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

Seventy-Fourth Session
February 9, 2007

The Committee on Commerce and Labor was called to order by Chair John Oceguera at 11:38 a.m., on Friday, February 9, 2007, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/74th/committees/. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Mr. John Oceguera, Chair
Mr. Marcus Conklin, Vice Chair
Ms. Francis Allen
Mr. Bernie Anderson
Mr. Morse Arberry, Jr.
Ms. Barbara E. Buckley
Mr. Chad Christensen
Mrs. Heidi S. Gansert
Mr. William Horne
Mrs. Marilyn Kirkpatrick
Dr. Garn Mabey, M.D.
Mr. Mark Manendo
Mr. David R. Parks
Mr. James Settelmeyer

STAFF MEMBERS PRESENT:

Brenda Erdoes, Committee Counsel
Dave Ziegler, Committee Policy Analyst
Earlene Miller, Committee Secretary
Gillis Colgan, Committee Assistant

OTHERS PRESENT:

Jan Cohen, General Counsel, Public Utilities Commission of Nevada
Valerie M. Rosalin, Director, Governor's Office for Consumer Health Assistance
Paulette Gromniak, Governor's Office for Consumer Health Assistance
Lawrence P. Matheis, Executive Director, Nevada State Medical Association
Alice A. Molasky-Arman, Commissioner of Insurance, Division of Insurance, Nevada Department of Business and Industry
Thelma Clark, Nevada Silver Haired Legislative Forum
Mary D. Roberts, Senior Citizen Legislative Forum

[The roll was called and a quorum was present.]

Chairman Oceguera:
I have a list of requests for seven bill drafts. They are:

- Makes various changes regarding the office of the Labor Commissioner.
- Makes various changes concerning asbestos abatement and removal.
- Makes various changes related to Unemployment Insurance.
- Revises provisions on regulation and providers of telecommunication services.
- Revises provisions on franchising and regulating video service providers.
- Revises provisions governing the regulation of banking.
- Makes various changes concerning landlords and tenants.

This is just a request for bill drafts. Does anyone have any issues with those? [There were none.]

ASSEMBLYMAN ARBERRY MOVED TO ACCEPT THE SEVEN BILL DRAFTS.

ASSEMBLYMAN CONKLIN SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

Chairman Oceguera:
We have a request from the Governor's Office for Consumer Health to introduce on the floor. It is a provision governing the collection of debts by collection agencies.

BDR 54-630—Revises provisions governing regulation of collection agencies (later introduced as Assembly Bill 88).

ASSEMBLYMAN ARBERRY MOVED TO INTRODUCE BDR 54-630.

ASSEMBLYMAN CONKLIN SECONDED THE MOTION.

Chairman Oceguera:
Is there any discussion on the motion? [There was none.]

THE MOTION CARRIED UNANIMOUSLY.

We will introduce that for the Governor's Office for Consumer Health.

We will open the hearing on Assembly Bill 27.

Assembly Bill 27: Revises provisions relating to penalties assessed by the Public Utilities Commission of Nevada. (BDR 58-551)

Jan Cohen, General Counsel, Public Utilities Commission of Nevada:
This bill allows the Public Utilities Commission (PUC) to impose administrative fines directly rather than go to court to impose these fines. The impetus for this bill was because of small water companies and small fines—sometimes $1 to $200. It is not cost effective to have to go to court to impose those fines. Most state agencies have the ability to impose these fines. The bill converts the prior wording "civil penalty" to state "administrative fine." The administrative fine will go to the General Fund. There is a provision for judicial review available to anyone who has a fine imposed on them. The Commission is also allowed to consider mitigating and aggravating factors in making this decision. It allows the PUC to use its expertise to determine if a fine is appropriate instead of going to the court, which is cumbersome and time consuming.

Chairman Oceguera:
Mrs. Gansert?

Assemblywoman Gansert:
I am not sure how many small utilities there are in the State which would be affected by this. Some of the fines are substantial. Does this just affect the major utilities?

Jan Cohen:
This would affect all utilities and those that are not utilities. For example, if there was a construction site and they did damage at a railroad crossing, it would allow the imposition of a fine. The fine would probably be negligible. It does not happen often, and it is hard to quantify how much it would be. It mainly affects small water companies and the fine would be appropriate to their size, which is why there is an allowance for mitigating and aggravating circumstances. You have to consider the size of the utility. A $50 fine might be more appropriate for a smaller utility. We do not generally impose fines and it may not happen. This would allow the possibility of imposing fines rather than going to court.

