MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Third Session
February 9, 2005

The Committee on Health and Human Services was called to order at 1:37 p.m., on Wednesday, February 9, 2005. Chairwoman Sheila Leslie presided in Room 3138 of the Legislative Building, Carson City, Nevada, and, via simultaneous videoconference, in Room 4406 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. Sheila Leslie, Chairwoman
Ms. Kathy McClain, Vice Chairwoman
Mrs. Sharron Angle
Ms. Susan Gerhardt
Mr. Joe Hardy
Mr. William Horne
Mrs. Ellen Koivisto
Mr. Garn Mabey
Ms. Bonnie Parnell
Ms. Peggy Pierce
Ms. Valerie Weber

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Maurice Washington, Washoe County Senatorial District No. 2

STAFF MEMBERS PRESENT:

Barbara Dimmitt, Senior Research Analyst, Legislative Counsel Bureau
Julie Morrison, Committee Manager
Paul Partida, Committee Attaché
Joe Bushek, Committee Attaché

OTHERS PRESENT:

Joseph Q. Jarvis, M.D., MSPH, Associate Professor, School of Medicine University of Nevada, Reno, and President, Utah Health Alliance
Betty Pardo, speaking on behalf of Ruth Mills, President, Nevada Health Care Reform Project
Patricia van Betten, Director at Large, Nevada Nurses Association
Roger Volker, Executive Director, Nevada State Medical Association
Bobbie Gang, Legislative Advocate Representing Nevada Women's Lobby
Gayle Holderer, Concerned Citizen
Jan Gilbert, Northern Nevada Coordinator, Progressive Leadership Alliance of Nevada, Reno, Nevada
Larry Struve, Advocate, Religious Alliance in Nevada
Claire Boutin, Past President, National Alliance for the Mentally Ill of Southern Nevada
Elsie Dupree, Concerned Citizen
Charles Duarte, Administrator, Nevada Check Up and the Nevada Medicaid Programs

Chairwoman Leslie:
[Introduced Committee members and staff.] We'll go to the next item, which is the adoption of the Committee Standing Rules (Exhibit B). I'll take a motion if people are ready.

ASSEMBLYWOMAN McCLAIN MOVED TO ADOPT THE PROPOSED STANDING RULES FOR THE ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES SEVENTY-THIRD SESSION.

ASSEMBLYMAN HORNE SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

Chairwoman Leslie:
Thank you. We have no Committee introductions of bill drafts today. We did receive 11 bills on the first day. I've asked Barbara Dimmitt to lead us through the Committee Brief. [Introduced Barbara Dimmitt.]

Barbara Dimmitt, Senior Research Analyst, Legislative Counsel Bureau:
The first section [of the brief, (Exhibit C)] after the Table of Contents, which starts on page 1, is the jurisdiction of the Committee. The first title that we received bills for—the public welfare bills in Title 38. This contains all the welfare programs, children's homes, foster care, assistance to indigent and

homeless people, services and facilities for children, and protection from child abuse and neglect, and other similar legislation.

[Barbara Dimmitt, continued.] Title 39, we also receive typically the bills for this. Obviously, there can be some differences in referrals, but typically we receive Title 39 bills which are for mental health. This includes admission to mental health facilities, treatment or hospitalization records, services to the developmentally disabled, and the community mental health programs.

Title 40, we receive most of those bills and they are about public health and safety. That includes the administration of all public health programs, licensure and regulation of different medical facilities, maternal and child health programs, the county hospitals and hospital districts, regulation of controlled substances, diseases, communicable diseases. The amount of bills that we receive regarding disaster preparedness would come under this Title. We do not receive water pollution and hazardous waste in this Committee normally.

Title 51, we receive some of that in regulation of food, meat, fish, poultry and eggs, et cetera, and some drug and cosmetic regulation. The second section of the Brief involves significant policy issues that were enacted in 2003. The Section A on page 2 involves the issues affecting the elderly. Training for providers of care, prescription drug assistance, et cetera. Then we have a series of bills that were enacted last session on children, primarily regarding abuse and tragic events that occurred with children. We've got revisions of the provisions on guardianship, changes in multi-disciplinary teams reviewing the death of a child, and so forth.

Public health. We did have some Legislation on emergency preparedness last time: arthritis prevention and control programs, warnings about fetal alcohol syndrome in terms of pregnant women drinking, that sort of thing. Issues affecting health care providers, there was one bill that attempted to deal with the shortage of physicians through various means. Then we go on to numerous bills that affected various medical facilities. This ranges from anything from the assisted living facilities that try to keep people out of long-term care, institutional care, down to hospitals, half-way houses, et cetera.

Then Medicaid and prescription drug coverage. You probably will recall there was legislation authorizing a preferred drug list. There were some bills on Medicaid estate recovery. Then going on to mental health, we had legislation regarding detention for medical evaluation—medical treatment of mentally ill people before they can be referred to a program, and a suicide prevention bill.

[Barbara Dimmitt, continued.] There were some other miscellaneous things. On page 9, we go into a brief description, extremely brief, because each of these has its own bulletin which you've received. On the interim study committees of the Legislative Committee on Health Care, which had numerous subcommittees—the Task Force for a Fund for a Healthy Nevada, which is going to be meeting a little bit through this session in order to continue its work.

Then additional studies that are highlighted on page 10. The reason we've put these in is, let's say you needed to give a speech or something, and you couldn't remember which one that was. We've got the numbers here, and I believe you have a full set. So you should be able to find these by number, if you do have that full set.

Page 11 is possible health issues for 2005. It is likely that the Legislature will be considering various bills regarding prescription drugs for seniors. Not just because of the program itself, but because of the Medicare Modernization Act and the new Part D for prescription drugs.

Mental health services is another major issue that will be covered this session, and we'll be looking into that, this Committee, next week. Medicaid issues are always an ongoing concern and they will continue to be, as will access to health insurance. There are several options for addressing this issue that are upcoming.

On page 13 and 14, if you just want to take a quick scan at that, it indicates that other states are experiencing similar concerns. This gives an idea of how extreme the issues are getting in some of the states, particularly Medicaid funding and access to health care.

Federal issues, again, here's a brief overview of some of the key issues that have been in the news lately. Medicaid funding and reform; the implementation of the Medicare prescription drug program, which is going to be a major challenge for all the states; disclosure of clinical drug trial information and the prescription drug reimportation, which also may involve some state legislation. Then finally, on page 17, this is the part that people often save when the usefulness of the whole document may be waning, and that's the contact list for most of the State agencies that we deal with and some local organizations, state-run organizations.

The only thing I'd like to say in conclusion is that I'm available for Committee business at the direction of the Chair. In addition to that, the Research Division and all of its staff are available to you individually for requests on a confidential basis. I look forward to working with you all. Are there any questions?

Chairwoman Leslie:
Are there any questions for Ms. Dimmitt on the policy brief? Thank you very much. We do have a special meeting scheduled tomorrow night at 6:00. We are still having that meeting, even though the Health Services Coalition was able to settle with the hospitals. Speaker Perkins has asked us to go forward. It's very important for us to determine why we have this crisis in Las Vegas every three years. We need the Committee's input on what direction we want to go this session on that critical issue.

Next week we're going to be focusing on another critical issue, mostly affecting Las Vegas, but it does affect the entire state. That's the mental health crisis in emergency rooms in Las Vegas. Let's start our feature presentations concerning the future of health care coverage in Nevada. We are very fortunate to have with us Dr. Joseph Jarvis, who's an Associate Professor at the School of Medicine at the University of Nevada, Reno, and also the President of the Utah Health Alliance.

Joseph Q. Jarvis, M.D., MSPH, Associate Professor, School of Medicine, University of Nevada, Reno, and President, Utah Health Alliance:
I'm the former State Health Officer for the State of Nevada. I am going to refer to a number of documents, one of which is a PowerPoint presentation (Exhibit D), which is entitled "SB 289: Ensuring Health Care for All Nevadans," Beginning, though, with a bit of a disclaimer, I am very proud to have been affiliated for many years now with the State of Nevada's School of Medicine, mostly as a volunteer faculty member. Since I left the State after resigning as the State Health Officer, I've maintained that affiliation and have been here every year a number of times to teach and work with the medical students and residents. I am voluntary with them; I'm not a paid faculty member, and the work product that I have prepared for you today is my own work and does not represent the point of view of the School of Medicine.

Senate Bill 289 of the 72nd Legislative Session apparently required a study during the interim of single-payer health care. That is the reason I was asked to come and present before the Interim Committee on Health Care.

Before I describe what single-payer is and what its advantages might be as a means of ensuring financing for health care for all Nevadans, let me turn your attention to the second slide on my PowerPoint presentation, to review a few of the basic facts that bring us Americans repeatedly to discuss the topic of health care and health care policy.

