MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Seventy-fourth Session
March 20, 2007

The Senate Committee on Commerce and Labor was called to order by Chair Randolph J. Townsend at 8:01 a.m. on Tuesday, March 20, 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 Michael A. Schneider
Senator Maggie Carlton

STAFF MEMBERS PRESENT:

Gloria Gaillard-Powell, Committee Secretary
Kelly S. Gregory, Committee Policy Analyst
Wil Keane, Committee Counsel
Marsheilah D. Lyons, Principal Research Analyst
Scott Young, Committee Policy Analyst
Jeanine Wittenberg, Committee Secretary

OTHERS PRESENT:

Valerie M. Rosalin, R.N., Director, Office for Consumer Health Assistance, Office of the Governor
Lawrence P. Matheis, Executive Director, Nevada State Medical Association
Fred L. Hillerby, Nevada Optometric Association
Keith L. Lee, Nevada Board of Contractors
Margi A. Grein, Executive Officer, State Contractors' Board
Jeanette K. Belz, Liberty Mutual Insurance Group
Gary E. Milliken, Associated General Contractors, Las Vegas Chapter
Robert A. Ostrovsky, Employers Holdings, Incorporated

Kate Diehl, Property Casualty Insurers Association of America
John Wiles, Division Counsel, Division of Industrial Relations, Department of Business and Industry
James Wadhams, American Insurance Association
James M. Livermore, Alternative Service Concepts
Danny L. Thompson, Nevada State AFL-CIO
John E. Jeffrey, Southern Nevada Building and Construction Trades Council
Barbara Gruenewald, Nevada Trial Lawyers Association
Nancyann Leeder, Nevada Attorney for Injured Workers, Department of Business and Industry
Patrick T. Sanderson, Laborers Local No. 872

CHAIR TOWNSEND:
I will now open the hearing to Senate Bill (S.B.) 280. This bill is on behalf of the Legislative Committee on Health Care (LCHC).

Who was the chair of that committee?

SENATE BILL 280: Revises provisions related to patients' bills. (BDR 54-303)

MARSHEILAH D. LYONS (Principal Research Analyst):
Senator Washington was the chair. He asked that I introduce this bill for him this morning.

As a staff member of the Legislative Counsel Bureau, I may not advocate or oppose any legislation that comes before this or any other body.

Senate Bill 280 basically does two things; it requires that a provider of health care give an itemized bill to a patient within 120 days, and tries to clarify that licensed hospitals and their billing requirements are already covered under *Nevada Revised Statute* (NRS) 449.243.

VALERIE M. ROSALIN R.N. (Director, Office for Consumer Health Assistance, Office of the Governor):
I have provided the Committee with a copy of my written testimony (Exhibit C). This bill would fix problems for some because providers would now have a billing timeline to consumers.

SENATOR HECK:
We spent a fair amount of time on this bill in the interim on the LCHC. Why did your office submit the original version of your bill to the Assembly? We now have two competing versions, and I thought we reached agreement in the LCHC.

MS. ROSALIN:
When we testified before the LCHC, we proposed this timeframe. There were multiple time frames discussed and we did not know the bill was accepted by the LCHC with our original proposed timeframe. That is why we submitted our own bill, Assembly Bill 40.

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

SENATOR HECK:
I would beg to differ. Right now I am reading the minutes from that work session. In those minutes, it states that the recommendation to submit the bill with the provisions agreed to by all present was made and unanimously passed by the LCHC. I am concerned that we now have two competing bills taking up time in both Houses when we came to consensus in the LCHC.

MS. ROSALIN:
I apologize, I was not aware of that.

CHAIR TOWNSEND:
I am looking at both bills on this. It appears you used up one of your bills in a competing manner and apparently the LCHC thought everyone had agreed to S.B. 280. Is my understanding correct?

MS. ROSALIN:
It was not our understanding that these two bills had gone forward. It was only after we started looking at the bill drafts that we saw the second bill.

SENATOR CARLTON:
Ms. Rosalin, of the billing complaints you receive, how many are hospital related?

MS. ROSALIN:
The information I provided to you is both hospital and provider. I will get the hospital-only information to you.

SENATOR CARLTON:
I am interested in that information because if we are going to exempt hospitals, I want to make sure they are not the biggest problem. I want to make sure we are addressing the one that causes the biggest concern.

