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ASSEMBLY BILL 289 – AN OVERVIEW OF NEVADA'S HEALTH CARE COST CONTAINMENT INITIATIVE OF THE 1987 LEGISLATIVE SESSION

Background

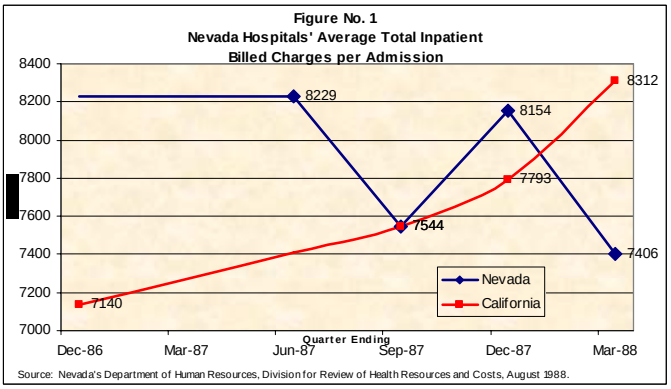
Following recommendations by a 1985 interim study, the 1987 Legislature adopted, and the Governor signed, Assembly Bill 289 (Chapter 344, *Statutes of Nevada 1987*), which established a comprehensive set of provisions designed to reduce health care costs. Major sections of that legislation:

- Required certain hospitals to reduce their billed charges to patients to a specified level, while also reducing their revenue per inpatient – hospitals were required to roll back these charges for Fiscal Year (FY) 1987-1988, and maintain a freeze on these factors through FY 1988-1989;
- Required other hospitals to reduce their percentage of income to operating expenses;
- Mandated continued quality of care;
- Specified that any savings accrued by health insurers from these provisions be passed along to the consumer through reduced health care insurance premiums;
- Prohibited certain transactions between hospitals and their affiliates and between insurers and affiliated health facilities;
- Prohibited agreements between physicians and hospitals if such agreements contain financial inducements for physician referrals;
- Revised state certificate of need requirements to raise the threshold for review of medical projects and equipment to $2 million – projects below that amount were no longer subject to review;
- Established hospital and health care cost data collection procedures;
- Required hospitals to treat and share the costs of the medically indigent; and
- Established the Legislative Committee on Health Care to provide oversight of the bill's provisions and other health care related matters.

Immediate Impact of the Bill on Health Care Costs

The 1989 Legislature reviewed the impact of the cost containment package. In brief, findings from the Legislative Committee on Health Care's 1989 report included the following:

- All hospitals met their targeted reduction of billed charges per inpatient admission, lowering costs in Nevada relative to California (see Figure 1);



- The most significant savings from A.B. 289 were realized during the first year of the law since the measure allowed hospitals to apply various credits and carryovers to their targets in future years. Starting the third year of the law, hospitals were allowed to adjust revenues based upon the medical component of the *Consumer Price Index* (CPI);
- Using data from historical records, the expected amount of increase for hospital net inpatient revenue was the portion that was saved by A.B. 289 – the law slowed the increase in inpatient care, effectively retarding the medical inflation rate in Nevada for FY 1987-1988;

- The bill did not slow the net increase in overall health care costs – while hospital inpatient costs were moderated, outpatient, pharmacy, provider, and other components increased their market share of the health care dollar;
- The measure targeted a small but significant portion of Nevada's health care expenditures– health insurers reported that the bill only had an impact upon 8.2 percent of the total claims dollars for inpatient hospital care – savings in the inpatient component of costs were offset by increases in the other components, and any cost savings "pass along" for the consumer could not be easily identified by Nevada's Insurance Commissioner;
- The number of indigents seen by county facilities declined slightly, while the number seen by noncounty facilities increased by approximately the same amount;
- The rate of inappropriate transfers of indigent patients to county facilities was reduced; and
- No cost savings could be identified from changing the Certificate of Need statutes.

Status of Major Provisions

A number of the original provisions of A.B. 289 are still incorprated within the *Nevada Revised Statutes* (NRS). Due primarily to major changes in the health insurance industry (principally the shift toward negotiated rates through preferred providers and managed care arrangements), the billed charges and revenue reduction provisions were allowed to expire; other portions were signifcantly revised or repealed. Following is the current status of major provisions:

Limiting Billed Charges – This was the portion of the bill that garnered the bulk of the cost savings. Following the initial rollbacks of 1987-1988, this program limited the billed charges of hospitals with more than 200 beds to the medical component of the CPI. The provisions of A.B. 289 were carried on to some extent in 1991 legislation – A.B. 577 – which sought to continue to limit increases in charges for inpatient hospital care. The Legislature allowed the program to expire on June 30, 1999. According to minutes of the April 28, 1999, Joint Hearing of the Assembly Ways and Means and Senate Finance Subcommittee on K-12/Human Resources from the 1999 Legislative Session, in FY 1998, the impact of these provisions was minimal since only 3.6 percent of hospital patients actually paid billed charges.

Certificate of Need – Over the years, the Legislature has relaxed most Certified of Need (CON) requirements. Clark and Washoe Counties were exempted from the CON requirements in 1991 as a result of A.B. 299. Other significant changes to the CON occurred in 1995. At this time, the dollar threshold for CON in rural counties was dropped from $4 million to $2 million. Further, the statute was amended to apply only to the construction of new health facilities. Currently, NRS 439A.100 applies only to rural counties. The law requires an entity that is located in a county whose population is less than 100,000 and that intends to construct a health facility costing in excess of $2 million must secure approval from the state's Department of Human Resources. Requirements for prior approval for facilities adding certain high cost units, such as burn care units and trauma centers, still remain within NRS 449.087.

Miscellaneous Provisions – The Legislative Committee on Health Care still exists within 439B.200 *et seq*., although amendments have been made over time. All major provisions concerning treatment and reporting of indigent care cases remain within NRS 439B.300 *et seq*. Uniform fiscal and patient reporting requirements remain, and hospital obligations to treat emergency patients, along with prohibited acts for hospitals, continue within the remainder of Chapter 439B. Provisions remain in NRS 450.425 authorizing county commissioners to levy an ad valorem tax for emergency room services for indigents. Provisions prohibiting transactions with parent corporations, subsidiaries, and affiliates (altering profit margins and true operating results) still exist, although amended in NRS 680A.320.

Additional Information

The Effect of Assembly Bill 289 in Controlling Health Care Costs. Legislative Counsel Bureau Background Paper No. 88-4.

Report of the Nevada Legislature's Committee on Health Care. Legislative Counsel Bureau Bulletin No. 89-8.

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