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

Seventy-Fourth Session
February 28, 2007

The Committee on Commerce and Labor was called to order by Chair John Oceguera at 1:39 p.m., on Wednesday, February 28, 2007, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 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:

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

GUEST LEGISLATORS PRESENT:

Assemblyman Tick Segerblom, Assembly District No. 9

STAFF MEMBERS PRESENT:

Brenda Erdoes, Committee Counsel
Dave Ziegler, Committee Policy Analyst
Judith Coolbaugh, Committee Secretary
Gillis Colgan, Committee Assistant

OTHERS PRESENT:

Sheri Mabey, Office Manager for Dr. Garn Mabey, Las Vegas, Nevada
Lawrence P. Matheis, Executive Director, Nevada State Medical Association
Jack H. Kim, Director of Legislative Programs, Government Affairs and Special Projects, Sierra Health Services, Inc.
Robert A. Ostrovsky, President, Government Affairs Consultants, Ostrovsky and Associates, representing Nevadans for Affordable Healthcare

Chair Oceguera:
[Roll called.] We are opening the hearing on Assembly Bill 133.

Assembly Bill 133: Revises certain provisions relating to the status of policies covering patients for health or dental care. (BDR 57-807)

Assemblyman Garn Mabey, M.D., Assembly District No. 2:
I appreciate the opportunity to testify. My wife, Mrs. Mabey, is my office manager, and she will be available from Las Vegas to answer questions. Several sessions ago, I presented a bill with similar intent. Therefore, some of you may have heard these issues in the past.

The problem is a widespread issue, and I have no intention of singling out any specific insurance company. I have sat down with others to resolve the problem, but that action has not succeeded. Hopefully, passage of this bill will solve the problem. There are intertwined federal and state laws that complicate the issue. Assembly Bill 133 addresses medical insurance billing for services rendered. All of us have had experience with doctors joining special Health Maintenance Organization (HMO) staff models, so they do not have to deal with insurance billing. Some doctors have quit taking patients who have private insurance coverage.

I would like to give an example of what happens in a physician's office with insurance billing for patient care. In 2004, I provided services for a patient, and

on February 15, 2007, I got a letter from the insurance company asking for the money back. Even though we had called the insurance company to see if the patient was a participant in the insurance plan and if she was covered—to which they concurred—they contacted me two and a half years later to say she was not covered. They asked us to refund the money.

Currently, Nevada law allows a 30-day grace period. Therefore, it is possible a patient could be covered even though they are in the grace period. If the insurance premium payment is not made by the end of the grace period, the insurance company can retroactively terminate the patient's coverage. This bill will require the insurance company to say whether or not the person is covered, and if they are in the grace period. If the patient is in the grace period, the physician's office will notify them. Under these circumstances, the physician has the right to bill the patient for the medical services. The physician's office would still bill the insurance company, and upon receipt of any insurance payment, the doctor's office would reimburse the patient.

There is an alternative option to this method. If the insurance premium was due a month earlier than the actual effective date, then the grace period would be the last day before the coverage would be dropped. Insurance fraud is practiced by some patients. For example, a person is fired. The person will still come into the office for medical care, but they do not tell the doctor they are uninsured. I would be happy to answer any questions.

Assemblyman Horne:
My question is for clarification. If a patient is in the grace period, a doctor would charge the patient for the medical services. If the insurance payment is later received, the doctor would reimburse the patient. Is that correct?

Assemblyman Mabey:
That would be the intent of the bill. The physician's office staff would notify the patient that they are in the grace period, and tell them that without payment of the insurance premium, the insurance policy would be retroactively terminated. Under Assembly Bill 133's provisions, the physician would be able to bill the patient. If the insurance payment was received, then the doctor's office would reimburse the patient.

Assemblyman Horne:
When a patient goes to a doctor's office, they sign a form stating they agree to make the payment if the insurance company does not. That is a mechanism already in place. Therefore, even if they are in the grace period, or the policy has lapsed, or the insurance company goes bankrupt, the patient has signed an

agreement that states the patient is ultimately responsible for payment of services rendered.

Assemblyman Mabey:
That is true. This bill would protect the patient from receiving a medical bill after their coverage is retroactively cancelled. The patient cannot always afford to pay the bill. If the patient had known their insurance was not in force, they could elect not to have the medical procedure performed. It is often difficult to find people and collect the money owed after the medical care is provided.

