MINUTES OF THE
SENATE COMMITTEE ON COMMERCE, LABOR AND ENERGY

Seventy-sixth Session
March 21, 2011

The Senate Committee on Commerce, Labor and Energy was called to order by Chair Michael A. Schneider at 1:10 p.m. on Monday, March 21, 2011, 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 Michael A. Schneider, Chair
Senator Shirley A. Breeden, Vice Chair
Senator David R. Parks
Senator Allison Copening
Senator James A. Settelmeyer
Senator Elizabeth Halseth
Senator Michael Roberson

GUEST LEGISLATORS PRESENT:

Senator Joseph (Joe) Hardy, Clark County Senatorial District No. 12

STAFF MEMBERS PRESENT:

Scott Young, Policy Analyst
Matt Nichols, Counsel
Linda Hiller, Committee Secretary

OTHERS PRESENT:

Erika Loveland, Select Home Care; Personal Care Agencies of Nevada
Tibi Ellis, Home Helpers; Personal Care Agencies of Nevada
Danny Thompson, Nevada State AFL-CIO
Jack Mallory, International Union of Painters and Allied Trades, District Council 15; Southern Nevada Building and Construction Trades Council
Jim Burrell, Communications Workers of America

Lisa Foster, Northern Nevada Association of Service Providers
Tray Abney, Reno Sparks Chamber of Commerce
Allan Ward, Home Instead Senior Care; Personal Care Agencies of Nevada
Christopher Roller, American Heart Association; Nevada Tobacco Prevention Coalition
Tom McCoy, American Cancer Society Cancer Action Network
Amy Beaulieu, American Lung Association
Elizabeth Fildes, Ed.D., Nevada Tobacco Users Helpline
Margaret Curley, R.N.
Jack Kim, United Healthcare Services, Inc.
Erin McMullen, Las Vegas Chamber of Commerce
Constance Brooks, Clark County
Rusty McAllister, Professional Firefighters of Nevada
Erin Russell, Aflac
Liz MacMenamin, Retail Association of Nevada
Robert Ostrovsky, United HealthCare Services, Inc.
Susan Fisher, Nevada Anesthesia Patient Safety PAC
Scott Fielden, M.D., Nevada State Society of Anesthesiologists
Jonathan Zucker, M.D., American Society of Anesthesiologists
Robert Wagner, American Academy of Anesthesiologist Assistants
Denise Selleck Davis, Nevada Osteopathic Medical Association
Keith Lee, Board of Medical Examiners
Mark Corrigan, M.D. Desert Anesthesiologists
Annette Teijeiro, M.D.
Steven M. Sertich, Nevada Association of Nurse Anesthetists
Rhett Wiggen, Certified Registered Nurse Anesthetist

CHAIR SCHNEIDER:
I am opening the hearing on Senate Bill (S.B.) 252.

SENATE BILL 252: Revises provisions governing compensation for overtime. (BDR 53-1054)

SENATOR JOSEPH (JOE) HARDY (Clark County Senatorial District No. 12):
This bill, S.B. 252, makes the caregiver employed by a licensed agency exempt from the State eight-hour wage rule as it pertains to overtime. The bill defines "caregiver" on page 2, lines 34-37. The proposed amendment (Exhibit C) we submitted clarifies it is the agency providing the caregiver we propose to license.

ERIKA LOVELAND (Select Home Care; Personal Care Agencies of Nevada):
I am a personal care agency (PCA) owner representing thousands of elderly and disabled clients in the Las Vegas area. I represent the caregivers, too. Passing S.B. 252 will help both clients and caregivers by ensuring continuity of care for clients while keeping their costs down. It would also keep the State's costs down by allowing people to stay in their homes rather than going into State-subsidized facilities. This bill would also allow our caregivers the number of hours they need to provide for their families. I support this bill and have submitted my written testimony (Exhibit D).

TIBI ELLIS (Home Helpers; Personal Care Agencies of Nevada):
I am also a PCA owner and am here representing more than 100 agencies in Nevada and thousands of caregivers and recipients of our services. Our caregivers often perform the most intimate services—bathing, grooming, dressing, feeding and even toileting. Many of our senior clients have dementia or Alzheimer's disease and it is necessary for them to maintain a sense of familiarity of the people around them. Our goal is to keep the number of strangers entering their world to a minimum. I have submitted my written testimony (Exhibit E) and support this bill.

DANNY THOMPSON (Nevada State AFL-CIO):
We oppose this bill. This group of workers is no different than nurses, police officers, corrections officers and firefighters who work around the clock. Overtime laws apply to them and should also apply to caregivers.

SENATOR SETTELMEYER:
Corrections officers are already exempt. Are you against corrections officers who want to work a 12-hour day without being paid overtime?

MR. THOMPSON:
There is a provision in the law for corrections officers to work four ten-hour shifts. If a group of people come together and make an agreement with their employer to work the 12-hour shifts, this is different. It is the industry saying they are speaking on behalf of all their employees that we object to. In reality, they are speaking on behalf of themselves.

SENATOR SETTELMEYER:
Would you be happy with an amendment allowing an employee to work longer than an 8-hour day without being paid overtime, still working 40 hours per week? This would be at the employee's request.

MR. THOMPSON:
No, you are talking about two different things. When a group of corrections officers, for example, all come to you and say they want to change the law so they can work a different schedule, that is one thing. Changing the law for everyone is another thing. The problem I have with this bill is the fact that it is a group of owners coming forward to say they want to change the law. This would be akin to hospital administrators saying all of their employees do not want to get overtime anymore, and therefore we want to change the law that applies to nurses. Not all employees may be in favor of this change.

