to be given such assistance to the poor person as is in accordance with the policies and standards established and approved by the board of county commissioners and within the limits of money which may be lawfully appropriated for this purpose pursuant to NRS 428.050 [, 428.265, 428.275 or 428.285.] *and 428.285 and section 42 of this act.*

2. If the sick person dies, the board of county commissioners shall give or order to be given to the person a decent burial or cremation.

3. The board of county commissioners shall make such allowance for the person's board, nursing, medical aid, burial or cremation as the board deems just and equitable, and order it paid out of the county treasury.

4. The responsibility of the board of county commissioners to provide medical aid or any other type of remedial aid under this section is relieved to the extent of the amount of money or the value of services provided by:

(a) The welfare division of the department of human resources to or for such persons for medical care or any type of remedial care under the state plan for assistance to the medically indigent; and

(b) The fund for hospital care to indigent persons under the provisions of NRS 428.115 to 428.255, inclusive.

Sec. 54. NRS 680A.320 is hereby amended to read as follows:

680A.320 1. For the purposes of this section:

(a) [A "subsidiary" is a person of which either the insurer and the parent corporation or the insurer or the parent corporation holds practical control.

(b)] An "affiliated person" is a person controlled by any combination of the insurer, the parent corporation, a subsidiary or the principal stockholders or officers or directors of any of the foregoing.

(b) "Health facility" has the meaning ascribed to it in NRS 439A.015.

(c) A "subsidiary" is a person of which either the insurer and the parent corporation or the insurer or the parent corporation holds practical control.

2. No insurer [shall] *may* engage directly or indirectly in any transaction or agreement with its parent corporation, or with any subsidiary or affiliated person which will result or tend to result in:

(a) Substitution contrary to the interest of the insurer and through any method of any asset of the insurer with an asset or assets of inferior quality or lower fair market value;

(b) Deception as to the true operating results of the insurer;

(c) Deception as to the true financial condition of the insurer;

(d) Allocation to the insurer of a proportion of the expense of combined facilities or operations which is unfair and unfavorable to the insurer;

(e) Unfair or excessive charges against the insurer for services, facilities, supplies or reinsurance;

(f) Unfair and inadequate charges by the insurer for reinsurance, services, facilities or supplies furnished by the insurer to others;

(g) Payment by the insurer for services, facilities, supplies or reinsurance not reasonably needed by the insurer; [or]

(h) Depletion of the insurer's surplus, through payment of dividends or other distribution or withdrawal, below the amount thereof reasonably required for conduct of the insurer's business and maintenance of growth with safety to policyholders [.] *; or*

(i) Payment by the insurer for services or products for which the health facility has charged less than fair market value, unless the reduced charge is reflected in the form of reduced premiums. In determining what constitutes fair market value, consideration must be given to reasonable agreements for the preferential provision of health care, in accordance with regulations adopted by

the commissioner. An insurer which ~~charges~~ pays less than fair market value for services or products in a transaction which is subject to the provisions of this paragraph shall annually file a certification with the commissioner that the reduced ~~charge~~ payment has been reflected in the form of reduced premiums, together with documentation supporting the certification.

(SB 142 - 1989)

3. In all transactions between the insurer and its parent corporation, or involving the insurer and any subsidiary or affiliated person, full recognition [shall] *must* be given to the paramount duty and obligation of the insurer to protect the interests of policyholders, both existing and future.

4. If a health facility is a parent, subsidiary or affiliate of an insurer or of a parent or facility of an insurer, and the insurer purchases medical or any other services or products from the health facility, the health facility may not:

(a) Attempt artificially to reduce or increase its margin of profit by altering the charges to the insurer.

(b) Alter its true operating results or financial condition through charges to the insurer for services or products.

This subsection does not prohibit activities authorized pursuant to paragraph (i) of subsection 2.

5. If a health facility is found, after notice and a hearing, to have violated the provisions of subsection 4, the commissioner may impose an administrative fine of not more than $5,000 for each violation.

Sec. 55. 1. **Each hospital whose percentage of income to operating expenses for the calendar year 1986 exceeded 17 percent shall:**

(a) For the fiscal year 1987-1988, reduce its billed charges for inpatients by at least 25 percent below its billed charges in effect on March 31, 1987 and reduce its net revenue per inpatient admission by an average of 15 percent below its net revenue per inpatient admission in the fiscal year 1986-1987; and

(b) Except as otherwise provided in subsections 5 and 8, for the fiscal year 1988-1989, maintain its billed charges for inpatients and net revenue per inpatient admission at a level which is not higher than that required for the fiscal year 1987-1988.

2. Each hospital whose percentage of income to operating expenses for the calendar year 1986 exceeded 12 percent but did not exceed 17 percent shall:

(a) For the fiscal year 1987-1988, reduce its billed charges for inpatients by at least 12 percent below its billed charges in effect on March 31, 1987 and reduce its net revenue per inpatient admission by an average of 7.5 percent below its net revenue per inpatient admission in the fiscal year 1986-1987; and

(b) Except as otherwise provided in subsections 5 and 8, for the fiscal year 1988-1989, maintain its billed charges for inpatients and net revenue per inpatient admission at a level which is not higher than that required for the fiscal year 1987-1988.

(AB 615-1957)

3. Each [Non-profit] hospital whose percentage of income to operating expenses for the calendar year 1986 exceeded 7 percent but did not exceed 12 percent shall reduce its billed charges by an amount which is sufficient to result in a percentage of income to operating expenses of not more than 7 percent for the fiscal years 1987-1988, 1988-1989, 1989-1990 and 1990-1991.

4. A hospital which:

(a) Is not subject to the requirements of subsection 1, 2 or 3 in the fiscal year 1987-1988; and

(b) Exceeds in the calendar year 1987 one of the respective percentages of income to operating expenses specified in those subsections,

shall in the fiscal year 1988-1989 comply with the requirements of the applicable subsection for the fiscal year 1987-1988.

5. A hospital which is subject to the requirements of subsection 1 or 2 in the fiscal year 1987-1988 may increase its billed charges and its net revenue per inpatient admission in the fiscal year 1988-1989 to the extent authorized by this subsection. A hospital may increase its net revenue in the fiscal year 1988-1989 to the extent that the following costs increase in the fiscal year 1987-1988 over the corresponding amounts for the fiscal year 1986-1987:

(a) Salaries of employees of the hospital, excluding administrative employees;

(b) Malpractice insurance;

(c) Fees for licensing;

(d) Utilities; and

(e) Any other increases in costs which the director determines were beyond the control of the hospital.

A hospital must apply to the director for an increase pursuant to this subsection on or before September 30, 1988, by submitting information verifying increases specifically allowed or proposed for consideration pursuant to this subsection. The director shall, on or before November 15, 1988, determine the amount by which the hospital will be allowed to increase its net revenue in the fiscal year 1988-1989. The decision of the director is a final decision for the purposes of judicial review.

6. The hospital may increase its net revenue per inpatient admission in the fiscal year 1988-1989 by an amount which will result in the increase in net revenue authorized pursuant to this subsection. The hospital may increase its billed charges in the fiscal year 1988-1989 by 1 percent for each percent that it is authorized to increase its net revenue per inpatient admission. Except as otherwise provided in subsection 8, each hospital which is required to comply with the requirements of subsection 1, 2 or 4 shall not increase its billed charges for inpatients in the fiscal year 1989-1990 or in the fiscal year 1990-1991 by more than 4 percent above the percentage increase in the Consumer Price Index (Medical Care Component for all Urban Consumers), published by the Bureau of Labor Statistics of the Department of Labor, in the preceding calendar year.

7. A hospital which fails to reduce its billed charges or net revenue per inpatient admission or to maintain its billed charges or net revenue at the levels required by subsections 1, 2, 4, 5 and 6, shall, except as otherwise provided in subsection 8, pay a penalty of twice the amount of the difference between its total billed charges and its total authorized billed charges or twice the amount of the difference between its total net revenue and its total authorized net revenue, whichever is greater. A hospital which fails to reduce its percentage of income to operating expenses to the levels required by subsection 3 shall pay a penalty of twice the amount of the difference between its total income and its total authorized income. The director shall determine the amount of the penalty which a hospital must pay pursuant to this section and shall notify the hospital in writing of that amount on or before November 1 of each year. The director shall include in the penalty any amounts by which the hospital failed to meet its obligation in a preceding year which were not discovered at the time of the failure. Payment is due within 30 days after receipt of the notice. If a hospital fails to pay the penalty when it is due the hospital shall pay, in addition to the penalty:

(a) Interest at a rate of 1 percent per month for each month after the penalty is due in which it remains unpaid; and

(b) Any court costs and fees required by the director to obtain payment of the penalty and interest from the hospital.

8. The legislature has determined that the requirements of subsection 1 would result in the following reductions in net revenue if the amount of care provided in the fiscal year 1987-1988 were the same as was provided in the calendar year 1986:

Humana Hospital Sunrise $9,878,425
Valley Hospital Medical Center 5,103,931
Desert Springs Hospital 3,494,151

If the difference between a hospital's net revenue for the fiscal year 1987-1988 or 1988-1989 and the amount its net revenue would have been based upon its net revenue per inpatient admission in the fiscal year 1986-1987 exceeds the amount specified in this subsection, reduced by any credit approved pursuant to subsection 12, the hospital is exempt from any penalty which would otherwise be imposed pursuant to subsection 7. A hospital which increases its billed charges based upon a determination that the provisions of this subsection will exempt the hospital from any penalty for such action shall notify the director in writing of the increase and submit documentation in support of the hospital's determination. The director shall determine the amount by which a hospital's reduction in net revenue for the fiscal years 1987-1988 and 1988-1989 exceeded the amounts specified in this subsection, after deducting any applicable credit, and shall authorize the hospital to increase its net revenue per inpatient admission by an amount which is sufficient to allow the recovery of the excess in the fiscal year 1988-1989 or 1989-1990, as appropriate. The hospital may increase its billed charges in the fiscal years 1988-1989 and 1989-1990 by 1 percent for each percent that it is authorized to increase its net revenue per inpatient admission pursuant to this subsection for that fiscal year. Any increase authorized pursuant to this subsection is in addition to the increases authorized pursuant to subsections 5 and 6.

9. One-half of the money collected pursuant to this section must be deposited in the legislative fund and used for the support of the legislative committee on health care. The other half of the money must be deposited in the supplemental fund for assistance to indigent persons. The board of trustees of the fund for hospital care to indigent persons shall distribute to each county before May 1 from money deposited in the supplemental fund pursuant to this subsection an amount proportionate to the amount paid into the supplemental fund by the county in the previous fiscal year.

10. The division shall, on or before July 1, 1987:

(a) Determine the percentage of income to operating expenses for the calendar year 1986 for each hospital in this state based upon reports submitted by the hospitals to the division;

(b) Determine whether that percentage exceeds the amount specified in subsection 1, 2 or 3; and

(c) Notify each hospital which will be required to comply with the provisions of subsection 1, 2 or 3 and of subsection 6. Each hospital so notified, except a hospital which is subject to the provisions of subsection 3, shall within 30 days provide to the director a copy of its list of billed charges in effect on March 31, 1987.

The division shall make such other determinations as are necessary to carry out the provisions of this section.

11. The provisions of subsections 1, 2, 3 and 4 do not require a hospital to reduce the amount it receives pursuant to a contract in effect on the effective date of this section.

12. A hospital which is required pursuant to subsection 1, 2 or 4 to reduce or limit its net revenue per inpatient admission in a fiscal year is entitled to a credit against its net revenue used to compute its revenue per inpatient admission of $2 for each $1 spent by the hospital in the preceding calendar year to increase its ratio of nursing hours to patient days. The credit authorized pursuant to this subsection must not exceed 5.5 percent of the amount by which the net revenue of the hospital would otherwise be required to be reduced in the fiscal year 1987-1988. The credit applies only to nurses licensed pursuant to chapter 632 of NRS. To receive the credit, a hospital must:

(a) Increase its percentage of nurses who work at least 40 hours per week above the percentage for the preceding calendar year;

(b) Increase its ratio of nursing hours to patient days above the ratio for the calendar year 1986;

(c) Maintain its level of expenditures for medical education in Nevada at the level provided in the calendar year 1986, including education of allied health

students, education of students in medical school, postgraduate residency programs and continuing medical education for the hospital's staff; and

(d) Submit to the director on or before January 31 of the fiscal year in which the credit is claimed evidence of compliance with the requirements of paragraphs (a), (b) and (c).

The director may disallow all or any portion of the claimed credit which he determines is not supported by the evidence. The decision of the director is a final decision for the purpose of judicial review.

(Allow inclusion of rural affiliate or subsidiary to calculate income to operating expenses of non-profit.. AB 39 - 1989)

13. The director may adopt such regulations as he deems necessary to carry out the provisions of this section.

14. As used in this section: "Affiliate" means...

(a) "Director" means the director of the department of human resources.

(b) "Division" means the division for review of health resources and costs of the department of human resources. "Facility for skilled nursing" means...

(c) "Fiscal year" means a period beginning on July 1 and ending on June 30 of the following year.

(d) "Income" means all revenues earned from the care of inpatients, as determined by the division from reports submitted to the division by a hospital, minus operating expenses, before the payment of income taxes.

(e) "Net revenue per inpatient admission" means all revenues earned from medical care provided to inpatients by a hospital, excluding income from inpatients covered by Medicare or Medicaid, divided by the number of inpatients admitted, excluding inpatients covered by Medicare or Medicaid.

(f) "Operating expenses" means expenses of operation of a hospital which the division determines to be an allowable operating expense including:

(1) All operating expenses allowed by the Health Care Financing Administration for hospitals which receive payments for Medicare;

(2) Expenses for capital expenditures approved pursuant to NRS 439A.100; and

(3) Other operating expenses which the division determines to be directly related to the provision of care to inpatients.

(g) "Percentage of income to operating expenses" means income divided by operating expenses and then multiplied by 100.

(AB 39 1984) "Subsidiary" means.

Sec. 56. 1. The legislature intends that the reductions in revenue required of hospitals by section 55 of this act be carried out without affecting the service provided by such hospitals. The legislature hereby finds that any reduction in the number or quality of the employees of such hospitals would be contrary to the interests of the people of this state, and would endanger public health. The legislature further finds that any reduction in the salaries or benefits of the employees of such a hospital is likely to result in a reduction in the number and quality of the employees of the hospital.

2. A hospital which is required pursuant to subsection 1, 2 or 4 of section 55 of this act to reduce its net revenue per inpatient admission shall not:

(a) Reduce the wages, hours or benefits of any employee, except in the case of legitimate disciplinary action or at the request of the employee;

(b) Reduce the number of employees employed to perform any service; or

(c) Reduce the quantity or quality of service provided by the hospital, except to the extent that a reduction in quantity corresponds to a reduction in the level of occupancy of the hospital,

unless the hospital's action is approved by the director of the department of human resources.

3. For the purposes of this section, a reduction in the quality of service provided by a hospital includes:

(a) Reducing the number of hours employees are assigned to provide or assist in the provision of a service;

(b) Discontinuing any service which is provided to more than 50 persons in a year; and

(c) Any other action which reduces the quality of care received by patients in the hospital.

4. The director of the department of human resources may:

(a) Impose an administrative fine of not more than $5,000 per occurrence for each violation of this section; and

(b) Adopt regulations necessary to carry out the provisions of this section.

Sec. 57. 1. The legislature hereby finds and declares that:

(a) Rates charged by hospitals in this state are excessive and in need of control;

(b) The provisions of section 55 of this act would provide needed relief to the residents of this state from those rates;

(c) It is essential that the provisions of that section remain in force for the entire period prescribed by that section for the residents of this state to receive the full benefit of its requirements; and

(d) If those provisions are not in effect for the period prescribed by that section, it will be necessary for those provisions to take effect as soon as possible and for the amount of time required by that section.

2. If any of the provisions of section 55 of this act is enjoined, restrained or otherwise prevented by a court from taking effect, those provisions become effective on the date that those provisions are upheld by the Supreme Court of the United States or of Nevada, or on the date that the time for appealing the ruling of a lower court upholding those provisions expires. The times and amounts used to measure the obligation of a hospital and against which compliance is measured must be as stated in that section. The periods in which a hospital is required to comply must be measured from the date on which the provisions become effective pursuant to this subsection, with that date being the equivalent of July 1, 1987.

3. If any of the provisions of this act are found by a court to be unconstitutional, the legislature intends that the remaining provisions take effect with respect to the hospitals that would otherwise be subject to those provisions, and to this end the provisions of this act are hereby declared to be severable.

Sec. 58. 1. Each insurer, nonprofit corporation for hospital or medical service and health maintenance organization shall identify reductions in payments of claims which result from the provisions of this act and pass those savings on to their policyholders in the form of reduced premiums.

2. If an entity described in subsection 1 is found, after notice and hearing, to have failed to identify or pass on savings as required by subsection 1, the

commissioner of insurance may impose an administrative fine of not more than $5,000 and impose other sanctions authorized by law.

Sec. 59. The legislative committee on health care shall:

1. Review the actions of the director of the department of human resources in administering the provisions of this act, except section 35 of this act, and adopting regulations pursuant to those provisions. The director shall report to the committee concerning any regulations proposed or adopted pursuant to those provisions.

2. Report to the legislature on December 1, 1988, and December 1, 1990, concerning the effect of this act and the need for continued controls over the costs of health care.

Sec. 60. If a contract was in effect for the fiscal year 1986-1987 between a county and a hospital for the treatment of a majority of the indigent patients in the county, the total amount of reimbursement paid to the hospital by the county in the fiscal ~~year~~ years 1987-1988 and 1988-1989 for the treatment of indigent patients must not be less than the amount paid to the hospital in the fiscal year 1986-1987 if the hospital treats at least as many indigent patients.

(AB 645-1987)

Sec. 61. 1. This section and sections 55, 56, 57 and 58 of this act become effective upon passage and approval.

2. Sections 1 to 42, inclusive, 44, 45, 46, 48 to 54, inclusive, 59 and 60 of this act become effective on July 1, 1987.

3. Sections 43 and 47 of this act become effective at 12:01 a.m. on July 1, 1987.

APPENDIX B

"REPORT TO THE NEVADA LEGISLATIVE COMMISSION FROM THE LEGISLATURE'S COMMITTEE ON HEALTH CARE CONCERNING THE CONTAINMENT OF HEALTH CARE COSTS IN NEVADA"

REPORT TO THE NEVADA LEGISLATIVE COMMISSION FROM THE LEGISLATURE'S COMMITTEE ON HEALTH CARE CONCERNING THE CONTAINMENT OF HEALTH CARE COSTS IN NEVADA

INTRODUCTION

This report is submitted in compliance with Section 59 of Assembly Bill 289 of the 1987 legislative session (Chapter 377, Statutes of Nevada 1987, pages 862-891), a measure concerning the restraint of medical care costs. Section 59 requires the Nevada Legislature's Committee on Health Care (Nevada Revised Statutes 439B.200) to submit a report to the Legislature on December 1, 1990, concerning the effect of the bill and the need for continued controls over health care costs.

The Committee on Health Care was created by A.B. 289 in 1987. In 1989, the Legislative Commission appointed the following members to the committee:

Senator Raymond D. Rawson, Chairman
Assemblyman M. Marvin Sedway, Vice Chairman
Senator Bob Coffin
Senator Randolph J. Townsend
Assemblyman Morse Arberry, Jr.
Assemblyman David E. Humke
Assemblywoman Vivian L. Freeman (alternate)

After the untimely death of Assemblyman Sedway in July 1990, the Legislative Commission appointed Assemblyman Arberry to the Vice Chairmanship and Assemblywoman Freeman to full membership.

The committee held eight regular meetings and two subcommittee meetings from October 1989 through December 1990. Much of the committee's discussions concerned the future of A.B. 289 because the provisions of the bill which pertain to the restrictions on cost increases at certain Nevada hospitals will expire by limitation on July 1, 1991.

As required, this report will outline the effect of A.B. 289 on restraining health care costs in Nevada and the need for the continuation of controls.

THE EFFECT OF A.B. 289 ON NEVADA HEALTH CARE COSTS

Essentially, A.B. 289 required three major hospitals in Las Vegas (Desert Springs Hospital, Humana Hospital Sunrise and Valley Hospital) to reduce their billed charges to a certain level. Moderate increases were allowed according to a formula included in the bill. Any savings realized from the implementation of this measure were to be passed on to the Nevada health care consumer in the form of reduced health care insurance premiums.

Hospital Cost Reductions

The committee directed the Division for the Review of Health Resources and Costs to prepare an analysis of the hospital cost containment aspects of A.B. 289.

In its analysis, dated October 26, 1990, the division determined that A.B. 289 had an initial, substantial impact on charges and revenues for the targeted hospitals. The hospitals' compliance with the requirements of A.B. 289 resulted in costs rising much more slowly than they may have without the measure's controls.

For example, in 1988, the net revenue per admission at Nevada hospitals rose at a rate less than one-third the national average (2.6 percent for Nevada versus 8.2 percent for the United States). Billed charges per admission also rose more slowly in Nevada than in the rest of the country (7 percent versus 12.3 percent). In 1989, net revenue per admission continued to increase below the national average (7.2 percent versus 9.7 percent).

Profits of Nevada hospitals were also affected in both years, declining 19.4 percent in 1988 and 12 percent in 1989. In 1987, Nevada ranked first in the country for profits per day and per admission and for profit margin. In 1989, Nevada ranked second in profit per day, eighth in profit per admission and sixteenth in profit margin.

Enclosed as Appendix 1 is a copy of the analysis of A.B. 289 as presented to the committee by the division. It discusses the cost containment mechanisms and experiences of A.B. 289 in detail.

Insurance Premium Reductions

On May 15, 1989, Nevada's Commissioner of Insurance released a report showing the effect of A.B. 289 on health care insurance premiums in the state.

The commissioner found that the inpatient component of the health care dollar was reduced by A.B. 289, as the Division for the Review of Health Resources and Costs noted in its report cited previously. However, outpatient costs and charges by other sectors of the health care industry (which were not affected by A.B. 289) increased. Thus, savings in the inpatient component were offset by increases in other medical areas, and a reduction in the cost of health insurance as a result of A.B. 289 was not realized. Yet, it can be argued that the bill's impact on inpatient care costs held premium cost increases to a lower level than they might have been if A.B. 289 had not been passed.

Enclosed as Appendix 2 is a copy of Analysis of A.B. 289, the report of the commissioner as it was released in 1989. According to Theresa P. Froncek-Rankin, Chief Insurance Assistant in the Insurance Division, the division's position as stated in this report has not changed.

THE NEED FOR CONTINUING CONTROLS

According to the analysis prepared by the Division for the Review of Health Resources and Costs and testimony presented to the Committee on Health Care, Nevada's position among the other states in hospital costs comparisons has not changed much since A.B. 289 was introduced in 1987.

In 1987, Nevada led the rest of the nation with the highest billed charges per day, net revenue per admission, profit margin and profit per admission and day. The state ranked second for billed charges per admission and net revenue per day.

Although Nevada's hospital costs rose more slowly than did the other states' from 1987 through 1989, Nevada still ranked first in 1989 for billed charges per day. The state also moved into first from second for billed charges per admission.

In addition, Nevada placed second in 1989 for highest net revenue and profit per day. The state ranked third in the country for net revenue per admission.

The only significant decreases reflected in 1989 data were in profit per admission, which places Nevada eighth, and in profit margin which ranks Nevada sixteenth.

The charts supporting these rankings are enclosed as Appendix 3.

Based on this information, the Committee on Health Care recognizes that controls on health care costs in Nevada must be maintained and should be expanded.

COMMITTEE RECOMMENDATIONS

Enclosed as Appendix 4 is a copy of the Health Care Committee's "Summary Of Recommendations." This summary includes all of the recommendations approved by the committee to be included in its report to the 66th session of the Nevada Legislature.

It is the intent of the committee that the implementation of these recommendations will aid in the control of the overall cost of health care in Nevada. In Recommendation No. 7, the committee offers the following suggestions to control specific hospital costs:

- Continue the limitations on increases in hospital billed charges for inpatient services by restricting such increases to 60 percent of the Consumer Price Index (All Items);
- Exempt hospitals whose profit margins are less than 2 percent;
- Require hospitals to bill patients covered by negotiated contracts at an average negotiated rate; and
- Freeze hospital billed charges for outpatient services at current rates for 2 years.

CONCLUDING REMARKS

Assembly Bill 289 was a complex bill directed at a complex industry. It appears that the measure accomplished its stated mission: the reduction of billed charges for inpatient services at some of the largest hospitals in the state. These charges were lowered and subsequently increased at a relatively slow rate.

However, Nevada still ranks among the top three states in the areas of hospital billed charges and net revenue. The health care insurance industry is not reducing premiums as a result of savings from A.B. 289 because costs in areas outside the purview of the measure continue to increase. In sum, the cost of health care in Nevada is still unacceptably high, despite 4 years of A.B. 289.

Therefore, the Legislature's Committee on Health Care has concluded that state controls on health care costs continue to be necessary and justified. As a result, the committee recommends that the 1991 Nevada Legislature amend the provisions of A.B. 289, as outlined in this report, to sufficiently address the problem.

BOB MILLER
Governor

STATE OF NEVADA

JERRY GRIEPENTROG
Director

STEPHEN LEWIS
Administrator

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF HEALTH RESOURCES AND COST REVIEW
Room 603, Kinkead Building
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Carson City, Nevada 89710
(702) 687-4176

October 26, 1990

MEMORANDUM:

TO: Senator Raymond D. Rawson, Chairman
Legislative Committee on Health Care

FROM: Stephen Lewis, Administrator
Health Resources and Cost Review

SUBJECT: Report on Hospital Cost Containment Under AB289

Per your request, attached is the Division's report on hospital cost containment under AB289. It was drafted in consultation with committee staff, and discusses Nevada hospital costs compared with the experience of other states.

This report is limited to the hospital cost containment aspects of AB289. If our Division can be of service in investigating other issue areas please let me know.

SL/tab

Attachment

cc: Governor Bob Miller
Jerry Griepentrog

AB 289 and Hospital Cost Containment in Nevada

NOTE: AB 289 is a complex law dealing with a wide variety of health care cost containment topics. The following discussion is restricted to hospital charges and revenues, and the portions of AB 289 that address them.

On March 19, 1987 Governor Richard Bryan testified before a joint meeting of the Senate Human Resources and Facilities Committee and the Assembly Committee on Health and Welfare. As sponsor of AB 289 he cited the following reasons for passage of the bill:

--Nevada ranked first in the nation among states for hospital inpatient billed charges, on both a per-day and per-admission basis.

--Nevada hospitals also ranked first in net revenue and in profits.

--Hospital billed charges were a critical issue because the uninsured were forced to pay billed charges, charge-based hospital payments by indemnity carriers were increasing at 24% per year, SAIS rates were based on median billed charges, and high billed charges were causing carriers to reduce benefits and increase premiums.

--Marketplace competition was not effectively controlling hospital costs.

AB 289 has been in force since July 1, 1987. As the 1991 legislature considers options for further cost containment legislation it is appropriate to review Nevada's hospital cost experience since that time. Based solely on the cost data, it would be extremely difficult to judge whether AB 289 has been successful, or for that matter, what would constitute success. However, the data provide an indication of what changes have or have not occurred since 1987, and what needs have to be addressed.

Today, Nevada's hospital cost picture looks much like 1987:

--Inpatient billed charges per day for the year ended September 1988, the most recent year for which comparative data are available, are the highest in the nation and increasing faster than in California, the second-ranked state (Table 1a). Charges per admission are second to Washington, DC (Table 1b). It is worth noting that the fiscal year ending June 30, 1988 was the year mandated revenue reductions were in effect for Nevada's major investor-owned hospitals--in other words, the year when charges and revenues for those hospitals were the lowest since AB 289 went into effect.

--Inpatient net revenues per day are second to Alaska (Table 1c); per admission net revenue is third behind Washington, DC and Alaska (Table 1d).

--Hospital profits statewide are the highest in the nation, approximately three times the national median (Table 1e).

--Not only are Nevada's statewide charges higher than other states, the same is true for the "Big Six" compared with California's investor-owned hospitals, and with those of California's most comparable geographic areas (Figure 1a). Again, Nevada is pulling away from California, and the "Big Six" are pulling away from California's large complex facilities (Figure 2).

--Billed charges remain the primary issue in hospital costs. As the cost shift to billed charges intensifies, the charge-based patient (who typically has no choice in his type of coverage, if any) bears most of the brunt of the increased costs.

Based on these observations it appears that the job of cost containment is not finished. To the extent hospitals have essentially complied with the revenue and charge targets set by AB 289, it can be said that the law has worked; that charges and revenues could conceivably have risen faster in the absence of its controls. On the other hand, Nevada's ranking compared with other states has not changed, and the rate of increase in Nevada's hospital charges is accelerating. These facts would seem to indicate that much remains to be done. Thus it appears that AB 289 has functioned successfully in the technical sense, but may not necessarily have been designed to fulfill the state's expectations of it.

Nevada's Experience Under AB 289

The historical data indicate that AB 289 had an initial, substantial impact on charges and revenues for the affected hospitals. In the years leading up to passage, the state was experiencing sharp increases in both measures. Immediately following passage, with its mandated rollbacks of billed charges and inpatient net revenue for the three largest investor-owned facilities, both measures declined substantially for the first year then began to increase again at their pre-1987 rates (Tables 3a-f, Figures 3a-f). When the compliance test shifted to gross (billed) charges for 1990, the rate of increase continued or accelerated for both charges and net revenues. Following the national pattern, profits generally flattened--though at a level several times above the rest of the country.

AB289 Compliance - A Historical Perspective

For-profit hospitals

For fiscal years 1988 and 1989, the for-profit hospitals were required to reduce their net revenues per inpatient admit (Non-Medicare and Non-Medicaid only) by a set dollar amount, calculated at 15% of net revenues of the base period. For 1989 the hospitals were allowed a credit for increases in certain expenses, and were also allowed to carryfoward any excess reduction from the prior year. (Note: There was also a test that required gross revenues for these patients to be reduced by 25%, but as long as a hospital complied with the net revenue test, no penalties could be assessed for non-compliance with the gross revenue test).

For fiscal year 1990 the compliance test changed to billed charges for all inpatients (measured on a per day basis). An increase of 4% over the medical care component of the Consumer Price Index was allowed. Additionally, excess reductions from 1988 and 1989 were allowed to be carried forward on a percentage basis. No other credits were allowed. (Table 4)

Some inferences may be drawn from this experience:

--First, the rollback provisions of AB 289 probably did reduce costs for one year to patients and their insurance carriers. Both billed charges and net revenues per case were lower in 1988 than in 1987. This reversal in the upward trend of both indicators can more plausibly be attributed to the mandated reductions than to any other single factor. For example, there was no significant change in the competitive environment among providers to account for the shift. Moreover, the one "Big Six" facility not subject to the rollbacks, Washoe Medical Center, recorded substantial increases in both measures in 1988 (Table/Figure 3f).

--Second, the law's mechanisms to restrain the rate of growth after the rollback did not appear to slow the rate of increase. One year after the rollbacks (1989) the savings in billed charges per patient, and in some cases net revenue as well, had been wiped out and the rates of growth were as fast as in 1987.

