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

Seventy-Fourth Session
March 21, 2007

The Committee on Commerce and Labor was called to order by Chair John Oceguera at 1:45 p.m., on Wednesday, March 21, 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:

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

STAFF MEMBERS PRESENT:

Brenda Erdoes, Committee Counsel
Dave Ziegler, Committee Policy Analyst

Judith Coolbaugh, Committee Secretary
Gillis Colgan, Committee Assistant

OTHERS PRESENT:

Alice A. Molasky-Arman, Commissioner of Insurance, Insurance Division, Department of Business and Industry
Robert A. Ostrovsky, President, Ostrovsky and Associates, representing Employer's Insurance Company of Nevada
Lawrence P. Matheis, Executive Director, Nevada State Medical Association
James L. Wadhams, Attorney at Law, Jones Vargas, representing the Nevada Association of Health Underwriters, Anthem Blue Cross & Blue Shield, and the Nevada Independent Insurance Agents
Matthew L. Sharp, Attorney at Law, representing Nevada Trial Lawyers Association
Robert Tretiak, Ph.D., Business Development Officer, representing International Energy Conservation
Judy Stokey, Director, Government Affairs, representing Nevada Power Company and Sierra Pacific Power Company
C. Kirby Lampley, Director of Regulatory Operations, Public Utilities Commission of Nevada (PUC)
Ray Bacon, representing the Nevada Manufacturers Association

Chair Oceguera:
[Roll called.] We have a very busy schedule during the next three and a half weeks. It will require us to start on time. Each day next week we will have five bills, and there will be a work session on every one of those days. This Friday, we will have nine bills on the work session. The following week we have six bills on three of our meetings days, and we will have an evening session on Monday, April 2, at 6:00 p.m. Next week, we will have ten bills on Monday, seven on Wednesday, and a work session all day Friday. The quantity of bills is not the result of poor planning. It reflects the number of bills we received at the last minute. Some Floor Sessions have been canceled so the morning committees can have more time. The workload will be heavy, and we will start at 1:00 p.m. on some days. We are opening the hearing on Assembly Bill 161.

Assembly Bill 161: Revises various provisions governing insurance. (BDR 57-586)

Alice A. Molasky-Arman, Commissioner of Insurance, Insurance Division, Department of Business and Industry:
I appreciate the opportunity to present A.B. 161. This bill represents lessons the Division has learned from our experience in regulating insurance. It contains many provisions on a variety of insurance matters. I also have some proposed amendments to the bill because items came to our attention after the bill was printed. The Division's proposed amendments are in your package. There is a separate document that contains amendments proposed by the industry that the Division supports. You also have a copy of our PowerPoint presentation (Exhibit C). For purposes of the testimony and the PowerPoint presentation, we have attempted to group the sections together by subject matter.

The provisions in Sections 1 through 3 will enable the Division to effectively track and regulate the activities of producers acting on behalf of business organizations, such as a corporation that is licensed as a producer or an agent. Section 1 of the bill adds a new subsection to Chapter 683A of the *Nevada Revised Statutes* (NRS). It will require a business entity licensed as a producer of insurance to notify the Commissioner within 15 days after the business entity employs a producer to sell insurance on its behalf. It will also require a business entity to notify the Commissioner within 30 days after a producer's authority is terminated.

The Division's enforcement efforts have been severely limited in this area because of the lack of specificity in these laws. Sections 2 and 3 carry out the intent of Section 1 by deleting the phrase "affiliated with" and replacing it with the phrase "authorized to transact business on behalf of." This new language more fully describes the legal relationship between the business organization and the producer of the insurance. Sections 2 and 3 will require the business entity that is licensed as a producer of insurance to notify the Commissioner of all persons authorized to transact business on its behalf.

Sections 18 and 28 of the bill apply to title insurance and bail agents. Under NRS 683A.331, the provisions will require the business entity to notify the Commissioner on the appointment and termination of title insurers and surety agents. Currently, there are no clear provisions in the insurance code to require those insurers to notify the Division of appointments and terminations of their agents.

Sections 4 through 6 of the bill address the detection, prevention, and reporting of insurance fraud. The first step in finding insurance fraud is to identify it. Section 4 requires insurers and Health Maintenance Organizations (HMOs) to implement an anti-fraud program for the detection, prevention, and prosecution of insurance fraud by using investigators or by instituting a written fraud

program. With respect to this Section, the Nevada Trial Lawyers Association (NTLA) approached me with some questions. I did agree with their concerns. On page 5 of the amendments (Exhibit D) that resulted from my discussion with the NTLA, Section 4, subsection 4 of the bill will be deleted. This subsection would have required persons to submit a copy of the required fraud program to the Commissioner. It is a requirement that we do not desire. The amendment proposed by the NTLA will clearly establish the Commissioner's authority to examine the fraud programs to ensure compliance. Another amendment replaces subsection 4. It will prohibit an insurer from delaying or denying legitimate claims under the guise of a fraud program.

Section 6 expands the scope of persons who must report fraud to include HMOs, third-party administrators, and any other person required to be licensed pursuant to the insurance code. The reporting requirements extending the scope of fraud include activities that may reasonably be believed to be insurance fraud as opposed to just reporting confirmed fraud.

Insurance fraud is one of the cost drivers of insurance. Yesterday, the California Commissioner of Insurance issued a statement saying that fraud in their state costs every person $500 annually. On a national level, it is estimated that the cost of insurance fraud is $96.8 billion a year. Health insurance fraud is estimated to cost consumers over $60 billion a year. Fraud involving property is estimated to cost at least $20 billion a year. According to data from the National Crime Information Center (NCIC), Las Vegas ranks second in the nation for automobile theft. The number of automobile thefts in Las Vegas is trending higher. It is an alarming statistic, and it is the likely contributor to high automobile premiums paid by southern Nevadans.

The chart on page 7 of the PowerPoint package indicates that the number of automobile thefts in Nevada has increased dramatically since 2000. In 2003, the number of automobile thefts began to significantly exceed the national average. These types of activities constitute insurance fraud, and they are the activities that will be required to be reported pursuant to Section 6 of A.B. 161.

The chart on page 8 compares the increasing amount of automobile theft with the State's population growth. In 2004 for the first time, the rate of auto theft in Nevada exceeded the rate of population growth. This phenomenon emphasizes that additional measures must be taken to detect automobile theft and related insurance fraud.