Among first-world nations, we are the only one that has an uninsurance problem. That problem is now measured in the tens of millions of our citizens,

and in Nevada, in the hundreds of thousands. The numbers are there. They are somewhat outdated. I think, just for perspective, when Bill Clinton declared it a national crisis and held a national debate about health policy now a dozen or so years ago, we had 30 million uninsured Americans. This is a problem that continues to progress, as do the costs associated with health care in our country. Year 2004 was the fourth year in a row nationally with double-digit increase in premiums for businesses. Our health care costs on a per capita basis, likewise, are the most rapidly rising in the world. We are now at about $6,500 per person per year for health care in the United States, far more that what is paid in any other country. Our uninsured people suffer from lack of financing and access to health care.

[Joseph Jarvis, continued.] Turning to the next slide, I use it to illustrate what I think every American ought to understand about the basic underpinnings of our health care system. Each of those bars represents the per capita cost in 1998 for various countries, mostly in Europe and Asia, compared to the United States. The other countries all are completely tax-based health care systems. Some of them are socialized and I'll describe that a little bit later, and others are not. They all provide financing by taxing their citizenry for health care.

The U.S. bar, which is by far the longest, and again that's because we spend far more than any other country does on a per capita basis, is divided into two portions. The larger portion is our public financing on a per capita basis for health care. The smaller portion to the right is what comes privately out of pocket and from private employers for health care purposes. The point I'd like to make out of this slide, besides the size of our bar and how big our per capita costs are compared to other nations, is that we do not have a privately financed health care system. We have a tax-dollar financed health care system. Approximately 60 percent of the dollars in health care in the United States are tax dollars. If we were to make this a year 2004 bar, the bar would go off the chart to the right, because of the increase that has occurred since then.

We are also the nation that has the largest per capita tax burden for health care in the world. Our taxpayers, let me say that again, pay more for health care than do the taxpayers of any other nation, important points to remember as you consider the next slide. Despite our generosity for health care, and we Americans really do care about health care, we pay more than anyone else. We have the only first-world nation where citizens are unable to get what they need in health care when they are ill. One in five Americans postpone getting needed health care because of financial reasons. One in seven have problems paying for medical bills.

[Joseph Jarvis, continued.] I'll discuss in a moment that impact on family finances in terms of personal bankruptcy. This is a study dated in 2002 from the Kaiser Commission; 10 percent of Americans do not get prescription drugs that they need, because they can't afford them.

That leads to the next finding, which is a summary slide from a study conducted by the Institute of Medicine. It's commonly said in our country, at least I've often heard it, that because emergency rooms and urgent care centers are available for people to receive care, whether they can pay or not, that everyone has access to health care and therefore, uninsurance really isn't that much of a problem. The Institute of Medicine was asked if it is a problem or not, and they did the study in 2002. It's called "Care Without Coverage," and they discovered even though they confined their study to Americans age 25 to 65 and limited their look at causes of mortality that were among the top or the leading causes of mortality in the United States, they nonetheless found that approaching 20,000 deaths occur annually in the United States due to uninsurance. It is a problem that creates unusual morbidity and mortality. It's the reason why I said that Americans are sick too often and die too young.

Beyond these public health problems and these financial problems that our health system creates, I want to turn your attention for a moment to the problems it creates for running a business in our country. There are compelling business reasons to look hard at the way we finance health care and what our health policies are. I've provided you with some quotes that date back about 1 1/2 years, to the last major discussion between the United Auto Workers and the "Big Three" automakers in the United States [Chevrolet, Ford, and General Motors]. I think you can substitute any American business that's trying to compete in the global economy for our auto industry.

This is a statement from Uwe Reinhardt, who is one of our nation's preeminent health care economists. "It is insane to think that a company embedded in a fierce global competition can function as social insurance system." Turning it over, the Wall Street analysis of the same problem, Goldman Sachs said, "Big Three automakers are HMOs [health maintenance organizations] with wheels that only happen to make cars." As long as our businesses are only incidentally making their products in order to sustain a bad health care habit, whatever that cost is, how can we possibly ever believe that our economy is ever going to thrive in this increasingly competitive global economy?

Beyond that, in addition to the global economic strains that having this albatross around our businesses' necks provides, our domestic market is weakened by the fact that our people are the only people in the first-world at risk for bankruptcy because of health care costs. Illness and injury causes about half of the personal

bankruptcies in our country. That's data that dates only a week ago to a Health Affairs journal article, published from the Harvard School of Medicine and Harvard School of Law. Half of the people who end up declaring bankruptcy are people that got there because they were either injured or ill, or someone in their family was. Most of these families started that injury and illness experience with health insurance which failed to protect them from the financial breakdown that ultimately occurred.

[Joseph Jarvis, continued.] In addition to having a weakened domestic market and a difficult time stretching to try to compete with global competitors who don't carry the social benefits system on their backs, American businesses, because of the very arcane and difficult way it takes to try to understand and purchase health care benefits for their employees, spend seven times what other companies do in other countries, just trying to figure out the internal issues. The arcane purchase of policy issues that go with health care in our country. The reference for that is from the *New England Journal of Medicine* in August of 2003.

The question is, can we actually change the way we do business and the way we finance health care in a way that provides for a better result? That covers more people; does so without increasing the cost rapidly or stabilizes them; provides us a way of reducing our morbidity and mortality. I think the answer is yes, providing we're willing to shift our paradigm of what we consider health care to be.

On this next slide, I quote from Tony Snow, a commentator who wrote a column during the Clinton health care debates. This small quote comes from that time, 1993. "In the real world," he says, "People stampede when somebody puts up a sign that reads 'free.' This is the theory behind bargain basements, but it also applies to hip replacements and appendectomies." Mr. Snow here is providing us with what is a common way of thinking about health care as a commodity. That is, if it's priced low enough, people will demand it at an increased rate. This is true of any real commodity. People who seek a car, if it's a BMW priced at $50,000, comparing it to a Ford at a lower price, may wish to buy the lower cost automobile. On the other hand, if you switch the BMW to the lower cost, you'll have an increased demand for that. That inverse relationship between the price of something and its demand is a hallmark, a key feature of a commodity.

I'd like to argue that isn't true of health care. I've often given my audiences, as I speak about health care, a thought experiment. If I were to offer a $50,000 item, either one of which two of these are offered, either one of which you could choose to have this afternoon. One being a $50,000 car and the other a

$50,000 heart surgery, how many people in the room would choose the heart surgery and get admitted to the hospital for a cracking of their chest tomorrow morning as opposed to the car? Relatively few would. In fact, I've never had anyone offer to take that heart surgery. It is not something that has any value to anyone outside of the person who is persuaded by their physician that they need that service. If we stop thinking about health care in commodity terms and stop thinking about the efficiencies of a market as a thing to distribute health care, we might be able to make the paradigm shift that I'm talking about.

[Joseph Jarvis, continued.] I refer you to the next slide using the words of an economist. I'm not an economist, but I used Mr. Robert Kuttner, who is an economist, as a way of describing what the prerequisites are for a free market and how that doesn't apply in the health care system. Free markets have a supply side that is absolutely free of barriers, so people who want to sell something in a market can get to the market easily, without any interruption.

In health care, we don't allow just anybody to hang a shingle out, and we don't allow just any business to relabel its building a hospital and begin welcoming patients. As the Health Officer in this state, I spent a lot of time on facility regulation. For good reason, we want people who are admitted to facilities to be treated correctly and in an ethically responsible fashion. The supply side is not free entry in health care, nor is the demand side. That is the "come-up customer side," characterized by "let the buyer beware," where there's infinite information to the purchaser of the item, where the purchaser or the buyer has the time and the wherewithal to do the shopping.

These things are not true of patients, who are the people actually getting the health care and purchasing it. They have neither the information they need, because they have to depend on doctors in order to even begin to understand what they really need, nor do patients have the time to devote to shopping. Supply- and demand-side issues really make it not a market. Beyond that, we have social safety nets that we've created because we care whether people get health care in our country. Again, I ask you, what market is it that is 60 percent tax dollar? That by itself is a contradiction of terms.

The final issue that Mr. Kuttner brought up in his book was that positive externalities are not true of a free market. A positive externality exists when somebody other than the buyer and the seller cares about the transaction between the two. I don't care whether you go to the grocery store and buy hamburger or steak or not any meat at all. That is up to you. It's not an issue that I really particularly have "a dog in the fight," as people say in the South.

[Joseph Jarvis, continued.] I do care whether or not you get good health care. I do care whether or not you're an active case of tuberculosis and are properly diagnosed and treated. That does matter to me as a member of society. It also matters whether your children are immunized properly, and it makes a difference to me when you need surgery you get it properly, so that the nurses and doctors that provide that care are always in practice, always sharp on their skills, for the time when I need that same service. It matters a great deal to me how health care is delivered to everybody else in our society. Positive externalities negate a free market. It makes it an inefficient way to conceptualize and distribute those entities. I'm arguing that health care is not a commodity and our pretense in the United States is, in fact, a direct cause of the high costs and the lack of coverage and the increasingly poor quality that we're delivering.

