Chairman Bennett called the meeting of the Committee on Health and Welfare to order at 5:00 p.m. with the following members present:

MEMBERS PRESENT: Mr. Bennett
Mr. Chaney
Mr. Bergevin
Mrs. Ham
Mr. Mello
Mr. Nicholas
Mr. Thompson

A.B. 549 - Provides for local issuance of parking permits for persons having temporary handicaps.

There was no one present to testify on this bill but Mr. David A. Nicholas, A.D. #23, stated he could provide some information. He explained that the intest of this bill is to assist those who can drive motor vehicles but who are at least partially disabled, to make their way into commercial areas. If there is a question involving this, it might be the time limit provided; our standard meter time now is for a maximum of one hour and this requests as much as four hours without any particular penalty. From his standpoint, he is in favor of giving the benefit to the handicapped driver and if there were a debate, it would be on the time line provisions. It is a very simple bill and basically self-explanatory.

A.B. 550 - Requires state to pay under certain circumstances cost of transferring person who is involuntarily admitted to mental health facility.

Testifying in support of this bill was Mr. Ken Sharigian, Deputy Administrator of the Division of Mental Hygiene and Mental Retardation. He explained this is not his agency's bill and he does not know who is responsible for introducing it however, they have no problem with the bill. They would like to, however, bring to the Committee's attention that there is a fiscal impact of approximately $54,150 in the first year of the biennium and $59,565 in the second year of the biennium. Those numbers are essentially best estimates since the cost that this bill gives to the state is somewhat uncontrollable. Essentially, what the bill does, is state that any person who is transferred from a division of mental health facility out of a county into a facility in another county, the cost is upon the state that is provided by Subsection 2 of Section 1 on the first page of the bill. The second change, which is operative, provides that the person who is court committed is delivered to the closest mental health facility, not to the most appropriate one. For example, in Las Vegas there have been times when the Las Vegas Mental Health Center, which has 50 adult in-patient beds, is full and the County District Court civily commits ten people. If there is space at the Sparks Mental Health Institute, they merely notify

the County and the County arranges to transport those people to Sparks; that's where the space is and the appropriate facility. What this bill would permit would be merely taking those ten people to the Las Vegas Mental Health Center leaving them there - there would be no space at that Center and then they would have to transport those persons themselves to Sparks. Additionally, people in the rural areas might be civilly committed inasmuch as there are no in-patient facilities in the rural areas, an individual might be brought to the local out-patient mental health clinic after civil committment. The state would be responsible for transferring the person to Sparks because there would be no place to keep them in rural Nevada.

Mr. Bergevin asked Mr. Sharigian if they were experiencing problems with the way the law stands now and was advised that they are not presently, but they have had in the past. Eight months ago they were transferring about 18 persons per month from Las Vegas, and that problem has been handled through the development of additional resources approved by the Interim Finance Committee and the county has paid for that transportation. The major on-going problem is that there are no in-patient facilities in rural Nevada, therefore the cost for transportation is usually borne by the sheriff and the county when someone is civilly committed. There are about 104 admissions to the institute from rural Nevada per year so you can figure this situation would be a pretty large cost upon the state.

Mr. Nicholas pointed out that he is having a little difficulty with the language provided on line 11 and explained his thinking. He reminded the committee that we are processing legislation at this time, dealing with patient rights under the circumstances that are described in this bill. He finds the dialogue in lines 11 and 12 does not take into consideration the direction which stipulates that the patient, or someone who can speak for the patient, will have the discretion as to whether or not the patient can be moved at all. He finds a conflict between the language we have in this bill and what we have been considering under another cover. In the circumstances, he voiced an objection to any movement of this bill until we have had a chance to determine whether this bill conflicts with the first bill.

Mr. Sharigian responded to the objection raised by Mr. Nicholas by stating that the bill he is referring to is Senate Bill No. 259. This language we are looking at tonight simply gives the state the authority to move the patients at their discretion and is somewhat in conflict with the Senate Bill. The issue, as he sees it, is that this is enabling legislation to move people but it is fiscal motivation as the counties do not have money in their budgets for transfer costs. There was no further testimony on this bill and no action was taken.

A.B. 551 - Requires certain insurers to review health care for adequacy and need.

