# Legislative Committee on Health Care


Legislative Counsel Bureau

Bulletin No. 93-14

October 1992

# REPORT OF THE LEGISLATIVE COMMITTEE ON HEALTH CARE

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OCTOBER 1992

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## SUMMARY OF RECOMMENDATIONS

## LEGISLATIVE COMMITTEE ON HEALTH CARE

The Legislative Committee on Health Care recommends that the 67th Session of the Nevada Legislature:

### HEALTH INSURANCE

1. Establish within the Department of Insurance a small employer insurance purchasing pool (for firms with less than 26 employees) which would:

   a. Require participating insurers to utilize statewide "community rating."

   b. Require that pre-existing condition provisions do not exclude coverage for a period beyond 6 months.

   c. Eliminate multiple waiting periods for pre-existing conditions.

      (In the event of a change in employer, the employee must not be required to satisfy another waiting period for the same condition.)

   d. Apply employee participation and employer contribution requirements uniformly among all employer groups.

   e. Allow employers to credit an amount equal to $25 per eligible employee per quarter on the employer's business activities tax as specified in *Nevada Revised Statutes* 364A as an incentive to draw small employers into a health care purchasing pool.

   f. Guarantee that every participating firm will be able to get its health insurance policy renewed. (BDR 57-1064)

2. Allow employers who provide basic health insurance coverage to employees and pay at least 50 percent of each employee's premium to have a dollar-for-dollar deduction against the business activities tax specified in *Nevada Revised Statutes* 364A to a maximum of $75 per employee per quarter. (BDR 32-1065)

3. Implement health insurance reform by:

   a. Creating a reinsurance pool within the Department of Insurance to assist with costs associated with high-risk cases. (Utilize the National Association of Insurance Commissioners' model act for developing a State reinsurance pool.) (BDR 57-1066)

   b. Requiring that all small employer premium rates, other than those set by the Small Employer Insurance Purchasing Pool (see Recommendation No. 1), be established by such factors as health status, occupation, and claims experience of employees in similar firms. (BDR 57-1066)

4. Extend the evaluation deadlines of the small employer health insurance plans specified in Senate Bill 503 (Chapter 648, *Statutes of Nevada 1991*, pages 2152-2155) from 1993 to 1995, and 1995 to 1997. (BDR S-1067)

5. Establish a high-risk insurance pool within the Department of Insurance for people denied health insurance due to medical conditions. Require all insurance companies doing business in the State to participate by accepting eligible high-risk patients based on their share of the insurance market in Nevada. Limit premiums to 150 percent of the premium charged to insure a healthy individual. (BDR 57-1068)

6. Amend statutes to reform medical malpractice insurance by:

   a. Limiting recovery of noneconomic damages to $250,000.

   b. Prohibiting attorneys from collecting "contingency fees."

   c. Permitting collateral sources of recovery to be admitted as evidence.

d. Requiring the Medical Legal Screening Panel to recommend alternative dispute resolutions such as mediation and arbitration. (BDR 3-1069)

## MEDICAID

7. Require all health care professionals licensed in Nevada to accept a minimum number of Medicaid and other low-income patients as a condition of establishing or maintaining licensure. (BDR 40-1070)

8. Provide increased support for Nevada Medicaid's managed care program by:

   a. Appropriating $214,510 in fiscal year 1994 and $198,573 in fiscal year 1995 to the Department of Human Resources to increase relevant staffing levels. (BDR S-1071)

   b. Appropriating $_____ to expand the University of Nevada System's health care clinics. (BDR S-1071)

   c. Requiring the Department of Human Resources to apply to the U.S. Health Care Financing Administration for a "freedom of choice" waiver for Nevada Medicaid's managed care program. (In general, this Federal waiver would allow Nevada to operate a statewide, mandatory Medicaid managed care program.) (BDR S-1071)

   d. Urging that the United States Congress enact the Medicaid Coordinated Care Improvement Act of 1992 (S. 3191) which would provide states greater discretion in Medicaid program design. (The law would enable Nevada to operate a mandatory Medicaid managed care program without requiring a Federal "freedom of choice" waiver.) (BDR R-1072)

9. Expand the funding of current initiatives to control Medicaid costs by:

   a. Approving the Department of Human Resources' budget request for Nevada's Maternal Obstetrical Management Services (MOMS) program of $364,369 in fiscal year 1994 and $504,968 in fiscal year 1995. (This program provides case management services to Medicaid-eligible, high-risk pregnant women.) (S-1073)

b. Appropriating $2.85 million to the Department of Human Resources to cover the projected increase in caseload of the Rehabilitation by Case Management program. (This program provides case management services primarily to Medicaid recipients with traumatic brain injuries. An additional 50 cases are expected over the biennium--the average case incurs approximately $57,000 per year per client.) (S-1073)

c. Appropriating $380,000 in fiscal year 1994 and $690,000 in fiscal year 1995 to the Department of Human Resources to add staff and expand the services of the Community Home-based Improvement Program. (This program allows Medicaid to finance care for people in homes or community facilities who would otherwise be institutionalized.) (S-1073)

10. Streamline the Medicaid eligibility process by:

a. Requiring Nevada Medicaid to institute presumptive eligibility for pregnant women. (This option allows pregnant women to gain access to prenatal care more quickly than if they were required to follow the regular application time line to apply for full Medicaid coverage.) (BDR 38-1074)

b. Encouraging Nevada Medicaid to shorten its application form. (BDR R-1075)

c. Requiring Nevada Medicaid to make a Spanish version of the application form available to applicants. (BDR R-1075)

11. Require that the Department of Human Resources investigate the possible use of "intergovernmental transfers" to secure Federal Medicaid matching funds and report its findings to the relevant committees of the Legislature or to the Interim Finance Committee by October 1, 1993. (BDR R-1076)

12. Require the Department of Human Resources to:

a. Amend its Federal Medicaid plan to include coverage for the full cost of kidney transplants. (Currently Medicaid does not cover the cost of acquiring the organ.)

b. Reimburse transplant patients for the cost of anti-rejection medication for life.

c. Require the consideration of Medicaid coverage for transplants of organs, other than kidneys, on a case-by-case basis. (BDR 38-1077)

13. Urge Congress to allow physicians a 5-day grace period for evaluating hospital patients without risking the loss of Medicaid reimbursement. (Generally, a physician must evaluate a patient every 30 days to continue coverage by some government programs, regardless of when the 30th day falls in the week. The recommendation proposes that if a physician is working in the hospital on the 25th or 35th day, he/she should be allowed to evaluate patients at that time without the risk of losing reimbursement.) (BDR R-1078)

## HEALTH CARE COST CONTAINMENT

14. Establish an independent commission to plan, develop and enforce global budgeting for all hospitals, nursing homes, home health, hospice and related agencies. Grant the commission the authority to negotiate with representatives of each of the healing professions to establish fees or other methods of payment as guidelines for providers and consumers. (BDR 40-1079)

15. Prohibit physicians from referring patients to health care facilities in which the physician has a direct financial interest. This prohibition, upon application to the Department of Insurance, could be waived in instances where facilities and resources are limited, such as in small, rural or underserved communities. (BDR 40-1080)

16. Require the Department of Human Resources to develop a uniform electronic billing mechanism and mandate its use by all health care providers in the State. Require the Department of Insurance to develop a uniform electronic billing mechanism and mandate its use by all insurers doing business in the State. (BDR 40-1081)

17. Require the Department of Human Resources to establish guidelines to standardize medical practice using agreed upon criteria in order that medical procedures found to be unnecessary or inappropriate are eliminated. Mandate DHR to involve health care professionals in the development of the practice guidelines. (BDR 40-1082)

## COMMUNITY HEALTH

18. Establish a 5 percent service tax, administered by the Department of Human Resources, on the net revenue of all health care providers. Allow deductions to reduce the tax to as low as 2 percent for those providers who accept their share of Medicaid and other low-paying patients. Further require that an account be established within the State General Fund for these revenues to be used to:

    a. Expand the number of clients in the Community Home-based Improvement Program (CHIP) which supports frail elderly in their homes rather than transferring them to nursing homes. Such a tax would allow the State to offset the cost of Federal mandates in the Medicaid program.

    b. Require the Department of Human Resources to develop community health centers to increase the role of prevention through early diagnosis and treatment.

    c. Encourage the education and practice of certain health care professions in the State by requiring the University of Nevada System to administer a fund offering scholarships and loan-forgiveness for:

        1. Physicians' assistants and nurse practitioners; and

        2. Primary-care physicians practicing in underserved areas of Nevada.

    This program is to be based on relevant components of Minnesota's recently adopted "HealthRight Law". (BDR 40-1083)

19. Encourage Nevada employers to implement employee wellness programs that provide accurate information to assist individuals in making healthy choices throughout their life spans. (BDR R-1084)

20. Appropriate $125,000 to the Department of Human Resources (DHR) to develop and administer a grant program for organizations which provide prenatal care to low-income women. No more than $20,000 may be used by DHR to administer the grant program. (BDR S-1085)

## CHILD HEALTH

21. Require the Department of Human Resources and Department of Education and appropriate $_____ to provide school health services, primarily through school-based centers. Programs should be designed to enable parents to choose which services they would allow their children to use. (BDR S-1086)

22. Require that physical education classes be incorporated into school curricula on a daily basis in kindergarten and grades 1-12. (BDR 34-1087)

## ORGAN TRANSPLANTATION

23. Increase public awareness regarding organ donation by:

    a. Urging the State Board of Education to include information regarding organ donation and transplantation in the health curriculum of high school students;

    b. Declaring an annual Organ Donation Day in Nevada to encourage Nevadans to determine their preferences regarding organ donation and make them known to family members. (BDR R-1088)

24. Require physicians and families to honor the permission granted by an organ donor card. (BDR 40-1089)

## MISCELLANEOUS RECOMMENDATIONS

25. Require the Department of Human Resources (DHR) to organize an annual health-related quality improvement conference to bring national health care experts, patients, quality improvement coordinators, scientists, and health care workers together to share information. The costs of the conference should be borne by registration fees paid by conference participants. Appropriate $10,000 to the DHR for the publication and distribution of an annual monograph of Nevada's health care quality agenda, including, but not limited to, relevant papers from the conference. (BDR 40-1090)

26. Require the Department of Human Resources (DHR) to eliminate efforts to collect information which may duplicate UB-82 data. Require DHR to configure the

State's health database to track individuals from birth to death, and report outcome information through an identifier, such as a Social Security number, if one is available. (Recent DHR regulations permit gathering this type of information, but only the last six digits of Social Security numbers are used to protect the confidentiality of patients.) Require DHR to coordinate birth and death records with the UB-82 data. Authorize DHR to utilize the UB-82 form to collect information in addition to that required by the Federal Government. (BDR 40-1091)

27. Require the Legislative Counsel Bureau to regularly publish and distribute information regarding all proposed and adopted changes to the *Nevada Administrative Code*. Use a format similar to that in the *Federal Register*. (BDR 18-1092)

# NEVADA'S LEGISLATIVE COMMITTEE ON HEALTH CARE

## I. INTRODUCTION

In compliance with *Nevada Revised Statutes* 439B.200 through 439B.240, the Legislative Committee on Health Care oversees the effects of legislation on the health care industry and monitors health care activities in Nevada.

Members of the committee during the 1991-92 interim period were:

Assemblyman Morse Arberry, Jr., Chairman
Senator Joseph M. Neal, Jr., Vice Chairman
Senator Raymond D. Rawson
Senator R. Hal Smith (appointed following resignation of Senator Randolph J. Townsend)
Assemblywoman Vivian L. Freeman
Assemblyman James A. Gibbons

Legislative Counsel Bureau staff services were provided by:

Caren Jenkins, Senior Research Analyst (principal staff)
Kerry Carroll, Senior Research Analyst
Lorne Malkiewich, Legislative Counsel
Leigh C. O'Neill, Deputy Legislative Counsel
Ellen R. Nelson, Senior Research Secretary

The six-member committee held nine meetings between November 1991 and October 1992 in Carson City, Reno and Las Vegas. Individual committee members coordinated presentations which directed the testimony and subsequent recommendations toward certain topics, including health promotion and wellness, access to health care, quality of care, cost containment and Medicaid.

At its final work session of the 1991-1992 interim period, the committee adopted 27 recommendations regarding health insurance, Medicaid, health care cost containment, community health, child health and organ transplantation. Detailed descriptions of these recommendations and discussion of the testimony presented to the committee are provided in this report.

## II. REVIEW OF COMMITTEE STATUTORY FUNCTIONS

The following sections of law regulate the Legislative Committee on Health Care:

- *Nevada Revised Statutes* 439B.200 through 439B.240 (see Appendix A) outline the role and operations of Nevada's Legislative Committee on Health Care;

- *Nevada Revised Statutes* 449.465 provides for the financial support of the committee;

- *Nevada Revised Statutes* 439A.105 directs Nevada's Department of Human Resources (DHR) to report to the committee about the effects of legislation on the costs of health care; and

- The Reviser's Note for *Nevada Revised Statutes* 449.037, "Standards for licensing; regulations," mentions that the Nevada Rural Hospital Project shall report regularly to the committee.

Three measures passed by the 1991 Nevada Legislature added certain responsibilities to the committee:

- *Nevada Revised Statutes* 439B.225, added in 1991 by Assembly Bill 469 (Chapter 358, *Statutes of Nevada 1991*), requires the committee to review regulations relating to licensing certain practitioners of health care;

- *Nevada Revised Statutes* 426A.060, added by Assembly Bill 201 (Chapter 385, *Statutes of Nevada 1991*), creates an advisory committee on traumatic brain injuries and directs it to report to the committee; and

- Senate Bill 503 (Chapter 648, *Statutes of Nevada 1991*) directs the Board of Regents of the University of Nevada System to conduct a study of persons in the State who are not covered by health insurance and report its findings to the committee by October 1, 1992.

## III. COMMITTEE BACKGROUND AND HISTORY

The 1985 Nevada Legislature directed the Legislative Commission to explore ways of restraining the costs of health care in Nevada while ensuring a high quality of services. Various recommendations of that interim study

became part of Assembly Bill 289 (Chapter 377, *Statutes of Nevada 1987*), Nevada's first major effort in health care cost-containment legislation. One component of A.B. 289 was the formation of a statutory legislative oversight committee. The committee was charged with supervising the effects of legislation on the health care industry and monitoring health care activities in Nevada.

The Legislative Committee on Health Care's first study period was busy with proposals affecting the health care industry, industry regulators, and public health agencies. Although the original provisions of A.B. 289 provided a primary focus, the committee also made recommendations concerning the State's health care data collection system, health maintenance organizations, medical-legal screening panels, various programs for the elderly, and several public health concerns, including acquired immunodeficiency syndrome (AIDS).

The second interim period, following the 1989 Legislative Session, brought further study of Nevada's health care systems. Proposals were made to "fine-tune" certain provisions of A.B. 289. Additionally, the committee recommended modifications to the laws regarding DHR, health care professionals, health insurance, health planning, Medicaid, welfare, State social services, and the regulation of rural hospitals.

In 1991, Assembly Bill 577 (Chapter 706, *Statutes of Nevada 1991*) made numerous changes to the State's health care environment. Among other things, this legislation increased the Federal matching money for Medicaid; continued and renewed certain provisions of A.B. 289; and created a Commission for Hospital Patients, wellness programs in hospitals and a nursing foundation.

This report follows the committee's sixth year. Ironically, despite significant legislative changes and reforms to the health care industry in the Nation and the State, many of the issues and concerns originally addressed in 1985 remain.

The shift of responsibility from the Federal Government to State and local governments for many health care programs continues. Although this shift provides the states with more control, it also demands that state governments expand their participation in, and financing of, numerous aspects of the health care field. This document outlines the committee's recommendations for responses to new and continuing demands.

## IV. DISCUSSION OF TESTIMONY AND RECOMMENDATIONS

At the start of the interim period, the chairman noted that the people of this State face many health care challenges such as access, insurance, quality, and costs. The chairman emphasized the committee's responsibility to cooperate with interest groups, hospitals, providers, insurers and communities in developing ways to address Nevada's health care problems. He asked committee members to approach their duties with the same spirit of cooperation.

In addition to fulfilling its statutory duties, the committee agreed to address the following issues during the 1991-1992 study period:

- Health care cost containment;
- Quality of health care and outcomes;
- Disease prevention, health promotion and wellness;
- Medicaid funding and services; and
- Affordable access to health care.

One of these topics was highlighted at each public meeting. Guest speakers from California, Oregon, Colorado, and Washington, D.C., as well as Nevada, appeared before the committee. Following are brief summaries of the testimony presented. Additional details and background materials may be found in the committee's minutes which are available at the Research Library of the Legislative Counsel Bureau.

### A. REGULATIONS REVIEW

From time to time, confusion over legislative intent has hampered the development and enforcement of administrative regulations. *Nevada Revised Statutes* 439B.225 specifies that the committee must review and notify the agency of its opinion of each proposed or adopted regulation which relates to the licensure of certain health professionals. The review process is intended to facilitate communication between the Legislature and relevant agencies.

The committee reviewed 23 regulations during the course of the interim. In that time, concern was expressed about the public distribution of regulations subject to review. Testimony before the committee indicated that the public is often given inadequate notification of hearings and insufficient time to review the proposed regulations prior to the committee hearings. The same situation appears to be associated with the review of regulations as performed by the Legislature's Committee on Industrial Insurance (Senate Bill 7, Chapter 723, *Statutes of Nevada 1991*).

Because this broad concern was also expressed in relation to hearings of Executive agencies, the committee recommends that the 67th Session of the Nevada Legislature:

> **Require the Legislative Counsel Bureau to publish and distribute information regularly regarding all proposed and adopted changes to the *Nevada Administrative Code*. Use a format similar to that in the *Federal Register*.** (BDR No. 18-1092)

B. WELLNESS AND HEALTH EDUCATION

According to the State Health Officer, an estimated 62.1 percent of Nevada hospitals' billed charges in 1990 could be directly attributed to lifestyle choices including obesity, smoking, chewing tobacco, alcohol, diet, stress, and suicide. Medical procedures related to these lifestyle choices translate into 51,514 hospital discharges costing over $827 million.

**1990 EFFECTS OF LIFESTYLE CHOICES IN NEVADA**

| Condition | Hospital Discharges | Billed Charges |
|---|---|---|
| Obesity | 3,404 | $ 40,716,851 |
| Smoking | 33,305 | 623,604,737 |
| Chewing Tobacco | 168 | 2,840,234 |
| Alcohol | 6,833 | 78,716,157 |
| Diet/Stress | 7,440 | 79,582,354 |
| Suicide/Self-Inflicted Injury | 364 | 2,057,910 |
| Total | 51,514 | $827,518,243 |

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

Employee Wellness

The committee was informed that one of the least costly approaches to health promotion in the workplace is educating employees about health and fitness issues through newsletters, brochures, posters, and so on. A difficulty with

this approach is the inability to document its effect on an individual's lifestyle. Establishment of physical facilities may be costly, but more comprehensive wellness programs are likely to offer tangible effects by providing opportunities for employee health awareness, education, assessment and training.

Tangible benefits of employee wellness programs were expressed to the committee through the description of a local government program. The City of Florence, South Carolina, implemented a "total wellness program" for city employees in 1983. As early as 1987:

- Unexcused absences were reduced by 66 percent;
- Terminations due to excessive absenteeism decreased by 90 percent; and
- Employees filed 72 percent fewer medical claims.

Testimony indicated that participation in employee wellness programs improves overall health and reduces the risk of premature disability or death. Participants in such activities claim to feel healthy and have better self-images, more energy and positive attitudes. Changing lifestyles, exercise and prevention patterns may help to reduce health care spending.

Therefore, the committee recommends that the Nevada Legislature:

> **Encourage Nevada employers to implement employee wellness programs that provide accurate information to assist individuals in making healthy choices throughout their life spans.** (BDR No. R-1084)

Child Fitness

Another aspect of wellness which concerned the members was child fitness. Testimony noted that children with long-term health problems may account for increased health care costs nationwide. Early prevention, diagnosis and treatment can decrease the probability of many illnesses and reduce lifetime medical costs.

The President's Council for Physical Fitness and Sports (PCPFS) was created in 1956 to foster youth fitness in the

United States. According to a PCPFS representative, many children in the U.S. have unhealthy lifestyles. For example:

- Approximately 40 percent of children between 5 and 8 years old already show signs of cardiac risk factors such as obesity, elevated blood pressure, high cholesterol and physical inactivity.

- For boys between the ages of 6 and 12 years, 33 percent cannot run a mile in less than 10 minutes, and 25 percent cannot do one pull-up.

- Of girls between the ages of 6 and 17 years, 50 percent cannot run a mile in less than 10 minutes, and 55 percent cannot do one pull-up.

The PCPFS sponsors an annual national school fitness competition. In 1991, 139 schools from various states were honored as champions. Three Nevada schools were recognized: Pioche Elementary in Pioche; and St. Viator Catholic School and Tomiyasu Elementary School, both in Las Vegas.

The committee heard testimony that adding daily physical education to school curricula is necessary throughout the Nation. Instilling healthy lifestyle habits in youth may decrease overall health care costs.

As a result, the committee recommends that the 67th Session of the Nevada Legislature:

> **Require that physical education classes be incorporated into school curricula on a daily basis in kindergarten and grades 1-12.** (BDR No. 34-1087)

School Health Care

According to testimony from the Technical Advisory Committee (TAC) to the Board of Regents' Study of Persons Not Covered by Health Insurance (Senate Bill 503, Chapter 648, *Statutes of Nevada 1991*), over 66,500 children in Nevada do not have health insurance. Gaining access to health care for these children is difficult and expensive. Generally, uninsured children receive emergency room attention for conditions which could have been mitigated or even prevented with proper immunizations, well-child care, and early diagnosis and treatment of illness.

The committee became interested in an innovative program in Memphis, Tennessee, which promotes early health care

intervention for students in the classroom. Doctors rotate between schools on a monthly basis, providing free preventive care.

Additionally, the concept of school-based centers was discussed. One example of this type of program is a 5-year project in Los Angeles, California. School-based health services are being funded by the Robert Wood Johnson Foundation, other similar foundations, and in-kind contributions from the school systems. The Los Angeles Unified School Board created a task force to consider realigning city/county funds and avoiding a duplication of efforts in the provision of health services to the schools.

The establishment of school-based clinics needs to be a community endeavor, involving both the private and public sectors, with details of the operation determined by the needs of each community.

Therefore, it is recommended that the Nevada Legislature:

> **Require the Department of Human Resources and Department of Education and appropriate $_____ to provide school health services, primarily through school-based centers. Programs should be designed to enable parents to choose which services they would allow their children to use.** (BDR No. S-1086)

(PLEASE NOTE: Certain recommendations contained in this document lack fiscal information. Prior to their final consideration during the legislative process, a dollar amount will be specified. The committee did not estimate costs due to the general nature of the recommendations.)

Organ Donation and Transplantation

The United Network of Organ Sharing (UNOS) is a private organization under contract with the Federal Government to distribute organs equitably throughout the Country and promote organ donation and transplantation. Testimony explained that local transplant centers are given the first opportunity to use organs donated to the procurement agency within a region. Individuals waiting for available organs are segregated and ranked based on their blood and tissue types and length of time on the waiting list. In effect, the list is "blind" to the transplant facility which the patient has chosen, the patient's age, medical condition, race and sex. When an organ becomes available, it is

assigned to the next patient on the UNOS list. The system is accepted as being equitable by physicians and patients alike.

Because the supply of organs does not meet the demand, the death rate for people on the waiting lists is approximately 44 percent. In 1990, 2,200 persons in the U.S. died waiting for organs -- one-third for a heart and one-quarter for a liver. Based on Nevada's population, the following organ donations will be needed in the coming year: 67 to 164 hearts, 30 to 59 livers, 19 heart/lung combinations, 72 kidneys, and 17 pancreata.

Therefore, the committee agreed to recommend that the Nevada Legislature:

**Increase public awareness regarding organ donation by:**

a. **Urging the State Board of Education to include information regarding organ donation and transplantation in the health curriculum of high school students;**

b. **Declaring an annual Organ Donation Day in Nevada to encourage Nevadans to determine their preferences regarding organ donation and make them known to family members.** (BDR No. R-1088)

The committee heard testimony that, at or near the time of death, family members are often unaware of the individual's wishes regarding organ donation. If the family decides not to donate, physicians have been reluctant to honor a previously expressed wish or follow the direction of a legally executed organ donor card.

Thus, the committee recommends that the 67th Nevada Legislature take action to:

**Require physicians and families to honor the permission granted by an organ donor card.** (BDR No. 40-1089)

In addition, public health care programs currently cover only part of the costs of organ transplantation. The committee recommends that certain modifications be made to the existing Medicaid coverage:

**Require the Department of Human Resources to:**

a. **Amend its Federal Medicaid plan to include coverage for the full cost of kidney transplants;**

**(Currently Medicaid does not cover the cost of acquiring the organ.)**

**b. Reimburse transplant patients for the cost of anti-rejection medication for life; and**

**c. Require the consideration of Medicaid coverage for transplants of organs, other than kidneys, on a case-by-case basis.** (BDR No. 38-1077)

C. ACCESS TO HEALTH INSURANCE

One of the main barriers to health care in the U.S. is cost. As a result, access to health insurance has consistently been a major topic of consideration for the committee. The committee found that barriers to health insurance include current or previous medical conditions, employment status, financial ability to pay premiums, and so on.

