MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Seventy-fourth Session
February 27, 2007

The Senate Committee on Commerce and Labor was called to order by Chair Randolph J. Townsend at 8:02 a.m. on Tuesday, February 27, 2007, in Room 2135 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412E, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Randolph J. Townsend, Chair
Senator Warren B. Hardy II, Vice Chair
Senator Joseph J. Heck
Senator Maggie Carlton

COMMITTEE MEMBERS ABSENT:

Senator Michael A. Schneider (Excused)

GUEST LEGISLATORS PRESENT:

Senator Bob Coffin, Clark County Senatorial District No. 10

STAFF MEMBERS PRESENT:

Laura Adler, Committee Secretary
Kelly S. Gregory, Committee Policy Analyst
Wil Keane, Committee Counsel
Gloria Gaillard-Powell, Committee Secretary

OTHERS PRESENT:

Thomas J. Burns, Vice President, Cragin and Pike
Robert A. Ostrovsky, Employers Incorporated; Nevadans for Affordable Healthcare
George Ross, Nevada Self-Insurers Association

Jeanette K. Belz, Property Casualty Insurers Association of America
Redentor Villanueva, Quality Assurance Specialist, Office for Consumer Health Assistance, Office of the Governor
Danny Thompson, Executive Secretary-Treasurer, Nevada State American Federation of Labor-Congress of Industrial Organizations
John E. Jeffrey, Southern Nevada Building and Construction Trades Council
Gary Cooper, Chief Insurance Examiner, Self-Insured Workers' Compensation, Division of Insurance, Department of Business and Industry
Patrick T. Sanderson, Laborers' International Union Local 872
Donna Sweger, Supervising Attorney, Nevada Attorney for Injured Workers, Department of Business and Industry
Barbara Gruenewald, Nevada Trial Lawyers Association
Lewis Musgrove, Chair, Task Force on Prostate Cancer, Health Division, Department of Health and Human Services
Michael Hackett, Nevada State Medical Association
Jack Kim, Sierra Health Services, Incorporated; Nevada Association of Health Plans
Fred L. Hillerby, Renown Health; Hometown Health Plan
Helen A. Foley, PacifiCare of Nevada
Sabra Smith-Newby, Director, Intergovernmental Relations, Clark County

CHAIR TOWNSEND:
I will take a motion to introduce Bill Draft Request (BDR) 54-650.

BILL DRAFT REQUEST 54-650: Revises provisions governing the use of interpreters in judicial proceedings for persons with certain disabilities. (Later introduced as Senate Bill 165.)

SENATOR CARLTON MOVED TO INTRODUCE BDR 54-650.

SENATOR HECK SECONDED THE MOTION.

THE MOTION PASSED. (SENATOR SCHNEIDER WAS ABSENT FOR THE VOTE.)

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CHAIR TOWNSEND:
I will open the hearing on Senate Bill (S.B) 99.

SENATE BILL 99: Revises provisions concerning consolidated insurance programs. (BDR 53-1010)

SENATOR HARDY:
I introduced this bill at Thomas Burns's suggestion to clarify an inequity that exists.

THOMAS J. BURNS (Vice President, Cragin and Pike):
I am here to clarify and address the issues on S.B. 99. Under Nevada law, the losses that pertain to workers' compensation follow the sponsor of Owner Controlled Insurance Program (OCIP). We have been asked by our clients to amend the law. In 48 other states, the loss follows the employer of the injured employee. The only portion of the workers' compensation that an employer can control is their expense modification. Under the current law, they do not enjoy the experience or the credit that would follow them for future pricing on their workers' compensation. It penalizes the employers who are on an OCIP project under workers' compensation. It does not encourage those who are unsafe or have difficult loss history on OCIP projects to improve their safety. The purpose of this bill would be determining the loss experience of the owner or the principal contractor. The expense of the loss, or event, does not follow the employer and does not follow the employers' insurance companies. The insurance carrier would take care of adjudicating any claim that occurs under the OCIP regardless of the life of the claim.

SENATOR CARLTON:
Who is actually contributing to the premium and what are the percentages?