Assemblyman Horne:
The doctor may be receiving private information from the insurance company. The patient may not want the insurance company telling anyone that they are in a grace period or behind in payments. Do you think this type of information could be considered confidential?

Assemblyman Mabey:
I had not considered that possibility. The premiums are collected on a monthly basis, so I do not believe it would be an undue burden. I do not think it is appropriate that the physician, who rendered the services in good faith, is later told they will not get paid by the insurance company.

Assemblyman Anderson:
Most insurance companies have a list of preferred medical providers. A range of fees for medical procedures is established in advance. If a patient elects to have the procedure done, are they billed at the negotiated rate? The physician may choose to charge the patient more than the agreed upon amount due an insurance company. What happens in these circumstances?

Assemblyman Mabey:
An addendum could be made to the bill stating the physician would bill the patient the customary amount, which is the amount the physician would normally receive from the insurance company.

Assemblyman Anderson:
That stipulation is not covered in this bill.

Assemblyman Mabey:
If the Committee proceeds with this bill, I would be glad to include that stipulation.

Assemblywoman Gansert:
If the patient has pre-approval, the insurance company should not try to renege on that approval. It should stand. We listened to Assembly Bill 40 earlier in the Session, and it talked about a 60-day time frame for a physician to bill for services. Perhaps a longer time frame is required. Do you have a pre-approval process for all your patients? Or do you only do the ones who have insurance?

Assemblyman Mabey:
Every insured patient has their insurance coverage checked. Certain procedures do not require pre-authorization. However, even with prior approval, the insurance companies always include a disclaimer saying payment is not guaranteed. If a doctor receives the insurance payment, and he is later told by the insurance company that the patient was not covered, the doctor has to pay the insurance company back. If he does not do so, the insurance company will deduct the amount from his future legitimate insurance payment claims. That is how the insurance companies equalize the situation.

Assemblywoman Kirkpatrick:
What is the ratio of patients you see who actually have this situation occur? My frustration is the flip-side. If I do get a pre-authorization, and I do not have the medical care performed by the end of the year, then I am unable to have the procedure performed.

Assemblyman Mabey:
I would like to ask my wife to respond to that question.

Chair Oceguera:
We will hold off on that for the moment.

Assemblyman Settelmeyer:
This bill makes sense because it attempts to encourage doctors to stay in the profession in this State. A person or company may be in the process of switching insurance carriers. The person does not remember that there is a grace period with the new company. If an employer notifies his employees of a carrier change, then a patient could notify the doctor of the switch. It would alleviate the problem of billing the wrong insurance carrier or having payment denied in those circumstances.

Chair Oceguera:
Are there any other questions?

Sheri Mabey, Office Manager for Dr. Garn Mabey, Las Vegas, Nevada:
Approximately 5 to 10 percent of our patients fall into this category. They are terminated because of insufficient hours, or non-payment of premium, or for some other minor bureaucratic paper issue that the insurance company has with the patient. In this last two-week period, I have four requests from insurance companies for reimbursement of payment because of retroactive denial of claims. Our office also has re-payment notices from 2005 and 2006. It is becoming a fairly common occurrence. Billing and collecting have become a nightmare. Collecting payments from patients after the fact is almost impossible. Out of every ten denied claims, a doctor's office may receive one payment. Once a patient leaves the doctor's office, the opportunity to collect payment is virtually lost.

Assemblyman Mabey:
I hope after this hearing all parties can sit down and work out some solution.

Chair Oceguera:
Is there anyone else who wishes to testify in favor of A.B. 133?

Lawrence P. Matheis, Executive Director, Nevada State Medical Association:
We do support this bill and the resolution of the problem of retroactive requests for repayment of paid claims by insurance companies. How many people would tolerate a retroactive withdrawal of prior approval? We have created a complex system for handling health care insurance coverage. There should be a way to ensure that people who are sick or injured receive the required medical care. The complexity of the system keeps a barrier between the patient and the health insurance company. This bill is trying to take a piece of the overall issue and make it workable. When is an authorization not an authorization? How do we navigate through the complexities of the payment system?

We encourage this Committee, or a subcommittee, to work on the language of the bill, so one more impediment in the relationship between patient and care giver can be removed.