CHAIR TOWNSEND:
Senator Heck, do you have any insight on what Senator Carlton just asked?

SENATOR HECK:
There was discussion regarding hospitals. James Wadhams, the representative of the Nevada Hospital Association, presented information that the hospitals are already required under other statutes to bill in a timely manner. Therefore, including them in this bill was not necessary.

CHAIR TOWNSEND:
Ms. Lyons, is Senator Heck's recollection correct?

MS. LYONS:
Yes.

LAWRENCE P. MATHEIS (Executive Director, Nevada State Medical Association):
We do not disagree with the intent of the bill. We cannot support this bill as written because there are a lot of occasions where there are provider insurance contracts that simply do not allow direct billing to the patient until the payer has made determination on a bill. Address changes for patients are an issue and the provider may not be able to get a correct address for the patient within this 120-day timeline. The issue, as discussed at the interim LCHC hearing, was primarily about a few cases that Ms. Rosalin was able to present. These cases were about collection agencies that approached patients several years after services were rendered and the patient was unaware of a financial obligation. Really, the clock for the provider should start when a determination is made by the payer. In the case of Medicare, federal rules would override state rules. The recurring problem is, before we make this change, how many cases are we really talking about and what are the details?

SENATOR CARLTON:
A few years ago we were having discussions about doctors waiting too long for payment. If we look back at those conversations and then add something like this to it, it will take even longer for them to get paid, especially if you want the clock to start after the payer determination.

MR. MATHEIS:
I do not think so because we tried to change the policies of dragging out claims processing through statute.

The real problem is that provider contracts prohibit direct patient billing until a determination is made. My concern is that there will be two clocks running and the provider has rendered services without having a way to recover payment.

SENATOR CARLTON:
The doctors want timely payment, yet they do not want to take responsibility for getting a bill out in a timely manner?

MR. MATHEIS:
No. If you start the clock before they are legally permitted to bill a patient, you have reduced the amount of time they have when they finally get all of the information they need to bill.

Most provider contracts do not permit simultaneous billing. The 120-day timeline is generally not a problem as long as we qualify the exceptions. I would be happy to work with the Committee on the exceptions. Mr. Hillerby has a suggested amendment (Exhibit D).

SENATOR HARDY:
I completely understand the amendment and the purpose. The only reason the 120-day time frame makes sense to me is the insurance issue. I cannot image any other scenario where the 120-day time frame to bill makes sense. If we accept the amendment, does it really need to be 120 days? Once the insurance is resolved, there would not be any other outstanding issues for billing the patient. Am I correct?

MR. MATHEIS:
Generally, yes, but there could be secondary-payer issues that could take time to resolve. That needs to be taken into consideration.

The issue that was presented to the LCHC was about patients being sent to a collection agency years after services were rendered.

SENATOR HARDY:
If we could find a timeline that makes sense, would you be averse to lowering the 120 days after the insurance issues have been resolved?

MR. MATHEIS:
I think the underlying problem and the reason these issues have to be reviewed session after session is that we have created a complex system to define coverage for health benefits. The case of a long-standing late bill that comes years after an event should appropriately be taken to a person's licensing board.

FRED L. HILLERBY (Nevada Optometric Association):
I have offered an amendment. Exhibit D addresses the insurance issue. I know that any time you set an arbitrary timeline for billing a patient, you want to have some ability to deal with unforeseen delays.

SENATOR HECK:
I appreciate Mr. Hillerby's amendment because I think it takes care of the biggest issues of health care professionals. For a few reasons, I personally believe the 120 days is reasonable. After the insurance determination is made and the provider has a balance to bill, sometimes the patient is no longer residing at the given address. If you have to bill and have the patient receive that bill in 120 days, there could be a lag in time trying to find current address information.

In addition, sometimes the health care professional is notified of the denial faster than the patient. If we move the 120 days up too much, the patient could be receiving a bill prior to receiving their explanation of benefits from the insurer. I think the 120-day time frame arrived at by the LCHC was an attempt to come to a fair compromise.

CHAIR TOWNSEND:
We will open the hearing on S.B. 279.

SENATE BILL 279: Provides express authority for the State Contractors' Board to collect and disseminate data and to conduct investigations. (BDR 54-624)

KEITH L. LEE (Nevada Board of Contractors):
I have provided the Committee with a proposed amendment (Exhibit E), which explains why we requested a bill draft and then at the presentation of the bill we are offering an amendment.