--It appears the cost-restraint mechanisms created an environment that contributed to the rapid growth in charges and revenues following the 1988 rollbacks. For example:

The 1989 switch to a gross-charges compliance test, after two years when hospitals were not penalized for noncompliance with the rollback in gross charges, permitted hospitals to increase gross charges in 1990 from a higher base rate than contemplated. Most of the affected hospitals do not appear to have reduced billed charges by the mandated 25%.

Crediting facilities (until 1991) for certain costs and their previous-year savings over their targets had the effect of eliminating those savings and ensuring that facilities would in fact not reduce costs below their targets. The targets thus created defact floors from which facilities could increase rates.

The formula for 1990 factored in those credits as a percentage of the previous year's revenue, which had the effect of multiplying the base rate for the compliance year by a value of 1 plus the percentage value of the credit rather than simply adding the credit to the base. Thus 1989 savings added more than 100% of those savings to the 1990 allowable target.

In addition to the growth patterns for charges and revenues as they relate to the provisions of AB 289, other characteristics of recent experience have implications for cost containment. Among the most important are the following:

--Gross charges are rising faster than net revenue, both in total and per admission (Figures 3a-f). This is true even for 1990, when AB 289 compliance focused specifically on billed charges. This pattern reflects the continuing cost shift from patients and payers with negotiated hospital contracts to those who pay on the basis of charges--those who have no access to managed-care programs or no coverage at all. While this component of the patient base is relatively small (about 20% in Las Vegas, 35% in Reno), it suffers a disproportionate share of the cost burden--usually for reasons beyond the patient's control.

--Outpatient services are increasing as a percentage of hospital operating revenues (Appendix), while hospital services in total are declining as a percentage of health care expenditures, indicating a rise in non-hospital services.

These observations appear to have some clear implications for further cost containment efforts:

--Hospital inpatient cost containment should continue to focus on billed charges. If anything, this is an even more important need today than in 1987. Basic equity requires that the patient (and his payer) who must pay on the basis of billed charges not be forced to subsidize the hospital's marketing strategy of attracting managed care business. For that matter, those managed care contractors whose contracts are based on discounted charges are also victims of the managed-care cost shift.

This is important because there is a common pattern in hospital managed-care contracting for a hospital to demand that upon renewal, the terms of an established contract be switched from a risk basis (e.g. per diem rates) to a percentage discount from charges. Given established utilization patterns, especially in an oligopolistic market like Clark or Washoe County, the purchaser rarely has a choice but to comply.

Moreover, to the extent marketplace competition is working, it benefits only a subset of the managed care component and is reflected in the cost shift to the charge-based patient.

The increasing role of outpatient care may also aggravate the cost shift to the charge-based inpatient, given that cost-conscious patients can price-shop for outpatient services more effectively than they can inpatient care, when the choice of hospital is typically made by the physician.

--There needs to be some organizational locus of authority over the program, to monitor its effectiveness and enforce compliance. This entity also must have the authority to roll back charges to bring Nevada hospitals into line with the rest of the country.

--The compliance test ought to be the same for all target facilities. There is an equity issue among providers when the basis of the test is fundamentally different from one to another. Moreover, if the precedent is established of allowing one hospital to negotiate a "custom" formula, it becomes difficult to deny

others the same privilege. A mosaic of custom formulae would be not only extremely difficult to monitor and regulate, but would also minimize the effectiveness of the cost containment program.

--The compliance test, based on billed charges, should remain consistent over time. A change in tests allows the hospitals to manipulate the development of the base rates on which compliance is tested. Long-term consistency would also allow hospitals, payers and other interested parties to plan more effectively for the future. For similar reasons, the cost containment program should be in place indefinitely, without a sunset date. Not only does a short-term program make evaluation of its effectiveness extremely difficult, but it is easier for facilities to manipulate the components of a short-term formula than one that can be monitored for several years. If flaws become apparent over time they can be corrected either legislatively or by regulation.

--There is a need for commonly understood, clearly articulated cost containment objectives, measures of their achievement and the relationships between the operational elements of the program and those measures of achievement--in other words, what is to be accomplished, how success will be measured and how the mechanisms should produce results that can be expected to meet those measures.

--As the committee has already noted, there is a need to develop ways to bring outpatient care under the cost containment umbrella. Anecdotal evidence indicates that outpatient costs at some hospitals are beginning to exceed inpatient costs for the same services, and the same may be true in other outpatient settings as well. The appropriate first step in this process is to initiate the study referenced in the committee's work document.

Within the broader context of health policy, there are also a number of issues which do not directly fall under the heading of cost containment but would be appropriate to deal with in parallel with restraining provider costs. Examples include factors that contribute to health care production costs, such as the professional liability environment, unreimbursed care, manpower shortages and cost-ineffective regulation.

Outpatient Services

Due to the significantly increased importance in outpatient business to the hospitals' overall operations, industry reporting has focused more on adjusted days and admissions as a way of measuring total hospital operations. To calculate adjusted days (or admits), total gross revenues are divided by actual gross revenue per day (or admit) for inpatients only to arrive at adjusted days (or admits).

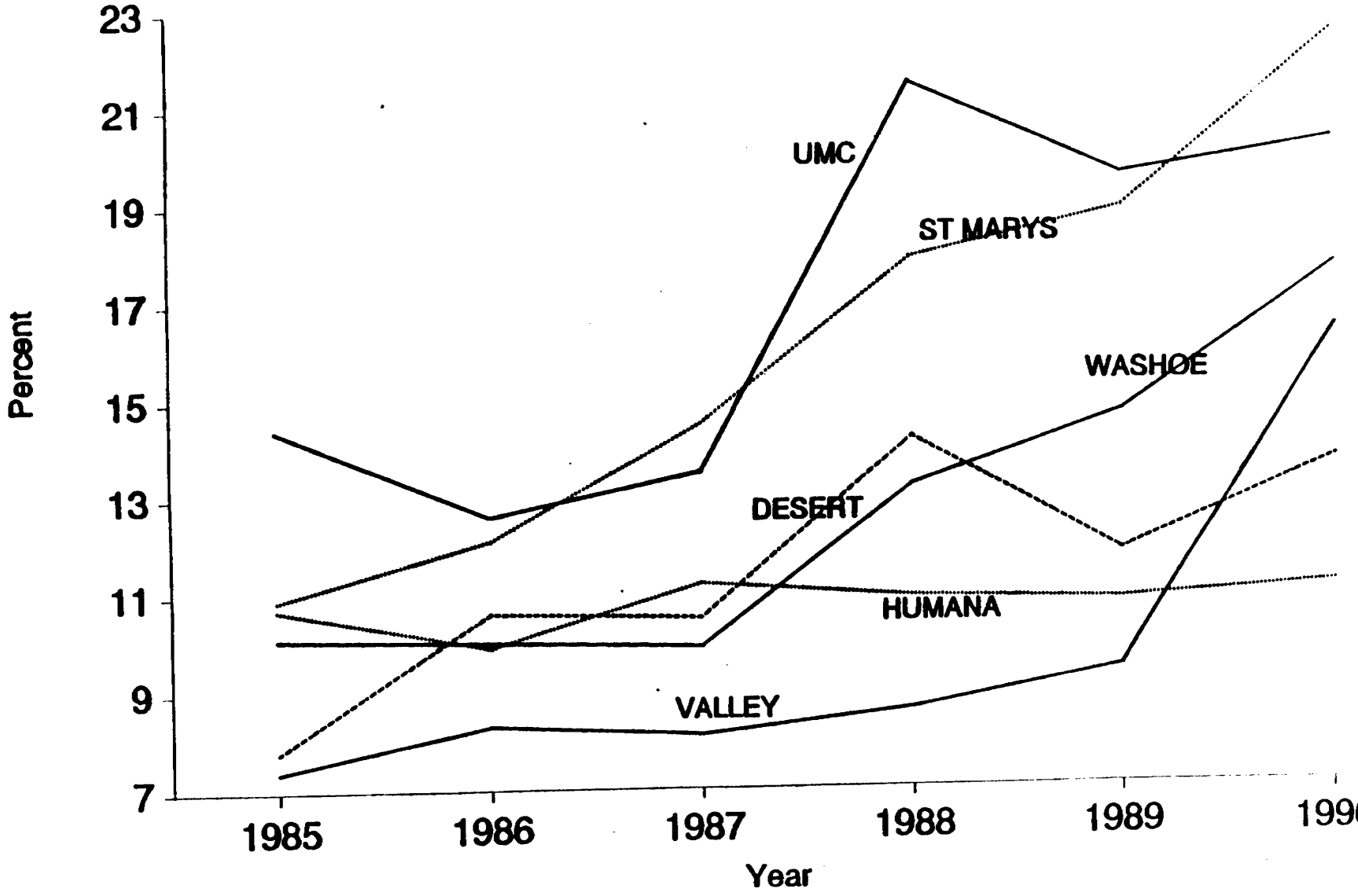
The gross amounts are therefore the same whether calculated on just inpatient data, or on total revenues and adjusted days. The net revenue per day (or admit) generally increases somewhat, because contractual allowances (the difference between billed charges and what the hospital actually collects) is usually higher for inpatients than outpatients. While this may cause some distortion in net revenue for inpatients, it is necessary to do this in order to calculate profits on a per day or per admit basis, because hospitals do not generally distinguish between inpatient and outpatient expense. Also much of the other state and national information does not break down contractual allowances (or bad debts) between inpatient and outpatient, such that the only fair comparison that can be made is on the basis of adjusted days or admissions.

Outpatient net revenue as a percentage of total patient revenue for the fiscal years ended June 30, 1985 through 1990, for each of the six largest hospitals in Nevada.

	1985	1986	1987	1988	1989	1990
Desert	7.8%	10.6%	10.5%	14.2%	11.8%	13.7%
Humana	10.7%	9.9%	11.2%	10.9%	10.8%	11.1%
St. Mary's	10.9%	12.1%	14.5%	17.9%	18.9%	22.5%
University	14.4%	12.6%	13.5%	21.5%	19.6%	20.3%
Valley	7.4%	8.3%	8.1%	8.6%	9.4%	16.4%
Washoe	10.1%	10.0%	9.9%	13.2%	14.7%	17.7%

From 1985 until 1990, 5 of the 6 hospitals have experience a significant increase in their outpatient net revenue as a percentage of total revenue. Only Humana has remained relatively stable. St. Mary's and Valley have both more than doubled over the period, while Desert and Washoe are up approximately 75%; University is up 40%.

OUTPATIENT NET REVENUE
PERCENTAGE OF TOTAL PATIENT REVENUE, 1985 - 1990



Appendix
Table 1

HOSPITAL COSTS
GROSS REVENUE PER DAY BY STATE
FISCAL YEAR ENDED SEPTEMBER 30, 1988

STATE	GROSS REVENUE PER DAY	STATE RANKING	% BELOW NEVADA
NEVADA	$1,287.88	1	0.00%
CALIFORNIA	1,194.44	2	7.26%
WASHINGTON DC	1,152.91	3	10.48%
ALASKA	1,130.00	4	12.26%
ARIZONA	1,014.14	5	21.26%
FLORIDA	993.62	6	22.85%
PENNSYLVANIA	922.00	7	28.41%
OREGON	912.17	8	29.17%
NEW MEXICO	911.97	9	29.19%
MICHIGAN	908.16	10	29.48%
TEXAS	858.71	11	33.32%
ILLINOIS	842.67	12	34.57%
CONNECTICUT	829.52	13	35.59%
WASHINGTON	821.67	14	36.20%
ALABAMA	811.57	15	36.98%
COLORADO	811.49	16	36.99%
MISSOURI	809.25	17	37.16%
DELAWARE	808.90	18	37.19%
LOUISIANA	802.66	19	37.68%
MASSACHUSETTS	795.90	20	38.20%
UTAH	767.56	21	40.40%
OHIO	764.46	22	40.64%
OKLAHOMA	755.39	23	41.35%
TENNESSEE	743.59	24	42.26%
VIRGINIA	741.06	25	42.46%
GEORGIA	728.95	26	43.40%
INDIANA	708.69	27	44.97%
SOUTH CAROLINA	704.35	28	45.31%
KENTUCKY	701.06	29	45.56%
NEW HAMPSHIRE	700.94	30	45.57%
WEST VIRGINIA	698.24	31	45.78%
ARKANSAS	667.46	32	48.17%
HAWAII	663.19	33	48.51%
NORTH CAROLINA	644.24	34	49.98%
MARYLAND	629.74	35	51.10%
VERMONT	628.32	36	51.21%
RHODE ISLAND	626.96	37	51.32%
NEW YORK	611.11	38	52.55%
KANSAS	605.10	39	53.02%
IDAHO	597.80	40	53.58%
MAINE	579.25	41	55.02%
NEW JERSEY	565.82	42	56.07%
WISCONSIN	552.59	43	57.09%
MINNESOTA	550.34	44	57.27%
MISSISSIPPI	538.25	45	58.21%
IOWA	525.35	46	59.21%
NEBRASKA	524.49	47	59.27%
WYOMING	455.40	48	64.64%
NORTH DAKOTA	445.99	49	65.37%
MONTANA	432.39	50	66.42%
SOUTH DAKOTA	431.73	51	66.48%
TOTAL U.S.	$789.27		38.72%

SOURCE: "HOSPITAL STATISTICS", 1989-90 EDITION
DATA FROM THE AHA 1988 ANNUAL SURVEY

HOSPITAL COSTS
GROSS REVENUE PER ADMISSION BY STATE
FISCAL YEAR ENDED SEPTEMBER 30, 1988

STATE	GROSS REVENUE PER ADMISSION	STATE RANKING	% BELOW NEVADA
WASHINGTON DC	$8,776.48	1	-9.58%
NEVADA	8,009.33	2	0.00%
CALIFORNIA	7,564.14	3	5.56%
PENNSYLVANIA	6,977.13	4	12.89%
FLORIDA	6,965.13	5	13.04%
MICHIGAN	6,749.04	6	15.74%
ALASKA	6,592.82	7	17.69%
MASSACHUSETTS	6,246.46	8	22.01%
ILLINOIS	6,213.58	9	22.42%
CONNECTICUT	6,167.54	10	23.00%
ARIZONA	6,051.04	11	24.45%
MISSOURI	6,047.46	12	24.49%
NEW YORK	5,890.08	13	26.46%
HAWAII	5,888.93	14	26.47%
COLORADO	5,768.32	15	27.98%
DELAWARE	5,684.70	16	29.02%
ALABAMA	5,581.18	17	30.32%
TEXAS	5,340.12	18	33.33%
OHIO	5,259.50	19	34.33%
NEBRASKA	5,195.65	20	35.13%
VIRGINIA	5,186.25	21	35.25%
NEW MEXICO	5,151.70	22	35.68%
TENNESSEE	5,138.37	23	35.85%
LOUISIANA	5,052.20	24	36.92%
OKLAHOMA	5,046.96	25	36.99%
RHODE ISLAND	5,042.69	26	37.04%
OREGON	4,985.24	27	37.76%
GEORGIA	4,961.42	28	38.05%
SOUTH CAROLINA	4,959.37	29	38.08%
MINNESOTA	4,934.42	30	38.39%
NEW HAMPSHIRE	4,777.57	31	40.35%
WEST VIRGINIA	4,729.92	32	40.94%
KANSAS	4,712.71	33	41.16%
NORTH CAROLINA	4,712.26	34	41.17%
INDIANA	4,694.40	35	41.39%
NORTH DAKOTA	4,680.56	36	41.56%
MAINE	4,667.30	37	41.73%
WASHINGTON	4,656.51	38	41.86%
VERMONT	4,647.89	39	41.97%
KENTUCKY	4,524.03	40	43.52%
MARYLAND	4,362.82	41	45.53%
ARKANSAS	4,358.77	42	45.58%
IOWA	4,307.30	43	46.22%
NEW JERSEY	4,188.24	44	47.71%
UTAH	4,134.42	45	48.38%
WISCONSIN	4,101.37	46	48.79%
IDAHO	4,091.14	47	48.92%
MONTANA	4,085.76	48	48.99%
SOUTH DAKOTA	3,897.82	49	51.33%
MISSISSIPPI	3,708.31	50	53.70%
WYOMING	3,458.19	51	56.82%
TOTAL U.S.	$5,693.15		28.92%

SOURCE: "HOSPITAL STATISTICS", 1989-90 EDITION
DATA FROM THE AHA 1988 ANNUAL SURVEY

HOSPITAL COSTS
NET REVENUE PER DAY BY STATE
FISCAL YEAR ENDED SEPTEMBER 30, 1988

STATE	NET REVENUE PER DAY	STATE RANKING	% BELOW NEVADA
ALASKA	$899.16	1	-9.61%
NEVADA	820.32	2	0.00%
CALIFORNIA	769.62	3	6.18%
WASHINGTON DC	759.23	4	7.45%
ARIZONA	721.64	5	12.03%
OREGON	705.63	6	13.98%
CONNECTICUT	663.63	7	19.10%
WASHINGTON	659.68	8	19.58%
NEW MEXICO	642.61	9	21.66%
FLORIDA	638.04	10	22.22%
MICHIGAN	627.69	11	23.48%
UTAH	620.23	12	24.39%
MASSACHUSETTS	603.17	13	26.47%
COLORADO	601.70	14	26.65%
DELAWARE	600.00	15	26.86%
ILLINOIS	595.48	16	27.41%
OHIO	593.92	17	27.60%
PENNSYLVANIA	585.02	18	28.68%
TEXAS	577.37	19	29.62%
INDIANA	569.15	20	30.62%
LOUISIANA	566.81	21	30.90%
MISSOURI	565.84	22	31.02%
NEW HAMPSHIRE	555.22	23	32.32%
MARYLAND	555.10	24	32.33%
OKLAHOMA	535.61	25	34.71%
VIRGINIA	524.90	26	36.01%
TENNESSEE	520.64	27	36.53%
GEORGIA	518.20	28	36.83%
HAWAII	510.89	29	37.72%
ALABAMA	509.46	30	37.89%
KENTUCKY	504.34	31	38.52%
RHODE ISLAND	495.56	32	39.59%
VERMONT	492.71	33	39.94%
WEST VIRGINIA	491.57	34	40.08%
NORTH CAROLINA	489.42	35	40.34%
NEW JERSEY	488.82	36	40.41%
SOUTH CAROLINA	488.19	37	40.49%
WISCONSIN	482.66	38	41.16%
IDAHO	479.44	39	41.55%
ARKANSAS	476.44	40	41.92%
NEW YORK	472.56	41	42.39%
MAINE	462.48	42	43.62%
KANSAS	453.74	43	44.69%
MINNESOTA	446.42	44	45.58%
IOWA	419.27	45	48.89%
NEBRASKA	416.70	46	49.20%
WYOMING	380.84	47	53.57%
MISSISSIPPI	377.85	48	53.94%
NORTH DAKOTA	371.08	49	54.76%
SOUTH DAKOTA	361.31	50	55.96%
MONTANA	360.36	51	56.07%
TOTAL U.S.	$565.47		31.07%

SOURCE: "HOSPITAL STATISTICS", 1989-90 EDITION
DATA FROM THE AHA 1988 ANNUAL SURVEY

HOSPITAL COSTS
NET REVENUE PER ADMISSION BY STATE
FISCAL YEAR ENDED SEPTEMBER 30, 1988

STATE	NET REVENUE PER ADMISSION	STATE RANKING	% BELOW NEVADA
WASHINGTON DC	$5,779.58	1	-13.29%
ALASKA	5,246.00	2	-2.83%
NEVADA	5,101.57	3	0.00%
CONNECTICUT	4,934.11	4	3.28%
CALIFORNIA	4,873.83	5	4.46%
MASSACHUSETTS	4,733.86	6	7.21%
MICHIGAN	4,664.73	7	8.56%
NEW YORK	4,554.72	8	10.72%
HAWAII	4,536.53	9	11.08%
FLORIDA	4,472.58	10	12.33%
PENNSYLVANIA	4,427.04	11	13.22%
ILLINOIS	4,390.89	12	13.93%
ARIZONA	4,305.81	13	15.60%
COLORADO	4,277.05	14	16.16%
MISSOURI	4,228.45	15	17.11%
DELAWARE	4,216.58	16	17.35%
NEBRASKA	4,127.90	17	19.09%
OHIO	4,086.17	18	19.90%
MINNESOTA	4,002.64	19	21.54%
RHODE ISLAND	3,985.86	20	21.87%
NORTH DAKOTA	3,894.39	21	23.66%
OREGON	3,856.45	22	24.41%
MARYLAND	3,845.74	23	24.62%
NEW HAMPSHIRE	3,784.35	24	25.82%
INDIANA	3,770.08	25	26.10%
WASHINGTON	3,738.50	26	26.72%
MAINE	3,726.44	27	26.96%
VIRGINIA	3,673.49	28	27.99%
VERMONT	3,644.75	29	28.56%
NEW MEXICO	3,630.08	30	28.84%
NEW JERSEY	3,618.26	31	29.08%
TENNESSEE	3,597.75	32	29.48%
TEXAS	3,590.56	33	29.62%
WISCONSIN	3,582.35	34	29.78%
NORTH CAROLINA	3,579.86	35	29.83%
OKLAHOMA	3,578.53	36	29.85%
LOUISIANA	3,567.68	37	30.07%
KANSAS	3,533.86	38	30.73%
GEORGIA	3,527.03	39	30.86%
ALABAMA	3,503.56	40	31.32%
IOWA	3,437.59	41	32.62%
SOUTH CAROLINA	3,437.35	42	32.62%
MONTANA	3,405.18	43	33.25%
UTAH	3,340.85	44	34.51%
WEST VIRGINIA	3,329.96	45	34.73%
IDAHO	3,281.10	46	35.68%
SOUTH DAKOTA	3,262.03	47	36.06%
KENTUCKY	3,254.54	48	36.21%
ARKANSAS	3,111.37	49	39.01%
WYOMING	2,891.97	50	43.31%
MISSISSIPPI	2,603.24	51	48.97%
TOTAL U.S.	$4,078.84		20.05%

SOURCE: "HOSPITAL STATISTICS", 1989-90 EDITION
DATA FROM THE AHA 1988 ANNUAL SURVEY

Hospital Financial Information
Operating Margins - National Comparisons
Hospital Fiscal Years Ending in 1988

	Percentile 50th	70th
Total U.S.	2.09%	5.61%
Nevada	6.03	15.22
Other Western States		
Arizona	1.21	7.42
California	1.38	5.06
Idaho	4.89	7.06
Montana	3.73	7.72
Oregon	4.13	7.89
Utah	3.64	7.72
Washington	2.83	5.73
Investor Owned		
All Hospitals	4.04	10.43
250 to 399 beds	8.84	14.04
400 and over	12.77	18.54
Not For Profit		
All Hospitals	2.11	5.12
250 to 399 beds	3.18	5.67
400 and over	3.48	6.15

Source: The Sourcebook, The Comparative Performance of U.S. Hospitals, a joint publication by Deloitte & Touche and Health Care Investment Analysts, Inc.

ACUTE CARE HOSPITALS
MARKUP RATIO
PERIODS AS NOTED

FACILITY OR GROUP	FYE 6/30/89	FYE 6/30/88
Desert Springs Hospital	1.947	1.821
Humana Hospital Sunrise	2.464	2.101
St. Mary's Regional M C	1.583	1.536
University Medical Center	1.800	1.834
Valley Hospital	2.564	2.375
Washoe Medical Center	1.767	1.589
TOTAL STATE	1.897	1.761

NATIONAL COMPARISONS Markup Ratios	1988	1987
All USA Upper quartile	1.470	1.412
Far West Region Upper quartile	1.433	1.398
Proprietary Chains Upper quartile	1.514	1.501

$$\text{MARKUP RATIO} = \frac{\text{GROSS PATIENT REVENUE + OTHER OPERATING REVENUE}}{\text{OPERATING EXPENSES}}$$

ACUTE CARE HOSPITALS
OPERATING MARGIN COMPARISONS
PERIODS AS NOTED

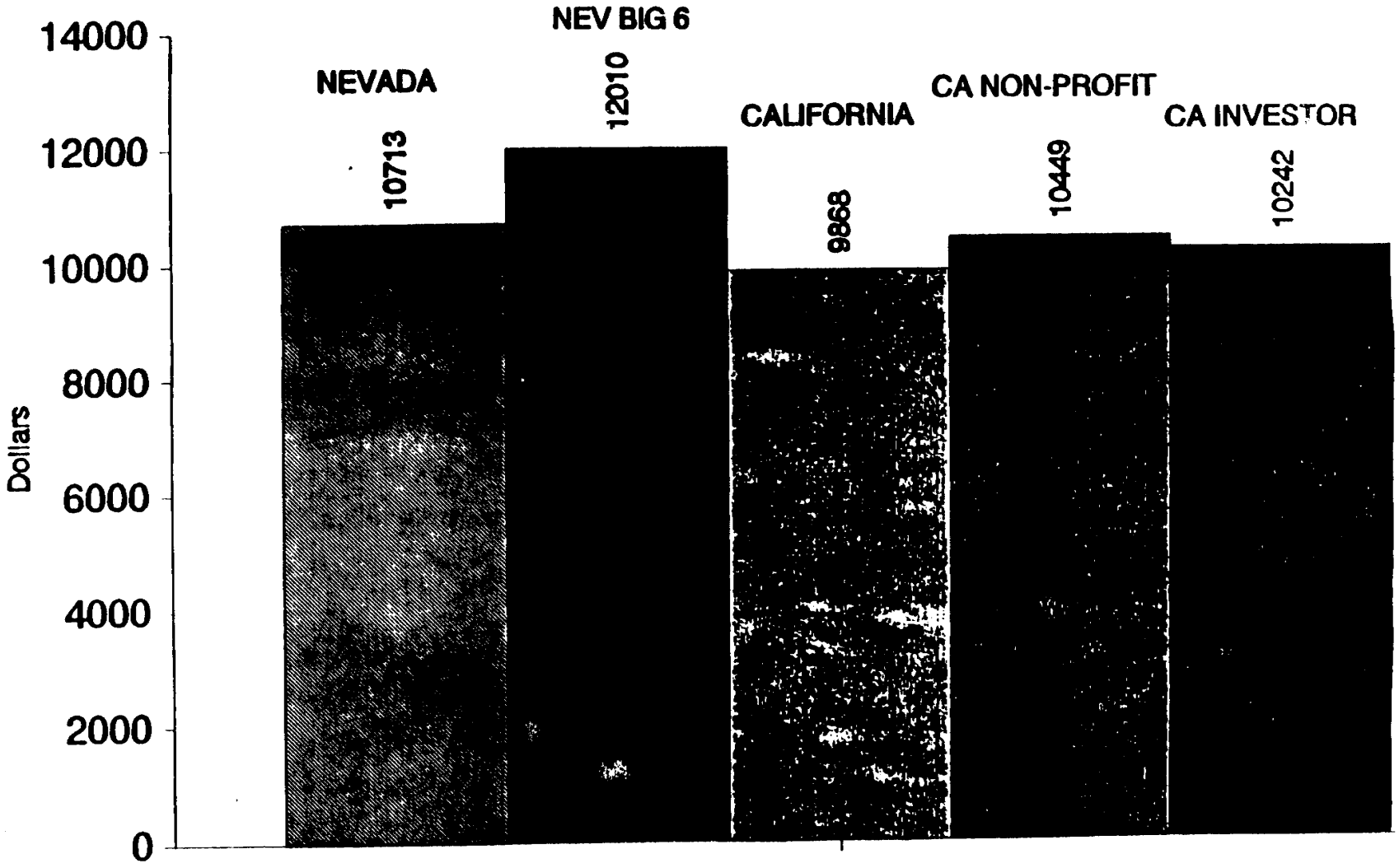
FACILITY OR GROUP	FYE 6/30/89	FYE 6/30/88
Desert Springs Hospital	0.085	0.134
Humana Hospital Sunrise	0.174	0.143
St. Mary's Regional M C	0.055	0.076
University Medical Center	-0.082	-0.130
Valley Hospital	0.223	0.216
Washoe Medical Center	0.049	0.031
TOTAL STATE	0.060	0.060

NATIONAL COMPARISONS Operating Margin	1988	1987
All USA Upper quartile	0.044	0.051
Far West Region Upper quartile	0.051	0.062
Proprietary Chains Upper quartile	0.060	0.065

$$\text{OPERATING MARGIN} = \frac{\text{OPERATING INCOME}}{\text{NET OPERATING REVENUE}}$$