According to the TAC report, the total number of Nevadans covered by health insurance is 1,082,514 or 80.6 percent. The total number of uninsured persons is 261,042 or 19.4 percent. Of this amount, 194,279 are adults and 66,763 are children.

An uninsured Nevadan most likely fits the following profile:

- Resides in metropolitan southern Nevada;
- Is Hispanic or Black;
- Has a household income of less than $10,000;
- Has a lower educational level than the average Nevadan; and
- Is between 19 and 24 years of age.

The study found that only 33 percent of the uninsured are unemployed; 50 percent have permanent jobs. A majority of the respondents stated that health insurance is the most important employee benefit that employers can provide.

The committee agreed that offering access to health care for all Nevadans is of utmost importance, and that certain insurance reforms are necessary.

Employer-Provided Health Insurance

Primarily due to the difficulties experienced by small employers, the National Association of Insurance Commissioners has drafted a model act proposing certain health insurance reforms. For example, in the model act, access may not be denied to any employer, employee or dependent;

very strict medical underwriting standards apply; pre-existing conditions may not be reimposed if an employee changes jobs or the employer changes insurers; and continuity and portability of coverage are assured. Restrictions are placed on cancellations, nonrenewals, disclosure to the purchasers of the rating structure, and the renewal rating factors used.

The committee heard testimony which offered Oregon's experience as an example of the potential for certain reforms in Nevada. In 1991, Oregon made changes to the small group insurance market which apply to employee groups of three through 25. All businesses applying for coverage must be allowed to purchase insurance. The system has a modified community rating structure, and limits are placed on the variation between premiums charged to different employer groups. The exclusion period for preexisting conditions may be no more than 6 months, and pregnancy may not be considered a preexisting condition. Policies are guaranteed to be renewable, and rate increases are limited. All small group carriers must offer a standard benefit package defined by the state.

To respond to the need for change in Nevada, the committee recommends that the Nevada Legislature:

**Implement health insurance reform by:**

**a. Creating a reinsurance pool within the Department of Insurance to assist with costs associated with high-risk cases;**

**(Utilize the National Association of Insurance Commissioners' model act for developing a State reinsurance pool.)**

**b. Requiring that all small employer premium rates, other than those set by the Small Employer Insurance Purchasing Pool, be established by such factors as health status, occupation, and claims experience of employees in similar firms.** (BDR No. 57-1066)

The committee found that another challenge in obtaining health insurance relates to small employers' access to affordable plans. The 1991 Legislature authorized insurers to offer less expensive policies to qualified small businesses. Chapter 689C of NRS, "Health Insurance For Small Employers," enables small employers to purchase catastrophic coverage without certain health care benefits mandated by

Nevada law. Although two insurance carriers have been authorized to offer these plans in Nevada, few policies have been sold. As a result, the committee was told that meaningful information about the impact of these policies would not be available within the time period outlined in statute.

Therefore, the committee recommends that the 67th Nevada Legislature:

**Extend the evaluation deadlines of the small employer health insurance plans specified in Senate Bill 503 (Chapter 648, *Statutes of Nevada 1991*, pages 2152-2155) from 1993 to 1995, and 1995 to 1997.** (BDR No. S-1067)

Affordable access to employee health insurance for small employers also may be facilitated by sharing risk. The committee recommends that the Legislature:

**Establish within the Department of Insurance a small employer insurance purchasing pool (for firms with less than 26 employees) which would:**

a. **Require participating insurers to utilize statewide "community rating";**

b. **Require that preexisting condition provisions do not exclude coverage for a period beyond 6 months;**

c. **Eliminate multiple waiting periods for pre-existing conditions;**

   **(In the event of a change in employer, the employee must not be required to satisfy another waiting period for the same condition.)**

d. **Apply employee participation and employer contribution requirements uniformly among all employer groups;**

e. **Allow employers to credit an amount equal to $25 per eligible employee per quarter on the employer's business activities tax as specified in *Nevada Revised Statutes* 364A as an incentive to draw small employers into a health care purchasing pool; and**

f. **Guarantee that every participating firm will be able to get its health insurance policy renewed.** (BDR No. 57-1064)

Although the next recommendation overlaps the provisions of subsection e. above, the committee expressed a desire to encourage a lively discussion regarding such tax credits and chose to recommend both ideas.

> **Allow employers who provide basic health insurance coverage to employees and pay at least 50 percent of each employee's premium to have a dollar-for-dollar deduction against the business activities tax specified in *Nevada Revised Statutes* 364A to a maximum of $75 per employee per quarter.**
> (BDR No. 32-1065)

Medically Uninsurable Persons

In 1987, a U.S. Department of Health and Human Services study indicated that 2.5 percent of the Nation's population was prevented from obtaining health insurance coverage by a medical problem. The TAC's 1991 survey found that 2 percent to 3.5 percent of Nevada's uninsured had been rejected by an insurance company due to health reasons in the previous year.

To address the problem, 25 states either operate high-risk insurance pools for medically uninsurable persons or have passed legislation authorizing the creation of such pools. Insurance companies in 11 other states are required to provide open enrollment periods for high-risk individuals.

Once again, Oregon may provide an example for Nevada legislators. In Oregon, approximately 2,000 individuals are enrolled in a high-risk pool for medically uninsurable persons. The pool initially was funded with seed money from the Oregon General Fund, premiums from beneficiaries and assessments on the insurers and reinsurers in the state. General fund money no longer was added to the pool after the second year of operation.

Although over 20,000 Oregonians are presumed to be eligible to participate, only 2,000 persons are presently enrolled. Any person who either has been denied or quoted excessive rates by two or more insurance companies qualifies for the high-risk pool. A certain number of slots are opened each month in order to maintain fiscal control. In the 12 months ending May 1992, at any given time, between 50 and 80 people were waiting for an opening on the list. Usually, applicants are accepted as soon as new slots become available. No sliding scale is provided on premiums or deductibles for

low-income people, and deductibles are comparable to standard insurance policies. These financial requirements may be among the reasons that only 2,000 people are enrolled and the waiting list is short.

High-risk pools can be costly. In Illinois, such a pool has been in operation for approximately 5 years and covers 5,000 people. In that time, it has expended between $5 million and $15 million. Within the last 2 years, due to escalating costs, Illinois implemented a managed care approach to the program.

Currently, no high-risk pool nor insurance company with an open enrollment period for the medically uninsurable exists in Nevada. Although such pools have been developed using a variety of approaches, the committee focused its recommendation on requiring all health insurers to organize as an association and remain members as a condition of their doing business within Nevada. The association would offer health insurance to eligible individuals and charge a premium not to exceed a certain percentage of the standard individual premium, based on age and sex of the insured. Association members would share the expenses not covered by the premium revenue through assessments apportioned to their share of total health insurance premiums received within the State. Testimony indicated that high-risk pools in 16 states use a similar method.

The committee recommends that the 67th Nevada Legislature:

> **Establish a high-risk insurance pool within the Department of Insurance for people denied health insurance due to medical conditions. Require all insurance companies doing business in the State to participate by accepting eligible high-risk patients based on their share of the insurance market in Nevada. Limit premiums to 150 percent of the premium charged to insure a healthy individual.** (BDR No. 57-1068)

D. ACCESS TO CARE FOR INDIGENT PERSONS

As noted earlier, the committee concluded that access to health care is important, and a major obstacle is cost. Most indigent persons are provided access to care through the government-administered Medicaid program. While Medicaid covers many Nevadans, restrictions imposed by the Federal Government, coupled with the financial limits of the State, leave a significant number of Nevadans without coverage.

Medicaid

The committee heard testimony that, in Nevada, from 1986 to 1991, the Medicaid caseload grew faster than the State's population. A 31 percent rise in Nevada's population was shadowed by a 79 percent increase in the number of Medicaid recipients. In the same time period, overall Medicaid expenditures grew from $79 million to over $178 million (125 percent).

The committee expressed an interest in ensuring that the greatest number of eligible persons have access to this important program. To accomplish this goal, it was determined that the State should implement measures to control costs, ensure an adequate supply of providers, facilitate the Medicaid application process, and take other similar actions.

- Require that the Department of Human Resources investigate the possible use of "intergovernmental transfers" to secure Federal Medicaid matching funds and report its findings to the relevant committees of the Legislature or to the Interim Finance Committee by October 1, 1993. (BDR No. R-1076)

- Require all health care professionals licensed in Nevada to accept a minimum number of Medicaid and other low-income patients as a condition of establishing or maintaining licensure. (BDR No. 40-1070)

- Urge Congress to allow physicians a 5-day grace period for evaluating hospital patients without risking the loss of Medicaid reimbursement.

  (Generally, a physician must evaluate a patient every 30 days to continue coverage by some government programs, regardless of when the 30th day falls in the week. The recommendation proposes that if a physician is working in the hospital on the 25th or 35th day, he/she should be allowed to evaluate patients at that time without the risk of losing reimbursement.) (BDR No. R-1078)

- Establish a 5 percent service tax, administered by the Department of Human Resources, on the net revenue of all health care providers. Allow deductions to reduce the tax to as low as 2 percent for those providers who accept their share of Medicaid and other low-paying patients. Further require that an account be established within the State General Fund for these revenues to be used to:

a. Expand the number of clients in the Community Home-based Improvement Program (CHIP) which supports frail elderly in their homes rather than transferring them to nursing homes. Such a tax would allow the State to offset the cost of Federal mandates in the Medicaid program.

b. Require the Department of Human Resources to develop community health centers to increase the role of prevention through early diagnosis and treatment.

c. Encourage the education and practice of certain health care professions in the State by requiring the University of Nevada System to administer a fund offering scholarships and loan-forgiveness for:

   1. Physicians' assistants and nurse practitioners; and

   2. Primary-care physicians practicing in under-served areas of Nevada.

This program is to be based on relevant components of Minnesota's recently adopted "HealthRight Law." (BDR No. 40-1083)

Managed Care in Medicaid

The U.S. Health Care Financing Administration (HCFA) regulates managed care Medicaid programs. Such programs operate under different structures.

Through Nevada Medicaid's managed care program, recipients in Reno and Las Vegas are assigned a primary care physician. However, referrals to other providers are authorized, and 24-hour care for urgent needs is available. This system has not yet been instituted in rural Nevada. The University of Nevada School of Medicine and a private provider offer managed care under contract with Nevada Medicaid.

In the fourth quarter of 1992, based on a comparison method approved by HCFA, Nevada Medicaid's managed care program saved $40 per person, per month, when compared to recipients of traditional fee-for-service care. Recipients over 65 years of age cost Medicaid $81 less per person, per month, than their peers.

In addition, because of current client access problems and the cost-effectiveness of managed care, Medicaid intends to

pursue a mandatory managed care enrollment program. However, before program selection can be made compulsory, states must apply for and receive a Federal wiaver. This process is time-consuming and costly.

Therefore, the committee recommends that the Nevada Legislature:

- **Provide increased support for Nevada Medicaid's managed care program by:**

  a. **Appropriating $214,510 in fiscal year 1994 and $198,573 in fiscal year 1995 to the Department of Human Resources to increase relevant staffing levels;**

  b. **Appropriating $____ to expand the University of Nevada System's health care clinics;**

  c. **Requiring the Department of Human Resources to apply to the U.S. Health Care Financing Administration for a "freedom of choice" waiver for Nevada Medicaid's managed care program;**

     **(In general, this Federal waiver would allow Nevada to operate a statewide, mandatory Medicaid managed care program.)**

  d. **Urging that the United States Congress enact the Medicaid Coordinated Care Improvement Act of 1992 (S. 3191) which would provide states greater discretion in Medicaid program design.**
     (BDR No. R-1072)

     **(The law would enable Nevada to operate a mandatory Medicaid managed care program without requiring a Federal "freedom of choice" waiver.)**

- **Expand the funding of current initiatives to control Medicaid costs by:**

  a. **Approving the Department of Human Resources' budget request for Nevada's Maternal Obstetrical Management Services (MOMS) program of $364,369 in fiscal year 1994 and $504,968 in fiscal year 1995;**

     **(This program provides case management services to Medicaid-eligible, high-risk pregnant women.)**

b. **Appropriating $2.85 million to the Department of Human Resources to cover the projected increase in caseload of the Rehabilitation by Case Management program.**

**(This program provides case management services primarily to Medicaid recipients with traumatic brain injuries. An additional 50 cases are expected over the biennium--the average case incurs approximately $57,000 per year per client.)**

c. **Appropriating $380,000 in fiscal year 1994 and $690,000 in fiscal year 1995 to the Department of Human Resources to add staff and expand the services of the Community Home-based Improvement Program (CHIP).**

**(This program allows Medicaid to finance care for people in homes or community facilities who would otherwise be institutionalized.)** (BDR No. S-1073)

Prenatal Care

According to testimony, pregnant women who do not receive prenatal care are three times more likely to deliver babies who require stays in the neonatal intensive care unit (NICU) at a cost of approximately $1,600 per day. It is estimated that, for every $1 spent on prenatal care, $4 to $7 of actual costs for infant care are saved. In addition, the cost of medical care over an individual's lifetime is significantly higher for those who required NICU services at birth. Regardless, early prenatal care can prevent the need for expensive medical care following birth -- both for the parents and to the taxpayers. For example, Nevada Medicaid paid over $625,000 in 1991 for medical care of a now deceased 5-year-old who was born prematurely and whose mother received no early prenatal care.

The committee heard testimony that one way to improve access to prenatal care for indigent pregnant women is the concept of presumptive eligibility. Presumptive eligibility means that most low-income pregnant women are presumed to be eligible for Medicaid and should receive needed medical treatment immediately. This process eliminates the 30- to 90-day wait for approval and encourages women to seek care earlier in their pregnancies. If later determined to be ineligible, the patient would need to seek help elsewhere. This concept has been among the recommendations of the committee many times.

Testimony also revealed that among the barriers to early prenatal care for low-income women are: (1) the length and complexity of the Medicaid application form, and (2) the difficulty of the application process for persons who do not read or speak the English language.

In response to this information, the committee recommends that the Nevada Legislature:

> **Appropriate $125,000 to the Department of Human Resources (DHR) to develop and administer a grant program for organizations which provide prenatal care to low-income women. No more than $20,000 may be used by DHR to administer the grant program.** (BDR No. R-1076)

In addition,

> **Streamline the Medicaid eligibility process by:**
>
> a. **Requiring Nevada Medicaid to institute presumptive eligibility for pregnant women;** (BDR No. 38-1074)
>
> b. **Encouraging Nevada Medicaid to shorten its application form;** (BDR No. R-1075)
>
> c. **Requiring Nevada Medicaid to make a Spanish version of the application form available to applicants.** (BDR No. R-1075)

E. HEALTH CARE COST CONTAINMENT

Cost-Containment Commission

Testimony indicated that increasing hospital costs continue to be a problem despite the Nevada Legislature's regulatory efforts such as requiring financial reports and imposing price freezes. Citizens continue to complain about high hospital costs, and despite recent reform legislation, Nevada's rank among the states has not improved in this regard.

The committee received testimony comparing actual cost versus billed charges for various items used in hospitals. A consensus was reached that health care regulators need to consider the consumer's viewpoint.

The committee recommends that the Legislature:

> **Establish a commission to plan, develop and implement global budgeting for all hospitals, nursing homes, home**

**health, hospice and related agencies. Grant the commission the authority to negotiate with representatives of each of the healing professions to establish fees or other methods of payment as guidelines for providers and consumers.** (BDR No. 40-1079)

Physician Self-Referral

The committee heard testimony that Florida conducted an extensive study of joint ventures and reviewed outpatient testing clinics which were owned wholly or partly by physicians. The *New York Times* reported that the Executive Director of the Florida Health Care Cost Containment Board found the figures from the Florida study very disturbing, noting that "joint ventures perform more tests per patient, have higher charges, and provide a lower quality of services."

Testimony to the committee indicated that permitting a medical provider to refer a patient to a facility or service in which the provider has a financial interest tends to increase the number of medical procedures utilized and, thus, the cost of care.

Current Nevada law requires that physicians disclose to patients any financial interest in facilities to which patients are being referred, but does not prohibit such referrals. Accordingly, the committee recommends that the Nevada Legislature:

**Prohibit physicians from referring patients to health care facilities in which the physician has a direct financial interest. This prohibition, upon application to the Department of Insurance, could be waived in instances where facilities and resources are limited, such as in small, rural or underserved communities.** (BDR No. 40-1080)

Administrative Procedures and Costs

A portion of health care costs is attributable to the administration of care and insurance, according to testimony. If the administrative burden were reduced, it is likely that costs would decrease. In addition, the increasing number of forms, bills and other paperwork related to a health care experience are confusing to the patient. Finally, no mechanism exists which allows regulators to identify and monitor procedural or insurance abuses.

Therefore, the committee recommends the 67th Session of the Nevada Legislature:

> **Require the Department of Human Resources to develop a uniform electronic billing mechanism and mandate its use by all health care providers in the State. Require the Department of Insurance to develop a uniform electronic billing mechanism and mandate its use by all insurers doing business in the State.**
> (BDR No. 40-1081)

F. QUALITY AND LIABILITY

Quality of Health Provision

While the committee found that access to care is important to all Nevadans, they also agreed that the quality of that care is likewise important. Health care professionals need to be involved in developing guidelines and determining acceptable criteria for clinical performance. The creation and use of these quality criteria could be encouraged by the Nevada Legislature, not by mandate but through facilitation of the development of such standards.

The committee envisioned:

- An assessment of existing data regarding the quality of treatment;
- Consideration of patient satisfaction, appropriateness of care, cost and access;
- Monitoring and evaluation of related changes and trends; and
- Gathering health care providers and consumers to discuss the quality of care in Nevada.

One member of the committee emphasized that Nevada can hasten a national solution to the quality of care challenge. Health care reforms can be accomplished in Nevada which larger states would find more difficult and expensive to implement. With the data collected, norms can be established for this region of the U.S. which may assist in determining the quality of care to be incorporated into the national solution.

The committee recommends that the Nevada Legislature:

> **Require the Department of Human Resources to organize an annual health-related quality improvement conference to bring national health care experts, patients, quality improvement coordinators, scientists, and health care workers together to share information. The costs of the conference should be borne by registration fees paid by conference participants. Appropriate $10,000 to the DHR for the publication and distribution of an annual monograph of Nevada's health care quality agenda, including, but not limited to, relevant papers from the conference.** (BDR No. 40-1090)

An overwhelming volume of information regarding health care in Nevada is gathered and produced by various agencies, including Nevada's Bureau of Health Planning, State Industrial Insurance System, State Board of Health, and University of Nevada School of Medicine. The committee agreed that it might be more effective for the State to bring its health-related databases together to avoid duplication of effort.

According to testimony, the "Uniform Billing - 1982" form, more commonly known as the UB-82, is used to collect hospital discharge information mandated by the Federal Government in 1982. Specific software and procedures were developed to computerize these data and make them comparable across facilities in Nevada.

The UB-82 form collects a variety of information, including:

- Age and sex of the patient;
- Name of attending physician;
- Codes relevant to diagnoses which are limited to an individual's stay within the hospital;
- The number of days of the stay;
- International Classification of Disease codes;
- Primary payer;
- Service units for various kinds of activities; and
- Unit charges.

The committee was intrigued by the prospect of studying the actual outcome of care -- what happens to a patient, not only from the time of entering a hospital, but following discharge, and in the entire lifetime of the disease or treatment. One concise, centralized record currently is unavailable. If a patient's experience in the health care

system could be tracked in some way, not only questions of quality but also the appropriateness of care and cost-containment issues could be addressed.

The committee recommends that the 67th Session of the Nevada Legislature:

> **Require the Department of Human Resources (DHR) to eliminate efforts to collect information which may duplicate UB-82 data. Require DHR to configure the State's health database to track individuals from birth to death, and report outcome information through an identifier, such as a Social Security number, if one is available. (Recent DHR regulations permit gathering this type of information, but only the last six digits of Social Security numbers are used to protect the confidentiality of patients.) Require DHR to coordinate birth and death records with the UB-82 data. Authorize DHR to utilize the UB-82 form to collect information in addition to that required by the Federal Government.** (BDR No. 40-1091)

Medical Malpractice Liability

Testimony indicated that the costs associated with traditional medical liability resolution contribute substantially to the rise in overall health care costs. Factors such as the price of medical malpractice insurance, the scope of large jury awards and the practice of defensive medicine were cited as adding a significant burden to health care costs in general.

When the cost of malpractice insurance escalates, doctors frequently:

- Limit high-risk services;
- Refuse to staff emergency rooms;
- Withdraw from specialties such as obstetrics;
- Retire early; or
- Move to states with favorable legal climates and lower malpractice insurance premiums.

The primary purpose of Nevada's Medical Legal Screening Panel (MLSP) is to identify frivolous claims of medical malpractice so that the court system is not used as a mechanism for resolving such claims. Also, the MLSP can prompt quicker settlements where malpractice has occurred. The overall objective is to reduce costs, including liability premiums and legal fees associated with defensive medicine practices.

The committee recommends that the Nevada Legislature:

**Amend statutes to reform medical malpractice insurance by:**

**a. Limiting recovery of noneconomic damages to $250,000;**

**b. Prohibiting attorneys from collecting "contingency fees";**

**c. Permitting collateral sources of recovery to be admitted as evidence;**

**d. Requiring the Medical Legal Screening Panel to recommend alternative dispute resolutions such as mediation and arbitration.** (BDR No. 3-1069)

The 1987 Legislature passed measures which required the establishment of quality assurance committees in major hospitals. The committee heard testimony that these committees were perceived to be ineffective. To meet Federal accreditation standards, the 1991 Legislature redefined quality assurance committees.

Further testimony indicated that these groups are hampered by the threat of liability should their proceedings become discoverable by attorneys. The committee expressed a desire to release members of quality assurance committees from the responsibility of setting standards on medical practice. However, it recognized that the input of these individuals in a process led by State Government is of great value.

As a result, the committee recommends that the Nevada Legislature:

**Require the Department of Human Resources to establish guidelines to standardize medical practice using agreed upon criteria in order that medical procedures found to be unnecessary or inappropriate are eliminated. Mandate DHR to involve health care professionals in the development of the practice guidelines.**
(BDR No. 40-1082)

## V. CONCLUSION

This report discusses the major health care topics presented to Nevada's Legislative Committee on Health Care during this interim period. These subjects include important health

care issues that Nevada will face in the near future and, in some cases, in the long-term as well. Many of the issues addressed in this report have been discussed by past Nevada Legislatures and will doubtless be part of future debates. Since legislation governing these topics will affect a wide variety of private and public organizations as well as the State's citizens, it is expected that each issue will undergo intense scrutiny. This report is one part of the legislative effort to review the regulation, financing and operation of Nevada's health care systems. The Nevada Legislature undoubtedly will continue to debate these issues for some time as concerns about the cost, availability and quality of health care for Nevadans will not be easy to resolve.

## VI. APPENDICES

# APPENDIX A

*NEVADA REVISED STATUTES* 439B.200
THROUGH 439B.240

## APPENDIX A

*Nevada Revised Statutes* 439B.200 through 439B.240

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

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

2. No member of the committee may:

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

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

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

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

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

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

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

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

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

(Added to NRS by 1987, 863; A 1989, 1841; 1991, 2333)

**439B.210 Meetings; quorum; compensation.**

1. The members of the committee shall meet throughout each year at the times and places specified by a call of the chairman or a majority of the committee. The director of the legislative counsel bureau or a person he has designated shall act as the nonvoting recording secretary. The committee shall prescribe regulations for its own management and government. Four members of the committee constitute a quorum, and a quorum may exercise all the powers conferred on the committee.

2. Except during a regular or special session of the legislature, members of the committee are entitled to receive the compensation provided for a majority of the members of the legislature during the first 60 days of the preceding regular session for each day or portion of a day during which he attends a meeting of the committee or is otherwise engaged in the business of the committee plus the per diem allowance provided for state officers and employees generally and the travel expenses provided pursuant to NRS 218.2207.

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

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

**439B.220 Powers.**

The committee may:

1. Review and evaluate the quality and effectiveness of programs for the prevention of illness.

2. Review and compare the costs of medical care among communities in Nevada with similar communities in other states.

3. Analyze the overall system of medical care in the state to determine ways to coordinate the providing of services to all members of society, avoid the duplication of services and achieve the most efficient use of all available resources.

4. Examine the business of providing insurance, including the development of cooperation with health maintenance organizations and organizations which restrict the performance of medical services to certain physicians and hospitals, and procedures to contain the costs of these services.