MR. BURNS:
The premium would be paid by the sponsor of the program, either the general contractor who has purchased the program, or the owner of the site.

SENATOR CARLTON:
The same person would pay the premium, but the loss modifier will go to the direct employer of the injured worker.

MR. BURNS:
That is correct.

SENATOR HARDY:
I should make a disclosure; Mr. Burns is the director of the Associated Builders and Contractors. He is an insurance agent that primarily deals with construction. I wanted to make that disclosure so I can vote on the legislation.

CHAIR TOWNSEND:
Mr. Burns, how many other states do this?

MR. BURNS:
Forty-eight states at present.

CHAIR TOWNSEND:
We will close the hearing on S.B. 99. With Senator Schneider absent, we will hold these bills so all of our Committee members can vote. We will open the hearing on S.B. 119.

SENATE BILL 119: Makes various changes to provisions relating to benefits for certain workers with injuries. (BDR 53-257)

ROBERT A. OSTROVSKY (Employers Incorporated):
I am in support of S.B. 119. I have passed out background documentation (Exhibit C) about how we arrived at the statute. In the Seventieth Session of the Legislature, this body passed S.B. No. 37 of the 70th Session and S.B. No. 38 of the 70th Session. The bills were in conflict relative to this section of the law. Previously there was a provision in the law that stated if the medical bill was under $500 you could close the claim administratively and the claimant had no right to appeal. Changes were made during that session which said the amount will be $300, and we want notice given to the claimant they have the right to appeal. The $300 and language change was put into one bill and the $500 and language change was put into another bill. Those changes are noted in the handouts.

In the 71st Session, the Legislative Counsel Bureau (LCB) made a change with the $300 limitation. If an individual is injured on the job, has medical care only with no loss of time from work and medical bills of less than $300, the insurer can close the claim administratively for life. Notice would then be given to the claimant affording the opportunity to appeal the decision. This modifies the lifetime reopening rights of an individual. In the handout is a copy of the medical

fee schedule, which lists the guideline the insurer uses for the termination of paying claims. This identifies the cost associated with each medical procedure.

The issue today is a policy decision regarding what the amount should be. Since 1999, the amount has been $300. The company I represent, Employers Incorporated, closed 1,631 claims in 2006 under the provisions of this law. There were no appeals other than individuals stating their claim was more than $300. In those cases, it was reversed without an appeal process because all the bills had not come in for that claim. In 2005, we closed 2,104 claims; in 2004 we closed 2,479 claims. The amount of claims we are closing as a result of the $300 limitation is actually going down. The cost of medical care is rising and fewer medical-only claims result in bills less than $300. If the dollar limitation had been set at $1,000 we would have closed an additional 1,254 claims in 2006.

If you go to an emergency room, the charge will be close to $1,000, so you would not fall into the provisions of this bill. This bill is meant to cover people who have minor injuries and end up at their own physician's office, or referred to a clinic. Without the law, we would be carrying those claims for the life of the claimant. We would like the Committee's consideration in raising the number. We are not asking for any change in the claimants' right to appeal.

SENATOR CARLTON:
How would these affect self-insured groups?

MR. OSTROVSKY:
Self-insured employers, self-insured groups and the fully insured would all fall under the same rule. They are able to close claims under $300 and they would continue to do so at whatever number this Committee determines.

GEORGE ROSS (Nevada Self-Insurers Association):
We want to be on record of supporting S.B. 119.

JEANETTE K. BELZ (Property Casualty Insurers Association of America):
We support this bill.

REDENTOR VILLANUEVA (Quality Assurance Specialist, Office For Consumers Health Assistance, Office of the Governor):
I want to go on record in support of the bill.

DANNY THOMPSON (Executive Secretary-Treasurer, Nevada State American Federation of Labor-Congress of Industrial Organizations):
Once a claim has been closed it cannot be reopened. Workers' compensation insurance is designed to protect the employer and the employee, returning the employee to work. It is a no-fault system and you cannot sue your employer. I believe the amount needs to be left as is. Most people do not go to an emergency room. Many employers have agreements with physicians of their choice. The physicians have to agree to a deflated scale.