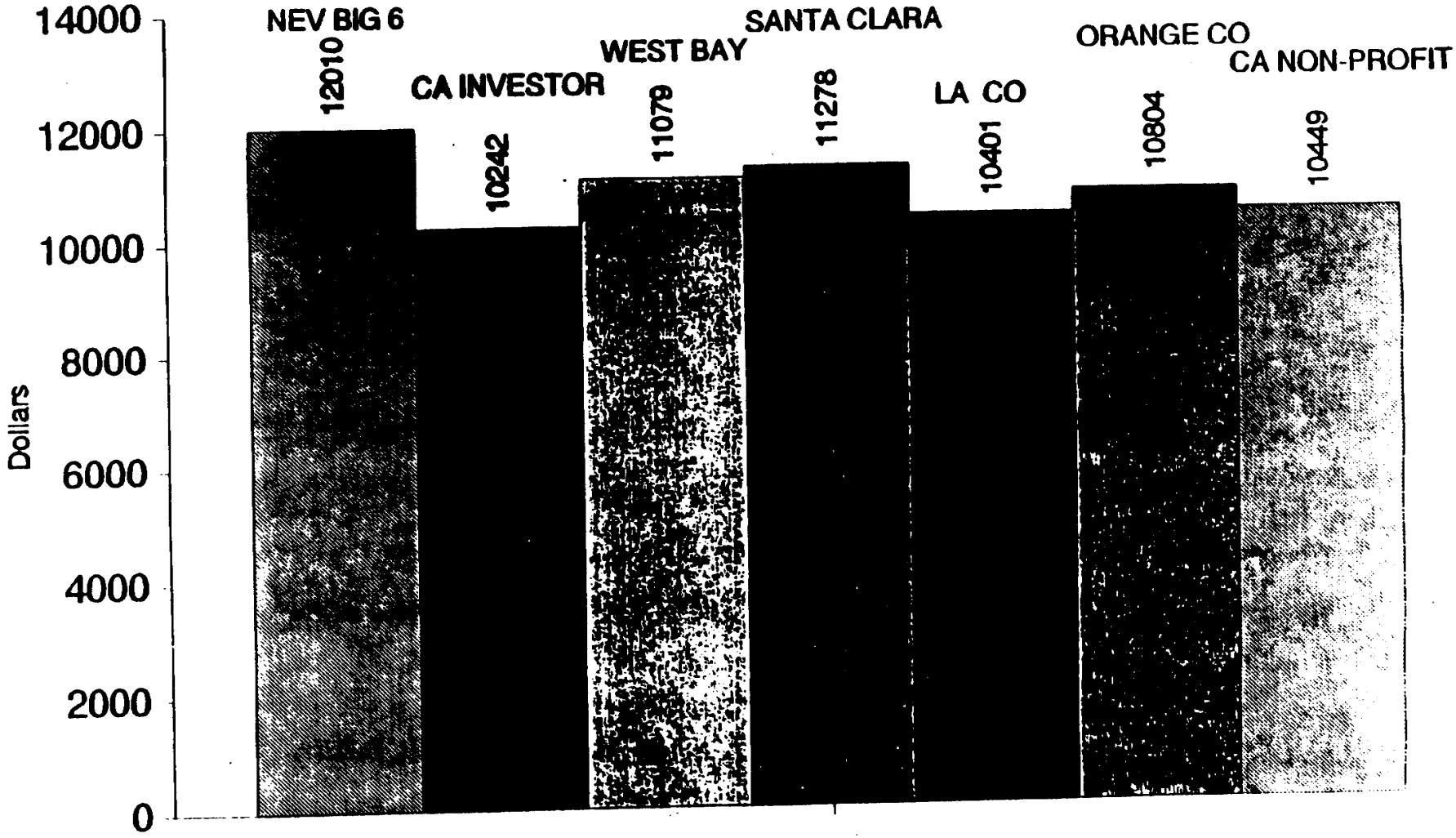
NEVADA - CALIFORNIA GROUP COMPARISONS

GROSS REVENUE PER ADMISSION, 1989



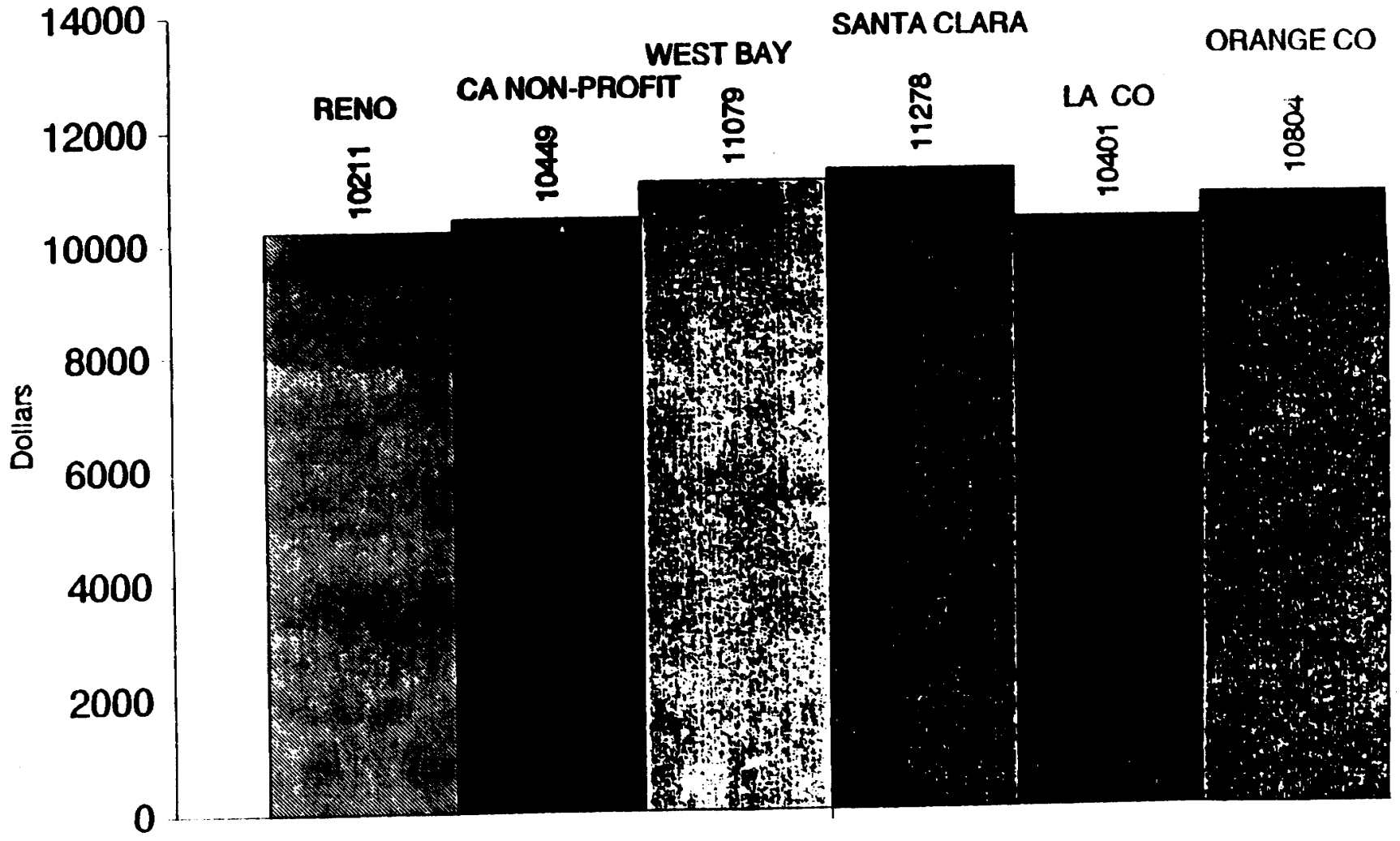
NEVADA BIG 6 - CALIFORNIA GROUP COMPARISONS

GROSS REVENUE PER ADMISSION, 1989



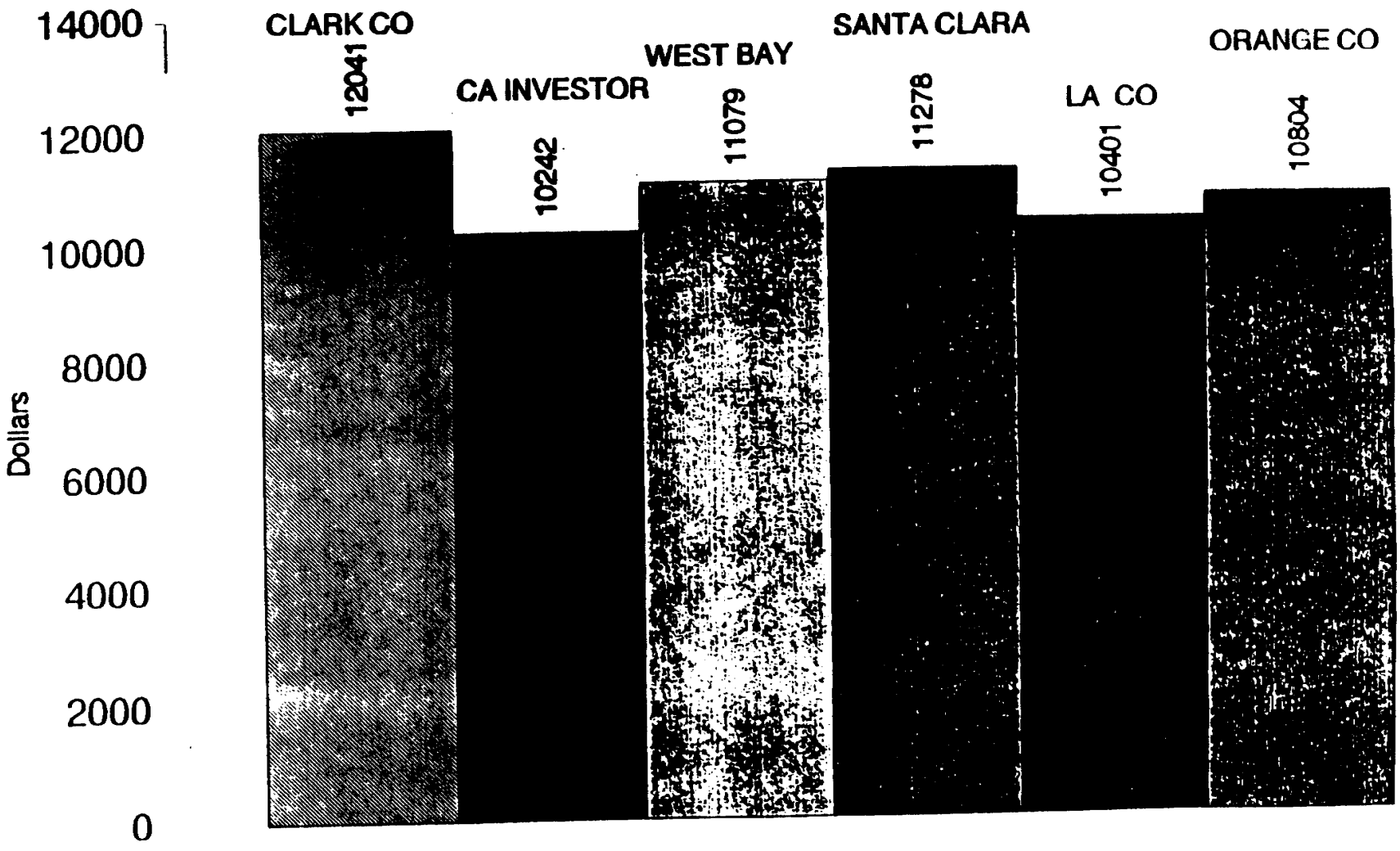
RENO/SPARKS - CALIFORNIA GROUP COMPARISONS

GROSS REVENUE PER ADMISSION, 1989



CLARK COUNTY - CALIFORNIA GROUP COMPARISONS

GROSS REVENUE PER ADMISSION, 1989



GROSS REVENUE PER DAY
COMPARISON OF CALIFORNIA AND NEVADA
QUARTERLY FINANCIAL INFORMATION
SEPTEMBER, 1987 THRU DECEMBER, 1989

QUARTER	----CALIFORNIA----		-----NEVADA-----		NEVADA PE ABOVE CAL
	STATE	LARGE COMPLEX	STATE	BIG 6	STATE
SEPTEMBER 1987	$1,115	N/A	$1,307	$1,313	17.22%
DECEMBER 1987	1,179	N/A	1,353	1,362	14.76%
MARCH 1988	1,230	N/A	1,506	1,555	22.42%
JUNE 1988	1,269	N/A	1,466	1,518	15.53%
SEPTEMBER 1988	1,333	N/A	1,589	1,643	19.17%
DECEMBER 1988	1,375	1,501	1,670	1,724	21.48%
MARCH 1989	1,422	1,570	1,697	1,760	19.34%
JUNE 1989	1,464	1,636	1,801	1,866	22.99%
SEPTEMBER 1989	1,532	1,703	1,849	1,909	20.71%
DECEMBER 1989	1,586	1,755	1,931	2,000	21.78%

Chart 3

HOSPITAL COMPARISONS
FOR THE PERIOD 1/1/88 - 12/31/88
RANKED BY NET REVENUE PER STAY

RANK	HOSPITAL	STATE	BEDS	OWNER	GROSS PER STAY ($)	GROSS PER DAY ($)	NET PER STAY ($)	NET PER DAY ($)
1	STANFORD	CA	663	NP	13,932	2,204	10,336	1,635
2	UNIVERSITY	WA	368	GOV	10,838	1,345	9,498	1,179
3	MT ZION HOSP/MED CTR	CA	439	NP	11,138	1,354	9,390	1,141
4	LOMA LINDA	CA	549	NP	13,841	1,821	8,959	1,179
5	ST JOHN'S	CA	551	NP	9,539	1,362	8,390	1,198
6	HUMANA, WEST ANAHEIM	CA	243	P	11,165	1,956	8,273	1,449
7	HUMANA, WEST HILLS	CA	236	P	10,919	1,854	8,191	1,391
8	SAN JOSE MED CTR	CA	539	NP	9,921	1,592	7,698	1,235
9	BROTMAN MED CTR	CA	495	P	10,385	1,366	7,597	999
10	WEST SEATTLE	WA	198	P	9,329	1,559	7,591	1,268
11	ST JOSEPHS	CA	647	NP	9,643	1,056	7,271	796
12	LOS ROBLES REG.	CA	208	P	7,680	1,497	7,071	1,378
13	MERCY GEN.	CA	489	NP	12,354	1,764	6,998	999
14	DOCTORS MED CTR	CA	419	P	12,272	2,024	6,893	1,137
15	TACOMA GEN	WA	487	NP	8,691	1,503	6,490	1,123
16	WASHOE MED	NV	522	NP	10,473	1,626	6,456	1,002
17	SACRED HEART	WA	631	NP	7,807	1,084	6,409	890
18	SWEDISH	WA	641	NP	6,925	1,204	6,309	1,097
19	ST JOSEPH,TACOMA	WA	340	NP	8,481	1,514	6,255	1,116
20	PUGET SOUND	WA	160	P	9,045	1,538	6,170	1,049
21	DESERT SPRINGS	NV	225	P	10,451	1,660	6,158	978
22	HUMANA SUNRISE	NV	679	P	11,596	1,778	6,129	940
23	DEACONESS	WA	363	NP	7,983	1,399	6,100	1,069
24	COASTAL COMMUNITIES	CA	215	P	6,136	1,651	6,038	1,625
25	FOUNTAIN VALLEY	CA	287	P	9,004	1,877	5,850	1,219
26	VALLEY	NV	310	P	11,419	1,838	5,799	934
27	AMERICAN RIVER	CA	250	NP	8,049	1,311	5,619	915
28	AUBURN GEN	WA	149	P	7,130	1,548	5,540	1,203
29	SOUTHWEST	WA	435	NP	7,071	1,570	5,401	1,199
30	ST. MARY'S	NV	367	NP	7,788	1,379	5,148	912
31	UNIVERSITY MED.	NV	445	PUB	9,232	1,370	4,375	650

DATA OBTAINED FROM:
WASHINGTON DEPARTMENT OF HEALTH
CALIF. STATEWIDE HEALTH PLANNING & DEVELOPMENT
NEVADA DIVISION FOR HEALTH RESOURCES & COST REVIEW

OWNERSHIP LEGEND

P = Profit GOV = Government
NP = Non Profit PUB = Public

Chart 1

HOSPITAL COMPARISONS
FOR THE PERIOD 1/1/88 - 12/31/88
RANKED BY GROSS REVENUE PER STAY

RANK	HOSPITAL	STATE	BEDS	OWNER	GROSS PER STAY ($)	GROSS PER DAY ($)	NET PER STAY ($)	NET PER DAY ($)
1	STANFORD	CA	663	NP	13,932	2,204	10,336	1,635
2	LOMA LINDA	CA	549	NP	13,841	1,821	8,959	1,179
3	MERCY GEN.	CA	489	NP	12,354	1,764	6,998	999
4	DOCTORS MED CTR	CA	419	P	12,272	2,024	6,893	1,137
5	HUMANA SUNRISE	NV	679	P	11,596	1,778	6,129	940
6	VALLEY	NV	310	P	11,419	1,838	5,799	934
7	HUMANA, WEST ANAHEIM	CA	243	P	11,165	1,956	8,273	1,449
8	MT ZION HOSP/MED CTR	CA	439	NP	11,138	1,354	9,390	1,141
9	HUMANA, WEST HILLS	CA	236	P	10,919	1,854	8,191	1,391
10	UNIVERSITY	WA	368	GOV	10,838	1,345	9,498	1,179
11	WASHOE MED	NV	522	NP	10,473	1,626	6,456	1,002
12	DESERT SPRINGS	NV	225	P	10,451	1,660	6,158	978
13	BROTMAN MED CTR	CA	495	P	10,385	1,366	7,597	999
14	SAN JOSE MED CTR	CA	539	NP	9,921	1,592	7,698	1,235
15	ST JOSEPHS	CA	647	NP	9,643	1,056	7,271	796
16	ST JOHN'S	CA	551	NP	9,539	1,362	8,390	1,198
17	WEST SEATTLE	WA	198	P	9,329	1,559	7,591	1,268
18	UNIVERSITY MED.	NV	445	PUB	9,232	1,370	4,375	650
19	PUGET SOUND	WA	160	P	9,045	1,538	6,170	1,049
20	FOUNTAIN VALLEY	CA	287	P	9,004	1,877	5,850	1,219
21	TACOMA GEN	WA	487	NP	8,691	1,503	6,490	1,123
22	ST JOSEPH,TACOMA	WA	340	NP	8,481	1,514	6,255	1,116
23	AMERICAN RIVER	CA	250	NP	8,049	1,311	5,619	915
24	DEACONESS	WA	363	NP	7,983	1,399	6,100	1,069
25	SACRED HEART	WA	631	NP	7,807	1,084	6,409	890
26	ST. MARY'S	NV	367	NP	7,788	1,379	5,148	912
27	LOS ROBLES REG.	CA	208	P	7,680	1,497	7,071	1,378
28	AUBURN GEN	WA	149	P	7,130	1,548	5,540	1,203
29	SOUTHWEST	WA	435	NP	7,071	1,570	5,401	1,199
30	SWEDISH	WA	641	NP	6,925	1,204	6,309	1,097
31	COASTAL COMMUNITIES	CA	215	P	6,136	1,651	6,038	1,625

DATA OBTAINED FROM:
WASHINGTON DEPARTMENT OF HEALTH
CALIF. STATEWIDE HEALTH PLANNING & DEVELOPMENT
NEVADA DIVISION FOR HEALTH RESOURCES & COST REVIEW

OWNERSHIP LEGEND

P = Profit
NP = Non Profit
GOV = Government
PUB = Public

CALIFORNIA AND NEVADA
AVERAGE QUARTERLY NET REVENUE PER ADMISSION

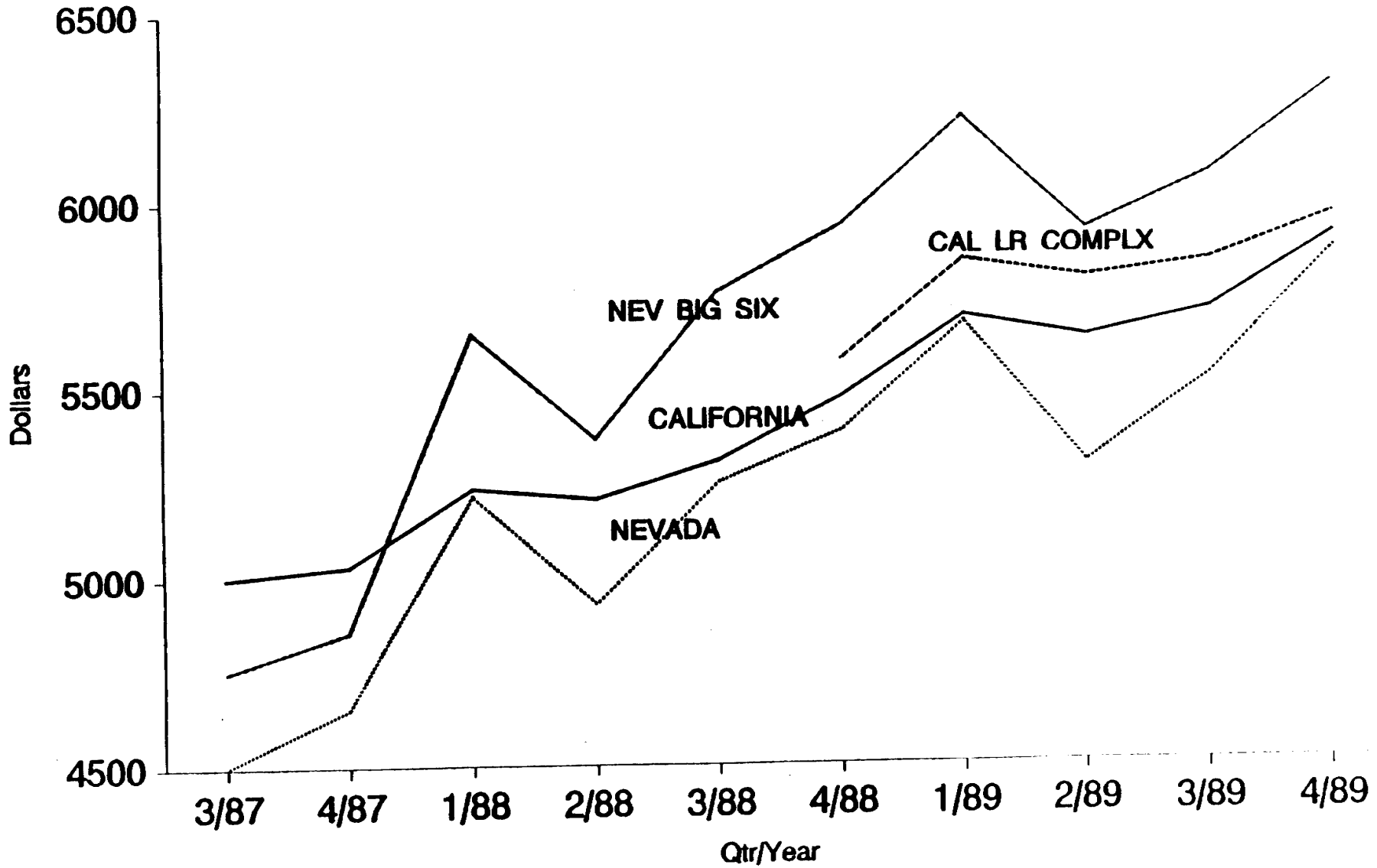


Figure 2

DESERT SPRINGS HOSPITAL
FINANCIAL SUMMARY
FOR THE FISCAL YEARS ENDED 6/30/85 - 6/30/90

	Fiscal Year Ended June 30,					
	1985	1986	1987	1988	1989	1990
GROSS REVENUE	$51,622,013	$58,232,335	$81,858,597	$96,011,564	$115,836,334	$138,990,209
Inpatient	47,619,596	52,087,140	73,249,018	82,717,911	101,910,122	123,858,118
Outpatient	4,002,417	6,145,195	8,609,579	13,293,653	13,926,212	15,132,091
DEDUCTIONS	15,265,990	17,689,703	28,448,428	35,322,067	51,015,940	65,789,473
Inpatient	14,082,370	15,822,928	25,456,329	30,636,768	44,726,443	60,719,731
Outpatient	1,183,620	1,866,775	2,992,099	4,685,299	6,289,497	5,069,742
NET REVENUE	36,356,023	40,542,632	53,410,169	60,689,497	64,820,394	73,200,736
Inpatient	33,537,226	36,264,212	47,792,689	52,081,143	57,183,679	63,138,387
Outpatient	2,818,797	4,278,420	5,617,480	8,608,354	7,636,715	10,062,349
OTHER OPERATING REVENUE	284,064	227,024	379,247	441,131	434,839	343,568
TOTAL OPERATING REVENUE	36,640,087	40,769,656	53,789,416	61,130,628	65,255,233	73,544,304
OPERATING EXPENSES	36,174,334	29,234,412	40,065,185	52,954,882	59,718,129	66,957,770
NET OPERATING REVENUE	465,753	11,535,244	13,724,231	8,175,746	5,537,104	6,586,534
Non-operating revenue	0	0	0	0	0	0
Non-operating expense	600,000	338,622	64,565	2,275,556	3,791,391	3,445,436
REVENUE OVER EXPENSES	($134,247)	$11,196,622	$13,659,666	$5,900,190	$1,745,713	$3,141,098

DESERT SPRINGS HOSPITAL
FINANCIAL SUMMARY
FOR THE FISCAL YEARS ENDED 6/30/85 - 6/30/90

	Fiscal Year Ended June 30,					
	1985	1986	1987	1988	1989	1990
INPATIENT DAYS	42,520	37,514	46,013	54,456	55,106	58,663
ADMISSIONS	7,067	6,042	7,179	8,538	8,806	8,948
AVERAGE LENGTH OF STAY	6.02	6.21	6.41	6.38	6.26	6.56
AVERAGE DAILY CENSUS	116	103	126	149	151	161
OCCUPANCY PERCENTAGE	51.77%	45.68%	56.03%	66.13%	67.10%	71.43%
Adjusted I/P days*	46,347	42,103	51,660	63,498	62,871	65,993
Adjusted admissions*	7,703	6,781	8,060	9,956	10,047	10,066
PER ADJ. ADMISSION						
Gross Revenue	$6,738	$8,621	$10,203	$9,688	$11,573	$13,842
Net Revenue	4,757	6,012	6,674	6,140	6,495	7,306
Op. expenses	4,696	4,311	4,971	5,319	5,944	6,652
Profit	60	1,701	1,703	821	551	654
PER ADJUSTED DAY						
Gross Revenue	$1,120	$1,388	$1,592	$1,519	$1,849	$2,111
Net Revenue	791	968	1,041	963	1,038	1,114
Op. expenses	781	694	776	834	950	1,015
Profit	10	274	266	129	88	100

*Admissions and Inpatient Days adjusted for outpatient and other operating revenue.

HUMANA HOSPITAL SUNRISE
FINANCIAL SUMMARY
FOR THE FISCAL YEARS ENDED 6/30/85 - 6/30/90

	Fiscal Year Ended June 30,					
	1985	1986	1987	1988	1989	1990
GROSS REVENUE	$196,857,908	$216,385,458	$244,058,870	$235,186,531	$319,102,317	$411,234,324
Inpatient	175,718,827	194,891,542	216,673,876	208,770,033	285,877,884	369,737,083
Outpatient	21,139,081	21,493,916	27,384,994	26,416,498	33,224,433	41,497,241
DEDUCTIONS	75,009,336	89,178,575	107,416,023	105,101,398	163,156,951	229,949,721
Inpatient	66,954,651	80,320,324	95,363,246	92,873,390	146,846,586	208,566,142
Outpatient	8,054,685	8,858,251	12,052,777	12,228,008	16,310,365	21,383,579
NET REVENUE	121,848,572	127,206,883	136,642,847	130,085,133	155,945,366	181,284,603
Inpatient	108,764,176	114,571,218	121,310,630	115,896,643	139,031,298	161,170,941
Outpatient	13,084,396	12,635,665	15,332,217	14,188,490	16,914,068	20,113,662
OTHER OPERATING REVENUE	4,559,385	2,704,026	909,569	1,170,258	1,591,267	1,969,723
TOTAL OPERATING REVENUE	126,407,957	129,910,909	137,552,416	131,255,391	157,536,633	183,254,326
OPERATING EXPENSES	114,697,192	102,637,689	102,315,939	112,501,758	130,151,456	156,760,540
NET OPERATING REVENUE	11,710,765	27,273,220	35,236,477	18,753,633	27,385,177	26,493,786
Non-operating revenue	0	0	0	7,479,072	9,575,750	9,022,354
Non-operating expense	0	0	683,043	12,670,562	13,187,937	13,241,672
REVENUE OVER EXPENSES	$11,710,765	$27,273,220	$34,553,434	$13,562,143	$23,772,990	$22,274,468

HUMANA HOSPITAL SUNRISE
FINANCIAL SUMMARY
FOR THE FISCAL YEARS ENDED 6/30/85 - 6/30/90

	Fiscal Year Ended June 30,					
	1985	1986	1987	1988	1989	1990
INPATIENT DAYS	132,871	121,065	122,707	129,258	143,361	158,045
ADMISSIONS	20,241	19,444	19,369	19,346	22,387	24,003
AVERAGE LENGTH OF STAY	6.56	6.23	6.34	6.68	6.40	6.58
AVERAGE DAILY CENSUS	364	332	336	354	393	433
OCCUPANCY PERCENTAGE	53.61%	48.85%	49.51%	52.01%	57.85%	63.77%
Adjusted I/P days*	152,303	136,097	138,731	146,338	160,820	176,625
Adjusted admissions*	23,201	21,858	21,898	21,902	25,113	26,825
PER ADJ. ADMISSION						
Gross Revenue	$8,681	$10,023	$11,187	$10,791	$12,770	$15,404
Net Revenue	5,448	5,943	6,281	5,993	6,273	6,832
Op. expenses	4,944	4,696	4,672	5,137	5,183	5,844
Profit	505	1,248	1,609	856	1,090	988
PER ADJUSTED DAY						
Gross Revenue	$1,322	$1,610	$1,766	$1,615	$1,994	$2,339
Net Revenue	830	955	992	897	980	1,038
Op. expenses	753	754	738	769	809	888
Profit	77	200	254	128	170	150

*Admissions and Inpatient Days adjusted for outpatient and other operating revenue.

ST. MARY'S REGIONAL MEDICAL CENTER
FINANCIAL SUMMARY
FOR THE FISCAL YEARS ENDED 6/30/85 - 6/30/90

	Fiscal Year Ended June 30,					
	1985	1986	1987	1988	1989	1990
GROSS REVENUE	$84,797,000	$85,393,000	$97,877,000	$121,285,528	$139,966,242	$157,540,827
Inpatient	75,545,000	75,033,000	83,722,000	102,282,060	115,039,743	127,332,463
Outpatient	9,252,000	10,360,000	14,155,000	19,003,468	24,926,499	30,208,364
					0	
DEDUCTIONS	12,916,000	15,122,000	21,436,000	36,389,893	45,737,070	55,571,113
Inpatient	11,506,766	13,287,377	18,335,919	32,579,387	38,664,323	48,309,904
Outpatient	1,409,234	1,834,623	3,100,081	3,810,506	7,072,747	7,261,209
NET REVENUE	71,881,000	70,271,000	76,441,000	84,895,635	94,229,172	101,969,714
Inpatient	64,038,234	61,745,623	65,386,081	69,702,673	76,375,420	79,022,559
Outpatient	7,842,766	8,525,377	11,054,919	15,192,962	17,853,752	22,947,155
OTHER OPERATING REVENUE	987,000	1,402,000	1,891,000	1,746,530	2,216,133	2,905,968
TOTAL OPERATING REVENUE	72,868,000	71,673,000	78,332,000	86,642,165	96,445,305	104,875,682
OPERATING EXPENSES	65,383,000	66,929,000	68,829,000	80,092,678	89,798,732	97,721,965
NET OPERATING REVENUE	7,485,000	4,744,000	9,503,000	6,549,487	6,646,573	7,153,717
Non-operating revenue	1,272,000	1,015,000	1,427,000	2,778,319	4,595,500	5,436,754
Non-operating expense	6,001,000	799,000	720,000	1,202,012	992,756	619,730
REVENUE OVER EXPENSES	$2,756,000	$4,960,000	$10,210,000	$8,125,794	$10,249,317	$11,970,741

ST. MARY'S REGIONAL MEDICAL CENTER
FINANCIAL SUMMARY
FOR THE FISCAL YEARS ENDED 6/30/85 - 6/30/90

	Fiscal Year Ended June 30,					
	1985	1986	1987	1988	1989	1990
INPATIENT DAYS	80,294	69,530	70,519	79,009	78,655	73,197
ADMISSIONS	15,024	13,875	12,757	14,049	13,032	11,917
AVERAGE LENGTH OF STAY	5.34	5.01	5.53	5.62	6.04	6.14
AVERAGE DAILY CENSUS	220	190	193	216	215	201
OCCUPANCY PERCENTAGE	59.94%	51.91%	52.64%	58.82%	58.72%	54.64%
Adjusted I/P days*	91,177	80,429	84,035	95,038	97,213	92,233
Adjusted admissions*	17,060	16,050	15,202	16,899	16,107	15,016
PER ADJ. ADMISSION						
Gross Revenue	$5,028	$5,408	$6,563	$7,280	$8,827	$10,685
Net Revenue	4,271	4,466	5,153	5,127	5,988	6,984
Op. expenses	3,832	4,170	4,528	4,739	5,575	6,508
Profit	439	296	625	388	413	476
PER ADJUSTED DAY						
Gross Revenue	$941	$1,079	$1,187	$1,295	$1,463	$1,740
Net Revenue	799	891	932	912	992	1,137
Op. expenses	717	832	819	843	924	1,060
Profit	82	59	113	69	68	78

*Admissions and Inpatient Days adjusted for outpatient and other operating revenue.