5. Examine hospitals to:

(a) Increase cooperation among hospitals;

(b) Increase the use of regional medical centers; and

(c) Encourage hospitals to use medical procedures which do not require the patient to be admitted to the hospital and to use the resulting extra space in alternative ways.

6. Examine medical malpractice.

7. Examine the system of education to coordinate:

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

(b) The education of those who provide medical care.

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

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

10. Examine the effectiveness of any legislation enacted to accomplish the purpose of restraining the costs of health care while ensuring the quality of services, and its effect on the subjects listed in subsections 1 to 9, inclusive.

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

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

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

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

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

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

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

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

16. Direct the legislative counsel bureau to assist in its research, investigations, review and analysis.
17. Recommend to the legislature as a result of its review any appropriate legislation.
(Added to NRS by 1987, 864)

**439B.225 Committee to review certain regulations proposed or adopted by licensing boards; recommendations to legislature.**

1. As used in this section, "licensing board" means any board empowered to adopt standards for licensing or for the renewal of licenses pursuant to chapter 449, 630, 631, 632, 633, 637B, 639, 640, 641, 641B, 652 or 654 of NRS.
2. The committee shall review each regulation that a licensing board proposes or adopts that relates to standards for licensing or to the renewal of a license issued to a person or facility regulated by the board, giving consideration to:
(a) Any oral or written comment made or submitted to it by members of the public or by persons or facilities affected by the regulation;
(b) The effect of the regulation on the cost of health care in this state;
(c) The effect of the regulation on the number of licensed persons and facilities available to provide services in this state; and
(d) Any other related factor the committee deems appropriate.
3. After reviewing a proposed regulation, the committee shall notify the agency of the opinion of the committee regarding the advisability of adopting or revising the proposed regulation.
4. The committee shall recommend to the legislature as a result of its review of regulations pursuant to this section any appropriate legislation.
(Added to NRS by 1991, 940)

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

1. In conducting the investigations and hearings of the committee:
(a) The secretary of the committee, or in his absence any member of the committee, may administer oaths.

(b) The secretary or chairman of the committee may cause the deposition of witnesses, residing either within or outside of the state, to be taken in the manner prescribed by rule of court for taking depositions in civil actions in the district courts.

(c) The chairman of the committee may issue subpenas to compel the attendance of witnesses and the production of books and papers.

2. If any witness refuses to attend or testify or produce any books and papers as required by the subpena, the chairman of the committee may report to the district court by petition, setting forth that:

(a) Due notice has been given of the time and place of attendance of the witness or the production of the books and papers;

(b) The witness has been subpenaed by the committee pursuant to this section; and

(c) The witness has failed or refused to attend or produce the books and papers required by the subpena before the committee which is named in the subpena, or has refused to answer questions propounded to him,

and asking for an order of the court compelling the witness to attend and testify or produce the books and papers before the committee.

3. Upon such petition, the court shall enter an order directing the witness to appear before the court at a time and place to be fixed by the court in its order, the time to be not more than 10 days from the date of the order, and to show cause why he has not attended or testified or produced the books or papers before the committee. A certified copy of the order must be served upon the witness.

4. If it appears to the court that the subpena was regularly issued by the committee, the court shall enter an order that the witness appear before the committee at the time and place fixed in the order and testify or produce the required books or papers. Failure to obey the order constitutes contempt of court.

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

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

Each witness who appears before the committee by its order, except a state officer or employee, is entitled to receive for his attendance the fees and mileage provided for

witnesses in civil cases in the courts of record of this state. The fees and mileage must be audited and paid upon the presentation of proper claims sworn to by the witness and approved by the secretary and chairman of the committee.

(Added to NRS by 1987, 866)

## APPENDIX B

## SUGGESTED LEGISLATION

SUMMARY--Requires commissioner of insurance to create health insurance risk pool for certain small businesses and provides certain tax credits to small businesses participating in the pool. (BDR 57-1064)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to health insurance; directing the commissioner of insurance to create a health insurance risk pool for employees of certain small businesses; providing certain tax credits to a small business participating in the pool; and providing other matters properly relating thereto.

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

**Section 1.** Title 57 of NRS is hereby amended by adding thereto a new chapter to consist of the provisions set forth as sections 2 to 9, inclusive, of this act.

**Sec. 2.** As used in sections 2 to 9, inclusive, of this act, unless the context otherwise requires:

1. "Eligible person" means an employee of a small business that participates in the risk pool.

2. "Group health insurance" means health insurance issued by the risk pool which provides coverage to two or more persons.

3. "Risk pool" means the health insurance risk pool for small businesses established by regulation pursuant to subsection 1 of section 3 of this act.

4. "Small business" means a business that employs less than 26 persons.

**Sec. 3.** 1. The commissioner shall by regulation establish a health insurance risk pool for small businesses to provide group health insurance to eligible persons through insurers that are members of the risk pool.

2. Any insurer transacting health insurance in this state may become a member of the risk pool.

3. The risk pool must perform its functions under a plan of operation set forth in regulations adopted by the commissioner pursuant to section 4 of this act.

**Sec. 4.** The commissioner shall adopt regulations that:

1. Set forth a plan of operation for the risk pool, including:

(a) A means of spreading any burden imposed by the risk pool equitably and efficiently among insurers who are members of the risk pool;

(b) A method of underwriting and classifying risks;

(c) A procedure for adjusting and processing claims; and

(d) Specific criteria of eligibility for small businesses seeking to participate in the pool, including financial criteria.

2. Establish the minimum scope of coverage required to be provided under a policy of group health insurance.

3. Establish the optional coverage that must be offered to eligible persons.

4. Specify deductibles and copayment amounts to be paid by persons insured under a policy of group health insurance.

5. Establish the premiums for specific geographical areas in this state that each insurer shall charge when issuing a policy of group health insurance within those geographical areas.

6. Set forth a schedule of reasonable medical fees that are payable under a policy of group health insurance.

7. Set forth a procedure for arranging agreements with preferred providers of health care and health products.

8. Establish permissible exclusions under a policy of group health insurance. To the extent deemed necessary by the commissioner, the coverage provided under such policies may vary from the coverage required by chapter 689B of NRS.

9. Establish a procedure that permits the continuation of coverage provided to a person under a policy of group health insurance when the employment of the person is terminated.

10. Prohibit an insurer from canceling or failing to renew a policy of group health insurance for reasons related to risk.

**Sec. 5.** The commissioner shall by regulation divide businesses into groups as he deems reasonable and necessary. For each group, he shall:

1. Specify the minimum percentage of the premium for a policy of group health insurance that an employer must contribute, excluding any premiums for coverage for the dependents of an employee; and

2. Specify the minimum percentage of persons employed by the same employer that must be included in the coverage provided by the policy, as a condition of participation in the risk pool.

**Sec. 6.** 1. Employees insured under a policy of group health insurance must be offered the option of extending the policy to cover their dependents.

2. Every policy of group health insurance must allow for the reduction of liability of the risk pool because of benefits provided to a person under another valid policy of insurance. To the extent authorized by the commissioner, the reduction in liability may include the right to subrogation.

**Sec. 7.** 1. A person is not eligible for coverage under a policy of group health insurance during the first 6 months following the effective date of coverage of the policy for any condition which during the 6 months immediately preceding the effective date of coverage:

(a) Manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment; or

(b) For which medical advice, care or treatment was recommended or received.

2. The exclusion for a preexisting condition pursuant to subsection 1 must be waived to the extent to which a similar exclusion, if any, has been satisfied in accordance with any previous policy of group health insurance that was terminated as a result of a change of employment if an application for coverage under a policy of group health insurance is made within 31 calendar days after the previous coverage was terminated. Coverage provided by the

risk pool pursuant to this subsection is effective from the date on which the previous coverage was terminated.

**Sec. 8.** The commissioner may:

1. Employ technical, actuarial, rating, clerical and other assistants as he deems necessary to carry out the provisions of sections 2 to 9, inclusive, of this act.

2. Employ an administrator to administer the risk pool. The administrator may be paid out of the premiums charged by the risk pool for policies of group health insurance.

3. Contract for and procure the services of examiners and other specialized technical or professional assistance as he deems necessary to carry out the provisions of sections 2 to 9, inclusive, of this act.

**Sec. 9.** An agent, broker or other licensee enrolling a person or marketing coverages from the risk pool shall not receive more than 2 percent of the total premium from the person for the enrollment or marketing.

**Sec. 10.** Chapter 364A of NRS is hereby amended by adding thereto a new section to read as follows:

*1. An employer who participates in the health insurance risk pool for small businesses established by regulation pursuant to subsection 1 of section 3 of this act is entitled to a credit against his liability for the tax imposed by this chapter.*

*2. Except as otherwise provided by this subsection, the employer's credit provided in subsection 1 must be calculated as $25 for the calender quarter for each employee who on the 12th day of the 1st month of the calendar quarter is insured by a policy issued by the health insurance risk pool for small businesses.*

*The credit calculated for any calendar quarter must not exceed the amount of the tax due for that calendar quarter and does not carry forward to the next calendar quarter.*

*3. Before deducting the credit from the amount of the tax due, the employer must obtain the approval of the department by submitting on an application provided by the department evidence satisfactory to the department that he has complied with the provisions of subsection 1. After obtaining the approval of the department, the employer may deduct the credit from the payment of the tax due for each calendar quarter in which he meets the requirements of subsection 1.*

SUMMARY--Provides credit against business tax for health insurance. (BDR 32-1065)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to taxation; providing a credit, against the tax imposed upon the privilege of conducting business, for the provision of health insurance; 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 364A of NRS is hereby amended by adding thereto a new section to read as follows:

*1. A person conducting business who provides to his employees health insurance with benefits which equal or exceed those required for a plan adopted pursuant to chapter 689C of NRS is entitled to a credit against his liability for the tax imposed by this chapter if he:*

*(a) Pays at least one-half of each employee's premium for the coverage selected by the employee, excluding any premiums for coverage for the dependents of the employee; or*

*(b) Is self-insured and meets the requirements of the Employee Retirement Income Security Act (29 U.S.C. §§ 1001 et seq.).*

*2. The credit is the amount of premium paid or credited to a reserve for self-insurance per quarter, or $75 per quarter for each covered employee, whichever is less. The credit calculated for any calendar quarter must not exceed the amount of the tax due for that calendar quarter and must not be applied to any other quarter.*

*3. Before deducting the credit from tax paid, the person conducting business must obtain the approval of the department by submitting an application and showing that his plan meets the requirements of this section. After obtaining approval, the person conducting business may deduct the credit from each required payment of tax for a quarter in which he met the requirements of this section.*

# SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY MODEL ACT (PROSPECTIVE REINSURANCE WITH OR WITHOUT AN OPT-OUT)

## Section 11. Small Employer Carrier Reinsurance Program

A. A reinsuring carrier shall be subject to the provisions of this section.

**Drafting Note:** Delete Subsection A if participation in the reinsurance program is mandatory.

B. There is hereby created a nonprofit entity to be known as the [insert name of state] Small Employer Health Reinsurance Program.

C. (1) The program shall operate subject to the supervision and control of the board. Subject to the provisions of Paragraph (2), the board shall consist of [eight] members appointed by the commissioner plus the commissioner or his or her designated representative, who shall serve as an ex officio member of the board.

(2) (a) In selecting the members of the board, the commissioner shall include representatives of small employers and small employer carriers and such other individuals determined to be qualified by the commissioner. At least five (5) of the members of the board shall be representatives of reinsuring carriers and shall be selected from individuals nominated by small employer carriers in this state pursuant to procedures and guidelines developed by the commissioner.

(b) In the event that the program becomes eligible for additional financing pursuant to Subsection L(3), the board shall be expanded to include two (2) additional members who shall be appointed by the commissioner. In selecting the additional members of the board, the commissioner shall choose individuals who represent [include reference to representatives of sources for additional financing identified in Subsection L(3)(d)(ii)]. The expansion of the board under this subsection shall continue for the period that the program continues to be eligible for additional financing under Subsection L(3).

(3) The initial board members shall be appointed as follows: two (2) of the members to serve a term of two (2) years; three (3) of the members to serve a term of four (4) years; and three (3) of the members to serve a term of six (6) years. Subsequent board members shall serve for a term of three (3) years. A board member's term shall continue until his or her successor is appointed.

(4) A vacancy in the board shall be filled by the commissioner. A board member may be removed by the commissioner for cause.

D. Within sixty (60) days of the effective date of this Act, each small employer carrier shall make a filing with the commissioner containing the carrier's net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.

E. Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to assure the fair, reasonable and equitable administration of the program, and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the commissioner.

F. If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The commissioner shall amend or rescind any plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.

G. The plan of operation shall:

(1) Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal reporting to the commissioner;

(2) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(3) Establish procedures for reinsuring risks in accordance with the provisions of this section;

(4) Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program; and

(5) Provide for any additional matters necessary for the implementation and administration of the program.

H. The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program shall have the specific authority to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;

(3) Take any legal action necessary to avoid the payment of improper claims against the program;

(4) Define the health benefit plans for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this Act;

(5) Establish rules, conditions and procedures for reinsuring risks under the program;

(6) Establish actuarial functions as appropriate for the operation of the program;

(7) Assess reinsuring carriers in accordance with the provisions of Subsection L, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

(8) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program;

(9) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets;

I. A reinsuring carrier may reinsure with the program as provided for in this subsection:

(1) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(2) A small employer carrier may reinsure an entire employer group within sixty (60) days of the commencement of the group's coverage under a health benefit plan.

(3) A reinsuring carrier may reinsure an eligible employee or dependent within a period of sixty (60) days following the commencement of the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty (60) days of the commencement of his or her coverage.

(4) (a) The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for such employee or dependent of $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for ten percent (10%) of the next $50,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carriers' liability under this subparagraph shall not exceed a maximum limit of $10,000 in any one calendar year with respect to any reinsured individual.

(b) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Department of Labor, Bureau of Labor Statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

(5) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

[(6) Premium rates charged for reinsurance by the program to a health maintenance organization that is federally qualified under 42 U.S.C. Sec. 300c(c)(2)(A), and as such is subject to requirements that limit the amount of risk that may be ceded to the program that is more restrictive than those specified in Paragraph (4), shall be reduced to reflect that portion of the risk above the amount set forth in Paragraph (4) that may not be ceded to the program, if any.]

**Drafting Note:** Federal law prohibits federally-qualified health maintenance organizations from reinsuring the first $5,000 of covered benefits. States that adopt an initial retention level of less than $5,000 under Paragraph (4) should include the above language.

(7) A reinsuring carrier shall apply all managed care and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

J. (1) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates which shall be multiplied by the factors set forth in Paragraph (2) to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the approval of the commissioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan (adjusted to reflect retention levels required under this Act).

(2) Premiums for the program shall be as follows:

(a) An entire small employer group may be reinsured for a rate that is one and one-half (1.5) times the base reinsurance premium rate for the group established pursuant to this paragraph.

(b) An eligible employee or dependent may be reinsured for a rate that is five (5) times the base reinsurance premium rate for the individual established pursuant to this paragraph.

(3) The board periodically shall review the methodology established under Paragraph (1), including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the commissioner.

(4) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

K. If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in Section 6.

L. (1) Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(2) Any net loss for the year shall be recouped by assessments of reinsuring carriers.

(a) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers. The assessment formula shall be based on:

(i) Each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers; and

(ii) Each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring carriers.

(b) The formula established pursuant to Subparagraph (a) shall not result in any reinsuring carrier having an assessment share that is less than fifty percent (50%) nor more than 150 percent of an amount which is based on the proportion of (i) the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to (ii) the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers.

(c) The board may, with approval of the commissioner, change the assessment formula established pursuant to Subparagraph (a) from time to time as appropriate. The board may provide for the shares of the assessment base attributable to total premium and to the previous year's premium to vary during a transition period.

(d) Subject to the approval of the commissioner, the board shall make an adjustment to the assessment formula for reinsuring carriers that are

approved health maintenance organizations which are federally qualified under 42 U.S.C. Sec. 300, et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

(e) Premiums earned by a reinsuring carrier that are less than an amount determined by the board to justify the cost of assessment collection shall not be considered for purposes of determining assessments.

(3) (a) Prior to March 1 of each year, the board shall determine and file with the commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(b) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in Subparagraph (c), the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the commissioner within ninety (90) days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file a report with the commissioner within ninety (90) days following the end of the applicable calendar year, the commissioner may evaluate the operations of the program and implement such amendments to the plan of operation the commissioner deems necessary to reduce future losses and assessments.

(c) For any calendar year, the amount specified in this subparagraph is five percent (5%) of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers.

(d) (i) If assessments in each of two (2) consecutive calendar years exceed the amount specified in Subparagraph (c), the program shall be eligible to receive additional financing as provided in Item (ii).

(ii) The additional funding provided for in Item (i) shall be obtained from [the state should specify one or more sources of additional revenue to fund the program. States may wish to consider the alternative revenue sources provided in the NAIC Model Health Plan for Uninsurable Individuals Model Act]. The amount of additional financing to be provided to the program shall be equal to the amount by which total assessments in the preceding two (2) calendar years exceed five percent (5%) of total premiums earned during that period from small employers from health benefit plans delivered or issued for delivery in this state by reinsuring carriers. If the program has received additional financing in either of the two (2) previous calendar years pursuant to this subparagraph, the amount of additional financing shall be subtracted from the amount of total assessments for the purpose of the calculation in the previous sentence.

(iii) Additional financing received by the program pursuant to this subparagraph shall be distributed to reinsuring carriers in proportion to the assessments paid by such carriers over the previous two (2) calendar years.

**Drafting Note:** The purpose of the five percent (5%) limitation is to prevent the program from placing too heavy of a burden on the small employer marketplace. States could also consider suspending the guarantee issue provision in Section 8 if assessments exceed the five percent (5%) threshold.

(4) If assessments exceed net losses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, "future losses" includes reserves for incurred but not reported claims.

(5) Each reinsuring carrier's proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the reinsuring carriers with the board.

(6) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(7) A reinsuring carrier may seek from the commissioner a deferment from all or part of an assessment imposed by the board. The commissioner may defer all or part of the assessment of a reinsuring carrier if the commissioner determines that the payment of the assessment would place the reinsuring carrier in a financially impaired condition. If all or part of an assessment against a reinsuring carrier is deferred the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subsection. The reinsuring carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the assessments.

M. Neither the participation in the program as reinsuring carriers, the establishment of rates, forms or procedures, nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.

N. The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into the consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide on-going service to the small employer, the levels of compensation currently used in the industry and the overall costs of coverage to small employers selecting these plans.

O. The program shall be exempt from any and all taxes.

SUMMARY--Delays required reports concerning certain plans of health insurance for small employers. (BDR S-1067)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to insurance; delaying for 2 years the dates on which the commissioner of insurance is required to report to the legislature concerning certain plans of health insurance for small employers; 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 16 of chapter 648, Statutes of Nevada 1991, at page 2154, is hereby amended to read as follows:

Sec. 16. The commissioner of insurance shall report to the legislature on or before April 1, [1993,] *1995,* and April 1, [1995,] *1997,* concerning the plans of insurance established by this act, including the number of enrollees, premiums, profit and losses, consumer complaints and other relevant information concerning the operation and effectiveness of the plan.

**Sec. 2.** This act becomes effective upon passage and approval.

SUMMARY--Requires commissioner of insurance to establish risk pool for persons who are medically uninsurable. (BDR 57-1068)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to insurance; requiring the commissioner of insurance to establish a risk pool for persons who are medically uninsurable; establishing requirements for the operation of the pool; establishing requirements for participation in the pool; and providing other matters properly relating thereto.

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

**Section 1.** Title 57 of NRS is hereby amended by adding thereto a new chapter to consist of the provisions set forth as sections 2 to 20, inclusive, of this act.

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

1. "Administrator" means the insurer designated by the commissioner to administer the pool pursuant to section 5 of this act.

2. "Health insurance" includes any policy or contract of health insurance issued pursuant to chapter 689A, 689B, 695B or 695C of NRS.

3. "Medically uninsurable person" means a natural person who is eligible for health insurance coverage by the pool pursuant to section 9 of this act.

4. "Pool" means the state health insurance pool created pursuant to section 3 of this act.

**Sec. 3.** 1. There is hereby created a nonprofit, unincorporated, legal entity to be known as the state health insurance pool to provide health insurance coverage for medically uninsurable persons.

2. All insurers that issue health insurance in this state are members of the pool and must be and remain members of the pool as a condition of their authority to transact insurance in this state.

3. The administrator shall ensure that the pool performs its functions pursuant to a plan of operation established and approved by the commissioner. The powers of the pool must be exercised through the administrator.

**Sec. 4.** 1. The commissioner shall:

(a) Establish, review and regulate the operation of the pool.

(b) Adopt such regulations as are necessary to carry into effect the provisions of this chapter.

2. The regulations must establish procedures for the operation of the pool including procedures for:

(a) Handling and accounting of the assets and money of the pool;

(b) Selecting the administrator of the pool and any successor as required;

(c) Determining the amount of assessments to be collected from the members which must be proportionate to each member's share of the market of health insurance in this state;

(d) Conducting reviews and examinations by the commissioner; and

(e) Publicizing the existence of the pool, the requirements for eligibility and the procedures for enrollment.

3. The regulations must state the benefits to be offered. Benefits must be reasonably related to the operation of the pool and designed to lower the cost of coverage for each enrollee and the pool.

4. The regulations must include provisions concerning:

(a) The method and determination of charges for premiums and administrative costs;

(b) A review of the system of managed care administered pursuant to subsection 3 of section 7 of this act;

(c) The terms of contracts with providers; and

(d) Reinsurance, if any, purchased by the administrator.

**Sec. 5.** 1. After requesting bids and holding a public hearing to obtain information relating to the bids, the commissioner shall select one or more insurers to administer the pool.

2. The commissioner shall establish criteria to evaluate bids. The criteria must include:

(a) The ability of the insurer to provide individual accident and health insurance;

(b) The efficiency of the procedures of the insurer to pay claims;

(c) The total amount the insurer will charge for administering the plan; and

(d) The ability of the insurer to administer the pool in a manner that minimizes costs.

3. The administrator of the pool is subject to the provisions of this Title that are not inconsistent with the provisions of this chapter. Any cost for an examination of the administrator concerning the operation of the pool is not a charge against the administrator.

**Sec. 6.** 1. The portion of the premiums designated by the commissioner for payment of the administrative expenses of the administrator must not exceed the amount approved by the commissioner pursuant to the bid made by the insurer selected to be the administrator.

2. The administrator shall not realize a profit on the operation or administration of the pool. As used in this subsection, "profit" means net operational gains based upon statutory accounting.

**Sec. 7.** The administrator shall:

1. Establish an organization of preferred providers for the pool.

2. Negotiate rates of reimbursement for physicians and other providers of health care, including hospitals.

3. Administer the benefits of the pool using managed care, utilization review and other prudent measures to limit the cost of claims.

**Sec. 8.** With the approval of the commissioner, the administrator may:

1. Enter into contracts to carry out the provisions of this chapter.

2. Enter into an agreement with the pool of another state to perform common administrative duties.

3. Enter into an agreement with a person to perform administrative duties.

4. Sue on behalf of the pool or defend a suit filed against the pool.

5. Take any legal action necessary to recover an assessment for, on behalf of or against a member of the pool.

6. Establish rates, schedules, adjustments, allowances for expenses, fees and claim reserve formulas, and perform any other actuarial function necessary for the operation of the pool.

7. Assess members of the pool in accordance with the provisions of this chapter and make advance interim assessments as are reasonable and necessary.

8. Issue a policy of insurance in accordance with the requirements of this chapter.

9. Appoint from among members of the pool such committees as are necessary to provide assistance in the operation of the pool.

**Sec. 9.** 1. Except as otherwise provided in this chapter, a person is eligible for coverage by the pool if he provides the administrator with evidence that he has been refused coverage by at least two health insurers within the 6 months immediately preceding the date on which he applies for coverage by the pool.

2. A person is not eligible for coverage by the pool if:

(a) He is eligible for health care benefits from any federal or state program of public assistance covering the provision of health care.

(b) His coverage by the pool was terminated, unless 12 months has passed since the termination.

(c) The pool has paid $50,000 in benefits on his behalf during the current calendar year or a total of $250,000 in benefits on his behalf.

(d) He is an offender who is sentenced to imprisonment in a state prison.

3. Except as otherwise provided in subsection 2, a person whose health insurance is involuntarily terminated for any reason other than nonpayment of a premium and who is not eligible for conversion, may apply to the pool for coverage. If the person applies for coverage within 60 calendar days after the involuntary termination and his premiums are paid from the date of the involuntary termination, the effective date of the coverage is the date of termination of the previous coverage.

4. A person who is eligible for coverage by the pool is not subject to medical or occupational underwriting.

**Sec. 10.** The administrator shall:

1. Perform all functions concerning payment of claims, eligibility and administration of the pool including:

(a) Making available information relating to the proper manner for submitting a claim for benefits to the pool and distributing forms for claims; and

(b) Evaluating each claim for payment by the pool.