Speaking in support of this measure was Ms. Myrl Nygren with the Office of Health Planning and Resources. Prior to explaining the purpose of the bill, she gave some background on how the bill came about. She explained that in December 16 and 17, 1980, the Senate Health Coordinating Counsel and the Governor's Office sponsored a Health Care Cost Containment Conference in Las Vegas. The purpose of the conference was to discuss some of the problems of the high cost of health care in Nevada and to come up with some recommendations as to how these costs could be contained. Present at that conference were many health care providers, many representatives of unions and major employers who are responsible for purchasing health care for their employees or their union members. This bill is an outgrowth of those discussions and recommendations and is essentially that - to contain health care costs through requiring insurers of groups of employees to set up some structure for reviewing the appropriatness, the necessity and quality of the health care provided.

For background information, she has compiled some date that was demonstrated by the Nevada Professional Standards Review Organization relative to Medicare and Medicaid recepients. (Attached as Exhibit I). She went over the data sheet with the committee explaining what the figures meant.

She suggested one amendment that was over-looked in the original bill and that is on page 4, line 11. It was the intent of the legislation to bracket out the words "group insurance" inasmuch as this legislation was intended to cover group insurance.

Mr. Bergevin requested an explanation of why her agency requested this peice of legislation and was advised that it is the result of the Governor's Health Care Cost Containment Conference. As a result of that Task Force recommendation, she met with the insurance division and with representatives of group insurance and they all drafted this bill.

In response to a question by Mr. Nicholas, Ms. Nygren explained that there should be no fiscal impact nor cost factors due to this proposed legislation.

Speaking in opposition to this bill was Ms. Georgia Massey, Nevada Insurance Division. She explained that the insurance division was in opposition to this bill and the bottom line is to determine whether this particular bill is really going to provide cost containment. It does say that insurers, through some type of determination, can cut the reimbursement to providers, but there is nothing in this bill that says that providers cannot go ahead and charge the patient anyway. The problem is that there isn't any provider in Nevada or anyplace else that is going to let an insurance company come in and determine whether their services or their treatment is appropriate and necessary. She feels this bill is not going to take care of the

problem as far as cost containment is concerned because unless you can go through and say to physicians, "if the insurance company says that your fees are not appropriate, then you can't charge them" then it isn't cost containment - all it says is that some poor employee is going to be out more expense because the insurance company is going to cut the reimbursement but the provider is not going to cut his fees. The insurance companies now have outlets within their contracts and within their administrative review to determine and to actually reduce the reimbursement by way of their customary system on surgical fees. This is through a provision in a policy which states that they will not pay for unnecessary treatment, so they have the outlet to review unnecessary treatment or services at the present time. Even when they do that, this is not going to prevent the provider, if an insurance company goes in and reduces the reimbursement on a surgical fee, the doctor still gets his fee because he goes ahead and bills the patient for it. Your cost containment has to be on two sides - it has to be on the facility side, that is the provider's side and the insurance industries. This is a one-sided bill and will not work. The Insurance Division would recommend against passage of this bill.

Mr. Milos Turzich, representing the American Counsel of Life Insurance, addressed the committee and explained that the group he is representing is stationed out of Washington, D.C., and has over 400 member companies, 85% of which write group health. He is here, primarily, to address the provisions contained in Sections 4 and 5 and noted that if the committee does process this bill, the health maintenance organizations are not included. He added the way some people feel about lawyers, and maybe the only comment necessary to kill the bill, is that this bill will make lawyers rich. It is a breeding ground for law suits; if the insurance company was mandated to adopt these procedures which would be reviewed by the insurance division and they denied claims or determined the services unnecessary, you can be assured the patient would go to an attorney and sue and more likely than not, they would win. For example, if a person pays a premium for an insurance policy which covers a specific area, such as cosmetic surgery or dental work which may not be necessary but would be beneficial to their appearance, they are paying for that premium and that coverage, so how do you distinguish between whether that treatment is necessary or unnecessary? This is a one-sided bill and if passed, it could make the insurance companies hire a specialized staff to oversee the quality, appropriateness and necessity in every single claim form doctors or other persons who would have this specialty. This would not reduce costs but would tend to increase them which would be passed on to the patient, so the bill insofar as the totality of it is a bad bill.

Speaking next was Mr. Bob Gilbert who explained that he has been in the group insurance business for 34 years and is with the Nevada Association of Employers and they have some 33,000 people

covered under various plans in northern Nevada. He read his testimony into the record which is attached as Exhibit II which contain as well as his comments, some suggested amendments to the bill.