UNIVERSITY MEDICAL CENTER
FINANCIAL SUMMARY
FOR THE FISCAL YEARS ENDED 6/30/85 - 6/30/90

	Fiscal Year Ended June 30,					
	1985	1986	1987	1988	1989	1990
GROSS REVENUE	$123,250,680	$134,762,128	$160,690,128	$160,954,977	$177,983,446	$213,772,192
Inpatient	105,454,901	117,731,389	139,013,081	138,188,960	152,455,553	180,171,913
Outpatient	17,795,779	17,030,739	21,677,047	22,766,017	25,527,893	33,600,279
DEDUCTIONS	58,193,416	63,413,381	83,769,027	83,804,415	87,325,939	104,754,151
Inpatient	49,791,051	55,399,433	72,468,612	77,613,880	79,563,627	93,288,070
Outpatient	8,402,365	8,013,948	11,300,415	6,190,535	7,762,312	11,466,081
NET REVENUE	65,057,264	71,348,747	76,921,101	77,150,562	90,657,507	109,018,041
Inpatient	55,663,850	62,331,956	66,544,469	60,575,080	72,891,926	86,883,843
Outpatient	9,393,414	9,016,791	10,376,632	16,575,482	17,765,581	22,134,198
OTHER OPERATING REVENUE	412,400	1,005,908	1,142,225	946,846	913,009	1,821,258
TOTAL OPERATING REVENUE	65,469,664	72,354,655	78,063,326	78,097,408	91,570,516	110,839,299
OPERATING EXPENSES	68,837,521	72,379,122	83,919,473	88,255,090	100,127,614	116,830,020
NET OPERATING REVENUE	(3,367,857)	(24,467)	(5,856,147)	(10,157,682)	(8,557,098)	(5,990,721)
Non-operating revenue	352,630	457,600	216,420	12,093,782	5,377,783	5,502,532
Non-operating expense	0	0	0	0	0	0
REVENUE OVER EXPENSES	($3,015,227)	$433,133	($5,639,727)	$1,936,100	($3,179,315)	($488,189)

Table 3d 1

UNIVERSITY MEDICAL CENTER
FINANCIAL SUMMARY
FOR THE FISCAL YEARS ENDED 6/30/85 - 6/30/90

	Fiscal Year Ended June 30,					
	1985	1986	1987	1988	1989	1990
INPATIENT DAYS	94,870	96,164	107,669	105,078	101,817	109,915
ADMISSIONS	14,871	15,006	17,358	16,352	14,478	16,818
AVERAGE LENGTH OF STAY	6.38	6.41	6.20	6.43	7.03	6.54
AVERAGE DAILY CENSUS	260	263	295	288	279	301
OCCUPANCY PERCENTAGE	59.61%	60.43%	67.66%	65.85%	63.98%	67.67%
Adjusted I/P days*	111,251	110,896	125,343	123,109	119,475	131,524
Adjusted admissions*	17,439	17,305	20,207	19,158	16,989	20,124
PER ADJ. ADMISSION						
Gross Revenue	$7,091	$7,846	$8,009	$8,451	$10,530	$10,713
Net Revenue	3,754	4,181	3,863	4,076	5,390	5,508
Op. expenses	3,947	4,183	4,153	4,607	5,894	5,805
Profit	(193)	(1)	(290)	(530)	(504)	(298)
PER ADJUSTED DAY						
Gross Revenue	$1,112	$1,224	$1,291	$1,315	$1,497	$1,639
Net Revenue	588	652	623	634	766	843
Op. expenses	619	653	670	717	838	888
Profit	(30)	(0)	(47)	(83)	(72)	(46)

*Admissions and Inpatient Days adjusted for outpatient and other operating revenue.

VALLEY HOSPITAL MEDICAL CENTER
FINANCIAL SUMMARY
FOR THE FISCAL YEARS ENDED 6/30/85 - 6/30/90

	Fiscal Year Ended June 30,					
	1985	1986	1987	1988	1989	1990
GROSS REVENUE	$98,685,148	$101,969,004	$120,400,152	$139,100,381	$156,514,814	$186,938,006
Inpatient	91,333,190	93,516,849	110,617,402	127,306,801	144,375,837	166,734,041
Outpatient	7,351,958	8,452,155	9,782,750	11,793,580	12,138,977	20,203,965
DEDUCTIONS	34,793,065	35,459,734	48,853,811	65,415,319	78,334,609	97,973,976
Inpatient	32,201,012	32,520,496	44,884,342	59,990,646	73,562,894	92,379,982
Outpatient	2,592,053	2,939,238	3,969,469	5,424,673	4,771,715	5,593,994
NET REVENUE	63,892,083	66,509,270	71,546,341	73,685,062	78,180,205	88,964,030
Inpatient	59,132,178	60,996,353	65,733,060	67,316,155	70,812,943	74,354,059
Outpatient	4,759,905	5,512,917	5,813,281	6,368,907	7,367,262	14,609,971
OTHER OPERATING REVENUE	793,375	940,056	2,559,920	2,193,386	835,469	858,489
TOTAL OPERATING REVENUE	64,685,458	67,449,326	74,106,261	75,878,448	79,015,674	89,822,519
OPERATING EXPENSES	43,660,106	45,804,944	51,792,981	59,490,003	61,374,095	70,538,718
NET OPERATING REVENUE	21,025,352	21,644,382	22,313,280	16,388,445	17,641,579	19,283,801
Non-operating revenue	0	515,387	935,814	0	490,670	502,040
Non-operating expense	0	120,566	2,429,317	0	1,324,998	1,614,095
REVENUE OVER EXPENSES	$21,025,352	$22,039,203	$20,819,777	$16,388,445	$16,807,251	$18,171,746

VALLEY HOSPITAL MEDICAL CENTER
FINANCIAL SUMMARY
FOR THE FISCAL YEARS ENDED 6/30/85 - 6/30/90

	Fiscal Year Ended June 30,					
	1985	1986	1987	1988	1989	1990
INPATIENT DAYS	69,513	62,027	65,348	74,875	76,462	77,283
ADMISSIONS	10,541	9,873	10,325	11,801	12,163	13,089
AVERAGE LENGTH OF STAY	6.59	6.28	6.33	6.34	6.29	5.90
AVERAGE DAILY CENSUS	190	170	179	205	209	212
OCCUPANCY PERCENTAGE	61.43%	54.82%	57.75%	65.99%	67.58%	68.30%
Adjusted I/P days*	75,712	68,257	72,640	83,101	83,333	87,046
Adjusted admissions*	11,481	10,865	11,477	13,098	13,256	14,742
PER ADJ. ADMISSION						
Gross Revenue	$8,665	$9,472	$10,714	$10,788	$11,870	$12,738
Net Revenue	5,634	6,208	6,457	5,793	5,961	6,093
Op. expenses	3,803	4,216	4,513	4,542	4,630	4,785
Profit	1,831	1,992	1,944	1,251	1,331	1,308
PER ADJUSTED DAY						
Gross Revenue	$1,314	$1,508	$1,693	$1,700	$1,888	$2,157
Net Revenue	854	988	1,020	913	948	1,032
Op. expenses	577	671	713	716	736	810
Profit	278	317	307	197	212	222

*Admissions and Inpatient Days adjusted for outpatient and other operating revenue.

WASHOE MEDICAL CENTER
FINANCIAL SUMMARY
FOR THE FISCAL YEARS ENDED 6/30/85 - 6/30/90

	Fiscal Year Ended June 30,					
	1985	1986	1987	1988	1989	1990
GROSS REVENUE	$113,673,300	$131,545,426	$148,339,875	$166,366,091	$214,861,134	$258,158,129
Inpatient	102,171,084	118,369,378	133,703,430	148,166,776	186,785,132	221,970,196
Outpatient	11,502,216	13,176,048	14,636,445	18,199,315	28,076,002	36,187,933
DEDUCTIONS	26,791,152	34,944,208	44,552,427	58,931,314	87,544,009	115,145,813
Inpatient	24,080,246	31,444,074	40,156,514	54,913,036	78,187,510	104,286,869
Outpatient	2,710,906	3,500,134	4,395,913	4,018,278	9,356,499	10,858,944
NET REVENUE	86,882,148	96,601,218	103,787,448	107,434,777	127,317,125	143,012,316
Inpatient	78,090,838	86,925,304	93,546,916	93,253,740	108,597,622	117,683,327
Outpatient	8,791,310	9,675,914	10,240,532	14,181,037	18,719,503	25,328,989
OTHER OPERATING REVENUE	1,008,132	954,801	1,177,015	1,737,308	1,151,192	1,647,730
TOTAL OPERATING REVENUE	87,890,280	97,556,019	104,964,463	109,172,085	128,468,317	144,660,046
OPERATING EXPENSES	85,047,588	94,294,350	105,579,234	105,763,490	122,230,706	140,269,820
NET OPERATING REVENUE	2,842,692	3,261,669	(614,771)	3,408,595	6,237,611	4,390,226
Non-operating revenue	1,214,517	2,295,546	1,931,029	1,767,915	1,208,842	1,966,032
Non-operating expense	50,147	0	0	1,509,369	0	0
REVENUE OVER EXPENSES	$4,007,062	$5,557,215	$1,316,258	$3,667,141	$7,446,453	$6,356,258

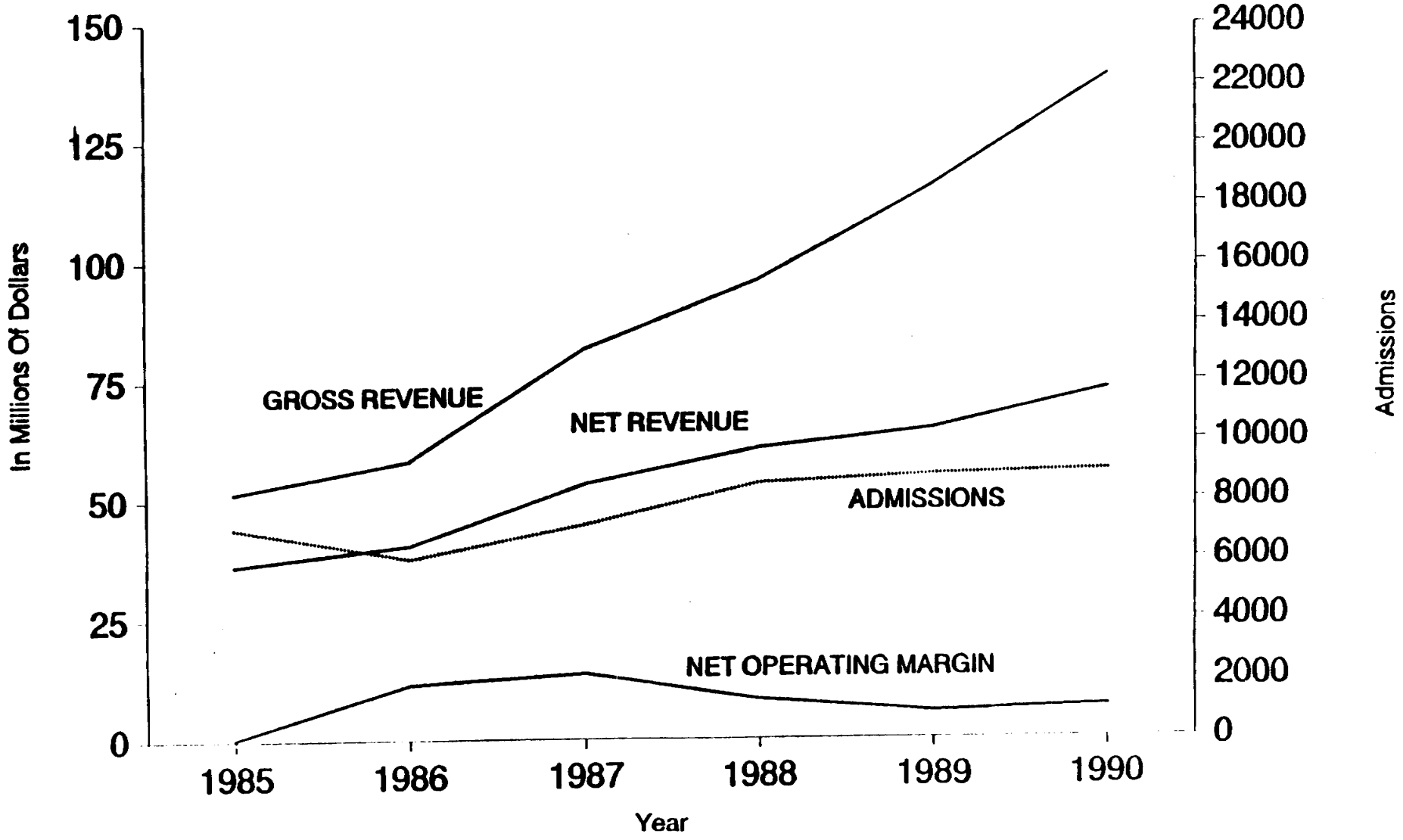
WASHOE MEDICAL CENTER
FINANCIAL SUMMARY
FOR THE FISCAL YEARS ENDED 6/30/85 - 6/30/90

	Fiscal Year Ended June 30,					
	1985	1986	1987	1988	1989	1990
INPATIENT DAYS	107,947	105,918	105,424	96,532	108,467	117,519
ADMISSIONS	19,054	19,503	19,908	14,524	17,003	19,518
AVERAGE LENGTH OF STAY	5.67	5.43	5.30	6.65	6.38	6.02
AVERAGE DAILY CENSUS	296	290	289	264	297	322
OCCUPANCY PERCENTAGE	63.06%	61.87%	61.58%	56.24%	60.16%	61.68%
Adjusted I/P days*	121,165	118,562	117,893	109,521	125,439	137,551
Adjusted admissions*	21,387	21,831	22,263	16,478	19,664	22,845
PER ADJ. ADMISSION						
Gross Revenue	$5,362	$6,069	$6,716	$10,202	$10,985	$11,373
Net Revenue	4,110	4,469	4,715	6,625	6,533	6,332
Op. expenses	3,977	4,319	4,742	6,418	6,216	6,140
Profit	133	149	(28)	207	317	192
PER ADJUSTED DAY						
Gross Revenue	$946	$1,118	$1,268	$1,535	$1,722	$1,889
Net Revenue	725	823	890	997	1,024	1,052
Op. expenses	702	795	896	966	974	1,020
Profit	23	28	(5)	31	50	32

*Admissions and Inpatient Days adjusted for outpatient and other operating revenue.

DESERT SPRINGS HOSPITAL

REVENUE SUMMARY 1985 - 1990



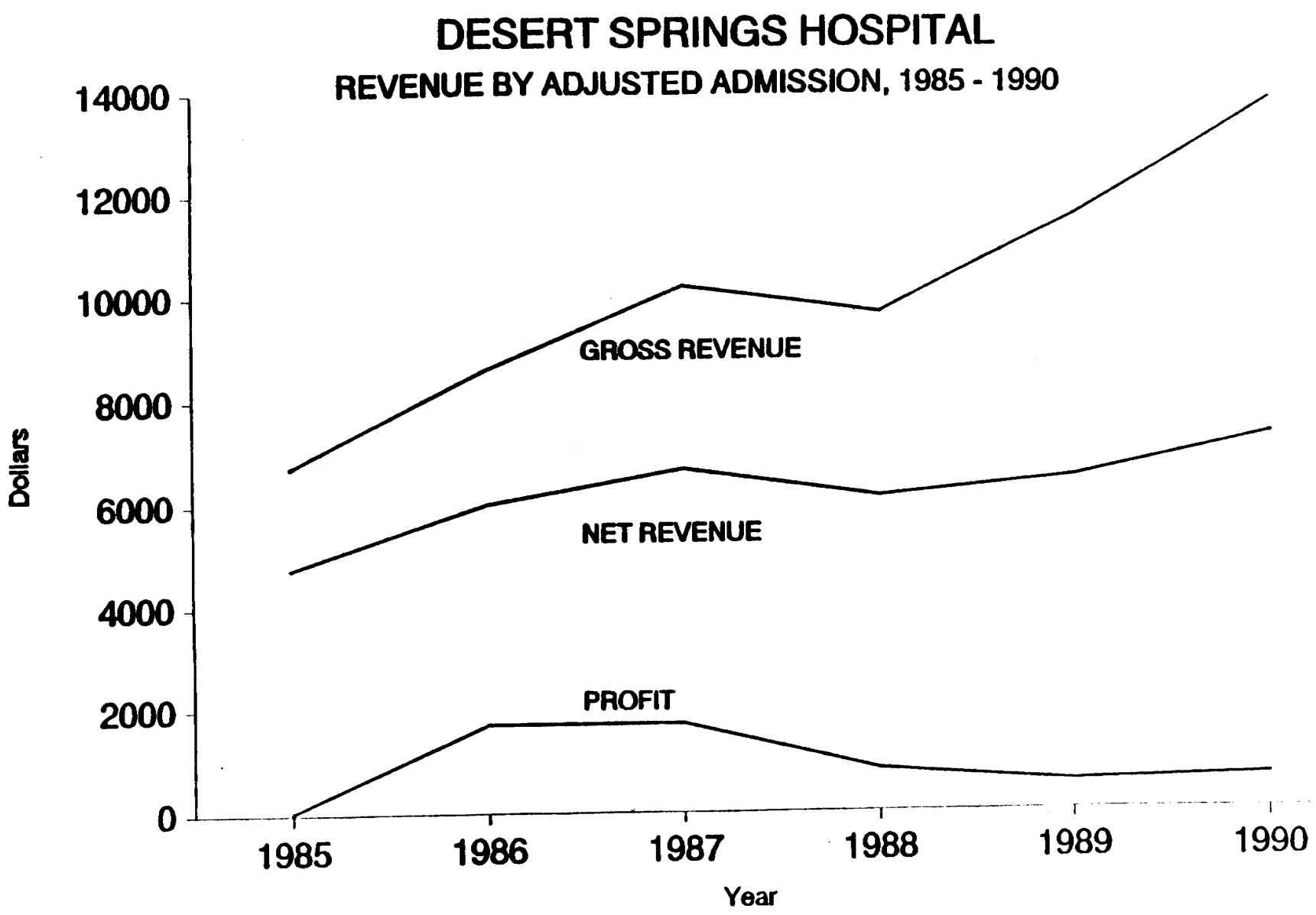
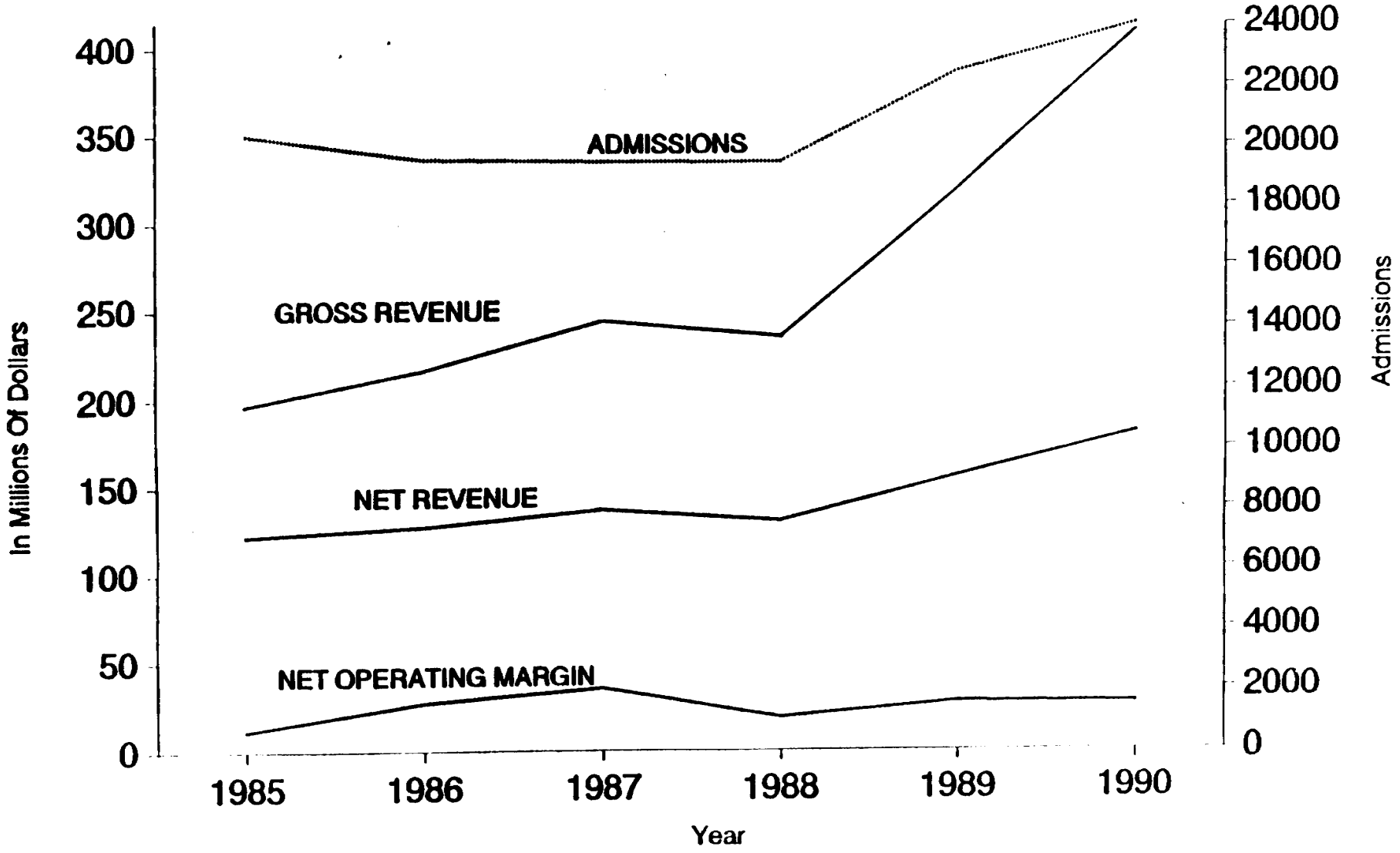

DESERT SPRINGS HOSPITAL
REVENUE BY ADJUSTED ADMISSION, 1985 - 1990
14000
12000
10000
8000
6000
4000
2000
0
Dollars
GROSS REVENUE
NET REVENUE
PROFIT
1985
1986
1987
1988
1989
1990
Year

Figure 3a 2

HUMANA HOSPITAL SUNRISE

REVENUE SUMMARY 1985 -1990



HUMANA HOSPITAL SUNRISE

REVENUE BY ADJUSTED ADMISSION, 1985 -1990

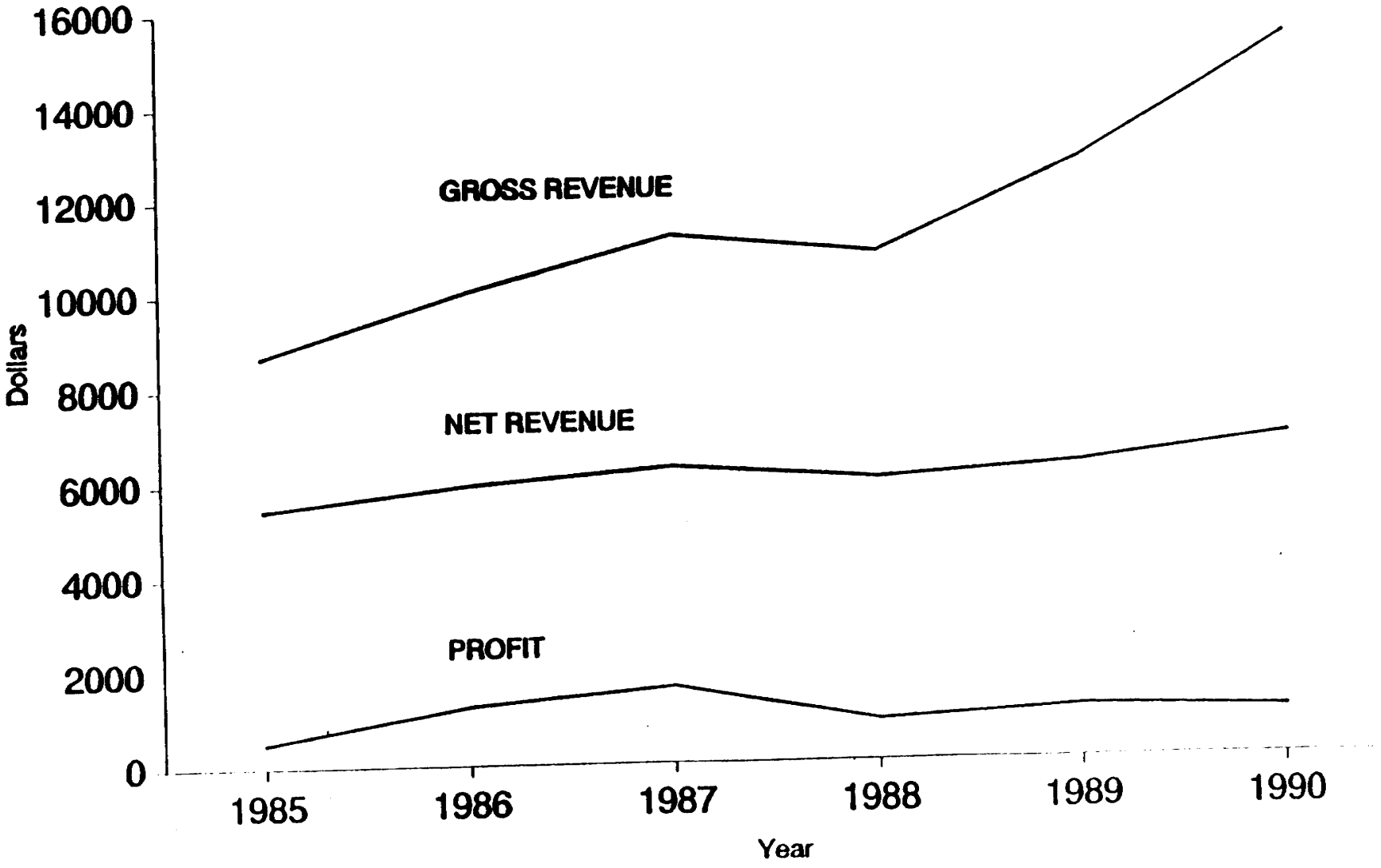


Figure 3b 2

ST. MARY'S MEDICAL CENTER

REVENUE SUMMARY 1985 - 1990

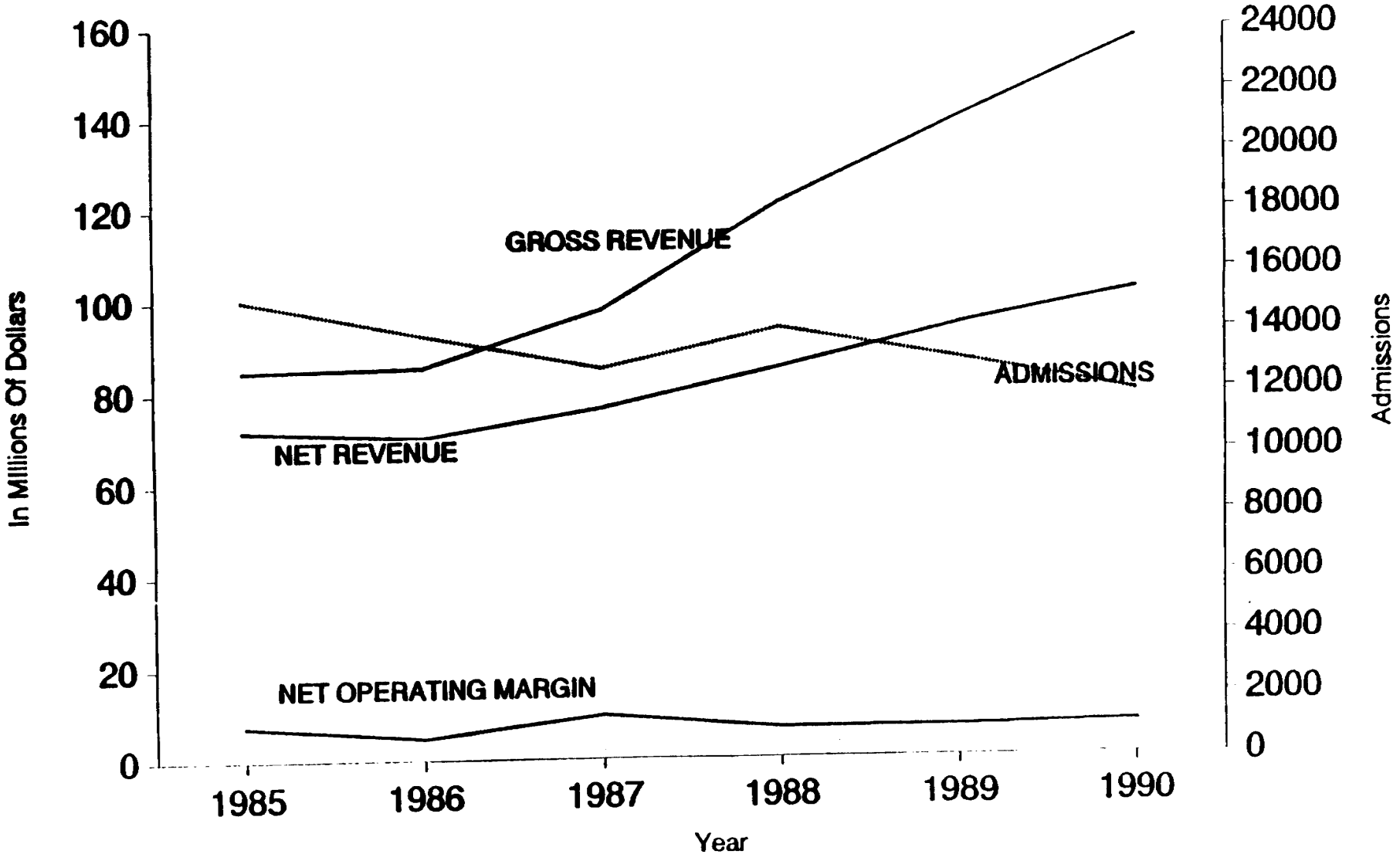
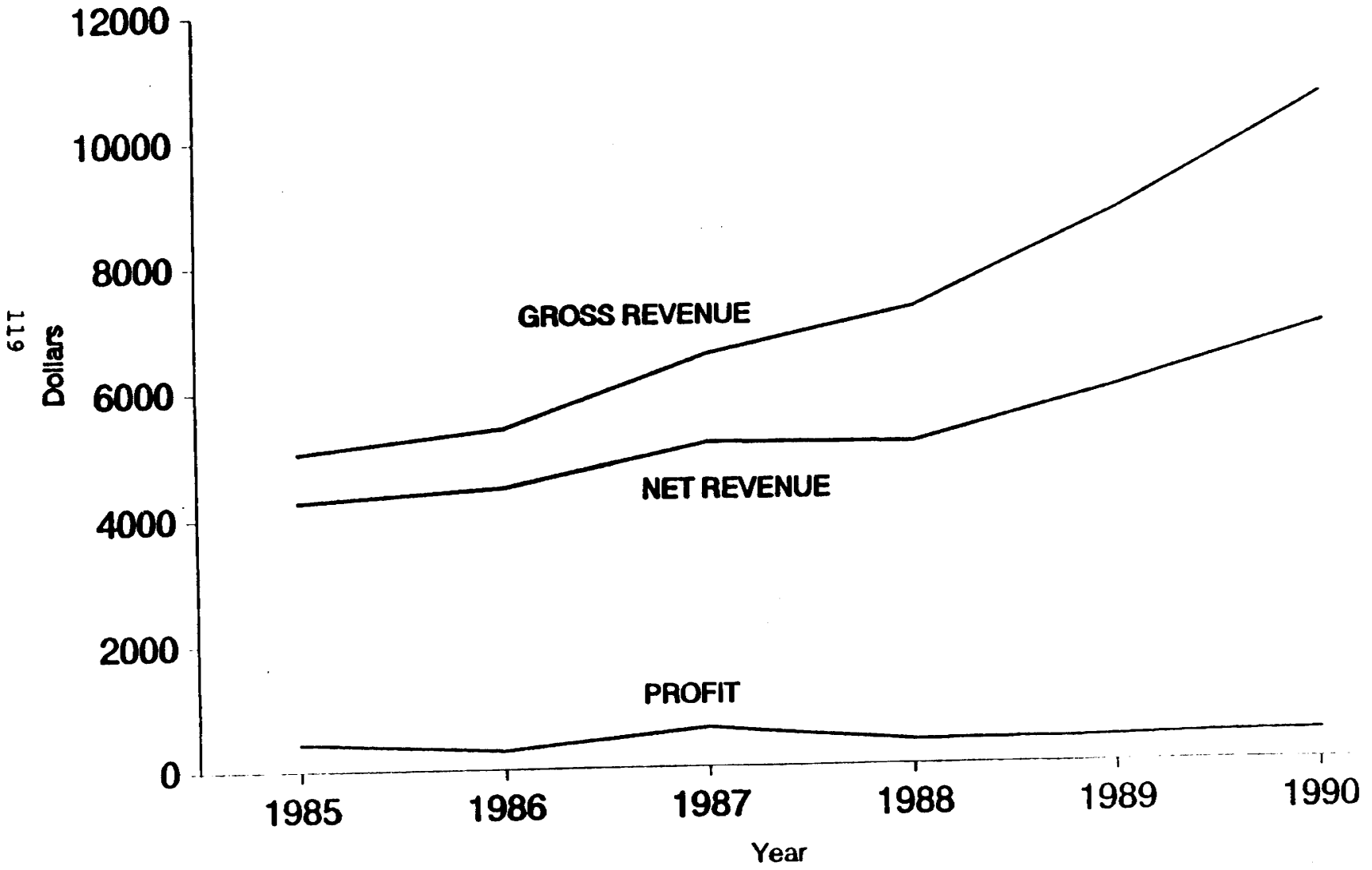