If, on the next slide, we agree that health care cannot be efficiently distributed in a free market, what are the alternatives we have for health policies? There are relatively few, one of which is the so-called "socialized medicine" model. This is the model where the government owns the means of financing health care. The revenues are all tax dollars, but the government also owns and operates all of the health facilities and employs the professionals in the system. This is what was true of the United Kingdom when they created, from scratch, their British health care system years ago. It has had, of course, a variety of variations since then, but that's what its original concept was. Socialized medicine, ownership of not only the revenues, but also the means, the delivery system, the doctors' and the hospitals' practices. That isn't a system that I'm arguing for; it isn't one that I think would work well in the United States.

The second option is incremental reforms. These basically don't do away with the underlying so-called market-based system that we already have. It's simply trying to add more people to the covered list by identifying more ways that government taxes can be spent on health care problems. A good example of an incremental reform was the Medicare Pharmacy Act of a year and some several months ago, back in Washington, D.C. They identified a problem, an uncovered situation. Seniors weren't getting the pharmaceuticals that they needed. They came up with a new budget to provide for that and now they are trying to deliver that service.

Over the next year or so, we'll hear a lot about that. Inevitably, with incremental reforms, you have the same inefficiencies that already exist in the system, and you add to them by finding more money for a system that already has far more money than any other system in the world. I argue that those things will never get us to the goal line, and they will always cost us more money.

[Joseph Jarvis, continued.] That leaves us the third alternative, which is the single-payer alternative that I've come here to talk to you about. This is an alternative where the government owns the means of financing health care. The revenues are government revenues, and that is pretty much what we already have; a 60 percent tax base for our health care system is in majority anyway. A government payment system, but it's a private health care delivery system, doctors in private practice mostly on fee for service, hospitals in the private sector, as are other institutions.

This is what I want to spend some time talking to you about. The next slide actually goes through a brief description of a single-payer health care system, which can be organized on both a national basis and on a more regionalized basis. I'm going to propose a state-based way of handling this, but there are many people who are advocating for a national Medicare for all sorts of single-payer systems. They all share these features, public financing from one community-owned payer.

Some people refer to Medicare as a single-payer and in that regard they are incorrect, because it doesn't come into the next level, which is a universal coverage system. Medicare only covers a selection of people in the United States, not everybody. A single-payer system covers everyone, all people, regardless of age, regardless of occupation, and a variety of other factors.

Third, it's comprehensive. By that I mean it covers all medically necessary care, things that a doctor and a patient agree are necessary for the prevention of impairment, disease and death, or for the treatment thereof. Third, it's private delivery. I've already mentioned this; I want to keep emphasizing it.

Single-payer is a private health care delivery system-doctors in private practice making decisions on what they want to practice and where they want to practice and how much they want to practice - and hospitals also primarily in the private sector. It controls costs through operating budgets which are based on economies of scale that are unfamiliar to us in the United States. It's one of the reasons why we lose so much in the inefficiency of a micromanaged, individual, 1,800 different payer, sort of system. You lose the ability to control the care over an entire population of people. It's portable. People who go on vacation, who move from one place to another, take the coverage with them. There is no more job lock related to health benefits. It's accountable to all Nevadans, because the payer is owned and operated by the people in this society.

There are many advantages. In the *New England Journal of Medicine,* August of 2003, which was about the twelfth study about these advantages that have

been published in about 10 years in the United States, they documented $300 billion per year wasted on bureaucracy in the U.S. that would be eliminated under a single-payer system. They went on a state-by-state basis and suggested that in Nevada there was almost $2 billion available for savings in bureaucratic and administrative waste. That's the money that we need to fund the health care that we're not funding now. It is the unfettered choice of physician, as opposed to the current practice of having businesses intervene between the patient and the doctor.

[Joseph Jarvis, continued.] This allows the patient to find their own doctor, choose their own doctor, move to another doctor if they want, get a second opinion if they want. This is the only decision that a patient can make alone, who will be their physician. All other decisions they make in conjunction with that doctor. It covers all people for all medically necessary care, without increasing the per capita cost.

In this way, it is the most conservative fiscal proposal for health policy change available to us. It will not increase the cost on a per capita basis. The private sector health care delivery system is preserved. It has been studied in the neighboring state of California as recently as about two years ago. The HCOP is the Health Care Options Project, which looked at nine different possible ways of getting California to universal coverage.

They basically divided into two groups, the incremental group and the single-payer group. No one studied in California the socialized medicine option. It's not something that is at all preferable in the United States. Between those two, the incremental and single-payer coverage, they documented over and over again that all the options for incremental coverage cost went up. For each of the options, and there were three for single-payer coverage, the cost went from where they were, down, less cost, covering everybody in California.

Single-payer increases the options, the choices that people really care about. I would submit to you that it really doesn't make that much difference to the patients in Nevada which health insurance company they are affiliated with. That's not a choice that they really care about. They do care about which doctor they go to see. That's the person they trust and to whom they offer the intimacies of their lives, someone upon whom they rely for some important decisions in their families. Single-payer makes that choice infinite, as opposed to any other business model.

Single-payer compares well with what has been repeatedly shown to be the mindset of Americans. This is a 1998 Harris poll, which documented that about four in five Americans said the government should provide quality medical

coverage to all adults, which of course is the segment of our society least able to get coverage. All young adults and middle aged adults. I could show you data like this from virtually every year dating back at least 20 years; four in five Americans are in favor of universal coverage in some form. The reason why, even with that high level of approval, we don't have the single-payer option is in the next slide.

[Joseph Jarvis, continued.] People generally agree with me when I talk about the advantages in single-payer health care, in terms of its efficiency and reduced cost and coverage of everyone. The main argument used against it is that it is not politically feasible, which you should read as the health care interests, the corporate interests, are able to control the policymakers such that we're never offered this option in a public policy discussion. I would ask you to consider where we would be in the United States today if Martin Luther King had waited until it was politically feasible to argue for civil rights.

I would ask you to think about where we would be in the world today if the free nations of the world had waited until it was politically feasible to pressure Communist nations. Would we have seen the Berlin Wall fall as soon as we did? This problem, this health care problem that we are all facing, truly has political feasibility issues attached to it. You all know that better than I. You're the politicians in the room. I'm going to argue that you need to think broadly about who benefits most and who expects the benefits from basically a taxpayer-based system that we have in the United States. I'm going to offer you six principles, which I think most Americans would agree with in terms of health coverage. The last one perhaps, being the one that's the most controversial.

The first is, and this I can say all health profession organizations would agree with, we should provide the necessary health care to every citizen. Most of the uninsured in our country are either taxpayers, are unemployed, or they're dependent on a taxpayer. These are the very taxpayers who are paying the world's largest tax burden for health care. Yet every time we come up with a policy change that is incremental, we ask them to kick in more money and they still don't get health coverage when they need it. This may be perhaps the most unfair tax policy that exists in the world.

The second: Let patients choose their own doctors. Stop having business interests intervene between the care that patients need and the people that they want to provide it to them. The business of health care interrupts that relationship. That relationship, unfortunately, once interrupted, becomes less able to deliver the quality of care that patients should expect at the high cost we're paying in our country. Close that loop. Let the patient/physician

relationship become again the sacrosanct relationship that allows for the highest quality health care.

[Joseph Jarvis, continued.] Third, do both of those things, even though they sound like they would involve more expense, without increasing the per capita cost for health care in the country. As I've already said, $6,500 per person per year, projected to be closing in on $10,000 per person per year by the end of this decade. We have enough money in the system already. Any proposal for health policy change that comes before you that starts by saying how much more money would be involved should be, on its face, considered not a viable solution to the problem that's before us. We are generous with health care and have always been generous with health care revenues in this country. They are primarily taxpayer revenues. They belong to the people and they should be used to fund health care for all of the people.

Fourth, we provide those benefits without increasing per capita cost by reducing the overhead, the bureaucracy that is involved with health care as it is today in the United States. We don't have the best health care system in the world. We have the most bureaucratic health care system in the world. We have the most profitable health care system in the world, but it is not the system that provides the best and highest quality care in the world. Our health care costs are causing us to spend $300 billion per year over what we should for bureaucratic services that are unnecessary.

Private insurance providers have higher overhead costs than government payers for health care, and every time there is a benefit denial process done by a private insurance company, there is a physician office or hospital that has to staff its bureaucracy up in order to fight to get paid. I think that I could find soulmates on that point in the two physicians on the Committee. There aren't doctors anywhere who don't know what kind of a paper war it is to try to practice medicine and get paid. When I was at National Jewish Center, one of the nation's best respiratory care facilities, receiving patients from all over the country, I spent as much time fighting bureaucrats on the phone as I did actually delivering health care. That high administrative cost is killing our system and reducing the quality that we can deliver. We fund this by getting rid of that extra bureaucracy.