Assemblyman Christensen:
Since you work closely with the insurance industry, I have some questions to ask based on your experience. What recourse does a doctor have in Nevada to prevent this situation? What recourse is available on a nationwide basis?

Lawrence Matheis:
Unfortunately, a doctor is faced with this problem on a daily basis. A doctor's recourse is to try to work with the patient to get the payment. It is difficult to do, and it is the reason why billing and collection industries have emerged. One

set of bureaucracies engages other sets of bureaucracies to do the collection work for them. That is why there is a lot of uncompensated health care. The uncompensated care costs can be written off by the doctor, but it is never totally written off. The cost is absorbed in future pricing. When the system fails because of its complexity, everyone is frustrated.

Physicians and all health care providers are frequently frustrated by the system. In effect, the "gatekeeper" is an organization that has promised compensation for covered services and benefits for the people they insure. The insurance company can determine if the care is covered and if it needs to be done. They can determine how much it should cost. On too many occasions, the insurance company decides retroactively that they were wrong in granting coverage. Because we have allowed various types of medical coverage programs to develop, the insurance companies have a strong hand. The problem is the medical care has already been provided. The authorization certifies the medical care is necessary, but later on the insurance company says, "We did not say we were going to pay for it." Or they say, "We did not say that person is actually covered." If they are covered, then all our pre-authorization says is, "It was a medically necessary procedure." This convoluted communication system can be interpreted to be an elaborate form of duplicity.

Assemblyman Christensen:
If a doctor receives approval for care from the insurance company and it later reneges on the authorization, is it now up to the doctor to go after the patient for payment? I can imagine a patient saying this was included in the insurance plan, so now the patient is frustrated. Is there a recourse process for the patient to go after the insurance company? Is this issue as prevalent in other states as it is in Nevada?

Lawrence Matheis:
Each person is bound by whatever the original contract said. That includes an appeal process. It can be a very frustrating process for everyone involved.

Assemblyman Settelmeyer:
Can you estimate how much medical costs will increase because insurance companies deny paid claims and want refunds?

Lawrence Matheis:
It is very difficult to give a figure because this happens in every aspect of the health care delivery system. The lack of payment is rebuilt into health care providers' pricing policies and into their availability. The costs are significant in terms of price and access to future medical care.

Chair Oceguera:
Are there others wishing to testify in favor of A.B. 133? Is there anyone wishing to testify in opposition?

Jack H. Kim, Director of Legislative Programs, Government Affairs and Special Projects, Sierra Health Services, Inc.:
I do understand Dr. Mabey's concerns and the problems he has experienced. Our organization has the same issues. This is really not an insurance issue as much as it is an employer issue. Employers in this State have a certain amount of time—in some contracts up to six months—to let the health care provider know that an employee is no longer covered by their insurance plan. The insurance company comes back to us for non-payment of the premium. We turn around and make an adjustment to the doctor's payment. Under federal law, COBRA (Consolidated Omnibus Budget Reconciliation Act) requires us to give employees a certain amount of time to pay. During that period of time, we are required to pay claims.

Some union plans give us six months to make adjustments to their premiums. The insurance company may say a person is a covered employee for the first five months. Then at six months, they say the person is no longer eligible for coverage, so they want the premium refunded.

The underlying problem is employers do not let insurance companies know that an employee is no longer part of the insurance plan. There are times when our organization has to try to recover claims the same way the doctors do by going after the patient. The employer component has a significant impact on the problem. Unless that problem is addressed, the rest of the issues will not be resolved.

I have some other issues with the bill. If the employer is in the policy grace period, an employee may go to a doctor and be told advance payment is required. It can delay the employee receiving the required medical care.

A pre-authorization from the insurance company should suffice to guarantee payment. Typically, when an insurance company gives a prior authorization it allows the doctor 60 to 90 days to perform the service. If a person knows they do not have insurance coverage, because they are in the grace period or have not paid the premium, they are committing insurance fraud. Some people actually use the wrong insurance company card. Our organization gets a medical bill, and the employer says that person is no longer part of the plan. The fundamental issue is how to get employers to give us the correct information on a timely basis. Once we are told an employee is no longer covered, it only takes us a few days to update our records. Some insurance contracts, like

those of the federal government, allow a two-year time frame to go back and deny a paid claim. Until the employer issue is dealt with, everything else in this bill will have problems.