Section 7 of the bill amends subsection 1 of NRS 686C.240 by restoring the annual administrative assessment to the members of the Nevada Life and Health

Insurance Guaranty Association (NLHGA) to $300 from $150. In 1997, the NLHGA proposed an amendment to increase the member companies' annual administrative assessment from $150 to $300. That increase was necessary due to the rising costs in administering insolvent estates. Unfortunately in 2001, when the NLHGA submitted the bill to amend provisions of the NRS 687B, the amount of the administrative assessment was inadvertently changed back from $300 to $150. The NLHGA has requested this correction on behalf of its members, the insurers, to ensure continued administrative operations.

Section 8 of the bill amends the NRS 687B.350 to require insurers to provide 30 days notice of altered terms of Workers' Compensation policies. There are two instances where this rule would not apply. The first is when the advisory organization changes or revises loss costs that apply to the policy based on approved rules. The second is when there is a correction to the experience of an employer pursuant to the approved experience rating plan. This change will allow an insured the opportunity to shop for alternative coverage, and it will promote a competitive marketplace.

The Division is proposing an amendment to Section 8, subsection 2 (a) of the bill that will delete the reference to statistical data reporting in the NRS 686B.1764. That was mistakenly added by the Legislative Counsel Bureau bill drafter who could not make the change after the bill had been printed. The deletion is due to the fact that the subject matter of the NRS 686B.1764 has no relationship to the added provision.

Chair Oceguera:
I need to ask you to pause for a question.

Assemblywoman Kirkpatrick:
I am on Section 8, page 8 of the bill, but what page are you on in the proposed amendment?

Alice Molasky-Arman:
It is on page 3 of the proposed amendments. I will try and be clear where I am in the documents.

Sections 9 through 14 of the bill update statutes that are related to prepaid funeral and cemetery contracts. These statutes were originally enacted in 1971, and except for a few minor changes in 1987, they have never been modernized. These sections refer to the funding of prepaid funeral and cemetery contracts. In today's market, the traditional payment of cash for a pre-need contract, where the seller holds the money in trust, have been replaced

by the sale of small face value life insurance policies. The proceeds of a life insurance policy are used to fund funeral and cemetery services when the beneficiary of a prepaid contract dies. The proposed amendments reflect modernized industry practices. These amendments provide for alternative funding by using the proceeds from a life insurance policy.

Similarly, Sections 10 and 13 of the bill allow the Commissioner discretion and flexibility in waiving the requirements for funeral or cemetery sellers to have a bond in place if the seller's only contracts are funded by the proceeds of a life insurance policy. They are not holding the cash of the beneficiary of the contract.

Sections 11 and 14 add new subsections to the NRS 689.315 and 689.560 whereby funeral and cemetery sellers are not required to establish a trust account if they collect no money for a prepaid contract that is funded from the proceeds of a life insurance policy.

Section 15 amends the NRS 689C.075 which covers small employers group health insurance policies. It will replace the language defining health benefit plans to comply with the federal Health Insurance Portability and Accountability Act (HIPAA). The HIPAA states that such plans are also sold to individuals and large employers. The amendment makes the definition of a "health benefit plan" compatible with the definitions in the other sections of the insurance code.

Section 16 amends the NRS 690B.260 to require medical malpractice insurers to report closed claims under a policy in a batch file 45 days after the close of a calendar quarter. The existing statutes require each closed claim to be reported immediately. This changes the requirement from a piecemeal reporting to a batch reporting. This method will increase efficiency and save time for both the insurers and the Division. This amendment will enable our staff to more effectively analyze the data and to better monitor and enforce the reporting requirement.

Section 17 of the bill amends the NRS 690C.080 to clarify that the physical structure of a manufactured home, such as walls, roof supports, and structural floor base, cannot be covered by a service contract. There has been confusion regarding the scope of coverage under a service contract. Companies have attempted to cover residential structures with a service contract. An indemnification policy covering a structure is considered insurance in Nevada whereas coverage under a service contract is not insurance.

Sections 19 through 22 of the bill, together with the repeal of the NRS 694C.260 in Section 32, subsection 2, relate to captive insurers. The Division's first proposed amendment (Exhibit E) is on page 1, and it does relate to these provisions. This amendment does not appear on the PowerPoint presentation. It calls for the first recital to be amended to correctly state that Section 19 of the bill combines the minimum capital and surplus requirements for captive insurers. The recital uses the word "increases" which is incorrect.

Sections 19 through 22 combine the minimum financial requirements currently found in the NRS 694C.250 and NRS 694C.260 into a single statute. The amended NRS 694C.250 will prescribe the minimum required combined capital and surplus amount for each type of captive insurer instead of stating these requirements separately. This amendment does not diminish or increase the required amounts. The two amounts are merged into a single dollar amount. This combining will enable a captive insurer to use one instrument, such as a single letter of credit, a surplus note, or a bank account, to meet the minimum financial requirements.

Section 31 of the bill would reclassify the Division captive administrator position to a new unclassified position of Deputy Commissioner. It is currently a classified position at Grade 42. The NRS 232.825 limits the Commissioner to two Deputy Commissioner appointments. This change would increase the number to three, and this amendment would also be contingent upon approval of our budget. The cost of reclassification is minimal, but the change will enhance the prestige of the position in the State of Nevada. Our chief competitors for new captive insurers—Vermont and Hawaii—designate their captive insurer administrator as a Deputy Commissioner.

The significance of the title change, in the world of captive insurance, would indicate that the individual holding the title is uniquely competent. That person holds the highest credentials, and has experience and knowledge in matters relating to captive insurance. Strategically, the change will also benefit the Division. The captive administrator is responsible for developing and preserving the captive insurance program. The work necessitates travel and the accumulation of variable time. According to state personnel rules, variable time must be taken during the same time period. That requirement has frequently created conflicts with the other obligations of the position. This measure will allow the Division greater flexibility with respect to the time that must be devoted to the position.

The last amendment affecting captive insurers is Section 23. It will require "sponsored captive insurers" to file annual financial reports. When this new

class of "sponsored captive insurers" was added in the 73rd Session, we failed to impose this requirement which is required for all other captive insurers.

Sections 24 and 25 of this bill amend the NRS 695D.270 and the NRS 695F.310, respectively, by extending the frequency of financial examinations for dental care providers and prepaid limited health service organizations to not less than once every three years. Our current law requires examinations of the dental care providers every six months for the first three years, and every year thereafter. The examinations for prepaid limited health service organizations are required once every two years. These examinations have proven to be very expensive for small operations. The new examination schedules will also make the requirements consistent with like providers and organizations.

Section 26 amends the NRS 696A.185 to authorize the Commissioner to impose an administrative penalty, similar to all other licensees, against a motor club if it fails to timely submit its annual $500 renewal fee. This penalty is the same as the penalty currently authorized for failure of a motor club to timely submit its annual report. Enactment of this amendment will provide an incentive for motor clubs to remit their fee in a timely manner.