Fifth, health care is, at its essence, quintessentially, not a competitive endeavor. Competition in health care, and I have many personal stories that I could relate about this, increases the price and reduces the quality. Health care is something best delivered in a cooperative fashion; cooperation between physicians and patients, nurses, facilities, public health agencies, throughout the society. We plan for high-tech services to be delivered in a cooperative way, and that's the

most efficient and cheapest way to provide high quality services. In addition, the for-profit motive—which is completely adverse or 180 degrees to the best patient care motive—has driven our large health care corporations to overreach, and health care fraud on the corporate level has become the white collar crime of this decade. I won't go into the details, but literally billions of dollars of fines were already agreed to.

[Joseph Jarvis, continued.] Finally, sixth principle, finance all health care in Nevada through a private nonprofit cooperative which I call the Nevada Health Cooperative (Exhibit E and Exhibit F.) You'll see in your handouts about a six-page summary of what the Nevada Health Cooperative is and how it would function, and very simply outlined in a question/answer format. We cannot have that, however, without the federal government getting out of the way of our health policy at a state level. Those of you who have seen efforts in the past to require certain benefits for insurers know that ERISA [The Employment Retirement Income Security Act of 1974] intervenes and gets in the way with providing that sort of health policy change. ERISA is only one example of many federal initiatives that have removed the states from primacy and health policy. It's a position that the *Constitution* guaranteed the states in the 10th Amendment. Anything not given to the federal government would be a state prerogative. That means that we would have to have a federal bill passed, which I've called the States' Right to Innovate in Health Care Act (Exhibit G and Exhibit H) and a copy of a draft of that bill is also in your handout in order to make this happen. This would be public financing and private health care delivery.

Finally, a couple of slides just to talk about steps that you could do, even this year, to begin the process to move Nevada in this direction. The first is you revive this constitutional authority that states should have to determine health policy; do so by passing a resolution calling on Congress to pass that States' Right to Innovate Health Care Act. Get through that perhaps by the involvement of a Nevada member of Congress to sponsor and push for that legislation. That by itself, of course, wouldn't commit Nevada to a single-payer way of financing health care. It would be a generic statement that states could then make their own determinations about health policy.

Secondly, another resolution to organize and fund a study here in Nevada which would confirm the administrative savings and deal with the due diligence issues which I won't detail for you. They're available for you in the handout. Due diligence about how you would make this really radical change, this dramatic transformation of health care.

[Joseph Jarvis, continued.] A final thought for you. Whether we do something this year in Nevada that's along these lines or something else, we have to remember that we have a very dysfunctional system. I've cited here a *San Francisco Chronicle* editorial from a year or so ago. It's a true statement. "Our health system, a fragmented hodgepodge of private and public health plans, is broken. We can't just expect that what we have will continue on indefinitely. Double-digit inflation year after year, with rising numbers of people unable to get health care and increasing numbers of Americans dying without it, will not stand. Whether we do anything with it now or not, there will be an inevitable collapse of what we have." I'm arguing that perhaps now is the time. Maybe Senate Bill 289 of the 72nd Legislative Session was the occasion for you all to begin planning for a much more reasoned and easy transformation to something else. Thank you very much.

Chairwoman Leslie:
Thank you for your testimony. Have you talked to any of our Congressional representatives about this?

Joseph Jarvis:
It's been 15 years since I was a Nevadan. You can't imagine how difficult it is to get a hold of a member of Congress when you don't live in the state anymore. So the answer is no, I haven't had a conversation that's within that last decade and a half.

Chairwoman Leslie:
Okay, and I know we're going to hear from other people today. Maybe they can enlighten us as well. Dr. Mabey.

Assemblyman Mabey:
Thank you, Madam Chairwoman. Just a few comments, very spirited thoughts. I can agree with some of those, I have an article here. I'm not an advocate for either. I know as a physician I would like to not have all the hassles. It is truly a hassle. I'm just concerned with the government taking over.

Let me just read a few quotes, because you mentioned that four out of five citizens in Nevada would support it. Last year a single-payer plan was rejected by a 4-to-1 ratio in Oregon. I know something similar has passed in Maine. I'd be curious to see what their experience has been. In Oregon it didn't do very well on the ballot. Another comment by an expert who quotes that Medicare and Medicaid spend about 27 cents on overhead for every dollar benefit. Private insurers spend about 16 cents. In Oregon a decade long attempt to rationalize Medicaid spending by running it like a single-payer system succeeded only in reducing access and doubling spending.

[Assemblyman Mabey, continued.] The poor performance of single-payer systems can be seen in cancer mortality ratios. The death rate divided by the incidence of disease for breast cancer, for example:

- In the U.S., mortality is 25 percent.
- In Canada and Australia, the mortality rate is 28 percent.
- In Germany, the mortality rate is 31 percent.
- In France, the mortality rate is 35 percent.
- In New Zealand and the United Kingdom, the mortality rate is 46 percent.

The death rate for prostate cancer:

- In the U.S., mortality rate is 19 percent.
- In Canada, the mortality rate is 25 percent.
- In New Zealand, the mortality rate is 30 percent.
- In France, the mortality rate is 49 percent.
- In the United Kingdom, the mortality rate is 57 percent.

Then you made a comment that not anybody could be a physician. That's not true. Anybody that wants to go through the steps can be a physician. If you want to go to medical school for four years and do a residency, comply with the requirements, anybody can be a physician. They just have to do the steps, just like for an attorney or anyone else.

Joseph Jarvis:
The various facts that were cited by Assemblyman Mabey are some I could dispute. I won't take the Committee's time to do that. As an example, Oregon has never had a single-payer system. They had an experiment with Medicaid by which they basically said, "We have a limited amount of money for Medicaid. We're going to try to organize our entire Medicaid service delivery system based on things that are most effective first, and things that are least affected funded last."

Therefore, some things were not funded in any given year depending on what they had as a budget. That's an entire different issue than a single-payer system. Whoever wrote that article was way out of line by calling it anything at all like a single-payer system. Yes, they had problems with that. Costs have gone up everywhere in the United States, not just in Oregon, over the years that that system has been in place in Oregon. Oregon did have on their ballot a referendum issue that would have been single-payer. It was heavily underfunded against the opposition. So it's true they lost, and by a big margin. They had a hard time selling their point because they couldn't get their education issues out. They didn't have the money to do it. They certainly have a formidable opposition who can rally lots of money against it.

[Joseph Jarvis, continued.] As an example, a single referendum item in Massachusetts about four years ago—and the Oregon one was about four years ago as well—was outspent $5 million to $50,000. Despite that, it almost won 52 percent to 48 percent.

I didn't say Nevadans, per se, are 80 percent favoring single-payer, I said that year after year in the United States, polling data says that people think that we should be funding health care for all people. If you're going to accept universal health care as a principle, you don't have many options for doing it, single-payer being one of the best and certainly the cheapest.

Assemblywoman Angle:
I want to clarify some things here. On the front of your presentation, it says that you're an Associate Professor at the University of Nevada School of Medicine, but you said it's been 15 years since you were in Nevada. Can you clarify that for me?

Joseph Jarvis:
I've been a volunteer member of the faculty ever since I left Nevada. When I was the State Health Officer, I had a full-time appointment. I've come back a number of times per year to teach and provide clinical services in a variety of other things, both in Reno and Las Vegas.

Assemblywoman Angle:
Where do you reside?

Joseph Jarvis:
Salt Lake City.

Assemblyman Hardy:
There were some statements made in your impassioned presentation, and I'm sensitive to some of those same issues that you are. “We don't have the best care in the world.” Then why do people come here? The patient in the single-payer source system is still not knowledgeable on who they see and who they go to. The quote, “the poor quality of care that we deliver,” again goes back to that first statement. Then why do we have people come from everywhere to get their care? So the inequities are real. I'm not going to contest that fact. The reality is that we do have the best medical care. I may not have the chapter and verse in the *New England Journal of Medicine* to show that, and I can say that yes, there are medical complications. The reality is, the perception is that we really do have good medical care. Getting it and delivering it, that is the issue. I think from our standpoint on the Committee, we're interested in delivering the care. There are many solutions. For every complex

problem, there's a simple solution that's wrong. You presented one solution that's very simple. Thank you.

Joseph Jarvis:
I would agree with you that we have care facilities that are the best in the world. I think I participated in one in Denver at the National Jewish Center. My statement was, we don't have the best health care system in the world. We have the most bureaucratic system in the world.

Chairwoman Leslie:
Thank you. Having lived in Spain when I was much younger, I guess I experienced socialized medicine. In our neighborhood, there was a clinic. When you had a sore throat you went to the clinic. No bureaucracy, and it seemed to work quite well. I know a lot of people in our country wait until they have strep throat or something so bad, and then they end up in the emergency room, which is the most expensive way to provide health care. I can identify with a lot of what you talk about. I think you said you presented this to the Interim Committee on Health Care. Did they take any action on your presentation?

Joseph Jarvis:
I don't know the answer to that.

