MINUTES OF THE MEETING
OF THE
LEGISLATIVE COMMITTEE ON HEALTH CARE
(*Nevada Revised Statutes* 439B.200 through 439B.240)
April 18, 2000
Las Vegas, Nevada

The fifth meeting of Nevada's Legislative Committee on Health Care for the 1999-2000 interim was held on Tuesday, April 18, 2000, at 9:30 a.m., in Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. This meeting was videoconferenced to Room 3138, Legislative Building, Carson City, Nevada. Pages 2 through 4 contain the "Meeting Notice and Agenda" for this meeting.

COMMITTEE MEMBERS PRESENT IN LAS VEGAS:

Assemblywoman Ellen M. Koivisto, Chairman
Senator Raymond D. Rawson
Senator Bernice Mathews
Senator Maurice E. Washington
Assemblywoman Merle A. Berman

COMMITTEE MEMBERS PRESENT IN CARSON CITY:

Assemblywoman Vivian L. Freeman

LEGISLATIVE COUNSEL BUREAU STAFF PRESENT:

Marla McDade Williams, Senior Research Analyst, Research Division
Risa B. Lang, Principal Deputy Legislative Counsel, Legal Division
Debby Richards, Manager of Office Services, Research Division
Paige Clyde, Senior Research Secretary, Research Division

MEETING NOTICE AND AGENDA

Name of Organization:	**Legislative Committee on Health Care** ***(Nevada Revised Statutes* 439B.200)**
Date and Time of Meeting:	Tuesday, April 18, 2000 9:30 a.m.
Place of Meeting:	Grant Sawyer State Office Building Room 4401 555 East Washington Avenue Las Vegas, Nevada

Note: Some members of the committee may be attending the meeting and other persons may observe the meeting and provide testimony, through a simultaneous video conference conducted at the following location:

Legislative Building

Room 3138
401 South Carson Street
Carson City, Nevada

If you cannot attend the meeting, you can listen to it live over the Internet. The address for the Legislative Web site is http://www.leg.state.nv.us. For audio broadcasts, click on the link "Listen to Meetings Live on the Internet."

A G E N D A

I. Opening Remarks by the Chairman

*II. Presentation Concerning Efforts in Nevada to Reduce the Rate of Teenage Pregnancies and Recommendations for Additional Efforts to Prevent or Reduce Teenage Pregnancies

A. Yvonne Sylva, Administrator, Health Division, Nevada's Department of Human Resources (DHR)

B. Mary Sassi, Bureau Chief, Bureau of Community Health Services, Health Division, DHR

C. Tony Williams, Metropolitan Family Resource Center

D. Trudy Larson, President, Nevada Public Health Foundation

E. Candy Krausmen, Community Action Team, Sunrise Children's Foundation

F. Allison Gaulden, Associate Vice President of Public Affairs, Planned Parenthood Mar Monte

G. Theresa King, Co-Chairperson, Las Vegas Community Action Team for Teen Pregnancy Prevention, Economic Opportunity Board of Clark County

*III. Report Concerning the Pediatric Diabetes and Endocrinology Center (PDEC), University of Nevada School of Medicine (UNSOM); Information Concerning the Activities of the Nevada Diabetes Council; and Recommendations for Legislation Concerning Access to Diabetes Care

A. Dr. Bernard Feldman, Chairman of the State Board of Health, Professor, and Chairman/Residency Director, Department of Pediatrics, UNSOM; Denise Hall, Diabetes Coordinator, PDEC; and Rosalie Montoya, Medical Social Worker, PDEC

B. Kevin Kennedy, Vice Chairman, Nevada Diabetes Council, and Carolyn Leontos, Member, Nevada Diabetes Council

C. Mylan Hawkins, Vice Chairman, Access to Care/Public Policy Committee, Nevada Diabetes Council, and Executive Director, Nevada Diabetes Association for Children and Adults, and Dr. Claude K. Lardinois, Member at Large, Nevada Diabetes Council

*IV. Background Information and Consideration of an Option to Expand Coverage in the Nevada Medicaid and Nevada Check-Up Programs by Adopting "Presumptive Eligibility" for Certain Pregnant Women and Children

A. Rhonda Gonzalez, Health Policy Specialist, National Conference of State

Legislatures

B. Mary Guinan, Ph.D., M.D., State Health Officer, Health Division, DHR

C. Jon L. Sasser, State Advocacy Coordinator, Washoe Legal Services

D. William R. Hale, Corporate Executive Officer, University Medical Center of Southern Nevada

E. Roger Volker, Executive Director, Great Basin Primary Care Association

F. Louise Bayard-de-Volo, Nevada Women's Lobby

*V. Presentation Concerning the Delivery of Health Insurance Coverage to Members of the Las Vegas Chamber of Commerce

Kami Dempsey, Manager of Government Affairs, Las Vegas Chamber of Commerce

*VI. Discussion of Recommendations Concerning Health Insurance Benefit Mandates and "Freedom of Choice" for Individual Purchasers of Health Insurance

Jeanette K. Belz, Director of Government Relations, Wadhams & Akridge

*VII. Presentation Concerning Rural Health Issues as They Affect Nevada's County Governments

Robert S. Hadfield, Executive Director, Nevada Association of Counties

*VIII. Discussion of Recommendations Concerning Rural Health Issues

Caroline Ford, M.P.H., Assistant Dean/Director, Center for Education and Health Services Outreach, UNSOM

IX. Discussion of Future Topics

X. Public Testimony

XI. Adjournment

*Denotes items on which the committee may take action.

Note: We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Research Division of the Legislative Counsel Bureau, in writing, at the Legislative Building, 401 South Carson Street, Carson City, Nevada 89701-4747, or call Kennedy at (775) 684 -6825 as soon as possible.

Notice of this meeting was posted in the following Carson City, Nevada, locations: Blasdel Building, 209 East Musser Street; Capitol Press Corps, Basement, Capitol Building; City Hall, 201 North Carson Street; Legislative Building, 401 South Carson Street; and Nevada State Library, 100 Stewart Street. Notice of this meeting was faxed for posting to the following Las Vegas, Nevada, locations: Clark County Office, 500 South Grand Central Parkway; and Grant Sawyer State Office Building, 555 East Washington Avenue.

OPENING REMARKS BY THE CHAIRMAN

Chairman Ellen M. Koivisto opened the meeting and asked the secretary to call the roll. She stated that recommendations for proposed legislation would be discussed and determined at the committee's final meeting in June 2000. Furthermore, issues and specific recommendations not previously reviewed by the Health Care Committee must be submitted on or before May 15, 2000, for inclusion in the work session document for consideration at the

June meeting.

PRESENTATION CONCERNING EFFORTS IN NEVADA TO REDUCE THE RATE OF TEENAGE PREGNANCIES AND RECOMMENDATIONS FOR ADDITIONAL EFFORTS TO PREVENT OR REDUCE TEENAGE PREGNANCIES

Yvonne Sylva

Yvonne Sylva, Administrator, Health Division, Nevada's Department of Human Resources (DHR), gave a slide presentation and stated that Nevada ranked second in the nation in teen pregnancy from 1990 to 1992 according to a report in published in 1995 by the Centers for Disease Control and Prevention (Exhibit A, Tab A). With regard to the Health Division's efforts to reduce teenage pregnancy rates, she noted:

- The Health Division and the Attorney General's Office formed a state team responsible for researching nationwide model programs that were scientifically evaluated and proven to be effective in preventing teen pregnancies. The team also conducted a series of community meetings in three Nevada cities: (1) Elko; (2) Las Vegas; and (3) Reno, for the purpose of gathering input and reviewing local, state, and national teenage pregnancy data. The state team concluded that teen pregnancy and the risk behaviors associated with it are multi-faceted and must be addressed in a multidisciplinary and comprehensive manner.

- Effective teenage pregnancy programs shared the following common characteristics: (1) they are age appropriate; (2) they provide format variety; (3) they provide an opportunity for youth to personalize the program goal; and (4) they provide activities addressing the social and media influences on sexual behavior.

- Common problems with school-based teenage pregnancy prevention programs include: (1) a curriculum content that varies and is not uniform by school or school district; (2) teenage adult males who are the fathers to babies born to teenage mothers, do not attend school regularly and they fail to benefit from the interaction and influential components of these programs.

- Common problems with Nevada programs include: (1) few are designed for non-pregnant youth but address teen mother or pregnant teenager issues; (2) a multifaceted approach is necessary because no single program is effective; (3) further examination of the disparity between pregnancy rates of various racial and ethnic groups is needed; and (4) teen pregnancy prevention extends beyond sexuality education, and youth need to be instilled with confidence and a sense of the future.

- Solutions for prevention of teenage pregnancy in Nevada include:

    1. The formation of a task force to reduce teen pregnancy rates amongst racial and ethnic segments of Nevada's population. Hispanic task forces in southern and northern Nevada will meet in May of 2000 to discuss concerns and develop strategies. Currently, the Health Division is promoting the availability of bilingual materials and developing Nevada-specific material in Spanish that was obtained from the National Campaign to Prevent Teen Pregnancy. Additionally, the Nevada Public Health Foundation (NPHF) hires Spanish-speaking consultants to provide programs such as "Positive Choices" and "Positive Futures."

Ms. Sylva reported that the rate among Hispanic teens increased less than one pregnancy per 1,000, from 124.5 in 1998 to 124.7 in 1999, and stated it is the smallest increase occurring within the Hispanic youth population in the past seven years. She reminded committee members that the 1999 data is preliminary and that finalized data would be available in July 2000.

