MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON COMMERCE AND LABOR

Seventy-Third Session
March 2, 2005

The Committee on Commerce and Labor was called to order at 2:00 p.m., on Wednesday, March 2, 2005. Chairwoman Barbara Buckley presided in Room 4100 of the Legislative Building, Carson City, Nevada, and, via simultaneous videoconference, in Room 4401 of the Grant Sawyer State Office Building, Las Vegas, Nevada. Exhibit A is the Agenda. All exhibits are available and on file at the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Ms. Barbara Buckley, Chairwoman
Mr. John Oceguera, Vice Chairman
Ms. Francis Allen
Mr. Bernie Anderson
Mr. Marcus Conklin
Mrs. Heidi S. Gansert
Ms. Chris Giunchigliani
Mr. Lynn Hettrick
Ms. Kathy McClain
Mr. David Parks
Mr. Richard Perkins
Mr. Bob Seale
Mr. Rod Sherer

COMMITTEE MEMBERS ABSENT:

Mr. Morse Arberry Jr. (excused)

GUEST LEGISLATORS PRESENT:

Assemblywoman Sheila Leslie, Assembly District No. 27, Washoe County

STAFF MEMBERS PRESENT:

Brenda J. Erdoes, Legislative Counsel
Diane Thornton, Committee Policy Analyst
Russell Guindon, Deputy Fiscal Analyst
Keith Norberg, Deputy Fiscal Analyst
Vanessa Brown, Committee Secretary

OTHERS PRESENT:

Dr. Timothy Coughlin, Medical Director, Bureau of Alcohol and Drug Addiction, State Health Division, Nevada Department of Human Resources; and representing Reno Family Physicians and the Nevada Health Professionals Assistance Foundation
Kevin Quint, Executive Director, Join Together Northern Nevada; and Officer, Nevada Adapts
Denise Everett, Member, Join Together Northern Nevada
Bill Bradley, Member, Board of Governors, Nevada Trial Lawyers Association
Laurel Stadler, Director, Lyon County Chapter, Mothers Against Drunk Driving (MADD)
Dr. Jay Coates, Vice Chair, Department of Trauma, University Medical Center Hospital and Trauma Center, Las Vegas, Nevada
Dan Musgrove, Director, Intergovernmental Relations, Office of the County Manager Clark County Nevada and representing University Medical Center Las Vegas, Nevada
Bob Ostrovsky, Legislative Advocate, representing Nevadans for Affordable Health Care
James Jackson, Legislative Advocate, representing America's Health Insurance Plan
Jack Kim, Director, Legislative Programs, Government Affairs and Special Projects Incorporated, Sierra Health Services
Janice Pine, Legislative Advocate, representing St. Mary's Health Plans, Reno, Nevada
Kay Lockhart, Executive Vice President, Nevada Independent Insurance Agents
Christina Dugan, Director of Government Affairs, Las Vegas Chamber of Commerce, Las Vegas, Nevada
Sam McMullen, Legislative Advocate, representing Hospital Corporation of America

Chairwoman Buckley:
[Called the meeting to order. Roll called.] We're honored to have Assemblywoman Sheila Leslie join us as a sponsor of this bill.

Assembly Bill 63: Prohibits certain practices by health insurers with regard to injuries sustained while under influence of alcohol or controlled substance. (BDR 57-207)

Assemblywoman Sheila Leslie, Assembly District No. 27, Washoe County:
A.B. 63 is about a provision in the law that gives insurance companies in our state the option of writing health insurance policies that allow them to deny medical reimbursements to patients who are under the influence of alcohol or narcotics. You'll hear us refer to it today as the UPPL, which stands for the Uniform Health Policy Provision Law.

State UPPL laws have their roots in the 1950 Uniform Accident and Sickness Policy Provision Law, a non-binding model act drafted by the National Association of Insurance Commissioners (NAIC). This model act was adopted by most states in the mid-1950s and included many required and optional provisions.

The UPPL was adopted by the NAIC in June 1950 as the result of a three-year study by the NAIC accident and health committee. The purpose of the study and the model act was to standardize provisions for individual and family expense policies of accident and sickness insurance that were based on the "Uniform Standard Provision Bill," adopted by the NAIC in 1912. The intoxicants and narcotics provision was a new optional provision that already appeared in the laws of some states. The purpose of the provision was to assure that where such an exclusion was used, it would be clear and unambiguous.

Nevada's UPPL was enacted in 1953 with the passage of Assembly Bill 218 of the 46th Legislative Session. In 1971, the Legislature looked at revising the Insurance Code with the passage of Assembly Bill 416 of the 56th Legislative Session. The UPPL provisions originally enacted in 1953 in Nevada were carried forward and are now codified in NRS Chapter 689A.

In the late 1990s, a national advocacy effort began to modify or repeal the UPPL provision addressing the denial of payment for intoxication-related claims. The main concern is that if emergency department physicians believe that

insurers would deny payment for such claims, they would avoid screening for alcohol intoxication or use of controlled substances and thus miss opportunities for counseling and referrals for treatment of the underlying cause of the injury.