I want to go on record in opposition of this bill. We think raising the amount to $1,000 is too high. Once this is done, those claims cannot be reopened.

JOHN E. JEFFREY (Southern Nevada Building and Construction Trades Council):
We are opposed to the bill for the same reasons Mr. Thompson stated. If someone goes to the emergency room, the bill will be over $1,000. With the amount set at $1,000, I am afraid you will have a lot of claims where there will be problems at a later date.

CHAIR TOWNSEND:
Does anyone have the numbers of the medical consumer price index (CPI) between then and now? Do we have any indication what the medical CPI would be?

MR. OSTROVSKY:
The information was collected when the fee schedule was developed.

CHAIR TOWNSEND:
Could you provide the information to this Committee, Mr. Thompson and Mr. Jeffrey? We need the medical CPI from the time the bill was passed to now.

SENATOR CARLTON:
Employees know how to work the system with attendance polices. I would be apprehensive because of the way this bill is written. It may cause an employee to use lost time in order for this to not apply to them.

MR. OSTROVSKY:
They would have to lose a total of five days over the required period of time in order to get the lost-time benefit. Some people have learned to manipulate the

system. I will also make sure the Division of Insurance submits something in writing so you have backup documentation so the Committee can make the policy decision.

GARY COOPER (Chief Insurance Examiner, Self-Insured Workers' Compensation, Division of Insurance, Department of Business and Industry):
The National Council of Compensation Insurance may have statistics of claims between $0-$500 and $500-$750. They may be able to provide information for medical-only claims.

PATRICK T. SANDERSON (Laborers' International Union Local 872):
I am speaking as a retired laborer. I understand closing the medical claims needs to be done but sometimes a small injury can turn into something major. It is not easy to reopen a claim. The way the bill stands is not good.

DONNA SWEGER (Supervising Attorney, Nevada Attorney for Injured Workers, Department of Business and Industry):
We are opposed to this bill. We have two reasons for opposing this bill. First, the claim cannot be reopened if it is closed under this statute. The employers' insurers have a benefit by opening claims under workers' compensation. It is a no-fault system. I have had cases where injured workers did not get benefits they were entitled because the claim could not be reopened. Doctors frequently take the most conservative treatment telling the injured worker to check back in three months. The claim can be closed if it is less than $300, but the doctor could decide the injured worker needs surgery relating to the industrial injury when they are seen at the three-month appointment. The injured worker was unable to receive the surgery, and the claim was closed forever. The injured worker would have to pay for the surgery out of pocket.

Regardless of the medical bills, the fee schedules differ, and that is my concern. The insurance reimbursement is different from what the worker would pay for the same treatment. If an injured worker has his case closed, but the doctor supports further treatment on a claim, that is an issue.

SENATOR TOWNSEND:
Ms. Sweger, an example of your scenario would be an injured worker needs surgery three months after the case is closed; the injured worker would now be responsible for the charges. This is an entirely different issue. Mr. Thompson,

do you understand what I am trying to say? I am trying to find a way to help claimants who legitimately have had this happen to them.

MR. THOMPSON:
The worker would be charged the billed amount and not the discounted rate in the medical fee schedule. The missing point is insurance companies would not pay the claim since it was related to the workers' compensation claim.

CHAIR TOWNSEND:
How can we keep a time frame open so a claimant does not have to pay the bill charges?

MS. SWEGER:
I have had several cases where there were misdiagnoses or in order to cut costs, diagnostic tests were not done. There are many examples where claims have been closed and then later discovered the claimant needed more treatment.

BARBARA GRUENEWALD (Nevada Trial Lawyers Association):
We oppose this bill because the claimant would not be able to reopen the claim. I have two examples. First, I had a police officer who was with the canine division. He was doing exercises with a dog and was bitten. He went to an emergency room where he was sutured. The bill was under $300. He ended up with nerve damage in his ring finger. This is an example where he could have problems later. If you raise the amount to $1,000, the claimant would not be able to reopen his claim.