Ms. Sylva continued listing Nevada's solutions to decrease teenage pregnancy rates:

2. In January of 1996 a plan for action was established with recommendations for state leadership, parental involvement, male involvement, community action, public information, and legislative action. The goal of this plan is to reduce Nevada's teen pregnancy rate in the 15 to 17 age group to no more than 50 pregnancies per 1,000 by the year 2000. At the time the action plan was developed, the teen pregnancy rate among this

age group was 63 pregnancies per 1,000, and has decreased to 48 pregnancies per 1,000 in 1998. Other major accomplishments include formation of the following: (1) the Governor's Youth Advisory Council (YAC); (2) the NPHF; and (3) more than 40 community action teams (CATs). The Governor's YAC developed a 40-minute presentation for middle-school aged children called "Abstinence Works," which has been provided to approximately 1,500 students statewide since August of 1999.

3. The Health Division is currently working with and forming new CATs. Some of those teams are beginning to form and assess their needs related to teen pregnancy prevention. Other teams are applying for funding, beginning to implement programs and activities, and are selecting or developing programs and activities based on the needs of their communities. Programs such as Apple Blossoms and Friends First promote abstinence while others offer education on contraception. Staff members are currently developing several task forces to begin addressing male involvement in teen pregnancy prevention in specific segments of communities, and she reported that male involvement is critical to teen pregnancy prevention.

4. The second action plan for teen pregnancy prevention in Nevada, titled "Meeting the Challenge of the New Millennium," was released in December 1999 and was developed by a state team including all divisions of the DHR and the State Department of Education. This plan contains recommendations for continuing and expanding teen pregnancy prevention efforts during the next five years, which emphasizes: (1) state leadership; (2) community involvement; (3) continued expansion of CATs; (4) increased family involvement; (5) male involvement; and (6) a focus on high-risk communities.

5. A public awareness campaign by the Health Division includes a Web page for teen pregnancy prevention at www.state.nev.us/health/teen. This Web site includes information on the action plan, CATs, and current data. Additionally, Reno hosted the first regional National Campaign to Prevent Teen Pregnancy in June 1999. May 2000 is National Teen Pregnancy Prevention Month.

Concluding her remarks, Ms. Sylva stated the Health Division and its partners would continue to place a high priority on reducing teenage pregnancy in Nevada by utilizing community-based strategies in both public and private sectors. Nevada must redouble its efforts to prevent teen pregnancy and its corresponding risk factors to improve adolescent health statewide. In her opinion, Nevada would achieve its greatest success in this endeavor through outreach efforts using an abstinence-based message combined with anatomical information, education on the proper use of contraception, and positive information regarding life options.

Senator Rawson expressed his concern regarding the statistic that three-quarters of the fathers of babies born to teen mothers are over the age of 19 and he stated that aggressive action should be taken regarding this issue. Responding, Ms. Sylva reported that the Health Division has worked extensively with the Attorney General's Office, the Governor's YAC, and the NPHF to address this issue. As a result, they have developed public service announcements to bring attention to sexual advances and assaults, and she said this issue needs resolution.

Continuing, Senator Rawson noted the figures of teenaged mothers who are having a second child and asked if this issue is under deliberation. Responding, Ms. Sylva stated that the Health Division is evaluating data, but its database is not sophisticated enough to collect second birth statistics. She also noted that the report does not differentiate between married and unmarried adolescents but that the Health Division generally reviews the 15 to 17 year old age bracket as that group that needs attention.

Mary Sassi

Mary Sassi, Bureau Chief, Bureau of Community Health Services, Health Division, DHR, provided comment on the bureau's teen pregnancy reduction efforts.

She stated that in 1993, with support of funding from the Federal Family Planning Program Title X, the bureau began a pilot project titled "Adolescent Pregnancy Prevention and Leadership Enhancement" (APPLE) (Exhibit B). This program focuses on developing problem solving and decision-making skills among youth to enhance their self-image and leadership qualities. In addition, a monetary incentive of $10 per meeting is provided to encourage teen attendance. She pointed out that while some individuals found the $10 incentive objectionable, it was insignificant when compared to the cost paid to families with a pregnant teenager.

Ms. Sassi reported that recent research has shown that two-thirds of teenage mothers have been sexually abused. Teenagers are a high-risk group for prenatal complications due to the lack of prenatal care, premature births, and low birth-weight babies. Thus, taxpayers are devoting millions of dollars in public funds for the care of children with special health care needs.

Ms. Sassi noted APPLE's primary objectives include delaying teenage pregnancy and promoting high school graduation among high-risk youth, ages 14 to 16. She stated that APPLE participants attend regularly scheduled biweekly meetings where information is provided on issues pertaining to family life, human sexuality, substance and alcohol abuse, contraception, personal relationships, and responsibilities of adulthood. Other sessions focus on self-esteem, setting goals, identifying and developing interests, and decision-making skills. Ms. Sassi reported that efforts are made to create a supportive and non-judgmental setting. She said that parental notification is encouraged for participation in the group.

Continuing, Ms. Sassi reported that the Health Division initially formed an APPLE group under the stewardship of community health nurses in three rural counties in Nevada with high teen birth rates: (1) Humboldt; (2) Lander; and (3) Lyon Counties

Ms. Sassi identified "Boys Encouraging Adolescent Responsibility" (BEAR) as a program similar in structure and format to APPLE. Funding for both programs is provided by Nevada's Family Grant on a permanent basis. Participants receive a $10 incentive for attending meetings. There are currently six APPLE programs and two BEAR groups, with Battle Mountain, Nevada, forming a third BEAR group in Fall 2000.

Ms. Sassi listed the factors that make teenagers high risk, which are also the eligibility requirements for admission in the APPLE and/or BEAR programs. Participation in the program is dependent upon:

- A negative result on a pregnancy test administered by a community health nurse or has not fathered a child.
- A parent who was a teenager at the time of the teenager's birth.
- A history of drug and/or alcohol abuse.
- A below grade level ranking in academic performance for at least one-year.
- A sibling who is a teen parent.
- Participation in the foster care system.
- A history of being sexually active or is currently sexually active.
- A history of juvenile probation.
- A history of being a victim of abuse or currently a victim of abuse.

Ms. Sassi concluded by giving examples of teenagers as victims and urged the committee to examine the successes of APPLE participants when making recommendations and she noted that 88 percent of high-risk teenagers in this program remain in school and do not become pregnant.

Tony Williams

Tony Williams, Case Manager, Center Director, Metropolitan Family Resource Center, North Las Vegas, Nevada, stated that the teen pregnancy prevention program began in July 1998. He said the neighborhood-based program stresses abstinence and encourages realistic discussions on sexuality. He reported that 37 to 51 teenagers participate in the program that encourages male involvement and only two cases of teen pregnancy have been reported since July 1998. In his opinion, it is the success of this program that has attracted ten additional faith-based organizations to model teen pregnancy prevention programs in a similar manner. He added that funding is through private donations.

Mr. Williams said the program's approach recognizes that cultural differences and attitudes toward teen pregnancy have been problematic but the message remains ". . .this is not a foreign land or third world country and it is unacceptable to become a teenage mother." He acknowledged barriers between cultures and said that parents are not invited into the discussion sessions for that reason.

Responding to a question from Assemblywoman Merle Berman, Mr. Williams clarified program funding saying a one-time payment of $5,000 was received to form CATs. He said that the Family Resource Center is funded through the State, but not the teen pregnancy prevention program. He added that other Family Resource Centers are working in collaboration with CATs on teen pregnancy issues, but no formal programs exist.

Trudy Larson, M.D.

Trudy Larson, M.D., President, NPHF, and Staff Member, University of Nevada School of Medicine, gave the committee an overview of the collaboration between the NPHF and the Health Division (Exhibit C). The NPHF was established in 1996 to attract resources and address the state's public health issues. Its first program focused on teen pregnancy prevention but now includes a variety of public health issues. With offices in Reno and Las Vegas, the NPHF operates the following organizations:

- The Teenage Pregnancy Prevention Program, which contributed three components of a document jointly issued by Nevada's Attorney General's Office and Nevada's State Health Division (*Responding to Teen Pregnancy in Nevada: A Four-Year Plan of Action to Reduce Teen Pregnancy [1999–2000]).* Those components are community action, media/public information, and parental involvement.

- The Parent Education program is funded through the U.S. Office of Populations Affairs and concentrates on educating parents of children 10 to 14 years of age. The curriculum focuses on value systems specific to culturally diverse communities. It provides parent training and is communicated through advertisements.

- The Statutory Rape Education program is funded through grants or contracts by the Welfare Division, DHR, and instructs counselors, educators, and law enforcement officials on how to aggressively enforce and interpret statutory rape laws.

- The Sexual Assault Prevention Education Program is funded through grants from the Health Division and the Attorney General's Office. Media campaigns include: (1) distribution of bilingual posters to middle and high schools; (2) date rape pamphlets for statewide circulation; (3) public awareness activities on high school and college campuses; and (4) educational presentations by a staff member traveling to high school campuses.

- The Healthy Communities Grant Distribution Program is funded through Washoe Health Systems and financially endows the following focus groups:

    1. The Moms & Mentor Program, which provides support to teen mothers by encouraging them not to have a second pregnancy.

    2. The Crisis Pregnancy Center that offers referrals and prenatal care.

    3. The program expansion of Reno's Planned Parenthood Mar Monte to include males.

Ms. Larson concluded by saying the NPHF will continue to focus resources on teen pregnancy with the goal of seeing diminishing figures.