MARGI A. GREIN (Executive Officer, State Contractors' Board):
This bill is a result of challenges that the State Contractors' Board (SCB) has faced regarding dissemination of complaint information to the public. *Nevada Revised Statute* 624.327 was amended in 2003 concerning complaint information provided to the public. We do not provide any complaint information, only statistical data to the public so they are able to make informed decisions prior to hiring a contractor. We have been legally challenged for doing that and that is why we are asking for clarification that we can continue with our current practice. Section 1, subsection 4 allows the Board to investigate alleged violations without a formal written complaint being filed. This clarifies the past and current practice of the Board.

There is an incorrect date on page 1 of Exhibit E. The SCB actually approved the proposed amendment on February 22, 2007, not 2006. The first amendment requested is in section 4, subsection 5 and is basically a handyman exemption. Most of our surrounding states have an exemption for a handyman, but Nevada does not. We do have an exemption in statute for an apartment-complex owner, which was put in by Senator Washington in 2001. We are extending that to all work performed that is under $500.

CHAIR TOWNSEND:
Why was the amount of $500 chosen?

MS. GREIN:
That is the amount in statute for the apartment-complex owner. We debated between $500 and $1,000 and felt the public would be best protected at $500 or less.

SENATOR CARLTON:
Would this exempt a large handyman company that installs a microwave?

MS. GREIN:
If the work required a permit, it would require that they have a contractor's license.

SENATOR CARLTON:
No permit is required. It is just a simple handyman repair done by an employee of a large company.

MS. GREIN:
It would be up to the individual contractor if he wanted to maintain his license so he could perform work that required a permit, or a job above $500.

SENATOR CARLTON:
Is this aimed more at the sole proprietor?

MS. GREIN:
Yes.

Under existing law, the SCB's investigative staff is organized into two divisions: compliance investigations and special investigations. The reason for the proposed amendment in sections 5 and 6 is that it would combine those two divisions into one investigation unit so we can cross train and have multi-work groups.

SENATOR CARLTON:
Are the hiring criteria the same for the compliance investigators and the special investigators?

MS. GREIN:
No.

SENATOR CARLTON:
Does that mean you will have two different classifications within the one unit?

MS. GREIN:
We are not changing job titles. We are changing the type of work they do. As an example, a compliance investigator will not be allowed to issue a citation unless he has Peace Officers' Standards and Training (P.O.S.T.) certification.

This just allows us to have one department instead of two and would better organize our investigative unit.

SENATOR CARLTON:
I have concerns about having P.O.S.T. classified employees in the same division with non-P.O.S.T. classified employees and how we ensure the lines are drawn. We can discuss this outside the Committee.

MS. GREIN:
The purpose of the proposed change in section 7 is that currently the law requires all licensees to submit an application for any change in officers, directors, general partners, members and managers of limited liability companies. Our proposed amendment allows the SCB to partially exempt corporations from requirements to continuously report all officer changes. We are asking that we limit that to the qualifier of key executive officers including the president, secretary and treasurer or officers responsible for the licensee in this State. That will be helpful to the companies that have hundreds of officers that are not directly involved in Nevada business. While this would reduce some of our fees that are generated, on the other hand it will reduce our workload.

Also in section 7, subsection 4 we have added that the recovery-fund fee is due each year. Later in the bill you will see that we are requesting to go to a two-year renewal and license fee.

Section 8 states that the SCB has the ability to suspend a license for failure to maintain industrial insurance. We feel this will provide added protection for the employees of the licensee and the general public.

Existing law requires that the process for establishing financial responsibility and monetary license limits is listed under NRS 624.263. In section 9 of the proposed amendment, we have changed the language so it strengthens the minimum standards of what we are requesting and improves financial-status reporting.

In section 10 of the amendment, we are requesting that the renewal and license issuance is a two-year term rather than the current one year. This should reduce our paperwork by 50 percent.

Sections 11, 12, 13 and 14 give us another tool to use against unlicensed contractors. Currently, we can issue administrative citations to licensees or applicants. We cannot issue administrative citations to unlicensed contractors unless they are an applicant. We are requesting a misdemeanor offense if they

fail to pay a fine assessed through an administrative citation. This would relieve some of the backlog at the district attorney's office.