Section 27 of the NRS 696B.330 addresses amendments for the handling of claims against an insolvent insurer when those claims have been placed in receivership by the Nevada Insurance Commission. The language of this proposed amendment was developed in consultation with receivership experts. The Division's experience with their only major insolvency, which is the ongoing First Nevada Insurance Company case, is also reflected in this amendment, as are similar laws in other states. It will enable the Commissioner as a receiver of an insolvent insurer, instead of a court, to make an initial determination, to provide notice of the approval or denial of proofs of claim, and to determine the class of the approved claims. Class of claims refers to a priority of distribution in our receivership laws. The claims of the administration of the estate have the first priority. Second party claims are those of the NLHGA. The remaining priorities are federal and state taxes and secured and unsecured creditors. Most frequently the assets of an estate are not sufficient to pay the claims in all of these classes.

This amendment will enable the receiver to make the initial determination of the class of claim. It also clarifies that unless an objection to the receiver's determination is made, there is no need for a court to schedule a hearing for each claim. In the instance of First Nevada Insurance Company, there are over 1,400 claims involved. It creates an enormous burden on the receivership and on the court. This amendment will provide our receivership with flexibility and,

in the event of future insolvencies, will improve our ability to deal with these situations. When this bill was returned to our office for review, the Deputy Receiver and other experts were not available to review the final version. Since that time they have reviewed it, and their review generated another amendment to the bill.

That amendment appears on page 4 of (Exhibit E). It is number 3 at the top of the page. The Sections are not numbered in the amendment list because we were uncertain where the changes would be placed within the bill. The purpose of the amendment is to establish a time period for filing a claim, as directed by a court. On page 5, subsection 4, the amendment would add the words "be required to," so the receiver will have discretion in whether to process claims in those classes when it appears that assets may not exist to pay that class of claim. The intent is to prevent a reinsurer from using the absolute requirement as a defense for not paying reinsurance monies into the estate.

The final proposal for an amendment to that Section is in subsection 6, which contains the new language that says, "The receiver shall submit to the court a report on the determination of the receiver on each claim approved, in whole or in part." Currently, only claims which the receiver has determined to be denied and to which an objection to determination has been filed, are addressed. The amendment addresses all approved claims and requires the receiver to submit a report on those approved claims to the court. The amendments in Section 27 and the additional amendments will provide judicial economy, will increase the efficiency of the administration of the insolvent insurer's estate, and will result in having greater assets available to pay claims.

Section 29 affects employers and employers' associations that self-insure for Workers' Compensation. The proposal clarifies that the definition of "tangible net worth" means the value of all assets minus the value of all liabilities. This amendment is intended to address concerns by some employers' self-insured associations who questioned whether liabilities must be deducted from assets to yield a "tangible net worth."

Section 30 also relates to employers' self-insured associations for Workers' Compensation. It would amend the NRS 616B.386 by increasing the number of day's coverage, from 30 to 60 days, that must be provided by a self-insured association for a member whose membership has been canceled or terminated. Thirty days is not sufficient time for a canceled or terminated employer member to effectively market and place coverage with another carrier.

Section 32 is a housekeeping measure. It will repeal the NRS 689A.735 that requires the trustee of a medical savings account to provide an annual report to

the Commissioner. That provision was originally established because of HIPAA requirements passed by the federal government in 1996. On December 8, 2003, the federal Medicare Prescription Drug Improvement and Modernization Act (MPDIMA) was enacted. This Congressional measure created Health Savings Accounts, and effectively made Medical Savings Accounts obsolete. That concludes my testimony. I would be happy to answer any questions, or I can proceed to the amendments that were proposed by the insurance industry.

Assemblyman Conklin:
I am looking at Sections 4 through 6, which is the insurance fraud portion of this bill. We are asking the insurance companies to do more policing of insurance fraud when the State has not stepped up its prosecution of insurance fraud. What does your Division do with reports of insurance fraud?

Alice Molasky-Arman:
Insurance fraud is prosecuted. The reports of fraud are submitted to the Office of the Attorney General and to my office. Sometimes those reports concern fraudulent activities or violations by members of the insurance industry—our licensees. Under those circumstances, we must take disciplinary action against those licensees. Fraud is also a criminal act and it is prosecuted by the Fraud Unit of the Attorney General's Office. They receive those reports, and they do have a very aggressive program of prosecution and conviction.

Assemblyman Conklin:
For clarification, they receive the fraud reports from your office, or directly from the insurer?

Alice Molasky-Arman:
They receive those reports directly from the insurer.

Assemblyman Conklin:
There is another issue that concerns me. What is the rationale for asking an insurance company to be more aggressive in determining fraudulent activities? Does that create a propensity to deny a claim that should not be denied? I am concerned about the consumers. What is to prevent that type of action from happening if we are onerous in the detection of fraud? I recognize fraud is a problem.

Alice Molasky-Arman:
The insurers are the first line of defense to detect possible fraud. It is incumbent upon them to make those determinations. The concern for consumer protection will be satisfied by the amendment that is proposed by the Nevada

Trial Lawyers Association (NTLA), which will protect the interests of consumers who have committed no fraudulent act.

Assemblyman Anderson:
I was under the impression that fraudulent acts were referred to the Secretary of State's Office and the insurer would ultimately lose their license. This would be in addition to the actual criminal action. Is that where the "hammer" really falls?

Alice Molasky-Arman:
We do have a provision in the insurance code that requires us to report a final order by the Commissioner to the Secretary of State's Office if a corporate entity is the insurer committing the unauthorized act. The result is their corporate status is effectively revoked. When we find fraud on any matter relating to the insurance code, we take administrative action to suspend the licensee during the process, and ultimately we can revoke the license. That is an administrative action; it is not a criminal action. The Attorney General has the sole authority to prosecute for insurance fraud.

Assemblyman Anderson:
I was under the impression that there were certain providers that the insurance companies dealt with and determined their actions resulted in fraudulent activity. They would be prosecuted for the fraudulent activity and also could potentially lose their business license through the Secretary of State's Office. How does it all fit together?

Alice Molasky-Arman:
I am not certain of the procedural aspects between the Office of the Attorney General and the Office of the Secretary of State. I do know with respect to our licensees, we do report fraudulent activities to the Office of the Secretary of State for action.

Assemblyman Settelmeyer:
On page 18, Section 24, I noticed the dental care providers frequency of financial examinations is currently every six months for the first three years, then once a year thereafter. You are suggesting changing the time frame to once in not less than three years. How did this suggested change come about? Would it be better to state that when the business is first established a financial examination should occur within the first six months, then thereafter every three years?