Mr. Bergevin asked Mr. Gilbert for his estimate on what it would cost the industry to implement this bill and was advised that it wouldn't cost anything as they have the mechanism set up right now to do it. They would work with the PSRO organizations that are already established in the hospitals which are not now going to be funded for the hospitalization stay. They would then pay so much, per admission, for each one of their patients which would be far less than the amount of money that is spent in the hospital for over-utilization. The industry, as such, would welcome that type of approach. As far as the doctors are concerned, the programs that would be sold would be "relative values" and you would have a Relative Value Schedule and then the people would buy on those layers on whatever conversion dollar factor they might want. Your medical associations, in most places other than in Nevada, have an insurance review committee. The insurance industry would name a person or persons to sit with that committee and then that committee would actually police itself. All of that would have to be backed up by legislation as nothing is going to be done in this field unless the legislature appropriates the authority and puts some teeth into it.

Testifying next was Mr. Jim Han, Executive Director of the Nevada Professional Standards Review Organization who spoke in favor of this measure. He stated he has some serious problems with the wording and suggested we provide similar language to the federal requirements. He called attention to two sections that need to be addressed to be a workable bill. #1 there needs to be much more specificity concerning what represents acceptable review procedures; who is going to be responsible for approving those review procedures etc. There should be requirements that only physicians can make decisions that are based on medical necessity. In quality of care, there should be some specifically defined appeal rights for patients when benefits are denied. You need to address the issue of access and confidentiality of medical records that will be used in making review decisions and you need to address the issue of immunity for persons making review decisions. If the committee intends to process this peice of legislation, there needs to be much more specificity in it..

Mr. Dick Garrod, representing the Farmers Insurance Group stated they have two life companies that write a certain amount of insurance and health and accident in the State of Nevada. They feel that this legislation will be giving them the same type of authority that the federal government has; they are going to be allowed to go

into a hospital and say we don't like what you are doing so you had better do it this way or you aren't going to get paid. This is granting police powers to private industry which he doesn't believe this legislature wants to do. They feel they would be so exposed to liability that they would have to take a hard look at any such legislation. They have a fear of this being the biggest can of worms in legislation that has been suggested in many sessions. He stated they were definitely opposed to passage of this measure.

Testifying in opposition to this bill was Mr. Ray Rothwell, President of Blue Shield of Nevada, who reiterated most of the comments heard previously. He feels the administrative costs in dealing with this type of legislation would be astronomical and urged no further consideration of the bill.

Mr. Ken Newcomb, Director of the Greater Nevada Health Systems Agency, spoke next and stated he could share some of his frustration as a person who has been involved in health care and concern with rising health care costs. He explained that it almost appears that nothing can be done even though they have tried planning, review of capital expenditures with marginal results, utilization review in hospitals of federal patients with questionable kinds of results. They are trying to spark private industry into trying to clean up their own act with some questionable problem spin-off. He concurred with the previous speakers in that the present bill is one-sided but also he asked this committee to establish an interim study committee to look at health care costs in Nevada. The committee could work with Nevada Blue Shield and the industry and try to come back with some reasonable, clear direction of how we can go in Nevada. Nevada is one of the bigest-health care cost states in the nation. We have many problems and he feels the most appropriate way to handle, at least this one area, is the interim study he suggested before.

At the conclusion of this testimony, a motion was made by Mr. Thompson, seconded by Mr. Mello that A.B. 551 be given no further consideration. The motion carried unanimously.

S.B. 525 - Extends existence of advisory task force on alcohol and drug abuse.

Senator Raggio, Washoe District #1, advised the committee that he served as Chairman of an Advisory Task Force which was created by the last Session of the legislature under S.B. 75. The Task Force was charged with reviewing the procedures employed by the Bureau of Drug and Alcohol Abuse for certifying persons accrediting programs and licensing facilities and recommending any necessary changes. Further, they were to advise the insurance division on carrying out the provisions on law relating to insurance coverage

for treatment of the abuse of alcohol and advising this session of the legislature on the appropriate maximum level of benefits and methods of determining future benefit levels for insurance coverage for the treatment of the abuse of alcohol. This Task Force met in the interim between sessions and were made very aware of the increase of problems being rooted in the abuse of alcohol. We have in the past sessions created legislation which requires optional coverage for alcohol abuse in policies and group policies of insurance. The Task Force was not able to come up with definite criteria for a benefit package as of this time but the committee did issue a report to the legislature and, although he did not have copies available for the committee members at this time, they can be obtained through the legislative Commission. One of the recommendations in the report was that the Task Force be extended and that its scope be broadened to include an assessment of the insurance industry and employer response to possible pilot projects which would include coverage in employer's group policies. Also recommended was the feasibility of a reduced workmans compensation premium rate for employers who create and maintain occupational assistance programs including this type of coverage. Also that the task force be enlarged to provide for the appointment of another representative (an employer representative) from one of the major employers in the state. The Legislative Commission approved this bill (SB 525) for this purpose and that's the reason it is here before the committee tonight; the Senate has acted favorably on it and they ask for favorable consideration by the Assembly.