Chairman Oceguera:
Mrs. Kirkpatrick?

Assemblywoman Kirkpatrick:
Who would enforce these fines when there is not a court order? What would be your collection time without the court's determination?

Jan Cohen:
The entire Commission would have to do this. It could not be arbitrarily imposed by the presiding officer of a case. The presiding officer would have to take it to the Commission. The Commission would have to approve the amount of the fine. They could compromise the fine at that time if they felt it was inappropriate. The final order would have to be entered by the Commission, and the judicial review process could be initiated. The fined entity would be able to go to court or have reconsideration from the Commission.

Chairman Oceguera:
Mr. Settelmeyer?

Assemblyman Settelmeyer:
How many civil penalties were assessed last year? How many do you think would occur with the change in this law?

Jan Cohen:
None were imposed last year and I doubt that there would be much of a change. All it does is allow for the possibility should it occur. It does not occur often.

Assemblyman Settelmeyer:
Would it require a full quorum of the Commission?

Jan Cohen:
Yes.

Chairman Oceguera:
Are there any other questions from the Committee? Mr. Conklin?

Assemblyman Conklin:
If you assign an administrative fine to a public utility, is that passed on to the tax payer?

Jan Cohen:
No, it cannot be passed to the rate payer. There is a provision in the bill.

Chairman Oceguera:
Mr. Horne?

Assemblyman Horne:
Will you have the power to enforce these fines? I assume there may be a time when you will have to litigate to enforce these fines.

Jan Cohen:
Yes, that possibility exists.

Assemblyman Horne:
I do not see a provision to allow you to recoup attorney costs and fees. Although many of your attorneys are on your Commission, there are still costs involved in that type of litigation.

Jan Cohen:
There is no ability to recoup those costs. If the decision was made to go to court to enforce the fine that we had imposed, and the fined party refused to pay, the commission would just have to absorb those costs. We could try to get them through court, but there is not a provision for that in the bill.

Assemblyman Horne:
It might be easier to have that provision in statute.

Jan Cohen:
Yes.

Assemblyman Horne:
If the PUC were forced to bring them to court for not complying and if the judge makes the determination in statute, and you made them go to court to get this enforced, are you now going to pay their attorney's costs and fees?

Jan Cohen:
Yes, absolutely.

Chairman Oceguera:
Mrs. Gansert?

Assemblywoman Gansert:
Do you have a count of how many people could have been fined because they were in violation of the regulations?

Jan Cohen:
What we presently have is the ability to revoke a Certificate of Public Convenience and Necessity (CPCN). This would allow the imposition of a fine. All regulated utilities have filing requirements as to their assessment. They have to pay based on the annual report which they have to file. We could impose a fine in lieu of that revocation. Often, it is a telecommunication provider who has gone bankrupt. Normally, they are the ones whose CPCN we revoke. That could presumably increase the fine. We could fine them instead of revoking their CPCN. It is a lesser penalty. We have about 50 utilities that are on the delinquent list that have not paid their assessment, or have not complied with their filing requirement. These are usually small, competitive local exchange carriers.

Chairman Oceguera:
Are there any further questions from the Committee? [There were none.] Is there anyone else to testify in favor of A.B. 27? Is there any one to testify against A. B. 27? We will close the hearing on A.B. 27.

We will open the hearing on Assembly Bill 40.

Assembly Bill 40: Establishes periods within which a provider of health care must provide a bill to a patient. (BDR 54-629)

Valerie M. Rosalin, Director, Governor's Office for Consumer Health Assistance:
I am in support of A.B. 40 and we submitted it (Exhibit C.) This bill was submitted because of complaints regarding provider late billings and notices of collections for services provided years earlier and, in some cases, with attached

fees and interest. Our bill draft excludes hospitals in the definition of "provider of health care." Our office already has final determination over hospital billing. If physicians or ancillary health providers such as laboratories, x-ray, medical equipment, or therapists are contracted with an insurer, they are required to submit their claims to the insurer in accordance with the contracted agreement or they do not get paid. That has some control on the provider. The Division of Insurance approves the insurance contract language. A problem occurs when the insurer sends the consumer an Explanation of Benefits (EOB) describing how the claim was paid and what the responsibility of the consumer is. The EOB states "This is not a bill." The consumer waits for the billing statement from the provider. If it is late or not sent, the consumer may lose his rights to the appeal process with the health plan. This is in cases of service dispute, coding errors, network provider co-pay, coinsurance, and deductible amounts. The uninsured lose negotiation possibilities to make payment arrangements with the provider and find themselves in collections or hearing. Specific time frames, the 60 days we requested, should be adhered to and would be beneficial to both the provider and the patient. This is a non-punitive bill. It would benefit providers and patients. It would put the onus on the billing department to bill in a timely manner.