[Assemblywoman Leslie, continued.] In June of 2001, the National Conference of Insurance Legislators (NCOIL) adopted a resolution in support of an amendment to the model UPPL provision to break down the barriers that deter alcohol screening in emergency rooms and trauma centers. The amendment would provide that the exclusion of coverage provision not be used with respect to medical expense policies. In July 2003, NCOIL subsequently passed a resolution (Exhibit B) to support the repeal of such exclusion and restriction provisions with respect to medical expense policies in the jurisdictions that have them. Many states are now in the process of repealing this provision when it appears in their statutes; the most recent state to do so is Washington. Two states, North Carolina and South Dakota, now have statutes that expressly forbid insurance companies from excluding coverage for injuries incurred while intoxicated.

This issue was brought to my attention during last year by various treatment and advocacy groups as well as trauma center physicians, and you will hear from these people today. You will hear about current practice in our state whereby physicians often do not routinely test for alcohol use at the time of the injury based on the logic that if a patient's drinking appears in the medical records, insurers cannot use the law to deny coverage. So they don't test because they're afraid the insurers are not going to pay the bill. The catch-22 is that is also discourages wider use of alcohol screening as a diagnostic procedure among emergency room patients, which is a group of very high risk for serious alcohol problems. Many physicians see this as a tremendous lost opportunity for treatment.

I have some studies here I won't go into because I think other people are. Up to 40 to 50 percent of people who come into trauma centers are there because of an alcohol problem. We're missing a huge opportunity to screen very high-risk patients simply because the doctors are afraid the insurance companies won't pay for their medical claims.

We're always interested what NCOIL has to say, and they support the repeal of the UPPL for a couple of reasons. One is it's anachronistic. It was written 50 years ago and it fails to take into account research gathered in subsequent decades that has led to a redefinition of alcohol abuse and dependency as a chronic illness that is responsive to treatment. It also fails to take into account the current existence of regional trauma centers.

[Assemblywoman Leslie, continued.] Studies demonstrate that 35 to 50 percent of injured patients treated in emergency departments and trauma centers are alcohol and/or drug intoxicated. This law provides physician and hospital administrators with a very strong financial disincentive to screen patients for substance abuse problems, resulting in less than 5 percent of trauma patients nationwide who are screened for alcoholism and provided with the necessary counseling.

Insurers are already currently paying for the treatment of alcohol-related injuries; however, because they cannot identify which patients are intoxicated, since emergency departments and trauma centers are not doing the screening.

Finally, some may say that the UPPL is fair because insurance rates are set based on expenses incurred by companies and that coverage of care for injuries involving alcohol will potentially affect the premiums of others. However, alcohol abuse and dependency is a disease. Insurance premiums should be based on the risk of sharing for all diseases. A diabetic who does not take their insulin still has medical coverage covered. A smoker who gets lung cancer still has their medical expenses covered. I ask you today to put aside the stigma that we still have in this country of not treating alcoholism and drug addiction as the disease it is. I strongly believe we should repeal the UPPL so that insurance companies do cover medical expenses of this disease as it does of any other disease.

Dr. Timothy Coughlin, Medical Director, Bureau of Alcohol and Drug Addiction, State Health Division, Nevada Department of Human Resources; and representing Reno Family Physicians and the Nevada Health Professionals Assistance Foundation:

At the Washoe Medical Center Trauma Center, when it first opened, everyone was screened for alcohol and drugs and appropriate referrals were made. However, they had several-hundred-thousand-dollar bills that went unpaid by the insurance company based on somebody being intoxicated, so they no longer screen for any of it. We're missing a golden opportunity to prevent accidents and loss of life in the future with this bill. I think it's having a chilling effect on doctors trying to make the appropriate referrals, and it seems like a common-sense kind of thing in 2005 that we would repeal this law. There's no question that insurance already pays for it. It's just people are not being referred and so they are continuing to repeat this, so we're having repeat offenders that we might be able to stop if we did the proper screening.

Assemblyman Hettrick:
The biggest concern I have with this is, how do we determine who's going to get screened? I don't doubt 40 percent are coming through and they've got alcohol-related problems, but even in the example given here, it says somebody could slip, come to the emergency room with a broken wrist who maybe had one beer, which had nothing to do with it. How are we going to determine who's going to get screened? Who's going to pay for the screening? Are we going to start screening everybody and have to add the expense for every single person that walks through the door?

Timothy Coughlin:
I think the trauma center screened everybody with significant enough trauma to have the trauma team involved. I think that makes sense. I think common sense would come into play otherwise. If somebody showed up with a broken ankle who obviously was speaking clearly, was clearheaded, and had no other problems, there would be no reason to screen them.

Assemblyman Hettrick:
So you're saying if beer is detected on them or they popped the top on a beer and before they ever took one swig, they fell down, the beer bottle broke, splashed it all over them and they broke their wrist, are they going to get screened?

Timothy Coughlin:
I think if they're making perfect sense, and their speech is clear and they explain it as you have, I doubt if they would be screened for that.

Assemblyman Hettrick:
That's why I have problem. I don't have a problem with the thrust of this bill. I have a problem with the poor devil who walks through the door who is not an alcoholic who's going to get forced into some kind of a screening. I just don't know how you handle that.