Assemblyman Mabey:
Our whole system is based on trust. I do not see how a system allows a party to go back up to six months later and change their mind. I understand there are federal laws, but we also have state laws that impact the problem.

Jack Kim:
When an employer says a person is no longer covered, the issue is the return of the premiums.

Assemblyman Mabey:
It would be appropriate. If that person was covered for those months and the services were rendered, why should the insurance company be able to go back and say we decided the employer did not notify the insurance company, so the person was not covered? The insurance carrier should not be allowed to go back and say they made a mistake. The insurance companies should say the employers cannot do that. They need to work with the employers.

Jack Kim:
In our contracts with the employers, there are provisions that allow them to do that. If the State wants to make it a law saying the employer cannot do that, then that is a decision for this Committee to make. In the past, I have not advocated for this provision. We collect premiums for people who are covered. If you are saying we should collect premiums for people that the employer does not consider to be employees, then that is a policy decision this Committee would make.

Chair Oceguera:
Are there any other questions?

Assemblywoman Buckley:
What is strange to me is the delay. I can understand a month delay. People may leave in the middle of the month. Why is the delay longer than that? I do not think an employer should be forced to pay premiums for someone who is not an employee. That would be an unfunded mandate on the employer. It does seem unfair to have a gap. Advance insurance authorization is received by the doctor's office and the service is provided. Then, there is no payment. Why does it take so long? Can the problem be fixed?

Jack Kim:
It is an employer issue. There are employers, especially larger ones, who have difficulty making the contact with the insurance company for whatever reasons. I expect the federal government would be one example. They may not know who has left the government employ. The unions are a unique example because they calculate the hours worked to determine whether employees are covered. It may take them a month or two to determine if someone is eligible for health insurance coverage. Then, they come back to us months and months later and say this person is no longer covered.

Chair Oceguera:
Are there any further questions?

Assemblywoman Gansert:
It should be an employer's responsibility. Do we have a law that states what the time frame delay should be?

Brenda Erdoes, Committee Counsel:
I do not believe we currently do, but I can check.

Assemblywoman Gansert:
It seems like the problem is a contracting issue between the insurance company and the employer. Employers should be able to clean up their records within 30 days versus 6 months. That is a long time.

Chair Oceguera:
We will get that answer for you.

Robert A. Ostrovsky, President, Government Affairs Consultants, Ostrovsky and Associates, representing Nevadans for Affordable Healthcare:
I represent the employers. Nevadans for Affordable Healthcare is made up of over 300 small employers throughout the State. There are some large employers, but most are small. The employers have joined together to work on insurance issues. Dr. Mabey met with me on this issue during the interim period. It has been very difficult to find language that will solve the problem and meet everyone's needs. Currently, there is a built-in bias in the system, because there are different interpretations of who is eligible. For example, did the insurance company know or not know who was eligible? Or, did the insurance company notify or not notify the employer? Somewhere in the process, the doctors and the other health care providers build in some piece of their unfunded cost, because they know they will not get compensated for certain procedures. It drives the cost of health insurance up for everyone else. They pay the bill. The mathematics have to be worked out so the provider can

stay in business, provide the service, and earn a decent living. Given that bias, there is a built-in cost in the system.

I would like to discuss how the employers make their payments to the insurance companies. Under Nevada law, there is a 30-day grace period. Most employers take full advantage of that time because of cash flow. For example, if their insurance premium is $10,000 a month, the employer will wait as long as they can to make the final transfer of the funds. With the payment, the eligibility list is also transferred. The payment and eligibility list transfers are never going to fall on the day they are due, because they have to evaluate if the employee worked enough hours last month to be eligible for coverage. Other questions come up, such as, was the dependent still of age to be covered? Was the dependent still in college? Has a new dependent been added to the policy? These are just some of the issues they have to consider. During the 30-day period, the employer uses the time to determine the answers and certify eligibility. Then the eligibility list and check are sent to the insurance company.

There is another provision in *Nevada Revised Statutes* (NRS) 608 that says, "If an employer stops paying the insurance premium on behalf of an employee, they have to notice the employee in writing." A lot of the eligibility issues are not a question of the employer not making the payment, but rather was the employee eligible for coverage that month. I sit as a trustee on a number of union trust funds where eligibility is always an issue. The employer waits for the union steward to determine if enough hours have been worked to determine which employees qualify for coverage. There may be more than one job site. It takes a little time to gather all the necessary information.