In section 15, existing law provides for annual renewals and fees. The proposed amendment clarifies the recovery-fund fee for each year of a two-year license renewal fee.

In section 16, existing law does not allow the SCB to impose fines against unlicensed contractors for unlawful advertising. The proposed amendment provides that authority.

SENATOR HARDY:
I have not had a chance to match your proposed amendment with the original bill. Do you want to maintain the portion of the bill relating to collecting and disseminating information and reports?

MS. GREIN:
Yes.

SENATOR HARDY:
I have always had a problem with convicting people before there has been a finding. At some point, I would like to speak with you about how this would relate to that. The majority of the changes in the amendment look good, but I still remain concerned about that issue.

MS. GREIN:
For clarification purposes, at the present time we report the number of complaints filed. We also have an allegation period for the first 20 days, which we do not report if the contractor corrects the problem. After that if a formal complaint is filed, when we report that information to the consumer or whoever has requested it, we also report the results of that complaint. For instance, if it is valid or invalid, we report both rather than just reporting the total number of complaints filed.

SENATOR HARDY:
Philosophically, I have difficulty with the way you currently do that. The intent of this seems to expand that, and I want a better understanding. I always get nervous when we talk about disseminating additional information based upon

complaints. You did indicate that you are just codifying what you are currently doing and if that is the case, then I am less troubled.

SENATOR SCHNEIDER:
I still have a problem with the $500 and think it should be $1,000. The typical homeowner compiles a list of things to be done at one time and does not necessarily call for repairs on each little thing as it comes along.

MS. GREIN:
Originally $1,000 was proposed and the SCB approved that amount. At second look, since $500 was already in statute, they decided to go with that amount. I cannot speak for the SCB, but they would probably accept what the Committee recommends.

CHAIR TOWNSEND:
It is my intention to hold a work session tomorrow on previously heard bills, including the bills we have heard so far this morning.

Michael K. Neschke faxed testimony for the record (Exhibit F).

JEANETTE K. BELZ (Liberty Mutual Insurance Group):
If the SCB moves to a biennial renewal, how will the workers' compensation insurance be verified?

CHAIR TOWNSEND:
We will take up that question in tomorrow's work session.

GARY E. MILLIKEN (Associated General Contractors, Las Vegas Chapter):
We have the same concerns of Senator Hardy regarding the validity of complaints.

CHAIR TOWNSEND:
Senator Hardy brought up an issue that has been before this Committee many times. It has come to our attention that releasing information on complaints has become a competitive tool in the construction industry. We have tried to be consistent through the years in terms of how all of the boards handle that information.

I will now open the hearing to S.B. 281.

SENATE BILL 281: Revises provisions governing industrial insurance. (BDR 53-1136)

KATE DIEHL (Property Casualty Insurers Association of America):
I have provided the Committee with a copy of my written testimony (Exhibit G).

ROBERT A. OSTROVSKY (Employers Holdings, Incorporated):
I can only speak for Employers Insurance Company of Nevada (EICON), relative to our history of benefit penalties (BPs), which I think is the heart of this bill. This section of the law was created many years ago for the purpose of substituting BPs for the former right of bad-faith litigation. It was the policy decision of this Legislature to remove that right from the claimant and instead substitute automatic BPs directly to the claimant for violations of the law.

In 2006, the EICON had 18 fines which totaled approximately $24,000. The company also had nine instances of BPs applied. Those BPs totaled approximately $100,000. Of the $100,000, only about $45,000 has been paid so far due to pending litigation. The company had no repeat BP violations assessed on a claim. However, because of the way the law is currently written, there were repeat violations assessed against the EICON. As violations for a company increase for repeat actions against all claimants, the amount of the penalty increases under the statute. To give you an idea of the magnitude, in 2006 the EICON had 5,065 either new or reopened claims. However, the EICON had 7,765 open claims due to the "tail" of claims from prior years. That means that the EICON had a little over 15 percent of the market and about 6 percent of the fines, assuming that all of the penalties are found to be appropriate.