Responding to questions by Assemblywoman Freeman, Ms. Larson said referral information is distributed in Washoe County schools, but she stressed that the "community voice" needs to be unanimous in sending a clear message to youth that premature pregnancy is not acceptable. She said that television, radio, and Web sites would be pivotal in reaching the appropriate audiences noting that school districts would need to establish uniform access to the Internet. Ms. Larson said the NPHF is funded through federal and foundation grants and fundraisers. The NPHF vigilantly avoids duplication of services and encourages active communication between all the programs that are serving similar

populations.

Candy Krausmen

Candy Krausmen, Community Action Team, Sunrise Children's Hospital Foundation, told committee members that Baby Think It Over is a grant-funded program within the foundation that targets teen pregnancy prevention. Presentations and curriculum were first introduced to 9,000 middle and high school students in 1999. The foundation currently loans plastic simulator babies to students for parental imitation purposes. Ms. Krausmen demonstrated for committee members how birth defects such as Fetal Alcohol Syndrome are programmed into plastic simulator babies with symptomology manifested by random crying and shaking. In 2000, 80 teachers are expected to participate in assisting the foundation by loaning plastic simulator babies to students.

Ms. Krausmen concluded by listing the options for pregnant teenagers: (1) abortion; (2) adoption; (3) marriage; and (4) single parenthood.

Responding to a question from Assemblywoman Berman, Ms. Krausmen identified difficulties in tracking and obtaining measurable results throughout a youth's critical years. She said there is a need for statistics, principally teenagers' first and subsequent birth rates.

Allison Gaulden

Allison Gaulden, Vice President of Public Affairs, Planned Parenthood Mar Monte, Reno, introduced her colleague, J. J. Straight, Director of Public Affairs, Planned Parenthood of Southern Nevada, Las Vegas. She said Planned Parenthood is recognized as the leading expert in women's health care including teen sexuality, education, and communication (Exhibit D). Ms. Gaulden told committee members that all of the previous testimony regarding teen pregnancy prevention programs is mirrored in Planned Parenthood services including the plastic simulator baby loan program. She stated that Planned Parenthood statistics show a 96 percent success rate in preventing second pregnancies of parenting teenagers.

Responding to questions from Assemblywoman Berman, Ms. Gaulden reported that statistics regarding prevention of first pregnancies in teenage women are not available. Continuing, Ms. Gaulden spoke of Planned Parenthood programs stressing abstinence and safe sex. She expressed concern for a perceived position by the Washoe County School District, which prohibits Planned Parenthood from speaking to teenagers about condoms and contraceptive methods in schools.

Ms. Gaulden said that Nevada is ranked at the top of national teen pregnancy studies despite recent declines in pregnancy rates within the state. She added that 40 percent of American teenagers have unintended, often unwanted, pregnancies each year, which negatively affect teen parents, their children, and society in general. Teenaged mothers are more likely to drop out of school, live in poverty, and their children frequently experience health and developmental problems. She listed the following statistics:

- Teenage pregnancy poses a significant financial burden with an estimated $7 billion loss of tax revenues and expenses for child health care, foster care, and involvement in the criminal justice system.
- Nearly one million teenaged women become pregnant, 78 percent of which are unintended.
- Teenage mothers are less educated, less likely to be married, and nearly 80 percent utilize the welfare system.
- Children of teen mothers are three times as likely to be incarcerated in adolescence or in their early 20s than children of older mothers.
- National and state polls consistently show that 80 to 90 percent of American adults support sex education in schools including contraception, disease prevention, and abstinence curriculums.

Ms. Straight informed committee members that an alarming number of teenage women are unaware of basic health education in the Clark County School District and spoke of the need for a revised curriculum to more accurately

reflect issues facing teens at high risk. She said that sex education in schools is failing.

Ms. Gaulden concluded by suggesting the implementation of mandatory, medically accurate sexuality education programs that are consistent in every Nevada school district beginning with middle-school. She said easy access to contraception and other forms of reproductive health care should be available, as well as straightforward public health media campaigns. She urged the committee to recognize the need for government to support the right of teenagers to access accurate information and confidential services.

Responding to questions by Assemblywoman Freeman, Ms. Gaulden said the Washoe County School District prevented Planned Parenthood from visiting schools, but allowed other programs such as the Crisis Pregnancy Center to make presentations to students. Ms. Straight said that in her opinion, the Clark County School Board did not view Planned Parenthood as a resource.

Continuing to respond to Assemblywoman Freeman's questions, Ms. Gaulden reported that the plastic simulated babies are privately funded and the biggest problem is not tampering, but early return. She said more plastic simulated babies are needed as well as a methodology of tracking the impacts of this program. She said that Planned Parenthood's Teen Success Program focuses on the prevention of a teen mother's second pregnancy

Mathew Dushoff

Mathew Dushoff, Deputy Attorney General, Las Vegas, made the following points on behalf of Attorney General Frankie Sue Del Papa. Ms. Del Papa is also a member of the Local and State Action Task Force of the Nevada Campaign to Prevent Teen Pregnancy, Washington D.C.:

- The Four-Year Action Plan was prepared in 1996 and expires this year.
- A single solution does not exist for teen pregnancy in Nevada because of the multifaceted nature of the problem.
- The Office of the Attorney General acknowledged Yvonne Sylva's involvement, commitment, and vision.
- The Campaign to Prevent Teen Pregnancy focuses on five issues: (1) taking a clear stand against teen pregnancy; (2) enlisting the help of the media and attracting powerful voices; (3) supporting and stimulating state and local action; (4) leading a national discussion on the role of religion, culture, and public value in an effort to build common ground; and (5) efforts are based on the best facts and research available.
- A document titled "Risky Business – A 2000 Poll," reveals insights on how participating teenagers feel about contraception and sex (Exhibit E).
- Preventing teen pregnancy is cost effective.
- Purposely involving diverse groups of teens from local organizations will contribute toward a stronger and more effective program.
- Nevada's teenage pregnancy figures are staggeringly high.
- The efforts of the legislative committee in this matter are applauded.

Mr. Dushoff then presented the proposed legislation of The Nevada Coalition Against Sexual Violence, which is an organization conceived by Ms. Del Papa. The mission of the Coalition is to eliminate sexual violence with both the enhancement of sexual assault prevention services through intervention, education, research, legislation, and public policy. He said the coalition seeks to form sexual assault response teams to coordinate efforts through rural communities and counties. This effort will enlist law enforcement, sexual assault nurses, and rape crisis counselors. Statewide multidisciplinary education is necessary to teach the issues of sexual assault. He reported that the coalition is the recipient of a $300,000 federal grant to combat Internet crimes against children.

On a related topic, Mr. Dushoff stated that sentencing is disproportional between lewdness and statutory seduction crimes regarding children under age 14. He directed the committee's attention to a document (Exhibit F) and explained that the coalition is considering a proposal to amend the statute because it is the Attorney General's opinion that a child under age 14 is mentally incapable of consensual sexual intercourse with an adult over age 21. He explained that NRS 200.364, "Definitions," addresses the current statutory sexual seduction law in Nevada, and it applies to all children under the age of 16. The proposed statute will apply to improper sexual conduct between certain school employees and pupils. The current law specifies that a school employee over 21 years of age is guilty of a category C felony if he is found to have had sex with a child 16 or17 years of age. This law does not apply to a 15-year old or younger victim.

Responding to a question from Senator Rawson, Mr. Dushoff clarified that 16 is the age of consent for statutory rape. Lewdness with a minor applies to children under the age of 14. He said these two laws need to be congruous. Mr. Dushoff stated his opinion that radical changes in the law were unrealistic and that is why the coalition proposed "small steps" in changing legislation to protect children under the age of 16.

Senator Rawson stated that he would support the coalition in this effort, saying that adults over age 21 should not have sexual intercourse with children under the age of 16. He pointed out that current laws are protecting men who are at the root of the teen pregnancy issue and all of its complications.

REPORT CONCERNING THE PEDIATRIC DIABETES AND ENDOCRINOLOGY CENTER, UNIVERSITY OF NEVADA SCHOOL OF MEDICINE; INFORMATION CONCERNING THE ACTIVITIES OF THE NEVADA DIABETES COUNCIL; AND RECOMMENDATIONS FOR LEGISLATION CONCERNING ACCESS TO DIABETES CARE

Bernard Feldman, M.D., M.P.H.

Bernard Feldman, M.D., M.P.H., Chairman of the State Board of Health, Professor, and Chairman/Residency Director, Department of Pediatrics, University of Nevada School of Medicine (UNSOM), stated that in 1985, Nevada had the lowest neonatal mortality rate nationally, but the State has spent the most money on intensive care. He highlighted the following expenditures of $369,500 appropriated to the School of Medicine for the expansion of the existing Pediatric Diabetes and Endocrinology Center (PDEC) for the care of children with diabetes and other endocrine disorders (Exhibit G):

- Billings generated by program physicians since July 1, 1999, totaled $352,116. The collection ratio in the south was 24 percent and 80 percent in the north. This ratio difference reflects the penetrance of Medicaid managed care and the commercial bargaining power of health maintenance organizations in the south as well as the numbers of children without medical insurance coverage, most of whom reside in Clark County. Thus, the payor mix is a major determinate affecting the program's self-sufficiency.

- Recruitment for a pediatric endocrinologist and psychologist are ongoing.

- An advisory board was created in compliance with Senate Bill 560, "Makes various changes relating to governmental administration," (Chapter 544, *Statutes of Nevada 1999*).