In another example, a temporary worker was doing inventory for a company that sold potato chips. She suffered an eye injury when Cajun spice from a vat of chips got into her eyes. She thought she was having an allergic reaction. An optometrist said it was not an allergic reaction, but a chemical reaction. Unfortunately, the correct treatment was not rendered. Because of the damage to her eye caused by the wrong treatment, she cannot wear contact lenses. She needs this case reopened so she can continue to get eyeglasses.

These are only two examples where the original claim was for a small amount but the injured workers should be allowed to have the right to reopen their cases. Because of the above examples and the fee increase, we oppose this bill.

CHAIR TOWNSEND:
We will close the hearing on S.B. 119 and we will open the hearing on S.B. 113.

SENATE BILL 113: Requires certain policies of health insurance and health care plans to provide coverage for annual screenings for prostate cancer in certain circumstances. (BDR 57-333)

SENATOR BOB COFFIN (Clark County Senatorial District No. 10):
I am here to present S.B. 113 concerning coverage for prostate cancer. We have living proof of why we should be concerned about prostate cancer as two of our last three governors have had the disease. It is time for intervention by those who set public policy. From the insurance carriers and those who administer health plans, you will hear their cause which will save a few pennies a month if you turn down this bill. The prostate-specific antigen (PSA) test needs to be done in conjunction with the digital-rectal exam. The PSA test might not be reliable on its own; therefore the digital-rectal exam needs to be done also.

LEWIS MUSGROVE (Chair, Task Force on Prostate Cancer, Health Division, Department of Health and Human Services):
I am a 15-year survivor of prostate cancer. I started the Las Vegas US TOO support group and am involved on a national basis. The US TOO is the largest prostate cancer support organization in the world, having over 330 chapters. I have the privilege of being chairman of the board.

Prostate cancer is called the silent killer. There are no outward signs of the disease. There are two tests for prostate cancer, PSA blood test and digital-rectal exam. The PSA is not a perfect test, but it has been demonstrated to show it is a better test than the mammogram for women. Early detection saves lives so we need testing at an earlier age than the Centers for Disease Control and Prevention (CDC) recommendations of 50 and 45 years of age for high-risk patients. The CDC is bound by law to follow the recommendations of the United States Preventative Services Task Force. They say there is no proof that early detection saves lives because they have no long-term studies. I call your attention to my handout (Exhibit D) with facts and figures for breast and prostate cancer. The handout shows that deaths from prostate cancer have gone down from 41,800 to 27,350 over a 10-year period from l997 to 2006.

I would like to call your attention to page 2 in my other handout (Exhibit E). The findings were taken from the *Journal of the National Cancer Institute*. How fast the amount of PSA in a man's blood increases is an accurate gauge of tumor aggression and danger according to new research. We are recommending men age 40, not 50, have their PSA checked to develop a baseline to compare future changes. A slight rise in the PSA may indicate a potential for cancer down the road. The National Comprehensive Cancer Network is an alliance of 20 of the world's leading cancer centers. They have recently changed their recommendation for screening to age 40. The Prostate Research Institute is recommending age 40 and 35 for screening. The National Alliance of State Prostate Cancer Coalitions screening recommendations are also age 40 and 35.

We are asking for screening at ages 40 and 35 in the bill, to establish a baseline PSA. A change in the PSA number is more important than the number itself. We want all men in the State of Nevada to know their PSA number and to keep track of it on an annual basis.

MICHAEL HACKETT (Nevada State Medical Association):
I am here today representing the Nevada State Medical Association and we are in support of this bill. We feel an ounce of prevention is worth a pound of cure. With breast and cervical cancer screening for women being a part of any kind of insurance coverage they have, we feel the prostate cancer screening process should be part of any coverage a man has. The American Cancer Society also supports this bill. Unfortunately, they were not able to have a representative present for the hearing. They have provided a copy of what they would like to have put on the record (Exhibit F).

ROBERT A. OSTROVSKY (Nevadans for Affordable Healthcare):
Nevadans for Affordable Healthcare is made up of over 300 small employers statewide. I have concerns with this bill. One concern is the issue of mandates. The mandates apply to small employers and do not apply to large employers, all of which are self-insured. The State does control the benefits payable by insured policies to small groups and individuals. We have and will continue to oppose mandates. We do not oppose the testing for prostate cancer and believe it is an important issue for men. All men should understand the risk involved in not being tested.