Figure 32

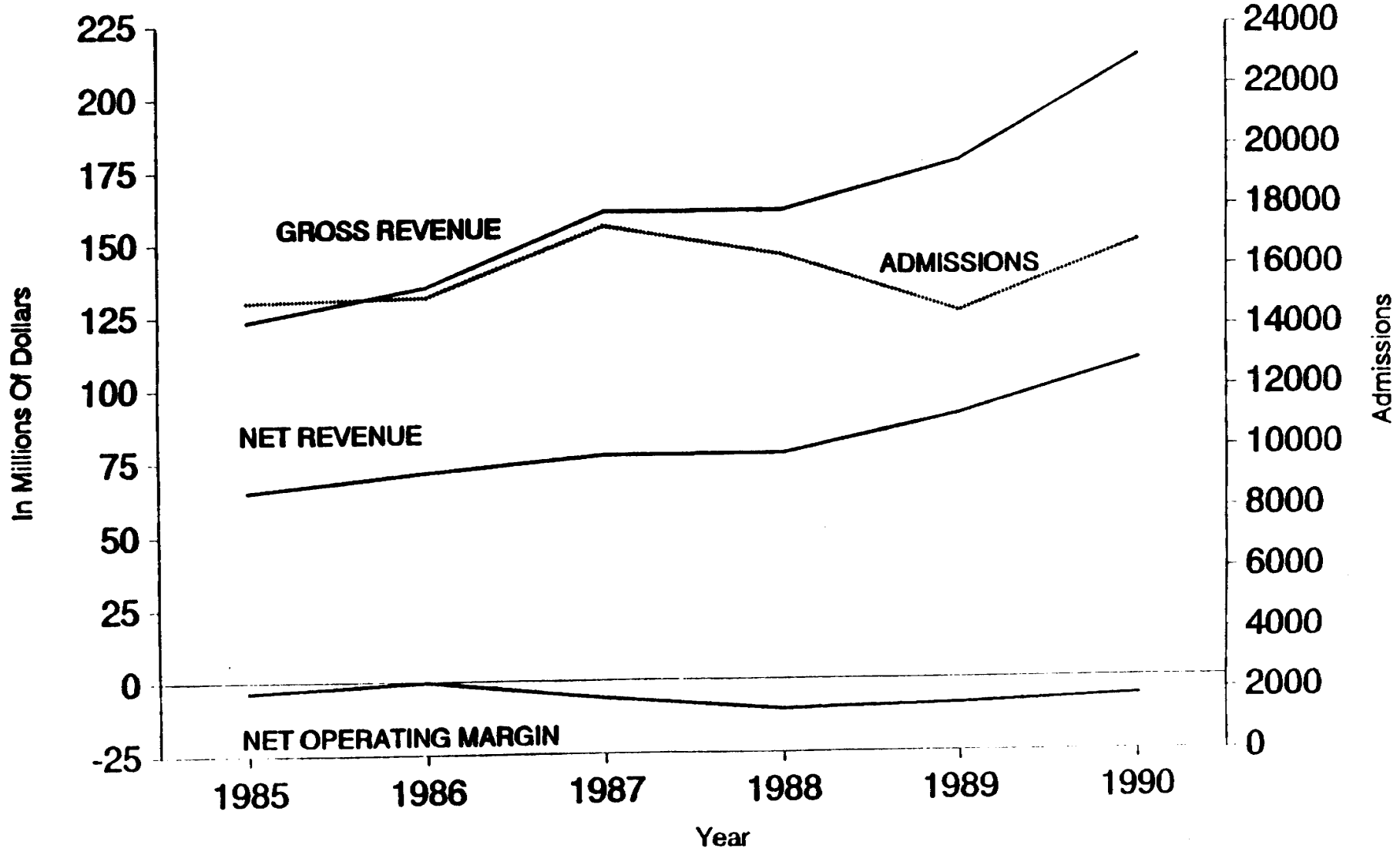
ST. MARY'S MEDICAL CENTER

REVENUE BY ADJUSTED ADMISSION, 1985 - 1990



UNIVERSITY MEDICAL CENTER

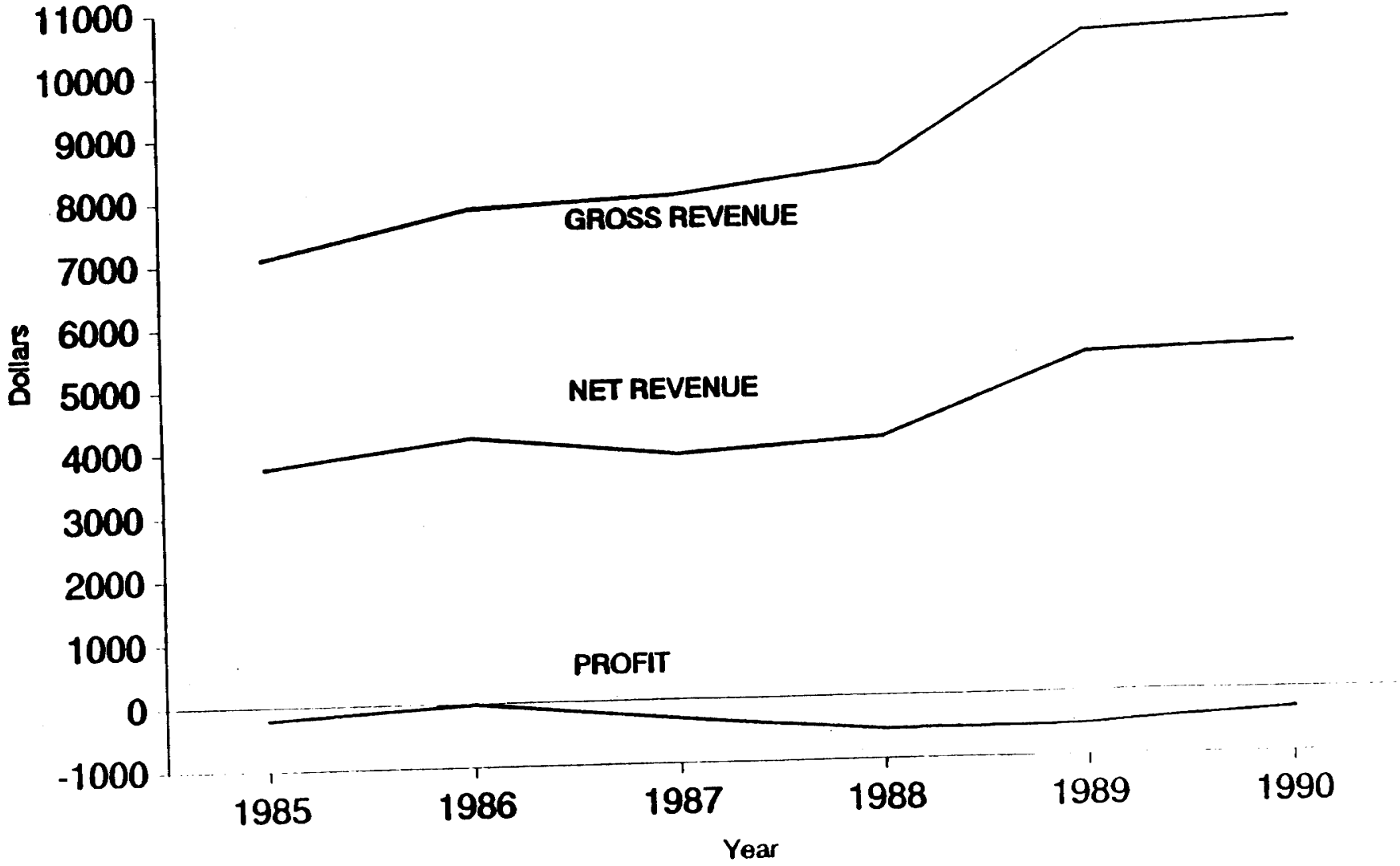
REVENUE SUMMARY 1985 - 1990



120

UNIVERSITY MEDICAL CENTER

REVENUE BY ADJUSTED ADMISSION, 1985 - 1990



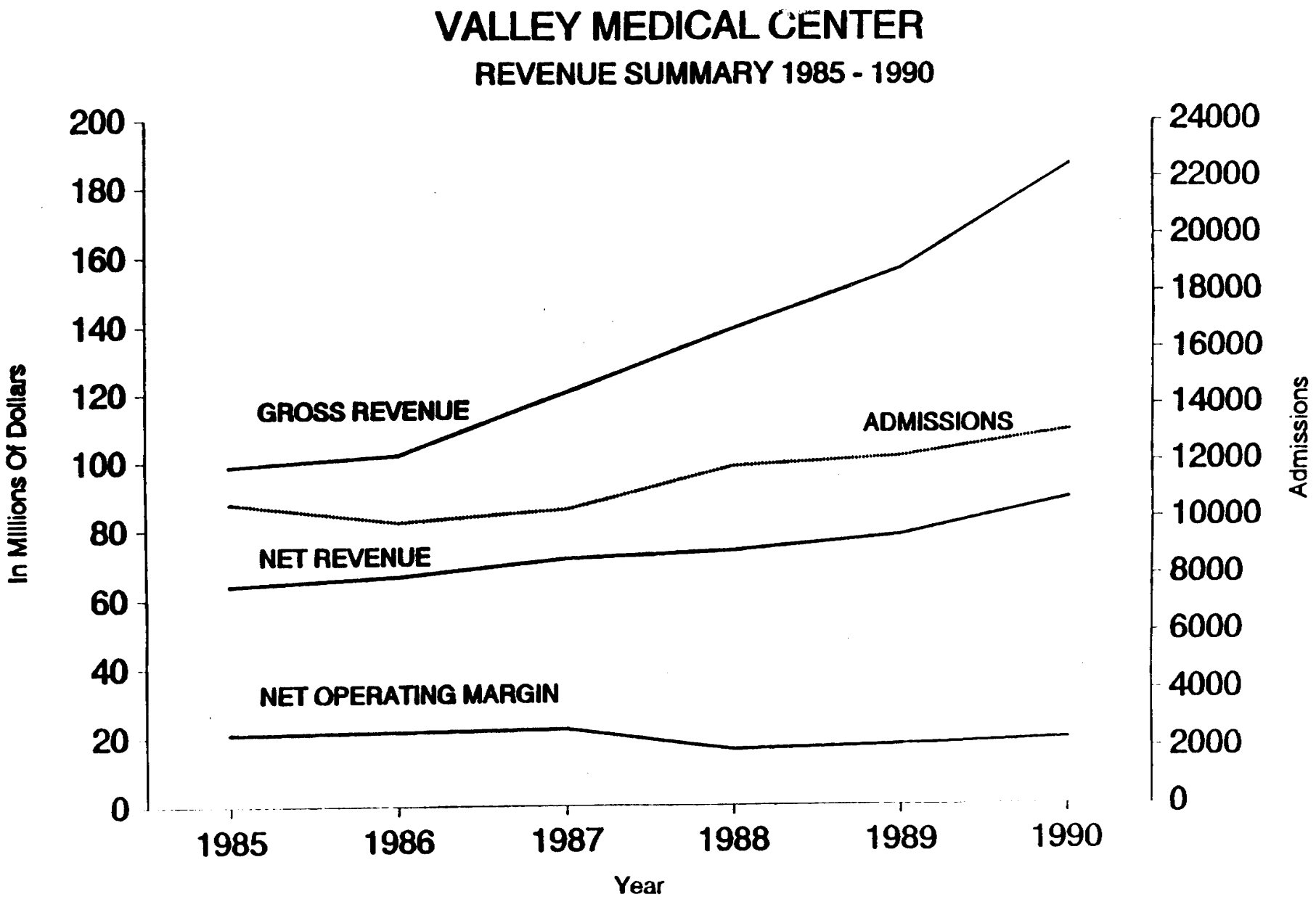

VALLEY MEDICAL CENTER
REVENUE SUMMARY 1985 - 1990
In Millions Of Dollars
Admissions
GROSS REVENUE
ADMISSIONS
NET REVENUE
NET OPERATING MARGIN
200
180
160
140
120
100
80
60
40
20
0
24000
22000
20000
18000
16000
14000
12000
10000
8000
6000
4000
2000
0
1985
1986
1987
1988
1989
1990
Year

Figure 3e 1

VALLEY MEDICAL CENTER

REVENUE BY ADJUSTED ADMISSION, 1985 - 1990

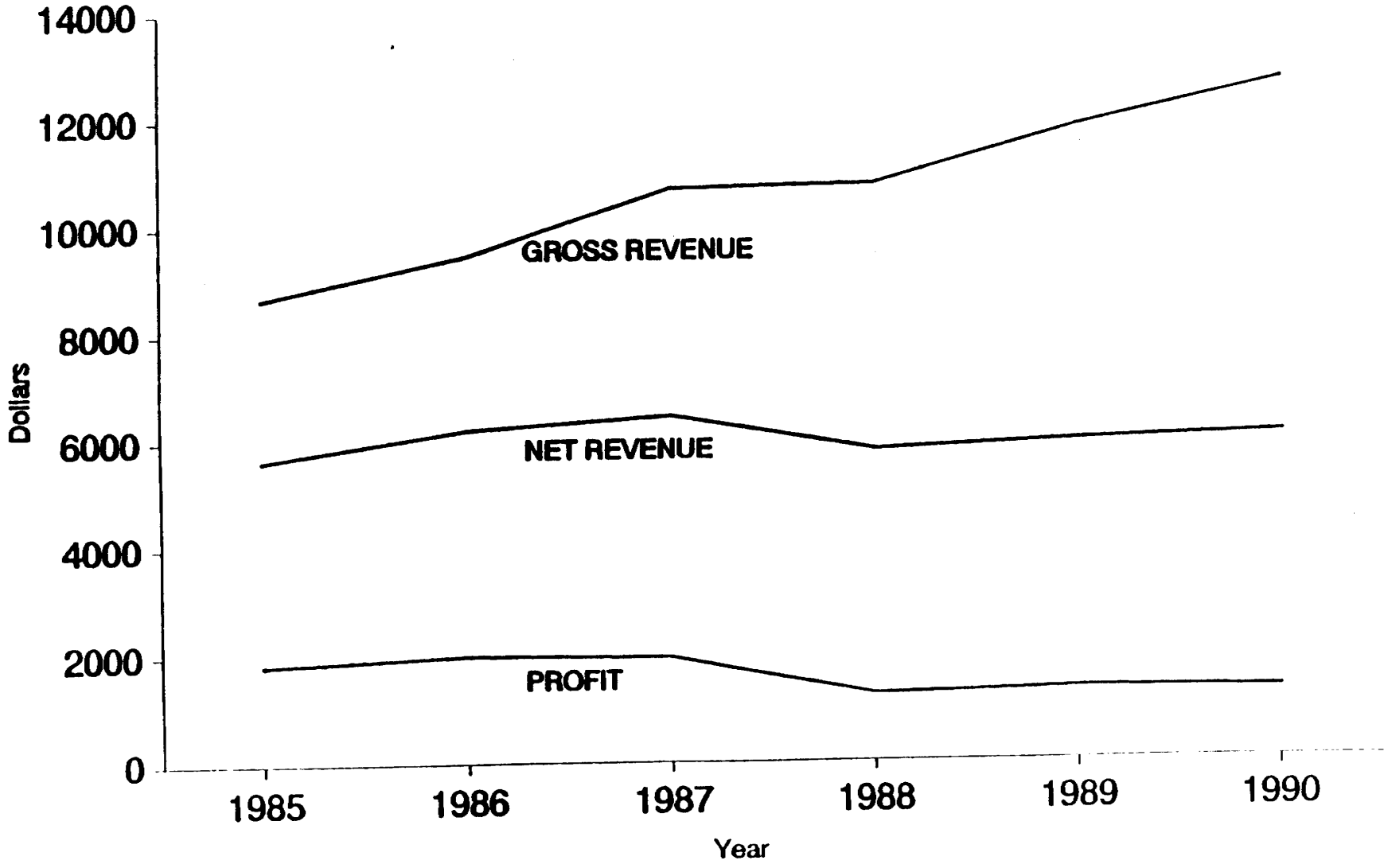


Figure 3e 2

WASHOE MEDICAL CENTER

REVENUE SUMMARY 1985 - 1990

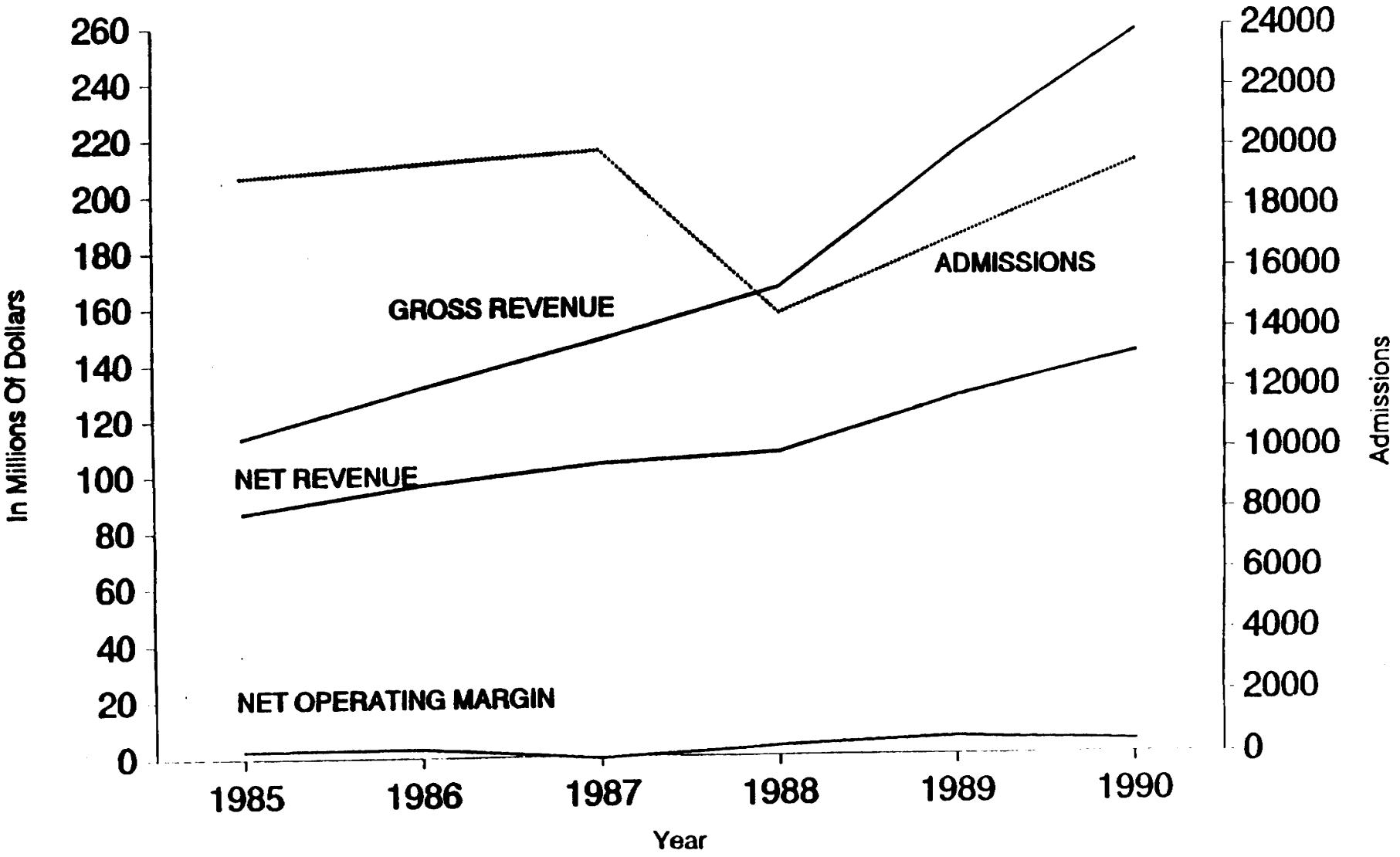


Figure 3 of 1

WASHOE MEDICAL CENTER

REVENUE BY ADJUSTED ADMISSION, 1985 - 1990

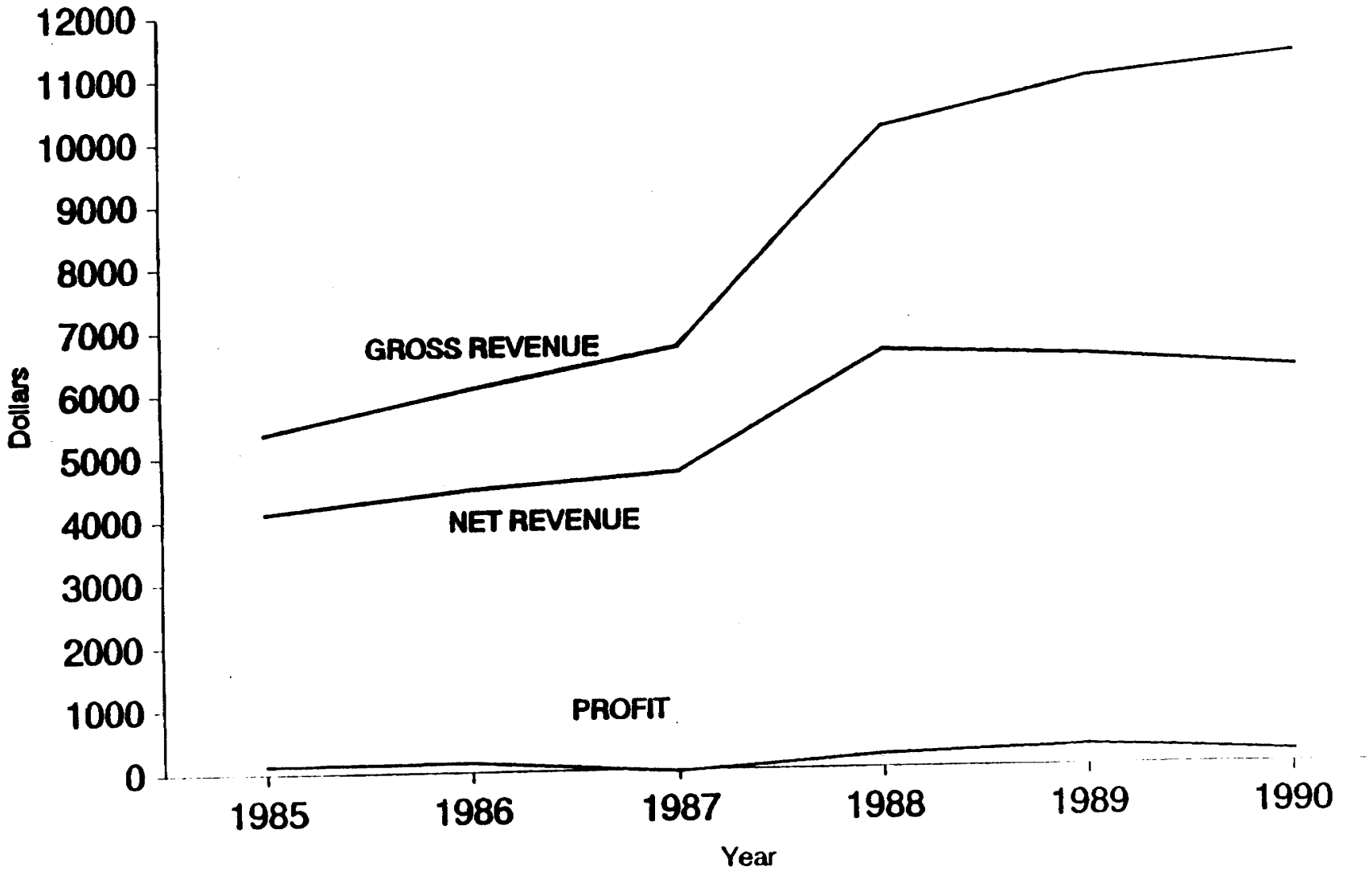


Figure 3F 2

COMPARISON OF NEVADA HOSPITAL DATA TO CONSUMER PRICE INDEX

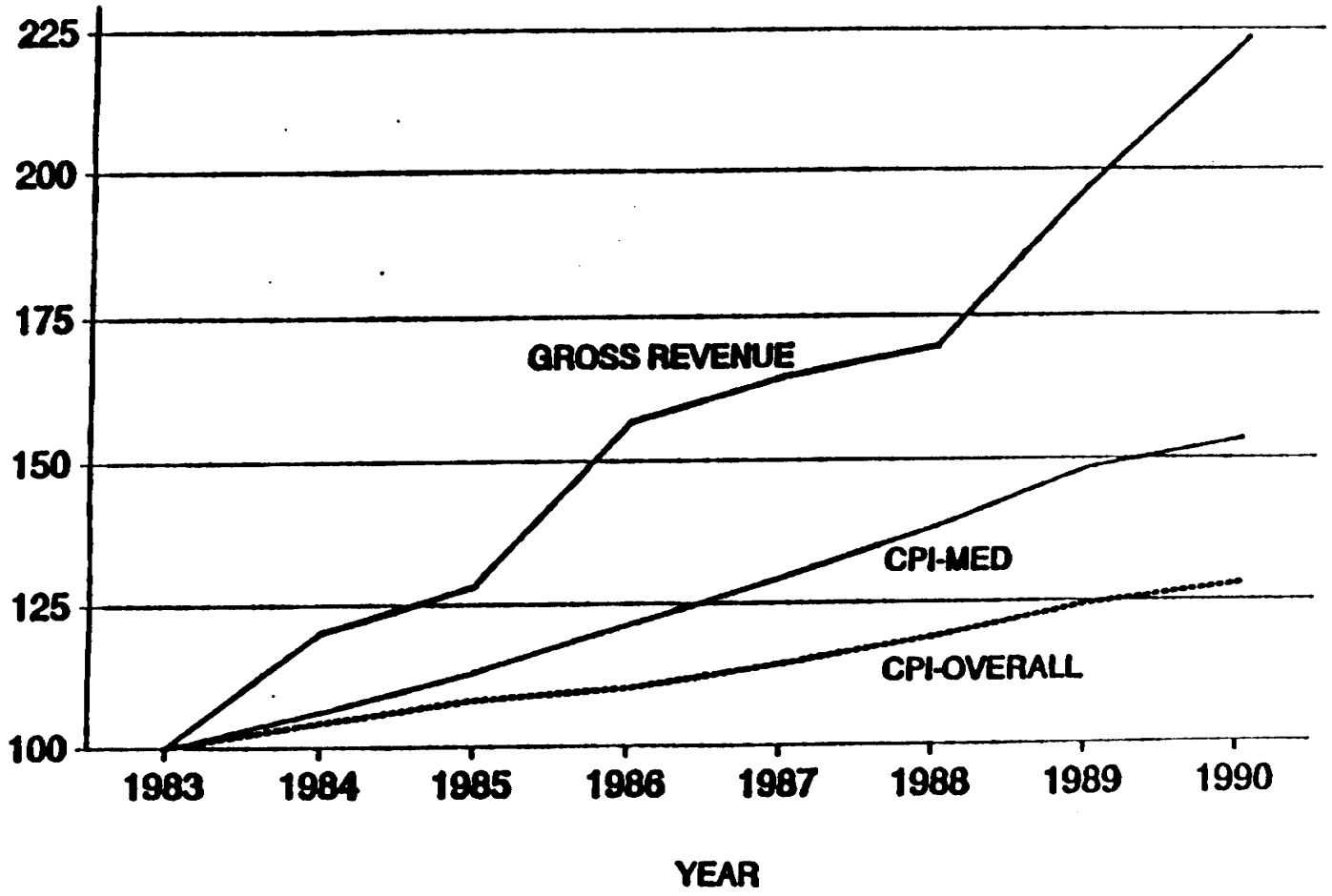


Figure 3.