Alice Molasky-Arman:
When Section 24 was initially adopted we did not have the same aggressive financial reporting requirements for our insurers that we currently do. Our office is responsible for receiving and analyzing, on a quarterly basis, all the financial statements of our domestic insurers. That satisfies the six-month requirement. The three years is the maximum number of allowable years, but it does not limit the Division in conducting examinations. The existing requirements do entail enormous costs for both the Division of Insurance and the insurer. It establishes a normal schedule. If we were to discover through the financial analysis that there were problems, we would not hesitate to conduct an examination.

Chair Oceguera:
Are there further questions from the Committee? Seeing none, we will move to the amendments.

Alice Molasky-Arman:
The proponents for these amendments (Exhibit D) are present, but I would like to give the overview. The first amendment is to the NRS 681B.050. The sponsor is the Employer's Insurance Company of Nevada (EICN), which Mr. Ostrovsky represents. The amendment would delete subsection 3. Currently, that subsection prescribes the minimum loss ratio requirement for casualty insurers to be included in the line of business described in the insurer's annual statement. The amendment will require insurers to report their actual loss ratio instead of an inflated amount in the interests of full and accurate disclosure. The amendment will also further the goal of uniform reporting by all insurers without regard to minimum loss ratios, and it is in the best interests of the public.

Robert A. Ostrovsky, President, Ostrovsky and Associates, representing the Employer's Insurance Company of Nevada:
I do not have a lot to add except we do provide significant information to the Division under the NRS 688.270, which is the modernized method of establishing risk-based capital qualifications. The statute that is suggested for deletion is one that has been on the books for a long time. I do not want to say it creates conflict, but it gave two ways to report to the Division. The method we are proposing to leave in the statute is the one adopted several sessions ago. It adopted the standards of the National Association of Insurance Commissioners (NAIC), which is the modernized method used in all other states. It actually provides additional information and sheds more light on the financial stability of the company. The old method has been retained in the statute, but it should probably have been deleted when we added the new method.

Alice Molasky-Arman:
If you do not mind me going out of order, I would like to propose another amendment that has been sponsored by the EICN. It is our last amendment.

Chair Oceguera:
That is fine.

Alice Molasky-Arman:
It would amend the NRS 616B. The purpose of the amendment is to promote parity in the Workers' Compensation market by allowing the members of the self-insured association to obtain claims information from their association in a timely manner. The amendment requires the association to provide the claims information upon request of the member employer within 30 days. The member can then efficiently determine whether it wishes to place its Workers' Compensation coverage with another insurer or another self-insured association. This amendment does mirror similar requirements that are imposed upon private insurers pursuant to the NRS 687B.355.

Chair Oceguera:
We need clarification of the page number.

Alice Molasky-Arman:
The proposed amendment appears on page 12 of (Exhibit D). It is last in the packet because it relates to the NRS 616B, which in our bills appears last after provisions of the insurance code. This is in a different title of the law.

Robert Ostrovsky:
This requirement currently applies to all self-insured products. The providers must give their policyholders the loss information within 30 days. This amendment adds the requirement that an association of self-insurers must meet the same 30-day standard. Currently, the law says they must provide the information, but it does not give a time frame. This information is only provided to the employer who is buying the policy. He can then decide whether or not to give that information to his agent or other company for the purposes of bidding out the product for future policy price quotes. The self-insured employer's association was made aware of this amendment prior to this session, and they had no objection to it.

Chair Oceguera:
Are there any questions? [There were none.]

Alice Molasky-Arman:
The next amendment has been proposed by the Nevada State Medical Association (NSMA) and it appears on page 2. Mr. Matheis, the proponent, is here to answer questions. This amendment would add a new section to the NRS 683A that governs third-party administrators. This amendment specifically makes applicable to a third-party administrator the law which prohibits charging health care providers a credentialing fee to be included on a list or panel of approved providers. The proposed amendment is in response to issues the Division experienced regarding enforcement of the broad prohibition of charging these health care providers a credentialing fee by a third-party administrator that administers claims for a self-funded health plan.

Lawrence P. Matheis, Executive Director, Nevada State Medical Association:
In 1999, a law was passed that limited the ability to charge panel fees. The charging of fees began in the mid-1990s. Physicians and health providers were charged fees for their name to be listed as an approved provider. The practice was unfair. Several problems were identified and Senate Bill No. 99 of the 71st Session was passed which banned panel fees, by whatever name. That prohibition was placed in the NRS 695G in the managed care organizations section. Following the 71st Session, there were two managed care organizations that claimed, that even though they looked like managed care organizations, they were not. Therefore, they did not come under that statute. Assembly Bill No. 320 of the 72nd Session took the same language used in Senate Bill No. 99 of the 71st Session and applied it to the NRS 616B, 689A, 689B, 689C, 695A, 695B, 695C, and 695G. So, if any of the managed care organizations did not get the point that fee charging was prohibited, they should have after that law was passed. There was actually a challenge in court to the Division's enforcement authority. The court said it is the law, and the Division is the enforcer. You are directed to stop charging panel fees. That particular company did stop charging the fees.

However, last summer a number of physicians and providers filed complaints with the Division that they had received a new panel fee invoice. The Division found that there is one organization that claims it does not supply the network of a provider panel to a regulated entity so it is not covered by the statute. This amendment should cover that situation.

Alice Molasky-Arman:
I would like to add that in this instance where we found some resistance the defense claimed the organization was under the Employment Retirement Income Security Act (ERISA), and therefore, it was exempt. Our Division did contact the Department of Labor and determined that the ERISA preemption would not apply in these instances.

Lawrence Matheis:
I would like to thank the Commissioner and the Division for enforcing this law and identifying problems. It has been frustrating for all of us.

Chair Oceguera:
Are there any questions? [There were none.]

Alice Molasky-Arman:
The next amendment appears on page 3 of (Exhibit D), and its proponent is the Nevada Association of Health Underwriters, represented today by James Wadhams. This would amend our third-party administrator laws. It would delete the language in the NRS 683A.08528 that requires third-party administrators that have assets greater than $100,000 to submit annual, audited financial statements that are prepared by a Certified Public Accountant (CPA). This amendment was proposed because it appears that this statute has been very detrimental to smaller third-party administrators. This would remove the requirement for audited statements and replace it with reviewed financial statements. This burden on third-party administrators does tend to create a lack of competition in the third-party administrator marketplace.

