REPORT OF THE NEVADA LEGISLATURE'S COMMITTEE ON HEALTH CARE

Bulletin No. 89-8

LEGISLATIVE COMMISSION
OF THE
LEGISLATIVE COUNSEL BUREAU
STATE OF NEVADA

JANUARY 1989

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LEGISLATIVE COUNSEL BUREAU

CARSON CITY, NEVADA

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ASSEMBLY BILL 289 (CHAPTER 377, STATUTES OF NEVADA, 1987)

*Assembly Bill No 289--Assemblymen Arberry, Schofield, Spinello, Wisdom, Wendell Williams, Myrna Williams, Price, Gaston, Thompson, May, Kissam, Triggs, Garner, Sader, Brookman, Haller, Freeman, Callister, Adler, Dini, Jeffrey, Nevin, Evans, McGaughey, Craddock, Swain and Porter

CHAPTER 377

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. 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:

(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. 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.

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.

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 care, including care provided by physicians and nurses, and to admit the patient where appropriate, regardless of the financial status of the patient.

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.

3. Each hospital which treats an indigent inpatient shall submit to the board of county commissioners of the county in which the patient resides 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.

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 and 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.

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:

(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 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 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.

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.

5. The provisions of subsections 1 to 4, inclusive, do not apply to hospitals in a county whose population is less than 30,000.

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.

(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;*

(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

(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).*

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

(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 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.*

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 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.

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.

3. Each 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.

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.

(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.

(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.

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 1987-1988 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.

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.

REPORT OF THE
NEVADA LEGISLATURE'S COMMITTEE ON HEALTH CARE

TO THE MEMBERS OF THE 65TH SESSION OF THE NEVADA LEGISLATURE:

This report is submitted in compliance with Nevada Revised Statutes 439B.200 (Assembly Bill 289, chapter 377, Statutes of Nevada, 1987). 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 leadership of both the senate and the assembly appointed the following members to the committee:

Senator Raymond D. Rawson, Chairman
Assemblyman Morse Arberry, Jr., Vice Chairman
Senator Bob Coffin
Senator Randolph J. Townsend
Assemblyman Vivian L. Freeman
Assemblyman Bob L. Kerns

Legislative counsel bureau staff services for the committee were provided by H. Pepper Sturm of the research division (principal staff), Lorne Malkiewich, legislative counsel of the legal division (legal counsel) and Ellen R. Nelson of the research division (committee secretary).

The committee held nine regular meetings from October 1987 through November 1988. Three additional subcommittee meetings were called by the chairman to consider action regarding the certification of nursing assistants and concerning the monitoring of hospital compliance with the provisions of A.B. 289.

The committee considered over 100 proposed recommendations. A total of 50 recommendations were approved in the areas of funding of health care, long-term care, the nursing shortage, public health, regulatory authority, and statewide health care systems. A separate background paper has been issued by the committee concerning the effect of A.B. 289 on health care costs.

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. The earlier report should be consulted for a review of the history of health care, industry trends, and for background information surrounding major issue areas.

Respectfully submitted,

Nevada Legislature's Committee on Health Care

Carson City, Nevada
January 1989

SUMMARY OF RECOMMENDATIONS

This summary presents the recommendations to the 65th session of the Nevada legislature by its committee on health care.

I. REGULATORY AUTHORITY

A. PROVIDERS OF HEALTH CARE

1. **Include in the committee's future work schedule the development of potential recommendations for modification of Nevada's certificate of need law.**

2. **Allow, by statute, counties to place social services representatives on site in county hospitals and in non-county hospitals in order to expedite the evaluation and processing of medical indigency claims.** (BDR 38-1225)

B. DATA COLLECTION/DISSEMINATION

3. **Include in the final report a statement that the health care committee will continue to fulfill and emphasize its responsibilities under Nevada Revised Statutes (NRS) 439B.200, subsections 10 and 11, to collect and evaluate data concerning quality of health care services within Nevada's hospitals.**

4. **Require the director of the department of human resources (DHR) to prepare semiannual reports concerning the cost of health care in Nevada.** (BDR 40-292)

5. **Require the inclusion of nurses on hospital committees for the advocacy of maintaining the quality of care by hospitals.** (BDR 40-614)

6. **Modify NRS 449.475 to exempt both the commissions for the advocacy of maintaining quality of care by hospitals and the hospital committees for the advocacy of maintaining quality of care by hospitals from Nevada's open meeting law requirements and to make their proceedings and actions nondiscoverable.** (BDR 40-1554)

7. **Include in the final report a statement that the health care committee will continue to fulfill and**

emphasize its responsibilities under NRS 439B.200, subsections 10 and 13, to evaluate the effectiveness of the division for review of health resources and costs, DHR, in carrying out its data-gathering and cost-containment functions.

C. MEDICAL MALPRACTICE

8. Repeal the "sunset" provisions of NRS 41A.016, et seq., and thus provide for continuation of the medical-legal screening panels established to review medical malpractice claims. (BDR 3-169)

9. Expand the size of the medical-legal screening panel member pools of attorneys and physicians, and incorporate an orientation and training component for all panel members. (BDR 3-169)

D. PUBLIC HEALTH

10. Establish legislation which designates public places as smoke free, expands the definition of public place, narrowly defines exceptions where smoking can occur, and provides a penalty for violations. (BDR 15-166)

11. Revise those sections of the Nevada Revised Statutes concerning sexually transmitted diseases as specified in the Nevada AIDS task force report titled, "Proposed legislative changes for communicable disease control." (BDR 40-1216)

12. Establish a public health surveillance system within the health division to monitor such diseases as chronic fatigue syndrome. (BDR 40-1227)

13. Require the establishment of a toll-free telephone service for the dissemination of information about the effects of exposure to teratogenic agents during pregnancy. (BDR 40-290)

E. PROGRAMS FOR THE ELDERLY

14. Appropriate $69,248 for staff and equipment to the aging services division, DHR, in order to institute a program within the existing home-delivered meal system that would offer therapeutic diets to those persons with certain medical conditions. (BDR S-167)

15. Direct the aging services division, DHR, to conduct a study to determine the best means of temperature maintenance for food provided by its program of the home-delivered meals for the elderly. (BDR S-167)

16. Expand the existing urban delivery system of the home-delivered meals program in order to decrease the time an eligible patient discharged from a hospital may spend on the program's waiting list. (BDR S-167)

17. Direct the aging services division, DHR, to evaluate a variety of food delivery systems and implement a delivery system that will allow clients from a larger area to be served by this program. (BDR S-167)

18. Direct the aging services division, DHR, to evaluate alternative ways of providing home-bound meals when extra nutritional needs are present or for assistance on weekends (alternatives could include a 1-day per week delivery of frozen meals in outlying areas or the delivery of canned food supplements). (BDR S-167)

19. Establish an "elder abuse hotline" within the DHR--similar to the existing "child abuse hotline"--to report cases of abuse of the elderly. (BDR 38-1217)

20. Require the DHR to create registries of substantiated claims of abuse, exploitation or neglect of defenseless, incapable or elderly persons. (BDR 38-1217)

F. HEALTH MAINTENANCE ORGANIZATIONS

21. Include in the committee's future work schedule development of potential recommendations to address concerns regarding health maintenance organizations (HMO's) solvency, acquisition/mergers, and unfair trade practices.

22. Direct the legislative commission to contract with consultants to conduct an interim study to determine enrollee satisfaction with HMO's; the results of which would be subject to review and approval by the committee on health care. (BDR S-294)

II. FINANCING OF HEALTH CARE

A. GENERAL

23. Include in the final report a statement encouraging those business entities which hold monopsony power over the health care industry to exercise their collective influence to restrain the costs of health care.

B. MEDICAID

24. Expand Medicaid coverage by adopting the federal option to implement a program for the medically needy. (Medicaid benefits would be made available to those individuals and families who do not qualify for Aid-to-Dependent-Children or Supplemental Security Income programs because their income is too high. Those eligible would contribute a small amount for care with Medicaid paying the remainder.) (BDR 38-1224)

25. Expand Medicaid eligibility to allow Medicaid coverage to children and pregnant women whose income does not exceed 185 percent of federal poverty guidelines (in order to take advantage of changes in federal law). (BDR 38-1221)

26. Amend Medicaid eligibility to include coverage for two-parent households in which the principal breadwinner is unemployed (as allowed under federal guidelines for Medicaid options). (BDR 38-1222)

27. Allow small businesses to "buy into" Nevada Medicaid in order to provide health care insurance for their employees. (BDR 38-1226)

28. Revise chapter 422 of NRS to allow persons whose monthly income is less than three times the income allowable to receive benefits pursuant to 42 United States Code §§ 1382 through 1383c to become eligible to receive assistance for the medically indigent for the purpose of long-term medical care. (BDR 38-1223)

C. STATE INDUSTRIAL INSURANCE SYSTEM

29. Include in the committee's future work schedule the development of potential recommendations concerning contracts with various categories of health care providers for the preferential provision of goods

or services within the state industrial insurance system.

D. HEALTH CARE INSURANCE

30. Direct the commissioner of insurance in the insurance division of the department of commerce to examine the practice of using regional morbidity factors to set insurance rates. (BDR R-293)

31. Include in the committee's future work schedule the development of potential recommendations to provide assistance to Nevada's retired public employees who are not eligible to receive Medicare benefits and who must pay a retiree differential to maintain their health insurance.

32. Include in the committee's future work schedule the development of potential recommendations relative to establishing a health insurance pool in Nevada for high-risk individuals. (Such a pool would address the needs of persons unable to obtain insurance due to preexisting medical conditions such as cancer, diabetes, and so on.)

III. HEALTH CARE SYSTEMS AND PERSONNEL

A. NURSING SHORTAGE

33. Establish a program to provide loans to nursing students, authorizing waivers of repayment of the loans upon practice of nursing in Nevada after graduation for a period of time determined by the total amount of the loan. (BDR 34-168)

34. Establish incentives for recipients of financial aid for nursing students to practice in rural areas. (BDR 34-168)

35. Send a letter to Nevada's congressional delegation encouraging support of the passage of United States Senate Bill 1402. (The bill would establish nurse recruitment centers to target potential candidates for the field; and encourage nursing schools to promote gerontological nursing as a career and nursing homes as a clinical setting.)

36. Send a letter to Nevada's congressional delegation encouraging the passage of U.S. Senate Bill 1765

which would provide incentives for increased use of nurse practitioners in nursing homes.

37. Send a letter to Nevada's congressional delegation encouraging the reinstatement of the Federal Nurse Training Act loan program, with the addition of program guidelines to encourage nurses to practice in long-term care facilities.

38. Send a letter to all schools of nursing in Nevada and to all of Nevada's nursing homes encouraging clinical affiliations between the nursing schools and nursing homes in order to promote student interest in the field of gerontological nursing.

39. Send a letter to all employers of nurses in Nevada encouraging the funding of scholarships to assist student nurses through their academic programs. (Students would contract with a facility to provide a "work" payback system as a guarantee for financial assistance.)

40. Send a letter to the board of regents for the University of Nevada System (UNS) encouraging all nursing schools to include funding requests for a statewide marketing campaign to promote the profession of nursing.

41. Send a letter to the board of regents for the UNS supporting funding requests for the system's nursing education programs, including increases in faculty size and salaries, and additional ancillary personnel.

42. Send a letter to the board of regents for the UNS expressing concern that the articulation difficulties between university and community college nursing programs be addressed immediately.

B. HEALTH CARE PROFESSIONS

43. Clarify the meaning of "unearned fee" in NRS 640.160 with regard to physical therapists. (BDR 54-291)

44. Require the certification of nursing assistants (including specifications for training requirements and qualifications), provide for their regulation, and require specific cooperative efforts among those state agencies which regulate facilities that employ nursing assistants. (BDR 54-165)

45. Include in the final report a statement encouraging the state board of nursing to make specific reference to excessive number of working hours in its regulations concerning professional impairment.

46. Direct that businesses that provide temporary medical personnel to health care facilities be regulated. (BDR 54-1555)

C. RURAL HEALTH CARE

47. Include in the final report a proposal not acted upon by the committee concerning the provision of financial incentives to hospitals that provide management assistance and other help to designated rural hospitals. (BDR S-1218)

48. Allow district hospitals to issue bonds in the same manner as county hospitals, i.e., to the limit established by the hospital board for specifically defined purposes. (BDR 40-1219)

49. Appropriate $10 million from the state general fund to the office of the state treasurer to create a permanent capital pool, with the principal balance remaining intact and the investment income being made available to meet the capital needs of rural hospitals. (BDR 40-1220)

50. Establish a Nevada health service corps in which, under certain conditions, a portion of a physician's medical school loans will be repaid by the board of regents of the University of Nevada System in exchange for the physician agreeing to practice for a specified time in Nevada's rural and underserved areas. (BDR 34-615)

REPORT TO THE 65TH SESSION OF THE NEVADA LEGISLATURE BY THE NEVADA LEGISLATURE'S COMMITTEE ON HEALTH CARE

I. INTRODUCTION - COST AND ACCESS ISSUES

America continues to expend a significant portion of the Gross National Product (GNP) on health care. In 1987, the United States spent 11 percent of the GNP on health care, the highest of any industrialized country in the world (see Figure No. 1). By the year 2000, these expenditures are expected to reach 15 percent of the GNP. In addition, estimates indicate that there are presently 30 million persons in this country without any health insurance coverage.

FIGURE NO. 1

Total Health Expenditure As A Percentage Of Gross Domestic Product, 1960-1986

	1960	1965	1970	1975	1980	1983	1984	1985	1986
Australia	4.6%	4.9%	5.0%	5.7%	6.6%	6.9%	6.9%	6.8%	6.8%
Austria	4.6	5.0	5.4	7.3	7.9	7.9	8.0	8.2	8.0
Belgium	3.4	3.9	4.0	5.8	6.6	7.2	7.2	7.2	7.1
Canada	5.5	6.1	7.2	7.3	7.4	8.6	8.5	8.4	8.5
Denmark	3.6	4.8	6.1	6.5	6.8	6.6	6.3	6.1	6.1
Finland	4.2	4.9	5.6	6.2	6.3	6.6	6.8	7.3	7.5
France	4.2	5.2	5.6	6.7	7.4	8.1	8.4	8.4	8.5
Germany	4.7	5.1	5.5	7.8	7.9	8.0	8.1	8.2	8.1
Greece	2.9	3.1	4.0	4.0	4.2	4.2	4.0	4.2	3.9
Iceland	5.9	6.0	8.7	11.1	6.9	8.2	7.3	7.8	7.5
Ireland	4.0	4.4	5.6	7.7	8.5	8.0	8.0	8.0	7.9
Italy	3.3	4.0	4.8	5.8	6.8	6.7	6.6	6.7	6.7
Japan	3.0	4.5	4.6	5.6	6.6	6.9	6.7	6.6	6.7
Luxembourg	-	-	3.8	5.3	6.1	6.9	6.6	6.7	6.9
Netherlands	3.9	4.4	6.0	7.7	8.2	8.6	8.3	8.3	8.3
New Zealand	4.4	4.5	5.1	6.4	7.2	6.3	-	-	6.9
Norway	3.3	3.9	5.0	6.7	6.6	6.8	6.5	6.4	6.8
Portugal	-	-	-	6.4	5.9	5.4	5.6	5.6	5.6
Spain	2.3	2.7	4.1	5.1	5.9	6.3	6.0	6.0	6.0
Sweden	4.7	5.6	7.2	8.0	9.5	9.6	9.5	9.4	9.1
Switzerland	3.3	3.8	5.2	7.1	7.2	7.8	7.7	7.9	8.0
Turkey	-	-	-	-	-	3.5	-	-	3.6
United Kingdom	3.9	4.1	4.5	5.5	5.8	6.2	6.2	6.1	6.2
United States	5.2	6.0	7.4	8.4	9.2	10.7	10.5	10.7	11.1
Mean	4.1	4.6	5.4	6.7	7.1	7.2 (7.3)*	7.3	7.3	7.2 (7.3)*

Source: Measuring Health Care 1960-1983 (Paris: Organization for Economic Cooperation and Development, 1985); and consistent updating.
* Mean excluding Turkey.

Nevada has historically experienced some of the highest health care costs in the country. In 1986, a year before the state's cost-containment legislation took effect, Nevada was ranked first in net revenue per inpatient day, far above

the Western States' average in this and in most other cost categories.

A difficult factor in any attempt to address the increasing cost of health care is the so-called "balloon effect." Attempts to push down costs in one segment of the system tend to result in a bulge in another area. This situation is becoming evident in programs at both the federal and the state levels. Nevada's health care system is sensitive to internal forces, such as Medicaid policies and public health concerns, as well as to external forces occurring at the national and corporate levels. The foundation and structure of health care is changing in this country. Nevada and all the other states are attempting to deal with this transformation and the "balloon effect" that is accompanying the rapid changes.

A. LEGISLATIVE ACTION IN 1987

In 1987, the Nevada Legislature debated a number of important bills related to the costs of health care. The most significant and controversial bills were Governor Richard Bryan's health cost-containment package and the Legislature's health care cost-containment package developed through a 2-year interim study. Both plans, while using different approaches, were designed to achieve equal access to quality medical care at an affordable price. A compromise bill emerged, Assembly Bill 289 (chapter 377, Statutes of Nevada, 1987 [NRS 439B.200]), which blended the primary concepts and components of both packages.

Assembly Bill 289 contained a comprehensive set of provisions designed to reduce health care costs. The bill required that several Nevada hospitals reduce their billed charges to an established level, while also reducing their revenue per inpatient. Other hospitals were required to reduce their percentage of income-to-operating expenses. Major sections of the bill also revised certificate of need (CON) requirements. In addition, the measure prohibited specified transactions between insurers and affiliated health facilities and between hospitals and their affiliates.

The bill also contained provisions designed to distribute the care of indigent patients more evenly in counties with more than one hospital. Additional sections contained provisions designed 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 established a legislative oversight committee to monitor the effectiveness of its provisions.

B. CREATION AND PURPOSE OF THE HEALTH CARE COMMITTEE

The legislative oversight committee, established through A.B. 289, was charged with reviewing health care activities in Nevada and monitoring certain provisions of the bill. The committee held nine regular meetings from October 1987 through November 1988. Three additional subcommittee meetings were called to consider action regarding the certification of nursing assistants and the monitoring of hospital compliance with the provisions of A.B. 289.

The committee received testimony on a wide variety of topics from all segments of the health care industry including dieticians, educators, hospitals, nurses, physical therapists, physicians, third party payers, various state agencies, and the public.

Robert Pierce, senior staff of the Health Care Cost Containment Project being conducted by the National Conference of State Legislatures (NCSL), apprised the committee of national trends and activities in other states. The committee also received information concerning state options for providing health insurance for the uninsured from Shelda Harden, an associate with NCSL.

A number of health care issues were considered by the committee. Many of these topics, such as the high cost of health care and funding for the medically indigent, have been considered before. However, several major issues, such as Acquired Immune Deficiency Syndrome (AIDS) and the current shortage of licensed nurses are relatively new to Nevada.

II. DISCUSSION OF ISSUES AND RECOMMENDATIONS

Based upon these extensive discussions, over 100 recommendations and concepts were considered by the committee. After careful consideration, 50 proposals (resulting in 26 bill draft requests) were recommended by the committee for the consideration of the 1989 legislature.

The proposals have been categorized into three general areas:

1. Regulatory considerations;
2. Financing of health care; and
3. Nevada's health care systems.

In addition to the basic recommendations, this bulletin contains material which is designed to supplement Legislative Counsel Bureau Bulletin No. 87-6 titled, Study Of Restraining Costs Of Medical Care, dated December 1986. The earlier report should be consulted for a review of the history of health care in Nevada and for background information surrounding major issue areas considered by the legislative commission's subcommittee to study restraining costs of medical care. These issues received considerable attention during the 1987 legislative session.

The members of the health care committee are aware that budget considerations may preclude passage of several proposals. It was the intent of the committee, however, to present a complete package of recommendations relative to the issues reviewed for the consideration of the full legislature.

The background for each of these recommendations is summarized in the following discussions.

A. REGULATORY CONSIDERATIONS

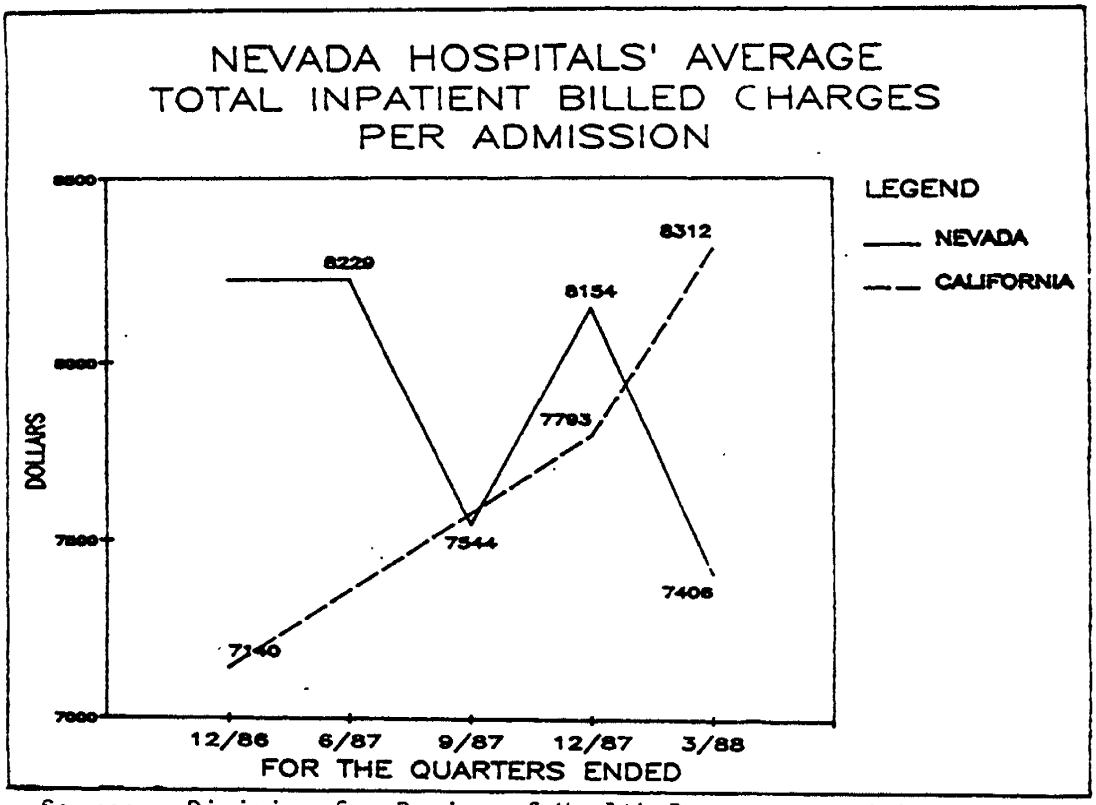
The health care committee reviewed a number of proposals affecting the health care industry, industry regulators, and public health agencies. Although the original provisions of A.B. 289 were the primary focus, the committee also made recommendations concerning the state's health care data collection system, the regulation of health maintenance organizations (HMO's), Nevada's medical-legal screening panels, various programs for the elderly, and several public health concerns, including AIDS.

1. Effect of A.B. 289

As noted earlier in this report, A.B. 289 established the Nevada legislature's committee on health care, revised certificate of need requirements and required that several Nevada hospitals reduce billed charges to an established level while also reducing their revenue per inpatient. Still other hospitals were required to reduce their percentage of income-to-operating expenses.

According to information presented to the health care committee, all hospitals affected by this legislation have met their respective targets for the fiscal year. Data provided by the department of human resources (DHR) has shown that Nevada's hospital costs are no longer the highest in the Nation. Although recent comparative data from other states is not available, California now exceeds Nevada in average cost per admission (see Figure No. 2).

FIGURE NO. 2



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

Proposals which affect the provisions of A.B. 289 are detailed in other sections of this report. They include proposals to add nurses to hospital committees for the advocacy of maintaining quality of care, further revision of Nevada's CON law, data reporting considerations, and incentives for hospitals affected by A.B. 289 to provide management assistance to rural hospitals. See Appendix A for an analysis of specific features of A.B. 289.

Topic: Certificate of Need Statutes

Nevada, like many other states, has a certificate of need program. Many states have altered their CON laws--some have raised dollar thresholds, some have deregulated certain types of expenditures, and several states have eliminated their CON programs altogether. Although the 1987 legislature made a number of changes to the state's CON statutes, Nevada's department of human resources has proposed major changes to the law. These changes include elimination of CON procedures for most projects, with the director of human resources retaining broad authority to monitor and evaluate projects and to impose moratoriums, if necessary.

Recommendation:

Include in the committee's future work schedule the development of potential recommendations for modification of Nevada's certificate of need law.

Topic: Indigent Care

Assembly Bill 289 also contained provisions designed to distribute more evenly the volume of indigent care among the hospitals within a community. In reviewing the effects of this provision, the health care committee noted that hospitals in both Reno and Las Vegas have had a large number of indigency claims denied. (See Table No. 1.)

TABLE NO. 1

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

Clark County - July, 1987 through June, 1988

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

Washoe County - July, 1987 through June, 1988

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

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

Source: Clark and Washoe County Social Service Departments

Further investigation revealed that confusion due to patient eligibility status caused many hospitals to submit incomplete claims for patients upon admission. Denials were made following the patient's discharge because further information revealed ineligible income levels or other criteria. At times the hospitals experienced an inability to locate the person to complete the evaluation process.