COMPARISON OF NEVADA HOSPITAL DATA TO CONSUMER PRICE INDEX

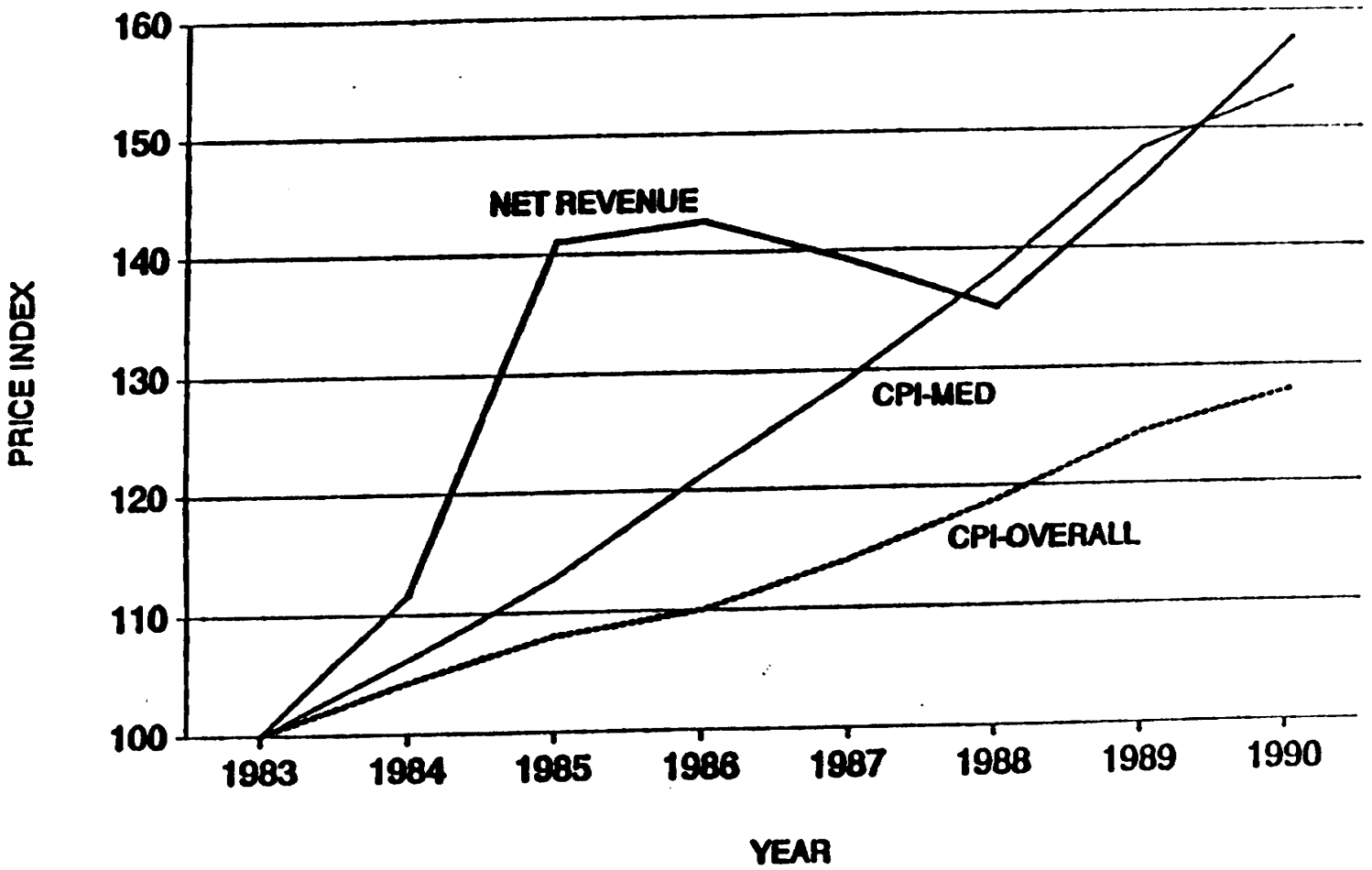


Figure #2

AB289 Compliance
Fiscal Years Ended June 30, 1988-1990

	Desert Springs	Humana Sunrise	Valley Hospital	Total
1988				
Actual reduction	$4,685,200	$11,308,297	$10,670,605	$26,664,102
Required reduction	3,494,151	9,878,425	5,103,931	18,476,507
Excess reduction	1,191,049	1,429,872	5,566,674	8,187,595
1989				
Actual reduction	$3,947,328	$10,650,180	$7,021,387	$19,846,015
Required reduction	3,494,151	9,878,425	5,103,931	18,476,507
Over (under) Required reduction	453,177	771,755	1,917,456	1,369,508
Allowable credits	2,357,489	4,370,635	1,283,309	8,011,433
Carryfoward from FY1988	1,191,049	1,429,872	5,566,674	8,187,595
Excess Reduction	$4,001,715	$ 6,572,262	$8,767,439	$17,568,536
Net Inpatient Revenue (non-Medicare, non-Medicaid)	$27,470,893	$92,815,241	$44,006,268	
Percentage Carryfoward	14.57%	7.08%	19.92%	
1990				
Increase of 4% Above Medical Care Component of Consumer Price Index	10.50%	10.50%	10.50%	
Total Increase Allowable	25.07%	17.58%	30.42%	
Average Gross Revenue Per Day (all patients)	1,849	1,994	1,888	
Target for Fiscal Year 1990	$2,313	$2,345	$2,462	
Average Gross Revenue Per Day	$2,111	$2,339	$2,157	
Target	2,313	2,345	2,462	
Amount under target	$ 202	$ 6	$ 305	

ANALYSIS OF AB 289

REPORT OF THE COMMISSIONER

OF INSURANCE

DEPARTMENT OF COMMERCE

STATE OF NEVADA

MAY 15, 1989

TABLE OF CONTENTS

REPORT ON AB 289 (1987)

I. EXECUTIVE SUMMARY

The Nevada Division of Insurance was given some responsibilities for the review of the reduction of health care costs in Nevada pursuant to AB 289, Chapter 377 of the Statutes of Nevada 1987, at page 862. This bill emphasized the reduction of profits received for inpatient care by three named hospitals. The Nevada Legislature wished to assure that savings for the cost of health care, received by insurers as the result of AB 289, were passed to the consumers in Nevada who purchased health insurance.

Section 58 of AB 289

Included in AB 289 was Section 58, which requires that insurers, health maintenance organizations and non-profit medical service corporations identify and pass on the savings incurred from the reduction in the cost of health care provided in AB 289. As described in this report, the division has adopted regulations to collect certain claims and statistical data from insurers on these reductions. The use of the UB82 form by hospitals for their billings, required by section 37 of AB 289 (NRS 449.485), precludes the identification of the "savings" from AB 289. Therefore, insurers were unable to identify the savings that may have resulted from the revenue reductions mandated by of AB 289.

Through the normal mechanism of group health rate making however, reductions in health care costs would be reflected in the reduced costs and claims experience of Nevada insureds. While insurers are unable to precisely identify the "savings" received from AB 289, the overall effect is that such savings appear to have been passed to Nevada consumers.

In addition, the data collected by the division indicates that the cost of health care, for other than inpatient care, has risen and that such increases may have overwhelmed the savings resulting from the reductions in hospital rates required by AB 289. This impact is particularly noticeable since a relatively small amount of the total dollars spent for health insurance claims was spent for inpatient claims in the three hospitals targeted by AB 289.

Section 54 of AB 289

Section 54 of AB 289 provides that if an insurer and health facility are affiliated corporations, their arrangements for payments for medical services or services by the insurer must meet the tests set forth in this Section. Specifically, if the charges by the health facility were for a cost less than fair market value, the reduction must be passed to the insureds of the affiliated insurer in the form of reduced premiums. This reduction must be certified to the division by the insurer. Only certain insurers

in the state are subject to the provisions of this Section. The division has conducted certain examinations to determine the compliance with this section.

Other Activities

The division has continued its review of the reduction in health care costs through the collection of certain statistical data and continues to assist the Legislature and the Interim Committee by providing additional information as requested. The division continues its examination of insurers to determine compliance with the provisions of AB 289.

II. INTRODUCTION

AB 289, Chapter 377 of the Statutes of Nevada, pages 862 to 891 (1987), contains an amendment to Chapter 680A of NRS and provides for the containment of health care costs through the monitoring of billed charges and net revenues of three specifically named hospitals. The intent of the bill was to reduce the profits received from inpatient treatment at these three hospitals.

The Department of Human Resources and the Division of Insurance both have functions to perform under the bill. The bill also provides for a permanent committee of the Nevada Legislature to review the containment of health care costs and related issues.

The Division of Insurance is effected by two Sections of the bill: Section 54, which amends NRS 680A.320, and Section 58 concerning the reduction of premiums by insurers. These two Sections focus on transactions between affiliated insurers and health facilities and require the reductions in health care costs realized from AB 289 to be reflected in reduced premiums for health insurance to Nevada insureds.

The following report summarizes:

1. The provisions of the bill related to insurance and contains an analysis of the Sections applied to insurers to determine their compliance;

2. The regulatory and review activities of the division related to those Sections of AB 289; and

3. The proposals by the division for future activities.

This report analyzes the legislation starting with Section 58 which affects all insurers and Section 54 which imposes additional duties upon affiliated insurers and health facilities.

III. ANALYSIS OF AB 289

A. SECTION 58 OF AB 289:

This Section of AB 289 (which is not codified in Title 57 of NRS), provides:

> 1. Each insurer, nonprofit corporation for hospital or medical service and health maintenance organization shall identify reductions in payments of claims which result from the provisions of this act and pass those savings on to their policyholders in the form of reduced premiums.
>
> 2. If an entity described in subsection 1 is found, after notice and hearing, to have failed to identify or pass on savings as required by subsection 1, the commissioner of insurance may impose an administrative fine of not more than $5,000 and impose other sanctions authorized by law.

1. ANALYSIS OF STATUTE:

AB 289 required certain hospitals to reduce their revenues by a stated amount. See: Section 55 of AB 289. The hospitals effected by this statute are: Humana Hospital Sunrise, Valley Hospital Medical Center and Desert Springs Hospital. Each hospital must meet this reduction by selecting certain medical services and reducing the charges for those services. The selection of the services, the time when the reduction would be applied and the amount of the reduction was left to the sole discretion of the hospital by AB 289. To assure that Nevada's citizens received the benefit of these reductions directly, the language of Section 58 was added to require insurers to consider the savings received through reduced claims costs when calculating premium rates for insureds. Health maintenance organizations and non-profit medical service corporations are also included in the requirements of Section 58.

Group health insurance contracts are regulated by two primary Chapters of NRS. Chapter 687B of NRS describes insurance contracts and chapter 689B of NRS lists the requirements for group health insurance policies. The division does not approve or regulate group health insurance rates, unlike most other insurance rates.

In simple terms, the theory of group health insurance rates is that an insurer will base a policyholder's group rate upon that particular policyholder's census, for instance, the number and type of employees and dependents in his group, and upon his experience, which is the frequency of claims and the average cost, or severity, of each claim. Consider two employers as group health policyholders, who have a similar number and mix (by age and sex) of employees. The employer whose employees, on average, went to the doctor or hospital fewer times or needed less expensive

services, would have better claims experience. If one employer's experience is better than the average policyholder's experience, he would be charged a smaller premium for the group health insurance than the other employer with higher claim costs.

Under this theory, if a group policyholder's employees used a hospital which was one of the three targeted by AB 289 for revenue reduction, then that policyholder would have his claim costs reduced by the amount that the hospital lowered its charges for the services provided. That policyholder would therefore have a better claims experience which should positively impact his claims history and his premium.

The health care cost containment provisions of AB 289 only targeted hospital inpatient charges for three specifically listed hospitals. Charges for hospital outpatient services and services provided in other settings, such as the physician's office and "free standing" surgical facilities, were not changed by AB 289.

2. PROCEDURES OF DIVISION:

To track the impact of AB 289, the division adopted a regulation requiring claims data to be reported by the health insurers described in Section 58. See: NAC 679B.501 to 679B.551, inclusive (effective January 20, 1988). The reports provided to the division show that an average of 42.4 percent of the claim dollar was spent in the hospital inpatient category, an average of 9.47 percent was spent on hospital outpatient services and an average of 48.01 percent was spent in "other" settings.

Since AB 289 only targeted certain hospitals, the division tracked in which hospitals the claim dollars for inpatient services were spent. Of the total inpatient dollars, an average of 28.75 percent was spent in the three targeted hospitals and an average of 71.25 percent was spent in other hospitals.

Of the total claims dollar paid in Nevada by insurers, only an average of 12.2 percent was spent in a hospital which would have reduced its revenues because of AB 289. This amount is calculated by comparing the total amount of dollars spent in the inpatient setting (42.41 percent) to the amount was spent in targeted hospitals (28.75 percent) for such care. Therefore, only 28.75 percent of the 42.41 percent, or 12.2 percent, was spent in a facility affected by AB 289.

Because AB 289 has a limited impact on the total payments for claims, it is likely that the benefits of the hospital inpatient claim cost reductions have been superceded by cost increases from the non-affected sectors. The division attempted to measure this directly, as opposed to using measures such as increases in the Consumer Price Index for Medical Costs, by comparing the actual prices charged to insurers for the same service over time. For instance, the cost of an appendectomy during different years for various insurers or health maintenance organizations.

Unfortunately, the insurers operating in Nevada (this includes indemnity insurers, health maintenance organizations and nonprofit medical service corporations) either because of the nature of the way that they pay for their services or limitations in their data gathering systems, were unable to furnish useful information for the comparison. In their reports to the division, many of these entities have stated that their overall claims costs have increased and that any savings from AB 289 were overwhelmed by the increases from other services, generally.

3. APPLICATION TO INSURERS IN NEVADA:

Before evaluating how insurers complied with AB 289, the types of policies sold must be reviewed. Traditional indemnity policies reimburse the insured for certain costs incurred when receiving treatment for covered conditions. Those insurance policies can be divided into two types, those with a preferred provider organizations (PPO) and those without.

In a PPO, the insurer has reached an agreement with various providers to accept a specific fee for a specific service. Often, the insurer and preferred provider prepare a fee schedule which is a compilation of the agreed-upon charges. To fully use the benefits of the PPO, the insurer uses differentials in the amount of reimbursement in the policy to encourage the insured to go to the participating physician. Typically, the insured receives a greater reimbursement when he uses a participating physician, and a lower sum when he does not. If a policy does not contain a PPO, the reimbursements are based upon billed charges.

Section 58 of AB 289 requires the described insurers to:

1. "Identify" savings from reductions resulting from AB 289; and

2. "Pass though" the savings to their policyholders in the form of reduced premium charges.

Section 37 of AB 289 (NRS 449.485) establishes the UB 82 Hospital Discharge form as the only billing form acceptable for billing hospital inpatient services. See: Exhibit A. Every inpatient service rendered must be billed to the insurer using a UB 82 form. Unfortunately, the UB 82 does not provide any information about the discount which might have been applied to a particular service by the hospital.

Since each targeted hospital could decide which type of service, when and by how much it would reduce its charge for a service, and since the insurer's bill never reflected these reductions, an insurer would not be able to identify the savings resulting from AB 289.

This situation is not much different for those insurers which had PPO's and those which did not. When negotiating the PPO, a

hospital usually does not provide the insurer with information about why it has agreed to a price for a particular service. Thus, even insurers with PPO's can not identify charges which have been reduced as a result of AB 289.

If insurers can not identify the savings from AB 289, the requirement that the division impose a sanction for the insurer's failure to identify and then pass on the savings becomes a difficult enforcement problem.

Fortunately, even if the insurer could not specifically identify the savings from the intervention of AB 289, the savings should have been passed on as reduced premiums. Consider the circumstance where the insured used the services of a targeted hospital and was charged the reduced prices. Although the insurer might have not known why or by how much the charges were reduced, if that insurer used those reduced claim costs in its rate development then that insured received the benefit of the lower costs. In other words, those insureds received the pass through of those savings, without even knowing that it occurred or why the rate was reduced. The insured would also share in the actual savings on his bill, if any, when he paid his portion of the actual hospital bill, through his copayment or deductible amount under his insurance policy.

Any review of the pass-through of reduced costs to insurers or to insureds in the form of reduced premiums, must consider the passive role of most insurers as third party payors. That is, except for those domestic insurers and health maintenance organizations with very active PPO networks in Nevada, most insurers still pay claims solely on an indemnity basis and do little to control the cost of health care at the source, the medical provider itself, whether a hospital, physician, or other provider. See: "Research Bulletin, Trends in Managed Care," Health Insurance Association of America, February, 1989.

B. SECTION 54 OF AB 289

1. ANALYSIS OF STATUTE:

NRS 680A.320 has been in the Insurance Code, Title 57 of NRS, since 1971 and is related to the provisions for transactions with affiliates found in Chapter 692C of NRS for holding companies. A Section similar to NRS 680A.320 can be found in NRS 692C.360. The standards in these Sections are used to review any transactions between insurers and their affiliates or holding companies.

AB 289 amended NRS 680A.320 by adding definitions of a health facility and subsidiary, and by describing certain payments for services between an insurer and health facility.

The analysis of this section must begin with paragraph (i) of subsection 2 of NRS 680A.320. This subsection states:

> 2. No insurer may engage directly or indirectly in any transactions or agreement with its parent corporation, or with any subsidiary or affiliated person which will result or tend to result in: . . .
> (i) Payment by the insurer for services or products for which the health facility has charged less than fair market value, unless the reduced charge is reflected in the form of reduced premiums. In determining what constitutes fair market value, consideration must be given to reasonable agreements for the preferential provision of health care, in accordance with regulations adopted by the commissioner. An insurer which charges less than fair market value for services or products in a transaction which is subject to the provisions of this paragraph shall annually file a certification with the commissioner that the reduced charge has been reflected in the form of reduced premiums, together with documentation supporting the certification. (Emphasis added.)

First, there is a drafting error in the language of this section, since "An insurer which charges less than . . . ." should read "An insurer which pays . . . ." Section 38 of the revisor's bill, SB 142 (1989) corrects this error.

Second, the paragraph requires that:

1. **An insurer receiving services at less than fair market value from a subsidiary or affiliated health facility must reflect the reduced charges in reduced premiums.**

2. **To determine fair market value, consideration must be given to reasonable agreements for preferred provider agreements (PPO's), in accordance with regulations of the commissioner.**

3. **An insurer receiving those services at less than fair market value must annually certify that its premiums reflect the reduced charges. See also: NAC 679B.541 (effective January 20, 1988).**

The amendments to NRS 680A.320 became effective on July 1, 1987. (See: Section 61 of AB 289).

2. PROCEDURES OF DIVISION:

As a part of a filing for a preferred provider organization (PPO), the division requires that the agreements between the insurer and provider be filed with the Division. This is done to verify that such contracts exist, that requirements for geographic

areas are met, and that other provisions for the contracts comply with the standards used by the Division. Such contracts must also meet the requirements in NRS 689B.061. In reviewing these contracts, the Division does not review the price for services agreed upon between the parties. This is a matter of contract between the parties. Often, such agreed-upon rates and prices are specifically omitted in the documents for the PPO filing since the insurers consider the information to be proprietary in nature.

By accepting a reduced price for its actual cost (as described above) for services in a PPO, the health facility could allow for its profit by recognizing the quick payments by the insurer under the PPO, the volume of patients referred through the PPO and other marketing advantages to the health facility for name recognition or other advantages.

The Division therefore does not, for a standard PPO filing, review whether the price agreed upon is a fair market value, meets the costs of the provider, or is otherwise competitive.

A review of NRS 680A.320 indicates that the term, "fair market value" was not defined by the Legislature. Since an insurer would generally pay the claims submitted to it, whether the price was at, above or below the market value, subject only to the insurance policy's restrictions, such as usual and customary rates, the analysis of fair market value must be made for the health facility.

The limitations in an insurance policy for usual and customary charges are not normally used for bills from hospitals; only for individual providers. In a typical PPO, the hospital's charges would be reduced by a percentage of discount from billed charges or a flat per diem rate for a specific level of care, for example, medical or surgical; intensive care; neonatal care; etc. For the purpose of the division's analysis, "per diem" means a flat rate charged by a hospital per day for inpatient care for the covered services described in the policy and PPO contract. The covered services are usually defined in the health insurance policy for the information of the insured and referred to in the PPO contract.

Legal definitions of the term "fair market value" are used primarily for real estate and tax transactions. These definitions focus on an arms-length transaction between a willing buyer and seller, made without compulsion and made with regard to the monetary cost or incentives to each party. See: Black's Law Dictionary and Corpus Juris Secundum.

In the legislative history for AB 289, there was some limited discussion on the term "fair market value," including a request that the bill be amended to refer to "customary charges". See: Minutes of the Nevada State Legislature Assembly Committee on Health and Welfare, April 7, 1987, on page 739 and 740. See also: Senate Committee on Human Resources and Facilities, May 22, 1987, on page 1026. While the legislative history centers on the "cost" to the hospital or its "charges", the actual language adopted by

the Legislature requires the commissioner to determine fair market value after considering reasonable agreements for PPO's.

To review any transaction between the insurer and its affiliates, the division would apply the standards in NRS 680A.320 and Chapter 692C of NRS. In any such transaction between affiliates, whether it was made at arms-length would be immediately subject to review by the division.

Several methods can be used to establish fair market value. Fair market value could be determined by a review of a hospital's cost. The cost could be set at a minimum value based upon several items, for example:

1. The actual cost of services plus a reasonable rate of return, plus a reasonable sum for contingencies;

2. The Diagnostic Related Groups (DRG) for that health facility; or

3. The semi-private room rate, since each inpatient hospital bill contains this component.

Fair market value could also be determined by comparing the other PPO agreements between hospitals and other insurers, health maintenance organization or other payers. This appears to be the standard contemplated by the Nevada Legislature. See: NRS 680A.320 and Legislative History, supra.

As noted above, when reviewing PPO agreements for the filing of insurance contracts, the Division does not review the prices charged. However, since AB 289, by amending NRS 680A.320, requires such a review, the Division has established the following procedures.

The price set by an insurer and health facility will be compared against the following:

1. Contracts between the insurer and health facility being reviewed and similarly situated providers in that same geographic area.

2. The cost to the provider in that geographic area to provide its services. For this comparison, "cost" means:

   (a) The semi-private room rate;
   (b) The average daily hospital cost in Nevada; and
   (c) DRG's.

3. The charges by the provider to government payors (Medicare and Medicaid) for similar services.

4. Contracts between other insurers or self-insured employers and other providers in the same area for similar services.

For the purpose of this review, "same geographic area" will mean the following three areas in Nevada:

1. Clark County;
2. Washoe, Carson City and Douglas counties; and
3. All other counties of Nevada.

All of these standards must be reviewed in light of the insurer's and provider's corporate affiliation, mutual bargaining power, ability to pay promptly, volume, utilization review agreements, and other mutual business considerations.

When applied against each of these tests for fair market value, the reasonableness of the contract for the PPO can be measured and the reduction of premiums can be reviewed.

Pursuant to Section 23 (effective July 1, 1987) and subsection 11 of Section 55 of AB 289 (effective June 10, 1987), existing contracts by health facilities with insurers or other persons remained effective. Therefore, contracts for preferential rates existing on June 10, 1987 or July 1, 1987, could be amended to comply with AB 289 at the termination of the contract, by agreement of the parties, or upon the lapse of the contract for any other reason. Without such changes in the contract, it appears that those preferential terms could remain in place, without review under the fair market value test in NRS 680A.320.

Once a determination is made that a price for services in a PPO contract is less than fair market value, and that the health facility and the insurer are affiliated corporations, then the insurer must certify to the commissioner that the premiums charged reflect the reduced costs under the PPO. The burden would shift to the insurer to show that such reduced costs have been passed to its insureds as a benefit from the PPO.

Section 54 of AB 289 does not indicate whether the calculation for reduced premiums, based upon the reduced charges, should be based upon the aggregate experience of all insureds or for each individual policyholder. Again, the Legislative History and the bill do not address this issue. Absent such direction in the statute, the division will accept certifications by insurers indicating that, on a gross basis using actual paid claims, the reductions in the claims were reflected as reduced premiums for all insureds in the aggregate. Section 54 of AB 289 is interpreted by the division to require a reduction in rates on a gross basis (total premiums collected to total losses paid), rather than on a per policy or individual basis (premiums charged to each policyholder for his individual claims).

3. APPLICATION TO INSURERS IN NEVADA:

To apply Section 54 of AB 289, there must be a health facility, as defined in NRS 680A.320, which is affiliated with the insurer. According to NRS 439.015, a health facility means:

> . . . a facility in or through which health services are provided, except for the office of a practitioner used solely to provide routine services for health to his patients. The term includes any parent, affiliate, subsidiary or partner of such a facility and any other entity which has a primary purpose of providing a benefit to such a facility. For the purposes of this section "office of a practitioner solely to provide routine services for health to his patients" does not include:
>
> 1. A facility which is or will be qualified to receive reimbursement, other than for the services of a practitioner, as a health facility from any public agency.
>
> 2. A facility which contains or will contain medical equipment which meets the threshold for review of costs pursuant to paragraph (d) of subsection 2 of NRS 439A.100.

When describing the fair market value for services in NRS 680A.320, the Legislature did not limit the review of these transactions to only those three targeted hospitals in Section 55 of AB 289.

Upon review of the division's records, the following affiliations are noted:

INSURER	**HEALTH FACILITY**
Humana Health Insurance of Nevada, Inc.	**Humana Sunrise Hospital, Inc.**
Valley Wide Insurance Company	**Valley Hospital Medical Center and Sparks Family Hospital**

HEALTH MAINTENANCE ORGANIZATIONS	HEALTH FACILITY
Hospital Health Plan, Inc.	Washoe Medical Center
Health Plan of Nevada, Inc.	Southwest Medical Associates, Inc.
Maxicare/UHS Nevada, Inc.	Valley Hospital Medical Center and Sparks Family Hospital

The HMO's are not subject to scrutiny under NRS 680A.320 since that statute does not apply to them pursuant to NRS 695C.050 and 695C.055. Regulations adopted by the division in NAC 695C.122 do require filings of holding company statements pursuant to Chapter 692C of NRS.

Transactions between the HMO's and their related health facilities therefore are not reviewed by the division under NRS 680A.320, as amended in AB 289. The division uses other regulatory authority to review such transactions.

For the insurers, Valley Wide Insurance Company was licensed on November 1, 1985 and its certificate of authority was suspended on February 23, 1988. This insurer's relationship and charges for services by the affiliated health facilities are therefore subject to NRS 680A.320, as amended on July 1, 1987, only if its PPO contracts were amended between July 1, 1987 and February 23, 1988.

The remaining insurer, Humana Health Insurance of Nevada, Inc., is subject to the review under NRS 680A.320 for transactions with Humana Hospital Sunrise. An outline of the PPO contracts between these two affiliates is contained in Exhibit B.

IV. ADDITIONAL DIVISION ACTIVITIES

In addition to the analysis and reviews under Sections 54 and 58 of AB 289, the division has taken an active role in regards to other matters related to AB 289.

A. AB 289 LEGISLATIVE INTERIM COMMITTEE MEETINGS:

The authority of the AB 289 Legislative Committee to review insurance activities related to health care is set forth in Section 20 of AB 289 and includes:

> 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. . . .

6. Examine medical malpractice. . . .

10. 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 9, inclusive. . . .

14. Conduct investigations and hold hearings in connection with its review and analysis. . . .

17. Recommend to the legislature as a result of its review any appropriate legislation.

During each meeting of the interim committee, the division reviewed the agenda, consulted with appropriate staff of the legislative counsel bureau, responded to any written or verbal request by the committee or its individual members, provided any written documents needed by the committee, and had an appropriate staff member of the division attend its meetings.

Subjects reviewed by the committee and for which the division provided assistance included:

1. Medical Legal Screening Panel, its sunset, composition, and effectiveness.

2. Medical Malpractice, rates, coverages, etc.

3. Health Insurance Risk Pools, whether for the medically uninsurable or indigent.

4. Insurance costs generally, and results of data collected by division.

5. Operations of health maintenance organizations, generally.

6. Other subjects, upon request.

B. **REGULATIONS:**

On January 20, 1988, the division adopted regulations for the collection of data from insurers and their payments to certain hospitals and other providers in Nevada. See: NAC 679B.501 to 679B.551, inclusive. The division hoped that this data would show whether the insurers were experiencing any reduction in the costs of claims from AB 289 or whether the increases in other health care costs would cause premiums to rise. These reports have been summarized to the AB 289 committee and made available to other persons upon request. Since the data has only been collected for

a short period of time, there are some questions about the accuracy of the conclusions to be drawn from the reports. In addition, to compare the data to that collected by the department of human resources is impossible, since their data is collected on gross charges from the UB 82 billing form without regard to any contractual discounts or other arrangements for payment between the providers and insurers.

C. EXAMINATIONS:

The division hired Lamar Walker and Associates, Inc., an actuarial firm, to conduct certain examinations of the rating practices of some insurers to confirm the premiums charged and determine if the savings from AB 289 were reflected in the premiums charged. Several domestic insurers, HMOs, non-profit medical service corporations, and foreign insurers were examined. Not all of these examination reports have yet been completed and made public.

The examination of Humana Health Insurance of Nevada, Inc. was only one of the examinations conducted by this firm.

The division staff has also sent two of its own examiners into these same entities to review compliance with the new PPO law, NRS 689B.061 and 695B.185. The division also changed its review of PPO's and its procedures to conform to the requirements of these statutes.

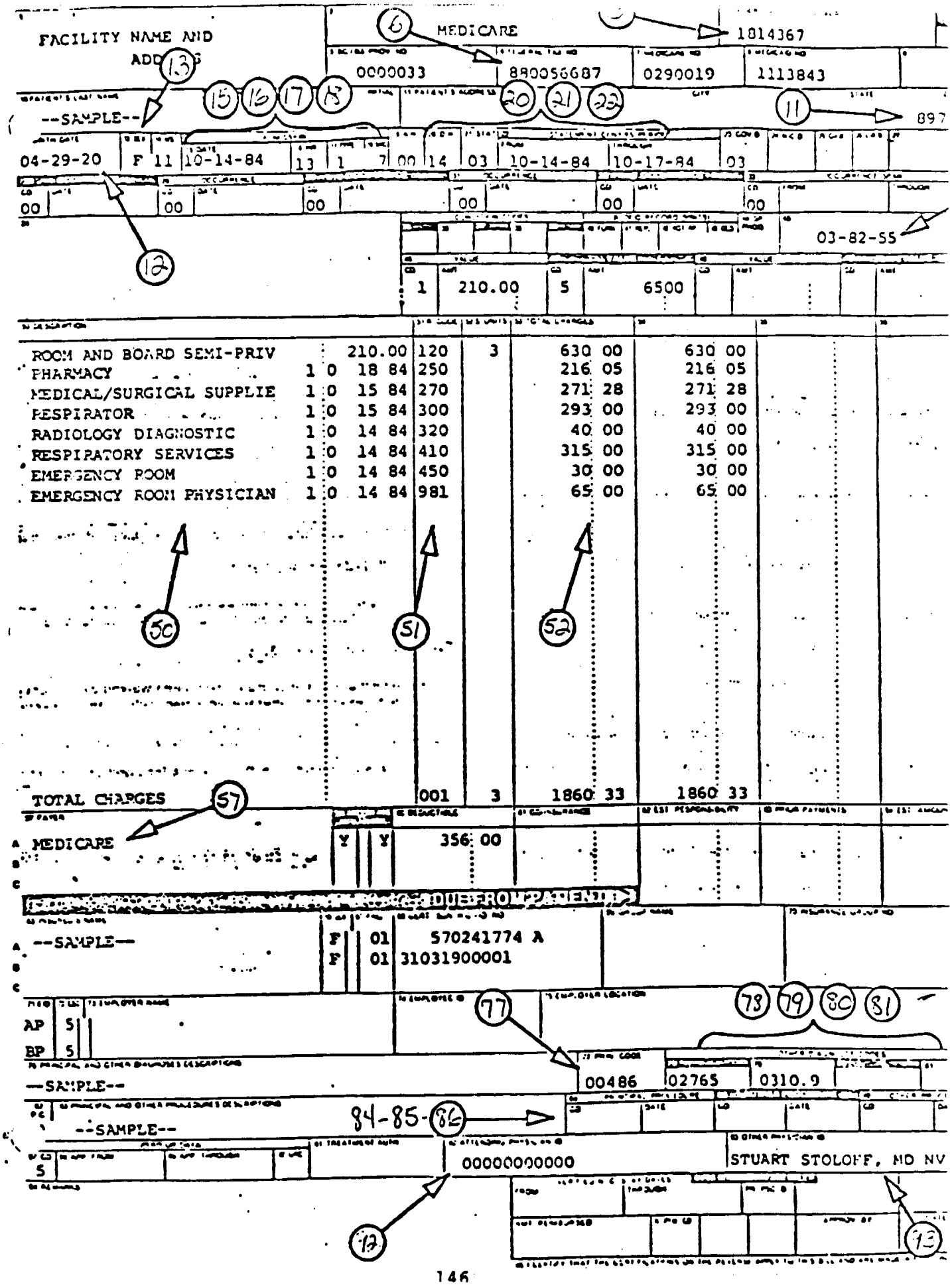
D. ADDITIONAL ACTIVITIES:

The division plans to conduct the following activities:

1. Completion of the examinations conducted concerning compliance with AB 278 and AB 289.

2. Continuation of the data collection pursuant to NAC 679B.50 to 679B.551, inclusive, and the analysis of that data.

3. Completion of its review and any administrative or disciplinary actions necessary under Sections 54 and 58 of AB 289, particularly for affiliated insurers and health facilities.