Chairwoman Leslie:
No, they did not. Mrs. Koivisto knew the answer to that. Thank you so much, Dr. Jarvis, for taking your time to come here today. We appreciate it. Thank you. Our next speaker is Ruth Mills, who is the President of the Nevada Health Care Reform Project. She's in Las Vegas.

Betty Pardo, Representing Ruth Mills, President, Nevada Health Care Reform Project:
I will be reading from the testimony of Ruth Mills. She's undergoing a medical procedure and unable to be with us. [Read excerpts from the prepared testimony of Ruth Mills, Exhibit I.] I'll read from the testimony of Ms. Mills. She's undergoing a surgery. She's the President of the Board of Nevada Health Care Reform Project.

> It was started by the League of Women Voters over 10 years ago with about a dozen members and now have over 100 members in the coalition. They represent at least one-half million Nevadans. Their mission is to assure all Nevadans the security that they will never again lose their health care coverage. The Health Care Reform Project wrote and worked on passage of the Nevada Patient Protection Act, the establishment of the office of Consumer

Health Assistance, and an external review bill with the assistance of Assemblywoman Barbara Buckley.

[Betty Pardo, continued.] Last session they spoke in support of Senate Bill 289 of the 72nd Legislative Session, requesting a study of single-payer in Nevada. As a result, Dr. Joseph Jarvis has made several presentations of a proposal for single-payer in Nevada. We were impressed with his proposal and ask you to enact legislation to facilitate this plan. That would mean requesting waivers for use of federal funds and a study of the economic possibility of single-payer in Nevada.

I must ask: How long can we ignore the growing number of uninsured and the underinsured in Nevada? Their poor health in some cases, as a result of lack of health care, is heartrending. The Nevada Health Care Reform Project continues to hear from those who have nowhere to turn for health care. We pay in tax money for their lack of health coverage. In today's politics, we talk of the moral imperative. Well, appropriate health care coverage certainly falls in that category.

As you may know, California has been working on a Health Care for All Act, single-payer. I would like to quote some of their reasons for wanting to implement their plan: "It would correct the underlying problems of inefficiency, waste, and partial or no coverage that continue to undermine our health care system. High administrative costs, overpriced pharmaceuticals, unneeded capital expenditures, and unnecessary emergency room use by uninsured and underinsured persons place a burden on all of us. It provides tools for effective cost control, while providing for universal coverage and comprehensive benefit. In short, it adds no new spending but shifts funds from administration to the provision of services to more people. In the long run, it controls the growth in health care spending." These reasons are applicable to single-payer in Nevada.

You have probably heard of plans in Maine and Oregon, but many places are trying to do something about this lack of health coverage. The city of Philadelphia has changed their constitution to guarantee all their citizens the right to health care. Michigan Legal Service Health Action Project has filed suit to pin down whether there is a plan to provide access to health care to all segments of

> the population, as provided in a statute that has been on the books since the 1980s.
>
> I implore you to act on this issue. Here is a plan to take care of this serious problem. Health care is a right, not a privilege. Thank you for allowing me to testify today. The Nevada Health Care Reform Project will be here this Session to support this legislation. [Signed] Ruth Mills, President, Nevada Health Care Reform Project.

[Betty Pardo, continued.] We now have several members of the Health Care Reform Project who would like to testify on this important issue.

Chairwoman Leslie:
We do appreciate your testimony and please give our best to Ms. Mills. Thank you very much. Next in Las Vegas, is Patricia van Betten, who is the Director at Large of the Nevada Nurses Association.

Patricia van Betten, Director at Large, Nevada Nurses Association:
[Spoke from prepared testimony (Exhibit J).] I am a registered nurse and a member of the Board of Directors of the Nevada Nurses Association. I'm here to speak on behalf of the Nevada Nurses Association in support of the proposal for universal health care for Nevadans.

> America's nurses have a long history of support for a quality health care system that is accessible and affordable. We call for an essential core of health care services available to everyone. We envision a restructured health care system that will focus on prevention and wellness, delivering care in familiar, convenient, community-based settings. We ask for the utilization of the most cost-effective providers in the most appropriate settings.
>
> Nursing's priorities for health care reform are reinforced by the Institute of Medicine of the National Academy of Sciences in their 2004 report, *Insuring America's Health: Principles and Recommendations*. I included a summary statement of their principles and recommendations as well as a website for their full report among my references, and you either have that in the fax that came up to you today, or you will have it in the mailing with my testimony. The ultimate goal of health care reform is to improve health. Expanding and providing coverage is the means.
>
> In an ideal world, we would approach and solve this dilemma nationally. But national health care failed in 1948 and in 1994.

While we pursue the National Institute of Medicine goal of universal coverage by 2010, we cannot neglect current responsibilities in Nevada because the needs are too great.

[Patricia van Betten, continued.] Political barriers will prevent the federal government from enacting any meaningful health care reform in the near future. The only possible hope is that Nevada will again initiate change and serve, in Justice Louis Brandeis' famous phrase, as "a laboratory of democracy."

You showed this to be true when you led the nation and passed the Patient Protection Act in the 1990s, after national health care failed. Nevada also passed legislation to help people with prescription drug costs. Several states are now exploring a variety of ways to provide health care, to demonstrate what can be done, and they're all willing to share with one another to help find workable solutions. This is necessary until such time that we can get the principle of universality embodied in federal public policy.

The State Children's Health Insurance Program is an example of a federal-state partnership. In fact, this is the approach that was encouraged by Ken Frisof in May of 2003. Dr. Frisof, a physician, is the National Director of the Universal Health Care Action Network. In his paper titled: "The Federal-State Partnership Health Care Reform Model," he writes how policy makers are being forced to look at health care reform, because managed care did not contain costs and it did not increase access. Disagreement about how to achieve universal coverage opens the door to new opportunity. He states that "the federal-state partnership model provides an opportunity to unify advocates of reform who agree on the goals of universal coverage, but disagree on which plan should be adopted to reach that goal. It permits states to choose how to organize their own medical care arrangements, while encouraging them to financially provide universal coverage that includes comprehensive benefits while ensuring fiscal viability, portability and administrative accountability. Federal standards would be established and federal legislation would be passed to offer financial support to those states that meet those standards. Outcomes could then be evaluated of the various state plans to set the stage for a national system."

I encourage you to agree to study this proposal by Dr. Jarvis, and to explore the request of federal waivers, especially on Medicaid. A

serious and immediate concern is the need to protect Medicaid from caps and cuts, which will erode care. Another concern is processing. I understand that federal agencies were quick to review and grant waiver requests in the past, but that there has been a major slowdown in the past few years.

[Patricia van Betten, continued.] Two strengths will help this plan succeed. One is the high level of skill that several of you have in dealing with legislative health issues; the second is the large and broad based advocacy group, the Health Care Reform Project, ready to help you garner public support for this very important issue. This plan for Nevada could become a demonstration project and a model for the rest of the country.

This health plan is necessary for Nevadans. In the words of those who work continually for reform, health care for all is a medical imperative, an economic imperative and moral imperative. Please act on this plan.

I have included a list of references with websites. If you're interested, it includes the website for UHCAN [Universal Health Care Action Network]. Dr. Ken Frisof is the director there. You can get a copy of his paper, as well as a lot of reports about what other states are doing, especially if you would like some detailed information about their involvement on this issue.

Chairwoman Leslie:
Roger Volker, the Executive Director of the Great Basin Primary Care Association.

Roger Volker, Executive Director, Great Basin Primary Care Association, Carson City, Nevada:
Our association represents Nevada's federally qualified health centers, including community health centers, tribal clinics, other safety net providers. Good afternoon, Madam Chair and members of the Committee.

We have a 1-page handout (Exhibit K). It's called “Nevada's Study of Uninsured Populations.” We're announcing that we published the 2005 edition of the uninsured population study this morning on the Internet. Down at the bottom of your handout in bold letters is the address where you can find the study. It's hundreds of pages long, if you count the tables. There's a 35-page trend analysis that actually most of us can make our way through it.

[Roger Volker, continued.] Several things about this study are relative to this afternoon's conversation. First of all, the study is a cooperative project between our association and the Nevada Division of Health Care Financing and Policy. It is pretty much recognized as the study for Nevada's state uninsured population.

There were several things in the study that caught our attention in this particular edition. The first one is that there's been a slight increase in the percentage of uninsured in Nevada. It went up about 1 percent, and it's to about 17 percent. The definition of "uninsured" in the study is if you had absolutely no insurance for a whole year, we count you. If you had any insurance during that year, we don't count you. All of us who understand tourism economies recognize that people fall in and out of jobs depending on high/low/shoulder seasons in the industry, and therefore there would be more people who didn't have insurance sometime during the year. That's not the definition used in this study. If you use that definition, the number is closer to 20 to 21 percent of people who did not have insurance sometime during the year. The reason that we use the baseline number is that we've done this for eight years. So in terms of a longitudinal study, we can see the growth. We're still growing; I think that's really the issue.