- Legislation requires the PDEC to conduct data analysis to evaluate its financial situation as well as the medical results of the patients who receive care under the program. There is currently no funding available to purchase the necessary software and a computer to accomplish this mandate because S.B. 560 specifically designated the appropriations for salaries and overlooked expenses for operations, supplies, or equipment.

Dr. Feldman concluded by saying it is evident from the first nine months of the PDEC program that the revenues collected will be insufficient to continue the expenses and salaries on an ongoing basis. He asked that a bill draft request be developed to provide funding for the program. Additionally, he asked that the committee allow funding for equipment, operating, and travel costs. He offered to supply a revised budget.

Responding to comments by Senator Rawson, Dr. Feldman said that a physician who formerly worked at the center may return to the program and said he would speak to the budget staff at UNSOM to ensure that the PDEC was included in its annual budget. Senator Rawson said the committee's Work Session should include a bill draft request to ensure financing for the PDEC.

Rosalie Montoya

Rosalie Montoya, Clinical and Medical Social Worker, PDEC, told committee members that she has been employed by the UNSOM since March 1999 as a Diabetes Support Coordinator. She listed several of her duties and spoke about the frustration of parents and children with diabetes regarding medical regime compliance, pain and suffering of the child, diabetic teen suicide ideation rates, managed care issues, and a continual search for financial assistant resources (Exhibit H). Ms. Montoya said additional duties as a coordinator include making referrals to diabetes support groups, camps, and home/public health agencies. She said that it is her job to make referrals to Child Protective Services for child medical neglect when the current system fails.

Continuing, Ms. Montoya stated her duties as a Medical Social Worker are to help families determine factors that interfere with their abilities to obtain medical, emotional, and physical care for their children with diabetes. Her job requires that she identify and find solutions for families with the following difficulties: (1) stress management; (2) bureaucracy; (3) childhood depression; (4) family dysfunction; and (5) life adjustment issues.

Concluding, Ms. Montoya said that financing support services to families with children with diabetes is cost effective because it reduces hospitalizations due to poor diabetic management and can decrease serious complications such as blindness and kidney disease.

Heather Skelton

Heather Skelton, mother of a child with diabetes, reported that her daughter was diagnosed nine years ago when Nevada did not have a pediatric center. She expressed her appreciation for the PDEC and commented on the efficiency of the multidisciplinary team to address all aspects of diabetes including psychosocial and medical issues. She thanked the committee for funding the School of Medicine and allowing the PDEC to exist.

Monica Meeham

Monica Meeham, mother, held her four-year old son Christopher to the microphone to tell committee members that he had diabetes and he "needed" Dr. Henry Artman. Ms. Meeham expressed appreciation for the multidisciplinary team, which assisted the entire family as well as her 4-year-old child. She said that hospitalization costs were dramatically reduced when physicians were available via telephone for advice and noted that the PDEC serves approximately 400 diabetic children.

Kevin Kennedy

Kevin Kennedy, Vice Chairman, Access to Care/Public Policy Committee, Nevada Diabetes Council, reported council activities:

- There are three measurable indicators of diabetes. Diabetic MediCal beneficiaries will receive annual hemoglobin A1C's, biennial eye exams, and biennial lipid profiles. In 1998, MediCal beneficiary statistics included:

  1. 70 percent received at least one hemoglobin A1C.

  2. 64 percent received an eye exam.

  3. 62 percent received lipid profiles.

Mr. Kennedy said that there is room for improvement and Nevada is "average" when compared to the management of diabetes by other states. He said that the Nevada Diabetes Council performs valuable interventions but needs the hemoglobin A1C, eye exam, and lipid profile statistics as a quantitative way to measure impact. Data from MediCare Part B claims and managed care organizations will support these indicators. He listed the proposed interventions on

behalf of the Nevada Diabetes Council:

- Distribution of clinical practice recommendations, which is a pocket card containing the latest diabetic care guidelines and a patient card to track lipid profile dates. This will be given to approximately 1,600 physicians to dispense to patients with diabetes.

- Adherence to mailing patient reminder cards, which improves compliance with keeping medical appointments.

- Flow sheets and tickler systems prompting patients to stay current.

Carolyn Leontos

Carolyn Leontos, Chairman, Patient and Professional Education Workgroup, Nevada Diabetes Council, told the committee she was also employed by the University of Nevada Cooperative Extension and spoke of her involvement with a program designed to reduce the risk of minority populations developing diabetes.

Ms. Leontos said the Nevada Diabetes Council is a voluntary organization of professionals dedicated to reducing the burden of diabetes in the state (Exhibit I). The council enlists assistance from pharmaceutical companies and other sources for individuals suffering from Type I and Type II Diabetes. She said that Type II Diabetes diagnoses are increasing in child populations. Diabetes educators are working together to reach physicians and patients and she anticipates positive responses from physicians.

Mylan Hawkins

Mylan Hawkins, Vice Chairman, Access to Care/Public Policy Committee, Nevada Diabetes Council, Executive Director of the Nevada Diabetes Association for Children and Adults, Member at Large, Nevada Diabetes Council, and Vice Chair, Access to Care/Public Policy Committee, Nevada Diabetes Council, told committee members her goal is to ensure that Nevadans with diabetes have access to care.

Ms. Hawkins stated that diabetes costs Nevada $665.4 million in lost productivity and medical expenses each year. She recommended the creation of programs focusing awareness on accessing care and listed several problems with Medicaid. She encouraged an open dialogue between Medicaid and the State of Nevada to decrease the risk of individuals losing limbs.

Claude K. Lardinois, M.D.

Claude K. Lardinois, M.D., President, Nevada Diabetes Association for Children and Adults, Member at Large, Nevada Diabetes Council, Professor, UNSOM, and Physician, Veterans Administration Hospital, spoke about preventative care. Dr. Lardinois reported that diabetes is the fourth leading killer in the United States and costs $135 billion, and 60 percent of the direct costs of diabetes are from inpatient care because of complications arising from heart disease, kidney failure, stroke, and amputations.

Dr. Lardinois said that landmark studies have indicated that reducing blood sugar levels in patients with diabetes lowers the risk for long-term complications. He said the same principal applies to preventive care with podiatry. An interdisciplinary team can reduce amputations by 40 to 50 percent. The cost of one amputation is $40,000 for the surgical procedure and related problems associated with the removal of a limb. He said this figure does not reflect the rehabilitative component, loss of future earnings, increased reliance on social programs, emotional trauma, or a decrease in the patient's quality of life. The Veteran Affair's Health Care System (VA) recognizes that 20 to 25 percent of outpatient services are for veterans afflicted with diabetes.

Continuing, Dr. Lardinois reported that he established a "critical pathway" in June 1992 at the VA. A critical pathway refers to the parameters that are assessed upon a diabetic patient's discharge from hospitalization. The parameters include: (1) hemoglobin A1C information; (2) blood pressure reading; (3) lipid count; and (4) foot care exam. Dr. Lardinois reported that other problems within the VA system were addressed in 1995 with the formation of an Interdisciplinary Diabetes Foot Clinic. He said the number of amputations within the first year of operation of the foot clinic decreased from 18 to 14 cases. He said that all VA providers now test for foot sensation with each

diabetic patient and provide easier patient access to podiatry physicians. Since 1996, the amputation rate has remained stable at a rate of 12 per year.

Dr. Lardinois concluded by saying Nevada's diabetes caseload is increasing, but the number of amputations performed is not. He urged a mandatory podiatry care review for all diabetic Medicaid patients because these individuals are at a 3 percent higher risk than the general population. Access to drugs is necessary to decrease hospitalizations and inpatient care for complications as a result of diabetes. He said the cost of preventive outpatient podiatry care is trivial when compared to the high cost of inpatient care for amputations.

BACKGROUND INFORMATION AND CONSIDERATION OF AN OPTION TO EXPAND COVERAGE IN THE NEVADA MEDICAID AND NEVADA CHECK-UP PROGRAMS BY ADOPTING "PRESUMPTIVE ELIGIBILITY" FOR CERTAIN PREGNANT WOMEN AND CHILDREN

Rhonda Gonzalez

Rhonda Gonzalez, Health Policy Specialist, National Conference of State Legislatures, told committee members her organization is nonpartisan and provides nonbiased information to all state legislatures in the United States. She gave a slide presentation on presumptive eligibility noting (Exhibit J):

- Presumptive eligibility is defined as a method under Medicaid that grants immediate, short-term Medicaid eligibility. The law allows traditional Medicaid providers to make presumptive eligibility determinations. During a presumptive period, providers are reimbursed for services without regard to final eligibility determinations. The federal regulations require that presumptive eligibility be made available statewide and cannot be made available only to certain subgroups of children.

- Reasons to use presumptive eligibility include: (1) it can increase and improve access to timely health care; (2) it may simplify the application process for families; (3) it can reimburse providers for health care services given to otherwise uninsured children; and (4) it can be an effective tool for accelerating enrollment.

- Reasons not to use presumptive eligibility include: (1) applicants may fail to submit necessary documentation for final determinations; (2) the potential for final denials and error rates may result in an increased cost to the state for applicants deemed ineligible; and (3) the state may need to fund, organize, and implement statewide training programs for providers.

- Six states are using presumptive eligibility for Medicaid children, 29 states are using presumptive eligibility for Medicaid pregnant women, and six states are using a combination of Medicaid expansions and state-designed plans for children.