Recommendation:

> **Allow, by statute, counties to place social services representatives on site in county hospitals and in non-county hospitals in order to expedite the evaluation and processing of medical indigency claims.** (BDR 38-1225)

In addition, A.B. 289 contained various provisions designed to eliminate the practice of illegal transfers of indigent patients. The committee on health care received reports that the incidence of patient "dumping" has declined. However, there is some debate over access to appropriate emergency room care for all persons. Further action may be necessary to clarify several provisions of the law. (See Appendix A for a more detailed discussion of the indigency provisions of A.B. 289.)

Topic: Quality of Care Concerns

Section 39 of A.B. 289 states that cost containment activities will not affect the quality of care provided by the hospitals affected by the bill. Various sections of the bill address staff reductions and the elimination of services. However, no clear method of measuring quality is defined or has been developed. It was the consensus of the committee that quality-of-care issues were extremely important in a cost containment environment.

Recommendation:

> **Include in the final report a statement that the health care committee will continue to fulfill and emphasize its responsibilities under Nevada Revised Statutes (NRS) 439B.200, subsections 10 and 11, to collect and evaluate data concerning quality of health care services within Nevada's hospitals.**

A major concern of the committee has been the quality of the data being received to measure hospital compliance with the provisions of A.B. 289. All hospitals in Nevada are required to submit cost information to the division for review of health resources and costs in Nevada's department of human resources. In addition, the hospitals affected by

A.B. 289's cost rollback provisions are required to submit additional data concerning billed charges and revenues. Because the system has been in place for a relatively short period of time, it is difficult to gauge the quality of the system or the data being gathered. Audits of the data are scheduled to be completed by the end of 1988, and the 1989 legislature will then be able to evaluate the data collection system.

Topic: Cost Data for the Health Care Consumer

Hospital cost data also is of interest to the consumer. Many citizens of Nevada make costly health care decisions with little or no available information. The committee expressed its opinion that certain cost information being gathered should be assembled in an understandable manner and be made available to the consumer on a regular basis.

Recommendation:

> **Require the director of the department of human resources to prepare semiannual reports concerning the cost of health care in Nevada.** (BDR 40-292)

Topic: Quality of Care Advocacy Committees

Section 39 of A.B. 289 also describes the composition and duties of hospital committees for the advocacy of quality of care. These committees were established to ensure that several potential quality of care problems would not occur following implementation of A.B. 289's cost containment features. Although physicians are represented on these panels, the committee felt that the nursing staff of these hospitals could have valuable input into the process.

Recommendation:

> **Require the inclusion of nurses on hospital committees for the advocacy of maintaining the quality of care by hospitals.** (BDR 40-614)

The effectiveness of the quality of care committees was also reviewed. The health care committee was informed that the physicians on these committees were reluctant to discuss specific quality of care problems due to confidentiality concerns. Current statutes (NRS) prohibit public discussions of confidential medical records, and concerns were raised with regard to legal liability on the part of quality of care committee members. With these concerns in mind, the health care committee felt that the effectiveness of the quality committees and commissions would be increased if

they were exempted from the open meeting law requirements and the proceedings were to be made nondiscoverable.

Recommendation:

> **Modify NRS 449.475 to exempt both the commissions for the advocacy of maintaining quality of care by hospitals and the hospital committees for the advocacy of maintaining quality of care by hospitals from Nevada's open meeting law requirements and to make their proceedings and actions nondiscoverable.** (BDR 40-1554)

Topic: Structure of the Division for Review of Health Resources and Costs

The agency given the primary responsibility for monitoring hospital compliance with A.B. 289 is the division for review of health resources and costs. A continuing interest of the committee has been the method by which the department has been structured, both internally and within the executive branch, in order to fulfill its responsibilities.

Recommendation:

> **Include in the final report a statement that the health care committee will continue to fulfill and emphasize its responsibilities under NRS 439B.200, subsections 10 and 13, to evaluate the effectiveness of the division for review of health resources and costs, DHR, in carrying out its data-gathering and cost-containment functions.**

2. Medical Malpractice

The topic of medical malpractice with its attendant legal disputes has been thought to contribute to the increasing costs of health care.

Topic: Medical-Legal Screening Panel Changes

The legislature's committee on health care also examined the effectiveness of the medical-legal screening panels in reducing malpractice claims. The panels, consisting of physicians and attorneys (as well as hospital administrators, if appropriate) review all complaints concerning medical malpractice.

A panel may subpena expert witnesses and records, and it conducts its deliberations in accordance with rules of practice and procedure promulgated by the commissioner of

insurance. The panel must determine whether the claim has sufficient merit to justify proceeding to file a case in court. The written findings of the screening panel are admissible in any action concerning the complaint which is subsequently filed in district court.

If the panel rejects the claim, the claimant may file an action in court only after posting a $5,000 bond. If the claimant does not prevail in court, the bond is forfeited.

If the panel decides that the claim has some merit, and the claimant files suit in the district court, the judge must order the claimant, the defendant, a representative of the defendant's insurance company and their attorneys to attend a settlement conference to attempt to determine a fair claim for the plaintiff's damages.

It was thought that a reduction of complaints would indirectly reduce health care costs. According to information presented to the committee by the insurance commissioner, the number of medical malpractice cases reaching court has been dramatically reduced. Table No. 2 illustrates the disposition of these cases as of December 31, 1988.

TABLE NO. 2

TOTAL MEDICAL MALPRACTICE ACTIONS
(By Year Filed*)

	1986	1987	1988**
Complaints	82	104	91
Respondents	175	219	180
Outcome by Respondent (By Year Filed)			
No finding of medical malpractice	114	124	18
Medical malpractice with injury	11	16	4
Medical malpractice with no injury	3	2	N/A
Unable to decide	15	27	6
Stayed	1	0	4
Pending reviews	0	12	136
Cases terminated prior to panel consideration	31	39	12

*Many cases filed late in the year are decided in the next year.

**As of December 31, 1988.

Due to the lag-time in processing court cases, it is difficult to make precise estimates of cost savings to the insurance industry. However, anecdotal information presented to the committee seems to indicate that physician malpractice premiums should decline or remain level in the near term. The commissioner also reported that the frequency of total malpractice claims filed may have significantly declined. More accurate data concerning this matter should be available in 1989.

The committee was urged to recommend repeal of the "sunset" provision of the law which otherwise terminate the panel process. The insurance commissioner [insurance division, department of commerce] also identified a personnel problem with the panels. Due to the extensive schedule of cases, the commissioner suggested that the physician and attorney member pools be increased and that an orientation and training program for all members of the panels be established.

Recommendations:

Repeal the "sunset" provisions of NRS 41A.016, et seq., and thus provide for continuation of the medical-legal screening panels established to review medical malpractice claims. (BDR 3-169)

Expand the size of the medical-legal screening panel member pools of attorneys and physicians, and incorporate an orientation and training component for all panel members. (BDR 3-169)

3. Public Health

A variety of public health issues including AIDS, smoking, and chronic fatigue syndrome were considered by the committee.

Topic: Smoking

The committee received testimony concerning public policy and smoking. Although smoking is statutorily banned in certain places, existing law generally allows areas within public places to be designated as "no smoking areas"--a proposed change to the law would reverse the logic and define public places as being smoke free unless certain conditions are met and unless they are otherwise posted.

Recommendation:

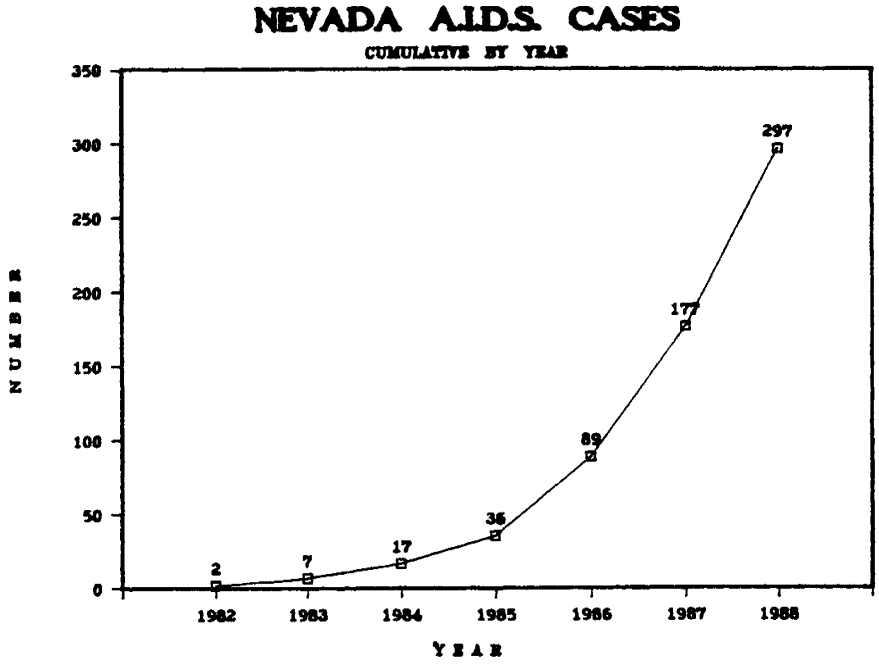
Establish legislation which designates public places as smoke free, expands the definition of public place, narrowly defines exceptions where smoking can occur, and provides a penalty for violations. (BDR 15-166)

Topic: AIDS

The United States Surgeon General, C. Everett Koop, has identified AIDS as the most challenging public health problem facing the Nation. It also is the number one public health challenge for the State of Nevada.

Since the first cases were reported in Nevada in 1982, the number of persons afflicted with AIDS has grown to over 295 cases, with 134 deaths for the period through December 31, 1988. The projected consequences of this disease are staggering. (See Figure No. 3.) According to information presented to the health care committee by the Nevada AIDS Task Force, the state can expect a minimum of 540 AIDS cases, with perhaps as many as 2,500 by 1991. Nevada's statutes relating to sexually transmitted diseases (STDs) were written in 1937. While many of the public health concerns are relevant today, the committee believes that a comprehensive approach to AIDS and other sexually transmitted diseases is necessary.

FIGURE NO. 3



Source: Health Division, Nevada's Department of Human Resources, June 1988.

The health care committee reviewed draft legislation based upon the recommendations of the AIDS Advisory Force. The proposals, if approved by the full legislature, will thoroughly revise the state's sexually transmitted diseases statutes. The task force also made a series of sweeping recommendations concerning AIDS confidentiality statutes and the powers of the health division to address such public health emergencies. The changes reviewed by the committee are designed to strike a balance between preserving patient confidentiality and protecting the public welfare.

The state's response to the AIDS epidemic will be one of the most difficult and emotional topics the 1989 legislature will have to face. However, the committee determined that a comprehensive bill is necessary in order to address all of the issues associated with AIDS. Such a measure, used in concert with the educational component for AIDS that is currently in place, should provide an effective response to this epidemic. It was the opinion of the committee that although this issue is difficult to address, and some hard choices will have to be made, government must act quickly and decisively in the interests of the people of the state.

Recommendation:

> **Revise those sections of the Nevada Revised Statutes concerning sexually transmitted diseases as specified in the Nevada AIDS task force report titled, "Proposed legislative changes for communicable disease control."** (BDR 40-1216)

Topic: Chronic Fatigue Syndrome

Diseases other than AIDS are of concern in Nevada. One of them, chronic fatigue syndrome, has not had a coordinated review on a statewide basis. The committee believed that a surveillance system needed to be put in place, or the existing system modified to effectively monitor such diseases within the state.

Recommendation:

> **Establish a public health surveillance system within the health division to monitor such diseases as chronic fatigue syndrome.** (BDR 40-1227)

Topic: Teratogen "Hotline"

In 1989, the Nevada March of Dimes will be starting a teratogen hotline--a toll-free telephone access to experts with information concerning the effects of a mother's

exposure to teratogenic agents during pregnancy. The "hot line" will be available both to health care professionals and to the public. Following a one year pilot project, the legislature has been asked to continue funding for the service. The committee received testimony concerning the effectiveness of similar hotlines in other states, and professional endorsements of the project were received from several physicians.

Recommendation:

Require the establishment of a toll-free telephone service for the dissemination of information about the effects of exposure to teratogenic agents during pregnancy. (BDR 40-290)

4. Programs for the Elderly

Topic: Home-Delivered Meals

The committee also considered a series of proposals regarding Nevada's program for home-delivered meals. Although the needs of most of the program's recipients is being met, the nutritional needs of persons recently discharged from the hospital are of particular concern. Such individuals often have poor nutrition and may even need to be readmitted for complications arising from their lack of proper diet. Others have special dietary needs, such as low-salt or low-fat diets.

The committee received reports that some persons were not able to participate in the program due to the limitations concerning the delivery area. Other persons, especially in urban areas, were not able to benefit immediately from the home-delivered meals program due to crowded delivery schedules. Several individuals were added to the program several days after discharge from the hospital.

Recommendations:

Appropriate $69,248 for staff and equipment to the aging services division, DHR, in order to institute a program within the existing home-delivered meal system that would offer therapeutic diets to those persons with certain medical conditions. (BDR S-167)

Direct the aging services division, DHR, to conduct a study to determine the best means of temperature maintenance for food provided by its program of the home-delivered meals for the elderly. (BDR S-167)

Expand the existing urban delivery system of the home-delivered meals program in order to decrease the time an eligible patient discharged from a hospital may spend on the program's waiting list. (BDR S-167)

Direct the aging services division, DHR, to evaluate a variety of food delivery systems and implement a delivery system that will allow clients from a larger area to be served by this program. (BDR S-167)

Direct the aging services division, DHR, to evaluate alternative ways of providing homebound meals when extra nutritional needs are present or for assistance on weekends (alternatives could include a 1-day per week delivery of frozen meals in outlying areas or the delivery of canned food supplements). (BDR S-167)

Topic: Elder Abuse

Cases of abuse of the elderly have also been of growing concern to the legislature. With the advent of Nevada's home- and community-based program for the elderly (an alternative to institutionalization) a need has developed for a better system for reporting cases of abuse in a prompt, effective manner. The health care committee has endorsed the concept of an elder abuse "hot line" much like the existing child abuse "hot line".

Recommendation:

Establish an "elder abuse hotline" within the DHR--similar to the existing "child abuse hotline"--to report cases of abuse of the elderly. (BDR 38-1217)

In addition, the committee emphasized the need for a coordinated, statewide repository for substantiated reports of abuse of the defenseless, incapable or elderly. Through such a registry, patterns of abuse could be discerned, allowing for prompt action in such cases. The committee envisioned that such a file would be accessible to state and local government social service agencies.

Recommendation:

Require the DHR to create registries of substantiated claims of abuse, exploitation or neglect of defenseless, incapable or elderly persons. (BDR 38-1217)

5. HMO Regulation

Topic: Health Maintenance Organizations

Concern relating to the practices of health maintenance organizations (HMO's) operating within Nevada was expressed by the public in several hearings of the health care committee. Several HMO's have withdrawn from the state, or have been bought out by larger HMO's. The health care committee considered proposals to address concerns regarding HMO solvency provisions in NRS, acquisition and mergers of such organizations, and unfair trade practices. The committee also received reports from consumers regarding policy decisions made by the HMO's concerning their health care problems. It was suggested that those persons leaving HMO's be surveyed to identify possible problems.

Recommendations:

Include in the committee's future work schedule development of potential recommendations to address concerns regarding HMO solvency, acquisition/mergers, and unfair trade practices.

Direct the legislative commission to contract with consultants to conduct an interim study to determine enrollee satisfaction with HMO's; the results of which would be subject to review and approval by the committee on health care. (BDR S-294)

B. FINANCING OF HEALTH CARE

1. Changes in Health Care Financing

At the national level, the health care industry is in a transition phase from a system that pays for services in a retrospective, cost-based manner to one that does so in a prospective, predetermined fashion.

Topic: Structural Changes in Health Care Financing

First, the change has eroded the traditional means the hospital industry has used to finance indigent care--cost shifting, or absorbing the costs of indigent patients within the revenue generated by paying patients. Second, a shift in the power structure has evolved. There is an increasing tendency toward the generation of agreements between the large providers of health care services, and the large purchasers such as governmental entities and corporate employers. This type of shift could allow those entities

with monopsony power--that is, buyers with the ability to substantially influence the price and product of the seller--to exercise their collective influence in order to restrain the costs of health care. The health care committee was encouraged by this trend.

Recommendation:

Include in the final report a statement encouraging those business entities which hold monopsony power over the health care industry to exercise their collective influence to restrain the costs of health care.

The structural changes happening on a national level have forced Nevada and other states to examine existing systems of financing health care. In order to offset the loss of the traditional method of financing indigent care, options such as the expansion of state Medicaid were reviewed by the committee. Several health insurance issues also were reviewed, along with proposals to ameliorate costs within the state industrial insurance system (SIIS).

2. Medicaid and Options for the Uninsured

On a national scale, the last 2 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. In addition, the U.S. Congress passed various federal mandates that will make it necessary to increase Nevada's Medicaid expenditures.

Topic: The Medically Indigent

From the fiscal perspective, expansion of Nevada's Medicaid program may be the most cost-effective method of financing care for the medically indigent. Most of this burden currently rests upon the shoulders of the counties, and transferring the responsibility from the counties to Nevada Medicaid would shift financial accountability to the state level. A portion of the impact of this shift would be offset by the prospect of obtaining matching federal dollars

to pay for half of the total cost of care. With the current system, the counties pay nearly all the cost, with no federal matching funds.

Recommendation:

> **Expand Medicaid coverage by adopting the federal option to implement a program for the medically needy. (Medicaid benefits would be made available to those individuals and families who do not qualify for Aid-to-Dependent-Children or Supplemental Security Income programs because their income is too high. Those eligible would contribute a small amount for care with Medicaid paying the remainder.)** (BDR 38-1224)

Topic: Medicaid Prenatal Care Option

Most premature (or low birthweight) babies are associated with costly medical care and high rates of chronic and disabling illnesses. Yet many premature births can be prevented by cost-effective prenatal care. A 1985 study of Utah Medicaid data revealed that the initial cost of a low birthweight baby averaged $63,000. Although only 1.7 percent of babies born to Medicaid mothers in Utah were low birthweight, they consumed $2.7 million (or 24 percent) of all Medicaid expenditures for initial hospital costs.

In addition, about 16 percent of very low birthweight babies are born with severe developmental disabilities and require additional health and social services. Disabilities include blindness, cerebral palsy, mental retardation and seizure disorders. A report issued by the Federal Government's Office of Technology Assessment estimates that the average net cost of low birthweight is between $14,000 and $30,000 per individual, until age 35.

The Institute of Medicine estimated that for every $1 spent for prenatal care for high-risk women, $3.38 would be saved in initial and long-term care costs for low birthweight infants. Pilot programs in other states have estimated the savings to be anywhere from $1.70 to $5 for every $1 spent on preventative care.

The Federal Government is cognizant of this cost ratio. The Medicare Catastrophic Coverage Act of 1988 mandated that by July 1, 1989, states provide Medicaid coverage for prenatal care to children and pregnant women whose income is below 75 percent of the Federal Poverty Level (FPL). By July 1, 1990, states must provide that service to those whose income is at or below 100 percent of the FPL. States are allowed to set eligibility up to 185 percent of the FPL.

Recommendation:

Expand Medicaid eligibility to allow Medicaid coverage to children and pregnant women whose income does not exceed 185 percent of federal poverty guidelines (in order to take advantage of changes in federal law). (BDR 38-1221)

Topic: Health Care for the Uninsured

According to a 1987 report issued by the Employee Benefit Research Institute, based upon 1985 census data, 21.3 percent (or 179,000) nonelderly Nevadans do not have any health insurance. Nationally, that figure is 15.2 percent. Nevada's high proportion of service industry jobs may explain the higher than average percentage of persons without insurance. Although the report does not give state-by-state estimates, nationally, approximately 75 percent of the uninsured in this country are employed.

The committee received testimony from a representative of the National Conference of State Legislatures concerning options for providing health insurance for the uninsured. Possible courses of action include the creation of what would amount to a state-administered HMO, such as the State of Washington's "Basic Health Plan"; providing special financial incentives to encourage hospitals to treat additional indigent cases; expansion of Medicaid to include several optional programs; and implementing of several other alternatives that could be tied to state Medicaid.

Recommendations:

Amend Medicaid eligibility to include coverage for two-parent households in which the principal breadwinner is unemployed (as allowed under federal guidelines for Medicaid options). (BDR 38-1222)

Allow small businesses to "buy into" Nevada Medicaid in order to provide health care insurance for their employees. (BDR 38-1226)

Topic: Supplemental Security Income Eligibility

Another discreet segment of the field of indigent care deals with the elderly indigents. 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.

Nevada's eligibility threshold for long-term care has been set since 1980 at $714 per month--at that time, three times the federal Supplemental Security Income (SSI) level. Based upon social security increases since 1980, the SSI maximum income limit for institutionalized individuals now stands at $1,020. Those elderly whose incomes lie between those two figures are, for the most part, cared for by the counties. As this gap widens, fewer and fewer of the elderly will be eligible for Medicaid and more of the payment burden will be shifted to the counties. Keith W. Macdonald, deputy administrator for Nevada Medicaid in the welfare division of the department of human resources, estimates the counties are picking up nearly $4 million of these costs. Should the income eligibility level be raised, the state would be able to fund the same amount of care for about $2 million--its share of the federal matching funds.

Recommendation:

Revise chapter 422 of NRS to allow persons whose monthly income is less than three times the income allowable to receive benefits pursuant to 42 United States Code §§ 1382 through 1383c to become eligible to receive assistance for the medically indigent for the purpose of long-term medical care. (BDR 38-1223)

3. State Industrial Insurance System (SIIS)

The 1987 legislature approved Assembly Bill 663, which allowed insurers providing state industrial insurance coverage to contract with preferred providers to supply goods and services for injured employees. Certain providers (such as primary care physicians, chiropractors, and acute care hospitals) were excluded from this authorization. The health care committee has reviewed a proposal to authorize additional categories of preferred providers. The proposal, and the question of preferred providers for SIIS, will have a profound impact upon health care costs to Nevada employers.

Recommendation:

Include in the committee's future work schedule the development of potential recommendations concerning contracts with various categories of health care providers for the preferential provision of goods or services within the state industrial insurance system.

4. Health Care Insurance

The committee on health care also reviewed several recommendations related to health care insurance.

Topic: Use of Regional Morbidity Factors

One concern related to the insurance industry practice of using regional morbidity factors to set insurance rates. According to information presented to the committee, such a methodology might skew Nevada's actual rate, potentially imposing an unnecessarily high rate on individuals insured in this state.

Recommendation:

> **Direct the commissioner of insurance in the insurance division of the department of commerce to examine the practice of using regional morbidity factors to set insurance rates.** (BDR R-293)

Topic: Retired Public Employees

The issue of health insurance benefits for retired public employees also was reviewed by the committee. Not all of Nevada's retired public employees are eligible for Medicare benefits. Many groups have contributed to Social Security or to the Medicare program. In Nevada, approximately 30 percent of the state's current employees are not eligible for Medicare. Retirees both in and out of Nevada's group insurance system pay a retiree differential. Those who do not have Medicare to provide a safety net are particularly vulnerable to rate increases. Retired members of the Clark County Classroom Teachers Association asked the committee for help with this specific situation.

Recommendation:

> **Include in the committee's future work schedule the development of potential recommendations to provide assistance to Nevada's retired public employees who are not eligible to receive Medicare benefits and who must pay a retiree differential to maintain their health insurance.**

Topic: Risk Pools

More than 15 states have enacted laws establishing risk pools for the purpose of offering to sell health insurance to high-risk individuals who are otherwise unable to purchase it. Most persons who benefit from such programs

have preexisting medical conditions such as cancer or diabetes which disqualify them for most insurance policies. Although Nevada's insurance commissioner is authorized to initiate a risk pool (NRS 686B.180), according to the commissioner, no one has come forth to promote the idea.

Recommendation:

Include in the committee's future work schedule the development of potential recommendations relative to establishing a health insurance pool in Nevada for high-risk individuals. (Such a pool would address the needs of persons unable to obtain insurance due to preexisting medical conditions such as cancer, diabetes, and so on.)

C. NEVADA'S HEALTH CARE SYSTEMS

The legislature's committee on health care examined a series of issues related to various components of Nevada's health care systems and the individuals who provide the care and services within these systems. The statewide nursing shortage received extensive attention as did rural health care concerns. The committee also made a series of recommendations concerning several health-related professions.

1. Nursing Shortage

The shortage of trained, professional nurses is a national phenomenon, and it is just beginning to be addressed by many states. Unlike past shortages, the current situation is based upon the evolving structure of health care, not solely upon nursing school enrollment figures or salary levels. The nationwide shortage has already had an impact upon health care in Nevada.

According to figures compiled for November 1987 by Nevada's state board of nursing, between 1,000 and 1,500 more nurses are needed statewide in order to fill existing vacancies. The reasons for the shortage in Nevada seem to be those given for the shortage nationally (see Figure No. 4). Additional analysis reflects a severe shortage of nurses in Clark County, Nevada, and several rural areas of the state. The shortage of trained personnel appears to be a major reason for the high incidence of "divert status" for hospitals in Clark County (see Figure No. 5).