Chairman Oceguera:
Are there any questions from the Committee?

Assemblywoman Gansert:
I have a disclosure. A member of my family is a provider of physician services. Since the benefit or detriment occurring is no greater than any other medical practitioner, I will be voting on this matter.

Chairman Oceguera:
Thank you for the disclosure. Ms. Buckley?

Assemblywoman Buckley:
On some occasions, after the insurance pays, there will not be a balance due from the patient. For example, the doctor may write it off, or with the co-pay there is none due. In those circumstances, would you envision that the provider of health care would be required to submit a bill?

Valerie M. Rosalin:
If the patient is insured, the provider has a certain time to submit a bill to the insurance company or they will not get paid. If the provider is contracted with an insurer, they cannot balance-bill the patient. The patient is only responsible for their co-pay, coinsurance, and deductible. It is the non-contracted provider that can balance-bill a patient.

Assemblywoman Buckley:
I do not know if that is true. Certainly, with some insurance, you cannot balance-bill. If you go to an out of network doctor and pay your co-pay at the time of service, the doctor bills the insurance company. The insurance company determines that the patient has not yet met their deductible. The doctor then bills the patient for a portion of the bill.

Valerie M. Rosalin:
If the patient has not met his deductible, he is responsible for it—that is out of pocket. If the patient is treated by a non-network provider and the insurance pays at a lower rate, there is provision for the provider to bill the consumer because he is not contracted with the insurance.

Assemblywoman Buckley:
If the insurance pays a substantial portion of the bill, and the doctor has decided that the patient does not need to pay any more, is the doctor still required to bill the patient? Should the language be modified to say that if the provider of health care believes that something is due from the patient, that they be required to submit the bill not later than 60 days?

Valerie M. Rosalin:
If the provider accepts the payment from the insurer and does not require further payment from the patient, that is at will. Some non-network providers will accept what the insurance pays to a non-network provider and not accept anything further other than what normally would have been the co-pay, coinsurance, and part of the deductible as if he were a network provider.

Assemblywoman Buckley:
I can ask our legal counsel to examine this. I do not think you understand what I am trying to say. I am looking at the specific language of the bill on page 2, lines 18 and 19. If the provider is not seeking further compensation, do they still have to submit the bill? I am not getting a clear answer. Perhaps, you can think about that and I can ask our legal counsel.

Chairman Oceguera:
Mr. Anderson?

Assemblyman Anderson:
Would this 60 day requirement for billing clarify the issue? When liens are going to be placed, would the balance be available in case there was a pending court case that involved reimbursement? This might occur in cases of victims of a crime or any other involvement in a court process.

Paulette Gromniak, Governor's Office for Consumer Health Assistance:
Assembly Bill 40 does not address hospitals. This is just for providers such as doctors, ancillary providers, and medical equipment. This does not address the hospitals at all.

Assemblyman Anderson:
On page 2, in subsection 4, it addresses service equipment, suppliers, and medical providers for patients and healthcare. You are talking about doctors' services and equipment. The insurance company has a set fee that they have agreed to pay and the provider has agreed to accept. Then there is a suit which may generate more dollars. Is this going to set the charges that are expected, so that in the suit everybody knows what the actual medical costs are and may determine what future medical costs might be, as well as what the amount of liens may be, which apparently has come to be a recent process?

Paulette Gromniak:
No, this is specifically for doctor and ancillary provider billing. If there is a patient who sees a doctor who is a contracted physician, and he bills the insurance, the insurance processes the claim and will assign whether there is a deductible, co-payment, or coinsurance. At that point, we are asking for the patient responsibility that is assigned by the insurance company to be billed to the patient within 60 days. If there is no balance due from the patient, then no statement would need to be sent. If it is an uninsured person, we are asking that a bill be sent directly to the patient within 60 days from the date that services are rendered. This does not affect liens.

Assemblyman Anderson:
If there is no billable amount, will there be a closing statement to verify the amount paid by the insurance?