As you know, the first BP starts at $5,000 and if you look back at the period of 2006, the EICON had a single BP of $5,000 paid to a claimant. According to statute, the next BP paid to any claimant has to be higher, up to a maximum amount of $37,500. The Division of Industrial Relations (DIR), Department of Business and Industry, which imposes the BPs, has some latitude in the statute as to the amount of the BP but has no latitude when it comes to "laddering up" the cost of the BPs. As an example, in 2006, we lost an appeals hearing that required us to pay 26 medical bills. Mistakenly, we only paid 25 of those bills and failed to pay a $36 prescription bill. Based on that, we had to pay the claimant $13,125 in BPs and a $1,500 administrative fine. It was "laddered up" to that amount because of prior violations. In another case, we were required to pay an injured worker $38,000 as settlement because the EICON has an internal

policy that any check over $30,000 requires two signatures. We made a mistake because the $30,000 check did not have two signatures. When the check was presented to the bank, they refused it because of the signature issue. We were notified and immediately reissued a second check with two signatures. This resulted in another BP of $20,000 and an administrative fine of $1,500. In this case, the claimant got $38,000 and an additional $20,000. We are not arguing the penalty, but think it was excessive based on the violation. The last example is that we failed to pay an $8.10 travel voucher which resulted in the EICON paying a $13,125 BP and a $1,500 administrative fee.

We are not taking a position that we should be relieved of paying BPs. We believe this proposed change in the statute will allow the DIR to make better judgments on what the appropriate level of penalty should be starting at $5,000 and not automatically starting at a higher level. We also think that if you take a claimant who has received a BP and make a second mistake on the same claim then the punishment should be greater.

MR. OSTROVSKY:
That is what this proposed change to the statute would do by inserting the words "in this claim" in addition to the language that already says "previously imposed."

If you are a self-insurer, the pattern of practice fines will still be referred over to the DIR or if you are an insurer, for a review of market conduct.

We would like to have the right to withhold payment if we are appealing at the district court level pursuant to NRS 616C.370, which is the judicial-review section.

The statute needs some certainty of what processing of a claim means. Accept and deny was the intent of the Legislature, and we feel putting in that language puts the onus on us to make that decision in a timely manner.

The heart of the bill is the question of should there be a windfall profit to a claimant, regardless of the harm done, just because of what may have previously been done to a claimant. We believe those issues are for the insurance commissioner to look at in terms of whether or not you are a suitable business in this State and not a question of how much should be paid to the individual claimant.

There are well over 250 insurers in this State but only 3 insurers represent about 75 percent of the insured businesses and we are 1 of those 3. All the rest of the 250 represent very small percentages of 1 to 2 percent or less of the market. We think the penalties are excessive if you consider the difference in volumes of claims between the 3 large insurers and the remaining 240-plus.

CHAIR TOWNSEND:
With the way the law is currently written, do you believe there is no flexibility other than going higher than the first $5,000 penalty?

MR. OSTROVSKY:
That is my understanding, but I think John Wiles could answer that better.

JOHN WILES (Division Counsel, Division of Industrial Relations, Department of Business and Industry):
It is our interpretation of NRS 616D.120 that the minimum BP is $5,000 and there is no latitude to go below that.

CHAIR TOWNSEND:
What is your understanding for the second violation?

MR. WILES:
We have addressed that in regulation and have developed a point system which adds exactly $1,625 to the minimum BP based upon the factors mentioned in the statute. One additional violation would be one more point and three or more violations would increase the BP higher as Mr. Ostrovsky referenced.

CHAIR TOWNSEND:
In regard to the $8.10 travel voucher error, is it your understanding that there is no flexibility relative to the severity of the issue?

MR. WILES:
We are required by statute to consider the amount of compensation due, but that is for the purpose of assessing a monetary amount greater than the minimum $5,000. In the case of the $8.10 travel voucher, we would not impose any additional BP based upon the compensation due, but we did increase the penalties based upon the number of prior violations.

SENATOR CARLTON:
Were the BPs put into statute before I became a part of this legislative body?

CHAIR TOWNSEND:
Yes.

SENATOR CARLTON:
In 1999, my first Legislative Session, we privatized workers' compensation and the BPs were already in statute. Have the BPs changed since then?

CHAIR TOWNSEND:
No.

SENATOR CARLTON:
The company that Mr. Ostrovsky is representing was an integral part of privatizing workers' compensation. They knew that the BPs were in statute. Is that correct?