FIGURE NO. 4

MOST FREQUENTLY CITED FACTORS AFFECTING SUPPLY

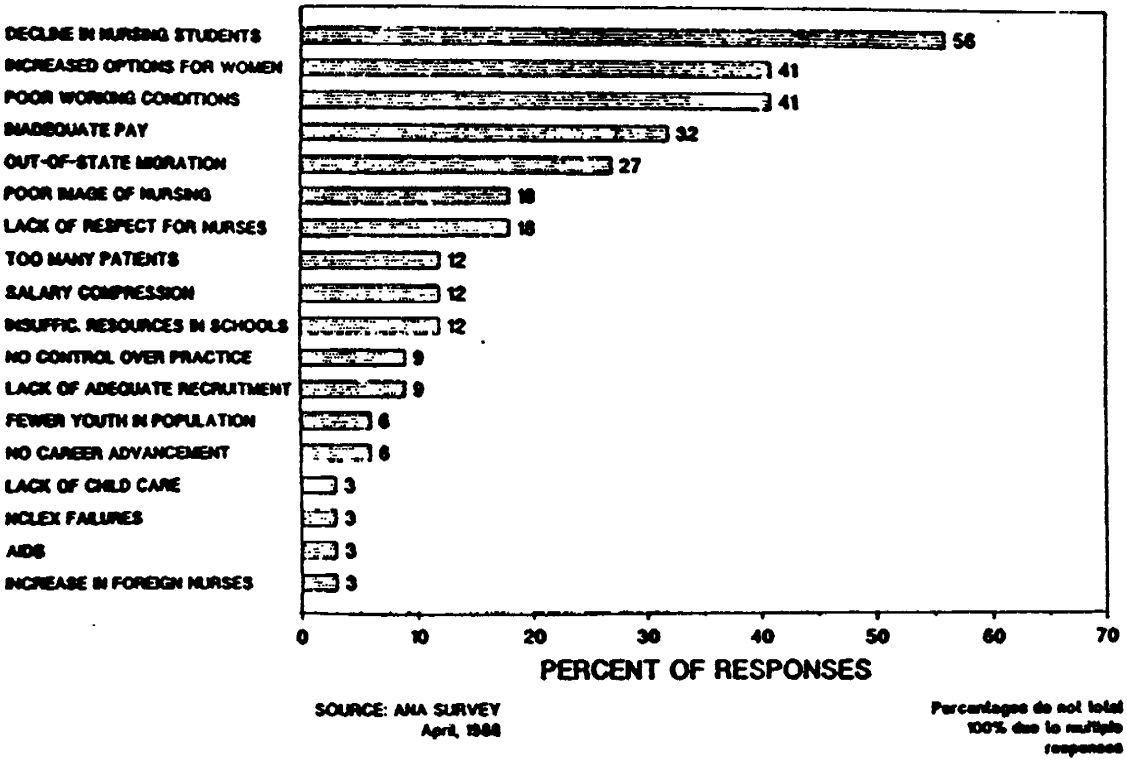
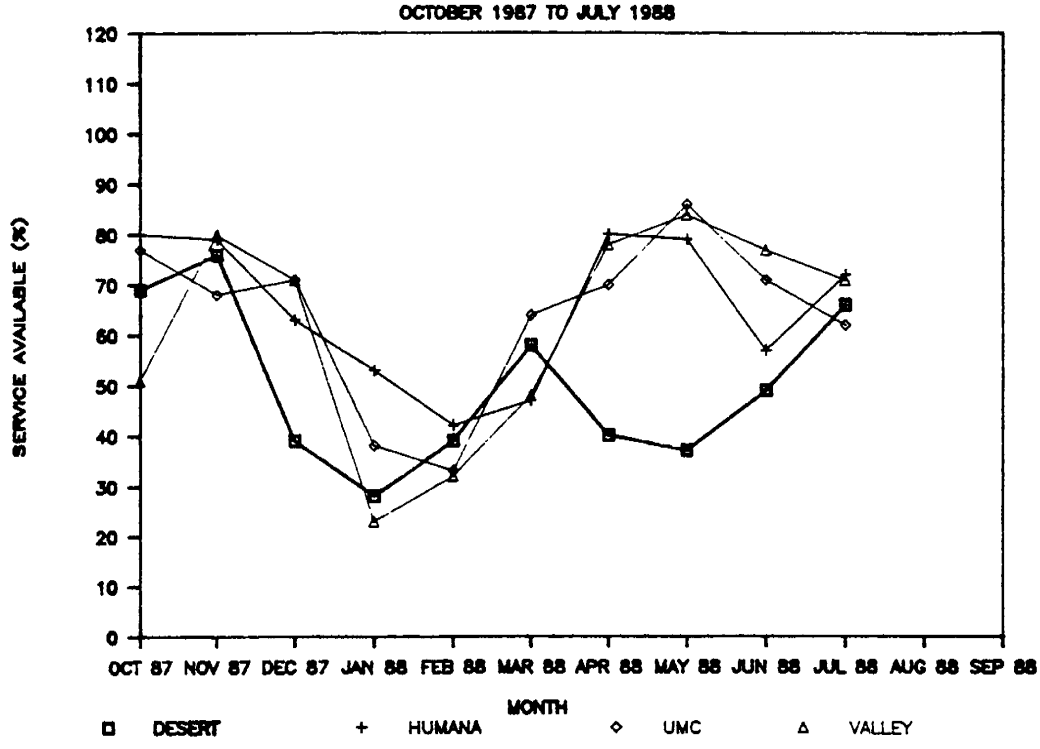


FIGURE NO. 5

HOSPITAL CRITICAL CARE DIVERT

OCTOBER 1987 TO JULY 1988



Topic: Loans for Student Nurses

The committee concluded that prompt action on the part of the legislature is necessary to help alleviate the crisis. In concert with representatives from education, industry and nursing associations, a proposal emerged which would establish a program to provide loans to nursing students, with authorized waivers of repaying the loans should the nurse choose to practice in Nevada following graduation. The work "pay back" time period would be a function of the amount of the loan. Incentives would be provided for those nurses who choose to work in underserved areas of the state.

Recommendations:

Establish a program to provide loans to nursing students, authorizing waivers of repayment of the loans upon practice of nursing in Nevada after graduation for a period of time determined by the total amount of the loan. (BDR 34-168)

Establish incentives for recipients of financial aid for nursing students to practice in rural areas. (BDR 34-168)

Topic: Support for Federal Legislation

In addition, the committee was asked to lobby Nevada's congressional delegation to act upon several pieces of legislation that would provide federal support to nursing students.

Recommendations:

Send a letter to Nevada's congressional delegation encouraging support of the passage of United States Senate Bill 1402. (The bill would establish nurse recruitment centers to target potential candidates for the field; and encourage nursing schools to promote gerontological nursing as a career and nursing homes as a clinical setting.)

Send a letter to Nevada's congressional delegation encouraging the passage of U.S. Senate Bill 1765 which would provide incentives for increased use of nurse practitioners in nursing homes.

Send a letter to Nevada's congressional delegation encouraging the reinstatement of the Federal Nurse Training Act loan program, with the addition of program

guidelines to encourage nurses to practice in long-term care facilities.

Topic: Industry Efforts to Ease the Nursing Shortage

The committee took note of the shortage of professional nurses within the long-term care industry, and was asked to recommend methods to encourage nursing students to consider gerontological nursing as a career option. In addition, the committee was impressed with the efforts of the health care industry with its programs to recruit and train future employees.

Recommendations:

Send a letter to all schools of nursing in Nevada and to all of Nevada's nursing homes encouraging clinical affiliations between the nursing schools and nursing homes in order to promote student interest in the field of gerontological nursing.

Send a letter to all employers of nurses in Nevada encouraging the funding of scholarships to assist student nurses through their academic programs. (Students would contract with a facility to provide a "work" payback system as a guarantee for financial assistance.)

Topic: University of Nevada Programs

The committee was asked to encourage a statewide public relations campaign to recruit students, and to support expansion of existing nursing programs in the University of Nevada and community colleges. In expressing its support for the schools of nursing within the University of Nevada System the committee has encouraged the board of regents to increase support for these programs. The committee also was very concerned that articulation difficulties continue to exist among the nursing schools. Such difficulties are felt to hinder nursing students from pursuing educational goals within the state, contributing to professional "burnout" and possibly the loss of some individuals to educational systems outside of the state.

Recommendations:

Send a letter to the board of regents for the University of Nevada System (UNS) encouraging all nursing schools to include funding requests for a statewide marketing campaign to promote the profession of nursing.

Send a letter to the board of regents for the UNS supporting funding requests for the system's nursing education programs, including increases in faculty size and salaries, and additional ancillary personnel.

Send a letter to the board of regents of the UNS expressing concern that the articulation difficulties between university and community college nursing programs be addressed immediately.

The committee was encouraged to note that solutions to the nursing shortage have emerged as part of a consensus effort between government and industry to improve working conditions and benefits for nurses and to support the selection of nursing as a viable career choice for those entering the work force. The committee found the parties involved with this issue to be in agreement concerning the scope of the problem and the options for its solution.

2. Other Health Care Professions

The conduct and qualifications of the various health care professions is a perennial topic of legislation. Relative to this broad area, the health care committee reviewed a number of recommendations.

Topic: Physical Therapists

At the request of the 1987 legislature, the Nevada Physical Therapy Association presented the health care committee with a proposed change to the language in NRS regarding the meaning of an "unearned fee" (NRS 640.160). The language is designed to prohibit conflicts of interest, whereby a physician-owned physical therapy practice would accept referrals from the physician-owner or closely affiliated individuals. The committee concurred with the changes.

Recommendation:

Clarify the meaning of "unearned fee" in NRS 640.160 with regard to physical therapists. (BDR 54-291)

Topic: Nursing Assistants

Much of the daily care of Nevada's long-term care patients has been in the hands of nursing aides. Many of these individuals have had minimal training, and there has been no standardized system available to educate them or to evaluate their qualifications or regulate their employment activities.

In concert with changes taking place at the federal level, the committee worked with the Nursing Care Assistant Task Force to develop draft legislation to regulate the certification of nursing assistants. The proposal, if approved by the full legislature, would establish training requirements and minimum qualifications for certification. Due to the often conflicting needs of the parties involved, the committee was especially active in developing the direction of this proposed legislation.

Recommendation:

Require the certification of nursing assistants (including specifications for training requirements and qualifications), provide for their regulation, and require specific cooperative efforts among those state agencies which regulate facilities that employ nursing assistants. (BDR 54-165)

Topic: Excessive Hours Worked by Nurses

The effect of 12-hour shifts on nursing performance and patient care was also a subject for discussion by the committee. Information was submitted to the committee which indicated that 12-hour shifts do not have a significant impact on the quality of patient care. Reports also were made to the committee concerning nurses exceeding a 40-hour work week. Anecdotal information indicated that some nurses would work their normal three 12-hour shifts, then work additional shifts at another hospital or in a physician's office. The committee expressed concern with regard to this situation and asked the state board of nursing to gather additional information about the prevalence of this practice. The committee also felt that the board should address excessive hours of work specifically in its guidelines for assessing professional impairment.

Include in the final report a statement encouraging the state board of nursing to make specific reference to excessive number of working hours in its regulations concerning professional impairment.

Topic: Nursing Registries

The committee on health care received information concerning the operation of nursing registries in Nevada. These businesses provide nurses and other skilled health professionals on a temporary basis to health care facilities. Current Nevada law does not specifically address the regulation of these businesses or the qualifications of their personnel.

Recommendation:

Direct that businesses that provide temporary medical personnel to health care facilities be regulated. (BDR 54-1555)

3. Rural Health Care

A variety of state-regulated health delivery systems exist at a statewide level. Such systems include the trauma network and the neonatal intensive care system. Health care services such as obstetric services, maternal/infant care, substance abuse and primary care also have a significant statewide impact. These health care components serve as linking systems and are particularly important to rural Nevada. Often these networks serve as the primary entry points for rural Nevadans to appropriate levels of care that are often unavailable outside of metropolitan areas.

Based upon the information received by the committee, it appears that a significant crisis is developing in rural Nevada with regard to the availability of health care facilities and services. It may be appropriate to call for a working conference dedicated to public health concerns in general and rural health in particular, and the committee on health care may be the best vehicle to begin the public discussion. That discussion would center around a process of prioritizing the types of service that are considered essential to rural Nevadans.

Topic: Rural Hospital Needs

Changes at the federal level in reimbursing Medicare hospital costs have had a significant effect on all hospitals. The change has, however, had an especially significant impact on rural hospitals, since these facilities treat a higher percentage of Medicare patients. Many rural hospitals face difficulties in obtaining bonds for capital projects due to insufficient patient volume. In addition, the Hill-Burton funding program, responsible for the creation of most of this country's small hospitals, has ended. Each of these problems has led to a decline in the ability of rural hospitals to replace aging facilities and to undertake other capital building projects.

The necessity for sophisticated management techniques is especially strong in rural hospitals. The prospective payment system used by Medicare, coupled with declining rates of occupancy and chronic personnel shortages, have combined to create an extremely difficult situation for many rural facilities. At the Montgomery Dorsey Symposium,

members of the committee learned of a successful program in other states where larger urban hospitals were encouraged to share their management expertise with rural facilities. Since conflicting information was presented concerning the application of the concept to Nevada, the committee decided to include the proposal without taking action upon it.

Recommendation:

Include in the final report a proposal not acted upon by the committee concerning the provision of financial incentives to hospitals that provide management assistance and other help to designated rural hospitals. (BDR S-1218)

The committee also reviewed a series of proposals designed to assist rural facilities in their capital construction requirements. One proposal requested the creation of a permanent pool of money to fund capital improvements for rural hospitals. Through such a program, hospitals would be able to request money from the interest generated by the trust fund. Another proposal recommended that district hospitals be allowed to issue bonds in the same manner as county hospitals.

Recommendations:

Allow district hospitals to issue bonds in the same manner as county hospitals, i.e., to the limit established by the hospital board for specifically defined purposes. (BDR 40-1219)

Appropriate $10 million from the state general fund to the office of the state treasurer to create a permanent capital pool, with the principal balance remaining intact and the investment income being made available to meet the capital needs of rural hospitals. (BDR 40-1220)

Topic: Shortage of Physicians in Rural Nevada

The overall shortage of physicians in rural Nevada has been a chronic problem for the state. The malpractice insurance crisis forced many physicians to limit their practices, further reducing services in these areas of the state. A health services corps for Nevada has been proposed, similar to the federal program that has remained unfunded in recent years. Such programs forgive student loans to medical school students in exchange for a scheduled amount of practice in underserved areas of the state.

Recommendation:

Establish a Nevada health service corps in which, under certain conditions, a portion of a physician's medical school loans will be repaid by the board of regents of the University of Nevada System in exchange for the physician agreeing to practice for a specified time in Nevada's rural and underserved areas. (BDR 34-615)

III. CONCLUSION

The package of recommendations discussed in this report provides a comprehensive view of the major health care topics presented to the legislature's committee on health care. The scope of the proposals reflects the major 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 are of concern to a significant number of individuals outside of the health care industry. Since legislation governing these topics will affect multiple sectors of Nevada's business and professional communities, it is expected that each major issue will be the subject of intense scrutiny and debate.

As noted earlier in the report, the committee reviewed over 100 proposals covering a broad range of health care topics. The committee on health care invested a significant amount of time and effort in analyzing the issues confronting the health care industry and the consumer. This report represents a continuation of the legislative effort to attempt a comprehensive analysis of the complex systems of regulating, financing, and operating the health care industry in Nevada.

Health care costs in Nevada are still among the highest in the Nation. The committee has identified many of the interrelated components that drive health care costs. Action on one segment invariably leads to reaction in another. As the cost-containment provisions of A.B. 289 continue to operate, the committee will continue to monitor its short-term and long-term effects.

The members of the committee would like to express their appreciation to those who participated in its investigations. Of particular assistance were the many special witnesses, state agency representatives, and other interested professionals who contributed their valuable time and effort. The various representatives from the nursing profession deserve special mention, along with the

representatives of the American Association of Retired Persons who provided valuable input to the committee.

Over the last decade there has been a shift of responsibility from the Federal Government to state and local governments for many health care fields. While this shift has given the states more control, it has also placed an increased demand on state government to become more sophisticated in these fields and to provide increased levels of funding. Recent years have also experienced a transformation in the health care industry from a retrospective system to a prospective system.

Most of the issues discussed in this report are the direct or indirect result of either the shift of federal responsibility or the transformation of the American health care system. Since Nevada is currently operating within the transitional phases of both trends, these topics will undoubtedly be debated for some time. The legislature will continue to grapple with these issues and will continue to be concerned about the cost, the availability and the quality of health care for the citizens of Nevada.

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V. APPENDICES

APPENDIX A

BACKGROUND PAPER 88-4 TITLED "THE EFFECT OF ASSEMBLY BILL 289 IN CONTROLLING HEALTH CARE COSTS," PREPARED BY H. PEPPER STURM, RESEARCH ANALYST, RESEARCH DIVISION, LEGISLATIVE COUNSEL BUREAU

APPENDIX A

BACKGROUND PAPER 88-4

THE EFFECT OF ASSEMBLY BILL 289 IN CONTROLLING HEALTH CARE COSTS

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THE EFFECT OF ASSEMBLY BILL 289 IN CONTROLLING HEALTH CARE COSTS

I. INTRODUCTION

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

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

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

A. HISTORICAL BACKGROUND OF A.B. 289

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

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

II. SCOPE AND ANALYSIS OF MAJOR COST-CONTAINMENT PROVISIONS

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

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

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

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

A. REQUIRED REDUCTIONS OF INPATIENT REVENUES

1. Description

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

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

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

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

2. Scope

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

Percentage of Income to Operating Expense Exceeds 17 Percent

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

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

No hospitals subject to this provision.

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

Saint Mary's Hospital, Reno, Nevada

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

3. Analysis

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

TABLE 1

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

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

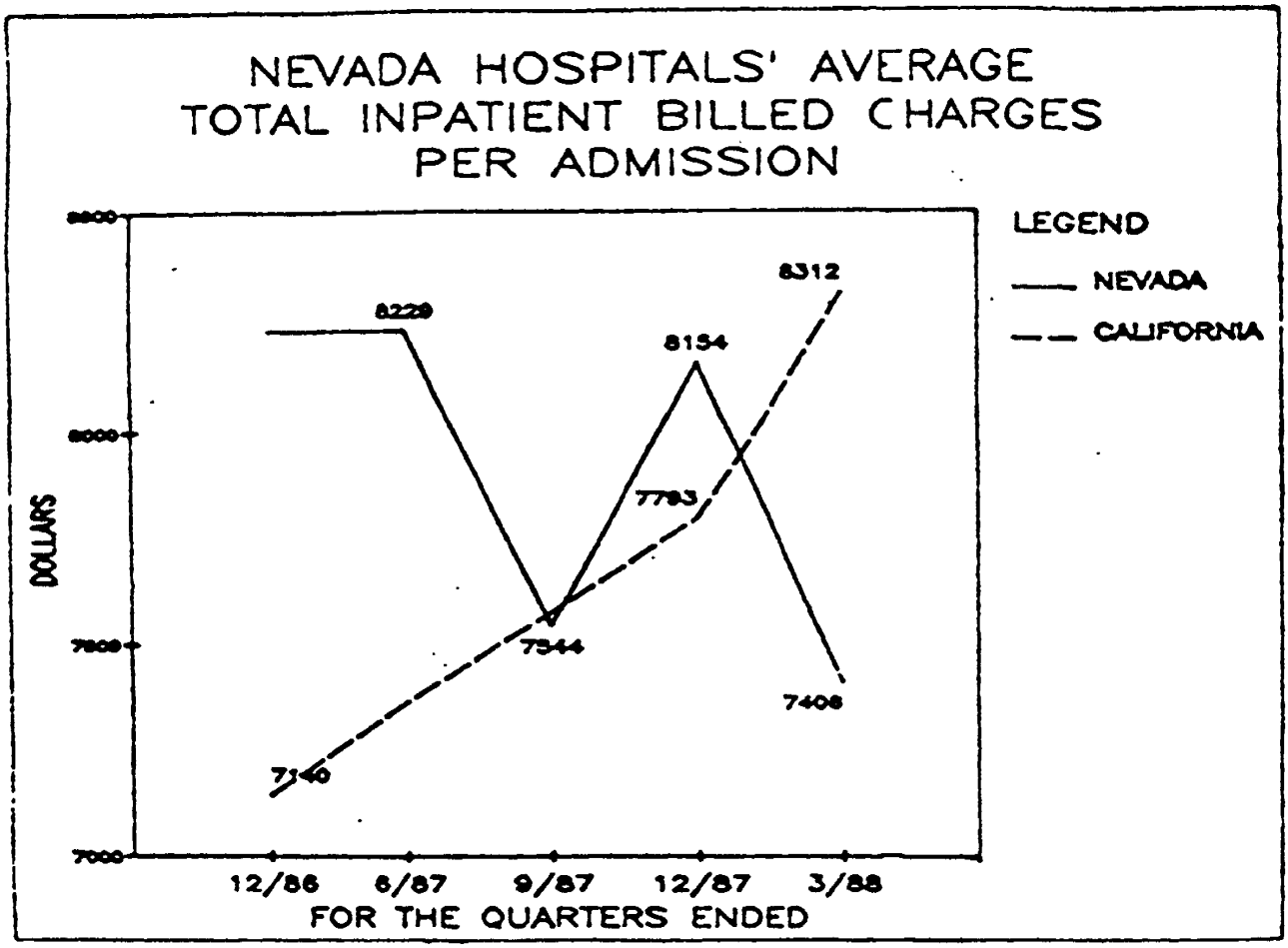
Source: Division for Review of Health Resources and Costs (DRHRC), Nevada's Department of Human Resources (August 1988, unaudited data).

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

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

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

FIGURE 1



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

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

TABLE 2

Total Hospital Inpatient Net Revenue
Nevada 1985 - 1987

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

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

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

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

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

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

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

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

B. INDIGENCY PROVISIONS

1. Description

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

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

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

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

2. Scope

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

3. Analysis

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

TABLE 3

NUMBER OF INDIGENT CASES BY FISCAL YEAR

Clark County, Nevada

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

Source: Clark County Social Service Department.

TABLE 4

Washoe County, Nevada

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

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

Source: Washoe County Social Services Department.

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

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

TABLE 5

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

Clark County - July, 1987 through June, 1988

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

Washoe County - July, 1987 through June, 1988

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

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

Source: Clark and Washoe County Social Service Departments.

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

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

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

C. CERTIFICATE OF NEED

1. Description

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

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

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

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

2. Scope

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

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

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

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

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

3. Analysis

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

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

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

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

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

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

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

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

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

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

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

III. MEASURING COMPLIANCE

A. DATA MONITORING

1. Description

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

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

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

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

2. Scope

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

3. Analysis

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

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

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

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

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

B. HEALTH INSURANCE PASS-ALONG

1. Description

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

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

2. Scope

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

3. Analysis

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

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

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

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

IV. SUMMARY

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

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

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

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

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

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

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

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

V. SELECTED REFERENCES

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

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

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

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

APPENDIX B

Suggested Legislation

The members of the health care committee are aware that budget considerations may preclude passage of several proposals. It was the intent of the committee, however, to present a complete package of recommendations relative to the issues reviewed for the consideration of the full legislature.

SUMMARY--Requires certification of nursing assistants. (BDR 54-165)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to nursing; requiring the certification of nursing assistants; requiring certain training and qualifications for nursing assistants; providing for their regulation; requiring certain cooperation among state agencies which regulate facilities which employ nursing assistants; providing a penalty; and providing other matters properly relating thereto.

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

Section 1. Chapter 632 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 20, inclusive, of this act.

Sec. 2. *"Agency to provide nursing in the home" has the meaning ascribed to it in NRS 449.0015.*

Sec. 3. *"Basic nursing services" means the performance of acts designated by the board which are within the practice of nursing under the direction of a registered nurse or a licensed practical nurse that do not require the substantial*

specialized skill, judgment and knowledge required of a registered nurse or licensed practical nurse.

Sec. 4. *"Certificate" means a document which authorizes a person to practice as a nursing assistant.*

Sec. 5. *"Facility for long-term care" means a facility for intermediate care, as defined in NRS 449.0038, or a facility for skilled nursing, as defined in NRS 449.0039.*

Sec. 6. *"Medical facility" has the meaning ascribed to it in NRS 449.0151.*

Sec. 7. *"Nursing assistant" means a person who, for compensation, performs basic restorative services and basic nursing services directed at the safety, comfort, personal hygiene, basic mental health and protection of patients and the protection of patients' rights in a medical facility.*

Sec. 8. *"Nursing assistant trainee" means a person who is:*

1. Enrolled in a training program required for certification as a nursing assistant; or

2. Awaiting the results of a certification examination.

Sec. 9. *1. The advisory committee on nursing assistants, consisting of nine members appointed by the governor, is hereby created.*

2. The governor shall appoint to the advisory committee:

(a) One representative of facilities for long-term care;

(b) One representative of medical facilities which provide acute care;

(c) One representative of agencies to provide nursing in the home;

(d) One representative of the health division of the department of human resources;

(e) One representative of the welfare division of the department of human resources;

(f) One representative of the aging services division of the department of human resources;

(g) One representative of the American Association of Retired Persons or a similar organization;

(h) A nursing assistant; and

(i) A registered nurse or a licensed practical nurse.