Responding to an observation by Senator Washington, Ms. Gonzalez confirmed that there are no states with a standalone CHIP that utilize presumptive eligibility. She said that other states are examining rates and costs. She reported that individual states design and submit a plan to the Health Care Financing Administration (HCFA), United States Department of Health and Human Services, that identifies matching state funding sources for the CHIP. Federally matching funds for the CHIP are enhanced and provide more than state funding, varying from 60 to 65 percent.

Responding to a question by Senator Rawson, Ms. Gonzalez stated Nevada could use presumptive eligibility with its current stand-alone program to determine the cost of the broader Medicaid program.

Ms. Gonzalez continued the slide presentation:

- Nebraska operates a Medicaid expansion under its CHIP program and utilizes presumptive eligibility for pregnant women. The presumptive eligibility application is the same as the Medicaid application, which alleviates the need for a follow-up application thus lessening a portion of administrative burdens. Since there is no time limit under presumptive eligibility, a case will remain open until ongoing eligibility is determined or services are terminated. In Nebraska, less than four-tenths of a percent of the average monthly number of children applying for CHIP do

so under presumptive eligibility. The majority of Nebraska's 75 presumptive eligibility providers are medical clinics in urban settings. Nebraska has tracked the application process but not utilization of presumptive eligibility or the service costs for children subsequently not determined eligible. For pregnant women, more than 85 percent of presumptive eligible applicants are accepted, so non-Medicaid participant costs remain low.

- New Mexico has a simplified application for pregnant women and children with eligibility beginning with the date of presumptive eligibility and ending on the last day of the following month. New Mexico presumptive eligibility providers and the percentage of service include: (1) Indian Health Services, 28.5 percent; (2) Department of Health, 19.5 percent; (3) Federally Qualified Health Centers, 19.1 percent; (4) hospitals, 12.8 percent; (5) other, 11.2 percent; and (6) schools, 8.9 percent. The New Mexico presumptive eligibility program has been effective in enrolling children and tracking eligibles but has no mechanism for tracking the CHIP denial rate. New Mexico has not examined presumptive eligibility utilization patterns to determine if there are large payments for services for those subsequently deemed ineligible. The majority of cases not found eligible for Medicaid are due to failure of follow-up and documentation on behalf of the applicant rather than a definitive finding of ineligibility

Responding to a question from Senator Washington, Ms. Gonzalez said a family could cause ineligibility by not providing necessary documentation required by the state for determination. The family can "re-up" although it is not encouraged by HCFA. Senator Washington pointed out that Nebraska has no limit while New Mexico uses the last day of the next month as the end of its presumptive eligibility period. Ms. Gonzalez said that Massachusetts has up to 60 days of eligibility and a state can determine its own time frame but is federally mandated to a minimum period of time for the presumptive eligibility period. She said that each state has individual demographics in terms of presumptive eligibility use. For example, New Mexico has mostly rural use while Nebraska has "urban pockets" of use.

Ms. Gonzalez concluded her slide presentation by stating why two states that considered adopting presumptive eligibility chose not to do so:

- Kentucky is not implementing presumptive eligibility because of the provider training issue, costs, and associated system barriers (i.e., computers and how best to educate providers).

- Colorado is not implementing presumptive eligibility because the cost is anticipated to be more than the ten percent administrative cap set for the CHIP by federal regulations.

Responding to a question by Senator Washington, Ms. Gonzalez said Kentucky has experienced difficulties in deciding how to train and educate presumptive eligibility providers. Training consists of matching services for children to specific guidelines mandated by Medicaid or CHIP. She said that time, logistics, costs, and staffing availability are factors frequently examined as each state considers presumptive eligibility.

Responding to a question by Chairman Koivisto, Ms. Gonzalez said indications were that Nevada would not be permitted to discontinue retroactive eligibility with the adoption of presumptive eligibility.

Jon L. Sasser, Esq.

Jon L. Sasser, Esq., State Advocacy Coordinator, Washoe Legal Services, stated he was also testifying on behalf of Clark County Legal Services and Nevada Legal Services. He identified himself as a member of a statewide steering committee for the Covering Kids Coalition that recruits children for participation in the Nevada Check-Up Program. The Check-Up Program is an insurance program, which covers future services based on pre-enrollment.

Mr. Sasser said he served as a lay member on the Committee on Health Care during the 1997 Interim, and he briefly discussed a measure that addressed presumptive eligibility from the 1999 Legislative Session, Assembly Bill 5, which "makes various changes concerning benefits provided to pregnant women and children through Medicaid and children's health insurance programs" (Exhibit K).

Further, he said he was in favor of Nevada adopting presumptive eligibility for the following reasons:

- To increase enrollment in and streamline entrance into the Check-Up Program. Nevada has been allotted approximately $30.4 million annually in federal funds and must expend $16.4 million in state funds each year.

Currently, Nevada must spend $10 million in state funds before September 30, 2000, and then expend $16.4 million each year thereafter. If not, Nevada may have to revert funds to the Federal Government. These funds could have been spent to insure children at a 65 percent federal match.

- To treat children when they are ill. Low-income Nevada families are eligible for Check-Up but do not think about health insurance until they actually need it. Under presumptive eligibility, selected providers can sign children up for Check-Up and receive payment for services rendered on the date the client is in the office or clinic.

- To offer immediate prenatal care to pregnant women who would otherwise wait 30 to 45 days before eligibility is determined. The same situation applies to low-income children who are diagnosed with cancer and need to begin immediate chemotherapy or radiation treatment.

Concluding, Mr. Sasser said that children in Nevada cannot continue to rely on an understaffed, mail-in application process to obtain health insurance. If the Legislature fails to accept the presumptive eligibility option, federal money will revert back to the government and will not be available for Nevada's children.

Responding to questions from Senator Washington, Mr. Sasser said federal funds allocated for the CHIP are in jeopardy if not used. He explained it is a "use it or lose it" program with a timeline of three years for utilization of funds and stated that Nevada is approaching the end of its first year. In regard to presumptive eligibility training, Mr. Sasser said that training has begun at the University Medical Center of Southern Nevada but the authority to make preliminary determinations has not been granted. He said this message has been communicated to Nevada Governor Kenny Guinn's office.

William R. Hale

William R. Hale, Corporate Executive Officer, University Medical Center of Southern Nevada (UMC), Las Vegas, presented testimony regarding presumptive eligibility, how it relates to the UMC, and why the center considers it a benefit to the population it currently serves.

Mr. Hale explained that UMC staff members have unique abilities and opportunities to develop personal relationships with families in the communities they serve. Additionally, these relationships allow staff to identify the mental, medical, and social needs of pregnant women with regard to healthy lifestyles. He noted that this form of care is difficult to provide in traditional medical formats with the exception of safety net institutions, such as the UMC.

Continuing, Mr. Hale stated the importance of children receiving immunizations in a timely manner. It is important that children are given early access to medical care so that costly acute care does not become a burden to the taxpayers.

Mr. Hale reported that each month, 30 to 40 pregnant women are admitted to the UMC without prior prenatal care, and they are statistically known to deliver babies requiring admittance to the UMC neonatal intensive care unit. He said that the availability of prenatal care is cost-effective to taxpayers in these cases because intensive neonatal care is more expensive than regular delivery costs.

Mr. Hale said that despite implementing measures for the UMC children's health program and facilitating Medicaid enrollment, the clinical system still documents a rise in uninsured patients. The UMC's pediatric outpatient clinic has experienced a 25 percent increase in clinic visits within the last year and a 10 to 20 percent increase in uninsured children. In 1999, 28 percent of UMC's total client volume was not covered by a payer source and the pediatric emergency room treated 15,000 uninsured patients. In Mr. Hale's opinion, presumptive eligibility administered by safety net providers allows straightforward access to care for pregnant women and children. However, criticism may arise regarding ineligible children receiving "free" services. Mr. Hale suggested that a solution to this problem is to educate staff to more accurately determine eligibility.

Further, Mr. Hale stated that institutions that are granted the opportunity to administer presumptive eligibility ultimately acquire obligations or risk receiving penalties if acceptable levels of eligibility determination are not obtained. He also expressed his concern regarding the importance of state education and health care issues relating to presumptive eligibility.

Concluding, Mr. Hale reported that the UMC is not authorized to perform presumptive eligibility but discussions with the DHR may change the current protocol. He encouraged the committee and the DHR to continue dialogue toward that solution.

Senator Washington commented on the pros and cons of presumptive eligibility and raised questions regarding potential costs to the state as a result of implementation. Mr. Hale stated that data is not available to quantify potential costs to states using presumptive eligibility.

Mary Guinan, Ph.D., M.D.

Mary Guinan, Ph.D., M.D., State Health Officer, Health Division, DHR, testified on the importance of prenatal care in the first trimester and presented data on infant health statistics (Exhibit L). She said Nevada is ranked fourth in the nation for lowest infant mortality rate because of a 33 percent decrease in that rate between the years of 1985 and 1995. However, Nevada's percent of low birth-weight infants increased by 7 percent. She said that low birth-weight babies are the most frequent reason for infant mortality and survivors risk a 50 percent rate of physical and mental disorders. So while the babies in Nevada stand a better chance of surviving, half of them will be mentally or physically challenged and will require special education.

Dr. Guinan stated that the most common preventable cause of low birth-weight is cigarette smoking during pregnancy, and 28 percent of women smoke during their pregnancy. A prevention program for pregnant women in their first trimester could reduce this rate. She urged the committee to recommend intervention through education.

Continuing, Dr. Guinan pointed out that Hispanic women had the highest rate of not receiving first trimester prenatal care in Nevada between the years 1993 and 1995 at a rate of 40 percent with American Indian women at 35 percent, and Black, non-Hispanic women at 32 percent.