Mr. Richard Ham, Director of the Bureau of Alcohol and Drug Abuse, was present and concurred with the recommendations made by Senator Raggio.

There being no further testimony to be heard, a motion was made to "do pass" by Mr. Bergevin, seconded by Mr. Mello and carried unanimously.

A work session followed with action being taken on the following bills:

S.B. 180 - Summary - Changes requirements concerning meetings of state welfare board and standing committees of medical care advisory group. A motion was made by Mr. Bergevin to "do pass"; seconded by Mr. Mello and carried unanimously.

A.B. 185 Summary - Makes administrative changes relating to medical laboratories. Mr. Mello moved to indefinitely postpone A.B. 185; motion seconded by Mr. Bergevin and carried by a vote of 5 voting aye, 2 voting nay. Voting nay were Assemblyman Bennett and Chaney.

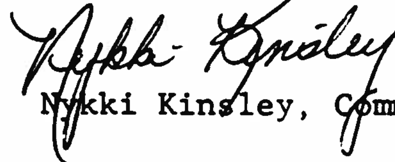
A.B. 350 - Summary - Changes qualifications of person in charge of state hygienic laboratory. A motion to indefinitely postpone was made by Mr. Bergevin, seconded by Mr. Mello and carried with a vote of 6 voting aye, Mr. Chaney voting nay.

A.B. 299 - Summary - Authorizes district health officers to issue citations for certain violations. Mr. Bergevin reminded the committee members that he had been requested to work with the Directors of Public Works for Washoe and Clark Counties on some amendments to this measure. They have worked out the necessary language and now feel they are ready to take action on this bill. He then moved to amend and do pass AB 299 as amended; motion seconded by Mr. Thompson and carried unanimously.

A.B. 549 - This bill was discussed earlier in this meeting and a motion was now made by Mr. Bergevin to "do pass" seconded by Mr. Mello and carried unanimously.

There being no further business, the meeting was adjourned.

Respectfully submitted,



Nykki Kinsley, Committee Secretary

ASSEMBLY

AGENDA FOR COMMITTEE ON Health and Welfare

Date Wed, Apr. 29, 1981 Time 5:00 pm Room 316

| Bills or Resolutions to be considered | Subject | Counsel requested* |
|---|---|---|
| A.B. 549 - | Provides for local issuance of parking permits for persons having temporary handicaps. | |
| A.B. 550- | Requires state to pay under certain circumstances cost of transferring person who is involuntarily admitted to mental health facility. | |
| A.B. 551- | Requires certain insurers to review health care for adequacy and need. | |
| S.B. 525- | Extends existence of advisory task force on alcohol and drug abuse. | |



*Please do not ask for counsel unless necessary.

7421

AB 551

OFFICE OF HEALTH PLANNING AND RESOURCES

COST SAVINGS RESULTING FROM REDUCED AVERAGE LENGTH OF STAY (ALOS) IN FIVE NEVADA HOSPITALS

| Hospital | ALOS/Total Patient Days* 1979 | 1980 | Savings in Patient Days | Average Revenue per Patient Day | Savings to Patient or 3rd Party Payer |
|---|---|---|---|---|---|
| A | 9.2/52,734 | 8.7/49,868 | 2,866 | $354.61 | $1,016,312.26 |
| B | 9.6/30,902 | 8.8/28,327 | 2,575 | 354.61 | 913,120.75 |
| C | 9.4/14,288 | 7.4/11,248 | 3,040 | 354.61 | 1,078,014.40 |
| D | 8.5/2,610 | 7.0/2,149 | 451 | 354.61 | 159,929.11 |
| E | 8.8/4,415 | 7.3/3,438 | 707 | 354.61 | 250,709.27 |
| Total Saved | | | 9,639 | $354.61 | $3,418,085.79 |

*Based on number of discharges

4/28/81
dg



Exhibit I

Bob Gilbert

# GOALS OF AB-551

THE PROBLEM WHICH AB-551 ADDRESSES IS TWO-FOLD: FIRST IS ASSURING QUALITY MEDICAL CARE IN NEVADA; SECOND IS INSTITUTING THE NECESSARY STEPS TO PROVIDE MEDICAL SERVICES AT AFFORDABLE PRICES. TWO EFFECTIVE WAYS TO ACCOMPLISH THIS IS FIRST TO MAKE SURE THAT THE MEDICAL CARE IS NECESSARY AND REASONABLY PRICED AND SECOND IS TO ELIMINATE DUPLICATE PAYMENTS FOR HEALTH CARE SERVICES.