3. The advisory committee shall advise the board with regard to matters relating to nursing assistants.

Sec. 10. *1. Any person, except a nursing assistant trainee, who for compensation practices or offers to practice as a nursing assistant in this state is required to submit evidence that he is qualified so to practice and must be certified as provided in this chapter.*

2. It is unlawful for any person:

(a) To practice or to offer to practice as a nursing assistant in this state or to use any title, abbreviation, sign, card or device to indicate that he is practicing as a nursing assistant in this state unless he has been certified pursuant to the provisions of this chapter.

(b) Who does not hold a certificate authorizing him to practice as a nursing assistant issued pursuant to the provisions of this chapter to perform or offer to perform basic nursing services in this state, unless the person is a nursing assistant trainee.

(c) To be employed as a nursing assistant trainee for more than 4 months unless he has successfully completed a training program and is awaiting the results of a certification examination.

Sec. 11. *1. An applicant for a certificate to practice as a nursing assistant must submit to the board written evidence under oath that he:*

(a) Is of good moral character;

(b) Is in good physical and mental health;

(c) Is at least 16 years of age; and

(d) Meets such other reasonable requirements as the board prescribes.

2. An applicant may be certified by examination if he:

(a) Submits a completed written application and the fee required by this chapter;

(b) Completes a training program approved by the board and supplies a certificate of completion from the program;

(c) Passes the certification examination approved by the board; and

(d) Has not committed any acts which would be grounds for disciplinary action if committed by a nursing assistant, unless the board determines that sufficient restitution has been made or the act was not substantially related to nursing.

3. An applicant may be certified by endorsement if he:

(a) Submits a completed written application and the fee required by this chapter;

(b) Submits proof of successful completion of a training program approved by the appropriate agency of another state;

(c) Has passed a certification examination approved by the board to be equivalent to the examination required in this state;

(d) Has not committed any acts which would be grounds for disciplinary action if committed by a nursing assistant, unless the board determines that sufficient restitution has been made or the act was not substantially related to nursing; and

(e) Submits documentation of employment as a nursing assistant for the 2 years preceding the date of the application.

4. The board shall issue a certificate to practice as a nursing assistant to each applicant who meets the requirements of this section.

Sec. 12. *1. The training program required for certification as a nursing assistant must consist of not less than 160 hours of instruction. The program must include 1 hour of instruction in theory for every 2 hours of clinical instruction. The program must be completed within 3 months after the nursing assistant trainee begins employment.*

2. Except as otherwise provided in this subsection, the instructor of the program must be a registered nurse with:

(a) Three years of nursing experience which includes direct care of patients and supervision and education of members of the staff; and

(b) Proof of successful completion of training for instructors which has been approved by the board.

The board may approve a licensed practical nurse as an instructor if the board determines that requiring instruction by a registered nurse would create a hardship.

3. Upon completion of the program, a nursing assistant trainee must pass a test in theory with an overall score of 80 percent and a test of skills on a pass or fail basis. The test of skills must be given by a registered nurse. If the nursing assistant trainee fails either of the tests, he must repeat the training program.

4. In a program which is based in a facility, a nursing assistant trainee may only perform those tasks he has successfully completed in the training program, and must perform those tasks under the direct supervision of a registered nurse or a licensed practical nurse.

5. The board shall adopt regulations:

(a) Specifying the scope of the training program and the required components of the program;

(b) Establishing standards for the approval of programs and instructors; and

(c) Designating the basic nursing services which a nursing assistant may provide upon certification.

Sec. 13. *1. The board shall authorize the administration of the examination of applicants for certification as nursing assistants.*

2. The board may employ, contract with or cooperate with any person in the preparation, administration and grading of a uniform national examination, but shall retain sole discretion and responsibility for determining the standards of successful completion of the examination.

3. The board shall determine whether an examination may be repeated and the frequency of authorized re-examinations.

4. If an applicant fails the examination twice, he must repeat the training program prescribed in section 12 of this act.

Sec. 14. *1. The board may certify a nursing assistant to perform designated acts in medical facilities which provide acute care in addition to basic nursing services if the nursing assistant:*

(a) Has 1,500 hours of experience;

(b) Has completed an additional training program approved by the board; and

(c) Performs only those acts which are approved by the board and included in the policies and procedures of the facility in which the nursing assistant is working.

2. The board shall adopt regulations:

(a) Specifying the training necessary for certification to perform additional acts pursuant to this section;

(b) Delineating the authorized scope of practice for nursing assistants who are certified pursuant to this section; and

(c) Establishing the procedure for application for certification pursuant to this section.

Sec. 15. *1. The certificate of a nursing assistant must be renewed biennially on the date of the certificate holder's birthday.*

2. The board shall renew a certificate if the applicant:

(a) Submits a completed written application and the fee required by this chapter;

(b) Submits documentation of completion of 24 hours of training in the previous 24 months in the type of facility in which he works; and

(c) Has not committed any acts which are grounds for disciplinary action, unless the board determines that sufficient restitution has been made or the act was not substantially related to nursing.

The training program completed pursuant to paragraph (b) must be approved by the board.

3. Failure to renew the certificate results in forfeiture of the right to practice unless the nursing assistant qualifies for the issuance of a new certificate.

4. Renewal of a certificate becomes effective on the date on which the application is filed or the date on which the renewal fee is paid, whichever is the later.

Sec. 16. *A suspended certificate is subject to expiration and must be renewed as provided in section 15 of this act. Renewal does not entitle the nursing assistant to engage in activity which requires certification until the completion of the suspension.*

Sec. 17. *The board may deny, revoke or suspend any certificate to practice as a nursing assistant applied for or issued pursuant to this chapter, or otherwise discipline a holder of a certificate upon proof that he:*

1. Is guilty of fraud or deceit in procuring or attempting to procure a certificate to practice as a nursing assistant.

2. Has been convicted of a felony or any offense substantially related to the qualifications, functions and duties of a nursing assistant.

3. Is unfit or incompetent by reason of gross negligence or a pattern of unsafe conduct in carrying out usual nursing functions.

4. Uses any controlled substance, dangerous drug, as defined in chapter 454 of NRS, or intoxicating liquor to an extent or in a manner which is dangerous or injurious to any other person or which impairs his ability to conduct the practice authorized by his certificate.

5. Is mentally incompetent.

6. Is guilty of unprofessional conduct, which includes but is not limited to the following:

(a) Conviction of practicing medicine without a license in violation of chapter 630 of NRS.

(b) Procuring, or aiding, abetting, attempting, agreeing, or offering to procure or assist at, a criminal abortion.

(c) Impersonating any applicant or acting as proxy for an applicant in any examination required under this chapter for the issuance of a certificate.

(d) Impersonating or representing himself as another nursing assistant, a licensed practical nurse, a registered nurse or a physician.

(e) Permitting or allowing another person to use his certificate for the purpose of practicing as a nursing assistant.

(f) Repeated negligence in performing the duties of a nursing assistant, which may be evidenced by claims settled against him.

(g) Conviction for the use or unlawful possession of a controlled substance or a dangerous drug as defined in chapter 454 of NRS.

(h) Physical, verbal or psychological abuse of a patient.

7. Has willfully or repeatedly violated the provisions of this chapter.

8. Is guilty of aiding or abetting anyone in a violation of this chapter.

9. Has been disciplined in another state in connection with a certificate to practice as a nursing assistant or has committed acts in another state which would constitute a violation of this chapter.

10. Has acted in a fraudulent or deceitful manner in the course of his practice.

For the purposes of this section, a plea or verdict of guilty or a plea of nolo contendere constitutes a conviction of an offense. The board may take disciplinary action pending the appeal of a conviction and regardless of any order entered pursuant to NRS 176.225 dismissing an indictment or information.

Sec. 18. *1. The following persons shall report to the board any conduct by a nursing assistant which constitutes grounds for the denial, suspension or revocation of a certificate:*

(a) Every physician, dentist, dental hygienist, chiropractor, optometrist, podiatrist, medical examiner, resident, intern, professional or practical nurse, physician's assistant, psychiatrist, psychologist, marriage and family therapist, alcohol or drug abuse counselor, driver of an ambulance, advanced emergency medical technician or other person providing medical services licensed or certified to practice in this state.

(b) Any personnel of a medical facility or facility for the dependent engaged in the admission, examination, care or treatment of persons or an administrator, manager or other person in charge of a medical facility or facility for the dependent upon notification by a member of the staff of the facility.

(c) A coroner.

(d) Every clergyman, practitioner of Christian Science or religious healer, unless he acquired the knowledge of the conduct from the offender during a confession, or a social worker.

(e) Every person who maintains or is employed by an agency to provide nursing in the home.

(f) Every attorney, unless he has acquired the knowledge of the conduct from a client who has been or may be accused of the conduct.

(g) Any employee of the welfare or aging services division of the department of human resources.

(h) Any employee of a law enforcement agency or a county's office for protective services or an adult or juvenile probation officer.

(i) Any person who maintains or is employed by a facility or establishment that provides care for older persons.

(j) Any person who maintains, is employed by or serves as a volunteer for an agency or service which advises persons regarding the abuse, neglect or exploitation of an older person and refers them to persons and agencies where their requests and needs can be met.

2. Every physician who, as a member of the staff of a medical facility or facility for the dependent, has reason to believe that a nursing assistant has engaged in conduct which constitutes grounds for the denial, suspension or revocation of a certificate shall notify the superintendent, manager or other person in charge of the facility. The superintendent, manager or other person in charge shall make a report as required in subsection 1.

3. A report may be filed by any other person.

Sec. 19. *The board may delegate its authority to conduct hearings pursuant to NRS 632.350 concerning the discipline of a holder of a certificate to a hearing officer. The hearing officer has the powers of the board in connection with the hearings, and shall report back to the board with findings of fact and conclusions of law within 30 days after the final hearing on the matter. The board may take action based upon the report of the hearing officer, refer the matter back to the hearing officer for further hearings, or conduct its own hearings on the matter.*

Sec. 20. *1. The board shall supply the health division of the department of human resources upon request with a list of each training program approved by the board.*

2. The board shall share with each state agency which regulates medical facilities and facilities for the dependent any information the board receives concerning disciplinary action taken against nursing assistants who work in the facilities.

Sec. 21. NRS 632.010 is hereby amended to read as follows:

632.010 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 632.011 to 632.019, inclusive, *and sections 2 to 8, inclusive, of this act,* have the meanings ascribed to them in those sections.

Sec. 22. NRS 632.100 is hereby amended to read as follows:

632.100 1. The board shall make and keep a full and complete record of all its proceedings, including a file of all applications for licenses *and certificates* under this chapter, together with the action of the board upon each

application, and including a register of all nurses licensed [to practice nursing] *and all nursing assistants certified* in this state.

2. The board shall maintain in its main office a public docket or other record in which it shall record, from time to time as made, the rulings or decisions upon all complaints filed with it, and all investigations instituted by it in the first instance, upon or in connection with which any hearing has been had, or in which the licensee *or holder of a certificate* charged has made no defense.

3. At least semiannually, the board shall publish a list of the names and addresses of persons licensed *or certified* by it under the provisions of this chapter, and of all applicants , [and] licensees *and holders of certificates* whose licenses *or certificates* have been refused, suspended or revoked within 1 year, together with such other information relative to the enforcement of the provisions of this chapter as it may deem of interest to the public.

Sec. 23. NRS 632.125 is hereby amended to read as follows:

632.125 Each hospital or agency in the state employing professional or practical nurses *or nursing assistants* shall submit a list of such nursing personnel to the board at least three times annually as directed by the board.

Sec. 24. NRS 632.250 is hereby amended to read as follows:

632.250 None of the provisions of NRS 632.130 to 632.240, inclusive, *and sections 2 to 20, inclusive, of this act* shall be construed as prohibiting:

1. The practice of nursing in this state by any legally qualified nurse of another state whose engagement requires him to accompany or care for a patient temporarily residing in this state during the period of one such

engagement not to exceed 6 months in length, provided such person does not represent or hold himself out as a nurse licensed to practice in this state.

2. The practice of any legally qualified nurse of another state who is employed by the United States Government or any bureau, division or agency thereof, while in the discharge of his official duties in this state.

3. Gratuitous nursing by friends or by members of the family of the patient.

4. Nursing assistance in the case of an emergency.

5. The practice of nursing by students enrolled in accredited schools of professional nursing, or by graduates of such schools or courses pending the results of the first licensing examination scheduled by the board following such graduation.

6. The incidental care of the sick by domestic servants or persons primarily employed as housekeepers if they do not practice nursing within the meaning of this chapter.

7. Nonmedical nursing for the care of the sick, with or without compensation, when done by the adherents of, or in connection with, the practice of the religious tenets of any well-recognized church or religious denomination, so long as such nursing does not amount to the practice of professional nursing as defined in NRS 632.010.

Sec. 25. NRS 632.345 is hereby amended to read as follows:

632.345 1. The board shall establish and may amend a schedule of fees and charges for the following items and within the following ranges:

	Not less than	Not more than
Application for license to practice professional nursing (registered nurse)	$45	$100
Application for license as a practical nurse	30	90
Application for temporary license to practice professional nursing (registered nurse) which fee must be credited toward the fee required for a regular license, if the applicant applies for a license	15	50
Application for temporary license as a practical nurse, which fee must be credited toward the fee required for a regular license, if the applicant applies for a license	10	45
Application for a certificate as a nursing assistant	*5*	*15*
Biennial fee for renewal of a license	15	50
Biennial fee for renewal of a certificate	*10*	*20*
Fee for reinstatement of a license	10	100
Application for recognition as an advanced practitioner of nursing	30	100
Biennial fee for renewal of recognition	15	50

Examination fee for registered nurse's license ...	20	100
Examination fee for practical nurse's license	10	90
Rewriting examination for registered nurse's license	20	100
Rewriting examination for practical nurse's license	10	90
Duplicate license.....	5	30
Duplicate certificate	*3*	*5*
Proctoring examination for candidate from another state.....	25	150
Fee for approving one continuing education course.....	10	50
Fee for reviewing one continuing education course which has been changed since approval.....	5	30
Annual fee for approval of all continuing education courses offered.....	100	500
Annual fee for review of training program.....	*25*	*60*
Certification examination.....	*10*	*90*
Approval of instructors of training programs.....	*20*	*50*
Approval of proctors for certification examinations.....	*20*	*50*
Approval of training programs.....	*50*	*150*

Validation of results of certification examinations 5 25

2. The board may collect the fees and charges established pursuant to this section, and those fees or charges may not be refunded.

Sec. 26. NRS 632.350 is hereby amended to read as follows:

632.350 1. Before suspending or revoking any license *or certificate* the board shall notify the licensee *or holder of the certificate* in writing of the charges against him, accompanying the notice with a copy of the complaint, if any is filed.

2. Written notice may be served by delivery of it personally to the licensee **[**,**]** *or holder of the certificate,* or by mailing it by registered or certified mail to **[**the**]** *his* last known residence address . **[**of the licensee.**]**

3. If the licensee *or holder of the certificate* desires, the board shall:

(a) Grant a hearing upon the charges, which hearing must be held not less than 10 days after prior notice in writing to the licensee *or holder of the certificate* nor more than 30 days after the filing of any complaint; and

(b) Furnish the licensee **[**,**]** *or holder of the certificate,* at the time of giving the notice, copies of any communications, reports and affidavits in possession of the board, touching upon or relating to the matter in question.

4. The hearing on the charges may be held by the board, or a majority thereof, at such time and place as the board prescribes. The hearing must be held, if the licensee *or holder of the certificate* desires, within the county where he resides.

Sec. 27. NRS 632.400 is hereby amended to read as follows:

632.400 1. The board shall render a decision on any complaint within 60 days [from] *after* the final hearing thereon. *For the purposes of this subsection, the final hearing on a matter delegated to a hearing officer pursuant to section 19 of this act is the final hearing conducted by the hearing officer unless the board conducts a hearing with regard to the complaint.*

2. The board shall give immediate notice in writing of the ruling or decision to:

(a) The applicant , [or] licensee *or holder of the certificate* affected thereby.

(b) The party or parties by whom the complaint was made where the investigation or hearing was instituted by a complaint.

Written notice [shall] *must* be given by registered or certified mail addressed to the last known address of the applicant [or licensee,] , *licensee or holder of the certificate* and party by whom the complaint was made.

3. If the ruling [shall be] *is* to the prejudice of, or [shall injuriously affect, the licensee,] *injuriously affects, the licensee or holder of the certificate,* the board shall also state in the notice the date upon which the ruling or the decision [shall become] *becomes* effective, which date [shall] *must* not be less than 30 days from and after the date of the notice.

4. The decision of the board [shall] *does* not take effect until 30 days after its date, and if notice of appeal and a demand for the transcript are served upon the board in accordance with the provisions of this chapter, then [such stay shall remain] *the stay remains* in force and effect until the decision of the district court after hearing the appeal. If the aggrieved party [shall fail]

fails to perfect his appeal, the stay [shall automatically terminate.] *automatically terminates.*

Sec. 28. NRS 632.420 is hereby amended to read as follows:

632.420 The decision of the board in refusing to grant a license [,] *or certificate,* or in suspending or revoking any license of a professional nurse or a practical nurse [, shall be] *or certificate of a nursing assistant, is* subject to review in accordance with the provisions of NRS 34.010 to 34.140, inclusive.

Sec. 29. NRS 632.475 is hereby amended to read as follows:

632.475 1. An employer shall not require a registered nurse, a licensed [vocational] *practical* nurse , *a nursing assistant* or any other person employed to furnish direct personal health service to a patient to participate directly in the induction or performance of an abortion if [such] *the* employee has filed a written statement with the employer indicating a moral, ethical or religious basis for refusal to participate in the abortion.

2. If the statement provided for in subsection 1 [of this section] is filed with the employer, the employer shall not penalize or discipline [such] *the* employee for declining to participate directly in the induction or performance of an abortion.

3. The provisions of subsections 1 and 2 [of this section] do not apply to medical emergency situations.

4. Any person violating the provisions of this section is guilty of a misdemeanor.

Sec. 30. NRS 632.480 is hereby amended to read as follows:

632.480 Whenever the board believes from evidence satisfactory to it that any person has violated or is about to violate any of the provisions of this chapter, or any order, license, *certificate,* permit, decision, demand or requirement, or any part or provision thereof, it may bring an action, in the name of the board, in the district court in and for the county [wherein such] *in which the* person resides, against [such] *the* person to enjoin [that person] *him* from continuing the violation or engaging therein or doing any act or acts in furtherance thereof. In the action an order or judgment may be entered awarding such preliminary or final injunction as may be proper, but no preliminary injunction or temporary restraining order [shall] *may* be granted without at least 5 days' notice to the opposite party.

Sec. 31. NRS 632.500 is hereby amended to read as follows:

632.500 1. Any person violating any of the provisions of this chapter [shall be] *is* guilty of a misdemeanor.

2. A court of competent jurisdiction [shall have] *has* full power to try any violations of this chapter, and upon conviction may, at its discretion, revoke the license *or certificate* of the person so convicted, in addition to imposing the other penalties [herein provided.] *provided in this chapter.*

Sec. 32. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

The board may adopt regulations governing reimbursement relating to nursing assistants that are consistent with the requirements and limits prescribed by federal law.

Sec. 33. Chapter 449 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The health division may review the personnel files of a medical facility or facility for the dependent to determine that each nursing assistant employed by the facility has a current certificate.

2. The health division shall review the qualifications of instructors of nursing assistants for each program of which the division is notified pursuant to section 20 of this act.

3. The health division may conduct the review of training programs for nursing assistants in facilities for long-term care.

4. The health division and any other state agency which regulates medical facilities and facilities for the dependent shall provide to the state board of nursing any information it discovers concerning:

(a) Programs and instructors for training nursing assistants which do not comply with the requirements established by the state board of nursing.

(b) The failure of a nursing assistant to perform consistently at a safe level.

(c) The results of any investigation of a facility if the investigation concerns a nursing assistant or instructor or training program for nursing assistants.

5. The state board of nursing shall investigate any report submitted pursuant to subsection 4 and may revoke approval of a program or instructor if the allegations of the report are true.

Sec. 34. 1. A person who is working as a nursing assistant on the effective date of this act is entitled to continue working as a nursing assistant if he:

(a) Has successfully completed a training program approved in another state;

(b) Has been employed for at least 1 continuous year before the effective date of this act as a nursing assistant at a medical facility;

(c) Has been employed as a nursing assistant for 2 or more years in the 5 years preceding the effective date of this act as a nursing assistant at one or more medical facilities;

(d) Has completed a course in nursing fundamentals in an accredited program of nursing education; or

(e) Has completed a training program for nursing assistants which has been approved by the board.

2. A person who is entitled to work as a nursing assistant pursuant to subsection 1 must submit an application for certification to the state board of nursing on or before January 1, 1990, with documentation of compliance with the appropriate requirement for certification and the fee for an application. If a person does not submit an application before January 1, 1990, he is not entitled to continue to work as a nursing assistant after that date.

3. The state board of nursing shall adopt standards for training programs, instructors and certification examinations for nursing assistants as soon as possible after the effective date of this act. A person who is certified pursuant to this section must pass the examination within 6 months after the effective date of the regulations. A person who fails the test may retake the test one time within the 6-month period. A person who fails the test twice or does not

pass the test within the 6-month period forfeits his certification on the date of the second test or the end of the 6-month period, whichever occurs first.

4. A certificate issued pursuant to this section must be renewed in the same manner and is subject to the same requirements as a certificate issued pursuant to section 11 of this act.

5. As used in this section, "medical facility" has the meanings ascribed to it in NRS 449.0151.

SUMMARY--Revises restrictions on smoking of tobacco. (BDR 15-166)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to public health; revising the restrictions on smoking of tobacco; providing a penalty; and providing other matters properly relating thereto.

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

Section 1. NRS 202.2491 is hereby amended to read as follows:

202.2491 1. [Except as otherwise provided in subsection 3, the] *The* smoking of tobacco in any form is prohibited if done in any:

(a) Public elevator, library, museum, or a bus used by the general public, other than a chartered bus.

(b) Room, including a lecture hall or university concert hall, located in a building owned or occupied by a public governmental agency, while a public meeting is in progress in the room.

(c) Hallway, waiting room or other area located in a building owned or occupied by a public governmental agency when so designated by the

governing body of that agency or the head of that agency, if no governing body exists.

(d) Public waiting room, lobby or hallway of any:

(1) Medical facility or facility for the dependent [as defined in chapter 449 of NRS] ; or

(2) Office of any chiropractor, dentist, physical therapist, physician, podiatrist, psychologist, optician, optometrist or doctor of traditional Oriental medicine.

(e) [Hotel, motel or restaurant when so designated by the operator thereof.

(f)] Public area of a store principally devoted to the sale of food for human consumption off the premises, except in those areas leased to or operated by a person licensed pursuant to NRS 463.160.

2. *Except as otherwise provided in subsections 6 and 7, the smoking of tobacco in any form is prohibited if done in any enclosed area not designated in subsection 1, which serves as a place of work or which is used by the public, including without limitation:*

(a) Commercial establishments such as retail stores, restaurants, banks and office buildings;

(b) Vehicles of public transportation such as trains, limousines for hire and taxicabs;

(c) Educational facilities, auditoriums and art galleries;

(d) Public areas of medical laboratories; and

(e) Indoor places of entertainment or recreation such as gymnasiums, theatres, concert halls, arenas and swimming pools.

3. The person in control of an area [listed in subsection 1:

(a) Shall post signs prohibiting smoking in the area except as provided in paragraph (b).

(b) May] *in which the smoking of tobacco is prohibited:*

(a) In subsections 1 and 2, shall request persons smoking in violation of this section to cease smoking.

(b) In subsection 2, may provide separate rooms or portions of areas where smoking is prohibited to be used for smoking.

[3.] *4. Where a smoking area is provided:*

(a) "Smoking Permitted" signs must be posted in sufficient numbers so as to be easily visible from all sections of the area in which smoking is permitted. The signs must be no smaller than 8 inches by 10 inches, with lettering no smaller than 1 inch. The color of the letters must contrast with the color of the background of the sign.

(b) Existing barriers and ventilation systems must be used to minimize the irritating and toxic effects of smoke in adjacent no-smoking areas.

In places consisting of a single room, the provisions of this subsection are complied with if no more than one-half of the room is reserved and posted as a smoking area and all persons requesting a seat in a nonsmoking area are accommodated.

5. No public place, other than a business which derives more than 50 percent of its gross receipts from the sale of alcoholic beverages or 50 percent of its gross receipts from gaming operations, may be designated as a smoking area in its entirety. If such a business is designated as a smoking area in its entirety, the

provisions of this section are complied with if the designation is conspicuously posted on all entrances normally used by the public.

6. The smoking of tobacco is not prohibited in [any] *:*

(a) Any room or area designated for smoking pursuant to paragraph (b) of subsection [2.

4.] *3.*

(b) An entire room or hall which is used for private social functions, if the seating arrangements are under the control of the sponsor of the function and not of the person in control of the place.

(c) Limousines for hire and taxicabs, where the driver and all passengers voluntarily consent to smoking in the vehicle.

(d) A private, enclosed office, occupied exclusively by smokers, even though the office may be visited by nonsmokers, except that this paragraph does not permit smoking in the reception areas of lobbies or offices.

(e) Any private, enclosed office not occupied exclusively by smokers, if nonsmoking persons normally occupying the office voluntarily consent to smoking there.

(f) Factories, warehouses and similar places of work not usually frequented by the general public, except that the department of industrial relations shall, in consultation with the state health planning and development agency, establish regulations to restrict or prohibit smoking in those places of work where proximity of workers or inadequacy of ventilation may cause smoke pollution detrimental to the health, comfort or convenience of nonsmoking employees.