Valerie M. Rosalin:
When you are insured, you get an EOB which will tell what the insurance paid the provider and what your coinsurance and co-payment are. It usually says "patient responsibility." If it says "zero", the patient will expect no bill. If there is something owed, then the patient will expect a billing statement from the provider within 60 days. If he is uninsured, that causes a problem. If the patient does not get a bill for three years and then is informed by a collection agency that he is also responsible for the fees, court costs, and has been subpoenaed, they have no appeals or negotiation rights at that time. That is the problem that our office has been receiving—we are getting information from consumers with a collection notice. When we investigate, they have never been billed. The bill says if the provider is held to 60 days, especially for the

uninsured, that there is protection for the provider as well as the patient. The provider is more likely to get his bill paid.

Assemblyman Anderson:
What happens if the insurance company does not pay the bill in a timely manner and the provider bills the patient? When does the 60 day timeline begin? It appears to begin on the date the insurance company sends a bill to the patient stating what his responsibility is.

Valerie M. Rosalin:
If the provider submits his claim "clean" to the insurance and the insurance company does not process it appropriately or timely, the Division of Insurance has regulatory powers over the insurance company.

Assemblyman Anderson:
But the lien still comes from the provider against the patient.

Valerie M. Rosalin:
Not if the provider is contracted with the insurance company. That is an obligatory behavior between the insurance company and the provider. If the insurance company does not follow through with its responsibility, the Division of Insurance makes the determination against the insurance company.

Chairman Oceguera:
Dr. Mabey?

Assemblyman Mabey:
I want to disclose that I am a physician. In line 2(a) it says "written." Does that mean I would have to write the bill in Spanish or some other language? As a provider, we may find out much later that the claim was paid but the patient was not insured. Retroactively, the insurance will be denied. Then the provider will have to find the patient in order to bill. It may be very difficult or impossible to find her. When would that clock start? I have seen the insurance company come back much later to say that the provider was paid inappropriately and take reimbursement. What if the claim is denied and the provider wants to appeal it with the insurance company? There are a lot of questions.

Paulette Gromniak:
The provider should have provisions in writing with their insurance company as to what they can and cannot do as far as their appeal process. What we are asking is that the time start at the last date of correspondence from the insurance company. If the provider receives a request from an insurance company for a refund because the patient was not eligible, and it wants

reimbursement, that would start the clock. That is the last date of correspondence. If the insurance company paid the claim and the provider needed to send out a bill for the coinsurance, deductible, or co-pay, we are asking that that be sent within 60 days.

Assemblyman Mabey:
I do not read the bill that way. If you cannot find the patient, what is the process? Do you have to prove that you sent a bill with a return receipt requested? How would you determine that the bill was sent within the 60 day period?

Valerie M. Rosalin:
As far as the provider finding out that the insurance company is requesting its payment be reimbursed for a time when the patient was not eligible, that then is a business decision between the provider and the patient. If the provider cannot find the patient, I do not have that resolved. That is usually not an issue here. The issue is we usually do not have timely payments. Regarding written language in terms a patient can understand, that is standard language in the bill. That is so the lay person can understand that they had a service on a particular date. It does not say what the service was, how much was charged, if the insurance was billed or not, nor how much is owed. Many people cannot read their bill. So this is making it simple for anybody to read.

Assemblyman Mabey:
So this would only be in English then? I agree with the part about only billing by code, and there should be a description.

Chairman Oceguera:
Mr. Settelmeyer?

Assemblyman Settelmeyer:
Who would be determined to be the patient? Would it be the individual who received the services, or would the bill to the insurance provider be sufficient to meet the 60 day requirement?

Valerie M. Rosalin:
Between a provider and the insurance, they have a contracted time frame. If they do not submit their claim to the insurance company within that time frame, they may have a "stale date" and may not get paid. Usually it is 120 days from the date of service to bill the insurance company. We are trying to close that gap for the uninsured to make it 60 days.

Chairman Oceguera:
Mrs. Gansert?

Assemblywoman Gansert:
My experience has been with hospital based physicians. Renown sees about 70,000 patients a year through their main facility. The physicians who are radiologists, emergency physicians, or on staff, rely on the information from Renown to be able to bill a patient. Sometimes, because of the volume, that information is lost for awhile. In the bill, there is no discretion regarding if that information was available to be able to bill a patient. I wonder why the 120 days to bill the insurance is not matched here, and why you asked for 60 days?