Timothy Coughlin:
Screening is to identify who has a problem from who doesn't. If there's a hint of a problem and you screen them, the screening can rule out the problem as well as rule it in. I think if you pass the MAST [Michigan Alcohol Screening Test] and you have no evidence of any problem whatsoever, I don't see how you'd be harmed by that. Raising the level of recognition of this can only benefit society as a whole.

Assemblyman Hettrick:
Don't misunderstand me; I'm not opposed to this bill.

Chairwoman Buckley:
We can save the debate for work session. There's nothing in the bill that requires a screening, anyway.

Kevin Quint, Executive Director, Join Together Northern Nevada; and Officer, Nevada Adapts:
I'm in favor of A.B. 63. As you've already heard, substance abuse does carry a great stigma in our society. Let me illustrate with a quick story. One day I was telling my sister about this possible bill and what it meant, and she said to me, "What's wrong with that?" She is educated, well informed, and has been in recovery for 22 years next month. I couldn't believe that she wouldn't think this is a great idea. Why would someone like that not understand what needs to be done here?

First, addiction is a chronic, debilitating disease that needs to be identified and treated just like other diseases. Chemical addiction is like asthma, diabetes, and high blood pressure, in that they are not always curable, but they do respond to treatment. We screen for glaucoma, diabetes, and many other diseases. We need to screen people for potential problems with addictive disorders. Early screening and referral to treatment saves dollars in the health care system and it saves lives. I'm amazed at the number of people whom I've talked to over the years who have never been told by anybody, including their doctor, they may have a drinking or drug problem, even though they do. The existing UPPL creates a major barrier to screening for substance abuse-related issues in the health care setting, and this bill will remove that barrier.

Second, re-screening in a primary health care setting actually can net results. The prevailing wisdom is that patients don't listen to their doctors. Studies have shown that people who have been told by their doctors to cut down or to not do it as much or to quit it, period, listen up to four to five years later.

Third, the idea is that when we fail to screen for addictive disorders in a primary health care level, it's just as serious as not screening for other chronic, serious illnesses. Finally, the UPPL is firmly rooted in the belief that the addicted person is bad, wrong, and does it to themselves on purpose. If that's true, then what about other diseases such as diabetes, high blood pressure, or asthma? Should you also withhold medical care for the diabetic who fails to keep their diet? Shouldn't you withhold medical care from the asthmatic for willfully refusing to use their inhaler medication? Of course not. These examples are about people

who have a documented, treatable medical condition that is prone to relapse. The same goes for chemical addiction.

[Kevin Quint, continued.] Times have changed in the last 50 years. We know a lot more about addiction than we did before. We know it's not curable, but it is treatable. We'll get one leg up on it by screening early.

Denise Everett, Member, Join Together Northern Nevada:
I'm here in favor of A.B. 63. There are a few points that I wanted to mention that really don't have anything to do with screening in trauma departments or emergency rooms. Several national organizations highly support repealing the UPPL in various states, including the American College of Surgeons Committee on Trauma, the National Highway Traffic Safety Administration, the Emergency Nurses Association, the American Medical Association, and NCOIL.

Even the creators and originators of this model law, NAIC, have subsequently changed their approach to the UPPL and have recommended to states that they not include exclusionary provisions in medical coverage. It's up to the states to adopt that or not as they see fit, but they were originators of the model law. I believe their decision was a result of the 50 years of experience that we have behind identifying drug and alcohol issues. When this law was originally passed, we didn't have trauma departments, we didn't have emergency rooms, we didn't have treatment facilities, we didn't have evidence-based treatment approaches.

Since 2001, at least five states have repealed the UPPL: Maryland, Vermont, North Carolina, Iowa and Washington. I know there are some other states that have repealing the UPPL on their legislative agendas.

I was talking to some law enforcement and medical personnel involved in cleaning up the aftermath of car crashes. One of the things that they were telling me was that in a situation with an impaired driver cited at the scene, there's about a 90 percent citation rate. If the impaired driver is injured and taken to the hospital, that rate of citation drops to less than 15 percent. Part of that is because often the person isn't screened for drugs and alcohol. The driver is thus not held responsible for their behaviors. Also, if the impaired driver is not screened for drugs or alcohol and there was victim in the accident, then there is no chance of that victim receiving any sort of compensation because it was never documented that the person was impaired in the first place.

If we're not screening for drugs and alcohol in trauma centers and emergency departments, we're missing a great opportunity to collect data on drug and

alcohol issues. Collecting data about alcohol- or drug-related vehicular crashes, domestic violence, or life-threatening accidents is really important in creating public policy, motivating legislative reform, and evaluating effectiveness of interventions.

[Denise Everett, continued.] I also believe that it's a consumer protection issue. One of the pieces of documentation in your packet (Exhibit B) tells of a 50-year-old woman in Washington State who went out to dinner with her husband to celebrate their anniversary. They had wine with dinner and came out of the restaurant, and it had been raining in Washington, imagine that. She slipped and fell and severely sprained her ankle. Her husband took her to the ER and her insurance company refused to pay. It's not only people that have drug and alcohol problems and issues, it can also be social drinkers. You, your neighbors, anybody in the state can be impacted by this particular law.