FACILITY NAME AND
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RESPIRATORY SERVICES 1 0 14 84 410 315 00 315 00
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CHART #5

INFORMATION BLOCK LOCATIONS TO BE CAPTURED
FROM THE UB-82 FORM

#3 - PATIENT CONTROL (ID) NUMBER
#6 - PROVIDER ID NUMBER
#11 - PATIENT ZIP CODE
#12 - PATIENT BIRTH DATA/AGE
#13 - SEX
#15-18 - ADMISSION INFORMATION
#20 - DISCHARGE HOUR
#21 - PATIENT DISPOSITION (STATU
#22 - STATEMENT COVER PERIOD
#45 - MEDICAL RECORD NUMBER
#50-53 - INDIVIDUAL CHARGE CATEGORIES
#68 - SSN
#57 - PRINCIPAL SOURCE OF PAYMENT
#77 - PRINCIPAL DIAGNOSIS
#78-81 - OTHER DIAGNOSIS
#84 - PRINCIPAL PROCEDURE/DATE
#85-86 - OTHER PROCEDURES/DATES
#92 - ATTENDING PHYSICIAN ID
#93 - OTHER PHYSICIAN ID

ITEM 57

PAYER IDENTIFICATION

Name and, if required, number identifying each payer organization from which the provider might expect some payment for the bill.

FORMAT: Last 5 characters on Line 57A reserved for State-required 98 codes

Maximum Characters: 3 fields, 25 characters each.

BC/BS	CHAMPUS	Commercial Insurance	Medicaid	Medicare	State	SIIS
R*	R	R**	R	R***	R****	R

*BLUE CROSS: When billing Blue Cross/Blue Shield as primary payer, enter "Blue Cross/Blue Shield" and the appropriate plan code number from the list on the following page.
CRIPPLED CHILDREN (BCCS): If the child is covered by Medicaid, then Medicaid is listed as the primary payer even when on the Crippled Children's Program.

**COMMERCIAL: When billing a Commercial Insurance enter the appropriate plan code number and name from the Commercial Insurance List.

***MEDICARE: If Medicare is entered in line 57A, this indicates that the provider has developed for other insurance and has determined that Medicare is the primary payer.

****STATE: Use of the following 98 codes on line 57A (last five characters) is required for all patients:

98910	Medicare
98911	Black Lung
*98912	Charity - no expectation of payment from <u>any</u> source at the time of provision of service.
98913	Hill-Burton
98914	CHAMPUS
98915	CHAMPVA
98916	Nevada Medicaid
98917	Other Medicaid
*98918	Self Pay - no insurance, but with expectation of payment from patient or guardian.
*98919	Miscellaneous - those not included on this list or, insurance other than commercial
98920	Other Commercial Insurer
98921	Negotiated Discounts - PPOs, etc.
98922	HMOs
*98923	County Indigent Referral - those already qualified for or being referred to the County Indigent Program
98924	SIIS

*The State requires that the hospitals make a determination regarding these categories based on the definition supplied.

EXHIBIT (B)

HUMANA HEALTH INSURANCE OF NEVADA, INC.

HOSPITAL CONTRACTS - HUMANA HOSPITAL SUNRISE

DATE OF CONTRACT	RATE
1. 04/24/84	1. 40% discount from usual and customary rates (UCR) 2. Adjust on September 1st for each year for preceding September 1st to August 31st.
2. 09/01/86 * (effective 9/1/86 to 8/31/87)	1. $125 per diem 2. 60% discount of UCR for out-patient services 3. Retroactive adjustments for fiscal year 1987
3. 01/01/88	1. For GP1000 Policy: a) $600 per diem b) 60% discount off UCR for out-patient services 2. For "other" policies: a) $125 per diem b) 60% discount off UCR for out-patient services
4. 09/01/88	Amends 01/01/88 contract, for "other" policy: 1. $156 per diem 2. 60% discount off UCR for out-patient services

* Unsigned by hospital

APPENDIX 5

HOSPITAL PROFITABILITY
PROFIT PER DAY BY STATE
FROM AHA 1987 ANNUAL SURVEY

RANK	STATE	PROFIT PER DAY	% BELOW NEVADA	BILLED CHARGES PER DAY	NET REVENUE PER DAY	PROFIT MARGIN
	TOTAL U.S.	$23.37	63.23%	$705.55	$524.72	4.22%
1	NEVADA	63.55	0.00%	1,248.93	829.52	8.26%
2	WASHINGTON DC	44.73	29.62%	1,012.03	686.69	5.82%
3	UTAH	40.02	37.03%	771.92	662.26	5.72%
4	WASHINGTON	39.09	38.49%	757.79	641.09	5.72%
5	MISSOURI	37.84	40.46%	728.79	544.39	6.46%
6	OREGON	37.41	41.14%	811.96	655.95	5.64%
7	KENTUCKY	36.95	41.86%	636.68	468.62	7.67%
8	GEORGIA	35.80	43.67%	624.91	455.12	7.23%
9	VIRGINIA	33.30	47.60%	642.56	474.42	6.57%
10	SOUTH CAROLINA	33.24	47.70%	604.91	445.73	7.17%
11	TENNESSEE	32.72	48.51%	651.73	468.27	6.51%
12	NEW HAMPSHIRE	32.53	48.82%	617.65	508.30	6.69%
13	HAWAII	32.29	49.19%	598.50	473.48	6.72%
14	NEW MEXICO	32.04	49.59%	776.78	560.88	5.11%
15	CALIFORNIA	31.44	50.52%	1,056.72	719.59	4.08%
16	PENNSYLVANIA	31.00	51.22%	833.08	554.70	5.46%
17	ARKANSAS	30.92	51.35%	569.85	424.26	6.89%
18	LOUISIANA	30.38	52.20%	676.72	509.73	5.14%
19	SOUTH DAKOTA	29.70	53.27%	374.66	319.89	8.11%
20	FLORIDA	27.89	56.12%	873.53	582.48	4.77%
21	ILLINOIS	27.77	56.30%	745.59	551.14	4.58%
22	IDAHO	27.06	57.42%	551.64	458.36	6.13%
23	ARIZONA	26.23	58.73%	929.33	689.98	3.72%
24	TEXAS	25.55	59.79%	758.33	529.39	4.36%
25	ALABAMA	25.15	60.42%	700.64	457.45	5.16%
26	NEBRASKA	24.98	60.69%	458.63	371.58	6.48%
27	MONTANA	24.84	60.92%	395.24	341.35	7.27%
28	OKLAHOMA	24.78	61.01%	677.20	502.85	4.66%
29	INDIANA	23.32	63.31%	629.95	527.97	4.39%
30	CONNECTICUT	22.19	65.09%	739.56	600.57	3.56%
31	NORTH CAROLINA	22.03	65.34%	563.33	441.20	5.01%
32	KANSAS	21.04	66.89%	546.83	423.17	4.77%
33	IOWA	20.69	67.44%	476.02	391.23	5.11%
34	OHIO	20.49	67.76%	688.48	559.64	3.52%
35	NORTH DAKOTA	20.42	67.87%	426.84	363.85	5.51%
36	MARYLAND	19.85	68.77%	592.63	510.76	3.69%
37	MISSISSIPPI	18.92	70.22%	495.71	356.43	5.26%
38	MICHIGAN	17.15	73.01%	808.07	592.50	2.81%
39	VERMONT	16.87	73.46%	550.78	445.12	3.66%
40	COLORADO	16.74	73.66%	731.98	562.70	2.84%
41	WISCONSIN	15.10	76.23%	486.09	445.74	3.29%
42	WYOMING	14.61	77.01%	429.78	377.98	3.60%
43	NEW JERSEY	14.33	77.46%	523.30	439.21	3.12%
44	MINNESOTA	14.01	77.96%	492.24	410.71	3.25%
45	DELAWARE	13.29	79.09%	707.59	538.95	2.38%
46	MAINE	9.54	84.98%	517.29	427.76	2.19%
47	WEST VIRGINIA	8.01	87.40%	612.53	454.98	1.69%
48	MASSACHUSETTS	5.84	90.81%	732.40	561.89	0.98%
49	NEW YORK	4.97	92.17%	564.94	442.95	1.02%
50	RHODE ISLAND	2.71	95.74%	568.07	464.85	0.55%
51	ALASKA	(13.89)	121.85%	1,022.79	847.58	-1.57%

"Hospital Statistics", tables 5 & 11.

HOSPITAL PROFITABILITY
PROFIT PER ADMISSION BY STATE
FROM AHA 1987 ANNUAL SURVEY

RANK	STATE	PROFIT PER ADMIT	% BELOW NEVADA	BILLED CHARGES PER ADMIT	NET REVENUE PER ADMIT	PROFIT MARGIN
	TOTAL U.S.	$168.06	55.88%	$5,069	$3,769	4.22%
1	NEVADA	380.93	0.00%	7,486	4,972	8.26%
2	WASHINGTON DC	349.70	8.20%	7,912	5,369	5.82%
3	MISSOURI	284.30	25.37%	5,476	4,090	6.46%
4	SOUTH DAKOTA	274.22	28.01%	3,460	2,954	8.11%
5	HAWAII	253.83	33.37%	4,704	3,722	6.72%
6	GEORGIA	246.83	35.20%	4,309	3,138	7.23%
7	NEBRASKA	239.91	37.02%	4,404	3,568	6.48%
8	VIRGINIA	235.72	38.12%	4,548	3,358	6.57%
9	KENTUCKY	235.24	38.24%	4,053	2,983	7.67%
10	SOUTH CAROLINA	233.94	38.59%	4,258	3,137	7.17%
11	PENNSYLVANIA	233.87	38.61%	6,284	4,184	5.46%
12	MONTANA	233.62	38.67%	3,718	3,211	7.27%
13	TENNESSEE	229.73	39.69%	4,576	3,288	6.51%
14	WASHINGTON	223.20	41.41%	4,327	3,661	5.72%
15	UTAH	217.25	42.97%	4,190	3,595	5.72%
16	NEW HAMPSHIRE	206.91	45.68%	3,929	3,233	6.69%
17	ARKANSAS	205.57	46.03%	3,789	2,821	6.89%
18	NORTH DAKOTA	205.50	46.05%	4,295	3,662	5.51%
19	ILLINOIS	204.89	46.21%	5,501	4,066	4.58%
20	CALIFORNIA	202.75	46.78%	6,814	4,640	4.08%
21	OREGON	198.18	47.98%	4,301	3,475	5.64%
22	FLORIDA	196.59	48.39%	6,158	4,106	4.77%
23	LOUISIANA	190.15	50.08%	4,236	3,190	5.14%
24	NEW MEXICO	181.34	52.40%	4,397	3,175	5.11%
25	ALABAMA	176.48	53.67%	4,916	3,210	5.16%
26	IDAHO	175.90	53.82%	3,585	2,979	6.13%
27	IOWA	169.16	55.59%	3,892	3,199	5.11%
28	OKLAHOMA	166.99	56.16%	4,564	3,389	4.66%
29	KANSAS	163.56	57.06%	4,250	3,289	4.77%
30	CONNECTICUT	161.95	57.49%	5,398	4,383	3.56%
31	NORTH CAROLINA	158.91	58.28%	4,063	3,182	5.01%
32	TEXAS	158.80	58.31%	4,712	3,290	4.36%
33	ARIZONA	155.35	59.22%	5,504	4,086	3.72%
34	INDIANA	152.11	60.07%	4,110	3,444	4.39%
35	MARYLAND	141.73	62.79%	4,233	3,648	3.69%
36	OHIO	140.89	63.01%	4,734	3,848	3.52%
37	MISSISSIPPI	129.34	66.04%	3,388	2,436	5.26%
38	MINNESOTA	125.95	66.94%	4,426	3,693	3.25%
39	VERMONT	125.52	67.05%	4,099	3,313	3.66%
40	MICHIGAN	125.50	67.05%	5,913	4,336	2.81%
41	COLORADO	114.76	69.87%	5,018	3,858	2.84%
42	WISCONSIN	112.96	70.35%	3,636	3,334	3.29%
43	NEW JERSEY	106.83	71.96%	3,902	3,275	3.12%
44	WYOMING	103.66	72.79%	3,049	2,681	3.60%
45	DELAWARE	91.84	75.89%	4,889	3,724	2.38%
46	MAINE	75.50	80.18%	4,092	3,384	2.19%
47	WEST VIRGINIA	54.20	85.77%	4,145	3,079	1.69%
48	NEW YORK	45.91	87.95%	5,213	4,087	1.02%
49	MASSACHUSETTS	44.95	88.20%	5,634	4,323	0.98%
50	RHODE ISLAND	21.66	94.31%	4,547	3,721	0.55%
51	ALASKA	(79.17)	120.78%	5,831	4,832	-1.57%

"Hospital Statistics", tables 5 & 11.

HOSPITAL PROFITABILITY
PROFIT PER DAY BY STATE
FROM AHA 1988 ANNUAL SURVEY

RANK	STATE	PROFIT PER DAY	% BELOW NEVADA	BILLED CHARGES PER DAY	NET REVENUE PER DAY	PROFIT MARGIN
	TOTAL U.S.	$20.28	58.91%	$789.27	$565.47	3.34%
1	NEVADA	49.35	0.00%	1,287.88	820.32	6.08%
2	OREGON	41.99	14.92%	912.17	705.63	5.63%
3	ARKANSAS	40.31	18.31%	667.46	476.44	8.01%
4	KENTUCKY	39.91	19.13%	701.06	504.34	7.60%
5	SOUTH CAROLINA	38.96	21.05%	704.35	488.19	7.60%
6	NEW HAMPSHIRE	38.43	22.13%	700.94	555.22	6.57%
7	GEORGIA	35.01	29.06%	728.95	518.20	6.35%
8	IDAHO	34.86	29.37%	597.80	479.44	7.09%
9	TENNESSEE	34.31	30.48%	743.59	520.64	6.22%
10	MISSOURI	33.69	31.74%	809.25	565.84	5.51%
11	ALABAMA	32.05	35.05%	811.57	509.46	5.96%
12	VIRGINIA	31.58	36.01%	741.06	524.90	5.64%
13	WASHINGTON	31.30	36.57%	821.67	659.68	4.24%
14	NORTH CAROLINA	28.03	43.20%	644.24	489.42	5.44%
15	NEBRASKA	27.53	44.22%	524.49	416.70	6.23%
16	INDIANA	26.54	46.22%	708.69	569.15	4.44%
17	COLORADO	25.94	47.45%	811.49	601.70	3.97%
18	HAWAII	25.80	47.72%	663.19	510.89	4.75%
19	CALIFORNIA	25.66	48.02%	1,194.44	769.62	3.09%
20	PENNSYLVANIA	25.61	48.10%	922.00	585.02	4.21%
21	FLORIDA	25.43	48.48%	993.62	638.04	3.79%
22	WASHINGTON DC	25.08	49.34%	1,152.91	759.23	2.99%
23	SOUTH DAKOTA	24.30	50.76%	431.73	361.31	6.33%
24	TEXAS	21.62	56.19%	858.71	577.37	3.33%
25	MISSISSIPPI	21.44	56.56%	538.25	377.85	5.40%
26	MONTANA	20.98	57.48%	432.39	360.36	5.60%
27	NEW MEXICO	20.31	58.85%	911.97	642.61	2.94%
28	IOWA	19.98	59.51%	525.35	419.27	4.42%
29	VERMONT	19.93	59.62%	628.32	492.71	3.90%
30	UTAH	19.85	59.78%	767.56	620.23	2.62%
31	MINNESOTA	19.77	59.94%	550.34	446.42	4.14%
32	OKLAHOMA	19.56	60.37%	755.39	535.61	3.45%
33	MICHIGAN	19.15	61.20%	908.16	627.69	2.89%
34	KANSAS	19.05	61.40%	605.10	453.74	4.08%
35	ILLINOIS	18.27	62.99%	842.67	595.48	2.80%
36	NORTH DAKOTA	17.46	64.63%	445.99	371.08	4.43%
37	OHIO	17.36	64.82%	764.46	593.92	2.76%
38	LOUISIANA	14.55	70.53%	802.66	566.81	2.35%
39	CONNECTICUT	13.99	71.66%	829.52	663.63	2.00%
40	ARIZONA	13.77	72.11%	1,014.14	721.64	1.78%
41	DELAWARE	13.46	72.73%	808.90	600.00	2.10%
42	WISCONSIN	12.70	74.26%	552.59	482.66	2.56%
43	WEST VIRGINIA	12.31	75.06%	698.24	491.57	2.43%
44	MAINE	10.14	79.45%	579.25	462.48	2.09%
45	MARYLAND	9.19	81.37%	629.74	555.10	1.56%
46	NEW JERSEY	8.26	83.26%	565.82	488.82	1.60%
47	WYOMING	2.66	94.61%	455.40	380.84	0.64%
48	NEW YORK	0.47	99.06%	611.11	472.56	0.09%
49	MASSACHUSETTS	(1.81)	103.68%	795.90	603.17	-0.27%
50	RHODE ISLAND	(8.79)	117.82%	626.96	495.56	-1.64%
51	ALASKA	(21.57)	143.72%	1,130.00	899.16	-2.30%

"Hospital Statistics", tables 5 & 11.

HOSPITAL PROFITABILITY
PROFIT PER ADMISSION BY STATE
FROM AHA 1988 ANNUAL SURVEY

RANK	STATE	PROFIT PER ADMIT	% BELOW NEVADA	BILLED CHARGES PER ADMIT	NET REVENUE PER ADMIT	PROFIT MARGIN
	TOTAL U.S.	$146.36	52.31%	$5,693	$4,079	3.34%
1	NEVADA	306.92	0.00%	8,009	5,102	6.08%
2	SOUTH CAROLINA	274.34	10.62%	4,959	3,437	7.60%
3	NEBRASKA	272.71	11.15%	5,196	4,128	6.23%
4	ARKANSAS	263.26	14.22%	4,359	3,111	8.01%
5	NEW HAMPSHIRE	261.94	14.65%	4,778	3,784	6.57%
6	KENTUCKY	257.56	16.08%	4,524	3,255	7.60%
7	MISSOURI	251.74	17.98%	6,047	4,228	5.51%
8	IDAHO	238.55	22.27%	4,091	3,281	7.09%
9	GEORGIA	238.29	22.36%	4,961	3,527	6.35%
10	TENNESSEE	237.10	22.75%	5,138	3,598	6.22%
11	OREGON	229.49	25.23%	4,985	3,856	5.63%
12	HAWAII	229.12	25.35%	5,889	4,537	4.75%
13	VIRGINIA	221.00	27.99%	5,186	3,673	5.64%
14	ALABAMA	220.43	28.18%	5,581	3,504	5.96%
15	SOUTH DAKOTA	219.39	28.52%	3,898	3,262	6.33%
16	NORTH CAROLINA	205.05	33.19%	4,712	3,580	5.44%
17	MONTANA	198.27	35.40%	4,086	3,405	5.60%
18	PENNSYLVANIA	193.84	36.84%	6,977	4,427	4.21%
19	WASHINGTON DC	190.34	37.98%	8,776	5,780	2.99%
20	COLORADO	184.37	39.93%	5,768	4,277	3.97%
21	NORTH DAKOTA	183.21	40.31%	4,681	3,894	4.43%
22	FLORIDA	178.24	41.93%	6,965	4,473	3.79%
23	WASHINGTON	177.41	42.20%	4,657	3,738	4.24%
24	MINNESOTA	177.28	42.24%	4,934	4,003	4.14%
25	INDIANA	175.81	42.72%	4,694	3,770	4.44%
26	IOWA	163.85	46.62%	4,307	3,438	4.42%
27	CALIFORNIA	162.47	47.06%	7,564	4,874	3.09%
28	KANSAS	148.35	51.67%	4,713	3,534	4.08%
29	MISSISSIPPI	147.69	51.88%	3,708	2,603	5.40%
30	VERMONT	147.40	51.97%	4,648	3,645	3.90%
31	MICHIGAN	142.30	53.64%	6,749	4,665	2.89%
32	ILLINOIS	134.69	56.12%	6,214	4,391	2.80%
33	TEXAS	134.47	56.19%	5,340	3,591	3.33%
34	OKLAHOMA	130.68	57.42%	5,047	3,579	3.45%
35	OHIO	119.46	61.08%	5,259	4,086	2.76%
36	NEW MEXICO	114.71	62.62%	5,152	3,630	2.94%
37	UTAH	106.91	65.17%	4,134	3,341	2.62%
38	CONNECTICUT	103.98	66.12%	6,168	4,934	2.00%
39	DELAWARE	94.57	69.19%	5,685	4,217	2.10%
40	WISCONSIN	94.28	69.28%	4,101	3,582	2.56%
41	LOUISIANA	91.55	70.17%	5,052	3,568	2.35%
42	WEST VIRGINIA	83.37	72.84%	4,730	3,330	2.43%
43	ARIZONA	82.14	73.24%	6,051	4,306	1.78%
44	MAINE	81.73	73.37%	4,667	3,726	2.09%
45	MARYLAND	63.69	79.25%	4,363	3,846	1.56%
46	NEW JERSEY	61.17	80.07%	4,188	3,618	1.60%
47	WYOMING	20.20	93.42%	3,458	2,892	0.64%
48	NEW YORK	4.48	98.54%	5,890	4,555	0.09%
49	MASSACHUSETTS	(14.24)	104.64%	6,246	4,734	-0.27%
50	RHODE ISLAND	(70.72)	123.04%	5,043	3,986	-1.64%
51	ALASKA	(125.87)	141.01%	6,593	5,246	-2.30%

"Hospital Statistics", tables 5 & 11.

HOSPITAL PROFITABILITY
PROFIT PER DAY BY STATE
FROM AHA 1989 ANNUAL SURVEY

RANK	STATE	PROFIT PER DAY	% BELOW NEVADA	BILLED CHARGES PER DAY	NET REVENUE PER DAY	PROFIT MARGIN
	TOTAL U.S.	$22.27	48.21%	$900.64	$617.74	3.38%
1	SOUTH CAROLINA	50.20	-16.71%	838.67	557.75	8.60%
2	NEVADA	43.01	0.00%	1,471.11	871.00	4.87%
3	KENTUCKY	42.38	1.47%	782.80	541.57	7.53%
4	NEW HAMPSHIRE	42.18	1.94%	821.17	624.55	6.43%
5	ALABAMA	40.26	6.40%	932.84	558.43	6.85%
6	NEW MEXICO	36.93	14.13%	904.94	605.83	5.13%
7	NEBRASKA	36.60	14.91%	595.61	460.22	7.65%
8	WASHINGTON	36.42	15.32%	954.83	741.21	4.65%
9	GEORGIA	36.34	15.51%	846.67	577.11	5.92%
10	IDAHO	35.75	16.87%	667.51	519.52	6.74%
11	OREGON	35.34	17.83%	998.34	743.54	4.54%
12	MISSOURI	34.32	20.21%	908.98	609.87	5.21%
13	SOUTH DAKOTA	34.18	20.54%	485.94	395.36	8.13%
14	VIRGINIA	32.75	23.85%	851.05	583.66	5.27%
15	MONTANA	30.26	29.64%	475.96	390.21	7.41%
16	ILLINOIS	29.19	32.12%	968.40	641.93	4.21%
17	FLORIDA	29.18	32.15%	1,157.73	708.30	3.91%
18	INDIANA	28.34	34.11%	796.56	610.27	4.41%
19	TENNESSEE	27.61	35.81%	843.06	577.34	4.51%
20	NORTH CAROLINA	27.44	36.20%	761.45	549.63	4.76%
21	TEXAS	27.00	37.21%	997.75	639.54	3.79%
22	KANSAS	27.00	37.22%	680.72	486.59	5.36%
23	OKLAHOMA	26.75	37.81%	835.00	577.85	4.37%
24	VERMONT	26.67	37.99%	736.30	560.66	4.57%
25	CALIFORNIA	26.65	38.04%	1,378.56	840.35	2.97%
26	IOWA	26.17	39.16%	574.86	448.76	5.42%
27	ARKANSAS	25.84	39.93%	725.50	498.81	4.95%
28	OHIO	25.32	41.12%	884.21	655.73	3.65%
29	LOUISIANA	24.44	43.18%	871.27	584.93	3.58%
30	COLORADO	24.08	44.01%	945.69	670.84	3.38%
31	UTAH	22.51	47.67%	987.92	776.11	2.83%
32	MISSISSIPPI	22.32	48.10%	616.64	417.47	5.12%
33	CONNECTICUT	19.50	54.65%	986.48	744.16	2.49%
34	WEST VIRGINIA	18.81	56.27%	784.55	540.49	3.40%
35	WISCONSIN	18.78	56.34%	638.00	528.72	3.47%
36	NORTH DAKOTA	18.59	56.78%	487.22	394.95	4.48%
37	MICHIGAN	18.48	57.02%	982.73	661.76	2.66%
38	PENNSYLVANIA	17.67	58.92%	1,053.35	626.90	2.73%
39	ARIZONA	17.06	60.34%	1,148.08	772.98	2.07%
40	MARYLAND	16.77	61.00%	698.93	604.30	2.62%
41	MINNESOTA	16.09	62.59%	644.68	490.35	3.08%
42	HAWAII	10.11	76.50%	735.06	528.08	1.80%
43	MAINE	9.71	77.43%	674.28	509.64	1.82%
44	WASHINGTON DC	8.35	80.59%	1,241.93	768.61	0.98%
45	WYOMING	8.20	80.93%	481.73	400.75	1.86%
46	NEW JERSEY	7.93	81.57%	628.19	543.84	1.38%
47	DELAWARE	3.23	92.48%	951.87	671.17	0.45%
48	MASSACHUSETTS	2.70	93.71%	893.49	665.97	0.37%
49	RHODE ISLAND	1.63	96.21%	753.38	570.65	0.26%
50	NEW YORK	(0.66)	101.54%	698.77	521.06	-0.11%
51	ALASKA	(15.57)	136.21%	1,225.28	962.84	-1.59%

"Hospital Statistics", tables 5 & 11.

HOSPITAL PROFITABILITY
PROFIT PER ADMISSION BY STATE
FROM AHA 1989 ANNUAL SURVEY

RANK	STATE	PROFIT PER ADMIT	% BELOW NEVADA	BILLED CHARGES PER ADMIT	NET REVENUE PER ADMIT	PROFIT MARGIN
	TOTAL U.S.	$161.40	40.25%	$6,525	$4,476	3.38%
1	NEBRASKA	354.27	-31.15%	5,766	4,455	7.65%
2	SOUTH CAROLINA	350.13	-29.62%	5,850	3,890	8.60%
3	SOUTH DAKOTA	324.77	-20.23%	4,618	3,757	8.13%
4	MONTANA	298.19	-10.39%	4,690	3,845	7.41%
5	NEW HAMPSHIRE	287.80	-6.55%	5,603	4,262	6.43%
6	ALABAMA	283.65	-5.01%	6,573	3,935	6.85%
7	KENTUCKY	280.74	-3.93%	5,186	3,588	7.53%
8	NEVADA	270.12	0.00%	9,239	5,470	4.87%
9	MISSOURI	257.30	4.75%	6,815	4,572	5.21%
10	IDAHO	248.98	7.83%	4,648	3,618	6.74%
11	GEORGIA	248.68	7.94%	5,794	3,949	5.92%
12	VIRGINIA	226.11	16.29%	5,876	4,030	5.27%
13	NEW MEXICO	224.10	17.04%	5,491	3,676	5.13%
14	IOWA	218.38	19.16%	4,797	3,745	5.42%
15	ILLINOIS	216.13	19.99%	7,169	4,752	4.21%
16	KANSAS	213.56	20.94%	5,384	3,849	5.36%
17	WASHINGTON	208.81	22.70%	5,474	4,250	4.65%
18	FLORIDA	203.22	24.77%	8,062	4,932	3.91%
19	NORTH CAROLINA	203.00	24.85%	5,633	4,066	4.76%
20	NORTH DAKOTA	198.99	26.33%	5,216	4,228	4.48%
21	OREGON	197.49	26.89%	5,579	4,155	4.54%
22	VERMONT	194.19	28.11%	5,361	4,082	4.57%
23	TENNESSEE	191.83	28.98%	5,858	4,011	4.51%
24	INDIANA	190.41	29.51%	5,352	4,101	4.41%
25	OKLAHOMA	182.46	32.45%	5,695	3,942	4.37%
26	ARKANSAS	180.04	33.35%	5,056	3,476	4.95%
27	OHIO	172.72	36.06%	6,031	4,472	3.65%
28	TEXAS	168.92	37.47%	6,241	4,000	3.79%
29	CALIFORNIA	168.89	37.47%	8,737	5,326	2.97%
30	COLORADO	163.22	39.57%	6,410	4,547	3.38%
31	LOUISIANA	156.35	42.12%	5,574	3,742	3.58%
32	MISSISSIPPI	155.32	42.50%	4,291	2,905	5.12%
33	CONNECTICUT	149.72	44.57%	7,572	5,712	2.49%
34	MINNESOTA	142.72	47.16%	5,718	4,349	3.08%
35	MICHIGAN	138.17	48.85%	7,346	4,946	2.66%
36	PENNSYLVANIA	135.15	49.97%	8,057	4,795	2.73%
37	WEST VIRGINIA	128.15	52.56%	5,346	3,683	3.40%
38	WISCONSIN	126.82	53.05%	4,309	3,571	3.47%
39	UTAH	123.66	54.22%	5,428	4,264	2.83%
40	MARYLAND	115.48	57.25%	4,812	4,161	2.62%
41	ARIZONA	97.75	63.81%	6,579	4,430	2.07%
42	HAWAII	91.29	66.20%	6,639	4,770	1.80%
43	MAINE	78.26	71.03%	5,435	4,108	1.82%
44	WYOMING	66.94	75.22%	3,932	3,271	1.86%
45	WASHINGTON DC	65.70	75.68%	9,773	6,049	0.98%
46	NEW JERSEY	58.49	78.35%	4,636	4,013	1.38%
47	DELAWARE	22.16	91.79%	6,527	4,602	0.45%
48	MASSACHUSETTS	20.69	92.34%	6,835	5,095	0.37%
49	RHODE ISLAND	12.20	95.48%	5,633	4,267	0.26%
50	NEW YORK	(6.64)	102.46%	6,992	5,214	-0.11%
51	ALASKA	(90.44)	133.48%	7,115	5,591	-1.59%

"Hospital Statistics", tables 5 & 11.