The second one is, I think, the most important one for me on this page, and that is there are more of Nevada's working poor without health insurance, and these are the people who have jobs, who pay taxes, but whose income is just above the poverty line, who cannot afford insurance and who work for companies who cannot provide insurance.

About 95 percent of all the companies in Nevada have less than 100 employees, and a great number of them do not offer, cannot afford to offer, health insurance to their employees. Dr. Jarvis mentioned a study that was just published last week, which said that the largest numbers of bankruptcies occurring in this country are among this group. People who don't make enough money to have health insurance are filing bankruptcy at a record rate.

What happens in a bankruptcy is that everybody loses. The family lost, because they no longer have any credit. They can't buy a home. They can't buy a car. They can't better themselves. The medical provider lost. They didn't get paid and all the other businesses to whom money was owed, they lost too. It is a bad situation when people go bankrupt because of medical expenses, and that's the number one reason in the country today why populations are going bankrupt.

[Roger Volker, continued.] The third item is that Nevada remains above the national average in uninsured persons. About 5 years ago we were about 6 percentage points higher than the national average. This year we're 1 percentage point higher. We didn't get any better. The rest of the country is getting worse. That's not good news for us either, because we are impacted, as you can see from the President's budget and everything else that's going on about the issues that affect the rest of the country, come home to Nevada.

Also, the Hispanic population in Nevada continues to rise. It is the fastest growing segment of our population, and Hispanics are twice as likely to be uninsured as the general population. That's a trend we need to take very seriously in terms of where our health care system is going. The next one is that fewer persons than the national average participate in Medicaid programs. I don't think that's news to any of us in the room or to our Medicaid administrators. We still rank low in the country. We've made progress, according to the study. We are getting more people into Medicaid, but we haven't leaped out of the bottom percentiles of the country, and that will concern you as you look at the dollars that need to be spent for Nevada's share of Medicaid.

Then the last one is, and this one also concerns me greatly, that women are a faster growing uninsured group than men. There are still more uninsured men in Nevada. However, when you look at the trend, women are becoming more uninsured faster. And why does this concern me? Because this means that more women of child bearing age are not going to access prenatal care, and we're going to have worse birth outcomes. That affects not only the woman but the whole family. It creates tremendous costs, not only to the health care system in dollars to pay for FAS [Fetal Alcohol Syndrome] babies, substance abused babies, but also the enormous cost to the families themselves in terms of the tragedy that happens when we don't have early intervention and prevention to our most vulnerable population.

Chairwoman Leslie:
Thank you, Mr. Volker. Did you say there's an executive summary on the website?

Roger Volker:
There is an executive summary on the website.

Chairwoman Leslie:
That will be helpful. You said we are now up to about 17 percent of our population in Nevada that has no health insurance?

Roger Volker:
Given the definition of the study.

Chairwoman Leslie:
Your definition?

Roger Volker:
Correct.

Chairwoman Leslie:
I know perhaps by other definitions we've been ranked as the fourth or the fifth worst state in terms of providing, having our residents with health insurance. Does this change that in any way?

Roger Volker:
It does not. In fact, it keeps us right in the very bottom of the states in terms of ranking.

Chairwoman Leslie:
We have Bobbie Gang and Gayle Holderer.

Bobbie Gang, Legislative Advocate Representing Nevada Women's Lobby:
Gayle Holderer, who is with me, is a member of our organization. Nevada Women's Lobby is supportive of the single-payer concept. We've seen this presentation before. We reviewed the material, and we feel that it would serve the citizens of Nevada very well.

Before I turn the mic over to Gayle, I would like to relate my experiences, having to deal with something that Dr. Jarvis said. That has to do with choice of doctor being very, very important to individuals. My doctor of 20 years, Dan Peterson, in Incline Village, has just been discontinued from the State health plan. With nine months to go until I can go on Medicare, I chose to continue seeing him after 20 years of medical history with him. I chose that I would pay the 50 percent co-pay instead of the 20 percent.

Also, with regard to doctor choice, some of you may have noticed that I'm limping around here a little bit now, walking a lot slower than in the past, I'm due for a knee replacement surgery. I have put this off until after the Legislative Session, possibly because I don't want to miss a day of this exciting experience and being here with you, but also because I want to choose my doctor and I want to choose the medical facility where the surgery will be done. I know once I'm on Medicare, I can do that. At this point, I'd like to turn the mic over to

Gayle Holderer, who has her own personal experience to relate about health insurance.

Chairwoman Leslie:
Gayle, we do have a copy of your testimony (Exhibit L).

Gayle Holderer, Concerned Citizen:
My problem with my health insurance carrier is my premiums have gotten so high that I can't afford them. They were reasonable until the year 2000. They started in a $90-range at the inception of the policy in May of 1990. The rate increases were very reasonable up until the year 2002. In April and May of 2002, my monthly premiums were $843.53 a month. In June of 2002, there was another increase, resulting in a monthly premium of $1,276.79 a month. From July 2002 to May of 2003, there was a slight decrease, resulting in a premium of $1,253.87. In May of 2004 my monthly premium increased to $1,794.18. On this past August 1, 2004, my monthly premium was increased to $2,368.32. That is $28,419.84 a year. I have no idea what the next increase will do to the premium until I get the notice. My next increase will be May 1, which is coming up this spring.

All premium increases are approved by the State Division of Insurance. I've talked to several people at the Division of Insurance and I've told them what I'm currently paying for health insurance premiums. They're glad they have theirs and they have no solution for my problem. What they've allowed Trustmark [Insurance Company] to do is to stop selling my policy. I have no idea when this has happened or how it has happened. So they've left all the unhealthy people in and they're not allowing any new healthy people into the policy.

I have no idea what I'm going to do when I no longer have health insurance. I'm disabled. I was badly injured in a car accident, December 24, 1992. I was left with herniated discs in both my neck and lower back, dashboard knees, and chronic pain. I've been told by my doctors that it will only get worse with age. It's not going to improve. I've gotten as far as I can. It's under control now, but it will get worse. I just have no idea what I'm going to do with the skyrocketing costs of medical care and the skyrocketing costs of my premiums. I just feel like I've got no place to go and that health insurance should be a right, not a privilege.

Chairwoman Leslie:
Thank you. It's always great to put a face on the problem. You have an individual policy and you have a preexisting condition that seems to be the crux of it. Is that correct?

Gayle Holderer:
That's the problem.

Chairwoman Leslie:
You are one of those people. We hear from people like you all the time. It's horrendous that you're in this situation.

Gayle Holderer:
It's horrendous that my rates have gone this high. I have no idea how this has happened. Even the Division of Insurance, when I talked to them, they were aghast and shocked at what I'm paying, but yet they have no solution. They're the ones that are granting the increases.

Chairwoman Leslie:
And you have no option because you can't change insurance carriers because of your preexisting condition.

Gayle Holderer:
Exactly.

Chairwoman Leslie:
You have my sympathies. I wish I had a magic answer for you.

Gayle Holderer:
I wish you did too.

Chairwoman Leslie:
We'll certainly enter your testimony into the record, and I thank you for coming down here to do that.

Gayle Holderer:
One other thing, 33 states out of the 50 provide some sort of health care programs for their uninsureds. That came from the Illinois Division of Insurance this month.

Chairwoman Leslie:
Other questions for this witness from the Committee members? You have lots of sympathetic ears, and as we go forward in this debate this session, we will keep you in mind with our decisions. We'll do all we can. Thank you very much. Jan Gilbert is next on our schedule.

Jan Gilbert, Northern Nevada Coordinator, Progressive Leadership Alliance of Nevada, Reno, Nevada:
I too support Dr. Jarvis's proposals. I would like to urge you to do something this session. We see you had a bill that you all passed and you were going to study and restudy and restudy, but people like Gayle are many. I worry about the young people coming up who can't get jobs that provide health insurance, because the businesses can't provide health insurance. I worry about the parents of the children who are in Nevada Check-Up Program. Their children are covered, but they're not covered. There are so many people falling through the cracks.

I don't know about you, but I have a little ways to go before I get to Medicare. You have to keep working, especially if you have a job that provides health care. Nonprofits are dying with health care coverage insurance. We've had meetings about how to cover employees that work for nonprofits because of the skyrocketing rates. My nonprofit had one of our members, one of our staff people, who got cancer this year. And so guess what? All our rates went up, in spite of the fact that I'm 57 years old and I've never had a problem. I go to the doctor once a year. That's pretty much it. Yet my husband and I, because we're the eldest in the organization, ours are the highest rates. They went up because one member of our staff got sick.

There's something wrong with the system. I urge you to do something, if it's a resolution, if it's a group of you going to speak to our Congressional delegation. Sometimes, you have a lot more power than we do. We'd love to see you get involved in the debate. Our health care system is broken. It's got to be fixed or it's going to dissolve. We'll all be sick and at the emergency room. I don't want to be that way. I'd like to see us all be provided for.