Doctor Larry Gentilello is a trauma surgeon in Texas. He's assisted a lot of states in helping to repeal the UPPL. He did a three-year study that showed that if a patient in the hospital received just 30 minutes of counseling—and we're not talking about somebody who is diagnostically dependent, but just people who have or may be starting to have a problem with addiction and just don't have the right education or information—just 30 minutes of counseling reduced trauma and ER admissions for those folks over the next three years by almost 50 percent. Other studies on cost-benefit analysis have shown that screening and intervention for alcohol and trauma patients saves $4 dollars for every dollar spent on doing screening and interventions and that 83 percent of trauma surgeons believe that the trauma center is an appropriate place to provide alcohol interventions.

The UPPL is not always enforced by insurance companies, but it's been used often enough that ER and trauma docs are very leery of doing screening these days. There are at least 47 studies that I know of that talk about the efficacy and the effectiveness of doing the early screening, even with folks who do not have a dependency issue with alcohol or drugs, just listening to what their doctors have to say can oftentimes change their behavior for the better. I strongly encourage you to pass A.B. 63 and repeal the UPPL.

Assemblyman Sherer:
Do you know which type of test they use for the screening?

Denise Everett:
In trauma departments very often they'll use a BAC or BAL, a blood alcohol concentration or blood alcohol level, which can be a blood test or a urine test.

We're talking about screenings, though. If somebody falls down and sprains their ankle very badly, a screening is usually only four or five questions. It takes all of three minutes. It's just to make a determination whether or not that person should receive further intervention. Oftentimes they don't, but the way we've sort of set up the system, we don't even have that opportunity.

Bill Bradley, Member, Board of Governors, Nevada Trial Lawyers Association:
We have seen another side of this bill, as you can imagine. We've seen those cases where someone who was innocent but had something to drink, but otherwise was not responsible for their injuries, be denied coverage because of this exclusion. Creating a blanket exemption and not allowing coverage for this seems, as other people have testified, antiquated and out of date. Consequently, we applaud Assemblywoman Leslie's efforts to get this bill passed and strongly support it.

Laurel Stadler, Director, Lyon County Chapter, Mothers Against Drunk Driving (MADD):
The mission of MADD is to stop drunk driving, support the victims of this violent crime, and prevent underage drinking. I have a handout that's coming around. I also was contacted by Dr. Gentilello of Texas about the problem and how often emergency rooms have become the safe havens for drunk drivers. Often, when the drunk drivers are transported to the ERs, there is no blood alcohol or alcohol screening done, and the drunk driver walks at that point. In a lot of places, these laws are being seen as soft on drunk drivers, and I'd like to say to this Committee that we don't see it as a bill soft on drunk driving. We see it as a way to identify those drunk drivers who are taken to the ER, a way for victims to have the option through the criminal justice system to see those perpetrators charged, and a way to find some justice and some recourse for the victims, if applicable.

The handout that I have says, "Click2Houston.com" from Dr. Gentilello (Exhibit C). He used to be an emergency room doctor here in the Las Vegas area, so he said that everything in this information does apply to Nevada, particularly to the Las Vegas area. The second article is a NHTSA [National Highway Traffic Safety Administration] article about the alcohol screening and brief intervention. People who come in can get their injury treated, get the screening they need, receive the referral to treatment, if applicable, and hopefully save a lot of future victims down the road.

Part of our mission is to prevent underage drinking, and a lot of juveniles end up in the emergency rooms. Again, because of the insurance laws, the doctors there do not test or document how many of the juveniles who come into their

emergency rooms are there because of an alcohol or drug problem that has caused or exacerbated the injury they are in the emergency room for. If they're there for an alcohol poisoning or overdose, that is not documented in the medical record, and it would certainly be better for that patient to get referred to the appropriate treatment if needed and get the early onset of these alcohol problems identified and some treatment in place. Again, we are supportive of this legislation.

Assemblyman Anderson:
I'm concerned about the issue that you've raised here. Maybe it's more proper to ask of the doctor whether the HIPAA [Health Insurance Portability and Accountability Act of 1996] regulations would prevent the police from obtaining information when they're on an accident case. You don't perceive that this is going to cause a dilemma for the doctor in his blood draw or screening to share the information that would be necessary? Are they going to have to do a separate one for the police when they're doing an investigation? Assuming that the doctor has this information, but no crime has been committed as far as they're aware, the patient would still be protected by HIPAA so doctors are not forced to give information to the police about the person who needs counseling to be put in an alcohol program. Is that where your concern comes from? I want to make sure that people who have broken the law are still going to be charged.

Denise Everett:
I cannot speak to HIPAA. I'm not familiar with it. I'm not exactly sure how that works. What I have been told is that the police would have a place to start if the alleged perpetrator did have an alcohol screening or evaluation level or a BAC level taken at the emergency room.

Generally, it would be nice for some of us in public safety issues to have some statistical information, particularly on the number of juveniles who visit the ER. We don't want to know the names, necessarily, of those particular individuals, but to collect some data as to how many times juveniles do end up in the ER because of underage drinking episodes so that area can be addressed more fully, carefully, and consistently by health professionals and the community as a whole.