Concluding, Dr. Guinan told committee members that prenatal care during the first trimester can maximize positive pregnancy outcomes, and she suggested the adoption of preventative measures such as screening expectant mothers for infections, diabetes, high blood pressure, and substance abuse. She said follow-up prevention would treat these conditions and offer proper nutrition for the prevention of birth defects.

Responding to a question from Chairman Koivisto, Dr. Guinan credited neonatal units and pediatric departments for improving Nevada's infant mortality rate by using high technology and state-of-the-art neonatal intensive care equipment to "save babies."

Responding to a question from Senator Rawson, Dr. Guinan said that one-third of Nevada women do not receive prenatal care because of financial concerns. She said that providing access to care is crucial to improving this statistic because of the difficulty in making women come in for care. She said that an investment in prevention will save the lives of children and will reduce the costs associated with birth defects.

Senator Washington asked for additional data on the actual numbers that were associated with the 7 percent increase in Nevada's low birth-weight rate. Dr. Guinan indicated that she would provide this information.

Roger Volker

Roger Volker, Executive Director, Great Basin Primary Care Association, urged the committee to consider presumptive eligibility by highlighting the following points (Exhibit A):

- The Great Basin Primary Care Association represents all of Nevada's community health centers including Health Access Washoe County and the Nevada Rural Health Centers, Inc. Most of the state's tribal health centers are represented in the association, and Great Basin is the lead agency for the Nevada Covering Kids Project.

- The Check-Up Program is of interest to associates with Great Basin and to the stakeholders in the Covering Kids Project because of the importance of reducing the number of uninsured people in the state, and the importance of facilitating access to health care to Nevada's underserved populations. Health coverage alone does not guarantee access to health care. Uninsured children are more likely to: (1) have health problems; (2) experience difficulty

obtaining needed care; (3) rely on emergency care; (4) utilize preventative care; and (5) cause financial adversity for parents. Studies also show that these children will be restricted in childhood activities such as roller blading, bicycle riding, or team sports due to parental concerns of possible accidents and the costs associated with them. Many of these children will also demonstrate an inability to perform routine classroom activities because of undetected health impairments. Improving access to health insurance helps reduce such disparities.

- Outreach for Check-Up is being redefined to recruit new and previously eligible but uninsured children into the program. Efforts are shifting away from traditional methods of signing people up for programs and toward specific activities to facilitate individual enrollment with funding from federal, private, and state sources to assist in the transformation. Enrollment strategies to institute presumptive eligibility in Nevada include: (1) hiring certified application assistants or health advocates; (2) creating a volunteer program to place 16 health advocates in clinics throughout the state; and (3) linking children to programs through "adjunctive eligibility."

Continuing, Mr. Volker suggested the following individuals and agencies be qualified to administer Medicaid enrollment: (1) non-governmental workers; (2) school health nurses; (3) local family resource centers; (4) hospitals; (5) mental health providers; (6) the Women, Infants, and Children Program (WIC); (7) Boys and Girls Clubs; (8) child care agencies; and (9) faith-based organizations.

Concluding, Mr. Volker stated that Nevada's presumptive eligibility care providers could benefit from $6.1 million in revenue generated from compensated first-visits at the prevailing rate. It is estimated that each patient visits a primary care provider 2.5 times a year, and presumptive eligibility would fund the first visit for approximately 70,000 uninsured children. He pointed out that the ability of the care providers to increase revenues would result in an expansion of health care services to Nevada's uninsured and underserved population.

Louise Bayard-de-Volo, Ed.D.

Louise Bayard-de-Volo, Ed.D., Steering Committee Member, Nevada Women's Lobby, told committee members that the majority of her testimony is directed toward pregnant women, but she expressed concern that Nevada achieve presumptive eligibility for children as well.

Dr. Bayard-de-Volo said Nevada joins the rest of the country in witnessing a decline in the number of children covered under Medicaid since welfare reform, but the state is notably low in reaching uninsured persons.

Dr. Bayard-de-Volo referred committee members to a document titled "Nevada Women's Lobby – Presumptive Eligibility for Pregnant Women" (Exhibit A) and noted that further discussion was needed for pregnant women. She cited the following statistics:

- The State's Bureau of Health Planning and Statistics, Health Division, DHR, reports that in 1998, 23 percent of pregnant women in Nevada did not receive prenatal care in the first trimester, compared to 18 percent nationally.

- The UMC reports that 50 women each month deliver without any prenatal care.

- National data shows that for every $1 spent on prenatal care there is $3 saved afterward in health costs.

Continuing, Dr. Bayard-de-Volo said that some reasons women do not get early prenatal care are due to delays for appointments and processing in the Baby Your Baby Program. She noted that this program has only one physician agreement in rural areas of the state.

Concluding, Dr. Bayard-de-Volo urged the committee to make presumptive eligibility for pregnant women and children a priority in the 2001 Legislative Session. She said Nevada cannot continue to accept its failure to provide health care to those without means nor can it afford the high public costs associate with this failure. She suggested that the committee access the report *Promising Ideas in Children's Health Insurance*, by Vicky Pulos of Families USA, which is being released this month on the Web site: www.familiesusa.org. She said this report is a comprehensive examination of presumptive eligibility, and it offers implementation ideas for states.

Chairman Koivisto asked Janice Wright to comment on presumptive eligibility.

Janice Wright

Janice Wright, Administrator, Division of Health Care Financing and Policy, DHR, said the Legislature has previously deterred adoption of presumptive eligibility due to the unknown cost variables and pointed out that Nevada's approach is not unique as other states also hesitate. The Medicaid program requires financial monitoring due to the nature of entitlement programs. She said that no state in the nation has a stand-alone CHIP program that is using presumptive eligibility, which makes cost comparison data difficult to obtain. Administrative functions require examination as well. She stated that federal dollars have not been completely "drawn down" due to inaccuracies in tracking numbers of uninsured Nevadans, and invited the Legislature to work with the division to gather vital facts and figures concerning this issue prior to the 2001 Session.

Chairman Koivisto asked who is responsible for costs incurred when a patient is mistakenly presumed to qualify for presumptive eligibility. Ms. Wright said the state is responsible for the costs incurred by a person determined ineligible for Nevada's Check-Up Program and Medicaid.

Senator Rawson pointed out that UMC was funded in 1999 with $22 million from property tax revenue to offset expenses incurred by patients who are not covered by any combination of federal, local, or state programs.

Responding to a comment by Senator Washington, Ms. Wright stated CHIP does not cover pregnant women, only children from birth through age 18, and it is a Title XXI program. She stated that the Title XIX Medicaid program covers pregnant women. Attempting to identify the population of children who are not enrolling in the CHIP program, but would enroll as a result of presumptive eligibility, is causing problems with accurate fiscal projections. During the 1999 Legislative Session, the division's budget limited coverage to 10,000 children in Nevada's Check-Up Program during the first year of the biennium and 11,750 in the second year. She offered to provide estimates of how many children might use the program sooner if presumptive eligibility is implemented.

Senator Rawson requested that Ms. Wright provide figures at a future meeting so the committee may examine cost factors and adjustments. Ms. Wright concurred.

Senator Rawson acknowledged that some of the greatest costs to Nevada can be attributed to pregnant women who do not obtain prenatal care and for the care and treatment of diabetic children. He speculated that it would be helpful if the information could be examined from a categorical or diagnosis aspect with the objective of access to health care being a preventative measure.

Responding to questions by Senator Washington, Ms. Wright said the implementation of presumptive eligibility would not affect the current system of reimbursing providers. However, she said if a child is not eligible for CHIP, the provider still receives payment for services the provider gave to the child under the presumptive eligibility system.

PRESENTATION CONCERNING THE DELIVERY OF HEALTH INSURANCE COVERAGE TO MEMBERS OF THE LAS VEGAS CHAMBER OF COMMERCE

Kami Dempsey

Kami Dempsey, Manager of Government Relations, Las Vegas Chamber of Commerce, Las Vegas, provided committee members with responses from a survey regarding increased health care premiums (Exhibit M) and noted:

- The Las Vegas Chamber of Commerce provides a health care incentive plan through Health Plan of Nevada (HPN) to chamber members. Orgill Singer and Associates brokers the plan on behalf of the chamber through HPN.

- All partnerships, corporations, and small businesses with chamber membership are eligible for coverage. The greatest benefit for small business owners to join is a two-year lock on rates.

- The association health plan has the advantage of "bundling." A member with one employee will pay the same rate as a member with 15. Employers have a limited pool of resources for benefits.

Continuing, Ms. Dempsey said that health care mandates have an adverse affect on the accomplishments of policymakers. Results from a survey conducted by the Las Vegas Chamber of Commerce demonstrate that employers cannot afford the premiums associated with mandated mental health, infertility, and osteoporosis coverage. The employer either forwards the cost to employees partially, completely, or cancels coverage entirely. The survey shows that the higher the increase, the more damaging the result will be for both the employer and employees as 49 percent of the survey respondents stated that they have considered dropping health care coverage due to rising premium costs. When employers cancel health coverage, a higher population of uninsured Nevadans is created for taxpayers to fund. Additionally, Ms. Dempsey said mandated costs are disproportionately placed on workers in smaller firms, which are the least able to bear the financial burden.

Concluding, Ms. Dempsey said the chamber recently renegotiated with the HPN due to rate increases. Current national trends indicate a 12 to 20 percent increase in medical premiums for the year 2001. Most of the businesses in the Las Vegas area are covered by John Alden and will receive an 18 to 35 percent increase for plan year 2000. All of the businesses with principal coverage are receiving up to a 45 percent increase in rates. Ms. Dempsey said the chamber reports a 10 percent increase for medical and dental coverage and 6 percent for vision.