NATIONAL HOSPITAL COMPARISONS
BILLED CHARGES PER DAY
AHA SURVEYS, 1987 - 1989

STATE	BILLED CHARGES PER DAY 1989	1988	1987	PERCENT CHANGE 1989-1988	1988-1987
TOTAL U.S.	$900.64	$789.27	$705.55	14.11%	11.87%
NEVADA	1,471.11	1,287.88	1,248.93	14.23%	3.12%
CALIFORNIA	1,378.56	1,194.44	1,056.72	15.42%	13.03%
WASHINGTON DC	1,241.93	1,152.91	1,012.03	7.72%	13.92%
ALASKA	1,225.28	1,130.00	1,022.79	8.43%	10.48%
FLORIDA	1,157.73	993.62	873.53	16.52%	13.75%
ARIZONA	1,148.08	1,014.14	929.33	13.21%	9.13%
PENNSYLVANIA	1,053.35	922.00	833.08	14.25%	10.67%
OREGON	998.34	912.17	811.96	9.45%	12.34%
TEXAS	997.75	858.71	758.33	16.19%	13.24%
UTAH	987.92	767.56	771.92	28.71%	-0.56%
CONNECTICUT	986.48	829.52	739.56	18.92%	12.16%
MICHIGAN	982.73	908.16	808.07	8.21%	12.39%
ILLINOIS	968.40	842.67	745.59	14.92%	13.02%
WASHINGTON	954.83	821.67	757.79	16.21%	8.43%
DELAWARE	951.87	808.90	707.59	17.68%	14.32%
COLORADO	945.69	811.49	731.98	16.54%	10.86%
ALABAMA	932.84	811.57	700.64	14.94%	15.83%
MISSOURI	908.98	809.25	728.79	12.32%	11.04%
NEW MEXICO	904.94	911.97	776.78	-0.77%	17.40%
MASSACHUSETTS	893.49	795.90	732.40	12.26%	8.67%
OHIO	884.21	764.46	688.48	15.67%	11.03%
LOUISIANA	871.27	802.66	676.72	8.55%	18.61%
VIRGINIA	851.05	741.06	642.56	14.84%	15.33%
GEORGIA	846.67	728.95	624.91	16.15%	16.65%
TENNESSEE	843.06	743.59	651.73	13.38%	14.09%
SOUTH CAROLINA	838.67	704.35	604.91	19.07%	16.44%
OKLAHOMA	835.00	755.39	677.20	10.54%	11.55%
NEW HAMPSHIRE	821.17	700.94	617.65	17.15%	13.49%
INDIANA	796.56	708.69	629.95	12.40%	12.50%
WEST VIRGINIA	784.55	698.24	612.53	12.36%	13.99%
KENTUCKY	782.80	701.06	636.68	11.66%	10.11%
NORTH CAROLINA	761.45	644.24	563.33	18.19%	14.36%
RHODE ISLAND	753.38	626.96	568.07	20.16%	10.37%
VERMONT	736.30	628.32	550.78	17.18%	14.08%
HAWAII	735.06	663.19	598.50	10.84%	10.81%
ARKANSAS	725.58	667.46	569.85	8.70%	17.13%
MARYLAND	698.93	629.74	592.63	10.99%	6.26%
NEW YORK	698.77	611.11	564.94	14.34%	8.17%
KANSAS	680.72	605.10	546.83	12.50%	10.66%
MAINE	674.28	579.25	517.29	16.41%	11.98%
IDAHO	667.51	597.80	551.64	11.66%	8.37%
MINNESOTA	644.68	550.34	492.24	17.14%	11.80%
WISCONSIN	638.00	552.59	486.09	15.46%	13.68%
NEW JERSEY	628.19	565.82	523.30	11.02%	8.13%
MISSISSIPPI	616.64	538.25	495.71	14.56%	8.58%
NEBRASKA	595.61	524.49	458.63	13.56%	14.36%
IOWA	574.86	525.35	476.02	9.42%	10.36%
NORTH DAKOTA	487.22	445.99	426.84	9.24%	4.49%
SOUTH DAKOTA	485.94	431.73	374.66	12.56%	15.23%
WYOMING	481.73	455.40	429.78	5.78%	5.96%
MONTANA	475.96	432.39	395.24	10.08%	9.40%

"Hospital Statistics", tables 5 & 11.

NATIONAL HOSPITAL COMPARISONS
BILLED CHARGES PER ADMISSION
AHA SURVEYS, 1987 - 1989

STATE	BILLED CHARGES PER ADMISSION 1989	1988	1987	PERCENT CHANGE 1989-1988	1988-1987
TOTAL U.S.	$6,525.19	$5,693.14	$5,068.55	14.62%	12.32%
WASHINGTON DC	9,773.19	8,776.50	7,912.15	11.36%	10.92%
NEVADA	9,239.05	8,009.36	7,486.08	15.35%	6.99%
CALIFORNIA	8,737.13	7,564.12	6,813.68	15.51%	11.01%
FLORIDA	8,061.75	6,965.12	6,158.15	15.74%	13.10%
PENNSYLVANIA	8,057.20	6,977.14	6,284.45	15.48%	11.02%
CONNECTICUT	7,572.45	6,167.57	5,397.92	22.78%	14.26%
MICHIGAN	7,345.71	6,749.01	5,913.39	8.84%	14.13%
ILLINOIS	7,169.14	6,213.58	5,500.74	15.38%	12.96%
ALASKA	7,115.37	6,592.84	5,831.04	7.93%	13.06%
NEW YORK	6,991.68	5,890.08	5,213.16	18.70%	12.98%
MASSACHUSETTS	6,835.00	6,246.45	5,634.45	9.42%	10.86%
MISSOURI	6,815.02	6,047.44	5,475.71	12.69%	10.44%
HAWAII	6,639.25	5,888.94	4,704.37	12.74%	25.18%
ARIZONA	6,579.31	6,051.04	5,504.02	8.73%	9.94%
ALABAMA	6,572.93	5,581.21	4,916.04	17.77%	13.53%
DELAWARE	6,527.04	5,684.67	4,888.98	14.82%	16.28%
COLORADO	6,410.00	5,768.31	5,018.45	11.12%	14.94%
TEXAS	6,241.17	5,340.12	4,712.46	16.87%	13.32%
OHIO	6,030.82	5,259.47	4,733.66	14.67%	11.11%
VIRGINIA	5,875.69	5,186.25	4,548.01	13.29%	14.03%
TENNESSEE	5,857.59	5,138.36	4,575.89	14.00%	12.29%
SOUTH CAROLINA	5,849.70	4,959.40	4,257.92	17.95%	16.47%
GEORGIA	5,793.72	4,961.42	4,308.57	16.78%	15.15%
NEBRASKA	5,765.62	5,195.68	4,404.18	10.97%	17.97%
MINNESOTA	5,718.43	4,934.39	4,425.58	15.89%	11.50%
OKLAHOMA	5,695.47	5,046.95	4,564.07	12.85%	10.58%
RHODE ISLAND	5,632.99	5,042.72	4,546.79	11.71%	10.91%
NORTH CAROLINA	5,632.93	4,712.26	4,063.38	19.54%	15.97%
NEW HAMPSHIRE	5,603.40	4,777.56	3,928.94	17.29%	21.60%
OREGON	5,578.89	4,985.24	4,301.45	11.91%	15.90%
LOUISIANA	5,574.29	5,052.18	4,235.69	10.33%	19.28%
NEW MEXICO	5,491.20	5,151.72	4,396.71	6.59%	17.17%
WASHINGTON	5,474.39	4,656.52	4,326.86	17.56%	7.62%
MAINE	5,434.97	4,667.32	4,091.77	16.45%	14.07%
UTAH	5,428.30	4,134.44	4,190.32	31.29%	-1.33%
KANSAS	5,383.89	4,712.69	4,250.41	14.24%	10.88%
VERMONT	5,360.57	4,647.90	4,099.32	15.33%	13.38%
INDIANA	5,352.24	4,694.37	4,109.60	14.01%	14.23%
WEST VIRGINIA	5,345.51	4,729.90	4,145.50	13.02%	14.10%
NORTH DAKOTA	5,215.85	4,680.57	4,295.45	11.44%	8.97%
KENTUCKY	5,185.93	4,524.03	4,053.43	14.63%	11.61%
ARKANSAS	5,055.70	4,358.79	3,789.28	15.99%	15.03%
MARYLAND	4,812.08	4,362.85	4,232.61	10.30%	3.08%
IOWA	4,797.48	4,307.31	3,891.67	11.38%	10.68%
MONTANA	4,690.26	4,085.78	3,717.57	14.79%	9.90%
IDAHO	4,648.23	4,091.16	3,585.36	13.62%	14.11%
NEW JERSEY	4,635.76	4,188.27	3,902.36	10.68%	7.33%
SOUTH DAKOTA	4,617.85	3,897.79	3,459.67	18.47%	12.66%
WISCONSIN	4,308.85	4,101.39	3,635.66	5.06%	12.81%
MISSISSIPPI	4,290.94	3,708.33	3,388.14	15.71%	9.45%
WYOMING	3,932.26	3,458.17	3,048.88	13.71%	13.42%

"Hospital Statistics", tables 5 & 11.

NATIONAL HOSPITAL COMPARISONS
NET REVENUE PER DAY BY STATE
AHA SURVEYS, 1987 - 1989

STATE	NET REVENUE PER DAY BY STATE 1989	1988	1987	PERCENT CHANGE 1989-1988	1988-1987
TOTAL U.S.	$617.74	$565.47	$524.72	9.24%	7.77%
ALASKA	962.84	899.16	847.58	7.08%	6.09%
NEVADA	871.00	820.32	829.52	6.18%	-1.11%
CALIFORNIA	840.35	769.62	719.59	9.19%	6.95%
UTAH	776.11	620.23	662.26	25.13%	-6.35%
ARIZONA	772.98	721.64	689.98	7.11%	4.59%
WASHINGTON DC	768.61	759.23	686.69	1.24%	10.56%
CONNECTICUT	744.16	663.63	600.57	12.13%	10.50%
OREGON	743.54	705.63	655.95	5.37%	7.57%
WASHINGTON	741.21	659.68	641.09	12.36%	2.90%
FLORIDA	708.30	638.04	582.48	11.01%	9.54%
DELAWARE	671.17	600.00	538.95	11.86%	11.33%
COLORADO	670.84	601.70	562.70	11.49%	6.93%
MASSACHUSETTS	665.97	603.17	561.89	10.41%	7.35%
MICHIGAN	661.76	627.69	592.50	5.43%	5.94%
OHIO	655.73	593.92	559.64	10.41%	6.13%
ILLINOIS	641.93	595.48	551.14	7.80%	8.05%
TEXAS	639.54	577.37	529.39	10.77%	9.06%
PENNSYLVANIA	626.90	585.02	554.70	7.16%	5.47%
NEW HAMPSHIRE	624.55	555.22	508.30	12.49%	9.23%
INDIANA	610.27	569.15	527.97	7.22%	7.80%
MISSOURI	609.87	565.84	544.39	7.78%	3.94%
NEW MEXICO	605.83	642.61	560.88	-5.72%	14.57%
MARYLAND	604.30	555.10	510.76	8.86%	8.68%
LOUISIANA	584.93	566.81	509.73	3.20%	11.20%
VIRGINIA	583.66	524.90	474.42	11.19%	10.64%
OKLAHOMA	577.85	535.61	502.85	7.89%	6.51%
TENNESSEE	577.34	520.64	468.27	10.89%	11.18%
GEORGIA	577.11	518.20	455.12	11.37%	13.86%
RHODE ISLAND	570.65	495.56	464.85	15.15%	6.61%
VERMONT	560.66	492.71	445.12	13.79%	10.69%
ALABAMA	558.43	509.46	457.45	9.61%	11.37%
SOUTH CAROLINA	557.75	488.19	445.73	14.25%	9.53%
NORTH CAROLINA	549.63	489.42	441.20	12.30%	10.93%
NEW JERSEY	543.84	488.82	439.21	11.26%	11.29%
KENTUCKY	541.57	504.34	468.62	7.38%	7.62%
WEST VIRGINIA	540.49	491.57	454.98	9.95%	8.04%
WISCONSIN	528.72	482.66	445.74	9.54%	8.28%
HAWAII	528.08	510.89	473.48	3.37%	7.90%
NEW YORK	521.06	472.56	442.95	10.26%	6.69%
IDAHO	519.52	479.44	458.36	8.36%	4.60%
MAINE	509.64	462.48	427.76	10.20%	8.12%
ARKANSAS	498.81	476.44	424.26	4.69%	12.30%
MINNESOTA	490.35	446.42	410.71	9.84%	8.69%
KANSAS	486.59	453.74	423.17	7.24%	7.22%
NEBRASKA	460.22	416.70	371.58	10.44%	12.14%
IOWA	448.76	419.27	391.23	7.03%	7.17%
MISSISSIPPI	417.47	377.85	356.43	10.48%	6.01%
WYOMING	400.75	380.84	377.98	5.23%	0.76%
SOUTH DAKOTA	395.36	361.31	319.89	9.43%	12.95%
NORTH DAKOTA	394.95	371.08	363.85	6.43%	1.99%
MONTANA	390.21	360.36	341.35	8.28%	5.57%

"Hospital Statistics", tables 5 & 11.

NATIONAL HOSPITAL COMPARISONS
NET REVENUE PER ADMIT BY STATE
AHA SURVEYS, 1987 - 1989

STATE	NET REVENUE PER ADMIT BY STATE 1989	1988	1987	PERCENT CHANGE 1989-1988	1988-1987
TOTAL U.S.	$4,475.56	$4,078.84	$3,769.50	9.73%	8.21%
WASHINGTON DC	6,048.50	5,779.58	5,368.59	4.65%	7.66%
CONNECTICUT	5,712.34	4,934.11	4,383.44	15.77%	12.56%
ALASKA	5,591.35	5,246.00	4,832.11	6.58%	8.57%
NEVADA	5,470.14	5,101.57	4,972.14	7.22%	2.60%
CALIFORNIA	5,326.00	4,873.83	4,639.87	9.28%	5.04%
NEW YORK	5,213.62	4,554.72	4,087.42	14.47%	11.43%
MASSACHUSETTS	5,094.54	4,733.86	4,322.65	7.62%	9.51%
MICHIGAN	4,946.49	4,664.73	4,335.87	6.04%	7.58%
FLORIDA	4,932.16	4,472.58	4,106.33	10.28%	8.92%
PENNSYLVANIA	4,795.28	4,427.04	4,184.41	8.32%	5.80%
HAWAII	4,769.82	4,536.53	3,721.68	5.14%	21.89%
ILLINOIS	4,752.22	4,390.89	4,066.13	8.23%	7.99%
DELAWARE	4,602.22	4,216.58	3,723.84	9.15%	13.23%
MISSOURI	4,572.45	4,228.45	4,090.24	8.14%	3.38%
COLORADO	4,547.01	4,277.05	3,857.89	6.31%	10.87%
OHIO	4,472.48	4,086.17	3,847.81	9.45%	6.19%
NEBRASKA	4,455.01	4,127.90	3,568.21	7.92%	15.69%
ARIZONA	4,429.73	4,305.81	4,086.47	2.88%	5.37%
MINNESOTA	4,349.50	4,002.64	3,692.60	8.67%	8.40%
RHODE ISLAND	4,266.72	3,985.86	3,720.63	7.05%	7.13%
UTAH	4,264.49	3,340.85	3,595.01	27.65%	-7.07%
NEW HAMPSHIRE	4,261.75	3,784.35	3,233.37	12.62%	17.04%
WASHINGTON	4,249.65	3,738.50	3,660.54	13.67%	2.13%
NORTH DAKOTA	4,228.10	3,894.39	3,661.55	8.57%	6.36%
MARYLAND	4,160.55	3,845.74	3,647.92	8.19%	5.42%
OREGON	4,155.04	3,856.45	3,474.96	7.74%	10.98%
MAINE	4,107.86	3,726.44	3,383.57	10.24%	10.13%
INDIANA	4,100.55	3,770.08	3,444.31	8.77%	9.46%
VERMONT	4,081.84	3,644.75	3,312.88	11.99%	10.02%
NORTH CAROLINA	4,065.96	3,579.86	3,182.44	13.58%	12.49%
VIRGINIA	4,029.58	3,673.49	3,357.92	9.69%	9.40%
NEW JERSEY	4,013.30	3,618.26	3,275.30	10.92%	10.47%
TENNESSEE	4,011.39	3,597.75	3,287.78	11.50%	9.43%
TEXAS	4,000.48	3,590.56	3,289.75	11.42%	9.14%
GEORGIA	3,949.13	3,527.03	3,137.94	11.97%	12.40%
OKLAHOMA	3,941.50	3,578.53	3,389.03	10.14%	5.59%
ALABAMA	3,934.79	3,503.56	3,209.72	12.31%	9.15%
SOUTH CAROLINA	3,890.26	3,437.35	3,137.48	13.18%	9.56%
KANSAS	3,848.51	3,533.86	3,289.25	8.90%	7.44%
MONTANA	3,845.25	3,405.18	3,210.69	12.92%	6.06%
SOUTH DAKOTA	3,757.12	3,262.03	2,953.87	15.18%	10.43%
IOWA	3,745.12	3,437.59	3,198.51	8.95%	7.47%
LOUISIANA	3,742.35	3,567.68	3,190.48	4.90%	11.82%
WEST VIRGINIA	3,682.62	3,329.96	3,079.19	10.59%	8.14%
NEW MEXICO	3,676.23	3,630.08	3,174.69	1.27%	14.34%
IDAHO	3,617.76	3,281.10	2,979.10	10.26%	10.14%
KENTUCKY	3,587.82	3,254.54	2,983.49	10.24%	9.09%
WISCONSIN	3,570.82	3,582.35	3,333.83	-0.32%	7.45%
ARKANSAS	3,476.01	3,111.37	2,821.15	11.72%	10.29%
WYOMING	3,271.25	2,891.97	2,681.37	13.11%	7.85%
MISSISSIPPI	2,904.97	2,603.24	2,436.23	11.59%	6.86%

"Hospital Statistics", tables 5 & 11.

NATIONAL HOSPITAL COMPARISONS
PROFIT PER DAY BY STATE
AHA SURVEYS, 1987 - 1989

STATE	PROFIT PER DAY BY STATE 1989	1988	1987	PERCENT CHANGE 1989-1988	1988-1987
TOTAL U.S.	$22.27	$20.28	$23.37	9.84%	-13.22%
SOUTH CAROLINA	50.20	38.96	33.24	28.84%	17.23%
NEVADA	43.01	49.35	63.55	-12.85%	-22.34%
KENTUCKY	42.38	39.91	36.95	6.17%	8.02%
NEW HAMPSHIRE	42.18	38.43	32.53	9.75%	18.15%
ALABAMA	40.26	32.05	25.15	25.59%	27.44%
NEW MEXICO	36.93	20.31	32.04	81.86%	-36.62%
NEBRASKA	36.60	27.53	24.98	32.94%	10.19%
WASHINGTON	36.42	31.30	39.09	16.34%	-19.92%
GEORGIA	36.34	35.01	35.80	3.80%	-2.20%
IDAHO	35.75	34.86	27.06	2.57%	28.80%
OREGON	35.34	41.99	37.41	-15.84%	12.25%
MISSOURI	34.32	33.69	37.84	1.87%	-10.97%
SOUTH DAKOTA	34.18	24.30	29.70	40.64%	-18.17%
VIRGINIA	32.75	31.58	33.30	3.71%	-5.18%
MONTANA	30.26	20.98	24.84	44.22%	-15.52%
ILLINOIS	29.19	18.27	27.77	59.83%	-34.23%
FLORIDA	29.18	25.43	27.89	14.77%	-8.82%
INDIANA	28.34	26.54	23.32	6.77%	13.83%
TENNESSEE	27.61	34.31	32.72	-19.53%	4.86%
NORTH CAROLINA	27.44	28.03	22.03	-2.11%	27.25%
TEXAS	27.00	21.62	25.55	24.88%	-15.38%
KANSAS	27.00	19.05	21.04	41.76%	-9.48%
OKLAHOMA	26.75	19.56	24.78	36.76%	-21.06%
VERMONT	26.67	19.93	16.87	33.86%	18.15%
CALIFORNIA	26.65	25.66	31.44	3.87%	-18.41%
IOWA	26.17	19.98	20.69	30.94%	-3.42%
ARKANSAS	25.84	40.31	30.92	-35.91%	30.40%
OHIO	25.32	17.36	20.49	45.84%	-15.27%
LOUISIANA	24.44	14.55	30.38	68.01%	-52.12%
COLORADO	24.08	25.94	16.74	-7.16%	54.95%
UTAH	22.51	19.85	40.02	13.39%	-50.40%
MISSISSIPPI	22.32	21.44	18.92	4.13%	13.28%
CONNECTICUT	19.50	13.99	22.19	39.46%	-36.97%
WEST VIRGINIA	18.81	12.31	8.01	52.83%	53.68%
WISCONSIN	18.78	12.70	15.10	47.83%	-15.90%
NORTH DAKOTA	18.59	17.46	20.42	6.48%	-14.51%
MICHIGAN	18.48	19.15	17.15	-3.46%	11.65%
PENNSYLVANIA	17.67	25.61	31.00	-31.02%	-17.38%
ARIZONA	17.06	13.77	26.23	23.91%	-47.52%
MARYLAND	16.77	9.19	19.85	82.44%	-53.67%
MINNESOTA	16.09	19.77	14.01	-18.62%	41.14%
HAWAII	10.11	25.80	32.29	-60.83%	-20.10%
MAINE	9.71	10.14	9.54	-4.28%	6.27%
WASHINGTON DC	8.35	25.00	44.73	-66.61%	-44.10%
WYOMING	8.20	2.66	14.61	208.29%	-81.80%
NEW JERSEY	7.93	8.26	14.33	-4.08%	-42.32%
DELAWARE	3.23	13.46	13.29	-75.98%	1.24%
MASSACHUSETTS	2.70	(1.81)	5.84	-249.01%	-131.06%
RHODE ISLAND	1.63	(8.79)	2.71	-118.56%	-424.83%
NEW YORK	(0.66)	0.47	4.97	-242.71%	-90.65%
ALASKA	(15.57)	(21.57)	(13.89)	-27.81%	55.36%

"Hospital Statistics", tables 5 & 11.

NATIONAL HOSPITAL COMPARISONS
PROFIT PER ADMISSION BY STATE
AHA SURVEYS, 1987 - 1989

STATE	PROFIT PER ADMISSION BY STATE 1989	1988	1987	PERCENT CHANGE 1989-1988	1988-1987
TOTAL U.S.	$161.40	$146.36	$168.06	10.28%	-12.91%
NEBRASKA	354.27	272.71	239.91	29.91%	13.67%
SOUTH CAROLINA	350.13	274.34	233.94	27.63%	17.27%
SOUTH DAKOTA	324.77	219.39	274.22	48.03%	-20.00%
MONTANA	298.19	198.27	233.62	50.40%	-15.13%
NEW HAMPSHIRE	287.80	261.94	206.91	9.87%	26.60%
ALABAMA	283.65	220.43	176.48	28.68%	24.91%
KENTUCKY	280.74	257.56	235.24	9.00%	9.49%
NEVADA	270.12	306.92	380.93	-11.99%	-19.43%
MISSOURI	257.30	251.74	284.30	2.21%	-11.45%
IDAHO	248.98	238.55	175.90	4.37%	35.62%
GEORGIA	248.68	238.29	246.83	4.36%	-3.46%
VIRGINIA	226.11	221.00	235.72	2.31%	-6.24%
NEW MEXICO	224.10	114.71	181.34	95.36%	-36.74%
IOWA	218.38	163.85	169.16	33.28%	-3.14%
ILLINOIS	216.13	134.69	204.89	60.46%	-34.26%
KANSAS	213.56	148.35	163.56	43.96%	-9.30%
WASHINGTON	208.81	177.41	223.20	17.70%	-20.51%
FLORIDA	203.22	178.24	196.59	14.01%	-9.34%
NORTH CAROLINA	203.00	205.05	158.91	-1.00%	29.04%
NORTH DAKOTA	198.99	183.21	205.50	8.62%	-10.85%
OREGON	197.49	229.49	198.18	-13.94%	15.80%
VERMONT	194.19	147.40	125.52	31.74%	17.43%
TENNESSEE	191.83	237.10	229.73	-19.09%	3.21%
INDIANA	190.41	175.81	152.11	8.31%	15.58%
OKLAHOMA	182.46	130.68	166.99	39.62%	-21.74%
ARKANSAS	180.04	263.26	205.57	-31.61%	28.06%
OHIO	172.72	119.46	140.89	44.58%	-15.21%
TEXAS	168.92	134.47	158.80	25.62%	-15.32%
CALIFORNIA	168.89	162.47	202.75	3.95%	-19.87%
COLORADO	163.22	184.37	114.76	-11.47%	60.65%
LOUISIANA	156.35	91.55	190.15	70.78%	-51.85%
MISSISSIPPI	155.32	147.69	129.34	5.17%	14.18%
CONNECTICUT	149.72	103.98	161.95	43.99%	-35.79%
MINNESOTA	142.72	177.28	125.95	-19.49%	40.75%
MICHIGAN	138.17	142.30	125.50	-2.90%	13.38%
PENNSYLVANIA	135.15	193.84	233.87	-30.28%	-17.12%
WEST VIRGINIA	128.15	83.37	54.20	53.72%	53.82%
WISCONSIN	126.82	94.28	112.96	34.52%	-16.54%
UTAH	123.66	106.91	217.25	15.67%	-50.79%
MARYLAND	115.48	63.69	141.73	81.30%	-55.06%
ARIZONA	97.75	82.14	155.35	19.01%	-47.12%
HAWAII	91.29	229.12	253.83	-60.15%	-9.73%
MAINE	78.26	81.73	75.50	-4.24%	8.26%
WYOMING	66.94	20.20	103.66	231.40%	-80.51%
WASHINGTON DC	65.70	190.34	349.70	-65.48%	-45.57%
NEW JERSEY	58.49	61.17	106.83	-4.37%	-42.75%
DELAWARE	22.16	94.57	91.84	-76.56%	2.97%
MASSACHUSETTS	20.69	(14.24)	44.95	-245.24%	-131.69%
RHODE ISLAND	12.20	(70.72)	21.66	-117.25%	-426.42%
NEW YORK	(6.64)	4.48	45.91	-248.15%	-90.23%
ALASKA	(90.44)	(125.87)	(79.17)	-28.15%	58.99%

"Hospital Statistics", tables 5 & 11.

APPENDIX 4

Please refer to the "Summary Of Recommendations" which appear on pages xv through xxi of this report.

APPENDIX C

LETTER DATED APRIL 26, 1990, TO DOROTHY S. GALLAGHER, CHAIRMAN, BOARD OF REGENTS, UNIVERSITY OF NEVADA SYSTEM, FROM SENATOR RAYMOND D. RAWSON, CHAIRMAN OF THE COMMITTEE ON HEALTH CARE

STATE OF NEVADA
LEGISLATIVE COUNSEL BUREAU
LEGISLATIVE BUILDING
CAPITOL COMPLEX
CARSON CITY, NEVADA 89710

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Donald A. Rhodes, *Director, Secretary*

INTERIM FINANCE COMMITTEE (702) 687-6821
WILLIAM J. RAGGIO, *Senator, Chairman*
Daniel G. Miles, *Fiscal Analyst*
Mark W. Stevens, *Fiscal Analyst*

JOHN R. CROSSLEY, *Legislative Auditor* (702) 687-6815
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LORNE J. MALKIEWICH, *Legislative Counsel* (702) 687-6830

April 26, 1990

Dorothy S. Gallagher, Chairman
Board of Regents
University of Nevada System
2601 Enterprise Road
Reno, Nevada 89512

Dear Chairman Gallagher:

At its meeting in Elko, Nevada, on April 11, 1990, the Nevada Legislature's Committee on Health Care (Nevada Revised Statutes 439B.200) discussed Nevada's nursing and related manpower shortage. During the meeting, the members of the committee agreed that one of the most important ways to impact the shortage is the education of higher numbers of nurses through the University of Nevada System (UNS).

Testimony indicated that UNS offers a fine nursing education on all levels; however, documentation exists that supports enlarging the programs. It appeared to the members of the committee that, while the UNS has expanded its programs, it is maintaining the "status quo" by graduating a number of students that may parallel the state's rate of growth, but that will never impact the nursing shortage in Nevada. The committee supports further expansion of the programs so that an increased number of students will graduate.

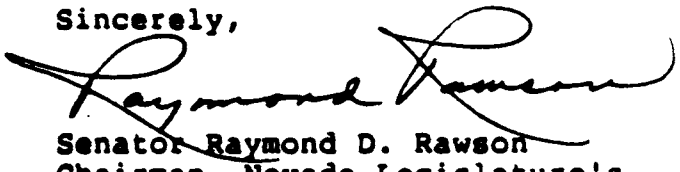
In addition, the committee suggests that UNS aggressively recruit talented Nevada students--both in high school and college--to nursing programs. Also important is that increased financial aid opportunities be offered to nursing students to maintain their participation.

Consequently, the Legislature's Committee on Health Care requests that UNS approach the 1991 Nevada Legislature with a bold plan to expand its nursing and other health occupational programs on all levels. The members expect such a plan to include innovative and progressive programs to recruit, maintain, and graduate an increased number of students qualified to fill positions ranging from technicians and auxiliaries to advanced nurse practitioners.

The committee pledges its support to UNS throughout the budget process in order to obtain the increases needed for nursing education in Nevada to realize its full potential. While recognizing that gaining the approval for the necessary funding may be difficult, the committee views the nursing shortage as a critical issue directly affecting the health of all Nevadans. We intend to impress this fact on our colleagues in the Legislature and will support the UNS request as a realistic, workable approach to the problem.

The Legislature's Committee on Health Care looks forward to working together with UNS in addressing this serious issue.

Sincerely,



Senator Raymond D. Rawson
Chairman, Nevada Legislature's
Committee on Health Care

RDR/sa:Health,L7
cc: Carolyn M. Sparks, Regent
Mark Dawson, Chancellor
Warren Fox, Vice Chancellor

bcc: Allison McPherson, Clark County Community College

APPENDIX D

Suggested Legislation

Copies of the suggested legislation were not completed at the time this report was printed. A list of the committee's recommendations and corresponding bill draft request (BDR) numbers, where appropriate, may be found in this report's "Summary Of Recommendations," pages xv through xxi.