Chairwoman Buckley:
Since HIPAA is so important and talked about so much, maybe we could get a copy of the statute and all of the exemptions for every member of the Committee's information.

Assemblyman Perkins:
There are some challenges right now throughout our state as it relates to not just the emergency room issues, but even the ambulance attendants and others who have to deal with those suspected DUI drivers and others who are then precluded from talking about somebody's medical condition. It has been a challenge for a number of the officers that I'm familiar with and it might be something this Committee would be interested in taking up.

Chairwoman Buckley:
We'll distribute that information.

Dr. Jay Coates, Vice Chair, Department of Trauma, University Medical Center Hospital and Trauma Center, Las Vegas, Nevada:
As someone who is on the front line of this issue, I see this absolutely every single day of my practice. The estimation that 40 to 50 percent of all injured patients who come through are in some way involved with alcohol or substance abuse is most likely an underestimation of the problem, quite frankly. With the law the way it is, it actually inhibits the identification and subsequent treatment of the patients as they come through the trauma centers. On behalf of the [University of Nevada] School of Medicine and the University Medical Center, we encourage your positive vote for A.B. 63. We feel this is antiquated law and should be changed.

Chairwoman Buckley:
Could you comment on what would be the likely method of doing the screen, how extensive the intervention is, and whether that would be overly burdensome for you in a trauma center?

Jay Coates:
In a trauma center, it's actually not burdensome in any way. It's usually a bundled set of laboratory values that are drawn on these patients as baseline labs. Blood alcohol level, or blood alcohol content, is often included in these. Again, there are many centers around the country that actually specifically pull these out of the bundle and no longer draw for them because they are not reimbursed for treatment.

Chairwoman Buckley:
What would you do if you found out someone's blood alcohol? What exactly would you do?

Jay Coates:
There are a number of programs in place. What the screening actually allows us to do is identify those patients who may or may not have problems with alcohol and/or substance abuse. It also creates for us a longitudinal record. Those patients who have chronic problems with alcoholism and or substance abuse tend to be frequent visitors to emergency departments and trauma centers. This allows us to keep a longitudinal record of these, and when we see patterns, it allows us to intervene and go through counseling, as in Dr. Gentilello's paper. A simple 30-minute session with patients often drastically reduces their repeat offenses and return business to the hospital.

Dan Musgrove, Director, Intergovernmental Relations, Office of the County Manager, Clark County, Nevada; and representing University Medical Center:
UMC sees a great deal of nonreimbursed costs through their trauma center that this change in law would definitely ameliorate. Clark County has two funds for our employees. We have a self-insured plan that does not contain a restriction, so there would be no effect on that. We do have a contract with Sierra Health Service that does contain that restriction, so Clark County is essentially taking a neutral position, but on behalf of UMC, it certainly would help us. Thank you.

Bob Ostrovsky, Legislative Advocate, representing Nevadans for Affordable Health Care:
[Submitted Exhibit D.] I want to talk to you about mandates. I don't want to talk to you specifically about the drug and alcohol provisions of this bill, but the overall impact of this bill. Nevadans for Affordable Health Care is a business coalition. One of the big things we exist for and about is trying to hold down health care costs for our small business members, and one of the issues that we always speak to is the issue of mandated benefits. We see this as a mandated benefit.

Nevada has 18 mandated benefits and 27 mandated provider persons-covered laws, for a total of 45 mandated benefits. There are only two states in the nation who have more mandated benefits than we do, California and Virginia, who each have 46 mandated benefits. We're tied with Connecticut, Florida, and Texas. Idaho has the fewest mandates, with 10. The reason I bring that to your attention is because mandated benefits have a cost to those who are covered by them. Clearly, you must understand that the laws that you wish to amend here affect two groups. They affect insurance, which is purchased by employers in the state, and for the most part that's small business employers who purchase group policies. It also covers individual policies that citizens might buy to cover themselves or their families.

[Bob Ostrovsky, continued.] The rest of the state is covered by self-insured programs covered by a federal law for which your mandate legislation does not apply. Or they're covered by Taft-Hartley [Labor-Management Relations Act of 1949], which are employer-bargained arrangements through a union. Those benefits aren't affected by these changes in the law. Another group I think is probably covered by that is public employees, who also have bargained plans, but those plans are covered by the *Nevada Revised Statutes*. In total, the changes you're talking about impact 35 or 40 percent of those persons who are insured in the state. It's important to know we are passing that cost along by changing this law. I think about the rising cost of health care and the pressure that puts on small employers who have to buy these policies. We've come to the Legislature on numerous occasions trying to find ways to make it more economically feasible. The Chairman of this Committee has spent a lot of time in the interim trying to find ways to help small employers purchase that insurance and we appreciate that. We're trying to hold those costs down.

Sixty-two percent of Nevadans get their health care from their employers. Two-thirds get it from small employers. A third of small employers don't have coverage. Health care has increased 51 percent since 1998. We're spending $3.80 an hour on employee benefits for insured employees now. We're spending about $7,904 a year per employee, yet we still have 354,000 Nevadans, 25.6 percent of the population, who aren't covered by insurance of any kind. You can find where we got those numbers (Exhibit D) on rising costs, mostly from presentations made at interim legislative committees or other documents that have been submitted. I ask you to keep in mind when you process this legislation, we do things that may in fact be the right thing to do, but they all translate into dollars that small employers continue to have to pay, making it increasingly difficult for small employers to continue to maintain their coverage or insure new employees.