(g) Performers upon the stage, if the smoking is part of a theatrical production.

7. A physician may authorize the smoking of tobacco in a facility for the dependent or a medical facility, by a specific patient thereof, in an area designated by the physician.

8. As used in this section, **[**"public meeting" means a gathering for which there is:

(a) Advance notice;

(b) A planned agenda; and

(c) A person presiding or otherwise in charge.

"Public meeting" does not include a trade show or exhibition.**]** *"facility for the dependent" and "medical facility" have the meanings ascribed to them in NRS 449.0045 and 449.0151, respectively.*

Sec. 2. NRS 202.2492 is hereby amended to read as follows:

202.2492 *1.* A person who *willfully* violates NRS 202.2491 shall be fined not less than **[**$10**]** *$25* nor more than **[**$100.**]** *$250 for each offense.*

2. Enforcement proceedings under this section may be initiated by the sworn complaint of an aggrieved person or by any peace officer.

SUMMARY--Makes appropriation to aging services division of department of human resources for studies and programs relating to delivery of meals to elderly persons at home. (BDR S-167)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Contains Appropriation.

AN ACT making an appropriation to the aging services division of the department of human resources for the performance of studies and the establishment of programs relating to the delivery of meals to elderly persons at home; and providing other matters properly relating thereto.

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

Section 1. There is hereby appropriated from the state general fund to the aging services division of the department of human resources the sum of $69,248 for:

1. A study of alternative systems, methods and schedules of food delivery for the delivery of meals to elderly persons at home;

2. The establishment of programs within the division to:

(a) Modify standardized recipes for such meals for persons with special dietary needs; and

(b) Provide those persons with appropriate information concerning diet and nutrition; and

3. An evaluation of programs for the delivery of such meals to persons in urban areas to determine whether those programs are adequate to meet the demand for their services.

Sec. 2. Any remaining balance of the appropriation made by section 1 of this act must not be committed for expenditure after June 30, 1990, and reverts to the state general fund as soon as all payments of money committed have been made.

Sec. 3. This act becomes effective upon passage and approval.

SUMMARY--Authorizes administration of financial aid to nursing students. (BDR 34-168)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Contains Appropriation.

AN ACT relating to education; authorizing the administration of financial aid to nursing students; authorizing waivers of repayment of the loans upon practice of nursing in Nevada after graduation; making an appropriation; and providing other matters properly relating thereto.

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

Section 1. Chapter 396 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 10, inclusive, of this act.

Sec. 2. *1. The board of regents may administer, directly or through a designated officer or employee of the University of Nevada System, a program to provide loans for fees, books and living expenses to students in the nursing programs of the University of Nevada System.*

2. Each student to whom a loan is made must:

(a) Have been a "bona fide resident" of Nevada, as that term is defined in NRS 396.540, for at least 6 months before his matriculation at the university;

(b) Be enrolled at the time the loan is made in a nursing program of the University of Nevada System for the purpose of becoming a licensed practical nurse or registered nurse;

(c) Fullfill all requirements for classification as a full-time student showing progression towards completion of the program; and

(d) Maintain at least a 2.00 grade-point average in each class and at least a 2.75 overall grade-point average, on a 4.0 grading scale.

3. Each loan must be made upon the following terms:

(a) All loans must bear interest at 8 percent per annum from the date when the student receives the loan.

(b) Each student receiving a loan must repay the loan with interest following the termination of his education for which the loan is made. The loan must be repaid in monthly installments over the period allowed with the first installment due 1 year after the date of the termination of his education for which the loan is made. The amounts of the installments must not be less than $50 and may be calculated to allow a smaller payment at the beginning of the period of repayment, with each succeeding payment gradually increasing so that the total amount due will have been paid within the period for repayment. The period for repayment of the loans must be:

(1) Five years for loans which total less than $10,000.

(2) Eight years for loans which total $10,000 or more, but less than $20,000.

(3) Ten years for loans which total $20,000 or more.

4. A delinquency charge may be assessed on any installment delinquent 10 days or more in the amount of 8 percent of the installment or $4, whichever is greater, but not more than $15.

5. The reasonable costs of collection and an attorney's fee may be recovered in the event of delinquency.

Sec. 3. *1. The loans made pursuant to sections 2 to 10, inclusive, of this act must not exceed the following amounts per student per semester. If the student is enrolled in a program of:*

(a) A community college, $1,700.

(b) The University of Nevada, Reno, or the University of Nevada, Las Vegas, $2,005.

2. Any money distributed pursuant to sections 2 to 10, inclusive, of this act must be distributed among the campuses of the University of Nevada System in amounts that will allow the same percentage of eligible students enrolled in the licensed practical nurse and registered practical nurse programs of each campus to receive loans.

Sec. 4. *1. Each student who receives a loan made pursuant to sections 2 to 10, inclusive, of this act shall repay the loan and accrued interest pursuant to the terms of the loan unless:*

(a) He practices nursing in a rural area of Nevada or as an employee of the state for 6 months for each academic year for which he received a loan; or

(b) He practices nursing in any other area of Nevada for 1 year for each academic year for which he received a loan.

2. The board of regents may adopt regulations:

(a) Extending the time for completing the required practice beyond 5 years for persons who are granted extensions because of hardship; and

(b) Granting prorated credit towards repayment of a loan for time a person practices nursing as required, for cases in which the period for required practice is only partially completed,

and such other regulations as are necessary to carry out the provisions of sections 2 to 10, inclusive, of this act.

3. As used in this section, "practices nursing in a rural area" means that the person practices nursing in an area located in a county whose population is less than 30,000 at least half of the total time the person spends in the practice of nursing, and not less than 20 hours per week.

Sec. 5. *The board of regents or its designee may require:*

1. A student to acquire, as security for a student loan, insurance on his life and on his health or against his disability, or both.

2. That a financially responsible person agree to be jointly liable with the recipient for the repayment of the loan.

Sec. 6. *The board of regents or its designee may require, upon notice to a recipient of a loan, that he repay the balance and any unpaid interest on the loan at once if:*

1. An installment is not paid within 30 days after it is due;

2. The recipient fails to notify the board of regents or its designee, within 30 days, of:

(a) A change of name or of the address of his home or place of practice; or

(b) The termination of the education for which he received the loan; or

3. The recipient fails to comply with any other requirement or perform any other obligation he is required to perform pursuant to any agreement with the board of regents or its designee.

Sec. 7. *A recipient of a loan made pursuant to sections 2 to 10, inclusive, of this act, shall comply with the regulations adopted by the board of regents. If he fails so to comply, the board of regents or its designee may:*

1. For each infraction, impose a fine of not more than $200 against any recipient in any academic year, and may deny additional money to any student who fails to pay the fine when due;

2. Increase the portion of any future loan to be repaid by the recipient; and

3. Extend the time a recipient is required to practice nursing to repay his loan.

Sec. 8. *1. The board of regents or its designee may, after receiving an application stating the reasons therefor, grant an extension of the period for the repayment of a loan in case of hardship arising out of the individual circumstances of a recipient. The extension must be for a period that will reasonably alleviate that hardship.*

2. Applications for extensions must be filed within the time prescribed by regulation of the board of regents.

Sec. 9. *A person obligated to repay a student loan may, as determined by the board of regents or its designee, receive credit towards payment of the loan*

for professional services provided without compensation to the state or any of its political subdivisions.

Sec. 10. *The board of regents may:*

1. Receive, invest, disburse and account for all money received for the program.

2. Report to the governor and the legislature before September 1 of any year preceding a regular session of the legislature, setting forth in detail the transactions conducted by it during the biennium ending June 30 of such year.

3. Make recommendations for any legislative action deemed by it advisable.

Sec. 11. 1. There is hereby appropriated from the state general fund to the board of regents of the University of Nevada System:

For the fiscal year 1989-90 ..... $250,000

For the fiscal year 1990-91 250,000

for use pursuant to sections 2 to 10, inclusive, of this act.

2. In addition to the money appropriated pursuant to subsection 1, not more than $250,000 for each of the fiscal years 1989-90 and 1990-91 received as matching money from any other source is hereby authorized for expenditure by the board of regents pursuant to sections 2 to 10, inclusive, of this act.

Sec. 12. This act becomes effective upon passage and approval.

SUMMARY--Makes various changes relating to medical malpractice screening panels. (BDR 3-169)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to medical malpractice screening panels; enlarging the pool of attorneys and physicians from which members of screening panels may be selected; requiring members of screening panels to attend courses of instruction; repealing the prospective expiration of provisions concerning screening panels and the limitation of medical malpractice actions; and providing other matters properly relating thereto.

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

Section 1. Chapter 41A of NRS is hereby amended by adding thereto a new section to read as follows:

1. The commissioner of insurance shall arrange for courses of instruction in the rules of procedure and substantive law appropriate for members of a screening panel.

2. Each person designated to serve on a tentative screening panel on or after July 1, 1989, shall attend the instruction provided pursuant to subsection 1 before serving on a particular screening panel.

Sec. 2. NRS 41A.023 is hereby amended to read as follows:

41A.023 1. The board of governors of the Nevada Trial Lawyers Association shall designate [20] *30* of its members to serve on the northern tentative screening panel and [20] *30* of its members to serve on the southern tentative screening panel. Each person so designated shall serve for a term of 1 year.

2. The executive committee of the Nevada State Medical Association shall designate [20] *30* of its members to serve on the northern tentative screening panel and [20] *30* of its members to serve on the southern tentative screening panel. Each person so designated shall serve for a term of 1 year.

3. The Nevada Hospital Association shall designate [20] *30* administrators of hospitals to serve as nonvoting members of the tentative screening panels. Each person so designated shall serve for a term of 1 year.

Sec. 3. Section 24 of chapter 620, Statutes of Nevada 1985, is hereby repealed.

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

TEXT OF REPEALED SECTION

Sec. 24. The provisions of this act expire by limitation on June 30, 1989.

SUMMARY--Requires establishment of toll-free telephone service for dissemination of information about effects of exposure to teratogenic agents during pregnancy. (BDR 40-290)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Contains Appropriation.

AN ACT relating to health care; requiring the health division of the department of human resources to establish a toll-free telephone service for the dissemination of information about the effects of exposure to teratogenic agents during pregnancy; requiring the health division to distribute information to the public about the service; making an appropriation; and providing other matters properly relating thereto.

WHEREAS, In celebration of the 50th anniversary of the March of Dimes, the Nevada chapter of the March of Dimes sponsored a teratogen information system, commonly called a "pregnancy risk hotline," which provides free access by telephone for all persons in Nevada during the 1989 calendar year to information on a personal basis about the effects of agents such as drugs, infections, diseases and chemicals on pregnancy; and

WHEREAS, Early prenatal care is one of the most financially effective life-enhancing methods of providing health care; and

WHEREAS, The goal of a system for the dissemination of information about the effects of exposure to a teratogenic agent during pregnancy is to help maximize the number of healthy mothers and healthy babies throughout its area of service; now, therefore,

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

Section 1. Chapter 442 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The health division shall:

(a) Establish a service accessible by telephone, free of charge to a party calling from within this state, which disseminates current and accurate information on a personal basis, about the effects of exposure to a teratogenic agent during pregnancy.

(b) Distribute promotional materials which foster public awareness and proper use of the service required by paragraph (a). The promotional materials must provide the telephone number of the service and its hours of operation.

2. As used in this section, "teratogenic agent" means a drug or other substance which may have an adverse effect on the health of a pregnant woman or the health of an unborn child.

Sec. 2. 1. There is hereby appropriated from the state general fund to the health division of the department of human resources for establishing a service to disseminate information about the effects of exposure to a teratogenic agent during pregnancy:

For the fiscal year 1989-90 ..... $10,000

For the fiscal year 1990-91 20,000

2. Any balance of the sums appropriated by subsection 1 remaining at the end of the respective fiscal years must not be committed for expenditure after June 30 and reverts to the state general fund as soon as all payments of money committed have been made.

Sec. 3. This act becomes effective on July 1, 1989.

SUMMARY--Clarifies circumstances when compensation by physical therapist for referral of patient is ground for disciplinary action. (BDR 54-291)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to physical therapists; clarifying the circumstances when the compensation provided by a physical therapist for the referral of a patient is a ground for disciplinary action; and providing other matters properly relating thereto.

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

Section 1. NRS 640.160 is hereby amended to read as follows:

640.160 1. The board, after due notice and hearing, and upon any ground enumerated in subsection 2, may take one or more of the following actions:

(a) Refuse to register or issue a license or temporary permit to any applicant.

(b) Refuse to renew the registration, license or temporary permit of any person.

(c) Suspend or revoke the registration, license or temporary permit of any person.

(d) Place any person who has been registered or issued a license or temporary permit on probation.

(e) Impose an administrative fine which does not exceed $500 on any person who has been registered or issued a license or temporary permit.

2. The board may take action pursuant to subsection 1 if an applicant or person who has been registered or issued a license or temporary permit:

(a) Is habitually drunk or is addicted to the use of a controlled substance.

(b) Has been convicted of violating any state or federal law relating to controlled substances.

(c) Is, in the judgment of the board, guilty of immoral or unprofessional conduct.

(d) Has been convicted of any crime involving moral turpitude.

(e) Is guilty, in the judgment of the board, of gross negligence in his practice as a physical therapist which may be evidenced by claims of malpractice settled against a practitioner.

(f) Has obtained or attempted to obtain registration by fraud or material misrepresentation.

(g) Has been declared insane by a court of competent jurisdiction and has not thereafter been lawfully declared sane.

(h) Has entered into any contract or arrangement which provides for the *direct or indirect* payment of [an unearned fee] *any portion of the money*

received from a patient for professional services to any person [following his] *in consideration for the* referral of [a] *the* patient.

(i) *Has entered into any contract or arrangement to provide a person with a credit, gratuity, commission, professional discount or wage in consideration for the referral of a patient.*

(j) Has employed as a physical therapist any unlicensed physical therapist or physical therapist whose license has been suspended.

[(j)] *(k)* Has had his license to practice physical therapy suspended or revoked by another jurisdiction.

[(k)] *(l)* Is determined to be professionally incompetent by the board.

[(l)] *(m)* Has violated any provision of this chapter or the board's regulations.

SUMMARY--Requires director of department of human resources to prepare certain reports at least semiannually. (BDR 40-292)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to health care; requiring the director of the department of human resources to prepare certain reports at least semiannually; and providing other matters properly relating thereto.

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

Section 1. NRS 449.510 is hereby amended to read as follows:

449.510 *1.* The director shall prepare and file *, at least once every 6 months, a compilation and summary based on the information filed with him under NRS 449.450 to 449.530, inclusive.*

2. The director shall prepare and file such *additional* summaries, compilations or other supplementary reports based on the information filed with him under NRS 449.450 to 449.530, inclusive, as will advance the purposes of those sections.

3. All such summaries, compilations and reports are open to public inspection **[**,**]** *and* must be made available to requesting agencies . **[**and must be

prepared within a reasonable time following the end of each institution's fiscal year or more frequently as specified by the director.]

SUMMARY--Directs Commissioner of Insurance to examine practice of using regional morbidity factors to set insurance rates. (BDR R-293)

CONCURRENT RESOLUTION--Directing the Commissioner of Insurance to examine the practice of using regional morbidity factors to set insurance rates.

WHEREAS, Insurance rates are a constant concern to the people of Nevada; and

WHEREAS, National and regional morbidity factors are used to determine insurance rates; and

WHEREAS, The use of regional morbidity factors greatly affects the rates paid by the people of Nevada; now, therefore, be it

RESOLVED BY THE OF THE STATE OF NEVADA, THE CONCURRING, That the Commissioner of Insurance is directed to examine the practice of using regional morbidity factors to set rates for insurance policies; and be it further

RESOLVED, That the Commissioner of Insurance report the results of his examination and any recommended legislation to the 66th session of the legislature; and be it further

RESOLVED, That a copy of this resolution be immediately transmitted by the of the to the Commissioner of Insurance.

SUMMARY--Directs legislative commission to contract with consultants to conduct interim study to determine enrollees' satisfaction with health maintenance organizations. (BDR S-294)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Contains Appropriation.

AN ACT relating to insurance; directing the legislative commission to contract with consultants to conduct an interim study to determine the enrollees' satisfaction with health maintenance organizations; appointing the legislative committee on health care to oversee the study; making an appropriation; and providing other matters properly relating thereto.

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

Section 1. The legislative commission shall:

1. Contract with consultants to conduct an interim study to determine the level of satisfaction held by persons currently and formerly receiving health care services provided by health maintenance organizations.

2. Appoint the legislative committee on health care to oversee the study.

Sec. 2. 1. The study must include a survey of persons whose health care was once provided by a health maintenance organization and who later decided to purchase health insurance.

2. The sample and study must be statistically supportable.

3. The legislative committee on health care shall:

(a) Define the scope of the study.

(b) Establish a schedule for completion of the study.

(c) Select the consultants and negotiate the terms of the contract.

(d) Require scheduled progress reports from the consultants to ensure that the consultants are adhering to the scope of the study as established by the legislative committee on health care.

4. The study must be completed and submitted to the legislative commission pursuant to the schedule set by the legislative committee on health care.

Sec. 3. The legislative commission shall submit a report of the study and any recommended legislation to the 66th session of the legislature.

Sec. 4. 1. There is hereby appropriated from the state general fund to the legislative fund, created pursuant to NRS 218.085, the sum of $5,000 for the support of the interim study conducted pursuant to section 1 of this act.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 1991, and reverts to the state general fund as soon as all payments of money committed have been made.

SUMMARY--Requires inclusion of nurses on hospital committees for advocacy of maintaining quality of care provided by hospitals. (BDR 40-614)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to hospitals; requiring the inclusion of nurses on hospital committees for the advocacy of maintaining the quality of care provided by hospitals; and providing other matters properly relating thereto.

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

Section 1. NRS 449.475 is hereby amended to read as follows:

449.475 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] *:*

(a) Four 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 **[.]** *; and*

(b) One nurse on the medical staff of the hospital who does not have a pecuniary interest in the hospital, who must be elected by a vote of all such nurses 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.

SUMMARY--Authorizes board of regents of University of Nevada System to create Nevada health service corps. (BDR 34-615)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Contains Appropriation.

AN ACT relating to education; authorizing the board of regents of the University of Nevada System to create the Nevada health service corps; making an appropriation; and providing other matters properly relating thereto.

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

Section 1. Chapter 396 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 5, inclusive, of this act.

Sec. 2. *The board of regents of the University of Nevada System may establish a Nevada health service corps to encourage physicians to practice in areas of Nevada in which a shortage of physicians exists.*

Sec. 3. *1. The board of regents may authorize the Nevada health service corps to administer a program under which $15,000 of loans are repaid*

on behalf of a physician for each year he practices medicine in an area of Nevada in which a shortage of physicians exists.

2. To qualify for the program the physician must have completed his primary care residency and hold an active license issued pursuant to chapter 630, 630A, 633 or 634 of NRS.

Sec. 4. *The primary purposes of the Nevada health service corps must be to:*

1. Recruit physicians for participation in the program;

2. Designate areas of Nevada in which a shortage of physicians exists;

3. Match physicians with the designated areas; and

4. Help physicians to negotiate contracts to serve in the designated areas.

Sec. 5. *The board of regents may:*

1. Apply for any matching money available for the program from the Federal Government.

2. Adopt regulations necessary to carry out the provisions of sections 2 to 5, inclusive, of this act.

3. Receive, invest, disburse and account for all money received from the Federal Government or any other source for this program.

Sec. 6. There is hereby appropriated from the state general fund to the board of regents of the University of Nevada System:

For the fiscal year 1989-90 ..... $120,860

For the fiscal year 1990-91 162,770

for use pursuant to sections 2 to 5, inclusive, of this act.

Sec. 7. This act becomes effective upon passage and approval.

SUMMARY--Provides comprehensive reform of law governing treatment and control of communicable diseases. (BDR 40-1216)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to public health; making various changes to the laws governing the control of communicable diseases; requiring the state board of health to adopt certain regulations; requiring the reporting of certain information to the state board of health; providing a penalty; and providing other matters properly relating thereto.

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

Section 1. Title 40 of NRS is hereby amended by adding thereto a new chapter to consist of the provisions set forth as sections 2 to 47, 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 12, inclusive, of this act have the meanings ascribed to them in those sections.

Sec. 3. "Board" means the state board of health.

Sec. 4. "Child care establishment" means any children's home, day nursery, kindergarten, nursery school or other similar establishment however designated, maintained or operated for the care of children for compensation or hire.

Sec. 5. "Communicable disease" means a disease which is caused by a specific infectious agent or its toxic products, and which can be transmitted, either directly or indirectly, from one organism to another.

Sec. 6. "Health authority" means the district health officer in a district, or his designee, or, if none, the state health officer, or his designee.

Sec. 7. "Health division" means the health division of the department of human resources.

Sec. 8. "Laboratory director" has the meaning ascribed to it in NRS 652.050.

Sec. 9. "Medical facility" has the meaning ascribed to it in NRS 449.0151.

Sec. 10. "Medical laboratory" has the meaning ascribed to it in NRS 652.060.

Sec. 11. "Physician" is limited to a person licensed to practice medicine pursuant to chapter 630 or 633 of NRS.

Sec. 12. "Provider of health care" means a physician, nurse, physician's assistant or veterinarian licensed in accordance with state law.

Sec. 13. The board shall adopt regulations governing the control of communicable diseases in this state, including regulations specifically relating to the control of such diseases in educational, medical and correctional institutions. The regulations must specify:

1. The diseases which are known to be communicable.

2. The communicable diseases which are known to be sexually transmitted.

3. The procedures for investigating and reporting cases or suspected cases of communicable diseases, including the time within which these actions must be taken.

4. For each communicable disease, the procedures for testing, treating, isolating and quarantining a person who has or is suspected of having the disease.

Sec. 14. The state health officer shall inform each local health officer of the regulations adopted by the board and the procedures established for investigating and reporting cases or suspected cases of communicable diseases.

Sec. 15. 1. A provider of health care who knows of, or provides services to, a person who has or is suspected of having a communicable disease shall report that fact to the health authority in the manner prescribed by the regulations of the board. If no provider of health care is providing services, each person having knowledge that another person has a communicable disease shall report that fact to the health authority in the manner prescribed by the regulations of the board.

2. A medical facility in which more than one provider of health care may know of, or provide services to, a person who has or is suspected of having a communicable disease shall establish administrative procedures to ensure that the health authority is notified.

3. A laboratory director shall, in the manner prescribed by the board, notify the health authority of the identification by his medical laboratory of the

presence of any communicable disease in the jurisdiction of that health authority. The health authority shall not presume a diagnosis of a communicable disease on the basis of the notification received from the laboratory director without first consulting with a physician who has examined the person from whom the laboratory specimen was obtained.

4. If more than one medical laboratory is involved in testing a specimen, the laboratory that is responsible for reporting the results of the testing directly to the physician caring for the patient shall also be responsible for reporting to the health authority.

Sec. 16. 1. A health authority who knows, suspects or is informed of the existence within his jurisdiction of any communicable disease shall immediately investigate the matter and all circumstances connected with it, and shall take such measures for the prevention, suppression and control of the disease as are required by the regulations of the board or a local board of health.

2. A health authority may:

(a) Enter private property at reasonable hours to investigate any case or suspected case of a communicable disease.

(b) Order any person whom he reasonably suspects has a communicable disease in an infectious state to submit to any medical examination or test which he believes is necessary to verify the presence of the disease. The order must be in writing and specify the name of the person to be examined and the time and place of the examination and testing, and may include such terms

and conditions as the health authority believes are necessary to protect the public health.

(c) Except as otherwise provided in section 39 of this act, issue an order requiring the isolation, quarantine or treatment of any person if he believes that such action is necessary to protect the public health. The order must be in writing and specify the person to be isolated, the time during which the order is effective, the place of isolation or quarantine and other terms and conditions which the health authority believes are necessary to protect the public health, except that no isolation or quarantine may take place if a physician determines that such action may endanger the life of the person.

(d) Each order issued pursuant to this section must be served upon each person named in the order by delivering a copy to him.

Sec. 17. 1. A person who has a communicable disease in an infectious state shall not conduct himself in any manner likely to expose others to the disease or engage in any occupation in which it is likely that the disease will be transmitted to others.

2. A health authority who has reason to believe that a person is in violation of subsection 1 shall issue a warning to him, in writing, informing him of the behavior which constitutes the violation and of the precautions that he must take to avoid exposing others to the disease. The warning must be served upon the person by delivering a copy to him.

3. A person who violates the provisions of subsection 1 after service upon him of a warning from a health authority is guilty of a misdemeanor.

Sec. 18. 1. A health authority who knows of the presence of a communicable disease within a school, child care establishment or medical facility, shall notify the principal, director or other person in charge of the school, child care establishment or medical facility of that fact and direct what action, if any, must be taken to prevent the spread of the disease.

2. The principal, director or other person in charge of a school, child care establishment or medical facility who knows of or suspects the presence of a communicable disease within the school, child care establishment or medical facility shall notify the health authority pursuant to the regulations of the board. The health authority shall investigate the report to determine whether a communicable disease is present and direct what action, if any, must be taken to prevent the spread of the disease.

3. A parent, guardian or person having custody of a child who has a communicable disease shall not knowingly permit the child to attend school or a child care establishment.

4. A director of a correctional facility who knows of or suspects the presence of a communicable disease within the facility shall notify the health authority of that fact. The health authority shall investigate the matter and direct what action, if any, must be taken to prevent the spread of the disease.