I would like to speak to the unintended consequences of what is going to happen if this situation continues. If an employee goes to see a doctor because they are ill, that visit is not pre-planned. The doctor's office calls the insurance company to check on coverage, and nine out of ten times the answer they get is, "The insurance is in its grace period." The medical care was sought in the current unpaid month. If an employee has to pay out-of-pocket, some will choose not to pay and not get the service. Then, the physician has to make the decision if he will treat the patient with no guarantee for payment. The employee has insurance, but every time they go to the doctor for immediate care, their policy is in the grace period, which means they may have to pay. The employee goes back to the employer and says your insurance is no good. The employer says, "It is and we have had the same insurance carrier for the last five years." The unintended consequence is it creates an employer/employee adversarial relationship.

Our position is neutral on the bill. We have not figured out how to fix the problem. Some people have suggested there should be a limit on the amount of time an employer has to notify the insurance company of employee eligibility. New provisions would require insurance companies to change their contracts with the employer. This bill will only affect small and medium-sized employers. Self-insured employers or employers under the Taft-Hartley Act are not affected because they are federally regulated. We are dealing with a very complicated set of issues, but we need to ensure that patients receive necessary medical services. The party responsible for payment should pay in a timely and appropriate manner. I would be happy to answer any questions.

Assemblyman Mabey:
I have two questions. Why do insurance companies and employers wait until the grace period to resolve the issues? Would you support making the grace period end the day before the premium was due? In other words, employers would pay the insurance premium a month in advance. With this method, no one would be in the grace period, because the grace period would expire when the premium was due. If this new system was used, everyone would have to "double-pay" in the start-up month. One payment would cover the old insurance system; the second would cover the new.

Robert Ostrovsky:
The reason employers cannot pay on the first day is they need the time to evaluate employee eligibility. It takes time for the payroll records to catch up to determine if an employee qualified for the insurance. Employers wait on paying the insurance premium, because the State law lets them wait. They will hold the money as long as they legally can.

The issue of pre-payment is a financial question. Does the Legislature want to require employers to put up an extra month's premium, because the first cycle would require double payment? What happens if an employee was determined to be ineligible? Do they go to the insurance company and get their premium back? There will always be questions. All we can do is "squeeze" down the number of problems we have, so we would be better off than we are today.

Chair Oceguera:
Are there further questions? Is there anyone else who wishes to testify on this bill? We are closing the hearing on A.B. 133 and opening a work session. We will consider Assembly Bill 2 first. This is Mr. Anderson's bill. We will ask him to "walk" us through some of the discussion that has taken place and tell us if any consensus has been reached.

Assembly Bill 2: Revises provisions relating to automotive repairs. (BDR 52-92)

Assemblyman Anderson:
I would like to refer to the work session document (Exhibit C). You have a mock-up in that packet that is the product of a meeting between several different interested parties. In Section 1 of the bill, a reference is made to "the person authorizing repairs," and that person agrees to a written estimate for the repair of the motor vehicle. The term, "person authorizing repairs," is defined under the existing NRS 597.480, Section 5, which states, "...a person who uses the services of a garage. The term includes an insurance company, its agents or representatives, authorizing repairs to motor vehicles under a policy of insurance." Therefore, under this definition, the person may be the owner of the vehicle or the representative of the insurance company who is arranging for the repair.

All the major parties who participated in the discussion have agreed to and signed off on the amendment. They are probably in a better position to answer further questions.

Chair Oceguera:
We are not ready to take any testimony, but we would like you to discuss what you just said in a little more detail. Some Committee members want clarification on this point. Could you reiterate what you just said?

Assemblyman Anderson:
We have made several suggestions in the mock-up, including deleting the language in Section 1, subsection 2. We added language that says, "...the garage or body shop shall perform the repair in accordance with any applicable instructions of the manufacturer of the motor vehicle...." Therefore, they will be following the guidelines set by the vehicle manufacturer. We also added language to clarify the written estimate that says, "...the version which is most recently agreed upon...." In most cases, the individual who brought the vehicle to the garage would be involved in the process. One insurance company offers pick up and delivery of the motor vehicle for repair, and returns the repaired vehicle to the owner. The customer is never really involved with the garage or the body shop. This language attempts to solve the problem of owner exclusion from the process. A body shop would have the same responsibilities as a garage.