2. Establish a procedure for the billing and collection of premiums from enrollees.

3. Submit reports to the commissioner concerning the operation of the pool. The commissioner shall determine the frequency, content and form of the reports.

**Sec. 11.** If an employer pays for a portion of the premiums of an employee, the payment must be for a minimum of 50 percent of the contribution of the

employee, excluding any premiums for coverage for the dependents of the employee.

**Sec. 12.** An agent, broker or other licensee enrolling a person or marketing coverages from the pool shall not receive more than 2 percent of the total premium from the enrollee for such enrollment or marketing.

**Sec. 13.** 1. After the close of each fiscal year, the administrator shall determine the net premiums, the expenses of administering the pool and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums and benefits paid by an insurer that are less than an amount determined by the administrator to justify the cost of collection must not be considered for the purpose of determining assessments.

2. An interim assessment imposed by the administrator must be credited as an offset against any regular assessment due after the end of the fiscal year.

3. Any losses from claims must be offset by a credit against premium taxes pursuant to chapter 680B of NRS.

4. As used in this section, "net premiums" means premiums less any allowances for administrative expenses.

**Sec. 14.** 1. If assessments exceed actual losses and expenses of administering the pool, the excess must be held in an interest-bearing account and used by the administrator to offset future losses or to reduce the premiums of the pool.

2. The administrator shall determine annually the proportion of participation in the pool of each member based on annual statements and other reports filed with the commissioner.

3. Any deficit incurred by the pool must be recouped by assessments apportioned pursuant to regulations adopted by the commissioner.

4. The administrator may abate or defer, in whole or in part, the assessment of a member if he determines that payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. If an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in regulations adopted by the commissioner. The member receiving an abatement or deferment is liable to the pool for the deficiency.

5. As used in this section, "future losses" includes reserves for incurred but not reported claims.

**Sec. 15.** 1. The administrator shall ensure that the pool offers basic benefits that include payment of major medical expenses on an expense incurred basis. The coverage may exclude benefits otherwise required pursuant to this Title.

2. The benefits offered by the pool are limited as follows:

(a) The annual maximum per enrollee is $50,000.

(b) The lifetime maximum per enrollee is $250,000.

(c) Coverage must exclude charges or expenses incurred during the first 6 months following the effective date of coverage as to any condition, which during the 6 months immediately preceding the effective date of coverage:

(1) Manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment; or

(2) For which medical advice, care or treatment was recommended or received.

3. The exclusion for a preexisting condition pursuant to subsection 2 must be waived to the extent to which a similar exclusion, if any, has been satisfied in accordance with any previous health insurance coverage that was involuntarily terminated if the application for coverage by the pool is made within 31 calendar days after the involuntary termination and coverage in the pool is effective from the date on which the previous coverage was terminated.

4. The commissioner or administrator shall not change the maximum limit or substitute an actuarial equivalent benefit.

**Sec. 16.** 1. A rate established pursuant to regulations adopted by the commissioner must not be unreasonable in relation to the coverage provided, the risk experience and the expense of providing the coverage.

2. The commissioner may adjust a rate or rate schedule or establish separate schedules of rates based on age, sex and geographical location for specific risks. The commissioner shall take into consideration risk factors in accordance with established actuarial and underwriting practices.

3. The commissioner shall adjust rates to provide fully for the expected costs of claims including recovery of previous losses, expenses of operation, investment income of claim reserves and any other cost factors, subject to the limitations provided in this chapter.

4. The administrator shall determine the rates for standard risks by calculating the average standard rate charge by the five largest insurers offering coverages in the state comparable to the coverage provided by the pool. If five insurers do not offer comparable coverage, the standard rate must be established using reasonable actuarial techniques and must reflect anticipated experience and expenses for such coverage. Rates must not exceed 150 percent of the rate for the applicable individual standard risk determined by the administrator.

5. All rates and rate schedules must be submitted to the commissioner for approval.

**Sec. 17.** Coverage by the pool must provide optional deductibles of $500 or $1,500 per annum per person, and coinsurance of 20 percent. The coinsurance and deductibles in the aggregate must not exceed $3,500 per person or $5,000 per family per annum. The administrator may adjust the deductibles and maximum coinsurance payment annually. An adjustment must not exceed the most recent increase of the Medical Care Component of the Consumer Price Index.

**Sec. 18.** 1. Benefits otherwise payable pursuant to coverage by the pool must be reduced by:

(a) All amounts paid or payable through any other health insurance.

(b) All hospital and medical expense benefits paid or payable pursuant to industrial insurance or motor vehicle insurance.

2. The administrator or the pool has a cause of action against an eligible person for the recovery of the amount of benefits paid that are not covered

expenses. Benefits due from the pool must be reduced or refused as a set-off against any amount recoverable pursuant to this section.

**Sec. 19.** In the case of any insolvency of the insurer of the pool, a claim to be paid by the pool is not subject to the provisions of chapter 686C of NRS and must not be assessed against the account for health insurance created pursuant to NRS 686C.130.

**Sec. 20.** The number of medically uninsurable persons who may be enrolled in the pool at any one time is limited to 500 persons. Each medically uninsurable person must be accepted into the pool on a first come, first served basis.

**Sec. 21.** NRS 686C.030 is hereby amended to read as follows:

686C.030 1. This chapter provides coverage for the policies or contracts described in subsection 2 to persons who are:

(a) Owners of or certificate holders under such policies or contracts, and who:

(1) Are residents of this state; or

(2) Are not residents, but only if:

(I) The insurers which issued the policies or contracts are domiciled in this state;

(II) Those insurers did not hold at the time the policies or contracts were issued a license or certificate of authority in the states in which those persons reside;

(III) The states in which the nonresident persons reside have associations for protection against impaired or insolvent insurers similar to the association created by this chapter; and

(IV) Those persons are not eligible for coverage by those associations; and

(b) Beneficiaries, assignees or payees of the persons covered under paragraph (a), wherever they reside, except for nonresident certificate holders under group policies or contracts.

2. This chapter provides coverage to the persons described in subsection 1 for direct, nongroup life, health and supplemental policies or contracts, and annuities, and certificates under direct group policies and contracts, and annuities, issued by member insurers, except as limited by this chapter.

*3. This chapter does not provide coverage for the policies or contracts available through the state health insurance pool pursuant to sections 2 to 20, inclusive, of this act.*

**Sec. 22.** NRS 686C.128 is hereby amended to read as follows:

686C.128 1. The association shall prepare, and submit to the commissioner for approval, a summary document describing the general purposes, exclusions and limitations of this chapter. No insurer may deliver a policy or contract described in *subsection 2 of* NRS 686C.030 to an intended holder unless the document is delivered to the intended holder before or at the time of delivery of the policy or contract. The document must also be available upon request by a policyholder. The distribution, delivery, contents or interpretation of this document do not mean that the policy or the contract or

the holder thereof would be covered in the event of the impairment or insolvency of a member insurer. The descriptive document must be revised by the association as amendments to this chapter may require. Failure to receive this document does not give the holder of a policy or contract, or an insured, any greater rights than those stated in this chapter.

2. The document prepared pursuant to subsection 1 must contain a clear and conspicuous disclaimer on its face. The disclaimer must:

(a) State the name and address of the association and of the [division;] *department;*

(b) Prominently warn the policy or contract holder that the association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this state;

(c) State that the insurer and its agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation or inducement to purchase any form of insurance;

(d) Emphasize that the holder of a policy or contract should not rely on coverage under the association when selecting an insurer; and

(e) Provide other information as directed by the commissioner.

**Sec. 23.** The commissioner shall submit a report to the director of the legislative counsel bureau for distribution to the legislature on or before February 1, 1995, and February 1, 1997, concerning the pool including the number of enrollees, premiums tax credits granted, profit and losses, consumer complaints and other relevant information concerning the operation and effectiveness of the pool.

**Sec. 24.** Initial rates for coverage established pursuant to section 16 of this act must not be less than 125 percent nor more than 150 percent of rates established as applicable for individual standard risks.

SUMMARY--Makes various changes relating to actions involving medical malpractice. (BDR 3-1069)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to actions involving medical malpractice; requiring certain actions to be submitted to nonbinding arbitration; limiting the amount of a contingency fee an attorney may collect in such actions; permitting collateral sources of recovery to be admitted as evidence for certain purposes; requiring, under certain circumstances, a screening panel to recommend alternative methods of resolving disputes; limiting the amount of an award of noneconomic damages; 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 38 of NRS is hereby amended by adding thereto a new section to read as follows:

*If, in an action involving medical malpractice filed in a district court in this state, the amount in issue does not exceed $10,000, the action must be submitted to nonbinding arbitration in accordance with the applicable arbitration rules adopted by the supreme court.*

**Sec. 2.** Chapter 41A of NRS is hereby amended by adding thereto the provisions set forth as sections 3 to 7, inclusive, of this act.

**Sec. 3.** *"Noneconomic damages" includes compensation for pain, suffering, inconvenience, physical impairment, disfigurement and loss of society, association and protection, and any other nonpecuniary damages.*

**Sec. 4.** *1. An attorney shall not enter into an agreement for, charge or collect a fee that is contingent on the outcome of the matter for representing a claimant in an action involving medical malpractice in excess of the following limits:*

*(a) Forty percent of the first $50,000 recovered.*

*(b) Thirty-three and one-third percent of the next $50,000 recovered.*

*(c) Twenty-five percent of the next $500,000 recovered.*

*(d) Fifteen percent of the amount recovered that exceeds $600,000.*

*2. If periodic payments are awarded or are agreed upon in settlement of a claim involving medical malpractice, the award or settlement must place a total value on these payments based upon the projected life expectancy of the claimant.*

*3. For the purposes of subsection 1:*

*(a) If periodic payments are not awarded and are not agreed upon in settlement of the claim, the amount recovered is determined by subtracting any disbursements or costs incurred in connection with prosecution or settlement of the claim from the total award or settlement recovered by the claimant.*

*(b) If periodic payments are awarded or are agreed upon in settlement of the claim involving medical malpractice, the amount recovered is determined by*

*subtracting any disbursements or costs incurred in connection with prosecution or settlement of the claim from the total value of the payments.*

*Costs of medical care incurred by the claimant and costs of operating an office incurred by the attorney representing the claimant are not costs incurred in connection with prosecution or settlement of the claim.*

**Sec. 5.** *Evidence that the claimant has received compensation from any source other than the defendant as payment or reimbursement of the costs of health care services for the injury alleged to have resulted from the medical malpractice is admissible in an action involving medical malpractice for the purpose of the calculation of damages by the factfinder.*

**Sec. 6.** *After the screening panel has made its findings in an action involving medical malpractice that is not subject to mandatory arbitration pursuant to section 1 of this act, the screening panel shall recommend that the action be submitted to arbitration, mediation or other alternative method of resolving disputes that is available to the parties if the screening panel determines that such participation would assist in the resolution of the dispute.*

**Sec. 7.** *For each cause of action involving medical malpractice, the amount of noneconomic damages awarded to an individual claimant must not exceed $250,000.*

**Sec. 8.** NRS 41A.003 is hereby amended to read as follows:

41A.003 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 41A.005 to 41A.013, inclusive, *and section 3 of this act,* have the meanings ascribed to them in those sections.

**Sec. 9.** An attorney is not prohibited from charging or collecting a contingency fee in an action involving medical malpractice that is in excess of the limits set forth in section 4 of this act if the fee is charged or collected pursuant to an agreement between the attorney and the claimant entered into before October 1, 1993.

SUMMARY--Requires certain providers of health care to provide health care for certain number of patients who are eligible for Medicaid. (BDR 40-1070)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to health care; requiring the department of human resources to obtain certain information relating to the provision of health care for persons eligible for Medicaid; requiring certain providers of health care to accept a certain number of patients eligible for Medicaid; making the refusal of certain providers of health care to accept a certain number of patients eligible for Medicaid 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.** Chapter 439 of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The department shall estimate the number of patients eligible for Medicaid who will require health care from each of the following categories of providers of health care each year:*

*(a) Physicians licensed pursuant to chapter 630 of NRS;*

*(b) Homeopathic physicians;*

*(c) Osteopathic physicians;*

*(d) Chiropractic physicians;*

*(e) Doctors of Oriental medicine;*

*(f) Podiatrists;*

*(g) Optometrists;*

*(h) Dispensing opticians;*

*(i) Hearing aid specialists;*

*(j) Audiologists and speech pathologists;*

*(k) Physical therapists;*

*(l) Occupational therapists; and*

*(m) Psychologists.*

*2. The department shall divide the amount estimated pursuant to subsection 1 for each category of provider of health care for the year by the number of licensed providers of health care in the category in the previous year to determine the number of patients eligible for Medicaid that each provider of health care in the category must accept each year.*

*3. The department shall, not later than December 15 of each year, send a written notice to the licensing board of each category of provider of health care described in subsection 1. The notice must set forth the number of patients eligible for Medicaid that each provider of health care who is licensed by that board must accept in the following year.*

*4. Acceptance of a patient as required by this section means the provision of all appropriate health care requested by the patient during the calendar year for which the patient is accepted. As used in this subsection, "appropriate health care" means health care that is:*

*(a) Beneficial to the patient; and*

*(b) Offered by the provider of health care in the ordinary course of his practice of the profession for which he is licensed.*

**Sec. 2.** Chapter 630 of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The board shall, within 10 days after it receives the notice required by subsection 3 of section 1 of this act, send a written notice to each physician licensed by the board setting forth the number of patients eligible for Medicaid that he must accept in the following year. The board shall enforce the requirements set forth in the notice.*

*2. Each physician shall, not later than January 15 of each year, submit to the board:*

*(a) The number of patients eligible for Medicaid who requested health care from him;*

*(b) The number of patients eligible for Medicaid that he accepted; and*

*(c) The total number of patients who received health care from him,*

*in the preceding calendar year.*

*3. Acceptance of a patient as required by this section means the provision of all appropriate health care requested by the patient during the calendar year for*

*which the patient is accepted. As used in this subsection, "appropriate health care" means health care that is:*

*(a) Beneficial to the patient; and*

*(b) Offered by the physician in the ordinary course of his practice of medicine.*

**Sec. 3.** NRS 630.305 is hereby amended to read as follows:

630.305 The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Directly or indirectly receiving from any person, corporation or other business organization any fee, commission, rebate or other form of compensation which is intended or tends to influence the physician's objective evaluation or treatment of a patient.

2. Dividing a fee between licensees except where the patient is informed of the division of fees and the division of fees is made in proportion to the services personally performed and the responsibility assumed by each licensee.

3. Referring a patient to any medical laboratory in which the licensee has a financial interest unless the laboratory is operated solely in connection with the diagnosis and treatment of his own patients.

4. Referring an injured employee to a health facility in which the licensee has a financial interest unless he first discloses that interest pursuant to NRS 616.690.

5. Charging for visits to the physician's office which did not occur or for services which were not rendered or documented in the records of the patient.

6. Aiding, assisting, employing or advising, directly or indirectly, any unlicensed person to engage in the practice of medicine contrary to the provisions of this chapter or the regulations of the board.

7. Delegating responsibility for the care of a patient to a person when the licensee knows, or has reason to know, that this person is not qualified to undertake that responsibility.

8. Failing to disclose to a patient any financial or other conflict of interest.

*9. Refusing to accept the minimum number of patients eligible for Medicaid required by the department of human resources pursuant to section 1 of this act or discouraging or attempting to discourage those patients from requesting health care from the physician.*

*10. Failing to submit to the board the information required by section 2 of this act.*

**Sec. 4.** Chapter 630A of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The board shall, within 10 days after it receives the notice required by subsection 3 of section 1 of this act, send a written notice to each homeopathic physician licensed by the board setting forth the number of patients eligible for Medicaid that he must accept in the following year. The board shall enforce the requirements set forth in the notice.*

*2. Each homeopathic physician shall, not later than January 15 of each year, submit to the board:*

*(a) The number of patients eligible for Medicaid who requested health care from him;*

*(b) The number of patients eligible for Medicaid that he accepted; and*

*(c) The total number of patients who received health care from him,*

*in the preceding calendar year.*

*3. Acceptance of a patient as required by this section means the provision of all appropriate health care requested by the patient during the calendar year for which the patient is accepted. As used in this subsection, "appropriate health care" means health care that is:*

*(a) Beneficial to the patient: and*

*(b) Offered by the homeopathic physician in the ordinary course of his practice of homeopathic medicine.*

**Sec. 5.** NRS 630A.360 is hereby amended to read as follows:

630A.360 The following acts, among others, constitute grounds for initiating disciplinary action or denying the issuance of a license:

1. Directly or indirectly receiving from any person any fee, commission, rebate or other form of compensation which tends or is intended to influence the physician's objective evaluation or treatment of a patient.

2. Dividing a fee between homeopathic physicians, unless the patient is informed of the division of fees and the division is made in proportion to the services personally performed and the responsibility assumed by each homeopathic physician.

3. Charging for visits to the homeopathic physician's office which did not occur or for services which were not rendered or documented in the records of the patient.

4. Employing, directly or indirectly, any suspended or unlicensed person in the practice of homeopathic medicine, or the aiding, abetting or assisting of any unlicensed person to practice homeopathic medicine contrary to the provisions of this chapter or the regulations adopted by the board.

5. Advertising the services of an unlicensed person in the practice of homeopathic medicine.

6. Delegating responsibility for the care of a patient to a person whom the homeopathic physician knows, or has reason to know, is not qualified to undertake that responsibility.

7. Failing to disclose to a patient any financial or other conflict of interest affecting the care of the patient.

*8. Refusing to accept the minimum number of patients eligible for Medicaid required by the department of human resources pursuant to section 1 of this act or discouraging or attempting to discourage those patients from requesting health care from the homeopathic physician.*

*9. Failing to submit to the board the information required by section 4 of this act.*

**Sec. 6.** Chapter 633 of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The board shall, within 10 days after it receives the notice required by subsection 3 of section 1 of this act, send a written notice to each osteopathic physician licensed by the board setting forth the number of patients eligible for Medicaid that he must accept in the following year. The board shall enforce the requirements set forth in the notice.*

*2. Each osteopathic physician shall, not later than January 15 of each year, submit to the board:*

*(a) The number of patients eligible for Medicaid who requested health care from him;*

*(b) The number of patients eligible for Medicaid that he accepted; and*

*(c) The total number of patients who received health care from him,*

*in the preceding calendar year.*

*3. Acceptance of a patient as required by this section means the provision of all appropriate health care requested by the patient during the calendar year for which the patient is accepted. As used in this subsection, "appropriate health care" means health care that is:*

*(a) Beneficial to the patient; and*

*(b) Offered by the osteopathic physician in the ordinary course of his practice of osteopathy.*

**Sec. 7.** NRS 633.511 is hereby amended to read as follows:

633.511 The grounds for initiating disciplinary action pursuant to this chapter are:

1. Unprofessional conduct.

2. Conviction of:

(a) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;

(b) A felony; or

(c) Any offense involving moral turpitude.

3. The suspension of the license to practice osteopathic medicine by any other jurisdiction.

4. Gross or repeated malpractice, which may be evidenced by claims of malpractice settled against a practitioner.

5. Professional incompetence.

*6. The refusal of a licensee to accept the minimum number of patients eligible for Medicaid required by the department of human resources pursuant to section 1 of this act or the discouragement or attempted discouragement of those patients from requesting health care from the licensee.*

*7. The failure to submit to the board the information required by section 6 of this act.*

**Sec. 8.** Chapter 634 of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The board shall, within 10 days after it receives the notice required by subsection 3 of section 1 of this act, send a written notice to each chiropractic physician licensed by the board setting forth the number of patients eligible for Medicaid that he must accept in the following year. The board shall enforce the requirements set forth in the notice.*

*2. Each chiropractic physician shall, not later than January 15 of each year, submit to the board:*

*(a) The number of patients eligible for Medicaid who requested health care from him;*

*(b) The number of patients eligible for Medicaid that he accepted; and*

*(c) The total number of patients who received health care from him,*

*in the preceding calendar year.*

*3. Acceptance of a patient as required by this section means the provision of all appropriate health care requested by the patient during the calendar year for which the patient is accepted. As used in this subsection, "appropriate health care" means health care that is:*

*(a) Beneficial to the patient; and*

*(b) Offered by the chiropractic physician in the ordinary course of his practice of chiropractic.*

**Sec. 9.** NRS 634.140 is hereby amended to read as follows:

634.140 The grounds for initiating disciplinary action pursuant to this chapter are:

1. Unprofessional conduct.

2. Conviction of:

(a) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;

(b) A felony; or

(c) Any offense involving moral turpitude.

3. Suspension or revocation of the license to practice chiropractic by any other jurisdiction.

4. Gross or repeated malpractice.

5. Referring an injured employee to a health facility in which the licensee has a financial interest unless he first discloses that interest pursuant to NRS 616.690.

*6. Refusing to accept the minimum number of patients eligible for Medicaid for health care required by the department of human resources pursuant to section 1 of this act or discouraging or attempting to discourage those patients from requesting health care from the licensee.*

*7. Failing to submit to the board the information required by section 8 of this act.*

**Sec. 10.** Chapter 634A of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The board shall, within 10 days after it receives the notice required by subsection 3 of section 1 of this act, send a written notice to each doctor of Oriental medicine and each doctor of acupuncture licensed by the board setting forth the number of patients eligible for Medicaid that he must accept in the following year. The board shall enforce the requirements set forth in the notice.*

*2. Each doctor of Oriental medicine and each doctor of acupuncture shall, not later than January 15 of each year, submit to the board:*

*(a) The number of patients eligible for Medicaid who requested health care from him;*

*(b) The number of patients eligible for Medicaid that he accepted; and*

*(c) The total number of patients who received health care from him,*

*in the preceding calendar year.*

*3. Acceptance of a patient as required by this section means the provision of all appropriate health care requested by the patient during the calendar year for which the patient is accepted. As used in this subsection, "appropriate health care" means health care that is:*

*(a) Beneficial to the patient; and*

*(b) Offered by the doctor of Oriental medicine or doctor of acupuncture in the ordinary course of his practice of Oriental medicine.*

**Sec. 11.** NRS 634A.170 is hereby amended to read as follows:

634A.170 The board may refuse to issue or may suspend or revoke any license for any one or any combination of the following causes:

1. Conviction of a felony, conviction of any offense involving moral turpitude or conviction of a violation of any state or federal law regulating the possession, distribution or use of any controlled substance, as shown by a certified copy of the record of the court;

2. The obtaining of or any attempt to obtain a license or practice in the profession for money or any other thing of value, by fraudulent misrepresentations;

3. Gross or repeated malpractice, which may be evidenced by claims of malpractice settled against a practitioner;

4. Advertising by means of a knowingly false or deceptive statement;

5. Advertising, practicing or attempting to practice under a name other than one's own;

6. Habitual drunkenness or habitual addiction to the use of a controlled substance;

7. Using any false, fraudulent or forged statement or document, or engaging in any fraudulent, deceitful, dishonest or immoral practice in connection with the licensing requirements of this chapter;

8. Sustaining a physical or mental disability which renders further practice dangerous;

9. Engaging in any dishonorable, unethical or unprofessional conduct which may deceive, defraud or harm the public, or which is unbecoming a person licensed to practice under this chapter;

10. Using any false or fraudulent statement in connection with the practice of Oriental medicine or any branch thereof;

11. Violating or attempting to violate, or assisting or abetting the violation of, or conspiring to violate any provision of this chapter;

12. Being adjudicated incompetent or insane;

13. Advertising in an unethical or unprofessional manner;

14. Obtaining a fee or financial benefit for any person by the use of fraudulent diagnosis, therapy or treatment;

15. Willful disclosure of a privileged communication;

16. Failure of a licensee to designate the nature of his practice in the professional use of his name by the term doctor of Oriental medicine, doctor of acupuncture or acupuncture assistant, as the case may be;

17. Willful violation of the law relating to the health, safety or welfare of the public or of the regulations adopted by the state board of health;

18. Administering, dispensing or prescribing any controlled substance, except for the prevention, alleviation or cure of disease or for relief from suffering; [and]

19. Performing, assisting or advising in the injection of any liquid silicone substance into the human body [.] ;

*20. Refusing to accept the minimum number of patients eligible for Medicaid required by the department of human resources pursuant to section 1 of this act or discouraging or attempting to discourage those patients from requesting health care from the licensee; and*

*21. Failing to submit to the board the information required by section 10 of this act.*

**Sec. 12.** Chapter 635 of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The board shall, within 10 days after it receives the notice required by subsection 3 of section 1 of this act, send a written notice to each podiatrist licensed by the board setting forth the number of patients eligible for Medicaid that he must accept in the following year. The board shall enforce the requirements set forth in the notice.*

*2. Each podiatrist shall, not later than January 15 of each year, submit to the board:*

*(a) The number of patients eligible for Medicaid who requested health care from him;*

*(b) The number of patients eligible for Medicaid that he accepted; and*

*(c) The total number of patients who received health care from him,*

*in the preceding calendar year.*

*3. Acceptance of a patient as required by this section means the provision of all appropriate health care requested by the patient during the calendar year for which the patient is accepted. As used in this subsection, "appropriate health care" means health care that is:*

*(a) Beneficial to the patient; and*

*(b) Offered by the podiatrist in the ordinary course of his practice of podiatry.*

**Sec. 13.** NRS 635.130 is hereby amended to read as follows:

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

(a) Refuse to renew a license.