Sec. 19. The health division shall control, prevent, treat and, whenever possible, ensure the cure of sexually transmitted diseases.

Sec. 20. The health division may establish and provide financial or other support to such clinics and dispensaries as it believes are reasonably necessary for the prevention, control, treatment or cure of sexually transmitted diseases.

Sec. 21. If a person in this state who has a sexually transmitted disease is, in the discretion of the health division, unable to afford approved treatment for the disease, the health division may provide medical supplies or direct financial aid to any physician, clinic or dispensary in this state, within the limits of the available appropriations and any other resources, to be used in his treatment. A physician, clinic or dispensary that accepts supplies or aid pursuant to this section shall comply with all conditions prescribed by the board relating to the use of the supplies or aid.

Sec. 22. A physician, clinic or dispensary providing treatment to a person who has a sexually transmitted disease shall instruct him in the methods of preventing the spread of the disease and in the necessity of systematic and prolonged treatment.

Sec. 23. A physician who, or clinic or dispensary which, determines that a person has a sexually transmitted disease shall encourage and, if necessary, attempt to persuade him to submit to medical treatment. Except as otherwise provided in section 39 of this act, if the person does not submit to treatment, or does not complete the prescribed course of treatment, the physician, clinic or dispensary shall notify the health authority who shall take action to ensure that the person receives adequate treatment for the disease.

Sec. 24. A person who has a sexually transmitted disease shall, upon request, inform the health authority of the source or possible source of the infection.

Sec. 25. A person who is diagnosed as having acquired immunodeficiency syndrome who fails to comply with a written order of a health authority, or

who engages in behavior through which the disease may be spread to others, is, in addition to any other penalty imposed pursuant to this chapter, subject to confinement by order of a court of competent jurisdiction.

Sec. 26. Except as otherwise provided in section 39 of this act, when any minor is suspected of having or is found to have a sexually transmitted disease, the health authority may require the minor to undergo examination and treatment, regardless of whether the minor or either of his parents consents to the examination and treatment.

Sec. 27. 1. As soon as practicable after a person has been arrested for the commission of a crime which the victim or a witness alleges involved the sexual penetration of the victim's body, the health authority shall test the arrested person for exposure to the human immunodeficiency virus and for any other disease that can be sexually transmitted.

2. The health authority shall disclose the results of all tests performed pursuant to subsection 1 to the victim or to the victim's parent or guardian if the victim is a minor.

3. Except as otherwise provided in section 39 of this act, if the health authority determines that an arrested person has been exposed to the human immunodeficiency virus or has a disease which can be sexually transmitted, it shall require the person to undergo examination and treatment, regardless of whether he consents to the examination and treatment.

4. As used in this section, the term "sexual penetration" has the meaning ascribed to it in NRS 200.364.

Sec. 28. The board shall evaluate and approve, by regulation, tests to detect exposure to the human immunodeficiency virus. The board shall not approve any test which has not been licensed by the United States Food and Drug Administration or with a sensitivity of less than 95 percent.

Sec. 29. The health division may establish such dispensaries, pharmacies or clinics for outpatient care as it believes are necessary for the care and treatment of persons who have acquired immune deficiency syndrome or a human immunodeficiency virus related disease, and provide those institutions with financial or other assistance within the limits of the available appropriations and any other resources.

Sec. 30. The health division shall control, prevent the spread of, and ensure the treatment and cure of tuberculosis.

Sec. 31. The health division may establish such clinics as it believes are necessary for the prevention and control of, and for the treatment and cure of, persons who have tuberculosis and provide those clinics with financial or other assistance within the limits of the available appropriations and any other resources.

Sec. 32. If a person in this state who has tuberculosis is, in the discretion of the health division, unable to afford approved treatment for the disease, the health division may provide medical supplies or direct financial aid, within the limits of the available appropriations, to be used in his treatment, to any physician, clinic, dispensary or medical facility. A physician, clinic, dispensary or medical facility that accepts supplies or aid pursuant to this section shall

comply with all conditions prescribed by the board relating to the use of the supplies or aid.

Sec. 33. 1. The health division shall, by contract with hospitals, clinics or other institutions in the state, provide for the diagnostic examination of, and inpatient and outpatient care for, persons who have tuberculosis.

2. If adequate facilities for examination and care are not available in the state, the health division may contract with hospitals, clinics or other institutions in other states which do have adequate facilities.

Sec. 34. Except as otherwise provided in section 39 of this act, a person who has tuberculosis and is confined to a hospital or other institution pursuant to the provisions of this chapter must be treated for tuberculosis and any related condition, and may be treated for any other condition which the health division determines is detrimental to his health and the treatment of which is necessary for the effective control of tuberculosis.

Sec. 35. The health division may contract with any private physician to provide outpatient care in those rural areas of the state where, in its determination, patients can best be treated in that manner.

Sec. 36. The health division may inspect and must be given access to all records of every institution and clinic, both public and private, where patients who have tuberculosis are treated at public expense.

Sec. 37. The board shall adopt regulations governing the control of rabies. The regulations must provide for:

1. The periodic inoculation of animals with approved vaccines.

2. The impoundment of animals suspected of having rabies and the disposition of those animals upon verification of the presence of the disease.

3. Treatment of persons who have been, or are suspected of having been, exposed to rabies.

Sec. 38. This chapter does not empower or authorize the health authority or any other person to interfere in any manner with the right of a person to receive approved treatment for a communicable disease from any physician, clinic or other person of his choice, but the board has the power to prescribe the approved method of treatment to be used by the physician, clinic or other person.

Sec. 39. A person who has a communicable disease and depends exclusively on prayer for healing in accordance with the tenets and precepts of any recognized religious sect, denomination or organization is not required to submit to any medical treatment, but may be isolated or quarantined in his home or other place of his choice acceptable to the health authority, and shall comply with all applicable rules, regulations and orders issued by the health authority.

Sec. 40. The health division may receive any financial aid made available by any grant or other source and shall use the aid, in cooperation with the health authority, to carry out the provisions of this chapter.

Sec. 41. Each health authority shall report each week to the state health officer the number and types of cases or suspected cases of communicable disease reported to him, and any other information required by the regulations of the board.

Sec. 42. All information of a personal nature about any person provided by any other person reporting a case or suspected case of a communicable disease, or by any person who has a communicable disease, or as determined by investigation of the health authority, is confidential medical information and must not be disclosed to any person under any circumstances, including pursuant to any subpena, search warrant or discovery proceeding, except as follows:

1. For statistical purposes, provided that the identity of the person is not discernible from the information disclosed.

2. In a prosecution for a violation of this chapter.

3. In a proceeding for an injunction brought pursuant to this chapter.

4. In reporting the actual or suspected abuse or neglect of a child or elderly person.

5. To any person who has a medical need to know the information for his own protection or well-being, as determined by the health authority in accordance with regulations of the board.

6. If the person who is the subject of the information consents in writing to the disclosure.

7. Pursuant to subsection 2 of section 27 of this act.

8. If the disclosure is made to the welfare division of the department of human resources and the person about whom the disclosure is made has been diagnosed as having acquired immunodeficiency syndrome or acquired immune deficiency related complex and is a recipient of assistance to the medically indigent.

Sec. 43. 1. A person who refuses to:

(a) Comply with any regulation of the board relating to the control of a communicable disease;

(b) Comply with any provision of this chapter;

(c) Submit to approved treatment or examination required or authorized by this chapter;

(d) Provide any information required by this chapter; or

(e) Perform any duty imposed by this chapter,

may be enjoined by a court of competent jurisdiction.

2. An action for an injunction pursuant to this section must be prosecuted by the attorney general, any district attorney or any private legal counsel retained by a local board of health in the name of and upon the complaint of the health authority.

3. The court in which an injunction is sought may make any order reasonably necessary to carry out the purpose or intent of any provision of this chapter or to compel compliance with any regulation of the board or order of the health authority relating to the control of a communicable disease.

Sec. 44. Except as otherwise provided in this chapter, a person shall not make public the name of, or other personal identifying information about, a person infected with a communicable disease who has been investigated by the health authority pursuant to this chapter, without the consent of the person.

Sec. 45. Except as otherwise provided, every person who violates any provision of this chapter is guilty of a misdemeanor.

Sec. 46. Every provider of health care, medical facility or medical laboratory that fails, neglects or refuses to comply with any regulation of the board relating to the reporting of a communicable disease or any requirement of this chapter is guilty of a misdemeanor and, in addition, is subject to an administrative fine of $1,000 for each violation.

Sec. 47. The district attorney of the county in which any violation of this chapter occurs shall prosecute the person responsible for the violation.

Sec. 48. NRS 460.020 is hereby amended to read as follows:

460.020 1. The state board of health, state health officer and any health authority, as defined in NRS 439.005, may disseminate to any blood bank in the State of Nevada identifying data concerning any person with a history of viral hepatitis.

2. The state board of health shall, pursuant to [NRS 439.210,] *section 13 of this act,* adopt regulations specifying the identifying data to be disseminated to blood banks pursuant to subsection 1.

3. Any identifying data received by a blood bank pursuant to this section is confidential and may be used only for screening prospective blood donors.

4. Any person who has access to identifying data disseminated to a blood bank pursuant to this section and who divulges or uses such information in any manner except to screen prospective blood donors is guilty of a misdemeanor.

Sec. 49. NRS 49.245 is hereby amended to read as follows:

49.245 There is no privilege under NRS 49.225 or 49.235:

1. For communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the doctor in the course of diagnosis or treatment has determined that the patient is in need of hospitalization.

2. As to communications made in the course of a court-ordered examination of the condition of a patient with respect to the particular purpose of the examination unless the court orders otherwise.

3. As to written medical or hospital records relevant to an issue of the condition of the patient in any proceeding in which the condition is an element of a claim or defense.

4. In a prosecution or mandamus proceeding under [chapter 441 of NRS.] *sections 2 to 47, inclusive, of this act.*

5. As to any information communicated to a physician in an effort unlawfully to procure a dangerous drug or controlled substance, or unlawfully to procure the administration of any such drug or substance.

6. As to any written medical or hospital records which are furnished in accordance with the provisions of NRS 629.061.

7. As to records that are required by chapter 453 of NRS to be maintained.

8. In a review before a screening panel pursuant to NRS 41A.003 to 41A.069, inclusive.

Sec. 50. NRS 129.060 is hereby amended to read as follows:

129.060 Notwithstanding any other provision of law, the consent of the parent, parents or legal guardian of a minor is not necessary in order to authorize a local or state health officer, [board of health,] licensed physician or clinic to examine or treat, or both, any minor who is suspected of being

infected or is found to be infected with any [venereal] *sexually transmitted* disease.

Sec. 51. NRS 244.358 is hereby amended to read as follows:

244.358 [1.] In order to control rabies and to protect the public health and welfare, the board of county commissioners of [any] *each* county of this state [may] *shall* enact an ordinance [requiring all dog owners to procure inoculation of their dogs against rabies.

2. Such ordinance may, in addition to such other provisions as may be appropriate to local conditions, contain any or all of the following provisions:

(a) Every dog owner shall, after his dog attains the age of 4 months and at such intervals as may be prescribed by rules and regulations of the state department of agriculture, procure the inoculation of each such dog by a licensed veterinarian with a canine antirabies vaccine approved by and in a manner prescribed by the state department of agriculture;

(b) All dogs under 4 months of age shall be confined to the premises of or kept under physical restraint by the owner, keeper or harborer, with full allowance for the sale or transportation of any such dog;

(c) Any violation of the ordinance or of such additional provisions as may be prescribed by the board of county commissioners shall result in the impounding of the dog in a manner as shall be provided by ordinance; and

(d) The board of county commissioners shall maintain or provide for the maintenance of a pound system and rabies control program for the purpose of carrying out and enforcing the provisions of the ordinance.] *providing for a*

rabies control program and shall include within the ordinance the requirements established by regulations adopted by the state board of health.

Sec. 52. NRS 268.427 is hereby amended to read as follows:

268.427 In order to control rabies and to protect the public health and welfare, the governing body of [any] *each* city or town incorporated under any law of this state [may] *shall* enact an ordinance [requiring all dog owners to procure inoculation of their dogs against rabies. Such ordinance may contain provisions appropriate to local conditions and may contain any or all of the provisions specifically set forth in subsection 2 of NRS 244.358, with appropriate reference to the governing body in lieu of the board of county commissioners.] *providing for a rabies control program and shall include within that ordinance the requirements established by regulations adopted by the state board of health.*

Sec. 53. NRS 269.227 is hereby amended to read as follows:

269.227 In order to control rabies and to protect the public health and welfare, [any] *each* town board or board of county commissioners [may] *shall* enact an ordinance [requiring all dog owners to procure inoculation of their dogs against rabies. Such ordinance may contain provisions appropriate to local conditions and may contain any or all of the provisions specifically set forth in subsection 2 of NRS 244.358.] *providing for a rabies control program and shall include within that ordinance the requirements established by regulations adopted by the state board of health.*

Sec. 54. Section 2 of chapter 449, Statutes of Nevada 1987, at page 1036, is hereby amended to read as follows:

Sec. 2. NRS 49.245 is hereby amended to read as follows:

49.245 There is no privilege under NRS 49.225 or 49.235:

1. For communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the doctor in the course of diagnosis or treatment has determined that the patient is in need of hospitalization.

2. As to communications made in the course of a court-ordered examination of the condition of a patient with respect to the particular purpose of the examination unless the court orders otherwise.

3. As to written medical or hospital records relevant to an issue of the condition of the patient in any proceeding in which the condition is an element of a claim or defense.

4. In a prosecution or mandamus proceeding under [chapter 441 of NRS.] *sections 2 to 47, inclusive, of this act.*

5. As to any information communicated to a physician in an effort unlawfully to procure a dangerous drug or controlled substance, or unlawfully to procure the administration of any such drug or substance.

6. As to any written medical or hospital records which are furnished in accordance with the provisions of NRS 629.061.

7. As to records that are required by chapter 453 of NRS to be maintained.

Sec. 55. NRS 202.140, 202.150, 202.160, 439.210, 439.215, 439.220, 439.500, 439.510, 439.530, 441.010, 441.020, 441.030, 441.035, 441.040, 441.050, 441.060, 441.070, 441.080, 441.090, 441.100, 441.110, 441.120, 441.130, 441.140, 441.150,

441.160, 441.170, 441.175, 441.180, 441.190, 441.200, 441.210, 441.220, 441.230, 441.240, 441.250, 441.260, 441.280, 441.290, 441.300, 441.320, 441.320, 443.015, 443.025, 443.037, 443.055, 443.057, 443.065, 443.075, 443.095, 443.105, 443.115, 443.125, 443.135, 443.170, 443.180, 443.190, 443.200, 443.210, 443.220, 443.230, 443.240, 443.250, and 443.260 are hereby repealed.

Sec. 56. This act becomes effective upon passage and approval.

LEADLINES OF REPEALED SECTIONS

202.140 Venereal diseases: Sexual intercourse during infectious affliction; physician to report diseases prostitute.

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SUMMARY--Requires establishment of registries of abuse, neglect or exploitation of older and defenseless persons. (BDR 38-1217)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to the public welfare; establishing registries for reporting the abuse, neglect or exploitation of an older or defenseless person; requiring certain persons to report the abuse, neglect or exploitation of a defenseless person; providing a penalty; and providing other matters properly relating thereto.

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

Section 1. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 2, 3 and 4 of this act.

Sec. 2. *As used in sections 3 and 4 of this act, unless the context otherwise requires:*

1. "Abuse" means willful and unjustified:

(a) Infliction of pain, injury or mental anguish; or

(b) Deprivation of food, shelter, clothing or services which are necessary to maintain the physical or mental health of a defenseless person.

2. "Defenseless person" means a person who has a physical or mental disability that prevents him from protecting or providing for himself without assistance.

3. "Exploitation" means wrongful use of a defenseless person or his money or property to the advantage of another.

4. "Neglect" means the failure of:

(a) A person who has assumed legal responsibility or a contractual obligation for caring for a defenseless person or who has voluntarily assumed responsibility for his care to provide food, shelter, clothing or services which are necessary to maintain the physical or mental health of the defenseless person; or

(b) A defenseless person to provide for his own needs because of inability to do so.

5. "Protective services" means services to prevent or remedy the abuse, exploitation or neglect of a defenseless person. The services may include, without limitation, investigation, evaluation, counseling, or arrangement or referral for other services or assistance.

Sec. 3. *The welfare division shall:*

1. Establish and maintain a central registry for the collection of information concerning the abuse, neglect or exploitation of a defenseless person. The registry must contain:

(a) The information in any report made pursuant to sections 12 and 13 of this act, and the results, if any, of the investigation of the report;

(b) Statistical information on the protective services provided in this state; and

(c) Any other information which the welfare division determines to be in furtherance of sections 2, 3, 4 and 10 to 22, inclusive, of this act.

2. Maintain a record of the names and identifying data, dates and circumstances of any persons requesting or receiving information from the central registry.

Sec. 4. *1. Information contained in the central registry or obtained for the registry must not be released unless the right of the applicant to the information is confirmed and the released information discloses the nature of the disposition of the case or its current status.*

2. Unless an investigation of a report conducted pursuant to section 17 of this act reveals some credible evidence of the alleged abuse, neglect or exploitation of a defenseless person, all information identifying the subject of a report must be expunged from the central registry at the conclusion of the investigation or within 60 days after the report is filed, whichever occurs first. In all other cases, the record of the substantiated reports contained in the central registry must be sealed no later than 15 years after the report was filed.

3. Any person who willfully releases data or information contained in the central registry to an unauthorized person in violation of this section is guilty of a misdemeanor.

Sec. 5. Chapter 427A of NRS is hereby amended by adding thereto the provisions set forth as sections 6, 7 and 8 of this act.

Sec. 6. *As used in sections 7 and 8 of this act, unless the context otherwise requires:*

1. "Abuse" means willful and unjustified:

(a) Infliction of pain, injury or mental anguish; or

(b) Deprivation of food, shelter, clothing or services which are necessary to maintain the physical or mental health of an older person.

2. "Exploitation" means wrongful use of an older person or his money or property to the advantage of another.

3. "Neglect" means the failure of:

(a) A person who has assumed legal responsibility or a contractual obligation for caring for an older person or who has voluntarily assumed responsibility for his care to provide food, shelter, clothing or services which are necessary to maintain the physical or mental health of the older person; or

(b) An older person to provide for his own needs because of inability to do so.

4. "Older person" means a person who is 60 years of age or older.

5. "Protective services" means services to prevent or remedy the abuse, exploitation or neglect of an older person. The services may include, without limitation, investigation, evaluation, counseling, or arrangement or referral for other services or assistance.

Sec. 7. *The division shall:*

1. Establish and maintain a central registry for the collection of information concerning the abuse, neglect or exploitation of an older person. The registry must contain:

(a) The information in any report made pursuant to NRS 200.5093 and section 23 of this act, and the results, if any, of the investigation of the report;

(b) Statistical information on the protective services provided in this state; and

(c) Any other information which the division determines to be in furtherance of NRS 200.5091 to 200.5099, inclusive, and sections 6, 7, 8 and 23 to 26, inclusive, of this act.

2. Maintain a record of the names and identifying data, dates and circumstances of any persons requesting or receiving information from the central registry.

Sec. 8. *1. Information contained in the central registry or obtained for the registry must not be released unless the right of the applicant to the information is confirmed and the released information discloses the nature of the disposition of the case or its current status.*

2. Unless an investigation of a report conducted pursuant to section 24 of this act reveals some credible evidence of the alleged abuse, neglect or exploitation of an older person, all information identifying the subject of a report must be expunged from the central registry at the conclusion of the investigation or within 60 days after the report is filed, whichever occurs first. In all other cases, the record of the substantiated reports contained in the central registry must be sealed no later than 15 years after the report was filed.

3. Any person who willfully releases data or information contained in the central registry to an unauthorized person in violation of this section is guilty of a misdemeanor.

Sec. 9. Chapter 200 of NRS is hereby amended by adding thereto the provisions set forth as sections 10 to 26, inclusive, of this act.

Sec. 10. *It is the policy of this state to provide for the cooperation of law enforcement agencies, courts of competent jurisdiction and all appropriate state agencies providing human services in identifying the abuse, neglect and exploitation of defenseless persons through the complete reporting of the abuse, neglect and exploitation of defenseless persons.*

Sec. 11. *As used in sections 12 to 22, inclusive, of this act, unless the context otherwise requires:*

1. "Abuse" means willful and unjustified:

(a) Infliction of pain, injury or mental anguish; or

(b) Deprivation of food, shelter, clothing or services which are necessary to maintain the physical or mental health of a defenseless person.

2. "Defenseless person" means a person who has a physical or mental disability that prevents him from protecting or providing for himself without assistance.

3. "Exploitation" means wrongful use of a defenseless person or his money or property to the advantage of another.

4. "Neglect" means the failure of:

(a) A person who has assumed legal responsibility or a contractual obligation for caring for a defenseless person or who has voluntarily assumed responsibility for his care to provide food, shelter, clothing or services which are necessary to maintain the physical or mental health of the defenseless person; or

(b) A defenseless person to provide for his own needs because of inability to do so.

5. "Protective services" means services to prevent or remedy the abuse, exploitation or neglect of a defenseless person. The services may, without limitation, include investigation, evaluation, counseling, or arrangement or referral for other services or assistance.

6. "Welfare division" means the welfare division of the department of human resources.

Sec. 12. *The welfare division shall establish and maintain a toll-free telephone number to receive reports of the abuse, neglect or exploitation of a defenseless person in this state 24 hours a day, 7 days a week. Any reports made to this number must be promptly transmitted to the agency providing protective services in the community where the defenseless person is located.*

Sec. 13. *1. If any of the persons listed in subsection 2 suspects an instance of abuse, neglect or exploitation of a defenseless person, he shall immediately report his suspicion to:*

(a) The local office of the welfare division;

(b) Any police department or sheriff's office; or

(c) The county's office for protective services, if one exists in the county where the suspected action occurred.

If the report of abuse, neglect or exploitation involves an act or omission of the welfare division or a law enforcement agency, the report must be made to an agency other than the one alleged to have committed the act or omission. Each agency, after reducing the report to writing, shall forward a copy of the report to the welfare division.

2. Reports must be made by:

(a) A physician, dentist, dental hygienist, chiropractor, optometrist, podiatrist, medical examiner, resident, intern, professional or practical nurse, physician's assistant, psychiatrist, psychologist, marriage and family therapist, alcohol or drug abuse counselor, driver of an ambulance, advanced emergency medical technician or other person providing medical services licensed or certified to practice in this state, who examines, attends or treats a defenseless person who appears to have been abused, neglected or exploited.

(b) The personnel of a hospital or similar institution engaged in the admission, examination, care or treatment of persons or an administrator, manager or other person in charge of a hospital or similar institution upon notification of the suspected abuse, neglect or exploitation of a defenseless person by a member of the staff of the hospital.

(c) A coroner.

(d) A clergyman, practitioner of Christian Science or religious healer, unless he acquired the knowledge of abuse, neglect or exploitation from the offender during a confession, or a social worker.

(e) A person who maintains or is employed by an agency to provide nursing in the home.

(f) An attorney, unless he acquired the knowledge of abuse, neglect or exploitation from a client who has been or may be accused of the abuse, neglect or exploitation.

(g) An employee of the welfare division.

(h) An employee of a law enforcement agency or a county's office for protective services or an adult or juvenile probation officer.

(i) A person who maintains or is employed by a facility or establishment that provides care for defenseless persons.

(j) A person who maintains, is employed by or serves as a volunteer for an agency or service which advises persons regarding the abuse, neglect or exploitation of a defenseless person and refers them to persons and agencies where their requests and needs can be met.

3. A physician who, as a member of the staff of a hospital or similar institution, has reason to believe that a defenseless person has been abused, neglected or exploited shall notify the superintendent, manager or other person in charge of the institution. The superintendent, manager or other person in charge shall make a report as required in subsection 1.

4. A report may be filed by any other person.

Sec. 14. *1. The report required pursuant section 13 of this act may be made orally, by telephone or otherwise. The person who receives the report must reduce it to writing as soon as possible.*

2. The report must contain the following information, when possible:

(a) The name and address of the defenseless person:

(b) The name and address of the person responsible for his care, if there is one;

(c) The name and address, if available, of the person who is alleged to have abused, neglected or exploited the defenseless person;

(d) The nature and extent of the abuse, neglect or exploitation;

(e) Any evidence of previous injuries; and

(f) The basis of the reporter's belief that the defenseless person has been abused, neglected or exploited.

Sec. 15. *Immunity from civil or criminal liability extends to every person participating in good faith in the making of a report pursuant to sections 12 and 13 of this act.*

Sec. 16. *In any proceeding resulting from a report made or action taken pursuant to sections 11 to 22, inclusive, of this act, or in any other proceeding, the report or its contents or any other fact related thereto or to the condition of the defenseless person who is the subject of the report may not be excluded on the ground that the matter would otherwise be privileged against disclosure pursuant to chapter 49 of NRS.*

Sec. 17. *1. An agency receiving a report of the abuse, neglect or exploitation of a defenseless person shall cause the investigation of the report within 3 working days. Upon completing the investigation, the agency shall report to the welfare division:*

(a) Identifying and demographic information on the person alleged to be abused, neglected or exploited, any person responsible for his welfare and the person allegedly responsible for the abuse, neglect or exploitation;

(b) The facts of the alleged abuse, neglect or exploitation, including the date, type and manner of alleged abuse, neglect or exploitation, and the severity of the injuries; and

(c) The disposition of the case.