James L. Wadhams, Attorney at Law, Jones Vargas, representing the Nevada Association of Health Underwriters, Anthem Blue Cross & Blue Shield, and the Nevada Independent Insurance Agents:
I would like to draw your attention to the language on page 4 that states the financial statement will still have to be reviewed by an independent CPA. There will still be independent oversight of their financial statements. We have found that there were third-party administrators that simply could not afford to do an audited financial statement. In many cases, they were not handling money, but processing claims on behalf of another entity. We have proposed this amendment to slightly lighten—not eliminate—the requirement. The amendment will change the word "audited" to "reviewed" financial statements. I would be happy to answer any questions.

Assemblywoman Buckley:
What is the difference?

James Wadhams:
I would have to defer to someone who represents accountants, but I believe there are three levels of a CPA's review. The most stringent level is audited, which requires the independent CPA to evaluate all of the transactions and verify the records for each of the underlying transactions. The reviewed statement requires a sampling and concludes that the financial statement is credible. The least of the levels is a compiled financial statement. In this case,

the CPA simply recognizes that the records that were presented to the CPA for review are in order.

Assemblywoman Buckley:
What is the cost difference?

James Wadhams:
For a small third-party administrator a fully audited financial statement is about $20,000; a reviewed statement is about $5,000; and, a compiled statement is fairly nominal since the review is the lightest of all.

Assemblywoman Buckley:
I am hesitant. We have had so many situations where people get "ripped off" because a company is not sound. I am wondering why an audit is such a big deal and whether this could create mischief. I am not convinced.

James Wadhams:
That is an excellent question. We have suggested that this entire section be reviewed. Third-party administrators are precisely that. They are acting on behalf of another entity. The Division has been diligent in holding the primary obligor responsible for the ultimate payment or claim, whatever it may have been. This financial review is a requirement for registration of the third-party administrator. It does not have to do with the monitoring of the solvency of the obligor and its ability to make the payment. The problem has been in the marketplace for third-party administrators. It has been constricted and only the largest third-party administrators have been able to stay in business.

Assemblywoman Buckley:
Who was it who got "ripped off" by a third-party administrator?

Alice Molasky-Arman:
It was an organization with initials.

James Wadhams:
It was L & H Administrators.

Alice Molasky-Arman:
Unfortunately, L & H Administrators was the third-party administrator for the State of Nevada's health plan.

Assemblywoman Buckley:
The issue of whether the insurance company itself is solvent is a separate concern. My concern is whether the third-party administrator who is handling

the claims begins to abscond with the money. Both are important issues, but they are separate issues.

James Wadhams:
That is the exact distinction. The third-party administrator is not handling the money; they are just handling the paperwork. They are still accountable to both their principal and, as a registrant, to the State. The issue is not the fiduciary accounts, which would not appear on the third-party administrator's operating statement. Trust accounts are not included in assets and liabilities. The audited financial statement of a registrant...

Assemblywoman Buckley:
You are confusing me even more. The third-party administrators are handling the paperwork. Are you saying this requirement does not apply to any organization that does not handle money?

James Wadhams:
I apologize. I do not mean to confuse you. We are trying to have the financial statement of the third-party administrator changed from a required audited financial statement to a reviewed one. I was only pointing out that the law does not require that the fiduciary accounts be audited at all. That would be done by an independent examination process.

Assemblywoman Buckley:
It might reveal problems within the company. I am not convinced that this would be good public policy for our State.

Assemblywoman Gansert:
I am looking at the language suggested for deletion. It actually had a threshold of size. You are suggesting that we remove all of the third-party administrators from the requirement of an audited financial statement versus just eliminating the requirement for the small third-party administrators.

James Wadhams:
The prior requirement stated if the total assets were less than $100,000 there was no requirement to supply an audited financial statement. The Commissioner has accepted the proposal that all third-party administrators will have a reviewed financial statement as opposed to making the distinction between them based on their business assets at the end of the year. The requirement will be the same for all third-party administrators irrespective of their asset size.

Assemblywoman Gansert:
I understand that. I was asking if there is a higher level of review for organizations that were larger. I am referring to those with more than $100,000 in assets. Should we suggest that those organizations under $100,000 be reviewed, and those over that threshold be audited?

James Wadhams:
That distinction certainly could be made. If we are going to have audited financial statements, it would be a more stringent requirement. The prior law did make a distinction based on size. The suggestion is all third-party administrators would have a reviewed financial statement.

Chair Oceguera:
Are there further questions? [There were none.]

Alice Molasky-Arman:
The next amendment appears on page 5 of (Exhibit D). The proponent of this amendment is the Nevada Trial Lawyers Association. I addressed this issue in my testimony on the bill. This includes the language that I have agreed upon. Matthew Sharp, the NTLA representative, is here to answer any questions.

Assemblywoman Buckley:
I have a question on this section itself. I do not understand why we even need this. Insurance companies already have a program to detect fraud. They have been coming to this Legislature for ten years urging the State to do more about fraud in the insurance industry. Why is the State mandating that a private business would have to set up a program, even though most of them already have one? As Mr. Conklin said, the insurance industry has been asking the State to do more on our part.

Alice Molasky-Arman:
Yes, most HMOs do have a program to detect fraud. Unfortunately, there have been too many occasions where our examiner has asked an examinee to review its anti-fraud program. The response has been, "We are not required to maintain one and if we do maintain one, it is proprietary and confidential." The Division wants the ability to make certain we have access to those anti-fraud programs to determine if they are being appropriately carried out.

Assemblywoman Buckley:
I do not know if I agree. It seems to be we are requiring these companies to do more paperwork and more regulation. This is an issue that they are already concerned about and working on. I do not understand why the State needs to put another mandate on these companies when they are already doing this.

Chair Oceguera:
We will hear from Mr. Sharp on this amendment.

Matthew L. Sharp, Attorney at Law, representing the Nevada Trial Lawyers Association:
The Commissioner has described the intent of the proposed amendment. From our perspective, if there is going to be a required program, any such program should be reasonable in its scope to detect and identify insurance fraud. We recognize that insurance fraud can occur on the part of both parties—the insurer and the insured. It is a problem and it should be dealt with. When you have a mandate to identify insurance fraud, it can become overzealous. In fact, it can have no correlation to actually finding insurance fraud, but it can have a distinct correlation to improperly enhancing the bottom line.

For example, a health insurance company in the State of Nevada had a department with a policy that any claim more than the insured's deduction was considered suspect. The claim was evaluated by that department under the guise of detecting fraud. The difference between the number of claims they were denying versus the number they were paying was considered a profit. The officials of the company were all given very large bonuses based on the amount each was saving the company. I do not think anyone here, including the Nevada Trial Lawyers Association and the Division of Insurance, wants to support this type of conduct. That is why we included in the language of Section 4 the statement that fighting fraud should not become a profit for the insurance industry. I would be happy to answer any questions.