(b) Suspend or revoke a license.

(c) Place a licensee on probation.

(d) Impose a fine not to exceed $1,000.

2. The board may take disciplinary action against a licensee for any of the following causes:

(a) The making of a false statement in any affidavit required of the applicant for application, examination or licensure under this chapter.

(b) Lending the use of the holder's name to an unlicensed person.

(c) If the holder is a podiatrist, his permitting an unlicensed person in his employ to practice as a podiatry hygienist.

(d) Habitual indulgence in the use of alcohol or any controlled substance which impairs the intellect and judgment to such an extent as in the opinion of the board incapacitates the holder in the performance of his professional duties.

(e) Conviction of a crime involving moral turpitude.

(f) Conduct which in the opinion of the board disqualifies him to practice with safety to the public.

(g) The commission of fraud by or on behalf of the licensee regarding his license or practice.

(h) Gross incompetency.

(i) Affliction of the licensee with any mental or physical disorder which seriously impairs his competence as a podiatrist or podiatry hygienist.

(j) False representation by or on behalf of the licensee regarding his practice.

(k) Unethical or unprofessional conduct.

(l) Willful or repeated violations of this chapter or regulations adopted by the board.

(m) Willful violation of the regulations adopted by the state board of pharmacy.

*(n) The refusal of a licensee to accept the minimum number of patients eligible for Medicaid required by the department of human resources pursuant to section 1 of this act or the discouragement or attempted discouragement of those patients from requesting health care from the licensee.*

*(o) The failure to submit to the board the information required by section 12 of this act.*

**Sec. 14.** Chapter 636 of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The board shall, within 10 days after it receives the notice required by subsection 3 of section 1 of this act, send a written notice to each optometrist*

*licensed by the board setting forth the number of patients eligible for Medicaid that he must accept in the following year. The board shall enforce the requirements set forth in the notice.*

*2. Each optometrist shall, not later than January 15 of each year, submit to the board:*

*(a) The number of patients eligible for Medicaid who requested health care from him;*

*(b) The number of patients eligible for Medicaid that he accepted; and*

*(c) The total number of patients who received health care from him,*

*in the preceding calendar year.*

*3. Acceptance of a patient as required by this section means the provision of all appropriate health care requested by the patient during the calendar year for which the patient is accepted. As used in this subsection, "appropriate health care" means health care that is:*

*(a) Beneficial to the patient; and*

*(b) Offered by the optometrist in the ordinary course of his practice of optometry.*

**Sec. 15.** NRS 636.295 is hereby amended to read as follows:

636.295 The following acts, conduct, omissions, or mental or physical conditions, or any of them, committed, engaged in, omitted, or being suffered by a licensee, constitute sufficient cause for disciplinary action:

1. Affliction of the licensee with any communicable disease likely to be communicated to other persons.

2. Commission by the licensee of a felony or a gross misdemeanor involving moral turpitude of which he has been convicted and from which he has been sentenced by a final judgment of a federal or state court in this or any other state, the judgment not having been reversed or vacated by a competent appellate court and the offense not having been pardoned by executive authority.

3. Commission of fraud by or on behalf of the licensee in obtaining his license or a renewal thereof, or in practicing optometry thereunder.

4. Habitual drunkenness or addiction to any controlled substance.

5. Gross incompetency.

6. Affliction with any mental or physical disorder or disturbance seriously impairing his competency as an optometrist.

7. Making false or misleading representations, by or on behalf of the licensee, with respect to optometric materials or services.

8. Practice by the licensee, or attempting or offering so to do, while he is in an intoxicated condition.

9. Perpetration of unethical or unprofessional conduct in the practice of optometry.

10. *The refusal of a licensee to accept the minimum number of patients eligible for Medicaid required by the department of human resources pursuant to section 1 of this act or the discouragement or attempted discouragement of those patients from requesting health care from the licensee.*

*11. The failure to submit to the board the information required by section 14 of this act.*

*12.* Willfully and repeatedly violating provisions of this chapter or regulations adopted by the board.

**Sec. 16.** Chapter 637 of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The board shall, within 10 days after it receives the notice required by subsection 3 of section 1 of this act, send a written notice to each dispensing optician licensed by the board setting forth the number of patients eligible for Medicaid that he must accept in the following year. The board shall enforce the requirements set forth in the notice.*

*2. Each dispensing optician shall, not later than January 15 of each year, submit to the board:*

*(a) The number of patients eligible for Medicaid who requested health care from him;*

*(b) The number of patients eligible for Medicaid that he accepted; and*

*(c) The total number of patients who received health care from him,*

*in the preceding calendar year.*

*3. Acceptance of a patient as required by this section means the provision of all appropriate health care requested by the patient during the calendar year for which the patient is accepted. As used in this subsection, "appropriate health care" means health care that is:*

*(a) Beneficial to the patient; and*

*(b) Offered by the dispensing optician in the ordinary course of his practice of ophthalmic dispensing.*

**Sec. 17.** NRS 637.150 is hereby amended to read as follows:

637.150 Upon proof to the satisfaction of the board that an applicant or holder of a license:

1. Has been adjudicated insane;

2. Habitually uses any controlled substance or intoxicant;

3. Has been convicted of a crime involving moral turpitude;

4. Has advertised in any manner which would tend to deceive, defraud or mislead the public;

5. Has presented to the board any diploma, license or certificate that has been signed or issued unlawfully or under fraudulent representations, or obtains or has obtained a license to practice in the state through fraud of any kind;

6. Has been convicted of a violation of any federal or state law relating to a controlled substance;

7. Has violated any regulation of the board;

8. Has violated any provision of this chapter;

9. *Has refused to accept the minimum number of patients eligible for Medicaid required by the department of human resources pursuant to section 1 of this act or has discouraged or attempted to discourage those patients from requesting health care from him;*

*10. Has failed to submit to the board the information required by section 16 of this act;*

*11.* Is incompetent;

[10.] *12.* Is guilty of unethical or unprofessional conduct as determined by the board;

[11.] *13.* Is guilty of repeated malpractice, which may be evidenced by claims of malpractice settled against a practitioner; or

[12.] *14.* Is guilty of a fraudulent or deceptive practice as determined by the board,

the board may, in the case of an applicant, refuse to grant him a license, or may, in the case of a holder of a license, place him on probation, reprimand him privately or publicly, require him to pay an administrative fine of not more than $10,000, suspend or revoke his license, or take any combination of these disciplinary actions.

**Sec. 18.** Chapter 637A of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The board shall, within 10 days after it receives the notice required by subsection 3 of section 1 of this act, send a written notice to each hearing aid specialist licensed by the board setting forth the number of patients eligible for Medicaid that he must accept in the following year. The board shall enforce the requirements set forth in the notice.*

*2. Each hearing aid specialist shall, not later than January 15 of each year, submit to the board:*

*(a) The number of patients eligible for Medicaid who requested health care from him;*

*(b) The number of patients eligible for Medicaid that he accepted; and*

*(c) The total number of patients who received health care from him,*

*in the preceding calendar year.*

*3. Acceptance of a patient as required by this section means the provision of all appropriate health care requested by the patient during the calendar year for which the patient is accepted. As used in this subsection, "appropriate health care" means health care that is:*

*(a) Beneficial to the patient; and*

*(b) Offered by the hearing aid specialist in the ordinary course of his practice of fitting and dispensing hearing aids.*

**Sec. 19.** NRS 637A.250 is hereby amended to read as follows:

637A.250 The board may revoke or suspend a license after a hearing which discloses that the licensee:

1. Has been convicted of a felony or a misdemeanor involving moral turpitude.

2. Obtained the license by fraud or misrepresentation.

3. Obtained any fee by fraud or misrepresentation.

4. Has made any false or fraudulent statements concerning hearing aids.

5. Has been guilty of negligence, incompetence or misconduct in the fitting of any hearing aid.

6. Has loaned or transferred his license to another person.

7. Willfully violated any law of this state or any provision of this chapter regulating hearing aid specialists.

8. Is habitually intemperate.

*9. Has refused to accept the minimum number of patients eligible for Medicaid required by the department of human resources pursuant to section 1*

*of this act or has discouraged or attempted to discourage those patients from requesting health care from him.*

*10. Has failed to submit to the board the information required by section 18 of this act.*

**Sec. 20.** Chapter 637B of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The board shall, within 10 days after it receives the notice required by subsection 3 of section 1 of this act, send a written notice to each audiologist and each speech pathologist licensed by the board setting forth the number of patients eligible for Medicaid that he must accept in the following year. The board shall enforce the requirements set forth in the notice.*

*2. Each audiologist and each speech pathologist shall, not later than January 15 of each year, submit to the board:*

*(a) The number of patients eligible for Medicaid who requested health care from him;*

*(b) The number of patients eligible for Medicaid that he accepted; and*

*(c) The total number of patients who received health care from him,*

*in the preceding calendar year.*

*3. Acceptance of a patient as required by this section means the provision of all appropriate health care requested by the patient during the calendar year for which the patient is accepted. As used in this subsection, "appropriate health care" means health care that is:*

*(a) Beneficial to the patient; and*

*(b) Offered by the audiologist or speech pathologist in the ordinary course of his practice of audiology or speech pathology.*

**Sec. 21.** NRS 637B.250 is hereby amended to read as follows:

637B.250 The grounds for initiating disciplinary action pursuant to this chapter are:

1. Unprofessional conduct.

2. Conviction of:

(a) A violation of any federal or state law regarding the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;

(b) A felony; or

(c) Any offense involving moral turpitude.

3. Suspension or revocation of a license to practice audiology or speech pathology by any other jurisdiction.

4. Gross or repeated malpractice, which may be evidenced by claims of malpractice settled against a practitioner.

5. Professional incompetence.

*6. The refusal of a licensee to accept the minimum number of patients eligible for Medicaid required by the department of human resources pursuant to section 1 of this act or the discouragement or attempted discouragement of those patients from requesting health care from him.*

*7. The failure to submit to the board the information required by section 20 of this act.*

**Sec. 22.** Chapter 640 of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The board shall, within 10 days after it receives the notice required by subsection 3 of section 1 of this act, send a written notice to each physical therapist licensed by the board setting forth the number of patients eligible for Medicaid that he must accept in the following year. The board shall enforce the requirements set forth in the notice.*

*2. Each physical therapist shall, not later than January 15 of each year, submit to the board:*

*(a) The number of patients eligible for Medicaid who requested health care from him;*

*(b) The number of patients eligible for Medicaid that he accepted; and*

*(c) The total number of patients who received health care from him,*

*in the preceding calendar year.*

*3. Acceptance of a patient as required by this section means the provision of all appropriate health care requested by the patient during the calendar year for which the patient is accepted. As used in this subsection, "appropriate health care" means health care that is:*

*(a) Beneficial to the patient; and*

*(b) Offered by the physical therapist in the ordinary course of his practice of physical therapy.*

**Sec. 23.** 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 issue a license or temporary license to any applicant.

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

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

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

(e) Impose an administrative fine which does not exceed $5,000 on any person who has been issued a license.

2. The board may take action pursuant to subsection 1 if an applicant or person who has been licensed pursuant to this chapter:

(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 a license 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 payment of an unearned fee to any person following his referral of a patient.

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

(j) Has had his license to practice physical therapy suspended, revoked or in any way limited by another jurisdiction.

(k) Is determined to be professionally incompetent by the board.

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

*(m) Has refused to accept the minimum number of patients eligible for Medicaid required by the department of human resources pursuant to section 1 of this act or has discouraged or attempted to discourage those patients from requesting health care from him.*

*(n) Has failed to submit to the board the information required by section 22 of this act.*

**Sec. 24.** Chapter 640A of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The board shall, within 10 days after it receives the notice required by subsection 3 of section 1 of this act, send a written notice to each occupational therapist licensed by the board setting forth the number of patients eligible for Medicaid that he must accept in the following year. The board shall enforce the requirements set forth in the notice.*

*2. Each occupational therapist shall, not later than January 15 of each year, submit to the board:*

*(a) The number of patients eligible for Medicaid who requested health care from him;*

*(b) The number of patients eligible for Medicaid that he accepted; and*

*(c) The total number of patients who received health care from him, in the preceding calendar year.*

*3. Acceptance of a patient as required by this section means the provision of all appropriate health care requested by the patient during the calendar year for which the patient is accepted. As used in this subsection, "appropriate health care" means health care that is:*

*(a) Beneficial to the patient; and*

*(b) Offered by the occupational therapist in the ordinary course of his practice of occupational therapy.*

**Sec. 25.** NRS 640A.200 is hereby amended to read as follows:

640A.200 1. The board may, after notice and hearing, suspend, revoke or refuse to issue or renew a license to practice as an occupational therapist or occupational therapy assistant, or may impose conditions upon the use of that license, if the board determines that the holder of or applicant for the license is guilty of unprofessional conduct which has endangered or is likely to endanger the public health, safety or welfare. The board may reinstate a revoked license upon application by the person to whom the license was issued not less than 1 year after the license is revoked.

2. As used in this section, "unprofessional conduct" includes:

(a) The obtaining of a license by fraud or through the misrepresentation or concealment of a material fact;

(b) The conviction of any crime, except a misdemeanor which does not involve moral turpitude; [and]

(c) *The refusal of an occupational therapist to accept the minimum number of patients eligible for Medicaid required by the department of human resources pursuant to section 1 of this act or the discouragement or attempted discouragement of those patients from requesting health care from him;*

*(d) The failure to submit to the board the information required by section 24 of this act; and*

*(e)* The violation of any provision of this chapter or regulation of the board adopted pursuant to this chapter.

**Sec. 26.** Chapter 641 of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The board shall, within 10 days after it receives the notice required by subsection 3 of section 1 of this act, send a written notice to each psychologist licensed by the board setting forth the number of patients eligible for Medicaid that he must accept in the following year. The board shall enforce the requirements set forth in the notice.*

*2. Each psychologist shall, not later than January 15 of each year, submit to the board:*

*(a) The number of patients eligible for Medicaid who requested health care from him;*

*(b) The number of patients eligible for Medicaid that he accepted; and*

*(c) The total number of patients who received health care from him,*

*in the preceding calendar year.*

*3. Acceptance of a patient as required by this section means the provision of all appropriate health care requested by the patient during the calendar year for*

*which the patient is accepted. As used in this subsection, "appropriate health care" means health care that is:*

*(a) Beneficial to the patient; and*

*(b) Offered by the psychologist in the ordinary course of his practice of psychology.*

**Sec. 27.** NRS 641.230 is hereby amended to read as follows:

641.230 The board may suspend the license of a psychologist, place a psychologist on probation, revoke the license of a psychologist, require remediation for a psychologist or take any other action specified by regulation if the board finds by a preponderance of the evidence that the psychologist has:

1. Been convicted of a felony.

2. Been convicted of any crime or offense that reflects the inability of the psychologist to practice psychology with due regard for the health and safety of others.

3. Engaged in gross malpractice or repeated malpractice or gross negligence in the practice of psychology.

4. Aided or abetted the practice of psychology by a person not licensed by the board.

5. Made any fraudulent or untrue statement to the board.

6. Violated a regulation adopted by the board.

7. Had his license to practice psychology suspended or revoked by another state.

8. Failed to report to the board within 30 days the revocation, suspension or surrender of a license or certificate to practice psychology issued by another state.

9. Violated or attempted to violate, directly or indirectly, or assisted in or abetted the violation of or conspired to violate a provision of this chapter.

10. Performed or attempted to perform any professional service while impaired by alcohol, drugs or by a mental or physical illness, disorder or disease.

*11. Refused to accept the minimum number of patients eligible for Medicaid required by the department of human resources pursuant to section 1 of this act or has discouraged or attempted to discourage those patients from requesting health care from him.*

*12. Failed to submit to the board the information required by section 26 of this act.*

SUMMARY--Makes appropriations relating to primary care case-management program and requires department of human resources to apply for related waiver. (BDR S-1071)

FISCAL NOTE: Effect on Local Government: No.

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

AN ACT relating to welfare; making certain appropriations relating to the primary care case-management program; requiring the department of human resources to apply for a waiver to allow it to require persons to enroll in the primary care case-management program as a condition of receiving certain 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.** 1. There is hereby appropriated from the state general fund to the welfare division of the department of human resources for increasing the staff responsible for the primary care case-management program:

For fiscal year 1993-94..... $214,510

For fiscal year 1994-95..... $198,573

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. 2.** 1. There is hereby appropriated from the state general fund to the University of Nevada System the sum of $150,000 to provide greater access to its health care clinics for indigent women and children.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 1995, and reverts to the state general fund as soon as all payments of money committed have been made.

**Sec. 3.** The department of human resources shall apply to the United States Secretary of Health and Human Services for a waiver pursuant to 42 U.S.C. § 1396(n) to allow the department of human resources to require a person to enroll in a primary care case-management program before he may receive benefits under the state plan for assistance to the medically indigent.

**Sec. 4.** This act becomes effective on July 1, 1993.

SUMMARY--Urges Congress to pass legislation substantially similar to Medicaid Coordinated Care Improvement Act of 1992. (BDR R-1072)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

JOINT RESOLUTION--Urging Congress to pass legislation that is substantially similar to the Medicaid Coordinated Care Improvement Act of 1992.

WHEREAS, Medicaid expenditures have been increasing at a rapid rate each year, placing tremendous pressure on state budgets, including the budget in Nevada; and

WHEREAS, Though coordinated care plans such as health maintenance organizations, preferred provider organizations and primary care case management programs are one of the few tools available to the states to control the costs of Medicaid without cutting benefits or restricting eligibility for recipients, states are presently forced to go through a lengthy and arduous waiver process through the Federal Government before they may establish a coordinated care program for Medicaid recipients; and

WHEREAS, The Medicaid Coordinated Care Improvement Act of 1992 (S. 3191) was introduced in Congress on August 12, 1992, to make it easier for states to enroll their Medicaid recipients in coordinated care programs and to

improve the access to, and quality and cost effectiveness of health care for Medicaid recipients; and

WHEREAS, Though Congress did not pass the Medicaid Coordinated Care Improvement Act of 1992, the legislation would have removed federal barriers that discourage states from giving Medicaid clients the benefits of coordinated care and would have provided for a program of quality assurance for the coordinated care programs; now, therefore, be it

RESOLVED BY THE AND OF THE STATE OF NEVADA, JOINTLY, That the Legislature of Nevada urges the Congress of the United States to pass legislation that is substantially similar to the Medicaid Coordinated Care Improvement Act of 1992 to increase the flexibility of states to use coordinated care programs for Medicaid recipients and to improve access to, and quality and cost effectiveness of health care for Medicaid recipients; and be it further

RESOLVED, That the of the prepare and transmit copies of this resolution to the Vice President of the United States as presiding officer of the Senate, the Speaker of the House of Representatives and each member of the Nevada Congressional Delegation; and be it further

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

SUMMARY--Makes appropriation to department of human resources for certain programs relating to provision of health care. (BDR S-1073)

FISCAL NOTE: Effect on Local Government: No.

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

AN ACT making an appropriation to the department of human resources for certain programs relating to the provision of health care; and providing other matters properly relating thereto.

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

**Section 1.** There is hereby appropriated from the state general fund to the department of human resources:

1. For the maternal obstetrical management services program:

   For the fiscal year 1993-94 ..... $364,369

   For the fiscal year 1994-95 ..... 504,968

2. For the expansion of the community home-based initiative program:

   For the fiscal year 1993-94 ..... $380,000

   For the fiscal year 1994-95 ..... 690,000

3. For the estimated increase in the cost of the traumatic head injury program, the sum of $2,850,000.

**Sec. 2.** Any remaining balance of the appropriation made by section 1 of this act must not be committed for expenditure after June 30, 1995, 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, 1993.

SUMMARY--Expands eligibility for coverage pursuant to state plan for assistance to medically indigent. (BDR 38-1074)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to public welfare; expanding eligibility pursuant to the state plan for assistance to the medically indigent to make ambulatory prenatal care available to a pregnant woman during a presumed period of eligibility; and providing other matters properly relating thereto.

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

**Section 1.** NRS 422.236 is hereby amended to read as follows:

422.236 1. As part of the health and welfare programs of this state, the welfare division may provide prenatal care to pregnant women who are indigent, or may contract for the provision of that care, at public or nonprofit hospitals in this state.

2. *Pursuant to 42 U.S.C. § 1396r-1, the administrator shall include in the state plan for assistance to the medically indigent the provision of ambulatory prenatal care to a pregnant woman during a presumptive period of eligibility.*

*3.* The welfare division shall provide to each person licensed to engage in social work pursuant to chapter 641B of NRS, each applicant for assistance to the medically indigent and any other interested person, information concerning the prenatal care available pursuant to this section.

[3.] *4.* The welfare division shall adopt regulations setting forth criteria of eligibility and rates of payment for prenatal care provided pursuant to the provisions of this section, and such other provisions relating to the development and administration of the program for prenatal care as the administrator and the board deem necessary.

SUMMARY--Directs Welfare Division of Department of Human Resources to shorten application for Medicaid and to make available application written in Spanish. (BDR R-1075)

CONCURRENT RESOLUTION--Directing the Welfare Division of the Department of Human Resources to shorten the application for Medicaid and to make available applications written in Spanish.

WHEREAS, The current application for the Medicaid program of the State of Nevada is unnecessarily lengthy and complex; and

WHEREAS, Spanish is the primary language for many residents of the State of Nevada; and

WHEREAS, It is important for the State of Nevada to ensure that persons eligible for and in need of assistance through Medicaid actually receive the medical care and services to which they are entitled; now, therefore, be it

RESOLVED BY THE OF THE STATE OF NEVADA, THE CONCURRING, That the Welfare Division of the Department of Human Resources is hereby directed to shorten the application for the Medicaid program; and be it further

RESOLVED, That the Welfare Division of the Department of Human Resources is hereby directed to make available to applicants an application for the Medicaid program written in Spanish; and be it further

RESOLVED, That the of the prepare and transmit a copy of this resolution to the State Welfare Administrator of the Welfare Division of the Department of Human Resources.

SUMMARY--Directs Department of Human Resources to conduct study of feasibility of transferring money between state and counties to obtain matching federal money for Medicaid. (BDR R-1076)

CONCURRENT RESOLUTION--Directing the Department of Human Resources to conduct a study of the feasibility of transferring money between the state and the counties to obtain matching federal money for Medicaid.

WHEREAS, The Federal Government has transferred to the states the responsibility of expanding the types of services available through Medicaid; and

WHEREAS, The Federal Government has transferred to the states the responsibility of increasing the number of persons who are eligible for Medicaid; and

WHEREAS, The Federal Government has enacted legislation which restricts the ability of the states to fund Medicaid through direct taxation; and

WHEREAS, The states are finding it increasingly difficult to locate alternative sources of funding for Medicaid in order to carry out their duties; now, therefore, be it

RESOLVED BY THE OF THE STATE OF NEVADA, THE

CONCURRING, That the Department of Human Resources is hereby directed to conduct a study to determine the feasibility of transferring money

between the state and the counties to obtain matching money available from the Federal Government for Medicaid; and be it further

RESOLVED, That the Department of Human Resources report its findings to the Senate Committee on Finance and the Assembly Committee on Ways and Means, if the Legislature is in session, or to the Interim Finance Committee if the Legislature is not in session, not later than October 1, 1993; and be it further

RESOLVED, That the of the prepare and transmit a copy of this resolution to the Director of the Department of Human Resources.

SUMMARY--Expands eligibility for coverage pursuant to state plan for assistance to medically indigent to include entire cost related to transplants of kidneys and certain transplants of other organs. (BDR 38-1077)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to public welfare; expanding eligibility pursuant to the state plan for assistance to the medically indigent by requiring the welfare division to provide assistance for the entire cost of a kidney transplant; requiring the welfare division to provide assistance to an organ recipient for the cost of anti-rejection medication for the duration of the recipient's life; requiring the welfare division to consider providing assistance for transplants of organs other than kidneys; and providing other matters properly relating thereto.

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

**Section 1.** Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

*1. As part of the health and welfare programs of this state, the welfare division shall:*

*(a) Provide assistance for the entire cost of a kidney transplant, including the cost of acquiring the donor organ;*

*(b) Provide assistance to persons who are organ recipients for the cost of anti-rejection medication for the duration of the organ recipient's life, even if the person is no longer eligible for Medicaid; and*

*(c) Consider, on a case by case basis, providing assistance to a person for the transplant of an organ other than a kidney.*

*2. The administrator shall include in the state plan for assistance to the medically indigent the provision of medical care and services related to the transplant of organs as set forth in subsection 1.*

*3. The welfare division shall adopt regulations setting forth the criteria for eligibility and the rates of payment for medical care and services provided pursuant to this section, and such other provisions relating to the development and administration of the program for organ transplants as the administrator and the board deem necessary.*

**Sec. 2.** NRS 422.060 is hereby amended to read as follows:

422.060 The administrator and the welfare division shall administer the provisions of NRS 422.070 to 422.410, inclusive, *and section 1 of this act,* subject to administrative supervision by the director.