Assemblyman Conklin:
You indicate that there is a cost pass-through to small businesses, but I'm not quite so sure that that's the case. Insurance companies charge their premiums based on the frequency and severity of incidents that they expect to cover over time. [Mr. Ostrovsky concurred.] If that is that case, and if in fact a large number of people are passing through our trauma centers and we are not helping them, chances are they will return again, which increases the number of incidents, increases frequency, and potentially increases severity because they have not been treated for their incidents. One could reasonably assume that if we offer this and allow insurance companies to cover it, the actual net result to premiums would decrease over time because we would be solving these issues instead of allowing them to happen over and over again.

Bob Ostrovsky:
I've seen an economic analysis and I've heard some people testify that there are hundreds of thousands of dollars of bills that go unpaid. Other people testify that we'll be screening these people out, so that their future cost will be less. I don't know what the answer is in the balance. I know we mandated things like screening for certain types of cancer. There's a real argument that's the right thing to do because if you catch colon cancer or breast cancer in the early stages, or when precursors to those, you've really stopped a larger claim later on. That's why I'm not suggesting that the Legislature made bad public policy decisions when they implemented some of these mandates. I assure you in the beginning there will be impacts from insurance companies and they're going to come to the table. Long term, whether it means savings, I don't know.

Assemblyman Conklin:
My only reason for pointing that out is because the testimony that we heard previously was, instead of denying these claims, we're just choosing to ignore that problem exists and so we're filing those claims already. That was the reason for my pointing it out. If we're filing them already, we're not stopping the problem from happening again, and that in my estimation would increase it. That was my point.

James Jackson, Legislative Advocate, representing America's Health Insurance Plan:
I don't want any of my comments to in any way intimate or suggest that I, my client, or any of its association members in any way disagree with the notion that increased screening intervention and treatment is not something that's needed and should not continue. The one concern that I wanted to express on the record, and I've shared this with Ms. Leslie, is that I think you're going to hear further from Jack Kim on this particular issue. Many of our association members have a felony offense exclusion in their policies. As I read the bill, I believe that the exclusion would also be compromised, meaning that somebody who commits a felony and injures themselves would still have to be covered under the policy. That's our concern and I just wanted to state that for the record.

Assemblyman Anderson:
The felon who commits the crime who has a medical problem, who's an alcoholic, would then be prevented from the insurance that he holds from getting the drug treatment program that he needs merely because his felonious act would preclude him from such? Is that what your concern is?

James Jackson:
That exclusion is currently in some health insurance contracts, and yes, if they commit a felony and are injured in the course and commission of that felony, that exclusion could apply to deny them coverage. There is an established body of law in the state of Nevada that those types of exclusions that exclude criminal acts from coverage, whether it be in this arena, liability arena or others, are valid exclusions.

Assemblyman Anderson:
A person breaks a leg while committing a felony, is arrested and brought to the hospital for treatment, and doctors determine he's an alcoholic. The insurance should not cover the broken leg; however, his treatment for alcoholism might be covered. Is that what we're trying to get to here?

James Jackson:
I think that under the current law, insurers are not able to preclude coverage for alcohol and drug treatment. The second provision of the current law requires that. You cannot deny alcohol treatment or substance abuse treatment.

Chairwoman Buckley:
I think that's reprinted on page 7 with regard to the repealed provision about not covering the injuries themselves.

James Jackson:
That's correct. And I see Mr. Kim has joined me to maybe help shed some more light on this.

Jack Kim, Director, Legislative Programs, Government Affairs and Special Projects Incorporated, Sierra Health Services:
I came up to clarify a point that Dan Musgrove made. He indicated that our policies have this type of exclusion that's referenced in the bill, and we don't. What we do have is a felony exclusion that indicates if you commit a felony and you are on cocaine or something of that nature, then there's an exclusion involved. That's fairly typical in a number of policies. If you broke a leg and committed a felony, that wouldn't fall into that exclusion, from my understanding. It's just if you commit a felony while you're on that illegal substance it would apply.

Chairwoman Buckley:
So if you're intoxicated but you're not involved in a felony, then both the treatment for the broken leg, for example, would be covered, as well as any alcohol and drug treatment.

Jack Kim:
In our plan it would be, but let's say if you injure someone in a felony DUI, then there would be an exclusion.

Chairwoman Buckley:
That person can get drug and alcohol treatment after that, correct?

Jack Kim:
They would fall under the policies of the alcohol and drug provisions in the policies; so as long as we're not talking about the felony exclusion, they get their required treatment. They would also be entitled to alcohol and drug treatment that wasn't part of their felony. I think that's where you're getting that. I don't think those provisions are impacted.