Chair Oceguera:
Are there any questions? [There were none.]

Alice Molasky-Arman:
The next amendment has been proposed by Anthem Blue Cross & Blue Shield. It is on page 7, and Mr. Wadhams will answer any questions. This amendment would allow carriers a greater flexibility in offering small employers a suite of health plans with different participation rates and employer contributions. The Division has reviewed this amendment and they do agree with it.

James Wadhams:
The words that are added to this section are at the end of the first paragraph in subsection 1. It allows that products can be offered based on participation and contribution. For example, if an employer has 75 percent participation and the employer makes at least a 75 percent contribution toward the premium, a product can be offered. The existing language said that the carrier could vary the application of requirements for minimum participation based only on the size

of the small employers group. A carrier could have a higher participation level for smaller employers and a lower participation level for larger ones. We are suggesting that the decision to vary the application of requirements be allowed based on the product being offered. Therefore, if two products are offered, one may have a 75 percent participation rate and the other might have a 60 percent participation rate. It would be a method of changing participation rates to employers as well. The purpose of the original statute, which predated HIPAA, was to avoid insurers making changes in the participation rates to accommodate health risk characteristics. The statute has value and that value is preserved by allowing the decision to be made on products offered as well as on the size of the employer.

Assemblywoman Buckley:
Is this the "bare bones" insurance policy with stripped down benefits for small employers that we passed in the 68th Session?

James Wadhams:
No, it is not. These policies have to meet all the currently mandated requirements. Offering two products with different premium rates is an incentive for employers who are not buying insurance to participate in an insurance program. Typically, it is the small employers who have not been buying insurance policies. This is not a "bare bones" alternative. It would be the full benefit package, only varied by participation rates or contribution levels.

Assemblywoman Buckley:
I still do not understand the language. An insurance company serving small employers has 2 to 50 participants. If I have a small business with ten employees, how does this amendment change the status quo?

James Wadhams:
That is an excellent question. This would allow a carrier to offer an employer the same insurance options that Anthem Blue Cross & Blue Shield has offered in other states. The employer would have a choice of two suites of products. Suite A, at a 75 percent participation rate, might be a Preferred Provider Organization (PPO) or an HMO with a particular benefit structure. Suite B would have a lower participation rate and perhaps a slightly different benefit structure. However, both would have to meet the mandated benefits with slight variations. The concept would encourage an employer to buy insurance by purchasing the cheaper product. If an employer was only offered one suite, he may not choose to purchase insurance. The employees would still pick between the PPO and the HMO version of the insurance policy.

Assemblywoman Buckley:
Are you saying this cannot be done under the current law?

James Wadhams:
No, it cannot. Anthem filed a similar product with the Division, which reviewed it. They determined that the only ways participation can be varied is by the size of the employer group or by forming a subsidiary insurance company which would only offer the alternative product. I believe that is why the Commissioner has indicated that the Division felt constrained by the language to deny that offering, otherwise it would have been approved.

Chair Oceguera:
Are there further questions? [There were none.]

Alice Molasky-Arman:
The final amendment that has been proposed is number 6 on the list at the bottom of page 7. However, the proposed change in language is on page 10. This proposal was brought to us by the Nevada Independent Insurance Agents. It would change the number of day's notice requirement that a member of the self-insured association must give to the association. When the member employer elects to terminate its membership, the number of days would change from 120 to 90. This change would allow those employers who desire to leave an association a reasonable time to market their account in the voluntary market while providing the association with sufficient notice on the termination of that member.

James Wadhams:
This modification is a reduction from 120 days to 90 days. We would prefer to see that number at 60 days, so it would be comparable to another amendment that has been presented. This change would facilitate the movement of employers from the self-insured market to the fully insured market depending on their choice. The current law requires that the notice be so far in advance that the data a competing insurer might want to look at is not current enough to allow a quote to be made. This amendment allows the clients I represent, the insurance brokers, a better opportunity to find a carrier for an employer who chooses to leave an association.

Chair Oceguera:
Are there any questions? [There were none.]

Alice Molasky-Arman:
This concludes our presentation unless there are further questions.

Chair Oceguera:
I do not see any questions. Are there others wishing to testify in favor of A.B. 161? Is there anyone in opposition? Anyone wishing to speak from a neutral position on this bill? [There were none.]

Assemblywoman Kirkpatrick:
Can we have these proposed amendments in a mock-up form?

Chair Oceguera:
Yes, Mr. Ziegler will prepare one. I will have it distributed to all the members of the Committee when we receive it. I am closing the hearing on A.B. 161 and opening the hearing on Assembly Bill 260.

Assembly Bill 260: Revises provisions governing the portfolio standards of providers of electric service. (BDR 58-1050)

Robert Tretiak, Ph.D., Business Development Officer, representing International Energy Conservation:
International Energy Conservation is a company primarily engaged in energy conservation measures and reduction of fossil fuel emissions. For clarification, we make reference in our handout (Exhibit F) to companies that have become self-supplied in energy. We cite one example of a company, Barrick Mining, which was the first to do so two years ago. However, we are not affiliated with Barrick Mining. We also included a letter from Senator Townsend to the Public Utilities Commission (PUC) dated late 2005. We have not had an opportunity to confer with Senator Townsend on his position on this bill. In addition, we also have several other letters of support and comment that we have included in our handout. We do not represent any of those companies at this hearing.

Prior to 2000, a utility in Nevada only had one energy resource, fossil fuel. Two years ago, the 100 percent dependence on fossil fuel was reduced by including 15 percent renewable energy resources, with the possibility of meeting 5 percent of their energy resources through Energy Conservation Measures (ECMs). There are significant benefits for a state to have ECMs. It will save tax dollars by implementing energy conservation measures in state facilities. It will save $6 billion for the statewide energy deficit because of peak-load purchases at high prices. By reducing energy usage, a deflationary effect is reflected in energy prices. The ECMs will create Nevada jobs through installing facilities and commissioning, measuring, and verifying energy conservation measures. It will improve the general financial health of our two utility companies, Sierra Pacific Power Company and Nevada Power Company. The ECMs will also contribute to the robustness of the electrical energy supply.