In the mock-up's Section 3, subsection 1, we added language that says a garageman will be required to post, in a conspicuous place, a sign that covers the rights of the vehicle owner. This language will require the same "due diligence" for body shops that garages currently have. The language in

Section 1, subsection 2, which raised some concerns, has been removed from the bill. I hope this explanation helps clarify the language of the bill.

Chair Oceguera:
It helps a lot. An important part of your comments is the fact that the insurance company already has the ability to bring a vehicle in for repairs, authorize the repairs, pick it up, and return the vehicle to the consumer.

Assemblyman Anderson:
Occasionally insurance companies are caught in the middle, because garages are not able to repair a vehicle to its original condition. Usually, this situation occurs when an improper part has been installed during a previous repair. This language clarifies that type of situation. The meetings were informative because insurance companies and State agencies did not realize how many customer complaints were not reaching them. With this legislation, they will be in the loop.

Assemblyman Settelmeyer:
I have a question about the language that states, "...applicable instructions of the manufacturer of the motor vehicle...." How would an individual know what a manufacturer wants? Sometimes a manufacturer will have a long, involved method for doing something. Often, the industry standard has a quicker way to make the repair. A farmer's method of fixing something can be a lot faster than what was laid out by an engineer. How do the consumers find the industry standard? Would you be open to changing the language to say, "common industry standard" instead of using "applicable instructions of the manufacturer"?

Assemblyman Anderson:
This was the language that was suggested and agreed to by the dealerships. They felt the customer needed to be aware that there is a quality standard for parts. This would prevent substitution of an inferior or cheaper part that may be less durable.

Assemblyman Settelmeyer:
Sometimes in rural communities dealerships are not readily available. This legislation could possibly discriminate against people living in rural areas, because they are being told they have to do the repair to the "applicable instructions of the manufacturer." Would it be possible to add to the bill language that says a repair cannot be made with used parts, and if the parts are used, the garage must inform the owner of the vehicle or the authorized agent?

Assemblyman Anderson:
This was the language that the parties agreed to. I recognize that sometimes the only place available for parts might be a "pick and pull" business. Sometimes you can find the part there, and it will serve as well as a new one.

Assemblyman Settelmeyer:
I remember when I had a 1952 Chevy pickup truck. It had a locking nut on the axle that was no longer made, so requiring replacement to industry standards would be virtually impossible. It would be easier to inform the owner and ask if they would like a used part, instead of custom ordering the part from the manufacturer.

Assemblyman Anderson:
I understand what you are trying to say. This was the language of choice.

Chair Oceguera:
Saying "in accordance with industry standards" is probably workable language. We can work with the language. Some of this language is already in the administrative code. If I am a consumer, I have the final say, and the insurance industry agrees with that. If I tell my insurance agent to go ahead and take care of the repair, that is fine. If they put in secondhand parts that is not my problem, because I said take care of it to the best of your ability. If they find the part for the best available price, I can allow them to do that. I have the final choice. If I say "no," I want to take care of the repair myself, that is my choice.

Assemblyman Anderson:
I do think the consumer cares what happens to his motor vehicle. The consumer assumes the repair shop will use the best part available. This language was suggested to ensure a quality repair to manufacturer's standards.

Assemblyman Manendo:
I am concerned with the language because it seems like only dealers can make the repairs. We need some clarification of the language. Are we going to hear from anyone else?

Chair Oceguera:
Who would you like to hear from?

Assemblyman Manendo:
I just wanted to know if anyone else is going to testify.

Chair Oceguera:
I do not want to rehear the bill, but if there is some specific question you have for a specific person, I would entertain that.

Assemblyman Manendo:
I want to look at Section 1, lines 5 and 6, in the mock-up version. I am keying on the language that says in accordance with industry standards. Who sets those standards?

Assemblyman Anderson:
The manufacturer of the vehicle puts out the applicable instructions in a large book.

Assemblyman Settelmeyer:
What are "reasonable" standards for the industry? If the repair is made outside the normal scope of repair, the consumer would have a way to hold the repair shop accountable. The manufacturer often has a complicated and involved process for making the repair. Often, people in the repair business have found a way to get around it. For example, if you lock your keys in your car, the manufacturer may state that you are supposed to find the access code, reprogram the key, find the remote control, push the button, and unlock the car. That is a very long process. A tow truck driver has a small air bag that is attached to the vehicle and it pops the lock.