**Sec. 3.** NRS 422.240 is hereby amended to read as follows:

422.240 1. Money to carry out the provisions of NRS 422.070 to 422.410, inclusive, *and section 1 of this act,* must be provided by appropriation by the legislature from the state general fund.

2. Disbursements for the purposes of NRS 422.070 to 422.410, inclusive, *and section 1 of this act,* must be made upon claims [duly] filed, audited and allowed in the same manner as other money in the state treasury is disbursed.

SUMMARY--Urges State Board of Health to extend time during which physician is required to evaluate person admitted to facility for care of adults during day. (BDR R-1078)

CONCURRENT RESOLUTION--Urging the State Board of Health to extend the time during which a physician is required to evaluate a person admitted to a facility for the care of adults during the day in order to receive a reimbursement from Medicaid for the evaluation.

WHEREAS, Pursuant to NRS 449.037, the State Board of Health is required to ensure that the practices and policies of a facility for the care of adults during the day adequately provide for the protection of the health, safety and physical, moral and mental well-being of each person accommodated by such a facility; and

WHEREAS, The State Board of Health, in accordance with the duty imposed by the provisions of NRS 449.037, has adopted regulations governing facilities for the care of adults during the day; and

WHEREAS, Pursuant to the requirements of NAC 449.4084 to 449.4089, inclusive, a physician, to receive reimbursement from Medicaid for treating a person admitted to such a facility, must conduct an evaluation of that person's physical and mental health within 30 days after the person has been initially admitted to the facility, regardless of the availability of the physician; and

WHEREAS, Physicians who treat persons admitted to such facilities are often unavailable on certain days because of unforeseen circumstances or other constraints on the physician's availability; now, therefore, be it

RESOLVED BY THE OF THE STATE OF NEVADA, THE

CONCURRING, That the State Board of Health is hereby urged to amend NAC 449.4087 to allow a physician to evaluate a person admitted to a facility for the care of adults during the day within 25 to 35 days after the date of the initial admission of such a person without the physician bearing the risk of losing reimbursement from Medicaid for the evaluation; and be it further

RESOLVED, That the of the prepare and transmit a copy of this resolution to the State Board of Health.

SUMMARY--Creates board to regulate cost of health care. (BDR 40-1079)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to health care; creating the board to regulate the cost of health care; prescribing its powers and duties; providing for the regulation of the rates charged by certain facilities which provide health care; 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 20, inclusive, of this act.

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

1. "Board" means the board to regulate the cost of health care.

2. "Department" means the department of human resources.

3. "Facility" includes a facility for the dependent as defined in NRS 449.0045 and a medical facility as defined in NRS 449.0151.

4. "State agency" includes all offices, departments, boards, commissions and institutions of the state and the state industrial insurance system.

**Sec. 3.** 1. The board to regulate the cost of health care, consisting of seven members, is hereby created.

2. The governor shall appoint to the board:

(a) One member who represents a facility;

(b) One member who is a physician licensed pursuant to chapter 630 of NRS and engaged in the practice of medicine in this state;

(c) One member who represents an insurance company; and

(d) Four members who are representatives of the general public, are not engaged in the administration or provision of health care and have no material financial interest in the administration or provision of health care.

**Sec. 4.** 1. After the initial terms, the term of office of each member of the board is 3 years. No member may serve on the board for more than two consecutive terms.

2. The governor shall designate one of the members to be the chairman of the board, to serve at the pleasure of the governor.

3. The board may adopt such bylaws as it deems proper for the conduct of its business.

4. The board shall hold at least four meetings each year and in addition shall meet at the call of the chairman or a majority of the members.

5. Four members of the board constitute a quorum.

6. The governor:

(a) May remove any member for inefficiency, neglect of duty or malfeasance in office; and

(b) Must remove any appointed member for a violation of NRS 281.481,

after notice and a hearing. The member against whom such action is taken must be given a copy of the charges and written notice of the time and place of the hearing at least 10 days before the hearing. A record of the hearing must be filed with the secretary of state if the member is removed from the board.

**Sec. 5.** A facility or a parent organization, affiliate or subsidiary of a facility shall not employ a former representative of the general public on the board for 2 years after the termination of his service on the board.

**Sec. 6.** The members of the board are entitled to receive:

1. A salary of $80 per day; and

2. The per diem allowance and travel expenses provided for state officers and employees generally,

while engaged in the business of the board.

**Sec. 7.** 1. The director of the department is ex officio the executive director of the board. The executive director is the chief administrative officer of the board and shall perform the duties prescribed by the board.

2. The executive director and the employees of the department shall carry out the duties of the board as directed by the board.

**Sec. 8.** The board may:

1. Adopt regulations to carry out the provisions of this chapter, including regulations necessary to clarify matters not specifically defined by the provisions of this chapter.

2. Exercise, subject to the limitations and restrictions imposed by this chapter, all other powers which are necessary to carry out the provisions of this chapter.

3. Create committees from its membership and appoint advisory committees which may include representatives of public or private groups or organizations.

4. Apply for and accept any grants, gifts or donations and enter into agreements to carry out its duties pursuant to this chapter, including the undertaking of any studies, plans, demonstrations and projects.

5. Hold public hearings, conduct investigations and require the filing of information relating to any matter affecting the cost of any service provided by a facility. The executive director of the board may administer oaths in any hearing or investigation.

**Sec. 9.** 1. The board shall adopt regulations which require each facility to use a uniform system of accounting and financial reporting, including a method for the allocation of costs which the board may prescribe. The system must provide a method for each facility to use to record its revenue, expenses, other income and outlays, assets and liabilities, and units of service.

2. The board may provide for modifications in the system of accounting and financial reporting to reflect accurately the differences in the scope or type of services and financial organization among the various categories, sizes or types of facilities.

**Sec. 10.** 1. Each facility shall file with the board the following financial statements or reports in a form and at intervals specified by the board:

(a) A balance sheet setting forth in detail the assets, liabilities and net worth of the facility for its fiscal year;

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

(c) Any other reports of the costs incurred by the facility to provide services which the board may prescribe.

2. The financial statements filed pursuant to this section must be prepared in accordance with the system of accounting and reporting adopted pursuant to section 9 of this act. The board shall require the certification of those financial statements or reports by a certified public accountant and may require an attestation from the person responsible for filing the statements or reports of the facility that the statements or reports have, to the best of his knowledge and belief, been prepared in accordance with the system of accounting and reporting prescribed by the board.

3. The board shall require the filing of each report or statement required pursuant to this section at least annually.

4. All reports and statements, except privileged medical information, which are filed with the board pursuant to this chapter are public records.

**Sec. 11.** 1. If the board determines that an investigation is necessary to verify the accuracy of any information contained in a report or statement filed with the board by a facility, the board may make an examination of the facility's records and accounts. An examination conducted pursuant to this section may include, but is not limited to, a full or partial audit of all records and accounts of the facility.

2. The board may, in carrying out its duties prescribed in this section, use the employees of the department or enter into an agreement with a person who is qualified to conduct such an examination. A person who conducts an examination pursuant to this section shall not release, publish or otherwise use

any information made available pursuant to the agreement unless permission is specifically granted by the board.

3. The facility which is the subject of the examination is responsible for payment of the costs of the examination.

**Sec. 12.** The board:

1. Shall conduct analyses and studies relating to the costs of health care in this state and other western states, the financial status of any facility and any other matters it considers necessary to carry out its duties.

2. May publish and disseminate any information relating to the financial aspects of health care which the board considers in the public interest.

3. Shall require the filing of information concerning the total financial requirements of each facility and the resources available or expected to become available to meet those requirements, including, without limitation, the effect of any proposal made by a local or state health planning agency. The information concerning each facility must be organized into the following categories:

(a) Assessments;

(b) Operating expenses;

(c) Interest on the amortization of debts incurred on capital improvements;

(d) Uncollectible charges and bad debts;

(e) Depreciation of property and equipment;

(f) Working capital; and

(g) Return on shareholder equity, if a facility is a corporation for profit.

**Sec. 13.** 1. The board shall prepare any summary, compilation or other supplementary report based on the information filed with the board which it considers necessary to carry out its duties.

2. Each summary, compilation or report prepared by the board must be:

(a) Prepared within a reasonable time after the end of each facility's fiscal year or more frequently as required by the board;

(b) Made available for public inspection; and

(c) Transmitted to any person who requests a copy.

**Sec. 14.** The board shall annually prepare and submit to the governor and to the legislative committee on health care a report of its operations and activities for the preceding fiscal year. The report must include copies of all summaries, compilations and supplementary reports required by this chapter and any facts, information and recommendations concerning proposed legislation which the board considers appropriate.

**Sec. 15.** The board shall:

1. Prescribe by regulation the types and classes of rates which must be approved by the board and may not be revised without the approval of the board.

2. Approve for each facility a schedule of rates of the types and classes prescribed pursuant to subsection 1 and any proposed revisions of the schedule.

3. Allow any facility which is organized pursuant to chapter 81 of NRS, otherwise organized not for profit, or operated by a local government, to

charge reasonable rates which will enable the facility to provide efficient services on a sound financial basis.

4. Allow a facility organized for profit to charge reasonable rates for the services it provides to enable the facility to provide:

(a) Efficient services; and

(b) A return to shareholders based upon the actual investment or fair value of the investment, whichever is less.

5. Consider:

(a) Any recommendations submitted to the board by a local or state health planning agency; and

(b) The results of the comparisons made pursuant to section 17 of this act, in determining reasonable rates for each facility.

6. Consider whether a facility will produce a sufficient amount of revenue to comply with the requirements set forth in this section in reviewing a request for a change in a schedule of rates.

**Sec. 16.** The board may:

1. Conduct reviews or investigations necessary to ensure that:

(a) The total costs of each facility are reasonably related to the total services offered;

(b) The aggregate rates of each facility are reasonably related to its aggregate costs; and

(c) The rates for the services each facility provides are allocated equitably among all users of those services without discrimination or preference.

2. Promote and approve alternative methods for determining rates and payments of an experimental nature which may be in the public interest.

3. Establish a uniform method of reimbursement and a schedule of maximum rates for a state agency which purchases services for health care. A state agency is not required to pay the maximum rates established pursuant to this subsection.

**Sec. 17.** 1. The board shall annually establish an estimate of the total amount to be spent during the succeeding year for:

(a) All services provided by facilities; and

(b) Services provided by each type of facility.

The board shall make separate estimates pursuant to this subsection for the total amount to be spent by state agencies during the succeeding year.

2. The board shall compare the estimates made pursuant to subsection 1 with the actual amount spent during the year and adjust the schedules of rates established pursuant to sections 15 and 16 of this act as the board deems appropriate.

**Sec. 18.** 1. Except as otherwise provided in this section, a facility shall not charge any person a rate for health care that is higher than the rate set forth in its schedule of rates approved by the board or change a rate without the approval of the board, if the rate is within a type or class that requires approval pursuant to regulations adopted by the board.

2. A facility may request a change in its schedule of rates if it submits to the board a written request and any supporting information required by the board concerning the request. Unless the board orders otherwise, no facility may

change its schedule of rates unless it provides at least 30 days' notice to the board. The board may, after receiving the notice, suspend the effective date of any change proposed by the facility for not more than 60 days after the date the change would otherwise have become effective. In any such case, the board shall promptly submit to the facility a written statement of the reasons for the suspension. Unless suspended or disapproved by the board, the proposed change is effective upon the date set forth in the facility's request.

3. If the board suspends the effective date of a change in a schedule of rates proposed by a facility, the board shall promptly begin proceedings to review the suspension of the proposed change. The proposed change is effective after the period of suspension unless the board disapproves the change.

4. The board may require that any such proposal be considered at a public hearing. The board shall fix a time and place for the hearing.

5. The board may allow a facility to make a temporary change in its schedule of rates effective upon submitting a request to the board if the board deems it in the public interest to do so. The board shall conduct a review of the temporary rate in the manner set forth in this section as soon thereafter as is practicable.

6. Each decision or order issued by the board pursuant to this section in any contested proceeding must be in writing and set forth the grounds for the board's action. Any order issued by the board pursuant to this section must be prospective in nature.

**Sec. 19.** 1. The board may, upon a majority vote of its members, issue subpenas for the attendance of witnesses and the production of books and papers.

2. If any witness refuses to attend or testify or produce any books or papers required by a subpena, the board may file a petition ex parte with the district court, setting forth that:

(a) Due notice has been given of the time and place for the attendance of the witness or the production of the books or papers;

(b) The witness has been subpenaed in the manner prescribed by this chapter;

(c) The witness has failed or refused to attend or produce the books or papers required by the subpena before the board in the cause or proceeding named in the subpena, or has refused to answer questions propounded to him in the course of the hearing; and

(d) The board therefore requests an order of the court compelling the witness to attend and testify or produce the books or papers before the board.

3. The court, upon such a petition, shall enter an order directing the witness to appear before the court at a time and place fixed by the court in the order, and then and there to show cause why he has not attended or testified or produced the books or papers before the board. The time may not be more than 10 days after the date of the order. A certified copy of the order must be served upon the witness.

4. If the court determines that the subpena was regularly issued by the board, the court shall thereupon enter an order that the witness appear before

the board at the time and place fixed in the order, and testify or produce the required books or papers. Failure to obey the order is a contempt of the court which issued it.

**Sec. 20.** 1. Any person who knowingly violates any of the provisions of this chapter or the regulations adopted pursuant thereto is guilty of a misdemeanor.

2. The board may impose an administrative fine of not more than $100 per day for each violation of a provision of this chapter or a regulation adopted pursuant thereto.

3. Any money collected as a result of an administrative fine imposed pursuant to subsection 2 must be deposited in the state general fund.

**Sec. 21.** NRS 439A.106 is hereby amended to read as follows:

439A.106 1. The department 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 listing must include information regarding each hospital's average and total contractual allowances to categories of payers who pay on the basis of alternative rates rather than billed charges.

2. The department shall not disclose or report the details of contracts entered into by a hospital, or disclose or report information pursuant to this section in a manner that would allow identification of an individual payer or other party to a contract with the hospital, except that the department may disclose to other state agencies the details of contracts between the hospital and a related entity. A state agency shall not disclose or report information disclosed to the agency by the department pursuant to this subsection in a

manner that would allow identification of an individual payer or other party to a contract with the hospital.

3. The department shall report quarterly to the *board to regulate the cost of health care and the* legislative committee on health care regarding the effects of legislation on the costs of health care and on the manner of its provision.

4. As used in this section, "related entity" means an affiliated person or subsidiary as those terms are defined in NRS 439B.430.

**Sec. 22.** NRS 439B.220 is hereby amended to read as follows:

439B.220 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.

*18. Review the activities of the board to regulate the cost of health care and cooperate with the board to accomplish the purposes of this chapter and sections 2 to 20, inclusive, of this act.*

**Sec. 23.** NRS 439B.400 is hereby amended to read as follows:

439B.400 *1.* 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.

*2. Each hospital in this state shall submit the uniform list of billed charges maintained pursuant to subsection 1 to the department at the end of each calendar quarter.*

*3. The charges specified in the uniform list of billed charges must not be higher than the rates set forth in the schedule of rates approved by the board to regulate the cost of health care.*

**Sec. 24.** 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. 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 board to regulate the cost of health care and* 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 *must be allocated as follows:*

*(a) Seventy percent of the amount collected must be deposited in the state general fund for the support of the board to regulate the cost of health care.*

*(b) Thirty percent of the amount collected must be deposited in the legislative fund* for the support of the legislative committee on health care . [must be deposited in the legislative fund.]

**Sec. 25.** NRS 449.485 is hereby amended to read as follows:

449.485 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,] *board to regulate the cost of health care,* 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. *The department shall require the provision of such information as is necessary to enable the department to carry out the duties of the board to regulate the cost of health care pursuant to sections 2 to 20, inclusive, of this act.*

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. 26.** NRS 616.412 is hereby amended to read as follows:

616.412 1. All fees and charges for accident benefits are subject to regulation by the department and must not:

(a) Exceed the fees and charges usually paid in the state for similar treatment.

(b) Be unfairly discriminatory as between persons legally qualified to provide the particular service for which the fees or charges are asked.

2. The director shall, giving consideration to the fees and charges being paid in the state, establish a schedule of reasonable fees and charges allowable for accident benefits. The director shall review and revise the schedule on or before October 1 of each year and shall not increase the schedule by any factor greater than the corresponding annual increase in the Consumer Price Index (Medical Care Component).

3. The director may request a health insurer, health maintenance organization or provider of accident benefits, an agent or employee of such a person, or an agency of the state, to provide the director with such information concerning fees and charges paid for similar services as he deems necessary to carry out the provisions of subsections 1 and 2. The director shall not require any person to record or report his fees or charges in a manner inconsistent with the person's own system of records. The director may require a person or entity providing records or reports of fees charged to provide interpretation and identification concerning the information delivered. The director may impose an administrative fine of $500 for each refusal to provide the information requested pursuant to this subsection.

4. The department may adopt reasonable regulations necessary to carry out the provisions of this section. The regulations must *be consistent with any uniform method of reimbursement and schedule of maximum rates adopted by the board to regulate the cost of health care and must* include provisions concerning:

(a) Standards for the development of the schedule of fees and charges;

(b) The periodic revision of the schedule; and

(c) The monitoring of compliance by providers of benefits with the adopted schedule of fees and charges.

5. The department shall adopt regulations requiring the utilization of a system of billing codes as recommended by the American Medical Association [.] *, except to the extent that a different system of billing is required for the system by the board to regulate the cost of health care.*

**Sec. 27.** 1. On or before October 1, 1993, the governor shall appoint to the board to regulate the cost of health care:

(a) Two members whose terms expire on July 1, 1994;

(b) Two members whose terms expire on July 1, 1995; and

(c) Three members whose terms expire on July 1, 1996.

2. On or before July 1, 1994, the board shall adopt the regulations required by section 9 of this act which establish a uniform system of accounting and financial reporting.

3. Each facility shall adopt the uniform system of accounting and financial reporting established pursuant to section 9 of this act on or before October 1, 1994.

4. On or before May 1, 1995, the board shall approve a schedule of rates for each facility, to become effective on July 1, 1995.

5. As used in this section, "board" and "facility" have the meanings ascribed to them in section 2 of this act.

**Sec. 28.** On July 1, 1993, the state controller shall transfer all of the remaining money deposited in the legislative fund for the support of the legislative committee on health care, less $15,000, to an account in the state general fund for the support of the board to regulate the cost of health care.

**Sec. 29.** 1. This section and sections 1 to 9, inclusive, 11 to 17, inclusive, and 19 to 28, inclusive, of this act become effective on July 1, 1993.

2. Section 10 of this act becomes effective on January 1, 1995.

3. Section 18 of this act becomes effective on July 1, 1995.

SUMMARY--Prohibits certain providers of health care under specified circumstances from referring patient to health care facility in which provider of health care has financial interest. (BDR 40-1080)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to health care; prohibiting certain providers of health care under specified circumstances from referring a patient to a health care facility in which the provider of health care has a financial interest; 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 439B of NRS is hereby amended by adding thereto a new section to read as follows:

*1. Except as otherwise provided in this section, a physician licensed under chapter 630, 630A or 633 of NRS, a chiropractor or a doctor of Oriental medicine in any form shall not refer a patient, for a service or for goods related to health care, to a health facility, medical laboratory or commercial*

*establishment in which the physician, chiropractor or doctor of Oriental medicine, has a financial interest.*

*2. Subsection 1 does not apply if the financial interest:*

*(a) Consists of securities issued by a publicly held corporation which are registered with a governmental authority or traded on a national exchange or over the counter;*

*(b) Is ownership of a health facility or medical laboratory where the service or goods are prescribed or provided solely for the patients of the physician, chiropractor or doctor of Oriental medicine or those of a group of physicians, chiropractors or doctors of Oriental medicine to which he belongs, and the service is performed or the goods are provided by him or under his supervision; or*

*(c) Arises from a relation of landlord and tenant between the physician, chiropractor or doctor of Oriental medicine and the enterprise performing the service or providing the goods, unless the rent is determined by the amount of business or the profitability of the enterprise or is unrelated to fair market value.*

*3. A physician, chiropractor or doctor of Oriental medicine in any form may apply to the department of insurance for a waiver from the prohibitions of subsection 1. The department of insurance shall grant the waiver if it determines that the facilities and resources in the community for the goods or service required are of such limited supply that the best interests of the patient would be served by granting the waiver. If a waiver is granted, before the referral, the physician, chiropractor or doctor of Oriental medicine shall inform the patient*

*of the financial interest and of the patient's right to obtain the service or goods from another enterprise of his choice.*

*4. A person who violates the provisions of this section is guilty of a misdemeanor.*

*5. As used in this section, "patient" means a person who consults with or is examined or interviewed by a practitioner or health facility for purposes of diagnosis or treatment.*

**Sec. 2.** NRS 439B.420 is hereby amended to read as follows:

439B.420 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] *The* rent required of a physician or entity which employs physicians by a hospital or related entity [may] *must not* 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] *A* health facility [may] *shall not* 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 35,000.

6. A hospital, if acting as a billing agent for a medical practitioner performing services in the hospital, [must] *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] *A* hospital or related entity [may] *shall not* 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] *Except as otherwise provided in this subsection, 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] *referring party* first discloses the interest [.] *to the patient. This subsection does not apply to practitioners subject to the provisions of section 1 of this act.*

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 NRS 439B.430.

**Sec. 3.** NRS 616.690 is hereby amended to read as follows:

616.690 1. A physician or chiropractor attending an injured employee shall not refer that employee to a health facility [or service] , *medical laboratory or commercial establishment* in which the physician or chiropractor has a financial interest [, including an interest as a limited partner,] *to which subsection 1 of section 1 of this act applies,* unless he first *obtains a waiver in compliance with subsection 3 of section 1 of this act and* discloses [that] *the financial* interest in writing to the injured employee and the insurer. Upon the request of an injured employee to whom such a disclosure is made, the

physician or chiropractor shall provide the injured employee with a referral to a health facility [or service] , *medical laboratory or commercial establishment* in which the physician or chiropractor does not have *such* a financial interest. The injured employee must not be penalized for refusing to use a health facility or service in which the physician or chiropractor has *such* a financial interest, if the injured employee promptly notifies the insurer in writing of his objection to using the *health* facility [or service.

2. As used in this section, "health facility" means any facility in or through which services related to the care and observation of patients, the diagnosis of human diseases, the treatment and rehabilitation of patients or other related services are provided. The term includes any parent, affiliate, subsidiary or partner of such a facility and any other entity which has a primary purpose of providing a benefit to such a facility.] , *laboratory or establishment.*

**Sec. 4.** NRS 630.305 is hereby amended to read as follows:

630.305 The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Directly or indirectly receiving from any person, corporation or other business organization any fee, commission, rebate or other form of compensation which is intended or tends to influence the physician's objective evaluation or treatment of a patient.

2. Dividing a fee between licensees except where the patient is informed of the division of fees and the division of fees is made in proportion to the services personally performed and the responsibility assumed by each licensee.

3. Referring , *in violation of section 1 of this act,* a patient to [any] *a health facility,* medical laboratory *or commercial establishment* in which the licensee has a financial interest . [unless the laboratory is operated solely in connection with the diagnosis and treatment of his own patients.]

4. Referring , *in violation of NRS 616.690,* an injured employee to a health facility , *medical laboratory or commercial establishment* in which the licensee has a financial interest . [unless he first discloses that interest pursuant to NRS 616.690.]

5. Charging for visits to the physician's office which did not occur or for services which were not rendered or documented in the records of the patient.

6. Aiding, assisting, employing or advising, directly or indirectly, any unlicensed person to engage in the practice of medicine contrary to the provisions of this chapter or the regulations of the board.

7. Delegating responsibility for the care of a patient to a person when the licensee knows, or has reason to know, that this person is not qualified to undertake that responsibility.

8. Failing to disclose to a patient any financial or other conflict of interest.

**Sec. 5.** NRS 630.352 is hereby amended to read as follows:

630.352 1. Any member of the board, except for an advisory member serving on a panel of the board hearing charges, may participate in the final order of the board. If the board, after a formal hearing, determines from clear and convincing evidence [,] that a violation of the provisions of this chapter or of the regulations of the board has occurred, it shall issue and serve on the

physician charged an order, in writing, containing its findings and any sanctions.

2. If the board determines that no violation has occurred, it shall dismiss the charges, in writing, and notify the physician that the charges have been dismissed. If the disciplinary proceedings were instituted against the physician as a result of a complaint filed against him, the board may provide the physician with a copy of the complaint, including the name of the person, if any, who filed the complaint.