Although the utility companies have always had a policy of paying for Renewable Energy Credits (RECs), they have not, in the last two years, deemed it appropriate to pay for Energy Conservation Measures credits. Two years ago, the term Portfolio Energy Credits (PECs) replaced the old term Renewable Energy Credits. Portfolio Energy Credits are basically environmental credits, given for reducing emissions, such as credits for reduction of sulfur dioxide, carbon monoxide, and carbon dioxide. There are reasons for environmental credits, but entities have to meet a specific standard. For example, the manufacturer has to cut down on pollution emissions, or a utility is supposed to reduce fossil fuel consumption. Often entities can meet those ECMs standards on their own, but if they cannot do so they have to purchase the credits from entities that have exceeded their own standard and have surplus credits to sell.

One of the unintended consequences of Assembly Bill No. 3 of the 73rd Session was that one-megawatt users who left the utility provider and installed their own generating plant also had to meet the PECs standard. Our organization believes they should be able to purchase PECs from their non-customers, because very often they have installed their own generating plant, they are their only customer. Therefore, they have no way to meet that PECs standard. Both ECMs and PECs provide a needed incentive to overcome the two main impediments to implementation of energy conservation, which are apathy and inertia of the status quo.

Our organization believes the free market should set the value of the Energy Conservation Measures PECs. By law, "green tags" [RECs] and "white tags" [Energy Conservation Measures PECs] can be purchased by a utility. For the utility provider to count Energy Conservation Measures PECs toward its Portfolio Energy Credits standard, the law states, "...it must directly reimburse, in whole or in part, the costs of acquisition or installation of the energy efficiency measure." The legislative intent at the time was to ensure that the utility made a financial contribution toward the cost of the ECMs since the credits from them were being counted toward the utilities' PECs standard.

The problem is the utility has taken an in-place rebate program—that partially reimburses customers for some of their energy efficiency measures—to give the utility 100 percent ownership of its customers' PECs. Senator Townsend, in his 2005 letter to the PUC said, that the narrow application of "...in whole or in part..." language undermines the intent of the legislation and retards, not advances, the development of these energy efficient measures and systems since customers would lose much of the incentive to install them.

We also included in our handout letters of support from an Energy Conservation Measures industry member, Energy Eye, and from several reputable and

responsible utility customers, such as Lexus of Las Vegas and the Molasky Group of Companies. We have received an email from Wal-Mart, Arkansas headquarters office, and the letter from Senator Townsend that I referred to earlier.

Although the Wal-Mart Corporation is in opposition to this bill because it does not go far enough, their General Counsel asked me to indicate to you that customers should receive all credits for energy efficiency; the utilities should receive none. Wal-Mart does not take any rebates from the utilities. There are a number of reasons why the customer should receive all of their PECs. The customer pays for the equipment or the retrofits or suffers economic sales loss in a demand response situation. The customer has already prepaid for the incentive in a utility line item rate. The customer gets penalized for having ECMs in place because they lose volume rate pricing. Since their energy consumption is down, they get bumped down to a lower level on the rate structure, and they end up paying a higher amount. The rebate paperwork that the utilities use to take the customers' right to their PECs is in such fine print that it puts the customer at an unfair disadvantage.

The solution is to utilize the free enterprise system. Free market pricing of Energy Conservation Measures PECs is the most efficient means of delivering the desired reduction of fossil fuel consumption and introducing innovation into the marketplace. Toward this end, the Energy Conservation Measures PECs must be owned by customers. The utility should only own those for which they pay in proportion to the amount that they rebate to the customer. I will take any questions.

Chair Oceguera:
Are there any questions?

Assemblyman Conklin:
A public utility can be considered a regulated monopoly. I am curious that you used the free market concept in your analysis. If the intent behind the legislation was not to provide incentives for people to save money in the long run by spending a little now, which is why they are offsetting a portion of the cost, then the rate payer would pay the full cost. The rate payer will end up paying no matter what because they will pay a partial cost supported by the utility. Someone else will eventually buy that credit. Therefore at some point, the credit will come back to the utility in the form of additional costs, which will add to the rate payer's bill. Your free market analysis is confusing.

Robert Tretiak:
There are several free market dynamics in play. By a reduction of energy usage, there will be a deflationary effect on the free market price because the reduction of usage will, in the long run, reduce the demand for energy. When someone puts in ECMs, they receive a rebate from the utility, but added to that are multiple layers of administration and marketing costs. Those marketing costs should be borne by companies that are selling the ECMs to the end-users. It will eliminate a lot of the utility costs. These utility costs are now being passed on to their customers. If enough PECs are put into the marketplace, the price for them will ultimately come down because there will be a free market in play. During the hearing on Senate Bill No. 188 of the 73rd Session, the question was asked, should there be some price mechanism that is defined by the law? The answer was the market should determine the price of the PECs. Currently, the market determines the price on the "green tags" [RECs]. When people generate electricity, they enter into a negotiated contract approved by the PUC to purchase those RECs. The same concept should be applied to the Energy Conservation Measures PECs. Does that answer your question?

Assemblyman Conklin:
I think we are talking about two different things.

Assemblyman Anderson:
Are you "harvesting" those PECs in a "bundling fashion" so you can market them to other groups that may not be able to make their ECMs standard? Or they may be short on PECs to meet their ECMs standard. Thus, you would be creating an artificial market.

Robert Tretiak:
There exists an evolving and expanding marketplace in this country for environmental credits. Credits are purchased by companies, from other companies who have a surplus, to meet their ECMs standard. The utility has a ECMs standard. They can meet their ECMS in one of two ways. They can put in "green" energy through the use of photovoltaic systems, but they do not do that. Typically, they purchase their PECs from another party. A customer supplying their own geothermal energy would sell their geothermal credits to the utility. The utility has the option of meeting their PECs by using 100 percent "green" energy sources. They do not have to do any Energy Conservation Measures. They are allowed to use ECMs because they are cheaper. For example, if a hotel saves power, they keep track of the amount. The amount of power they save should be measured and verified by a certified measurement and verification professional in accordance with national standards. Once that amount of energy is measured it becomes a commodity that can be sold in the free marketplace. The ECMs can be "bundled" by an aggregator and sold. The

Chicago Climate Change Exchange is going to start trading in these PECs. They can be sold to anyone. This concept gives the utility a free market method to set the price.

Assemblyman Anderson:
If the utility companies are currently able to meet their ECMs, why are we giving them any incentives at all? Why should we give them offsetting rebates? It seems like we would be putting a greater economic burden on consumers because ultimately the dollars will be coming out of their pockets, and we are not rebating back to them.