Senator Rawson commented that a 10 percent increase in health insurance rates was encouraging. He said that it would be financially catastrophic if Nevada had to become responsible for costs incurred by 25 to 35 percent uninsured citizens. He agreed with a moratorium on mandating new services until costs could be controlled. He said that members of the Legislature are constantly approached by individuals requesting ". . . just one more item" be included in health care benefits, but it he said it is time to examine the effects of these mandates.

Responding to a question from Senator Washington, Ms. Dempsey stated a Public Health Access Committee was formed with members from the business community and government sector to analyze bills passed during the 1999 Legislative Session. She said the access committee will submit a draft bill request based on research from impacts on employers as a result of mandated health care.

At the request of Senator Washington, Marla McDade Williams, Senior Research Analyst, Research Division, Legislative Counsel Bureau (LCB), Carson City, stated that she would request an update on activities from the committee that was formed pursuant to Senate Bill 556 (Chapter 598, *Statutes of Nevada 1999*), which "Creates task force on policy of State of Nevada concerning access to public health services," for distribution to committee members prior to the next meeting of the committee.

Responding to a question from Senator Washington, Ms. Dempsey stated that she was unaware of the Northern Nevada chamber of commerce's ability to poll or whether it will have results that are similar to the she presented. Senator Washington suggested that the committee receive an update on the federal Medical Savings Account program (MSA), including the level this program provides policies to states, by whom, and what the requirements are to access MSAs. He also suggested that the committee ask for recommendations from the MSA program as to what states can do to make this program more accessible to employers and employees. Senator Rawson concurred.

DISCUSSION OF RECOMMENDATIONS CONCERNING HEALTH INSURANCE BENEFIT MANDATES AND "FREEDOM OF CHOICE" FOR INDIVIDUAL PURCHASERS OF HEALTH INSURANCE

Jeanette K. Belz

Jeanette K. Belz, Director of Government Relations, Wadhams and Akridge, Las Vegas, stated she represented the Nevada Association of Health Underwriters (NAHU). She requested an opportunity to present an additional recommendation to the committee at a future date. She said the purpose of her testimony is to convey two recommendations from the NAHU.

Ms. Belz updated the committee on information presented by from Jeff Paine, Owner, Gold 'N Silver Inn, Reno, at a previous hearing. She stated that The Gold 'N Silver Inn insures an average of 29 employees per month in the past four years and has experienced a 60 percent increase in monthly health insurance premiums. Each year, the premium increase ranges between 10 and 26.5 percent despite Mr. Paine's strategy to contain costs by changing insurance carriers and reducing pharmacy benefits. In an effort to maintain health insurance for his business, Mr. Paine is contemplating requiring employee participation in sharing costs.

Ms. Belz said that employer mandates are cumulative, as a result when the Legislature imposes additional mandates, the employer is bound by it "forever." She pointed out that there are over 20 mandates and the cumulative effect is creating a negative experience for small business owners. She acknowledged that other economic factors, which are out of Nevada's control, are contributing to rising insurance costs: (1) pharmaceutical costs and availability; (2) provider fees; and (3) technology. She said that the Legislature has control over employer mandates and urged the committee to consider recommendations from the following two guest speakers.

Rich Nagler

Rich Nagler, Member, Marsh U.S.A. Incorporated, stated he represented an international insurance brokerage firm with offices in Reno and Las Vegas serving clientele from medium to large-sized firms. In terms of the cycle of increasing health insurance experienced by business owners, there appears to be a 10 to 40 percent increase causing an immediate need for solutions. Mr. Nagler listed several solutions and alternatives offered to business owners to prevent bankruptcy: (1) change insurance carriers; or (2) reduce benefits. This is accomplished by increasing co-payments for pharmacy benefits and instituting higher deductibles and co-pays.

Mr. Nagler said that employees and their families are assuming the financial responsibility of increased premium rates. Some employers cancel benefits and offer an insurance voucher instead. Many businesses self fund health insurance plans for two reasons: (1) state mandates can be bypassed; and (2) the State of Nevada premium tax does not apply. He summarized the consequence of creating mandates as generating negative financial cycles that preclude employee access to care. Ironically, the mandates have an opposite effect on the individuals they are intended to help because they create a cycle of increased costs and decreased benefits.

In conclusion, Mr. Nagler asked the committee to consider the effect of new health care mandates on employees and employers.

Tom Fischer

Tom Fischer, Insurance Consultant, Past President, NAHU, and President Elect, Nevada State Association of Heath Underwriters, Reno, told committee members he offered 25 years of experience in the insurance industry. He said that a process is needed for the consideration of bills that require health insurance policies to include mandated benefits (also known as employer mandates). The impact of government-imposed health insurance mandates presents a challenge to small employers who are often adversely affected due to their size and inability to represent themselves individually or collectively.

Mr. Fischer suggested the following requirement be added to Rule 18 of the Nevada Legislature:

- A written report addressing the criteria be made available to the standing committee members, the Senate, the Assembly, and to the Governor before the bill is considered for a vote or signature.

- A separate written report be created for amendments to the bill, which is extended beyond the standing committee to both houses and the Governor that includes: (1) financial impact; (2) the calculation of the impact of the cost of the insurance mandate on premiums; and (3) the consideration of the valuation criteria.

Larry Hardy

Larry Hardy, Legislative Chairman, NAHU, Sparks, said that NAHU writes 85 to 90 percent of individual and group insurance plans in the State of Nevada. Mr. Hardy noted 22 separate mandates for individual major medical policies. He said it is difficult for consumers to pay for major medical policies that are not applicable to them. Many individual policy carriers have left the State of Nevada, which has caused the market to "shrink."

Mr. Hardy suggested freedom of choice for purchasers of individual health insurance. An employee should not be mandated to buy health insurance coverage for a disorder when it is not needed or appropriate. The NAHU will recommend to the committee that the mandated insurance benefits be deleted from Chapter 689A, "Individual Health Insurance," of the *Nevada Revised Statutes*.

Ms. Belz concluded the presentation by informing the committee that NAHU is addressing the technical issues of adding Rule 18 with the advisement of LCB staff.

PRESENTATIONS CONCERNING RURAL HEALTH ISSUES AS THEY AFFECT NEVADA'S COUNTY GOVERNMENTS

Robert S. Hadfield

Robert S. Hadfield, Executive Director, Nevada Association of Counties (NACO), Carson City, introduced Cindy Hannah, Social Services Director, Churchill County, and President, NACO Human Services Administrators. He said that Nevada counties are responsible for providing health insurance for approximately 13,000 people, compared to the State of Nevada's employee population of 18,000. He cautioned the committee against continuously mandating additional health insurance benefits because employers have a major cost associated with caring for employee needs. He said the counties experience rate increases in their health plans and they experience subsequent reluctance from insurance companies to provide them coverage because of the increased cost of doing business in Nevada.

Continuing, Mr. Hadfield said that the counties are major providers of health care and they are also responsible for financing that role. He said that counties can be the provider of last resort, but they need a funding source to treat indigent clientele until payment for services is received. He said that the counties are also responsible for transporting individuals to a service provider. In his opinion, the counties are one of the least understood but most involved health care entities.

Mr. Hadfield updated the committee on several issues:

- The counties are the major provider of long-term care in terms of payment for services in the State of Nevada. There are concerns regarding long-term health facility availability and costs of care. The adult community concept is a new industry for individuals not needing 24-hour medical coverage and is increasing operations in rural Nevada counties. The rural county assumes responsibility for these elderly clientele when they become too ill to live in the adult community. This creates an additional need for counties to provide facilities and funding for long-term elderly care.

- Transporting clients in rural Nevada to major care facilities is problematic because volunteer rural fire personnel are responsible for providing this service. This is a limited resource and paid paramedics should replace the volunteers in order to meet new demands. Other problems beginning to occur in rural Nevada involve methods of transporting clientele to facilities located outside the range of medically equipped helicopters.

- Nevada's unique tax structure limits a community's ability to generate revenue to offset various levels of health care costs.

He concluded by saying the counties are a serious partner in the committee's endeavor to find health care solutions because of the counties' role as providers, transporters of clientele to providers, and the perception of being the payer of last resort for those services.

Cindy Hannah

Cindy Hannah, Social Services Director, Churchill County, Chairperson, NACO Human Service Administrators, Fallon, said rural counties accept Medicaid but do not have access to dentists, thus children in Churchill County must be transported to Carson City or Reno to receive dental treatment.

Continuing, Ms. Hannah said transportation in rural Nevada has a limited availability of services. She said that the Nevada Department of Transportation (NDOT) is instituting a "connecting highway plan," but it is unavailable at this time.

Ms. Hannah said that counties are frequently financing Medicaid clients but payment is not received for a minimum of 45 days. Counties are viewed as safety net providers of medical services, and she asked the committee to be aware of the 50-50 funding match relationship with the State.

DISCUSSION OF RECOMMENDATIONS CONCERNING RURAL HEALTH ISSUES

Caroline Ford

Caroline Ford, Assistant Dean, Director, Rural Programs, Center for Education and Health Services Outreach, UNSOM, began by discussing issues and recommendations presented at the last health care meeting regarding rural health care in Nevada. Ms. Ford requested that the committee continue to focus on rural Nevada's health care issues.