3. Except as otherwise provided in subsection 4, if the board finds that a violation has occurred, it may by order:

(a) Place the person on probation for a specified period on any of the conditions specified in the order;

(b) Administer to him a public reprimand;

(c) Limit his practice or exclude one or more specified branches of medicine from his practice;

(d) Suspend his license for a specified period or until further order of the board;

(e) Revoke his license to practice medicine;

(f) Require him to participate in a program to correct alcohol or drug dependence or any other impairment;

(g) Require supervision of his practice;

(h) Impose a fine not to exceed $5,000;

(i) Require him to perform public service without compensation;

(j) Require him to take a physical or mental examination or an examination testing his competence; and

(k) Require him to fulfill certain training or educational requirements.

4. If the board finds that the physician has violated the provisions of NRS 616.690 [, it] *or section 1 of this act, the board* shall suspend his license for a specified period or until further order of the board.

**Sec. 6.** NRS 634.140 is hereby amended to read as follows:

634.140 The grounds for initiating disciplinary action pursuant to this chapter are:

1. Unprofessional conduct.

2. Conviction of:

(a) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;

(b) A felony; or

(c) Any offense involving moral turpitude.

3. Suspension or revocation of the license to practice chiropractic by any other jurisdiction.

4. Gross or repeated malpractice.

5. Referring , *in violation of section 1 of this act or NRS 616.690,* an injured employee to a health facility , *medical laboratory or commercial establishment* in which the licensee has a financial interest . [unless he first discloses that interest pursuant to NRS 616.690.]

**Sec. 7.** NRS 634.190 is hereby amended to read as follows:

634.190 1. The person charged is entitled to a hearing before the board, but the failure of the person charged to attend his hearing or his failure to defend himself does not delay or void the proceedings. The board may, for good cause shown, continue any hearing from time to time.

2. If the board finds the person guilty as charged in the complaint, it may by order:

(a) Place the person on probation for a specified period or until further order of the board.

(b) Administer to the person a public or private reprimand.

(c) Limit the practice of the person to, or by the exclusion of, one or more specified branches of chiropractic.

(d) Suspend the license of the person to practice chiropractic for a specified period or until further order of the board.

(e) Revoke the license of the person to practice chiropractic.

(f) Impose a fine of not more than $5,000, which must be deposited with the state treasurer for credit to the state general fund.

The order of the board may contain such other terms, provisions or conditions as the board deems proper and which are not inconsistent with law.

3. If the board finds that a licensee has violated the provisions of NRS 616.690 **[**, it**]** *or section 1 of this act, the board* shall suspend his license for a specified period or until further order of the board.

**Sec. 8.** NRS 652.235 is hereby amended to read as follows:

652.235 1. A licensed physician may operate a medical laboratory solely in connection with the diagnosis or treatment of his own patients if the medical laboratory complies with the provisions of this section.

2. Each such medical laboratory shall:

(a) Register with the health division of the department of human resources.

(b) Comply with the rules and regulations adopted by the board pursuant to NRS 652.130.

(c) Submit to the inspections and tests provided for in subsections 1 and 2 of NRS 652.140.

[3. A licensed physician shall not refer a patient to a medical laboratory in which the physician has a financial interest unless it is operated solely in connection with the diagnosis or treatment of his own patients.]

SUMMARY--Requires director of department of human resources, in cooperation with commissioner of insurance, to develop uniform electronic system of billing for health services. (BDR 40-1081)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to planning for health care; requiring the director of the department of human resources, in cooperation with the commissioner of insurance, to develop a uniform electronic system of billing for health services; requiring certain providers of health services to use that system of billing; and providing other matters properly relating thereto.

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

**Section 1.** Chapter 439A of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The director shall, in cooperation with the commissioner of insurance, adopt by regulation a uniform electronic system of billing for health services provided by a health facility or any person licensed to practice one of the health professions regulated by Title 54 of NRS. The system of billing must comply*

*with any provision of NRS which sets forth requirements for billing patients for the provision of health services.*

*2. Each health facility and each person who is licensed to practice one of the health professions regulated by Title 54 of NRS shall use the system of billing adopted pursuant to subsection 1.*

**Sec. 2.** NRS 616.412 is hereby amended to read as follows:

616.412 1. All fees and charges for accident benefits are subject to regulation by the department and must not:

(a) Exceed the fees and charges usually paid in the state for similar treatment.

(b) Be unfairly discriminatory as between persons legally qualified to provide the particular service for which the fees or charges are asked.

2. The director shall, giving consideration to the fees and charges being paid in the state, establish a schedule of reasonable fees and charges allowable for accident benefits. The director shall review and revise the schedule on or before October 1 of each year and shall not increase the schedule by any factor greater than the corresponding annual increase in the Consumer Price Index (Medical Care Component).

3. The director may request a health insurer, health maintenance organization or provider of accident benefits, an agent or employee of such a person, or an agency of the state, to provide the director with such information concerning fees and charges paid for similar services as he deems necessary to carry out the provisions of subsections 1 and 2. The director shall not require any person to record or report his fees or charges in a manner inconsistent

with the person's own system of records. The director may require a person or entity providing records or reports of fees charged to provide interpretation and identification concerning the information delivered. The director may impose an administrative fine of $500 for each refusal to provide the information requested pursuant to this subsection.

4. The department may adopt reasonable regulations necessary to carry out the provisions of this section. The regulations must include provisions concerning:

(a) Standards for the development of the schedule of fees and charges;

(b) The periodic revision of the schedule; and

(c) The monitoring of compliance by providers of benefits with the adopted schedule of fees and charges.

[5. The department shall adopt regulations requiring the utilization of a system of billing codes as recommended by the American Medical Association.]

**Sec. 3.** NRS 689A.105 is hereby amended to read as follows:

689A.105 *1.* Every insurer under a health insurance contract and every state agency for its records shall accept from:

[1.] *(a)* A hospital the Uniform Billing and Claims Forms established by the American Hospital Association in lieu of its individual billing and claims forms.

[2. An individual]

*(b) A health facility a copy of any bill presented to a patient in the form required by the system of billing adopted pursuant to section 1 of this act.*

*(c) A person* who is licensed to practice one of the health professions regulated by Title 54 of NRS [such] *:*

*(1) Such* uniform health insurance claims forms as the commissioner shall prescribe, except in those cases where the commissioner has excused uniform reporting.

*(2) A copy of any bill presented to a patient in the form required by the system of billing adopted pursuant to section 1 of this act.*

*2. As used in this section, "health facility" has the meaning ascribed to it in NRS 439A.015.*

**Sec. 4.** NRS 689B.250 is hereby amended to read as follows:

689B.250 *1.* Every insurer under a group health insurance contract or a blanket health insurance contract and every state agency, for its records shall accept from:

[1.] *(a)* A hospital the Uniform Billing and Claims Forms established by the American Hospital Association in lieu of its individual billing and claims forms.

[2. An individual]

*(b) A health facility a copy of any bill presented to a patient in the form required by the system of billing adopted pursuant to section 1 of this act.*

*(c) A person* who is licensed to practice one of the health professions regulated by Title 54 of NRS [such] *:*

*(1) Such* uniform health insurance claims forms as the commissioner shall prescribe, except in those cases where the commissioner has excused uniform reporting.

*(2) A copy of any bill presented to a patient in the form required by the system of billing adopted pursuant to section 1 of this act.*

*2. As used in this section, "health facility" has the meaning ascribed to it in NRS 439A.015.*

SUMMARY--Requires director of department of human resources to adopt standards of care for provision of health services. (BDR 40-1082)

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 adopt standards of care for the provision of health services; requiring practitioners to comply with those standards of 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 439A of NRS is hereby amended by adding thereto a new section to read as follows:

*1. Except as otherwise provided in NRS 616.188, the director shall, after consulting with and considering the advice of practitioners, adopt regulations establishing standards of care for the provision of health services. The standards of care must:*

*(a) Include, but are not limited to, criteria and protocols to be used as minimal guides for evaluating and ensuring the appropriateness and quality of health services provided by practitioners;*

*(b) Be consistent with national or regional guidelines; and*

*(c) Be specific to the various occupations providing health services.*

*2. The director shall, after consulting with and considering the advice of practitioners, periodically review and revise as necessary the standards of care adopted pursuant to subsection 1.*

*3. Any practitioner providing health services in this state shall comply with the standards of care adopted pursuant to subsection 1.*

SUMMARY--Imposes tax on providers of health care. (BDR 40-1083)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to health care; imposing a tax on providers of health care; making a continuing appropriation of the proceeds of the tax; providing penalties; 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 63, 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 9, inclusive, of this act have the meanings ascribed to them in those sections.

**Sec. 3.** "Department" means the department of human resources.

**Sec. 4.** "Director" means the director of the department.

**Sec. 5.** "Medical facility" has the meaning ascribed to it in NRS 449.0151, but excludes a facility operated by the United States or an agency or instrumentality of the United States.

**Sec. 6.** "Net revenue" means the adjusted gross income of a natural person or the taxable income of a corporation, as defined in the Internal Revenue Code.

**Sec. 7.** "Person" includes a government, governmental agency or political subdivision of a government.

**Sec. 8.** "Practitioner" means a person licensed pursuant to chapter 630, 630A, 631, 632, 633, 634, 634A, 635, 636 or 640 of NRS.

**Sec. 9.** "Provider of health care" means a practitioner or a medical facility.

**Sec. 10.** 1. Except as limited or otherwise provided in this chapter, a tax is hereby imposed at the rate of 5 percent upon that portion of the net revenue of every provider of health care, who resides or has a place of business in this state, which is derived from providing health care. If a provider of health care has more than one place of business, at least one of which is outside this state, the tax is imposed upon that fraction of his net revenue from providing health care which equals the ratio of his gross revenue from the places of business in this state to his gross revenue from all places of business.

2. The director shall adopt regulations specifying the criteria for determining the portion of the net revenue of practitioners and medical facilities which is derived from providing health care.

3. The tax imposed by subsection 1 does not apply to compensation received for personal services from another provider of health care.

**Sec. 11.** 1. The tax imposed by this chapter on a provider of health care must be reduced pursuant to the regulations adopted by the department, but not below the rate of 2 percent, if the provider of health care accepts patients

whose care is paid for by or through the state plan for assistance to the medically indigent, by the state industrial insurance system, by a county as medical assistance to the indigent, by an indigent person directly, or by or through a similar source designated as eligible by the department, and makes no charge to the patient beyond the payment received from the eligible source.

2. The department shall by regulation:

(a) Establish, and change from time to time as the facts warrant, the proportion of patients qualified pursuant to subsection 1 which a provider of health care must accept in order to earn a reduction to the rate of 2 percent.

(b) Designate, as eligible, sources of payment whose payment for typical care is substantially less than the payment received for similar care from a commercial insurer or directly from a patient of ordinary means.

3. If a provider of health care accepts, during the period for which he makes a report, patients qualified pursuant to subsection 1 but his proportion of such patients is less than the proportion determined by the department pursuant to paragraph (b) of subsection 2, his rate of tax for that period is reduced by that fraction of 3 percent which equals the ratio of the proportion he accepts to the proportion determined by the department.

**Sec. 12.** The director shall adopt regulations appropriate to administer the provisions of this chapter and shall prescribe the form of returns to be made by persons upon whose net revenue the tax is imposed by this chapter.

**Sec. 13.** Except as otherwise provided in section 15 of this act, the tax imposed by this chapter is payable to the department monthly on or before the last day of the month next succeeding the month for which it is due.

**Sec. 14.** 1. On or before the last day of the month following each reporting period, a return for the preceding period must be filed with the department in such form as the director prescribes.

2. A return must be filed by each provider of health care on whose net revenue the tax is imposed by this chapter. The return must be signed by the person required to file the return or his authorized agent. The return is not required to be verified by oath.

**Sec. 15.** 1. The return must show the net revenue received by the taxpayer during the preceding reporting period on which the tax is imposed by this chapter.

2. The return must also show the amount of the tax for the period covered by the return and such other information as the department deems necessary for the proper administration of this chapter.

3. The person required to file the return shall deliver the return with a remittance of the amount of the tax due to the department.

4. The department, if it deems it necessary to ensure payment to or facilitate the collection of the amount of taxes, may require returns and payment of the amount of taxes for periods other than calendar months.

**Sec. 16.** The department may, for good cause, extend for a period not to exceed 1 month the time for making any return or paying any amount required to be paid pursuant to this chapter. If the tax is paid during the period of the extension, the tax must be accompanied by a payment of interest of 1.5 percent of the amount due, but no penalty may be imposed upon the payment.

**Sec. 17.** 1. If the department is not satisfied with the return or returns of the tax or the amount of tax required to be paid to the state by a provider of health care, or if no return was made, the department may compute and determine the amount required to be paid upon the basis of the facts contained in the return or returns or upon the basis of any information within its possession or that may come into its possession. One or more deficiency determinations may be made of the amount due for one or for more than one period.

2. In making a determination the department may offset an overpayment for a period, together with interest on the overpayment, against any underpayment for another period, against any penalty or interest on the underpayment.

3. The interest on an underpayment must be computed at the rate of 1.5 percent for each month or fraction of a month from the date the return was due to the date of payment. Interest on an overpayment must be computed in the manner set forth in section 43 of this act.

4. If any part of the deficiency for which a deficiency determination is made is because of fraud or an intent to evade the provisions of this chapter or any regulations adopted pursuant thereto, a penalty of 25 percent of the amount of the determination must be added to it.

5. If a practitioner discontinues his practice or a medical facility discontinues its operation, a determination may be made at any time thereafter concerning liability arising out of that practice or operation, whether or not the

determination is issued before the date the liability is due as otherwise specified in this chapter.

**Sec. 18.** 1. The department shall give written notice of its determination to each provider of health care affected by the determination.

2. The notice may be served personally or by mail. If the notice is served by mail, the notice must be addressed to the provider of health care at the address as it appears in the records of the department.

3. In the case of service by mail of any notice required by this chapter, the service is complete when the notice is deposited with the United States Postal Service.

**Sec. 19.** 1. Any provider of health care against whom a determination is made pursuant to section 17 of this act, or any other person directly interested, may petition for a redetermination within 30 days after service upon the person of the notice of the determination.

2. If a petition for redetermination is not filed within the 30-day period, the determination becomes final at the expiration of the period.

**Sec. 20.** 1. If a petition for redetermination is filed within the 30-day period, the department shall reconsider the determination and, if the provider of health care so requested in the petition, shall grant an oral hearing and give 10 days' notice of the time and place of the hearing.

2. The department may continue the hearing from time to time as necessary.

**Sec. 21.** The department may decrease or increase the amount of the determination before it becomes final, except that the amount may be

increased only if a claim for the increase is asserted by the department at or before the hearing.

**Sec. 22.** The order or decision of the department upon a petition for redetermination becomes final 30 days after the service upon the petitioner of the notice of the order or decision.

**Sec. 23.** All determinations made by the department pursuant to section 17 of this act, are due at the time they become final. If they are not paid when due, a penalty of 10 percent of the amount of the determination, exclusive of interest and penalties, must be added to it.

**Sec. 24.** Any notice required by sections 17 to 22, inclusive, of this act, must be served personally or by mail in the manner prescribed for service of notice of a deficiency determination.

**Sec. 25.** 1. The department, if it deems it necessary to ensure compliance with this chapter, may require any person subject to the chapter to place with it such security as the department may determine. The department shall fix the amount of the security which, except as otherwise provided in subsection 2, may not be greater than three times the estimated average tax due monthly of persons filing returns for monthly periods, determined in such manner as the department deems proper.

2. In the case of persons who are habitually delinquent in their obligations pursuant to this chapter, the amount of the security may not be greater than five times the average actual tax due monthly of persons filing returns for monthly periods.

3. The limitations provided in this section apply regardless of the type of security placed with the department.

4. The amount of the security may be increased or decreased by the department subject to the limitations provided in this section.

5. The department may sell the security at public auction if it becomes necessary to recover any tax or any amount required to be collected, interest or penalty due. Notice of the sale may be served upon the person who placed the security personally or by mail. If the notice is served by mail, service must be made in the manner prescribed for service of a notice of a deficiency determination and must be addressed to the person at his address as it appears in the records of the department. Security in the form of a bearer bond issued by the United States or the State of Nevada which has a prevailing market price may be sold by the department at a private sale at a price not lower than the prevailing market price.

6. Upon any sale any surplus above the amounts due must be returned to the person who placed the security.

**Sec. 26.** 1. If any amount required to be paid to the state pursuant to this chapter is not paid when due, the department may, within 3 years after the amount is due, file for record in the office of any county recorder a certificate specifying the amount, interest and penalty due, the name and address as it appears on the records of the department of the person liable for the amount due, and the fact that the department has complied with all provisions of this chapter in the determination of the amount required to be paid.

2. From the time of the filing for record, the amount required to be paid, together with interest and penalty, constitutes a lien upon all real and personal property in the county owned by the person or acquired by him afterwards and before the lien expires. The lien has the effect and priority of a judgment lien and continues for 5 years after the time of the filing of the certificate unless sooner released or otherwise discharged.

3. The lien may, within 5 years after the date of the filing of the certificate or within 5 years after the date of the last extension of the lien pursuant to this subsection, be extended by filing for record a new certificate in the office of the county recorder of any county, and from the time of filing, the lien is extended to the real and personal property in the county for 5 years, unless sooner released or otherwise discharged.

**Sec. 27.** If any amount required to be paid to the state pursuant to this chapter is not paid when due, the department may, within 3 years after the amount is due, file in the office of the county clerk of any county a certificate specifying the amount required to be paid, interest and penalty due, the name and address as it appears on the records of the department of the person liable, the compliance of the department with this chapter in relation to the determination of the amount required to be paid and a request that judgment be entered against the person in the amount required to be paid, together with interest and penalty as set forth in the certificate.

**Sec. 28.** The county clerk immediately upon the filing of the certificate shall enter a judgment for the State of Nevada against the person in the amount

required to be paid, together with interest and penalty as set forth in the certificate.

**Sec. 29.** Execution must issue upon the judgment upon request of the department in the same manner as execution may issue upon other judgments, and sales must be held pursuant to the execution as prescribed by law.

**Sec. 30.** 1. An abstract of the judgment or a copy thereof may be filed for record with the county recorder of any county.

2. From the time of the filing, the amount required to be paid, together with interest and penalty set forth, constitutes a lien upon all the real and personal property in the county owned by the person liable or acquired by him afterwards and before the lien expires. The lien has the effect and priority of a judgment lien and continues for 5 years after the date of the judgment so entered by the county clerk unless sooner released or otherwise discharged.

3. The lien may, within 5 years after the date of the judgment or within 5 years after the date of the last extension of the lien pursuant to this subsection, be extended by filing for record in the office of the county recorder of any county, an abstract or copy of the judgment, and from the time of filing, the lien is extended to the real and personal property in the county for 5 years, unless sooner released or otherwise discharged.

**Sec. 31.** 1. The department may at any time release all or any portion of the property subject to any lien provided for in this chapter from the lien or subordinate the lien to other liens and encumbrances if it determines that the amount, interest and penalties are secured sufficiently by a lien on other

property or that the release or subordination of the lien will not jeopardize the collection of the amount, interest and penalties.

2. A certificate by the department to the effect that any property has been released from the lien, or that the lien has been subordinated to other liens and encumbrances, is conclusive evidence that the property has been released or the lien has been subordinated as provided in the certificate.

**Sec. 32.** 1. At any time within 3 years after any person is delinquent in the payment of any amount required to be paid, or within 3 years after the last recording of an abstract pursuant to section 30 of this act, or a certificate pursuant to section 26 of this act, the department or its authorized representative may issue a warrant for the enforcement of any liens and the collection of any amount required to be paid to the state pursuant to this chapter.

2. The warrant must be directed to any sheriff or constable and has the same effect as a writ of execution.

3. The warrant must be levied and sale made pursuant to it in the same manner and with the same effect as a levy of and a sale pursuant to a writ of execution.

**Sec. 33.** 1. The department may pay or advance to the sheriff or constable the same fees, commissions and expenses for his services as are provided by law for similar services pursuant to a writ of execution. The department shall approve the fees for publication in a newspaper.

2. The fees, commissions and expenses are the obligation of the person required to pay any amount pursuant to this chapter and may be collected

from him by virtue of the warrant or in any other manner provided in this chapter for the collection of the tax.

**Sec. 34.** At any time within 3 years after any tax or any amount of tax required to be collected becomes due, and at any time within 3 years after the delinquency of any tax or any amount of tax required to be collected, or within 3 years after the last recording of an abstract pursuant to section 30 of this act or a certificate pursuant to section 26 of this act, the department may bring an action in the courts of this state, or any other state, or of the United States, in the name of the State of Nevada, to collect the amount delinquent together with penalties and interest.

**Sec. 35.** The attorney general shall prosecute the action and the provisions of NRS and the Nevada Rules of Civil Procedure and Nevada Rules of Appellate Procedure relating to service of summons, pleadings, proofs, trials and appeals apply to the proceedings.

**Sec. 36.** In the action a writ of attachment may issue, and no bond or affidavit previous to the issuing of the attachment is required.

**Sec. 37.** In the action a certificate by the department showing the delinquency is prima facie evidence of the determination of the tax or the amount of the tax, of the delinquency of the amounts set forth and of the compliance by the department with all the provisions of this chapter in relation to the computation and determination of the amounts.

**Sec. 38.** If a person who is liable for any amount pursuant to this chapter discontinues his practice or its operations, a purchaser of the assets shall withhold sufficient of the purchase price to cover that amount until the former

owner produces a receipt from the department showing that it has been paid or a certificate stating that no amount is due.

**Sec. 39.** 1. If a purchaser of assets fails to withhold the purchase price as required, he becomes personally liable for the payment of the amount required to be withheld by him to the extent of the purchase price, valued in money. Within 60 days after receiving a written request from the purchaser for a certificate or within 60 days after the date the former owner's records are made available for audit, whichever period expires later, but not later than 90 days after receiving the request, the department shall issue the certificate or mail notice to the purchaser at his address as it appears on the records of the department, of the amount that must be paid as a condition of issuing the certificate.

2. Failure of the department to mail the notice releases the purchaser from any further obligation to withhold the purchase price.

3. The time within which the obligation of a purchaser may be enforced begins when the former owner sells his enterprise or the determination against the former owner becomes final, whichever occurs later.

**Sec. 40.** If the department determines that any amount, penalty or interest has been paid more than once or has been erroneously or illegally collected or computed, the department shall set forth that fact in its records and certify to the state board of examiners the amount collected in excess of the amount legally due and the person from whom it was collected or by whom paid. If approved by the state board of examiners, the excess amount collected or paid must be credited on any amounts then due from the person pursuant to this

chapter, and the balance refunded to the person, or his successors, administrators or executors.

**Sec. 41.** No refund may be allowed unless a claim for it is filed with the department within 3 years after the last day of the month following the close of the period for which the overpayment was made, or, with respect to determinations made pursuant to sections 17 to 22, inclusive, of this act, within 6 months after the determinations become final, or within 6 months after the date of overpayment, whichever period expires later.

**Sec. 42.** 1. A claim must be in writing and must state the specific grounds upon which the claim is founded.

2. Within 30 days after disallowing any claim in whole or in part, the department shall serve notice of its action on the claimant in the manner prescribed for service of notice of a deficiency determination.

**Sec. 43.** 1. Interest must be paid upon an overpayment of tax at the rate of one-half of 1 percent per month from the last day of the calendar month following the period for which the overpayment was made. No refund or credit may be made of any interest imposed upon the person making the overpayment with respect to the amount being refunded or credited.

2. The interest must be paid:

(a) In the case of a refund, to the last day of the calendar month following the date upon which the person making the overpayment, if he has not already filed a claim, is notified by the department that a claim may be filed or the date upon which the claim is certified to the state board of examiners, whichever is earlier.

(b) In the case of a credit, to the same date as that to which interest is computed on the tax or amount against which the credit is applied.

3. If the department determines that any overpayment has been made intentionally or by reason of carelessness, it may not allow any interest on it.

**Sec. 44.** No injunction, writ of mandate or other legal or equitable process may issue in any suit, action or proceeding in any court against this state or against any officer of the state to prevent or enjoin the collection pursuant to this chapter of any tax or any amount of tax required to be collected.

**Sec. 45.** No suit or proceeding may be maintained in any court for the recovery of any amount alleged to have been erroneously or illegally determined or collected unless a claim for a refund or credit has been filed.

**Sec. 46.** 1. Within 90 days after the mailing of the notice of the department's action upon a claim filed pursuant to this chapter, the claimant may bring an action against the department on the grounds set forth in the claim in a court of competent jurisdiction in Carson City or Clark County for the recovery of the whole or any part of the amount with respect to which the claim has been disallowed.

2. Failure to bring an action within the time specified constitutes a waiver of any demand against the state on account of alleged overpayments.

**Sec. 47.** If the department fails to mail a notice of action on a claim within 6 months after the claim is filed, the claimant may, before the mailing of a notice by the department of its action on the claim, consider the claim disallowed and bring an action against the department on the grounds set forth

in the claim for the recovery of the whole or any part of the amount claimed as an overpayment.