MR. OSTROVSKY:
Yes. As a point of clarification, the statutes were changed to increase the penalties by 50 percent in the last Legislative Session.

SENATOR CARLTON:
You are looking for flexibility, yet there is no flexibility when it comes to the bad-faith argument of being able to sue over an incident. When I hear about 26 medical bills unpaid, you lost the appeal and had to pay them. It seems to me you would have been better off just paying the bills.

MR. OSTROVSKY:
It was not that we did not pay the 26 medical bills. The issue was the 26 medical bills were for a body part that the appeals officer later determined to be covered under workers' compensation.

SENATOR SCHNEIDER:
The company must handle tens of thousands of transactions a year. From what Mr. Ostrovsky describes, there were no malicious acts, just clerical errors. Is that correct?

MR. OSTROVSKY:
I would consider all of the examples I gave you, clerical processing mistakes. Egregious behavior by a claims examiner should warrant a greater penalty from the DIR. We understand that we are responsible for the actions of our employees and have an obligation to supervise them to ensure that behavior does not take place.

SENATOR SCHNEIDER:
Are you just looking for relief on the clerical errors?

MR. OSTROVSKY:
Yes, and I think what we are offering gives more latitude to the DIR in determining appropriate punishment without automatically having to "ladder up" the BP.

JAMES WADHAMS (American Insurance Association):
From a regulatory standpoint, I think the policy question you have been asked to consider is the separation of pattern of conduct and mismanagement versus errors on a particular claim. If management becomes abusive generally, there is a process for eliminating them from the market. If a claim has been mishandled, that is the purpose of the BP. Mixing the two should be taken into account by the changes represented in this bill.

JAMES M. LIVERMORE (Alternative Service Concepts):
We are a workers' compensation third-party administrator (TPA). I would like to address the issue of changing the language from process to accept or deny. I understand Ms. Diehl's desire for clarity and certainty, but I believe changing the language in that particular section goes against NRS 616C.065. It was changed in 2001 to remove the requirement of an administrator insurer to "accept" or deny a claim within 30 days. It was changed to allow flexibility for a third-party administrator to investigate a claim further. The requirement to "accept" was changed to become, "Commence payment of a claim for compensation or deny the claim and notify the ... administrator." The DIR put in regulations that require a determination to accept or deny the claims at some point later. Statute gives us the flexibility to simply commence payment when we know that an injured worker will be eligible for some benefits, but we are not certain of the extent of the injury. That statute is beneficial and helpful to us. I believe the language in NRS 616D.120 was changed at that time to accommodate the "commence payment" as opposed to accept or deny. Putting

accept or deny back in the language would be in conflict with NRS 616C.065. I would recommend an amendment to the language to simply state for clarity, "If the insurer refused to commence payment of the claim." That is plain and simple and fits into the existing statute while providing us clarity and certainty.

CHAIR TOWNSEND:
Ms. Diehl, do you understand Mr. Livermore's position?

MS. DIEHL:
We would have to look at the suggested amended language. I do not believe we would have a problem with the intent of the amendment. On the surface, it does not appear to be counter to our objective.

DANNY L. THOMPSON (Nevada State AFL-CIO):
In 1995, employees gave up their right to sue for bad faith. In place of that, a BP was put into statute. It all centered around a case where an individual was hurt and clearly it was a claim that should have been accepted. This case went all the way to the Nevada Supreme Court and they ruled in favor of the injured worker.

The BP was changed in the last Legislative Session because there were TPAs who were marketing themselves by telling employers they could save money by denying every claim. Of those denied, only 50 percent will appeal and of those 50 percent you will win 50 percent of the cases; therefore you will only pay on 25 percent of the claims.

This bill with the accept or deny language takes us back in time because it forces the claimant to go through the entire appeal process. In addition, they are forced to go to district court for conclusion.

I would like to propose an amendment to strike this bill and go back to bad-faith lawsuits. If you process this bill, the BP will not mean anything and you will force claimants back to losing everything they have before they can recover. It will also encourage the practices that caused the law to be changed in the first place.

CHAIR TOWNSEND:
The testimony was that approximately 3 companies do 70 percent of the business. Because of the voluminous nature of what they process, they will

make mistakes and pay a fine accordingly. I wonder why the other 30 percent who process 1 percent of the claims have not asked for this to be changed. They are the ones that would be hit harder financially by the BPs.