Finally, on NPR [National Public Radio] this morning, I heard the amount of Medicare, and I was asking a few people. I thought they said $800 billion was being spent on Medicare in this country, and that it's doubled over the past 5 years. I don't know, is that possible, that number? And yet we have people who don't get coverage, basic care. It's unbelievable. We're one of the wealthiest countries in the world, and yet we have people who can't get their health care coverage.

So please, I urge you to do something this session with this wonderful group of people. You all are so competent and caring, and I would just urge you to do something this session. Thank you.

Chairwoman Leslie:
Thank you, Jan. As you know there are several proposals in the works with the HIFA [The Health Insurance Flexibility and Accountability] waiver to increase coverage. I don't want anyone listening on the Internet to think that we're sitting down here doing nothing. There are going to be many proposals coming forward. But specific to Dr. Jarvis's testimony and the theme of today's meeting, what I heard you say is you'd like us to pass a resolution. Which of the resolutions were you referring to?

Jan Gilbert:
There is no resolution yet, but I think you could create one that would urge our federal government to examine a single-payer system. It would require waivers, if it were a state-run program or a federal-run program. It's going to require huge changes in our system, because it will dismantle Medicaid. It will dismantle Medicare. It would mean everyone would get coverage. The Health Care Reform Project might have some sample resolution language.

Chairwoman Leslie:
Yes, we do have one here from Dr. Jarvis, I was just wondering if you had reviewed these? You were not speaking specifically to his resolutions?

Jan Gilbert:
I have not. No, but it sounds excellent from what he said in his presentation, but I haven't seen it.

Chairwoman Leslie:
Any other questions for Ms. Gilbert? Thank you very much. Larry Struve.

Larry Struve, Advocate, Religious Alliance in Nevada:
Thank you, Madam Chairwoman. RAIN [Religious Alliance in Nevada] is a coalition of five faith communities, the Roman Catholic Dioceses in Reno and Las Vegas, the Episcopal Diocese of Nevada, the two districts of the United Methodist Church, the Nevada Presbytery, and the Lutheran Ministry in Nevada, which is part of the ELCA [Evangelical Lutheran Church in America]. There are approximately 500,000 Nevadans who worship in the various parishes and congregations in these churches. RAIN was formed to address issues in which they are in agreement and feel that they raise significant public policy issues for Nevada. Affordable and accessible health care for everyone is one of those issues of concern. You'll be getting the brochure of RAIN (Exhibit M) and you'll find it in the list of issues that concern this organization.

You have heard about Senate Bill 289 of the 72nd Legislative Session, which was strongly supported by RAIN in the last Legislative Session. It was our hope

when this bill was passed that we would be here today to examine with you a feasibility study of a single-payer system in the state of Nevada. That was the mandate. I've made copies of Senate Bill 289 of the 72nd Legislative Session (Exhibit N) which you will get. It says the feasibility of establishing a state health authority to coordinate a single-payer system in the state of Nevada, including a review of the different forms of single-payer systems, implemented or contemplated by other states, such as employer mandates, play or pay, tax incentives, and state purchasing plans, would be a focal point for this study.

[Larry Struve, continued.] Some of you have known me for years. I used to work in state government. Every time I got a mandate from the Legislature, I took it quite seriously and tried to comply with it. From what we have seen in RAIN, there has not been a report containing the information that is mandated in Senate Bill 289 of the 72nd Legislative Session. However, we do compliment the interim study committee for introducing us to Dr. Jarvis.

This past Sunday, as a result of the presentation that a couple of us heard when he spoke before the Interim Legislative Health Committee, we asked Dr. Jarvis to address the members of RAIN. We had about 60 people here in Carson City. I must tell you that in the hour and a half presentation, people were literally on the edge of their seats. I've never seen such interest in a topic as we have. The RAIN board met on Monday, and they directed me to come here to tell you that the Religious Alliance in Nevada is very supportive of this Legislature looking seriously in the ways described in Senate Bill 289 of the 72nd Legislative Session, at the feasibility of a single-payer system, or some other alternative that will assure that everyone in Nevada can have access to quality health care.

Dr. Jarvis did not include in his presentation to you today, but he did in his presentation to us, many scriptural references that talk about a global concept of health care being a gift to all mankind and not a commodity that can be used for profit-making. This is something all of us are entitled to. You can go into the Old Testament and find many scriptural references to that fact. It is our hope that at the end of this legislative session, the 2005 Nevada Legislature will take some action to move us forward towards the goal of trying to achieve universal or health care coverage for all.

I'm not going to read to you, Madam Chairwoman, what is in a three-page summary of an introduction to a social statement that was enacted in 2003 (Exhibit O) by the National Church Assembly of the Evangelical Lutheran Church in America [ELCA]. You have heard it said in today's meeting that health care for all raises a moral issue. In the social statement of the ELCA, called “Caring for Health: Our Shared Endeavor,” it lays out why these religious communities feel that providing health care for all is a moral imperative if we're going to

achieve a just society. In summary, health care is a shared endeavor in which we each have an individual responsibility to care for our own health, but also have a special social responsibility to care for the health of others, so that we may live in a just society. That's, in essence, what you'll find in this introduction.

[Larry Struve, continued.] RAIN is willing to work with this Committee and any of those staffers that you are working with. We think the proposal of Dr. Jarvis is certainly worth studying. We think the two resolutions you've made reference to, Madam Chairwoman, are certainly worth considering. If you at least get a green light from the Congress to look into this, then you should at least have a study going on in the next session to come back with a detailed feasibility study on whether we could do this. The bottom line is this: If in 2007 we have not made progress in reducing the number of people who are uninsured and who do not have access to health care in this state, then we are moving away from a more just society and towards an unjust one. Thank you.

Chairwoman Leslie:
Senator Washington is here. Senator Washington is the Chair of the Senate Human Resources Committee which meets at the same time. You're welcome to join the Committee, if you would like to ask any questions or participate.

Senator Maurice Washington, Washoe County Senatorial District No. 2:
I'm just here to observe.

Chairwoman Leslie:
We're honored by your presence. Claire Boutin is in Las Vegas. Please proceed.

Claire Boutin, Past President, National Alliance for the Mentally Ill of Southern Nevada:
Thanks. NAMI [National Alliance for the Mentally Ill] is based in Arlington, Virginia. It has over a thousand chapters in all states and also local affiliates. We're very active in southern Nevada. Our mental health system is in shambles regarding the shattered lives of individuals living with mental illness. Depicted in a national survey of 3,430 NAMI members, the results show a disenfranchised group of Americans whose lives have been placed on hold as they engage in a frustrating attempt to manage their illness in absence of effective services that can make recovery a real possibility.

- 86 percent of the individuals represented in the survey were between the ages of 18 and 54.
- 52 percent of the individuals represented in the survey were diagnosed with schizophrenia.
- 42 percent were diagnosed with bipolar disorder.

- 28 percent were diagnosed with major depression.
- 57 percent received more than one diagnosis.
- Just over two-thirds, or 67 percent, were unemployed.

[Claire Boutin, continued.] Medicaid and Medicare were the primary forms of health insurance among the people. Yet there's still another 37 percent that rely on private health insurance. It's inadequate and almost impossible to get, because once you have been diagnosed with a mental illness, they make it almost impossible. We have many, many family members whose loved ones are in a sufficient state of recovery where they can work, but they can't afford the premiums for health insurance, if they can get it at all, because they have the preexisting condition, although the outcomes for treatment are very positive with the new medications and treatments. We have many success stories. They require a lifetime commitment to having medications, sometimes hospitalizations. There is one family that I want to talk to you about here.

Chairwoman Leslie:
Is this something that's in the packet (Exhibit P) that you gave us that you can point us to?

Claire Boutin:
It is in the packet (Exhibit P). Sometimes they have to choose between working and if they earn too much money, they lose their Medicaid benefits. Medications can cost as much as $4,000 a month for the psychotropic medications and some of the insurance plans do not even pay for a fraction of it. People are stuck if they're in a situation where if they are working and then they have a terribly expensive insurance bill, and they're above the poverty level, but they are not eligible for other things. I think that possibly that universal coverage, private single-payer, might be of great benefit if it's structured right to include people with chronic ongoing illnesses.

Chairwoman Leslie:
You make a very excellent point, that there are chronic illnesses, and severe mental illnesses is surely one of them, where it's not something you take a magic pill tomorrow and your illness is gone.

Claire Boutin:
Right. It's a lifelong commitment to medication and treatment. Sometimes you have to have hospitalizations. There are a great many people in recovery, but they don't have access to a lot of the programs. Therefore, down here in Las Vegas, the only game in town is Southern Nevada Adult Mental Health Services. A lot of people pay; they are on a sliding scale. If there was universal

coverage, that would free Southern Nevada Adult Mental Health Services to service the indigent.

Chairwoman Leslie:
Yes, and we are going to be delving into that issue very heavily next week in this Committee, so I invite you to come back and participate.

Claire Boutin:
Thank you. We'll be back on February 14, with quite a of few NAMI [National Alliance for the Mentally Ill] people.