Janice Pine, Legislative Advocate, representing St. Mary's Health Plans, Reno, Nevada:
[Submitted Exhibit E.] We stand in opposition to subsections 1 of Sections 1 through 8 and subsection 1 of Section 10 of this bill. We are in opposition to any new mandates being placed upon the insurers. We believe that the responsibility for wrongdoing needs to be placed upon the wrongdoer. In this instance, other sections of NRS are very clear. NRS 484.379 states that it is unlawful for anyone under the influence of intoxicating liquor or an amount of a prohibited substance equal to or greater than the amount in the statute to drive or be in physical control of a vehicle. This is an illegal act which has increased legal consequences based upon the amounts of substances determined to have been ingested or injected, or however they got into the body, and the presence of an injury to another person.

Saint Mary's has specific exclusions in its "Health Plans Evidence of Coverage," which states that injuries sustained by the driver while driving under these unlawful circumstances are not covered. Further, we somewhat follow the language in the workers' compensation section, which states that "compensation is not payable for injuries occurring under the influence of either alcohol or a controlled substance." That is NRS 616C.230.

We have no concerns about subsections 2 and 3 about the issuance of the insurance policy. We would therefore suggest the deletion of subsection 1 in Sections 1 through 8 and 10 and the deletion of Section 14 of the bill, which would then replace the existing language back into the statute.

Further, should you decide to proceed with this bill, Section 13 is also problematic. The effective date appears to be October 1 of this year. All the

health plans have many contracts, which are multi-year contracts. These contracts are presently valid, have not taken into consideration, and have not been rated in any way for including this mandate, so if you were to proceed, we would hope that the effective date for new contracts being issued wouldn't be set until at least January 1, 2006, and for existing contracts, upon the renewal dates of those contracts. Subsection 2 of Section 13 would have to be reworded to accommodate that.

Assemblyman Hettrick:
It says "under the influence." Is it below 0.08 [blood alcohol content]? Any amount of alcohol? Any substance that's considered controlled—is that a prescription? I think part of what the contention is here is that we have someone who walks through a door and they're being denied because they have a tiny little amount of alcohol or a prescription that is a controlled substance. I think that's the question we need to have you address.

Janice Pine:
I tried to find a definition of "under the influence," and all I could find was the statute that is in the traffic section, NRS 484.379, which talks about the 0.08 BAC or greater. So, I believe that our evidence of coverage would follow that if somebody has had one glass of wine and it's 0.001 in their blood, we would pay for their injury, but if it's over 0.08, then—

Assemblyman Hettrick:
How do you handle that, then? I think it would be wise to put that in the contract because it leaves it open to interpretation. The other is, what about controlled substance, and how do we define that? Is it a prescription drug that was in the blood stream, and how are we testing for that, and what's the allowable limit on those things?

Janice Pine:
It is listed in the statute, and our evidence of coverage references the prescription by a physician.

Assemblyman Hettrick:
Are you aware if St. Mary's has ever been sued over this issue? Because I wondered what the judgment was when it went to court or in a settlement as to whether or not indeed the standards that you just expressed to us were applied to it and it resolved it. I don't care if they've been adjudicated. I wanted to know whether or not the solution fell down upon the information or the 0.08 BAC, or that determined yes or no. I think that would be helpful.

Janice Pine:
I do not know. I know there have been appeals that have quite possibly gone to a legal setting. I can get that information and certainly let you know. I don't know if any of them have been adjudicated. I'll get that information.

Assemblyman Conklin:
Is it standard practice at your facilities to test every person who comes in for illegal drugs and alcohol?

Janice Pine:
It is not standard practice to test everyone, or I don't know at what point it might be indicated. I think one of the physicians testified about using common sense, and if there is a slurring of words and you're bouncing off the walls, there would be a strong indication that you might be under some sort of substance. I'm pretty sure it's not standard practice to test everybody. Again, I could find that out, but I'm pretty certain that does not occur.

Kay Lockhart, Executive Vice President, Nevada Independent Insurance Agents:
I've listened to the testimony and have nothing to add to what's already been presented.

Chairwoman Buckley:
That exhausts my list of those who have signed in against and indicated they wanted to speak. Is there anybody else who didn't sign in who wants to speak?

Christina Dugan, Director, Government Affairs, Las Vegas Chamber of Commerce, Las Vegas, Nevada:
We are also members of Nevadans for Affordable Health Care, but we do have additional concerns about the situation with mandates. Our members have indicated to us through surveys and discussions that health care is one of the biggest issues they face currently, and it's a struggle for them to continue to provide health insurance for their employees. They are actively seeking to do so. We have put forward Chamber group plans to find ways to help them leverage their situation by creating a pool. We just ask the Committee consider when you do pass something like this forward and understand the cost that may be involved for small employers when you add additional mandates.

Sam McMullen, Legislative Advocate, representing Hospital Corporation of America (HCA):
HCA has units in southern Nevada: Sunrise Hospital and Medical Center, Southern Hills, and Mountain View. The Nevada Hospital Association said that I can put their name in support of this.