MR. THOMPSON:
I tend to look at things from the claimant's perspective. Consider this; you are injured on the job and there is some dispute. At that point your medical care is in dispute and unpaid, you go to your health care insurer and they send you straight back to your workers' compensation carrier. In the meantime, someone needs to be paying the bills. In most instances, the amount of money for bills incurred is more than the average person can pay.

Once contested, this bill forces someone to go through the entire appeals process including district court to get resolution.

SENATOR SCHNEIDER:
Do you have some language you could suggest regarding the clerical errors?

MR. THOMPSON:
We would be willing to talk about it. Realistically, this bill is not about clerical errors. This bill puts the claimant in a bad position. The district court aspect means an appeal could drag on for a very long time.

CHAIR TOWNSEND:
Is there something that we might be able to do to deal with this tremendously disproportionate thing that does not disadvantage the claimant? That is the key to this and I have given it a lot of thought and do not know how to do that. How do we get around things without diluting the value of the BP?

JOHN E. JEFFREY (Southern Nevada Building and Construction Trades Council):
I would caution the Committee to be careful about what kind of relief is granted in certain cases.

This bill does not talk about clerical errors, it talks about BPs. I feel good about this bill coming forward because there were no complaints when there was no remedy. Now that the DIR has the teeth to do what they need to, we are getting complaints. That tells me the law is working.

BARBARA GRUENEWALD (Nevada Trial Lawyers Association):
Previously, if there was one strike against the employer or insurer, we could go to court and sue in bad faith. That was taken away and now there are three strikes within five years. We would like it to remain that way.

Going to the DIR is the last resort that many claimants take after they have been continuously abused. Fines are how they get the attention of the insurance companies.

The issue I see the Committee wrestling with is that there must be a trigger to get to the BP. The Committee seems to have an issue with; is that BP going to be on an $8 medical bill that was not paid? I think before the Committee zeroes in on that, they need to go back and look at the history of everything that happened to get to that point.

Using the current words of refuse to process allows the DIR the flexibility to look at whether temporary total disability, permanent partial disability, a surgery or settlement was paid. If you take out those words and only put in refuse to accept or deny, then you are saying to the claimant you can only file a complaint with the DIR if the insurer refuses to accept or deny. The only other way you can file a complaint with the DIR is if you have finally gotten a hearing officer's or appeals officer's decision that was not enforced.

The entire process is working or the insurance company would not be here trying to change it. Please do not take away the only remedy the claimant has for the DIR to be able to look over the shoulder of the insurance company in ensuring they are doing what they are supposed to be doing.

CHAIR TOWNSEND:
Could you give me a percentage of how many claimants come to you as a result of a problem with a private carrier, versus a TPA or versus a self-insured?

MS. GRUENEWALD:
There are some companies whose claims examiners' names I see a lot. This whole process is designed to protect the claimant from the claims examiner that goes on a power trip. I personally think it is more the particular claims examiners rather than a pattern of abuse of an insurer.

CHAIR TOWNSEND:
I just wanted to make sure there was not a pattern from any particular group.

NANCYANN LEEDER (Nevada Attorney for Injured Workers, Department of Business and Industry):
In our experience, we go through the hearings and appeals process before going to the DIR. When that occurs, the DIR has an option of naming a clerical error, a minor violation. This does not allow for the possibility of a BP. In addition, the DIR can find that some action taken was reasonable. Unless it is classified as unreasonable, there is no BP. There has to be a fine to get a BP. Once the BP and fine are assessed, that can be appealed by the insurer. In the process of the appeal, there is negotiation. In most instances we are involved in, there is a negotiation which involves severe, gross diminution—gross in magnitude, not in value judgment—in the fine and BP.

In section 1, subsection 1, paragraph (d), change to the words "accept or deny" will severely restrict the parameters of the law. In 1995, this legislative body decided the method of enforcing timely administration of claims payment and production of benefits to injured workers was going to go through this process and not bad faith. Therefore, if you change the process to accept or deny, you will not in any way be affecting what would have been bad faith and what is currently in all of the methods of insurance. Bad-faith claims management would now no longer be included.