Chair Oceguera:
Let me ask our legal counsel. There are two issues here. One issue is the consumer having the final say. The other issue is defining the industry standard. Can we come up with language that would satisfy the Committee's concerns on those issues?

Brenda Erdoes, Committee Counsel:
I believe we can come up with some language that will take care of those issues.

Assemblyman Horne:
A consumer can get the information on the manufacturer or industry standard by using the Internet. I do not think lack of accessibility to those standards is a real issue. If you have a newer model vehicle and have it repaired to industry standard instead of manufacturer's standard, it is possible to void the warranty. Opening a locked vehicle is not a repair, because no parts or equipment are being replaced.

Assemblyman Mabey:
Perhaps the words "normal" or "customary" would be a better choice, instead of saying "in accordance with."

Chair Oceguera:
A repair shop would put itself in a liable position if they vary from the manufacturer's recommended method of fixing the vehicle.

Assemblyman Horne:
In the mock-up, it says the repair would be in accordance with manufacturer's standards. The suggestion was made to use the words "industry standards."

Assemblywoman Buckley:
We are over-thinking the language. This is a standard language that is used. Repair shops fix cars daily in accordance with those standards. We can have Mr. Anderson work with his experts, then turn the language over to the Legal Division, and we will be done.

Assemblyman Anderson:
I would be happy to take it back and have it looked over.

Chair Oceguera:
If we can come up with suitable language and turn it over to the Legal Department, we will then take another look at the bill. We are opening the work session on Assembly Bill 24.

Assembly Bill 24: Revises provisions governing the release of a consumer report by a credit reporting agency. (BDR 52-518)

Dave Ziegler, Committee Policy Analyst:
This bill has to do with freezes on consumer credit reports. The bill, as introduced, provides that a credit reporting agency may not charge a customer 62 years of age or older to place a security freeze on their file. They cannot charge a fee to temporarily release a report, or to remove a security freeze. A number of amendments are in your work session documents (Exhibit C). Kathleen Delaney, Senior Deputy Attorney General, submitted an amendment (Exhibit D) the day of the hearing.

James Jackson, representing the Consumer Data Industry Association, submitted a proposed amendment the day of the hearing. There is also a new amendment from Kathleen Delaney that is dated February 26, 2007. It would set a $10 maximum fee for placing, removing, or temporarily releasing a

security freeze, and not allow any charge for a consumer 65 years of age or older.

There was another amendment, but it has been pulled from consideration. On a special note, all of the proposed amendments and existing laws waive all fees for victims of identity theft. To sum up, there are three proposed amendments to the date of the hearing, and one new one dated February 26, 2007.

Chair Oceguera:
After having received 727 emails on this bill, we have developed some language that everyone will be happy with. Mr. Conklin and I worked on this diligently with several parties. The final, agreed upon solution is to establish a $10 fee and make the cut-off age 65 or older. If someone is a victim of identity theft, there would be no fee. Is there any discussion? Seeing none, I will consider a motion.

> ASSEMBLYWOMAN BUCKLEY MOVED TO DO PASS ASSEMBLY BILL 24 WITH THE PROPOSED AMENDMENT TO ADD THE FOLLOWING REFERENCES:
>
> - THE FEE WILL BE $10; AND
> - THE AGE WILL BE 65 YEARS OF AGE OR OLDER.
>
> ASSEMBLYWOMAN GANSERT SECONDED THE MOTION.

Chair Oceguera:
Is there any discussion on the motion? Seeing none, we will take the vote.

> THE MOTION CARRIED UNANIMOUSLY.

Mrs. Kirkpatrick will do the floor statement. We are opening the work session on Assembly Bill 47.

Assembly Bill 47: Revises circumstances under which an attorney is excluded from regulation as a collection agency. (BDR 54-792)

Dave Ziegler, Committee Policy Analyst:
This bill revises the circumstances under which an attorney is excluded from regulation as a collection agency. It relates to the definition of "collection agency" for the purposes of licensing and regulation. It provides that a licensed attorney does not fall under the definition of "collection agency" if he is retained to collect payment of clients' claims in the usual course of his practice.

No amendments were proposed (Exhibit C). In testimony on the day of the hearing, the Acting Commissioner of the Division of Financial Institutions said the bill would not affect his office's regulation of collection agencies.