**Sec. 48.** If judgment is for a refund, it must be credited on any tax imposed pursuant to this chapter due from the plaintiff. The balance of the judgment must be refunded to the plaintiff.

**Sec. 49.** In any judgment, interest must be allowed at the rate of 6 percent per annum upon the amount found to have been collected illegally from the date of the payment of the amount to the date of the allowance of credit on account of the judgment or to a date preceding the date of the refund warrant by not more than 30 days. The department shall determine that date.

**Sec. 50.** A judgment may not be rendered in favor of the plaintiff in any action brought against the department to recover any amount paid if the action is brought by or in the name of an assignee of the person paying the amount or by any person other than the person who paid the amount.

**Sec. 51.** 1. The department may recover any refund or part of a refund which is erroneously made and any credit or part of a credit which is erroneously allowed in an action brought in a court of competent jurisdiction in Carson City or Clark County in the name of the State of Nevada.

2. The action must be tried in Carson City or Clark County unless the court, with the consent of the attorney general, orders a change of place of trial.

3. The attorney general shall prosecute the action and the provisions of NRS, the Nevada Rules of Civil Procedure and the Nevada Rules of Appellate

Procedure relating to service of summons, pleadings, proofs, trials and appeals are applicable to the proceedings.

**Sec. 52.** 1. If any amount in excess of $25 has been illegally determined by the person filing the return or the department, the department shall certify that fact to the state board of examiners and the board shall authorize the cancellation of the amount upon the records of the department.

2. If an amount not exceeding $25 has been illegally determined by the person filing a return or the department, the department, without certifying this fact to the state board of examiners, shall cancel the amount upon the records of the department.

**Sec. 53.** The department may employ accountants, auditors, investigators, assistants and clerks necessary for the efficient administration of this chapter and may delegate authority to its representatives to conduct hearings or perform any other duties imposed by this chapter.

**Sec. 54.** Each person in this state who is liable for the tax imposed by this chapter:

1. Shall keep records, receipts, invoices and other pertinent papers in such form as the department may require.

2. Who files the returns required pursuant to this chapter shall keep the records for not less than 4 years unless the department in writing sooner authorizes their destruction.

3. Who fails to file the returns required pursuant to this chapter shall keep the records for not less than 8 years unless the department in writing sooner authorizes their destruction.

**Sec. 55.** 1. The department, or any person authorized in writing by it, may examine the books, papers, records and equipment of any taxpayer and may investigate the character of his business to verify the accuracy of any return made, or, if no return is made by the person liable, to determine the amount required to be paid.

2. Any person who keeps outside of this state his records, receipts, invoices and other documents relating to the total amount of the fees, charges and other consideration received by him on which the tax is imposed by this chapter, shall pay to the department an amount equal to the allowance provided for state officers and employees generally while traveling outside of the state for each day or fraction thereof during which an employee of the department is engaged in examining those documents, plus any other actual expenses incurred by the employee while he is absent from his regular place of employment to examine those documents.

**Sec. 56.** 1. Except as otherwise provided in this section, it is unlawful for any member of the Nevada tax commission or officer or employee of the department to make known in any manner whatever the business affairs, operations or information obtained by an investigation of records and equipment of any taxpayer or any other person visited or examined in the discharge of official duty or the amount or source of income, profits, losses, expenditures or any particular of them, set forth or disclosed in any return, or to permit any return or copy of a return, or any book containing any abstract or particulars of it to be seen or examined by any person not connected with the department.

2. The governor may, by general or special order, authorize the examination of the records maintained by the department pursuant to this chapter by:

(a) Other state officers;

(b) Tax officers of another state;

(c) The Federal Government, if a reciprocal arrangement exists; or

(d) Any other person.

The information so obtained may not be made public except to the extent and in the manner that the order may authorize that it be made public.

3. Successors, receivers, trustees, executors, administrators, assignees and guarantors, if directly interested, may be given information concerning the items included in the determination and amounts of any unpaid tax or amounts of tax required to be collected, interest and penalties.

4. Any relevant information may be disclosed as evidence in an appeal by the taxpayer from a determination of the tax due.

**Sec. 57.** The remedies of the state provided for in this chapter are cumulative and no action taken by the department or the attorney general constitutes an election by the state to pursue any remedy to the exclusion of any other remedy for which provision is made in this chapter.

**Sec. 58.** In all proceedings conducted pursuant to the provisions of this chapter, the department may act for and on behalf of the State of Nevada.

**Sec. 59.** 1. All fees, taxes, interest and penalties imposed and all amounts of tax required to be paid to the state pursuant to this chapter must be paid to the department in the form of remittances payable to the department.

2. The department shall deposit all fees, taxes, interest and penalties it receives under this chapter in the state treasury for credit to the medical tax account in the state general fund.

3. The money in the medical tax account may, upon order of the state controller, be used for refunds pursuant to this chapter.

4. Money in the medical tax account which is not needed for refunds is appropriated to the department to be used:

(a) To increase the number of participants in the program to maintain frail elderly persons in their homes who would otherwise require care in a nursing home;

(b) To develop local facilities for preventive medicine through early diagnosis and treatment; and

(c) In partial support of the Nevada health service corps and to extend that program to advanced practitioners of nursing.

A transfer of money pursuant to this subsection and the work program for its expenditure, if not included in the most recent budget approved by the legislature, must be approved by the interim finance committee.

**Sec. 60.** 1. If a medical facility fails to comply with any of the provisions of this chapter relating to the tax imposed by this chapter or any regulation adopted pursuant to this chapter, the department may, after a hearing of which the chief administrative officer of the facility was given prior notice of at least 10 days in writing specifying the time and place of the hearing and requiring him to show cause why the facility's license should not be revoked or suspended, revoke or suspend the license held by the facility.

2. The department shall give to the chief administrator written notice of the suspension or revocation of any of the facility's licenses.

3. The notice may be served personally or by mail in the manner prescribed for the service of a notice of a deficiency determination.

4. The department shall not issue a new license to a facility whose license has been revoked unless it is satisfied that the facility will comply with the provisions of this chapter and the regulations adopted pursuant thereto.

5. If a practitioner fails to comply with any of the provisions of this chapter relating to the tax imposed by this chapter or any regulation adopted pursuant to this chapter, the department shall notify the licensing board for his profession, and the failure constitutes a ground for discipline appropriate to the circumstances of the failure.

**Sec. 61.** Unless a greater penalty is provided in section 62 of this act, a provider of health care in this state who:

1. Fails or refuses to furnish any return required to be made;

2. Fails or refuses to furnish a supplemental return or other data required by the department; or

3. Makes a false or fraudulent return,

shall be fined not more than $500 for each offense.

**Sec. 62.** Any person required to make, render, sign or verify any report who makes any false or fraudulent return, with intent to defeat or evade the determination of an amount due required by law to be made, shall for each offense be fined not less than $300 nor more than $5,000, or be imprisoned for

not more than 1 year in the county jail, or be punished by both fine and imprisonment.

**Sec. 63.** 1. Except as otherwise provided by specific statute, any violation of this chapter is a misdemeanor.

2. Any prosecution for a violation of any of the penal provisions of this chapter must be instituted within 3 years after the commission of the offense.

3. In the determination of any case arising under this chapter, the rule of res judicata is applicable only if the liability involved is for the same period as was involved in another case previously determined.

**Sec. 64.** NRS 396.902 is hereby amended to read as follows:

396.902 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 NRS 396.900 to 396.903, inclusive.

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

*4. To the extent of money made available for the purpose pursuant to section 59 of this act or otherwise by legislative appropriation, extend the program to advanced practitioners of nursing.*

**Sec. 65.** Chapter 439A of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The department shall propose the allocation of money available under section 59 of this act among the purposes enumerated in subsection 4 of that section.*

*2. Within the limits of money whose allocation is approved, and of other legislative appropriation, the department shall plan and assist in the establishment of local facilities for preventive medicine through early diagnosis and treatment.*

SUMMARY--Encourages employers to establish programs to promote employee wellness, physical fitness and prevention of disease and accidents. (BDR R-1084)

CONCURRENT RESOLUTION--Encouraging employers to establish programs to promote employee wellness, physical fitness and the prevention of disease and accidents.

WHEREAS, The cost of health care for employees is frequently borne by their employers; and

WHEREAS, Evidence has increasingly demonstrated that the lifestyle of a person can significantly affect his health and, correspondingly, the cost of his health care; and

WHEREAS, Programs to promote employee wellness, physical fitness and the prevention of disease and accidents often result in healthier lifestyles of employees with a corresponding reduction in medical claims filed by them; now, therefore, be it

RESOLVED BY THE OF THE STATE OF NEVADA, THE CONCURRING, That the members of the Nevada Legislature encourage all employers in this state to establish programs to promote employee wellness, physical fitness and the prevention of disease and accidents.

SUMMARY--Makes appropriation to department of human resources for grants to organizations that provide prenatal care to low-income women. (BDR S-1085)

FISCAL NOTE: Effect on Local Government: No.

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

AN ACT making an appropriation to the department of human resources for the establishment of a grant program for organizations that provide prenatal care to low-income 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.** 1. There is hereby appropriated from the state general fund to the department of human resources the sum of $125,000 to be used to develop and administer a program of grants to organizations that provide prenatal care to low-income women.

2. The department of human resources shall establish criteria for:

(a) Determining the eligibility of organizations for grants through the program; and

(b) The awarding of grants pursuant to the program.

The department shall not use more than $20,000 of the amount appropriated pursuant to subsection 1 for the administration of the program.

3. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 1995, and reverts to the state general fund as soon as all payments of money committed have been made.

**Sec. 2.** This act becomes effective on July 1, 1993.

SUMMARY--Requires health division to establish pilot program to evaluate viability of providing health care centers for pupils. (BDR S-1086)

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 to establish a pilot program to evaluate the viability of providing health care centers for pupils; requiring the health division to establish a consent form for participation in the program; 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.** As used in this act, unless the context otherwise requires:

1. "Center" means a health care center for pupils that is located on school premises and which provides medical treatment and other services related to health care to pupils.

2. "Health division" means the health division of the department of human resources.

3. "Program" means the pilot program established pursuant to section 2 of this act.

**Sec. 2.** 1. The health division shall establish a pilot program to test the viability of providing health care centers for pupils.

2. The health division shall choose two elementary schools, middle schools and high schools, one in an urban area and one in a rural area, to participate in the program. The health division shall allocate the money appropriated pursuant to section 9 of this act and any money received from other sources to the school districts of the chosen schools to establish a center at those schools.

3. The department of education shall assist the health division in establishing and carrying out the pilot program upon the request of the health division.

**Sec. 3.** 1. The health division shall develop a consent form that includes a list of all of the services that each center will provide.

2. Before a center may provide health care services to a pupil, at least one parent or the legal guardian of the pupil must sign and complete the consent form. A consent form will not be complete until the parent or guardian specifies on the form the services that the center may provide to the pupil.

3. A center shall not provide a service to a pupil unless the pupil's parent or guardian has previously consented in writing to the provision of that service to the pupil.

**Sec. 4.** Each center may provide, but is not limited to, the following services:

1. Physical examinations.

2. Measuring blood pressure.

3. Referrals to dentists.

4. Testing of hearing and vision.

5. Screening of scoliosis.

6. Testing for the following illnesses:

(a) Diabetes;

(b) Anemia;

(c) Sickle cell anemia;

(d) Tuberculosis; and

(e) Strep throat.

7. Urinalysis.

8. Immunizations.

9. Treatment for the following medical problems:

(a) Common cold;

(b) Acne;

(c) Earaches;

(d) Influenza;

(e) Epilepsy;

(f) Migraine headaches; and

(g) Sprains, fractures and lacerations.

10. Counseling, referrals and education related to the following:

(a) Alcohol and substance abuse;

(b) Sexual behavior;

(c) Sexually transmitted diseases;

(d) Depression;

(e) Stress; and

(f) Nutrition.

**Sec. 5.** Each school district in which a center is located shall employ the staff necessary to carry out the functions of the center. The staff must consist of at least the following:

1. A school nurse.

2. A secretary.

3. A registered nurse practitioner.

4. A physician who is licensed to practice in this state.

5. A counselor or social worker.

**Sec. 6.** Any information about a pupil that is obtained from the pupil's participation in this program must remain confidential.

**Sec. 7.** 1. The money allocated by the health division pursuant to section 2 of this act may be used for centers which are established as:

(a) Part of a school program that is supervised by the school administrator;

(b) A contractual arrangement between a school and the local health department in which the staff and operating costs are shared;

(c) A leased facility and administered by an agency which is separate from the school; or

(d) Established in any other manner that is likely to accomplish the goals of the program.

2. Regardless of the manner in which a center is established, it must be located on school grounds.

**Sec. 8.** 1. The health division shall, in consultation with the department of education, evaluate the effectiveness of the centers established pursuant to this act. The evaluation must include a review of:

(a) The effect of the centers in reducing the absences of pupils;

(b) The effect of the centers in reducing the drop-out rate of pupils; and

(c) The improvement in the health of pupils as a result of the centers.

2. The health division shall submit a report of its findings and any recommendations for appropriate legislation for the expansion and development of the program to the director of the legislative counsel bureau for presentation to the 68th session of the legislature.

**Sec. 9.** 1. There is hereby appropriated from the state general fund to the health division of the department of human resources the sum of $750,000 to develop a pilot program to provide health care centers for pupils. The division may retain a maximum of $75,000 from the appropriation for its administrative costs or costs related to technical assistance.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 1995, and reverts to the state general fund as soon as all payments of money committed have been made.

3. The health division shall seek additional funding from:

(a) The Federal Government;

(b) Local governments; and

(c) Private contributions.

4. The health division shall apply for any available grants and may accept and use any gifts, grants or donations to aid in the development of the centers.

**Sec. 10.** This act becomes effective on July 1, 1993.

SUMMARY--Requires board of trustees of each school district to provide for daily instruction in physical education to all pupils. (BDR 34-1087)

FISCAL NOTE: Effect on Local Government: Yes.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to education; requiring the board of trustees of each school district to provide daily instruction in physical education to all pupils; 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 389.050 is hereby amended to read as follows:

389.050 1. [All school officers in control of public high schools in the state] *The board of trustees of each school district* shall provide for courses of instruction designed to prepare the pupils for the duties of citizenship, both in time of peace and in time of war. [Such instruction shall include:

(a) Physical training designed to secure the health, vigor and physical soundness of the pupil.

(b) Instruction] *The instruction must be* relative to the duties of citizens in the service of their country. It [shall be] *is* the aim of [such] *this* instruction to

inculcate a love of country and a disposition to serve the country effectively and loyally.

2. [Boards of trustees of school districts offering a 4-year high school course are] *The board of trustees of each school district:*

*(a) Shall provide to all pupils in kindergarten and grades 1 to 12, inclusive, daily instruction in physical education designed to secure the health, vigor and physical soundness of the pupil.*

*(b) Is* empowered to employ teachers of physical [training] *education* who shall devote all or part of their time to physical instruction for both boys and girls.

**Sec. 2.** This act becomes effective on July 1, 1993.

SUMMARY--Designates "Organ Donation Awareness Day." (BDR R-1088)

CONCURRENT RESOLUTION--Designating "Organ Donation Awareness Day" and urging the state board of education to require that information on the donation and transplantation of human organs be included in certain instruction.

WHEREAS, The transplantation of human organs has become increasingly successful, as 75 to 95 percent of the donees of human organs survive for at least one year from the date of the transplant; and

WHEREAS, Longer waiting lists of candidates for transplantations and a shortage of donors of human organs contributes to the death of many persons awaiting transplantation in this state; and

WHEREAS, Many potential donors of human organs who sign a document of anatomical gift pursuant to NRS 451.555 have their wishes undiscovered by providers of health care who do not adequately search for the document when the potential donor is admitted to a medical facility; and

WHEREAS, Because many potential donors do not inform their families of their intent to make an anatomical gift, members of their family do not consent to an anatomical gift when presented with that decision in the belief that it would be contrary to the wishes of the decedent; and

WHEREAS, The awareness of the success of transplantation, of the need for donors of human organs, of the necessity of identifying potential donors of human organs at their time of admittance to a medical facility and of the

importance of informing family members of the intent to make an anatomical gift may be substantially increased through education; now, therefore, be it

RESOLVED BY THE OF THE STATE OF NEVADA, THE

CONCURRING, That members of the 67th session of the Nevada Legislature hereby urge the state board of education to require that information regarding the donation and transplantation of human organs be included in the instruction in physiology provided to pupils in grades 9 to 12, inclusive; and be it further

RESOLVED, That the third Monday in April is hereby designated as "Organ Donation Awareness Day" in Nevada; and be it further

RESOLVED, That the of the prepare and transmit a copy of this resolution to the state board of education.

SUMMARY--Requires persons responsible for care of patient at or near time of death to cooperate in implementation of anatomical gift. (BDR 40-1089)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to anatomical gifts; requiring persons who are responsible for the care of a patient at or near the time of his death to cooperate in the implementation of an anatomical gift or to transfer their responsibilities to persons who are willing to cooperate in the matter; 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 451.577 is hereby amended to read as follows:

451.577 1. Every hospital shall establish policies and procedures to identify potential donors. The policies and procedures must require the administrator of the hospital or his representative:

(a) To determine whether a person is a donor.

(b) If the person is not a donor, to determine if the person is a potential donor including the consideration of:

(1) His religious and cultural beliefs; and

(2) The suitability of his organs and tissues for donation.

(c) At or near the time of death of a person identified as a potential donor, to request the person designated in subsection 1 of NRS 451.557, in the stated order of priority if persons in a prior class are not available, to consent to the gift of all or any part of the decedent's body as an anatomical gift.

(d) If he has actual knowledge of a contrary intent of the decedent or opposition by a person in the same class as or a prior class than a person who has consented to an anatomical gift, not to procure an anatomical gift.

(e) If an anatomical gift is made, to notify an organization which procures organs and tissues and cooperate in the procurement of the anatomical gift.

2. The following persons shall make a reasonable search for a document of gift or other information identifying the bearer as a donor or as a person who has refused to make an anatomical gift:

(a) A law enforcement officer, fireman, emergency medical technician or other emergency rescuer finding a person who the searcher believes is dead or near death; and

(b) A hospital, upon the admission of a person at or near the time of death, if there is not immediately available any other source of that information.

3. If a document of gift or evidence of refusal to make an anatomical gift is located by the search required by paragraph (a) of subsection 2, and the person or body to whom it relates is taken to a hospital, the hospital must be notified of the contents and the document or other evidence must be sent to the hospital.

4. If, at or near the time of death of a patient, a hospital knows that an anatomical gift has been made pursuant to subsection 1 of NRS 451.557 or that a patient or a person identified as in transit to the hospital is a donor, the hospital shall notify the donee if one is named and known to the hospital, or if not, it shall notify an appropriate procurement organization. [The] *Except as otherwise provided in this subsection, the* hospital *and each person in the hospital who is responsible for the care of the patient at or near the time of his death* shall cooperate in the implementation of the anatomical gift or release and removal of a part. *If a person is unwilling to cooperate in the implementation of the anatomical gift or the release or removal of a part, he shall take all reasonable steps as promptly as practicable to transfer his responsibilities to another person who is willing to cooperate in the matter.*

5. *The duties imposed by subsection 4 apply notwithstanding opposition to the anatomical gift by a member of the decedent's family, unless:*

*(a) The anatomical gift was made pursuant to subsection 1 of NRS 451.557; and*

*(b) The opposition is by a person in the same class as or a prior class than the person who consented to the anatomical gift.*

6. A person who fails to discharge the duties imposed by this section is not subject to criminal or civil liability but is subject to appropriate administrative sanctions.

SUMMARY--Requires department of human resources to hold conference and to publish report on improvement of health services. (BDR 40-1090)

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 department of human resources to organize and hold a conference on the improvement of the quality of health services; requiring the department to publish and distribute an annual report that sets forth an agenda for the improvement of health services; making an appropriation; and providing other matters properly relating thereto.

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

**Section 1.** Chapter 439A of NRS is hereby amended by adding thereto a new section to read as follows:

*The department shall:*

*1. Organize and hold an annual conference on the improvement of the quality of health services in this state.*

*2. Invite practitioners, patients, employees of providers of health care, representatives of institutions and agencies interested in the quality of health services, and educators, scientists and other national experts in health care to attend and participate in the conference.*

*3. Charge and collect a reasonable fee from the persons attending and participating in the conference. The cost of the conference must not exceed the amount collected pursuant to this subsection.*

*4. Publish an annual report that sets forth an agenda for the improvement of health services in this state. The report must include, but is not limited to, articles written by persons attending and participating in the conference which relate to the agenda. The department shall distribute the report to persons interested in improving health services in this state.*

**Sec. 2.** 1. There is hereby appropriated from the state general fund to the department of human resources the sum of $10,000 for the publication and distribution of the report described in subsection 4 of section 1 of this act.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed after June 30, 1995, 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, 1993.

SUMMARY--Requires department of human resources to maintain record of person's medical history from birth until death. (BDR 40-1091)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to health care; requiring the department of human resources to create a data base to maintain a record of a person's medical history from birth until death; requiring hospitals to provide the information necessary to maintain such records; 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 a new section to read as follows:

*The department shall:*

*1. Create a data base to maintain a record of the medical history of a person from birth until death.*

*2. Maintain such a record of medical history for each person in this state.*

*3. Establish a system for identifying each person in the data base while maintaining the confidentiality of the person.*

*4. Coordinate the records maintained pursuant to this section with information maintained pursuant to chapter 440 of NRS.*

**Sec. 2.** NRS 449.450 is hereby amended to read as follows:

449.450 As used in NRS 449.450 to 449.530, inclusive, *and section 1 of this act,* unless the context otherwise requires:

1. "Admitted health insurer" means an insurer authorized to transact health insurance in this state under a certificate of authority issued by the commissioner of insurance.

2. "Department" means the department of human resources.

3. "Director" means the director of the department.

4. "Institution" means any person, place, building or agency which maintains and operates facilities for the diagnosis, care and treatment of human illness and provides beds for inpatient care. The term includes but is not limited to hospitals, convalescent care facilities, nursing care facilities, detoxification centers and all specialized medical health care facilities.

**Sec. 3.** 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 1 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. 4.** NRS 449.485 is hereby amended to read as follows:

449.485 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.

*The information required to be included in the form and provided to the department must include information that will allow the department to maintain the records required to be maintained pursuant to section 1 of this act.*

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.

*5. The director shall, to the extent practicable, avoid requiring hospitals to submit information that duplicates information obtained pursuant to this section.*

SUMMARY--Requires legislative counsel to publish and distribute register of regulations. (BDR 18-1092)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to the Nevada Administrative Code; requiring the legislative counsel to publish and distribute a register of regulations; 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 233B of NRS is hereby amended by adding thereto a new section to read as follows:

*1. The legislative counsel shall semimonthly publish and distribute a register which contains information regarding proposed and adopted amendments to the Nevada Administrative Code. He shall include in the register:*

*(a) The text of each proposed or adopted regulation delivered to him pursuant to NRS 233B.063;*

*(b) Related notices; and*

*(c) Such other information as the legislative commission deems appropriate.*

*2. The legislative counsel shall prepare or cause the superintendent of the state printing and micrographics division of the department of general services*

*to prepare the register of regulations. The register must be provided to and kept respectively:*

*(a) By the secretary of state as the master copy;*

*(b) By the state librarian for public use;*

*(c) By the attorney general for his use and that of the executive department; and*

*(d) By the legislative counsel for his use and that of the legislature.*

*The legislative commission may direct the preparation of additional copies of the register and specify the places where those copies are to be kept and the uses to be made of them.*

*3. Each agency shall reimburse the legislative counsel bureau and the state printing and micrographics division of the department of general services for their respective costs in preparing an edition of the register which includes the regulations of the agency.*

*4. The legislative commission shall set sale prices sufficient to recover at least the cost of production and distribution of the register.*

*5. The legislative counsel is immune from civil liability which may result from any failure to include information in the register.*

**Sec. 2.** NRS 233B.0603 is hereby amended to read as follows:

233B.0603 1. The notice of intent to act upon a regulation must:

(a) Include a statement of the need for and purpose of the proposed regulation, and either the terms or substance of the proposed regulation or a description of the subjects and issues involved, and of the time when, the place

where, and the manner in which, interested persons may present their views thereon.

(b) State each address at which the text of the proposed regulation may be inspected and copied.

(c) Be mailed to all persons who have requested in writing that they be placed upon a mailing list, which must be kept by the agency for such purpose.

2. The attorney general may by regulation prescribe the form of notice to be used . [, which must be distributed]

*3. In addition to distributing the notice* to each recipient of the agency's regulations [. The] *, the* agency shall also solicit comment generally from the public and from businesses to be affected by the proposed regulation.

*4. A notice of intent to act may be delivered to the legislative counsel for inclusion in the register of regulations. The legislative counsel shall include any such notice if it is timely. The publication of a notice in the register of regulations does not satisfy the requirements for notice set forth in paragraph (c) of subsection 1.*