[Sam McMullen, continued.] It prevents insurance companies from accepting premiums for health care insurance and then refusing to pay for injuries incurred while under the influence of alcohol or controlled substances. The cost of medical care stops it from being shifted to taxpayers and others instead of the company who received the insurance premium. That is a key point to Sunrise Hospital, because Sunrise currently, not counting the other hospitals, covers 20 percent of the uninsured and indigent patients in the whole state. This would allow treating physicians to test for alcohol and controlled substances in patients without placing them at huge financial risk. These tests often are the first step in substance abuse treatment, as you've heard. They agree with that. It does not prevent insurance companies from charging differential premium rates for higher-risk patients.

We don't want the testimony to be interpreted as supportive to intoxicated drivers or anyone else who risks injuries to themselves and others while they're utilizing alcohol or drugs. They should meet with the full consequences of the law. But they should not have their health benefits suspended and the cost of their care levied upon others. We are in support of that.

Assemblyman Seale:
Is this an issue of where the costs are going to fall? The hospitals are going to give the treatment and the same amount of treatment whether or not the insurance company pays for it, correct? So, the issue is, who's going to pay for it? Is it going to be the hospitals or the insurance company?

Sam McMullen:
There's no health care or insurance issue today that isn't a follow-the-money type of issue, but I think his testimony tried to go beyond that to some of the beneficial impacts that you could have in terms of helping identify substance abuse issues and those types of things, so it's not only that.

Assemblyman Hettrick:
What happens if the patient refuses to be screened?

Timothy Coughlin:
It would be my impression that patients are allowed to refuse to be screened if they feel like doing that. Patients can refuse to have screening tests done. If you're simply brought in for drunk driving, you can refuse to have your blood drawn. I would assume it would extend to that. I'm frankly astounded that the hospital I practice in is speaking against this bill today. It really surprises me a great deal. I think the point needs to be made that these people are being seen, they're being taken care of, they're just simply not being screened, and no

effort is made to stop the recidivism that's going to go with it. By speaking against this bill, you're actually in favor of maintaining the status quo, where we pay for it anyway, but we don't do anything to stop the flow downstream. These people are going to go out and repeat it. If we can catch them and stop one out of ten, we would be saving a tremendous amount of money. It seems to me penny wise and pound foolish to do that.

I'll speak to the hospital people when I get back, not that I think it will make any difference, because it sounds like it's a money issue at this point. It's shortsighted.

At one point, Washoe Medical Center wanted to take Welbutrin off their formulary, which was Zyban, a drug to help stop smoking, because it was being prescribed too much. If you only stay with a health plan for two years and it takes six years for a stop-smoking program to show a profit, it is astoundingly cynical that your own health plan would stand in the way of you trying to do something as beneficial as stop smoking. I'm just disappointed in St. Mary's.

Assemblyman Hettrick:
If there was a refusal of screening, how's the insurance company going to handle it? I don't want a refusal of screening to be seen as a reason either to deny or not deny. Is it going to go on somebody's record? If somebody refuses to screen, are they going to be presumed to have been under the influence or presumed to have been somehow addicted or an alcoholic and need treatment?

Timothy Coughlin:
I can speak from the workers' comp standpoint that if you are involved in an accident on a job site and even if there is no suggestion that you're impaired in any way and you go to the hospital, the workers' comp company can show up, demand the urine of you, and if you refuse to give the urine, they will deny payment for all of this. My son-in-law had this happen to him. He had broken his knee and was lying on a gurney when the workers' comp people showed up and wanted the urine. He was in pain, irritated, and amazed that people could come and try and do something this invasive. Naïve about the law, he refused to give them the urine, although he came back the next day and did give them the urine that was completely clear, and they denied the whole claim, sticking him with the hospital bill for an operation.

Jack Kim:
I can only speak about my plan. I think this is an area that you've mentioned where the refused screening wouldn't show up in the claim form that we would get. It wouldn't fall under our exclusion anyway. That wouldn't be an issue with

our plan. As I briefly stated, our exclusion is a felony exclusion. If it occurs during the course of that felony and that's proven, that would apply. Under the typical situation that you've mentioned, it wouldn't be an issue for us.

Sam McMullen:
The issue on workers' comp was governed by specific statutes. In the absence of specific statutes relating to the impact or the effect of screening or nonscreening, there would be no impact.

Chairwoman Buckley:
We'll close the public hearing on Assembly Bill 63 and we thank all of the witnesses. You gave us a lot to think about, and we appreciate you all taking the time to come forward and provide us testimony. Seeing no further business to come before the Committee, we are adjourned [at 3:17 p.m.].

RESPECTFULLY SUBMITTED:

_____
Vanessa Brown
Committee Attaché

APPROVED BY:

_____
Assemblywoman Barbara Buckley, Chairwoman

DATE: _____

EXHIBITS

Committee Name: Commerce and Labor

Date: 3/2/05 **Time of Meeting: 2:00 p.m.**

Bill #	Exhibit ID	Witness	Dept.	Description
	A			Agenda
63	B	Denise Everett	Join Together Northern Nevada	National Conference of Insurance Legislators Resolution for Repeal of UPPL
63	C	Laurel Stadler	MADD	Click2Houston.com "Three Bills Could Change the System"
63	D	Bob Ostrovsky	Nevadans For Affordable Healthcare	Nevadans For Affordable Healthcare Numbers
63	E	Janice Pine	Saint Mary's Health Plans	Prepared Testimony