Chairwoman Leslie:
The last person I have is Elsie Dupree, who is representing herself. She's been in the news quite a bit lately with her issue.

Elsie Dupree, Concerned Citizen.
Now you have a face of someone who is uninsurable. We can't get him insurance. We've been told if he went off dialysis and his medications for six months we would be considered, when the life expectancy for someone on dialysis is 14 or 15 days without their medication or their dialysis. You have a paper from me with what I have to say (Exhibit Q). You'll see a lot of Bill [William Dupree] and me coming up here to testify and work. Uninsurable, something you could fix this session, would be a medical needy program, because he has a whole $24 over the federal poverty level. We can't give it back and we have no insurance. His father and I are helping support him because we love him.

Chairwoman Leslie:
Chuck [Charles Duarte], I have been wanting to ask you this question. What can we do about situations like her son is facing and what would it cost Nevada to address this?

Charles Duarte, Administrator, Nevada Check Up and the Nevada Medicaid Programs:
I think we've talked about options that might be available to individuals like Michael and one of them is a medically needy program. Approximately 37 states have a medically needy program. A medically needy program essentially allows individuals who don't otherwise qualify for Medicaid because of income to use their medical expenditures as a way of reducing their income for eligibility purposes and spend down into Medicaid.

Those are expensive programs. I think Oregon, just about a year ago, ended their medically needy program. We have done some estimates based on national

spending trend for the medically needy group. It makes about 13 percent of overall Medicaid spending in states that have a medically needy program. From a policy perspective, that is an option for individuals who otherwise don't qualify, because they're over income for Medicaid.

Chairwoman Leslie:
If you're $1 over income, it's the same as being $100,000 over the income? The line is where the line is.

Charles Duarte:
Yes, Madam Chair.

Chairwoman Leslie:
Who sets the line? Is that something we do in the Medicaid plan or is that something that the Feds do?

Charles Duarte:
We have the ability to establish different standards of income in order to help people qualify. Essentially, wherever you set the line, is where the line is, and there's always going to be somebody in a situation like this. That's why a number of the states have looked at medically needy programs, have established them, and run them. Not only do they benefit individuals who are in need of dialysis who have advanced renal disease or what have you, but they benefit pregnant women, benefit individuals with HIV [human immunodeficiency virus] and AIDS [Acquired Immune Deficiency Syndrome] who incur a large amount of monthly cost associated with their illness. It helps keep them a working member of society. These programs have their benefits, but they're expensive.

Chairwoman Leslie:
Where does Nevada rank in terms of Medicaid spending?

Charles Duarte:
We rank 51st, on a per capita basis, Madam Chair. We rank 51st and we have been for about the last 4 years. That's predominantly because we cover the minimum mandatory groups. We have some optional groups that we cover, mostly those involved with institutional care who would otherwise be the responsibility of the counties. We cover them, but essentially we cover the mandatory groups and, as a result, don't spend a lot per capita on Medicaid.

Chairwoman Leslie:
I know the Governor has put more money into Medicaid because of the growing case load and the HIFA [Health Insurance Flexibility and Accountability] waiver

and some of the other things we're looking at. But there is no plan in the budget for the next 2 years to look at a medically needy program?

Charles Duarte:
That's correct, Madam Chair, with a small, very small exception—that is, as a part of the Interim Health Committees and subcommittee to look at health care expansions. As a part of their work they did identify a group that I think was given the term medically needy, but really should be categorized as a catastrophic group, these are individuals who we would like to cover in the HIFA waiver who are primarily involved in trauma types of situations, who end up in institutions or hospitals. It's not really a medically needy group. That's the closest we really come to it.

Chairwoman Leslie:
This situation would not qualify for that?

Charles Duarte:
This situation would not qualify for that, Madam Chair.

Assemblyman Horne:
I understand how any state, not just Nevada, couldn't put in a more flexible, maybe a stopgap measure appeal process, for situations like you said, your $1, William's $24, go before board review, and say, "Okay. This person we're going to provide for." They are $24 over, but it's overly burdensome to keep them out. Until we can afford a needy program, it seems like any state should be able to have that type of flexibility.

Charles Duarte:
We do have that flexibility. Not to be facetious, we can use state General Funds to develop whatever kind of program we want. If there's an expectation of federal matching funds, then you have to follow existing rules. If you accept Medicaid funding, there are a whole bunch of rules that come along with it that make it challenging.

Chairwoman Leslie:
But there's no special appeals process in any state Medicaid plan?

Charles Duarte:
Not to my knowledge, Madam Chair.

Chairwoman Leslie:
I think that's a good idea, but the rules are the rules.

Elsie Dupree:
We've made so much fuss and bother about this. We had someone, we're not even sure who, who asked that we have an appeal and fill out all the paperwork again. We did that last August, and we have yet to get an answer back. It's been no answer at all. We have trouble corresponding with the Medicaid department. I know they have their rules and that these rules were set by this Legislature many years ago, saying we're going to do the bare minimum. They follow the rules. If you ask for an appeal and they can prove they followed the rules and you lose, then you're going to pay the expenses for the appeal, so you can't afford to even do an appeal.

Charles Duarte:
Essentially, Ms. Dupree is correct. If you appeal and your appeal is denied, then essentially you're responsible for the costs of that appeal.

Chairwoman Leslie:
What would the cost be, like the cost of the meeting or the cost of the staff working on the case?

Charles Duarte:
I'm assuming she's talking about representation of some kind, legal representation. Essentially that would be the cost to the recipient or the appellant.

Chairwoman Leslie:
That seems like a powerful disincentive to appeal a decision. I wasn't aware of that. Thank you for bringing that to my attention. We'll look into that.

Charles Duarte:
There was a comment made after Dr. Jarvis's testimony about the costs of Medicare and Medicaid, the administrative costs. Actually federally published reviews are done annually of that. It takes about 4 cents out of every dollar to run the Medicare program and about 5 to 6 cents of every dollar to run the Medicaid program nationally.

Chairwoman Leslie:
That's a national figure?

Charles Duarte:
Those are national figures. For Nevada it's about 6 cents. We are far more cost-effective for both federal Medicare and state Medicaid programs than private health insurance, I want to clarify that.

Assemblywoman Weber:
Mr. Duarte, this will be an anecdotal kind of a recollection more than scientific or any data that you've collected. How many cases like this are you aware of that you get through your office in a 12-month period of time? How would you categorize the more that are falling below the line that would not be served? Would they be in the category of major catastrophic event or trauma versus a chronic lifetime disease?

Charles Duarte:
We did a study, actually, and this is all done by the Welfare Division. They are responsible for eligibility determinations and handling of appeals. At the request of Ms. Dupree, we actually did a study, and I responded with information from the Welfare Division. Unfortunately, I can't remember all the details of that response. I'll be glad to provide it to the Committee, but there were a sizable number of individuals who we believe fell into the category that Ms. Dupree described. Maybe she remembers the details of that letter more precisely than I do.

Chairwoman Leslie:
Ms. Dupree. Please feel free to pass the letter on to the Committee when you find it.

Elsie Dupree:
We've asked. They still pay the Medicaid premium, which is $78 a month for Bill [William Dupree], but no other benefits. So we asked them to provide us with a number of how many people in the state only got that premium. These are the disabled people like Bill who they can't pay anything else except for the Medicare premium. They count for the month, and they quoted me about six different times. This is only a guesstimate, about 1,500.

Chairwoman Leslie:
A sizable number. Thank you, Ms. Weber, for that question. We are meeting again tomorrow night in an unusual meeting, 6:00 p.m. We'll have our next regular meeting Monday at 1:30. This meeting is adjourned [at 3:31 p.m.].

RESPECTFULLY SUBMITTED:

_____
Paul Partida
Committee Attaché

APPROVED BY:

_____
Assemblywoman Sheila Leslie, Chairwoman

DATE: _____

EXHIBITS

Committee Name: Health and Human Services

Date: February 9, 2005 Time of Meeting: 1:37 p.m.

Bill #	Exhibit ID	Witness	Dept.	Description
	A			Agenda
	B	Chairwoman Leslie		Standing Rules
	C	Barbara Dimmitt		Policy Brief
	D	Joseph Jarvis		PowerPoint Presentation
	E	Joseph Jarvis		Proposal for Financing Health care
	F	Joseph Jarvis		Resolution (Six Principles)
	G	Joseph Jarvis		States' Right to Innovate Health Care Act
	H	Joseph Jarvis		Resolution (States' Right)
	I	Ruth Mills		Testimony
	J	Patricia van Betten		Testimony
	K	Roger Volker		Study of Uninsured Populations
	L	Gayle Holderer		Testimony
	M	Larry Struve		RAIN mission statement
	N	Larry Struve		Copy of S.B. 289
	O	Larry Struve		Caring for Health: Our Shared Endeavor
	P	Claire Boutin		Packet
	Q	Elsie Dupree		Testimony