Ms. Ford repeated the need for a bill draft request to be called the "Rural Health Care Improvement Act of 2001." The proposed language in the act addresses: (1) education and training; (2) special population health care needs; (3) health services delivery; and (4) reimbursements. She referred committee members to a list of preliminary budget projections for this request (Exhibit N).

Ms. Ford listed proposed education and training components to include:

- An Emergency Medical Services (EMS) training academy located in the City of Elko to provide continuous education and training course work for all levels of EMS personnel. Curriculum will be offered by use of compressed video and on-site location training, and it will be a credentialed course approved by the State of Nevada through the EMS Division. The UNSOM will perform the research and development for the EMS training academy. Since initial costs are absorbed now, a budget should be initiated with a goal of opening the academy in 2001. The EMS academy will be created and administered by the Nevada Area Health Education Center Program (NEAHEC).

- Expansion of the currently operating Physician Assistant Training program (PA), which has been in operation since 1991 and trains at least three PAs per year. The PA program currently requires students to have at least two years of service to provide to medically underserved areas, primarily rural areas. Enhancements to the PA program include: (1) collaboration with the Nurse Practitioner Training programs; (2) that one-half of each graduating class provides clinical service to medically underserved areas; and (3) the offer of scholarship and loan repayment incentives. A cost study is also necessary to determine the impact on students who have made an obligatory commitment to rural areas.

- Special population health care needs will be administered to staff in rural Nevada clinics through the development of telemedicine support. The number of psychiatric workers within the Nevada Rural Mental Health clinics needs to be increased to enhance access to psychiatrists for scheduled and emergency mental health consultations.

- Improved health services delivery will coordinate NDOT's wide array of services with the goal of "on-demand transportation." Emergency medical personnel will be able to arrange transportation service plans for patients.

Responding to Senator Rawson's questions regarding transportation issues and the use of helicopters, Ms. Ford stated that the NDOT is aware of available health facilities, helicopter service areas, and EMS sites. She noted that some airports do not have adequate landing lights for nocturnal air assistance.

Ms. Ford continued her description of the proposed act:

- Delivery of perinatal health care services can be expanded. Currently, the UNSOM is operating a program to review special needs of a delivery and obstetrical service in rural Nevada. The UNSOM is developing a network inclusive to public health, as well as the overlay of ongoing emergency access services related to telemedicine. The connection of public health practitioners to telecommunications will address routine and emergency evaluations of patients and will enable appropriate referral and transportation procedures. There is a critical shortage of practitioners in both rural and urban medically underserved communities.

- Nevada operates a health service corps program, established by the 1989 Legislature, which offers financial incentives to practitioners working in underserved areas allowing them to accept patients regardless of their ability

to pay. Program expansion will identify critical areas needing EMS, dentists, dental hygienists, and nurses, with flexible contractual language regarding practice methods administered by such personnel. An update on the "Packham Study," released during the 1999 Session, is needed to systematically identify areas of critical health professional shortages in Nevada.

Further,

- Augmentation of the Capital Loan Pool, operating within the Nevada Rural Hospital Project (NRHP), will allow health care practitioners and other agencies within rural communities to access grants and loans for EMS medical equipment, vehicle replacement, and telecommunications technology. The Capitol Loan Pool needs to be appropriated to rural agencies and subcontracted to the NRHP to allow rural agencies to participate in an administrative oversight committee to review application requests and funding disbursement for medical equipment.

Responding to a question asked by committee members at the last meeting, Ms. Ford said that funding for this program would be administered through a state agency such as the Office of Rural Health in conjunction with administrative coordination from the NRHP.

Additionally,

- Reimbursement issues will be addressed in the bill draft request. A system should be created to reflect the differences between actual costs that are incurred of certain providers versus what Nevada Medicaid pays these providers for providing primary care services. There is currently no cost projection report established for review.

Concluding her remarks, Ms. Ford requested committee approval for the "Rural Health Care Improvement Act of 2001."

Chairman Koivisto suggested that Ms. Ford meet with Nevada Medicaid and LCB staff to compile a list of specific recommendations prior to the 2001 Legislative Session.

DISCUSSION OF FUTURE TOPICS

Chairman Koivisto listed possible topics for the next meeting of the committee on June 6, 2000:

- Details for a proposed school of pharmacy within the School of Medicine.
- A plan outlining needle stick protection protocol for medical care providers.
- A presentation from long-term care industry representatives.
- A report on senior pharmaceutical issues.
- A report on the number of children enrolled in Check-Up and specific outreach efforts to prevent de-linking of Medicaid from the Temporary Assistance for Needy Families Program.
- Development of a work session document containing issues for legislative consideration.

PUBLIC TESTIMONY

Bobbi Gang

Bobbi Gang, Lobbyist, Nevada Woman's Lobby, commented on the report previously discussed by Jeanette Belz regarding health insurance benefit mandates (Exhibit A, Tab D).

Ms. Gang requested that a comparison of potential cost saving issues relating to mandated benefits and the cost of health care be evaluated and included for consideration in conjunction with Ms. Belz's proposals.

ADJOURNMENT

There being no further business to come before the committee, Chairman Koivisto adjourned the meeting at 3:50 p.m.

Exhibit O is the "Attendance Record" for this meeting.

Respectfully submitted,

Sally Kennedy
Senior Research Secretary

Marla McDade Williams
Senior Research Analyst

APPROVED BY:

_____
Assemblywoman Ellen M. Koivisto, Chairman

Date: _____

LIST OF EXHIBITS

Exhibit A contains a one-volume set of documents that provide background information on selected agenda items. Arranged to correspond with the items on the meeting agenda, this document was prepared by Marla McDade Williams, Senior Research Analyst, Research Division, Legislative Counsel Bureau, Carson City, for members' reference.

Exhibit B is a packet of information submitted by Mary Sassi, Bureau Chief, Bureau of Community Health Services, Health Division, Department of Human Resources, containing:

A three-page chart dated April 12, 2000, titled "Teen Pregnancy (10 – 14 years) by Race/Ethnicity, Nevada Residents, 1993 – 1999 (Preliminary)."

A pamphlet from the Adolescent Pregnancy Prevention Leadership Enhancement program.

A pamphlet from the Boys Encouraging Adolescent Responsibility program.

Exhibit C is an 18-page spiral bound document titled "Nevada Public Health Foundation, Inc., 1996 – 1999," submitted by Dr. Trudy Larson, President, Nevada Public Health Foundation.

Exhibit D is a four-page copy of testimony dated April 18, 2000, by Allison Gaulden, Vice President of Public Affairs, Planned Parenthood Mar Monte, and J. J. Straight, Director of Public Affairs, Planned Parenthood of Southern Nevada.

Exhibit E is a 12-page packet of information submitted by Mathew T. Dushoff, Deputy Attorney General, Office of the Attorney General, which included:

A two-page document dated April 18, 2000, titled "Teen Pregnancy in Nevada: Where we are – How we got here – Where we need to go."

An eight-page document titled "Risky Business, A 2000 Poll, Teens Tell Us What They Really Think of Contraception and Sex."

A two-page spreadsheet titled "NCASV Membership."

Exhibit F is a one-page document titled, "Proposed Statutory Changes Involving Statutory Sexual Seduction," submitted by Mathew T. Dushoff, Deputy Attorney General, Office of the Attorney General.

Exhibit G is a three-page document titled "Progress Report to the Legislative Committee on Healthcare Regarding Pediatric Diabetes and Endocrine (PDEP)," submitted by Bernard H. Feldman, M.D., M.P.H., Chairman of the State Board of Health, Professor, and Chairman/Residency Director, Department of Pediatrics, University of Nevada School of Medicine.

Exhibit H is a one-page copy of testimony by Rosalie Montoya, Licensed Clinical Social Worker, Medical Social Worker, Pediatric Diabetes and Endocrinology Center, and Diabetes Support Coordinator, University of Nevada School of Medicine.

Exhibit I is a one-page document titled "The Burden of Diabetes in Nevada," submitted by Kevin Kennedy, Vice Chairman, Nevada Diabetes Council, and Carolyn Leontos, Member, Nevada Diabetes Council.

Exhibit J is a nine-page paper copy of a slide presentation dated April 18, 2000, titled "Presumptive Eligibility (PE)," submitted by Rhonda Gonzalez, Health Policy Specialist, National Conference of State Legislatures.

Exhibit K is a packet of information presented by Jon L. Sasser, Esq., State Advocacy Coordinator, Washoe Legal Services, containing:

A four-page copy of testimony given on April 18, 2000, titled "Testimony - Presumptive Eligibility."

A one-page document titled "A.B. 5."

A three-page memorandum dated April 12, 2000, from Janice A. Wright, Administrator, Division of Health Care Financing and Policy, to Jon Sasser, Esq., regarding presumptive eligibility – A.B. 5.

Exhibit L is a four-page copy of testimony dated April 18, 2000, by Mary Guinan, M.D., Ph.D., State Health Officer, Health Division, Department of Human Resources.

Exhibit M is a document titled "Health Care Fax Survey of Chamber Membership," and a six-page copy of testimony by Kami Dempsey, Manager of Government Affairs, Las Vegas Chamber of Commerce.

Exhibit N is a nine-page document titled "Specific Recommendations to the Legislative Committee on Health Care," submitted by Caroline Ford, M.P.H., Assistant Dean/Director, Center for Education and Health Services Outreach, University of Nevada School of Medicine.

Exhibit O is the Attendance Record for this meeting.

Copies of the exhibits are on file in the Research Library of the Legislative Counsel Bureau, Carson City, Nevada. You may contact the library at 775/684-6827.