2. If the investigation of the report results in the belief that the defenseless person is abused, neglected or exploited, the welfare division or the county's

office for protective services may provide protective services to the defenseless person if he is able and willing to accept them.

Sec. 18. *1. An agency which provides protective services may waive a full investigation of a report of the abuse, neglect or exploitation of a defenseless person made by another agency or a person if, after assessing the circumstances, it is satisfied that:*

(a) The person or other agency who made the report can provide services to meet the needs of the defenseless person, and this person or agency agrees to do so; and

(b) The person or other agency agrees in writing to report periodically on the defenseless person and to report immediately any threat or harm to the welfare of the defenseless person.

2. The agency which provides protective services shall supervise for a reasonable period the services provided by the person or other agency pursuant to subsection 1.

Sec. 19. *1. Reports made pursuant to sections 12 and 13 of this act are confidential.*

2. A person, law enforcement agency or public or private agency, institution or facility who willfully releases data or information concerning the reports and investigation of the abuse, neglect or exploitation of a defenseless person, except:

(a) Pursuant to criminal prosecution under the provisions of this section or section 4 or 22 of this act;

(b) As otherwise required pursuant to sections 10 to 22, inclusive, of this act; or

(c) To persons or agencies enumerated in subsection 3,

is guilty of a misdemeanor.

3. Data or information concerning the reports and investigations of the abuse, neglect or exploitation of a defenseless person is available only to:

(a) A physician who has in his care a defenseless person who he reasonably believes may have been abused, neglected or exploited;

(b) An agency responsible for or authorized to undertake the care, treatment and supervision of the defenseless person;

(c) A district attorney or other law enforcement officer who requires the information in connection with an investigation of the abuse, neglect or exploitation of the defenseless person;

(d) A court which has determined, in camera, that public disclosure of such information is necessary for the determination of an issue before it;

(e) A person engaged in bona fide research, but the identity of the subjects of the report must remain confidential;

(f) A grand jury upon its determination that access to such records is necessary in the conduct of its official business;

(g) Any comparable authorized person or agency in another jurisdiction;

(h) A legal guardian of the defenseless person, if the identity of the person who was responsible for reporting the alleged abuse, neglect or exploitation to the public agency is protected, and the legal guardian is not the person suspected of the abuse, neglect or exploitation; or

(i) The person named in the report as allegedly being abused, neglected or exploited, if that person is not legally incompetent.

4. If the person who is reported to have abused, neglected or exploited a defenseless person is the holder of a license or certificate issued pursuant to chapters 630 to 641B, inclusive, of NRS, information contained in the report must be submitted to the board which issued the license.

Sec. 20. *The welfare division shall:*

1. Identify and record demographic information on a defenseless person who is alleged to have been abused, neglected or exploited and the person who is alleged to be responsible for the abuse, neglect or exploitation.

2. Obtain information from programs for preventing abuse of defenseless persons, analyze and compare the programs, and make recommendations to assist the organizers of the programs in achieving the most efficient and effective service possible.

3. Publicize the provisions of sections 10 to 22, inclusive, of this act.

Sec. 21. *An agency which provides protective services must receive from the state, its political subdivisions and an agency of either, any cooperation, assistance and information it requests in order to fulfill its responsibilities under sections 2, 3, 4 and 10 to 22, inclusive, of this act.*

Sec. 22. *1. Any person who knowingly and willfully violates section 13 or 17 of this act is guilty of a misdemeanor.*

2. Any adult who willfully causes or permits a defenseless person to suffer unjustifiable physical pain or mental suffering as a result of abuse, neglect or exploitation, or who willfully causes or permits a defenseless person to be placed

in a situation where the person may suffer unjustifiable physical pain or mental suffering as the result of abuse, neglect or exploitation, is guilty of a gross misdemeanor unless a more severe penalty is prescribed by law for the act or omission which brings about the abuse, neglect, danger or loss through exploitation.

3. A person who violates any provision of subsection 2, if substantial bodily or mental harm results to the defenseless person, shall be punished by imprisonment in the state prison for not less than 1 year nor more than 6 years.

4. As used in this section, "permit" means permission that a reasonable person would not grant and which amounts to a neglect of responsibility attending the care and custody of a defenseless person.

Sec. 23. *The aging services division of the department of human resources shall establish and maintain a toll-free telephone number to receive reports of the abuse, neglect or exploitation of an older person in this state 24 hours a day, 7 days a week. Any reports made to this number must be promptly transmitted to the agency providing protective services in the community where the older person is located.*

Sec. 24. *1. An agency receiving a report of the abuse, neglect or exploitation of an older person shall cause the investigation of the report within 3 working days. Upon completing the investigation, the agency shall report to the aging services division of the department of human resources:*

(a) Identifying and demographic information on the person alleged to be abused, neglected or exploited, any person responsible for his welfare and the person allegedly responsible for the abuse, neglect or exploitation;

(b) The facts of the alleged abuse, neglect or exploitation, including the date, type and manner of alleged abuse, neglect or exploitation, and the severity of the injuries; and

(c) The disposition of the case.

2. If the investigation of the report results in the belief that the older person is abused, neglected or exploited, the welfare division of the department of human resources or the county's office for protective services may provide protective services to the older person if he is able and willing to accept them.

Sec. 25. *1. An agency which provides protective services may waive a full investigation of a report of the abuse, neglect or exploitation of an older person made by another agency or a person if, after assessing the circumstances, it is satisfied that:*

(a) The person or other agency who made the report can provide services to meet the needs of the older person, and this person or agency agrees to do so; and

(b) The person or other agency agrees in writing to report periodically on the older person and to report immediately any threat or harm to the welfare of the older person.

2. The agency which provides protective services shall supervise for a reasonable period the services provided by the person or other agency pursuant to subsection 1.

Sec. 26. *An agency which provides protective services must receive from the state, its political subdivisions and an agency of either, any cooperation, assistance and information it requests in order to fulfill its responsibilities under*

NRS 200.5091 to 200.5099, inclusive, and sections 6, 7, 8 and 23 to 26, inclusive, of this act.

Sec. 27. NRS 200.5092 is hereby amended to read as follows:

200.5092 As used in NRS 200.5091 to 200.5099, inclusive, *and sections 23 to 26, inclusive, of this act,* unless the context otherwise requires:

1. "Abuse" means willful and unjustified:

(a) Infliction of pain, injury or mental anguish; or

(b) Deprivation of food, shelter, clothing or services which are necessary to maintain the physical or mental health of an older person.

2. "Exploitation" means wrongful use of an older person or his money or property to the advantage of another.

3. "Neglect" means the failure of:

(a) A person who has assumed legal responsibility or a contractual obligation for caring for an older person or who has voluntarily assumed responsibility for his care to provide food, shelter, clothing or services which are necessary to maintain the physical or mental health of the older person; or

(b) An older person to provide for his own needs because of inability to do so.

4. "Older person" means a person who is 60 years of age or older.

5. "Protective services" means services [the purpose of which is to prevent and] *to prevent or* remedy the abuse, exploitation [and] *or* neglect of older persons. The services may include investigation, evaluation, counseling, *or* arrangement [and] *or* referral for other services [and] *or* assistance.

Sec. 28. NRS 200.5093 is hereby amended to read as follows:

200.5093 1. If any of the persons listed in subsection 2 suspects an instance of abuse, neglect or exploitation of an older person, he shall immediately report his suspicion to:

(a) The local office of the welfare or aging services division of the department of human resources;

(b) Any police department or sheriff's office; or

(c) The county's office for protective services, if one exists in the county where the suspected action occurred.

If the report of abuse, neglect or exploitation involves an act or omission of the welfare division, aging services division or a law enforcement agency, the report must be made to an agency other than the one alleged to have committed the act or omission. Each agency, after reducing the report to writing, shall forward a copy of the report to the aging services division of the department of human resources.

2. Reports must be made by:

(a) [Every] *A* physician, dentist, dental hygienist, chiropractor, optometrist, podiatrist, medical examiner, resident, intern, professional or practical nurse, physician's assistant, psychiatrist, psychologist, marriage and family therapist, alcohol or drug abuse counselor, driver of an ambulance, advanced emergency medical technician or other person providing medical services licensed or certified to practice in this state, who examines, attends or treats an older person who appears to have been abused, neglected or exploited.

(b) [Any] *The* personnel of a hospital or similar institution engaged in the admission, examination, care or treatment of persons or an administrator,

manager or other person in charge of a hospital or similar institution upon notification of the suspected abuse, neglect or exploitation of an older person by a member of the staff of the hospital.

(c) A coroner.

(d) [Every] *A* clergyman, practitioner of Christian Science or religious healer, unless he acquired the knowledge of abuse, neglect or exploitation from the offender during a confession, or a social worker.

(e) [Every] *A* person who maintains or is employed by an agency to provide nursing in the home.

(f) [Every] *An* attorney, unless he [has] acquired the knowledge of abuse, neglect or exploitation from a client who has been or may be accused of the abuse, neglect or exploitation.

(g) [Any] *An* employee of the welfare or aging services division of the department of human resources.

(h) [Any] *An* employee of a law enforcement agency or a county's office for protective services or an adult or juvenile probation officer.

(i) [Any] *A* person who maintains or is employed by a facility or establishment that provides care for older persons.

(j) [Any] *A* person who maintains, is employed by or serves as a volunteer for an agency or service which advises persons regarding the abuse, neglect or exploitation of an older person and refers them to persons and agencies where their requests and needs can be met.

3. [Every] *A* physician who, as a member of the staff of a hospital or similar institution, has reason to believe that an older person has been abused,

neglected or exploited shall notify the superintendent, manager or other person in charge of the institution. The superintendent, manager or other person in charge shall make a report as required in subsection 1.

4. A report may be filed by any other person.

[5. A division, office or department which receives a report pursuant to this section shall cause the investigation of the report within 3 working days.

6. If the investigation of the report results in the belief that the older person is abused, neglected or exploited, the welfare division of the department of human resources or the county's office for protective services may provide protective services to the older person if he is able and willing to accept them.]

Sec. 29. NRS 200.5095 is hereby amended to read as follows:

200.5095 1. Reports made pursuant to NRS 200.5093 and [200.5094] *section 23 of this act* are confidential.

2. [Any] *A* person, law enforcement agency or public or private agency, institution or facility who willfully releases data or information concerning the reports and investigation of the abuse, neglect or exploitation of *an* older [persons,] *person,* except:

(a) Pursuant to criminal prosecution under the provisions of *this section,* NRS [200.5092 to 200.5099, inclusive; and] *200.5099 or section 8 of this act;*

(b) *As otherwise required pursuant to NRS 200.5092 to 200.5099, inclusive, and sections 23 to 26, inclusive, of this act; or*

(c) To persons or agencies enumerated in subsection 3 of this section,

is guilty of a misdemeanor.

3. Data or information concerning the reports and investigations of the abuse, neglect or exploitation of an older person is available only to:

(a) A physician who has in his care an older person who he reasonably believes may have been abused, neglected or exploited;

(b) An agency responsible for or authorized to undertake the care, treatment and supervision of the older person;

(c) A district attorney or other law enforcement official who requires the information in connection with an investigation of the abuse, neglect or exploitation of the older person;

(d) A court which has determined, in camera, that public disclosure of such information is necessary for the determination of an issue before it;

(e) A person engaged in bona fide research, but the identity of the subjects of the report must remain confidential;

(f) A grand jury upon its determination that access to such records is necessary in the conduct of its official business;

(g) Any comparable authorized person or agency in another jurisdiction;

(h) A legal guardian of the older person, if the identity of the person who was responsible for reporting the alleged abuse, neglect or exploitation to the public agency is protected, and the legal guardian is not the person suspected of the abuse, neglect or exploitation; or

(i) The person named in the report as allegedly being abused, neglected or exploited, if that person is not legally incompetent.

4. If the person who is reported to have abused, neglected or exploited an older person is the holder of a license or certificate issued pursuant to

chapters 630 to [641A.] *641B*, inclusive, of NRS, information contained in the report must be submitted to the board which issued the license.

Sec. 30. NRS 200.5096 is hereby amended to read as follows:

200.5096 Immunity from civil or criminal liability extends to every person participating in good faith in the making of a report pursuant to NRS 200.5093 [and 200.5094.] *and section 23 of this act.*

Sec. 31. NRS 200.5097 is hereby amended to read as follows:

200.5097 In any proceeding resulting from a report made or action taken pursuant to NRS 200.5092 to 200.5099, inclusive, *and sections 23 to 26, inclusive, of this act,* or in any other proceeding, the report or its contents or any other fact related thereto or to the condition of the older person who is the subject of the report may not be excluded on the ground that the matter would otherwise be privileged against disclosure under chapter 49 of NRS.

Sec. 32. NRS 200.5098 is hereby amended to read as follows:

200.5098 The aging services division of the department of human resources shall:

1. Identify and record demographic information on [the] *an* older person who is alleged to have been abused, neglected or exploited and the person who is alleged to be responsible for the abuse, neglect or exploitation.

2. Obtain information from programs for preventing abuse of older persons, analyze and compare the programs, and make recommendations to assist the organizers of the programs in achieving the most efficient and effective service possible.

3. Publicize the provisions of NRS 200.5091 to 200.5099, inclusive [.] , *and sections 23 to 26, inclusive, of this act.*

Sec. 33. NRS 200.5099 is hereby amended to read as follows:

200.5099 1. Any person who knowingly and willfully violates NRS [200.5092 to 200.5095, inclusive,] *200.5093 or section 24 of this act* is guilty of a misdemeanor.

2. Any adult [person] who willfully causes or permits an older person to suffer unjustifiable physical pain or mental suffering as a result of abuse, neglect or exploitation, or who willfully causes or permits an older person to be placed in a situation where the person may suffer unjustifiable physical pain or mental suffering as the result of abuse, neglect or exploitation, is guilty of a gross misdemeanor unless a more severe penalty is prescribed by law for the act or omission which brings about the abuse, neglect, danger or loss through exploitation.

3. A person who violates any provision of subsection 2, if substantial bodily or mental harm results to the older person, shall be punished by imprisonment in the state prison for not less than 1 year nor more than 6 years.

4. As used in this section, "permit" means permission that a reasonable person would not grant and which amounts to a neglect of responsibility attending the care and custody of an older person.

SUMMARY--Provides incentive to certain hospitals to provide management and technical assistance to rural hospitals. (BDR S-1218)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to hospitals; providing credit against limitations upon billed charges and income to certain hospitals which provide management and technical assistance to rural hospitals; and providing other matters properly relating thereto.

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

Section 1. Section 55 of chapter 377, Statutes of Nevada 1987, as amended by chapter 681, Statutes of Nevada 1987, at page 1633, is hereby amended to read as follows:

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.

3. Each nonprofit 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,] *8 or 9*, 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,] *8 or 9*, 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,] *13*, 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. *A hospital subject to the provisions of subsection 3 or 6 is entitled to a credit against either its income used to compute its percentage of*

income to operating expenses or its total billed charges used to compute its percentage of increase in billed charges of $1 for each $1 spent by the hospital during the fiscal year to provide management and technical assistance to rural hospitals. To receive the credit a hospital must:

(a) Provide management or technical assistance to a rural hospital which is not its subsidiary or affiliate: and

(b) Submit evidence of such assistance to the director on or before July 31, of the fiscal year following the fiscal year for which the credit is claimed.

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.

10. 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.] *11.* 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.] *12.* 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.] *13.* 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.

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

[14.] *15.* As used in this section:

(a) *"Affiliate" means a rural hospital which is controlled by a hospital subject to the limitations imposed by subsection 3 or 6, the parent corporation of such a hospital, a subsidiary, or the principal stockholders or officers or directors of any of the foregoing.*

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

[(b)] *(c)* "Division" means the division for review of health resources and costs of the department of human resources.

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

[(d)] *(e)* "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)] *(f)* "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)] *(g)* "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)] *(h)* "Percentage of income to operating expenses" means income divided by operating expenses and then multiplied by 100.

(i) "Rural hospital" means a health facility which is:

(1) Located in a county in Nevada whose population is less than 30,000; and

(2) 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.

(j) "Subsidiary" means a rural hospital which is under the practical control of a hospital subject to the limitations imposed by subsection 3 or 6 or the parent corporation of such a hospital.

Sec. 2. This act becomes effective on July 1, 1989, and applies to assistance provided on or after that date.

SUMMARY--Expands authority of county hospital districts to issue and sell bonds. (BDR 40-1219)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to county hospital districts; authorizing the board of trustees of a district to issue and sell general and special obligation bonds; eliminating the limit on the amount of the bonds which may be issued; and providing other matters properly relating thereto.

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

Section 1. NRS 450.670 is hereby amended to read as follows:

450.670 The board of trustees **[**is empowered to prepare,**]** *may* issue and sell , **[**negotiable coupon bonds not exceeding $500,000 in amount, exclusive of interest,**]** for each district in its jurisdiction **[**,**]** *:*

1. General obligation bonds, payable from taxes;

2. General obligation bonds, payment of which is additionally secured by a pledge of gross or net revenues derived from the operation of hospital facilities; and

3. Special obligation bonds, payable solely from gross or net revenues derived from the operation of hospital facilities.

for the purpose of providing funds for the purchase of hospital equipment, the acquisition of property, the construction of buildings and improvement of [district-owned] property *owned by the district* for use in any one county hospital district.

Sec. 2. NRS 450.680 is hereby amended to read as follows:

450.680 1. If a board of trustees desires to avail itself of the power conferred by NRS 450.670 [, it] *and submission to the voters is required by the provisions of NRS 350.020 to 350.070, inclusive, the board* shall submit the question of issuing [such] *the* bonds to the registered voters of the district in accordance with [the provisions of NRS 350.020 to 350.070, inclusive.

2. If the issuance of such bonds is approved, they may be issued pursuant to the] *those provisions.*

2. The provisions of the Local Government Securities Law [.] *apply to any bonds authorized to be issued pursuant to NRS 450.670, except to the extent those provisions are inconsistent with the provisions of NRS 450.550 to 450.700, inclusive.*

SUMMARY--Creates fund for capital improvement of rural hospitals. (BDR 40-1220)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Contains Appropriation.

AN ACT relating to hospitals; creating a fund for the capital improvement of rural hospitals; establishing a procedure for allocation of money from the fund; making an appropriation; and providing other matters properly relating thereto.

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

Section 1. Chapter 449 of NRS is hereby amended by adding thereto the provisions set forth as sections 2, 3 and 4 of this act.

Sec. 2. *As used in sections 3 and 4 of this act, "rural hospital" means a facility which is:*

1. Located in a county whose population is less than 30,000; and

2. 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. 3. *1. The fund for the capital improvement of rural hospitals is hereby created as a trust fund. Money for the fund must be provided by direct legislative appropriation.*

2. The interest and income earned on the money in the fund, after deducting any applicable charges, must be credited to the fund.

3. Only the interest and income earned on the money appropriated to the fund may be allocated as provided by section 4 of this act.

Sec. 4. *1. A rural hospital that requires money for capital improvements may submit a request to the state board of examiners for an allocation by the interim finance committee from the fund for the capital improvement of rural hospitals.*

2. The state board of examiners shall consider the request, may require from the requester such additional information as it deems appropriate, and shall, if it finds that the allocation should be made, recommend the amount of the allocation to the interim finance committee for its independent evaluation and action. The interim finance committee is not bound to follow the recommendation of the state board of examiners.

3. The recommendation of the state board of examiners for an allocation from the fund must be transmitted to the director of the legislative counsel bureau, who shall notify the chairman of the interim finance committee. The chairman shall call a meeting of the committee to consider the recommendation.

4. If the interim finance committee, after independent determination, finds that an allocation recommended by the state board of examiners should and

may lawfully be made, the committee shall by resolution establish the amount and purpose of the allocation, and direct the state controller to transfer that amount to the rural hospital that applied for the allocation. The state controller shall thereupon make the transfer.

Sec. 5. NRS 218.6825 is hereby amended to read as follows:

218.6825 1. There is hereby created in the legislative counsel bureau an interim finance committee composed of the members of the assembly standing committee on ways and means and the senate standing committee on finance during the current or immediately preceding session of the legislature. The immediate past chairman of the senate standing committee on finance is the chairman of the interim finance committee for the period ending with the convening of each even-numbered regular session of the legislature. The immediate past chairman of the assembly standing committee on ways and means is the chairman of the interim finance committee during the next legislative interim, and the chairmanship alternates between the houses of the legislature according to this pattern.

2. If any regular member of the committee informs the secretary that he will be unable to attend a particular meeting, the secretary shall notify the speaker of the assembly or the majority leader of the senate, as the case may be, to appoint an alternate for that meeting from the same house and political party as the absent member.

3. The interim finance committee, except as provided in subsection 4, may exercise the powers conferred upon it by law only when the legislature is not in regular or special session. The membership of any member who does

not become a candidate for reelection or who is defeated for reelection continues until the next session of the legislature is convened.

4. During a regular session the interim finance committee may also perform the duties imposed on it by subsections 4 and 6 of NRS 284.115, subsection 3 of NRS 328.480, subsection 1 of NRS 341.145, NRS 353.220, 353.224, 353.335 and 428.375 . [and] chapter 621, Statutes of Nevada 1979 [.] . *and section 3 of this act.* In performing those duties, the senate standing committee on finance and the assembly standing committee on ways and means may meet separately and transmit the results of their respective votes to the chairman of the interim finance committee to determine the action of the interim finance committee as a whole.

5. The director of the legislative counsel bureau shall act as the secretary of the interim finance committee.

6. A majority of the members of the assembly standing committee on ways and means and a majority of the members of the senate standing committee on finance, jointly, may call a meeting of the interim finance committee if the chairman does not do so.

7. In all matters requiring action by the interim finance committee, the vote of the assembly and senate members must be taken separately. An action must not be taken unless it receives the affirmative vote of a majority of the assembly members and a majority of the senate members.

8. Except during a regular or special session of the legislature, each member of the interim finance committee and appointed alternate is 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 committee meeting or is otherwise engaged in committee work plus the per diem allowance and travel expenses provided for state officers and employees generally. All such compensation must be paid from the contingency fund in the state treasury.

Sec. 6. There is hereby appropriated from the state general fund to the fund for the capital improvement of rural hospitals the sum of $10,000,000.

Sec. 7. 1. This act becomes effective upon passage and approval.

2. The state board of examiners shall not consider an application for an allocation pursuant to section 4 of this act before July 1, 1991.

SUMMARY--Requires state welfare administrator to adopt regulations providing for medical assistance to certain children and pregnant women. (BDR 38-1221)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to the administration of programs of public assistance; requiring the state welfare administrator to adopt regulations extending coverage of the state plan for assistance to the medically indigent to certain children and pregnant women; and providing other matters properly relating thereto.

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

Section 1. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

The administrator shall adopt as part of the state plan for assistance to the medically indigent, regulations providing for the coverage of any child under 8 years of age and any pregnant woman, if the child or woman:

1. Has an income which does not exceed 185 percent of the federally designated level signifying poverty; and

2. Qualifies for mandatory or optional coverage pursuant to Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.).

SUMMARY--Requires state welfare administrator to adopt regulations providing for medical assistance to certain two-parent families. (BDR 38-1222)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to administration of programs for public assistance; requiring the state welfare administrator to adopt regulations extending coverage of the state plan for assistance to the medically indigent to certain two-parent families; and providing other matters properly relating thereto.

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

Section 1. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

The administrator shall adopt as part of the state plan for assistance to the medically indigent, regulations providing for the coverage of two-parent households in which the principal wage earner is unemployed, commonly referred to as "aid to families with dependent children - unemployed parent

families," who qualify for mandatory or optional coverage pursuant to Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.).

SUMMARY--Establishes limit on monthly income for eligibility for benefits for long-term medical care. (BDR 38-1223)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to public welfare; establishing a limit on monthly income for eligibility for benefits for long-term medical care; and providing other matters properly relating thereto.

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

Section 1. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

Any person whose monthly income is less than three times the income allowable to receive benefits pursuant to 42 U.S.C. §§ 1382 to 1383c, inclusive, is eligible to receive assistance to the medically indigent for the purpose of long-term medical care provided in a hospital, facility for intermediate care or facility for skilled nursing.

SUMMARY--Requires state welfare administrator to establish plan for assistance to medically needy. (BDR 38-1224)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to the medically needy: requiring the state welfare administrator to establish a plan for assistance; and providing other matters properly relating thereto.

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

Section 1. Chapter 422 is hereby amended by adding thereto the provisions set forth as sections 2, 3 and 4 of this act.

Sec. 2. *As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 422.005 to 422.055, inclusive, and section 3 of this act, have the meanings ascribed to them in those sections.*

Sec. 3. *"Assistance to the medically needy" means the program established to provide assistance for part or all of the cost of medical or remedial care rendered on behalf of indigent persons pursuant to the provisions of 42 U.S.C. § 1396a(a)(17), as it existed January 1, 1989.*

Sec. 4. *1. The administrator shall establish a plan for assistance to the medically needy. The plan is subject to the approval of the board. The plan must set forth the requirements for eligibility, 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 plan as the administrator and the board deem necessary.*

2. In developing and revising the plan, the administrator and the board shall consider, among other things, the amount of money available from the Federal Government for assistance to the medically needy, the conditions attached to the acceptance of the money and the limitations of legislative appropriations for such assistance.