Assemblyman Anderson:
I raised some concerns about this bill when it was first introduced. It is well intended, but I need clarification on the actions that were taken in the 73rd Session, which may have inadvertently caused a problem. We had a larger piece of legislation, and when the bill was passed, this particular part was agreed on.

Chair Oceguera:
We will ask our Legal Counsel about the previous bill and its history.

Brenda Erdoes:
I thoroughly researched the history of the bill with the help of the Research Library. The reference was in Section 59 of S.B. 431 of the 73rd Legislative Session. We found no specific comments to explain why the language was in the bill.

The information we do have was included in our Bill Draft Request (BDR) file from the head of the Division of Financial Institutions. It is a clarification of the treatment of attorneys in relation to the collection business and businesses that were associated with attorneys, but were still in the collection business. Since that bill was passed with the change, the State Bar Association, as well as the federal one, has come out with some new rules establishing how attorneys are to interact when they have a business that competes with a collection agency. I do not know whether or not they would prohibit this section, or request that it be removed. The Supreme Court tends to discourage this type of provision. Overall, we did not find much history on this bill.

Assemblywoman Buckley:
I also went back and reread the legislative history, because I had an attorney ask me why the Legislature is trying to usurp the jurisdiction of the State Bar of Nevada in regulating attorney conduct. This section was in the middle of a very large bill. The section was never pointed out to us, nor did we discuss it in full, because of the lateness of the session and the volume of the bills.

There are attorneys who do a professional job of collecting debts, and there are attorneys who do not. The proper regulatory scheme is that the State Bar of Nevada should be available to discipline attorneys if they do not do a good job. It is not the job of the Division of Financial Institutions. The proper regulatory body should always be the entity that can take your license away. Otherwise,

if the entity cannot remove a license, they are ridiculed. The State Bar of Nevada can fine, suspend, or discipline an attorney. They are the proper body, not the Division of Financial Institutions.

Additionally, the federal Fair Debt Collection Practices Act applies to attorneys. Attorneys who violate federal law are treated just like any other debt collector. They cannot call a person's employer to harass them or call late at night. They have to verify the debt, and include the notification that a person has the right to verify the debt within 30 days. If they violate the law, that attorney can be sued in federal court, just like any other debt collector. Statutory damages and attorney fees can be sought against that attorney. Attorneys are kept more in line than debt collectors, because they know the federal law very well. Therefore, the current regulatory scheme, with the State Bar Association and the federal Fair Debt Collection Practices Act, has given us the tools to make sure attorney debt collectors are following the law. I have no problem with waiting if there are questions to be answered.

Chair Oceguera:
I see Mr. Segerblom is in the audience as well. We are discussing your bill. Do you have anything to add? [Mr. Segerblom answered "no" from his seat in the audience. He did not come to the witness table.]

Assemblyman Anderson:
With the comments made by our Legal Counsel and Ms. Buckley, some of my concerns have been relieved. I am more comfortable now than I was before.

Chair Oceguera:
Are there further questions, comments, or discussion from the Committee? Mr. Anderson, would you be comfortable if we took a motion on this bill? [Mr. Anderson nodded in the affirmative.] I am willing to accept a motion.

> ASSEMBLYMAN CONKLIN MOVED TO DO PASS ASSEMBLY BILL 47.
>
> ASSEMBLYWOMAN KIRKPATRICK SECONDED THE MOTION.

Is there any discussion on the motion? Not seeing any, we will take the vote.

> THE MOTION CARRIED UNANIMOUSLY.

Assemblyman Anderson:
The discussion has alleviated some of my concerns, but I reserve my right to vote on the floor.

Chair Oceguera:
I will take this bill to the floor. Next week, this Committee has a full schedule. Some long hearings are scheduled on energy bills with three or four bills at each, including Friday.

[The meeting was adjourned at 3:09 p.m.]

RESPECTFULLY SUBMITTED:

_____
Judith Coolbaugh
Committee Secretary

APPROVED BY:

_____
Assemblyman John Oceguera, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Commerce and Labor

Date: February 28, 2007 Time of Meeting: 1:30 p.m.

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Rosters
AB 2 AB 24 AB 47	C	Dave Ziegler, Committee Policy Analyst	Work Session Packet for February 28, 2007
AB 24	D	Kathleen Delaney, Senior Deputy Attorney General	Proposed Amendment