Paulette Gromniak:
The statement we want is to be sent to the patient. If there is no insurance provided by the hospital to those radiologists or ancillary providers, we are asking that a bill be sent to that patient within 60 days. The address and contact information should be on the face sheets given to the physicians while they are treating the patients in the hospital. If that statement is sent to the patient, the patient can contact the provider to provide insurance information. If you do not get the statement out within 60 days, you may miss the time frame for those insurance companies which only allow 60 days for billing. This is to get the provider paid, and to allow the patients who are insured to have appeal rights and make sure that their health plan is paying according to their evidence of coverage.

Assemblywoman Gansert:
One problem is that the providers bill separately from the facility. It is a separate bill, and you have to be able to obtain that information. When people go through an emergency department, a lot of times they do not have that information. If someone is in an auto accident, it takes time to track the information. The 60 days seems short to be able to identify someone.

Paulette Gromniak:
On the hospital face sheet, there should be an address and contact information. If it is not on the date of service, it should be close to the time they entered the emergency room.

Chairman Oceguera:
Ms. Buckley?

Assemblywoman Buckley:
I know that there has been concern recently about hospitals selling their claims to collection agencies, sometimes years after the service, even after the statute

of limitations of six years has passed. The consumers cannot even find their insurance records after so many years have passed. I have not heard any complaints about doctors or providers selling their claims, only hospitals. What statistics do you have about the number of complaints that you have, concerning either physicians or other providers who would be covered by this bill?

Valerie M. Rosalin:
I would have to get back to you with those statistics. We have had a number of complaints regarding physicians and late submission of claims, and consumers receiving collection notices or threatening demands for payment.

Assemblywoman Buckley:
Thank you.

Chairman Oceguera:
Are there further questions from the Committee? [There were none.] Are there others wishing to testify in favor of A.B. 40?

Lawrence P. Matheis, Executive Director, Nevada State Medical Association:
We favor trying to address the specific problem that I think Ms. Rosalin is identifying. Nobody wants a patient, years later, to be surprised by bills they did not know they had for services that were appropriately rendered at some distant point. We share some of the growing concerns which the Committee has raised. Anytime we deal with the healthcare system, the complexity impels us to have to be very clear in intent so we do not create new problems. The particular chapter that is chosen here may start the problem. This is the statute on healing arts. It only deals with licensed health professions. It does not deal with the facilities. It is not intended to apply to hospitals, but it must. I do not know the specific cases that are driving the need to address this, but I would be surprised if they did not include hospitalizations and specialty services that were provided in association with hospital treatment. The complexity there is the relationship between the various specialties and the hospital in terms of getting information, and using that information to find the appropriate carrier to make sure there is appropriate billing and tracking. It would seem that should be fairly easy, but it is not. As a rule, people who enter the health care system through emergency care are not always very clear with information, and you would not expect them to be. Sometimes the information that is provided is incorrect, but not willfully. At times it is not clear who the insurer is, especially in an industrial insurance issue. The employer may have changed the plan and the patient is not clear.

There is a time period for all of the providers involved to figure out who should be billed. If they find that there is no one to be billed, they must be sure they have the proper information to bill the patient. That is a growing problem. I have had a number of practitioners call in the last few days to talk about the problem of getting incorrect addresses. I think we have a straight forward attempt to deal with a problem that almost everybody agrees should not exist. You can see why the original language of *Nevada Revised Statutes* 629 was kept fairly general, with the clear intent that people should be billed in a timely way for services received. We have to address the various circumstances of being covered by insurance. Sometimes, one or more of the providers will be contracted with the insurance covering a patient, while others participating in the treatment will not. Each provider will get different information at different times, and will bill in different ways. They will receive information back from the various insurers or health maintenance organizations in different ways. Notifying the patient becomes a secondary problem.