JACK KIM (Sierra Health Services, Incorporated; Nevada Association of Health Plans):
We oppose mandates. This bill mandates the testing standards to Nevada standards rather than national standards. We use national guidelines. The American Cancer Society has testing guidelines of age 50 and 45. This bill sets a standard of practice for physicians in the insurance statute. The standards of practice on clinical exams are changing, but if we are tied into one standard we are stuck. If this Committee wants to pass the bill, then tie it to national guidelines or standards. The change will then be supported by scientific evidence and we can change our coverage. We also have issues with the provisions of co-payments and deductibles. It would be hard for our company to administer the different tests covered under one co-payment.

FRED L. HILLERBY (Renown Health; Hometown Health Plan):
I would like to call your attention to page 2, line 29 of the bill. The insurance statute mandates coverage by saying what the annual screening must include. That is out of our control as an insurance company. If the physician does both the PSA and the digital-rectal examination, then it will be covered under this plan. If the physician does not do the tests, then you are mandating practice standards through this type of legislation. We do not require prior authorization but there must be some organizations that do or the language would not have been written this way. The way the bill is written, will be very difficult for us to administer.

CHAIR TOWNSEND:
Mr. Hackett, has the Nevada State Medical Association given you any concerns about dictating an insurance statute? Mr. Hillerby brings up a point that needs to be addressed.

MR. HACKETT:
No, they have not stated any specific concerns. In a general sense, they understand the acts that go along with mandating any type of early screening or early intervention. The physicians feel this is very worthwhile and something that really should go forward.

CHAIR TOWNSEND:
Telling a physician the type of thing you are going to use was the point Mr. Hillerby brought up. Doctor Heck could give us insight. We generally do not state in the insurance statute the actual type of test that is going to be done.

HELEN A. FOLEY (PacifiCare of Nevada):
We echo the comments of the previous speakers. The colorectal cancer screening coverage that was passed a few years ago said we had to follow guidelines which are published by the American Cancer Society or other guidelines published by nationally recognized professional organizations which include current or prevailing supporting scientific data. We believe this is better language than what is currently being proposed and will allow the flexibility to change with the times.

SABRA SMITH-NEWBY (Director, Intergovernmental Relations, Clark County):
Clark County is opposed to this bill, but just a couple of portions. The deductible and coinsurance should not be mandated in our view. We do not track the race of our members so the provisions that apply directly to African-Americans are troublesome for us. It would require us to start tracking the race. We do cover PSA testing on members 40 and older.

CHAIR TOWNSEND:
How many people are covered in Clark County under your plan?

MS. SMITH-NEWBY:
I am not sure.

SENATOR HECK:
Insurance mandates are always a difficult issue for me, being a physician. This bill poses some concerns that have already been addressed, but I want to give my take on them. Putting a standard of practice in an insurance statute is a concern of mine. It is important to remember the vast majority of these tests are not done by a specialist, but by the family practitioner. The PSA test does have a high rate of false positives and I am concerned about the follow-up tests that are done to chase down a test that is a false positive. It could be an ultrasound or repeated blood work and these tests could drive up the cost of health care. The more mandates we have, and Nevada has 50, each one of them could add 1 percent to the price of the policy. This could price people out of having health insurance altogether.

My concern is not only with this bill, but other mandates we pass as it excludes Medicaid. How can you say this is a standard of care for somebody who can buy insurance, but it is not the standard of care for someone whom the State pays for insurance? We put the burden on the private insurer, but we do not

take care of those for whom the State is responsible. I have a problem with two different standards and hope we can work out something.

Chair Townsend:
The hearing of the Senate Committee on Commerce and Labor is now adjourned at 9:36 a.m.

RESPECTFULLY SUBMITTED:

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Gloria Gaillard-Powell,
Committee Secretary

APPROVED BY:

_____
Senator Randolph J. Townsend, Chair

DATE:_____