CHAIR TOWNSEND:
The worry I have about adding "accept or deny" is that it is easier to deny to comply with the law and make sure there is no fine. When we initially worked on this legislation, we continually argued that we did not want to put the claimant in a position of having an insurer simply say, "We cannot figure it out and the date is too close, so we will deny." We were trying to avoid putting the burden back on the claimant by having to appeal. Is my recollection correct?

MS. LEEDER:
Yes.

SENATOR HECK:
For entities that I consult with, they do not accept a claim, but pay it under medical investigation until final determination is made. If the proposed

commence-payment language offered by Mr. Livermore was adopted, would that alleviate the concerns of accept or deny?

MS. LEEDER:
No. The word "process" includes many other things besides accepting or denying. In our statutory structure, the word "compensation" does not mean money. Compensation is any workers' compensation benefit. As an example, if an appointment with a physician is ordered to be scheduled and is not, that is not processing the claim but it would not be included in accepting or denying the claim.

Through the normal hearing process, we would attempt to get the appointment scheduled and treatment authorization. If that were not done, there would be a complaint to the DIR which would be included in "process" but not in "accept or deny."

SENATOR CARLTON:
Earlier you said in all this discussion of flexibility and clerical errors, there was already a way to solve that and we did not need a remedy. Could you explain that remedy?

MS. LEEDER:
We see cases involving clerical errors but do not win them because they are minor violations and they do not produce a BP. The DIR classifies certain things as minor violations or, alternatively, as reasonable errors.

SENATOR CARLTON:
Is that the discretion of the DIR?

MS. LEEDER:
Yes.

In section 1, subsection 3, line 12, the insertion of the words "in this claim" would mean that an insurer or TPA which repetitively does not clarify their procedures would continue making the same errors harming many injured workers.

In section 1, subsection 3, line 28, there is a reference to NRS 616C.370. This is the reference about having to go to district court. Currently, the procedure is

to go to the appeals officer, that is the reference to NRS 616D.140. In my opinion, the addition of the language would be ambiguous because it means either the appeal has to be filed to the appeals officer or district court. Alternatively, it could mean it goes to the appeals officer and then to district court.

SENATOR HECK:
Mr. Keane, this goes back to my previous question regarding changing the language to commence payment. In NRS 616A.090, compensation is defined as money payable. Do you believe a claim for compensation as listed in this bill would apply to things other than money as was suggested?

WIL KEANE (Committee Counsel):
"Thank you, Senator. Compensation is defined as money payable, but I would want the chance to confer with witnesses more to look into what they are saying."

SENATOR HECK:
I would appreciate that.

MS. LEEDER:
Nevada Revised Statute 616A.090 also says accident benefits, and if you look at accident benefits in NRS 616A.035, it states medical benefits. There is also a Nevada Supreme Court case which further explains it. The word "compensation" in Nevada means medical benefits and medical care in addition to monetary benefits.

MR. OSTROVSKY:
To correct the record, I noticed when the Chair spoke he quoted me as saying 75 percent of the insurance is written by 3 companies. I misspoke, it is 35 percent. Seventy-five percent is covered by the top twenty companies. The largest company is the EICON, followed by American Home Insurance Agency, Incorporated and then Builders Insurance Company, Incorporated.

PATRICK T. SANDERSON (Laborers Local No. 872):
After 40-some years of working construction, I have had plenty of my own workers' compensation claims. When you cannot get your claims paid or proper medical care, it ruins your whole life, not for a short time but often for the rest of your life in the construction trades. This is the second workers' compensation

bill this year and in my mind the workers' compensation companies are not happy with the amount of money they are making. There are 276 companies in this State that are selling workers' compensation insurance. If they were not making money, they would not be here. I am not complaining about making money, I am complaining about trying to take away benefits because they want to make more money. The small amount of money mentioned for the fines and BPs really does not make a difference for them in the overall financial scheme. It is not the fault of the working men and women in this State that they do not have their business in order. As far as I am concerned, this is greed. Changing the language as recommended in this bill is only helping the bottom line for them. Most of the small companies are where the main problems lie and not with Mr. Ostrovsky's organization.

CHAIR TOWNSEND:
Thank you. There being no further business before the Committee, the meeting is now adjourned at 10:16 a.m.

RESPECTFULLY SUBMITTED:

_____
Jeanine Wittenberg,
Committee Secretary

APPROVED BY:

_____
Senator Randolph J. Townsend, Chair

DATE:_____