We would propose several amendments. I have a summary sheet to address some of those issues. (Exhibit D) On line 13 of the bill, the point needs to be that to start the clock, the provider of health care has established that there is no coverage of the patient by a health or industrial insurer, and is provided the correct billing information to reach the patient. It seems like an obvious thing, but we have an extremely transient population and it can be quite complex. This may not be the right language; it may not apply in every case. What appears to be a simple bill may not be so simple. On line 7, where it states "written in terms in which a patient can understand," it seems to be simple and straight forward. Usually the claim that is submitted determines if the person is insured, and if the bill is going to go through their insurer. If that is not sufficient, and we are going to bifurcate the notice to the patient based on whether or not it goes to an insurer first, what language are we talking about? Who is going to set those standards? Is that going to be set for all of the health professions in this statute, and by whom? Will it be set by each of the licensing boards? Would it be set by the Commissioner of Insurance? The Commissioner of Insurance has adopted language that includes all the various insurers and health plans. If that language is used, is that sufficient? I am suggesting that if that is the direction you want to go, adding on line 7 after "understand", "or using a standard claim form approved by the Commissioner of Insurance" is not going to be sufficient. Earlier discussion indicated that the insurers have their systems to understand this code was being billed because this particular procedure was indicated by that particular condition. A series of numbers inserted in there, without the names of anything being done, is understood by the person billing on behalf of the physician, and the billing specialist at the insurers, but not by the rest of us. Who is going to translate all of that into

English and how? What are the variations, when is it appropriate communication? I am suggesting one way to have a starting point for that.

We think that the definition of health insurance is not complete enough. I am not sure it covers the Health Maintenance Organization setting completely, or Industrial Insurance. You can also have Medicaid, Medicare, State Children's Health Insurance Program (SCHIP), and other coverage programs which I am not sure are totally incorporated in this. We are willing to work with the Committee, and with Ms. Rosalin, to try to target the problems which she addressed, without creating a lot more problems.

Chairman Oceguera:
I think that is a good idea. We will stop questions unless there are some pressing questions. I will direct Mr. Matheis and Ms. Rosalin to get together and collaborate on this. I know that several members, Mrs. Gansert, Dr. Mabey, Ms. Buckley, and Mr. Anderson, have issues. If we can solve some of those issues, then we will be happy to look at the bill further. Is there someone else who has something to add?

Lawrence P. Matheis:
I suggest that the Commissioner of Insurance might also want to be involved.

Valerie M. Rosalin:
This has snowballed. The language that stands now is that the provider will submit a bill in a timely manner. We were just taking out the word "timely", and putting in "60 days", so it would be clearly stated instead of "timely", which could be whenever. That has been in lieu of not having a specific number.

Alice A. Molasky-Arman, Commissioner of Insurance, State of Nevada:
We have reviewed this bill and we have made some observations. We would be more than happy to also work with Ms. Rosalin and Larry Matheis to perfect this bill. We noticed some areas that were apparently not noticed, such as the fact that it refers to an administrator. All insurers do not use an administrator. That has various implications that should be addressed. We would be happy to work on this.

Chairman Oceguera:
Could the three of you report to Mr. Conklin in the Commerce and Labor Office by next Friday? Is that possible in the south?

Valerie A. Rosalin:
Yes, I will contact the Commissioner and set this up.

Chairman Oceguera:
Are there further questions from the Committee? [There were none.] I will close the hearing on A.B. 40.

I will reopen the hearing on A. B. 27 for one comment.

Thelma Clark, Nevada Silver Haired Legislative Forum:
The Silver Haired Legislative Forum is also interested in A.B. 27. Mary Roberts is here to say something about that bill. I do not have any problem with the PUC's bill, but I do not understand it. I want someone from the PUC to explain to me what it will do for them. Will it help them get the money sooner, or will they have to wait longer? It looks like they may have to wait longer to get their fines.

Chairman Oceguera:
I will have Ms. Wagner from the PUC call you.

I am closing the hearing on A.B. 27 and reopening the hearing on A.B. 40.

Mary Roberts, Senior Citizen Forum, Legislative Committee:
I just got a bill after 11 months. I fought with the insurance company. I think there should be a timely manner when insurance companies or doctors are allowed to send bills.

Chairman Oceguera:
Thank you for your testimony. We will close the hearing on A.B. 40.

The meeting is adjourned at 12:35 p.m.

RESPECTFULLY SUBMITTED:

Earlene Miller
Committee Secretary

APPROVED BY:

Assembly Member John Oceguera, Chair

DATE:

EXHIBITS

Committee Name: Committee on Commerce and Labor

Date: February 9, 2007 Time of Meeting: 11:38 a.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Sign In Sheets
A.B. 40	C	Valerie M. Rosalin, State of Nevada, Governor's Office for Consumer Health Assistance	Memorandum
A.B. 40	D	Lawrence P. Matheis, Nevada State Medical Association	Summary Sheet