Robert Tretiak:
Two years ago, during the testimony of the Governor's Energy Advisor, it was stated that it was important to include ECMs as a component of the portfolio standard because the cost of a typical "green" energy generating source was three times as much as the cost of using fossil fuels for the energy source. The point was made that ECMs could also be put in for about one-third the cost of renewable energy. That is why ECMs were put in as a component of the portfolio standard. Those Portfolio Energy Credits earned from ECMs are currently being treated differently. If a hotel puts in ECMs and gets a rebate, the utility is taking all of their PECs. We are saying the utility should get 20 percent of those PECs and the hotel should get 40 percent of them because the hotel spends the money for the ECMs.

Assemblyman Anderson:
You are saying it will encourage the hotel to put in ECMs.

Robert Tretiak:
Yes.

Chair Oceguera:
Others wishing to testify in favor of A.B. 260? [There were none.] Are there those opposed?

Judy Stokey, Director, Government Affairs, representing Nevada Power Company and Sierra Pacific Power Company:
We are in opposition to A.B. 260. We have spoken to the bill's sponsor and we have spoken numerous times to Mr. Tretiak. We understand his reasons for wanting this bill to pass. The power companies at this time do not believe there is a compelling economic reason for us to go forward with this program. We believe it will be detrimental to our rate payers. We have a very aggressive energy efficiency and conservation program in place at the power companies. Two years ago, the importance of energy efficiency and conservation was

added to the portfolio standard because this Body wanted the utility customers to know how important it was for them to also participate in energy conservation. With our currently approved PUC plan, the utility companies are going to hit that 25 percent ECMs standard fairly quickly. We do not want to "water down" the Renewable Energy Credits by changing the program. I will answer any questions.

Chair Oceguera:
Are there any questions?

Assemblywoman Gansert:
You mentioned the power companies were close to the 25 percent ECMs standard. Where exactly are they?

Judy Stokey:
I do not have the exact number, but with our three-year action plan that we just filed and got approved by the PUC, we should be at the 25 percent level by 2008 or 2009.

Assemblywoman Gansert:
Is the amount you provide for rebates the same amount given for the RECs? Do you have programs for the ECMs?

Judy Stokey:
We have numerous rebate programs for Energy Conservation Measures for both residential and commercial users. The whole point of not paying 100 percent, which is the amount in this bill, is to pay the minimal amount possible to encourage consumers to buy more efficient energy consuming products, like an energy efficient refrigerator. If we were to pay 100 percent, everyone would be knocking on our door wanting us to buy brand new products. That would ultimately cost our rate payers more.

Assemblywoman Gansert:
Mr. Tretiak indicated that the cost for Energy Conservation Measures is about one-third of the cost of renewable energy sources. If you have renewable energy, it would cost three times more to reduce the amount of usage. Is that correct?

Judy Stokey:
It would depend on the program. I do not have an exact number, but it depends on which renewable energy source and which Energy Conservation Measure you are using for comparison.

Assemblywoman Kirkpatrick:
Is it true that it is through your "Sure Bet" program that the dollars go back to the contributors? Are there renewable energy programs that also get federal credits in addition to your contributions?

Judy Stokey:
Yes, that is true. We have spent or will spend close to $39 million just in the Nevada Power service territory alone over the next three years for energy efficiency and conservation programs. The "Sure Bet" is one of our most popular and cost-effective programs.

Assemblywoman Kirkpatrick:
I brought that up because I learned about it when I was trying to get the State and local governments to be more energy efficient. That is how I know you have these programs out there.

Chair Oceguera:
Are there other questions?

C. Kirby Lampley, Director of Regulatory Operations, Public Utilities Commission of Nevada (PUC):
Ms. Stokey covered some of the economic aspects. The PUC's position is that given the wide-open nature of the credits it would seem like it would be very difficult for the PUC to implement this type of program. It would apply to nearly everyone and we would have to come up with some method to measure and verify that the energy efficiency measures were being obtained as they were represented. For example, both Nevada Power and Sierra Pacific Power spent a lot of time and resources in verifying exactly the extent that their "demand-side" measures are effective and how they equate to energy efficiency. From our perspective, keeping track of all the potential people who would be involved in this program would be an accounting nightmare. We would have to hire additional people, and we would have to enhance our computer capability to keep track of all the different items. I will answer any questions.

Chair Oceguera:
Are there any questions?

Ray Bacon, representing the Nevada Manufacturers Association:
The concept behind this bill is clearly something which is beneficial to the State, but the actual implementation, when you are talking 100 percent compliance, is probably a goal that makes the program unmanageable. In California, they have a bill proposing a mandate to phase out incandescent light bulbs. They would require everyone to go to compact fluorescent light bulbs. That would mean we

would have this program in operation for every consumer. I am not sure that there are enough people in the power companies and the PUC to figure out a rebate program that is going to compensate everybody for every light bulb they change. If this program were to have some limits, such as a ten-megawatt reduction in load, or a time limit was placed on the program, maybe a workable program could be developed. At this point, you would be heading down the path of a bureaucratic nightmare. Personnel and labor costs would be more than the amount of savings. It does not look like it is a practical program as currently constructed.

Chair Oceguera:
Are there any questions? Are there others wishing to testify in opposition of from a neutral position? Not seeing any, I am closing the hearing on A.B. 260. Once again for the Committee, I want to reiterate that there will be no more "short" hearings in Commerce and Labor. Friday, we have nine bills on the work session. If you have a bill that you would like to see come out of this Committee, you should be talking to me. There are five or six bills scheduled for most of the upcoming hearings. We will also have a 6 p.m. hearing on April 2. There will be some long days. We are also going to start our hearings at 1 p.m. on most days. On Fridays, we will try to start immediately following the Floor Session.

Assemblyman Anderson:
On a couple of those Fridays, there will be a conflict between the morning and afternoon sessions. What is your intended time so I can leave enough time for members of the Judiciary Committee to get here?

Chair Oceguera:
We will work it out. We will probably start at 1 p.m.

[The meeting was adjourned at 3:29 p.m.]

RESPECTFULLY SUBMITTED:

_____
Judith Coolbaugh
Committee Secretary

APPROVED BY:

_____
Assemblyman John Oceguera, Chair

DATE: _____

EXHIBITS

Committee Name: Committee on Commerce and Labor

Date: March 21, 2007 **Time of Meeting: 1:45 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
AB 161	C	Alice Molasky-Arman, Commissioner of Insurance	PowerPoint Presentation
AB 161	D	Alice Molasky-Arman, Commissioner of Insurance	Proposed Amendments by members of the Insurance Industry
AB 161	E	Alice Molasky-Arman, Commissioner of Insurance	Proposed Amendments by the Commissioner of Insurance
AB 260	F	Robert Tretiak, International Energy Conservation	Bill Introduction and Supporting Documents