Sec. 5. NRS 422.005 is hereby amended to read as follows:

422.005 [As used in this chapter, "administrator"] "*Administrator*" means the state welfare administrator.

Sec. 6. NRS 422.007 is hereby amended to read as follows:

422.007 [As used in this chapter, "aid] "*Aid* to dependent children" means the program established to provide assistance to needy dependent children pursuant to Title IV of the Social Security Act (42 U.S.C. §§ 601 et seq.) and other provisions of that act relating to assistance to dependent children.

Sec. 7. NRS 422.008 is hereby amended to read as follows:

422.008 [As used in this chapter, "assistance] "*Assistance* to the medically indigent" means the program established to provide assistance for part or all of the cost of medical or remedial care rendered on behalf of indigent persons

pursuant to Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.) and other provisions of that act relating to medical assistance to indigent persons.

Sec. 8. NRS 422.010 is hereby amended to read as follows:

422.010 [As used in this chapter, "board"] "*Board*" means the state welfare board.

Sec. 9. NRS 422.030 is hereby amended to read as follows:

422.030 [As used in this chapter, "department"] "*Department*" means the department of human resources.

Sec. 10. NRS 422.040 is hereby amended to read as follows:

422.040 [As used in this chapter, "director"] "*Director*" means the director of the department of human resources.

Sec. 11. NRS 422.050 is hereby amended to read as follows:

422.050 [For the purposes of this chapter, "public] "*Public* assistance" includes:

1. State supplementary assistance provided in connection with the supplemental security income program;

2. Services to the aged, blind or disabled;

3. Aid to dependent children; [and]

4. Assistance to the medically indigent [.] ; *and*

5. Assistance to the medically needy.

Sec. 12. NRS 422.052 is hereby amended to read as follows:

422.052 [As used in this chapter, "services] "*Services* to the aged, blind or disabled" means services provided to aged, blind or disabled persons who are

applicants for or recipients of benefits under the supplemental security income program, including state supplementary assistance, or who are otherwise eligible for such services, pursuant to Title XX of the Social Security Act, as amended from time to time, and other provisions of that act relating to social services, and the regulations of the welfare division.

Sec. 13. NRS 422.0525 is hereby amended to read as follows:

422.0525 [As used in this chapter, "state] "*State* supplementary assistance" means the program established to provide state assistance to aged or blind persons in connection with the supplemental security income program.

Sec. 14. NRS 422.053 is hereby amended to read as follows:

422.053 [As used in this chapter, "supplemental] "*Supplemental* security income program" means the program established for aged, blind or disabled persons pursuant to Title XVI of the Social Security Act (42 U.S.C. §§ 1381 et seq.), as amended from time to time.

Sec. 15. NRS 422.055 is hereby amended to read as follows:

422.055 [As used in this chapter, "welfare] "*Welfare* division" means the welfare division of the department of human resources.

Sec. 16. NRS 422.157 is hereby amended to read as follows:

422.157 1. The standing committees and the members of each committee of the medical care advisory group are as follows:

(a) A committee for recipients consisting of seven members who represent the general public or who represent [assistance programs,] *recipients of public assistance*, including but not limited to *recipients of* supplemental security

income, [state aid] *assistance* to the medically indigent [,] *or assistance to the medically needy*, or foster parents.

(b) A dental committee consisting of five dentists who are licensed to practice in the State of Nevada.

(c) A committee on hospitals consisting of seven administrators of hospitals representing private and public hospitals.

(d) A committee on long-term care consisting of five members, each of whom is the administrator of a facility for intermediate care or facility for skilled nursing.

(e) A committee on pharmacy consisting of six pharmacists who hold certificates as registered pharmacists in the State of Nevada.

(f) A committee of physicians consisting of 12 physicians who are licensed to practice in the State of Nevada.

2. At the first meeting subsequent to their appointment, the members of each committee shall elect a chairman.

3. Each committee shall meet at such times as the director, the chairman of the medical care advisory group or the committee deems necessary.

Sec. 17. NRS 422.215 is hereby amended to read as follows:

422.215 1. The administrator or his designated representative may administer oaths and take testimony thereunder and issue subpenas requiring the attendance of witnesses before the welfare division at a designated time and place and the production of books, papers and records relative to:

(a) Eligibility or continued eligibility for public assistance; and

(b) Verification of treatment and payments to a provider of medical care, remedial care or other services pursuant to the state plan for assistance to the medically indigent [.] *or the state plan for assistance to the medically needy.*

2. If a witness fails to appear or refuses to give testimony or to produce books, papers and records as required by the subpena, the district court of the county in which the investigation is being conducted may compel the attendance of witnesses, the giving of testimony and the production of books, papers and records as required by the subpena.

Sec. 18. NRS 422.270 is hereby amended to read as follows:

422.270 1. The department shall:

(a) Administer all public welfare programs of this state, including:

(1) State supplementary assistance provided in connection with the supplemental security income program;

(2) Aid to dependent children;

(3) Child welfare services;

(4) Services to the aged, blind or disabled;

(5) Assistance to the medically indigent; [and]

(6) *Assistance to the medically needy; and*

(7) Such other welfare activities and services as now are or hereafter may be authorized or provided for by the laws of this state.

(b) Act as the single state agency of the State of Nevada and its political subdivisions in the administration of any federal money granted to the state to aid in the furtherance of any of the services and activities set forth in paragraph (a).

(c) Cooperate with the Federal Government in adopting state plans, in all matters of mutual concern, including adoption of such methods of administration as may be found by the Federal Government to be necessary for the efficient operation of welfare programs, and in increasing the efficiency of welfare programs by prompt and judicious utilization of new federal grants which will assist the department to fulfill the terms of this chapter.

2. The department through the welfare division shall:

(a) [Make] *Adopt* regulations, subject to the approval of the board, for the administration of this chapter which are binding upon all recipients and local units.

(b) Observe and study the changing nature and extent of welfare needs and develop through tests and demonstrations effective ways of meeting such needs, employing or contracting for such personnel and services as may be provided through legislative appropriations from the state general fund or may become available through legislatively authorized or new money from federal or other sources.

(c) [Make] *Conduct* all investigations required by a court in adoption proceedings as provided by law.

(d) Establish reasonable minimum standards and regulations for foster homes, and [shall] license foster homes as provided by law.

(e) Provide services and care to children, [shall] receive any child for placement [, and shall] *and* provide for [their] *his* care directly or through agents.

(f) [Have the power to enter into reciprocal agreements with other states relative to public assistance, welfare services and institutional care.

(g) Make] *Enter into* such agreements with the Federal Government as may be necessary to carry out the supplemental security income program.

3. The department through the welfare division may enter into reciprocal agreements with other states relating to public assistance, welfare services and institutional care.

Sec. 19. NRS 422.285 is hereby amended to read as follows:

422.285 The department of human resources, through the welfare division, shall reimburse directly, under the state plan for assistance to the medically indigent [,] *or the state plan for assistance to the medically needy*, any registered nurse who is authorized pursuant to chapter 632 of NRS to perform additional acts in an emergency or under other special conditions as prescribed by the state board of nursing, for such services rendered under the authorized scope of his practice to persons eligible to receive that assistance if another provider of health care would be reimbursed for providing those same services.

Sec. 20. NRS 422.293 is hereby amended to read as follows:

422.293 1. When a recipient of assistance to the medically indigent *or assistance to the medically needy* incurs an illness or injury for which medical services are payable under the state plan and which is incurred under circumstances creating a legal liability in some person other than the recipient or the welfare division [,] to pay all or part of the costs of such services, the division is subrogated to the right of the recipient to the extent of all [such]

those costs and may join or intervene in any action by the recipient or his successors in interest to enforce [such] *the* legal liability.

2. If a recipient or his successors in interest fail or refuse to commence an action to enforce the legal liability, the welfare division may commence an independent action, after notice to the recipient or his successors in interest, to recover all costs to which it is entitled. In any such action by the division, the recipient or his successors in interest may be joined as third party defendants.

3. In any case where the welfare division is subrogated to the rights of the recipient or his successors in interest as provided in subsection 1, the division has a lien upon the proceeds of any recovery from the persons liable, whether the proceeds of the recovery are by way of judgment, settlement or otherwise. No such lien is enforceable unless written notice is first given to the person against whom the lien is asserted.

4. The recipient or his successors in interest shall notify the welfare division in writing before entering any [settlement] agreement *of settlement* or commencing any action to enforce the legal liability referred to in subsection 1.

Sec. 21. NRS 422.2933 is hereby amended to read as follows:

422.2933 1. In determining the eligibility of a married person for assistance under the state plan for assistance to the medically indigent [,] *or the state plan for assistance to the medically needy,* the assets of that person shall be deemed to have been transferred for full and adequate consideration if that person is considered to be living separately from his spouse pursuant to Title XIX of the Social Security Act and the regulations adopted pursuant to it, and

he has entered into a written agreement with his spouse dividing their assets into equal shares of separate assets.

2. The assets designated in an agreement as separate assets must be considered the separate assets of the spouse who is designated in the agreement as the owner of the assets. If the assets are made available to the spouse who is not the owner of the assets, the welfare division may include those assets in determining the eligibility of the spouse who is not the owner.

3. The welfare division shall:

(a) Adopt regulations necessary to carry out the provisions of this section; and

(b) Provide information to each applicant for assistance concerning his rights pursuant to this section and the regulations adopted pursuant to paragraph (a).

Sec. 22. NRS 422.2993 is hereby amended to read as follows:

422.2993 1. Except as otherwise provided in subsection 2, any information obtained by the welfare division in an investigation of a provider of services under the *state* plan for assistance to the medically indigent *or the state plan for assistance to the medically needy* is confidential.

2. The information presented as evidence at a hearing to review an action by the welfare division against a provider of services under the *state* plan for assistance to the medically indigent *or the state plan for assistance to the medically needy* is not confidential, except for the identity of any recipient of the assistance.

Sec. 23. NRS 422.2997 is hereby amended to read as follows:

422.2997 1. Upon receipt of a request for a hearing from a provider of services under the *state* plan for assistance to the medically indigent **[**.**]** *or the state plan for assistance to the medically needy*, the welfare division shall appoint a hearing officer to conduct the hearing. Any employee or other representative of the welfare division who investigated or made the initial decision regarding the action taken against a provider of services may not be appointed as the hearing officer or participate in the making of any decision pursuant to the hearing.

2. The welfare division shall adopt regulations prescribing the procedures to be followed at the hearing.

3. The decision of the hearing officer is a final decision. Any party, including the welfare division, who is aggrieved by the decision of the hearing officer may appeal that decision to the district court. The review of the court must be confined to the record. The court shall not substitute its judgment for that of the hearing officer as to the weight of the evidence on questions of fact. The court may affirm the decision of the hearing officer or remand the case for further proceedings. The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions or decisions are:

(a) In violation of constitutional or statutory provisions;

(b) In excess of the statutory authority of the welfare division;

(c) Made upon unlawful procedure;

(d) Affected by other error of law;

(e) Clearly erroneous in view of the reliable, probative and substantial evidence on the whole record; or

(f) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Sec. 24. NRS 422.400 is hereby amended to read as follows:

422.400 1. A provider of medical care, remedial care or other services who contracts with the division pursuant to the state plan for assistance to the medically indigent *or the state plan for assistance to the medically needy* shall not knowingly:

(a) Obtain or attempt to obtain by deception any payment to which he is not entitled.

(b) Apply for or accept any payment to which he is not entitled.

(c) Accept any payment in an amount greater than that to which he is entitled.

(d) Falsify any report or document required by this state or the Federal Government relating to payments for services rendered and supplies furnished by the provider.

(e) Accept, solicit or offer any bribe, rebate or other remuneration, whether in money or in kind, in connection with services rendered or supplies furnished by him.

2. In addition to the penalties prescribed in chapter 205 of NRS, a provider of medical care, remedial care or other services who willfully violates the provisions of subsection 1 is liable for:

(a) An amount equal to three times the amount unlawfully obtained;

(b) Not less than $500 for each act of deception; and

(c) Any reasonable expense incurred by the state in enforcing this section.

3. A provider of medical care, remedial care or other services who unknowingly accepts a payment in excess of the amount to which he is entitled is liable for the repayment of the excess amount. It is a defense to any action brought pursuant to this section that the provider of health care returned or attempted to return the amount which was in excess of that to which he was entitled within a reasonable time after receiving it.

4. The attorney general shall cause appropriate legal action to be taken on behalf of the state to enforce the provisions of this section.

5. Any penalty collected pursuant to this section is hereby appropriated to provide [medical aid to the indigent] *assistance to the medically indigent or the medically needy* through programs administered by the welfare division.

Sec. 25. NRS 428.030 is hereby amended to read as follows:

428.030 1. When any person meets the uniform standards of eligibility established by the board of county commissioners or by NRS 439B.310, if applicable, then he is entitled to receive such relief as is in accordance with the policies and standards established and approved by the board of county commissioners and within the limits of the money which may be lawfully appropriated pursuant to NRS 428.050, 428.285 and 450.425 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 payment required for providing the same treatment

to patients pursuant to the state plan for assistance to the medically indigent [.] *or the state plan for assistance to the medically needy* within the limits of money which may be lawfully appropriated pursuant to NRS 428.050, 428.285 and 450.425 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 deems necessary to oversee and provide the necessary maintenance of poor persons;

(c) Authorize the payment of cash grants 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).

Sec. 26. 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 NRS 439B.310, 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, 428.285 and 450.425.

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 [;] *or the state plan for assistance to the medically needy;* and

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

Sec. 27. NRS 274.270 is hereby amended to read as follows:

274.270 1. The governing body shall investigate the proposal made by a business pursuant to NRS 274.260, and if it finds that the business is qualified by financial responsibility and business experience to create and preserve employment opportunities in the specially benefited zone and improve the economic climate of the municipality and finds further that the business did not relocate from a depressed area in this state or reduce employment elsewhere in Nevada in order to expand in the specially benefited zone, the governing body may, on behalf of the municipality, enter into an agreement with the business, for a period of not more than 20 years, under

which the business agrees in return for one or more of the benefits authorized in this chapter and NRS 374.643 for qualified businesses, as specified in the agreement, to establish, expand, renovate or occupy a place of business within the specially benefited zone and hire new employees at least 35 percent of whom at the time they are employed are at least one of the following:

(a) Unemployed persons who have resided at least 6 months in the municipality.

(b) Persons eligible for employment or job training under any federal program for employment and training who have resided at least 6 months in the municipality.

(c) Recipients of benefits under any state or county program of public assistance, including aid to dependent children, [aid] *assistance* to the medically indigent *or assistance to the medically needy* and unemployment compensation who have resided at least 6 months in the municipality.

(d) Persons with a physical or mental handicap who have resided at least 6 months in the state.

(e) Residents for at least 1 year of the area comprising the specially benefited zone.

2. To determine whether a business is in compliance with an agreement, the governing body:

(a) Shall each year require the business to file proof satisfactory to the governing body of its compliance with the agreement.

(b) May conduct any necessary investigation into the affairs of the business and may inspect at any reasonable hour its place of business within the specially benefited zone.

If the governing body determines that the business is in compliance with the agreement, it shall issue a certificate to that effect to the business. The certificate expires 1 year after the date of its issuance.

3. The governing body shall file with the administrator, the department of taxation and the employment security department a copy of each agreement, the information submitted under paragraph (a) of subsection 2 and the current certificate issued to the business under that subsection. The governing body shall immediately notify the administrator, the department of taxation and the employment security department whenever the business is no longer certified.

Sec. 28. NRS 441.210 is hereby amended to read as follows:

441.210 The disclosure to any person of the name or address of any diseased person is unlawful except:

1. Where the disclosure is authorized or required by this chapter.

2. In prosecutions for violations of this chapter.

3. In mandamus proceedings authorized by this chapter.

4. In reporting an apparently abused or neglected child, but no other information may be disclosed.

5. Where the disclosure is made to the welfare division of the department of human resources and the diseased person:

(a) Has been diagnosed as having acquired immune deficiency syndrome or acquired immune deficiency related complex; and

(b) Is a recipient of assistance to the medically indigent [.] *or assistance to the medically needy.*

Sec. 29. NRS 442.215 is hereby amended to read as follows:

442.215 1. The administrator of the health division may recover costs of corrective treatment for crippled children from the parents of the child who receives the treatment, pursuant to subsections 2 and 3.

2. The administrator shall investigate the financial circumstances of a parent of a crippled child for whom an application is made to determine whether part or all of the expenses for treatment should be paid for by [such] *the* parent.

3. The administrator may authorize corrective treatment for a crippled child at state expense when it is determined that the parent of the child is unable to pay the cost of this treatment or any part thereof. A determination of ability to pay and eligibility for payment at state expense must be based on the following factors:

(a) Resources of the parent, including hospital and medical insurance;

(b) Other available sources of payment, including [state aid for] *assistance to the* medically indigent [families;] *or assistance to the medically needy;*

(c) Estimated cost of care;

(d) Length of treatment;

(e) Household size in relation to income; and

(f) Debts and obligations.

4. As used in this section, "parent" means a natural parent or an adoptive parent.

SUMMARY--Provides method for evaluating claims made by indigent patients seeking care in hospitals. (BDR 38-1225)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to health care; authorizing private hospitals to contract with counties for personnel to evaluate claims made by indigent patients; requiring counties to provide county hospitals with such personnel; and providing other matters properly relating thereto.

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

Section 1. NRS 428.030 is hereby amended to read as follows:

428.030 1. When any person meets the uniform standards of eligibility established by the board of county commissioners or by NRS 439B.310, if applicable, then he is entitled to receive such relief as is in accordance with the policies and standards established and approved by the board of county commissioners and within the limits of the money which may be lawfully appropriated pursuant to NRS 428.050, 428.285 and 450.425 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 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, 428.285 and 450.425 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 deems necessary to oversee and provide the necessary maintenance of poor persons;

(c) Authorize the payment of cash grants 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).

4. A hospital may contract with the board of county commissioners in the county in which it is located to obtain the services of a county employee to be assigned to the hospital to evaluate the eligibility of patients applying for indigent status. Payment for those services must be made by the hospital.

Sec. 2. 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**]** *shall* determine whether patients presented to the public hospital for treatment are subjects of charity **[**.**]** *by assigning to each such hospital an employee whose duty it is to evaluate the*

eligibility of patients applying for indigent status. Except as otherwise provided in NRS 439B.330, 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 NRS 439B.320, 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.

SUMMARY--Requires administrator of welfare to adopt regulations authorizing participation of certain businesses in state plan for assistance to medically indigent. (BDR 38-1226)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to programs of public assistance; requiring the state welfare administrator to adopt regulations authorizing the participation of certain businesses in the state plan for assistance to the medically indigent; and providing other matters properly relating thereto.

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

Section 1. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

The administrator shall adopt as part of the state plan for assistance to the medically indigent, regulations authorizing the participation in the plan of any business in this state with 25 or fewer employees.

Sec. 2. 1. In accordance with Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.), the administrator shall seek a waiver from the Secretary of Health and Human Services permitting the State of Nevada to put

into effect, as part of the state plan for assistance to the medically indigent, regulations authorizing the participation in the plan of any business in this state with 25 or fewer employees.

2. Upon receiving notification from the Secretary of his decision on whether to grant the requested waiver, the administrator shall inform the governor of the Secretary's decision. If the Secretary granted the waiver, the governor shall, as soon as practicable, publicly proclaim that fact.

Sec. 3. 1. This section and section 2 of this act become effective upon passage and approval.

2. Section 1 of this act becomes effective upon the public proclamation of the governor that the Secretary of Health and Human Services granted a waiver which permits the State of Nevada to put into effect, as part of the state plan for assistance to the medically indigent, regulations authorizing the participation in the plan of any business in this state with 25 or fewer employees.

SUMMARY--Requires state health officer to investigate confirmed or suspected cases of chronic fatigue syndrome. (BDR 40-1227)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to public health; requiring the state health officer to investigate all confirmed or suspected cases of chronic fatigue syndrome; and providing other matters properly relating thereto.

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

Section 1. Chapter 439 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The state health officer shall investigate each confirmed or suspected case of chronic fatigue syndrome.

2. Each confirmed or suspected case of chronic fatigue syndrome must be reported in the same manner as a reportable disease pursuant to NRS 439.210.

3. The state board of health shall adopt by regulation a definition of the term "chronic fatigue syndrome."

SUMMARY--Makes various changes to provisions concerning commissions and committees for advocacy of maintaining quality of care provided by hospitals. (BDR 40-1554)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to medical facilities; exempting meetings of commissions and committees for the advocacy of maintaining the quality of care provided by hospitals from the provisions governing meetings of public bodies; requiring that certain information presented to closed meetings of such commissions and committees be kept confidential; and providing other matters properly relating thereto.

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

Section 1. NRS 449.475 is hereby amended to read as follows:

449.475 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. *The provisions of chapter 241 of NRS do not apply to any meeting conducted by a commission or committee. Such a meeting must be closed to the public unless a majority of the members of the commission or committee vote to open the meeting to the public.*

5. 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 , *except as otherwise provided in subsection 6,* compile that information for publication

with similar information from other states. A committee may require such information from its hospital.

[5.] *6. When presented to a closed meeting of a commission or committee, the following information and documents are confidential and not subject to public inspection:*

(a) Information or documents concerning alleged mismanagement or other misconduct by an employee or member of the staff of a hospital;

(b) Records of discussions held by a commission or committee regarding such mismanagement or misconduct; and

(c) Information provided pursuant to subsection 8, indicating that the quality of care of a hospital is being compromised in the interest of economic considerations.

7. Each committee shall report quarterly to the commission for its county. Each commission shall report quarterly to the legislative committee on health care. A report made pursuant to this subsection must:

(a) Describe in general terms the quality of care being provided by hospitals subject to the provisions of NRS 449.450 to 449.530, inclusive; and

(b) Not contain any information required to be kept confidential pursuant to subsection 6.

8. 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.] *9.* 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. *Any information required to be kept confidential pursuant to subsection 6, must remain confidential if exchanged as authorized by this subsection.*

Sec. 2. 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, 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 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] *Except as otherwise provided in NRS 449.475, all* reports, except privileged medical information, filed under any provisions of NRS 449.450 to 449.530, inclusive, are open to public inspection and must be available for examination at the office of the department during regular business hours.

Sec. 3. NRS 449.500 is hereby amended to read as follows:

449.500 The director shall engage in or carry out analyses and studies relating to the cost of health care in Nevada and other states, the financial status of any institution subject to the provisions of NRS 449.450 to 449.530, inclusive, and any other appropriate related matters, and *except as otherwise provided in NRS 449.475,* he may publish and disseminate any information relating to the financial aspects of health care as he deems desirable in the public interest and in accordance with the provisions of NRS 449.450 to 449.530, inclusive. He shall further require the filing of information concerning the total financial needs of each institution and the resources available or expected to become available to meet such needs, including but not limited to the effect of proposals made by comprehensive areawide and state health

planning agencies. The information must be divided into at least the following components of an institution's expenses:

1. Operating expenses related to patient care.

2. Expenses incurred for rendering services to patients for whom payment is not made in full including, but not limited to, the separate expenses for contractual allowances imposed by federal or state law, charity care and uncollectible accounts.

3. All incurred interest charges on indebtedness for both capital and operating needs.

4. Costs of education, both primary and continuing.

5. Expenses for research related to patient care.

6. Depreciation expenses of both property and equipment.

7. Amortization of incurred capital and operating related indebtedness.

8. Requirements for capital expenditures for replacement, modernization, renovation and expansion of services and facilities.

9. Requirements for necessary working capital, including but not limited to operating cash, patients' accounts receivable and inventories.

10. Federal, state and local taxes not ordinarily considered operating expenses where applicable.

11. Operating surpluses necessary for a fair return to their owners equal to returns on investments in industries of comparable risk, or for the purpose of assuring continuity of operation and prudent management.

Sec. 4. NRS 449.510 is hereby amended to read as follows:

449.510 The director shall prepare and file such summaries, compilations or other supplementary reports based on the information filed with him under NRS 449.450 to 449.530, inclusive, as will advance the purposes of those sections. *The summaries, compilations and summary reports must not contain information and documents required to be kept confidential pursuant to NRS 449.475.* All such summaries, compilations and reports are open to public inspection, must be made available to requesting agencies and must be prepared within a reasonable time following the end of each institution's fiscal year or more frequently as specified by the director.

SUMMARY--Requires state board of nursing to adopt regulations governing licensing and operation of nursing pools. (BDR 54-1555)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to nursing; requiring the state board of nursing to adopt regulations governing the licensing and operation of nursing pools; and providing other matters properly relating thereto.

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

Section 1. Chapter 632 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. *"Nursing pool" means a business that provides or procures the temporary employment in a health care facility of nursing personnel.*

Sec. 3. *A person shall not operate a nursing pool that is not in compliance with regulations adopted by the board pursuant to subsection 1 of NRS 632.120.*

Sec. 4. NRS 632.010 is hereby amended to read as follows:

632.010 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 632.011 to 632.019, inclusive, *and section 2 of this act* have the meanings ascribed to them in those sections.

Sec. 5. NRS 632.120 is hereby amended to read as follows:

632.120 *1. The board shall adopt regulations governing the licensing and operation of nursing pools, and imposing a fee for licensure. The regulations must be designed to protect the public's right to high quality health care by assuring that nursing pools provide only competent and qualified nursing personnel to health care facilities.*

2. The board may adopt [such] *other* regulations, not inconsistent with law, as [may be] *are* necessary to enable it to administer the provisions of this chapter.