GOVERNOR LIST HAS GIVEN MEDICAL COST CONTAINMENT IN NEVADA A HIGH PRIORITY AND UNDERSTANDABLY SO. OUR NEIGHBORS IN CALIFORNIA HAVE LOST CONTROL AND HOSPITAL ROOMS THERE ARE NOW OVER $200 AND THE PER DIEM STAY HAS EXCEEDED $500. WHILE THIS IS CAUSED IN SOME DEGREE BY INFLATION IT IS PRIMARILY BECAUSE CALIFORNIANS RECEIVE COSTLY MEDICAL SERVICES WHICH ARE PAID BY THIRD PARTIES. THERE IS LITTLE INCENTIVE FOR THE PATIENT, THE HOSPITAL OR THE PHYSICIAN TO BE CONCERNED ABOUT COST EFFECTIVENESS. IT SERVES NO PURPOSE TO GIVE A PATIENT WITH A BROKEN ARM ALL THE EXPENSIVE TESTS AVAILABLE EVEN THOUGH THERE IS LITTLE OR NO COST TO THE PATIENT BECAUSE OF THE BENEFITS FROM HIS EMPLOYER-SPONSORED COVERAGE. WHERE IS THE ECONOMY IN REIMBURSING A PATIENT MORE THAN 100% OF THE CHARGES FOR THE MEDICAL SERVICES THEY HAVE RECEIVED? THERE IS VERY LITTLE INCENTIVE FOR A PATIENT TO LEAVE A HOSPITAL IF THEY ARE RECEIVING FROM WHATEVER MEANS $100 OR$200 ABOVE THEIR EXPENSES.

IT IS PARTICULARLY IMPORTANT FOR AB-551 TO ELIMINATE THE INCENTIVES FOR OVERUSE, OVERCHARGES, UNNECESSARY SERVICES, AND DUPLICATE COVERAGES AT THE SAME TIME AS THE FEDERAL GOVERNMENT REDUCES FUNDING FOR MEDICARE AND



Exhibit II

MEDICAID, HEALTH MAINTENANCE ORGANIZATIONS, PROFESSIONAL STANDARDS REVIEW ORGANIZATION AND OTHER INEFFECTIVE AND COSTLY MEDICAL SERVICES, MANY OF WHICH HAVE CAUSED OUR PRESENT PROBLEMS. NOW IS THE TIME FOR NEVADANS TO TAKE THE NECESSARY STEPS TO ASSURE THAT ANY FEDERAL REDUCTIONS FOR UNNECESSARY PROJECTS WITHIN THE MEDICAL INDUSTRY ARE NOT TRANSFERRED TO INDIVIDUAL NEVADANS OR TO THE EMPLOYERS OF OUR STATE. OUR SUGGESTIONS ARE TO STRENGTHEN AB-551 AND THEREFORE HOPEFULLY TO INCREASE THE POSSIBILITY OF ATTAINING THE SUCCESS IT NOT ONLY SHOULD BUT MUST ACCOMPLISH FOR THE PEOPLE OF THE STATE OF NEVADA.

Page 1 - Line 1

Every insurer who issued a policy of insurance shall adopt an industry-recognized program to determine the quality, appropriateness, and necessity of health care or services provided to the insured

Page 1 - Line 7

The insurer shall be relieved of liability for denying reimbursement and the patient, his family or employer shall not be financially responsible for health care or services that are determined to be of unacceptable quality, inappropriate, unnecessary, or unreasonably priced.

Page 2 - Line 40

There must be a provision in Individual, Group, Franchise, or other coverage as follows:

Page 3 - Line 46

The foregoing policy provisions must be inserted in all policies providing hospital, surgical, medical or major medical benefits whether or not the application includes a question as to other coverages.

Page 4 - Line 2

The insurer must make this provision applicable to either or both:

Page 4 - Line 10

Such term must include any group insurance, automobile medical payments or third party liability coverage.

Page 4 - Line 26

Same language as line 1 page 1 (revisions)

Page 4 - Line 30

Same language as line 7 page 1 (revisions)

Page 5 - Line 16

Every corporation which provides a plan subject to the provisions of this chapter shall adopt recognized programs to determine the quality, appropriateness, and necessity of health care or services provided to the employee.

Page 5 - Line 22

The corporation shall be relieved of liability, and the employee or covered family member shall not be financially responsible for whatever action is taken to correct any discovered deficiencies.