JACK MALLORY (International Union of Painters and Allied Trades, District Council 15; Southern Nevada Building and Construction Trades Council):
The United States Department of Labor's Fair Labor Standards Act (FLSA) exempts these individuals from coverage by the overtime law. The people of Nevada twice decided that the federal standard was not sufficient. I am speaking of the minimum wage changes we made. Our rate is higher than the federal standard. We agree that Nevada should be at a higher standard, but not at the expense of workers. The average wage of these caregivers is $10.50 per hour, hardly a living wage. To strip them of the ability to earn overtime is unconscionable

JIM BURRELL (Communications Workers of America):
I represent 540 members at St. Mary's Regional Medical Center in Reno. Some of these people work for other agencies and would be affected by S.B. 252. I agree that $10.50 per hour is barely a living wage, and many of these workers depend on overtime so they can pay their bills. If we change the law for this group of workers, do we limit it just to them? Why not just do away with overtime altogether instead of singling out a certain group? It is not right. These companies need to hire more people to maintain their overtime rather than putting it on the backs of the workers. When you work overtime, you should be compensated.

LISA FOSTER (Northern Nevada Association of Service Providers):
I represent four nonprofit service providers in northern Nevada. These organizations provide training, support services and work experience for people with disabilities. Most of their employees and clients are recipients of PCA services, and they support S.B. 252.

TRAY ABNEY (Reno Sparks Chamber of Commerce):
We support the concept behind this bill. This issue, daily overtime to home health-care providers, generated more unsolicited phone calls and e-mails to my office than any other issue during the interim. We support this exemption and also support the complete elimination of overtime in the State. The U.S. Chamber of Commerce released a report this month titled, "The Impact of State Employment Policies on Job Growth." In this report they ranked all 50 states into three tiers: excellent, good and poor. Nevada was ranked in the poor category, and one of the reasons mentioned in the study was the daily overtime requirement. We think this bill is a good start, and we support it.

SENATOR BREEDEN:
You mentioned receiving contacts from the public. Were those contacts from workers or owners?

MR. ABNEY:
Owners.

SENATOR BREEDEN:
Have you heard from any workers?

MR. ABNEY:
No.

SENATOR BREEDEN:
Have you asked the owners who contacted you if they consulted their employees on this?

MR. ABNEY:
The owners who contacted me said some of their workers find it difficult to work variable schedules. The owners also said it was difficult to hire as many workers as they would like to hire.

SENATOR BREEDEN:
I started out as an hourly worker and worked up to become an administrator and was eventually salaried. I can see where salaried employees and owners would say that overtime is not necessary. I will not be supporting this bill.

ALLAN WARD (Home Instead Senior Care, Personal Care Association of Nevada):
We typically work around the clock, not just during the weekdays. We perform very personal services, unlike many of the other 24-hour professions. Any cab driver can pick you up around the clock, any cashier can check you out at a store, but who is going to change you, bathe you, or put that ointment in a personal area? This continuity of care is important to our clients.

It is not just physical needs we attend to; it is also mental and emotional needs. We have many clients with dementia, and that population is growing. If family members work full-time, they may need someone in the home ten hours a day to care for their loved one. With the current laws, this would require two different caregivers. On an overnight shift, caregivers can have hours with no care required, but then they will have to get up and respond quickly to someone getting up who is a fall risk. I have submitted letters to help illustrate the personal side of home care and the benefit of S.B. 252 to both caregivers and clients (Exhibit F, Exhibit G, Exhibit H, and Exhibit I). There are only six states that do not comply with the FLSA overtime exemption, and Nevada is one of them.

CHAIR SCHNEIDER:
Do you ever put a caregiver in a home to live there?

MR. WARD:
No, that would not work under our laws. We also have a unique definition of our workday in Nevada through *Nevada Revised Statute* (NRS) 608.0126, which reads: "'Workday' means a period of 24 consecutive hours which begins when the employee begins work."

MS. LOVELAND:
I want to address the question of payer source. When firefighters, nurses, corrections officers and police officers get paid overtime, it is usually from a government or private insurance revenue source. Most of our clients, up to 75 percent, are private payers. Insurance does not cover personal in-home care, so any overtime cost is paid by the client.

CHAIR SCHNEIDER:
I will close the hearing on S.B. 252 and open the hearing on S.B. 253.

SENATE BILL 253: Requires certain policies of health insurance and health care plans to provide coverage for tobacco cessation treatments. (BDR 57-1052)

SENATOR HARDY:
Tobacco is one of the best known carcinogens lethal to the human body. This bill, S.B. 253, is aimed at helping Nevadans stop smoking with the support of their health-care coverage.

CHRISTOPHER ROLLER (American Heart Association; Nevada Tobacco Prevention Coalition):
Smoking continues to be the leading preventable cause of disease and death in Nevada. No other habit or addiction costs our State, health plans and consumers more. We have the ninth highest smoking rate in the United States, and we are the third highest for smoking-attributable mortality. Our workplace exposure to cigarette smoke is the highest in the country. This bill aims to standardize coverage for smoking cessation services by requiring all health plans in the State to cover these programs. I have submitted my written testimony, along with some data about smoking and quitting tobacco (Exhibit J). We support this bill.

TOM MCCOY (American Cancer Society Cancer Action Network):
Over the last 12 years, the Nevada Legislature has done a good job of covering cancer issues for Nevadans. An adult female smoker in Nevada belongs to the most deadly club in America. Nevada is first in the nation in lung cancer deaths among women. Cessation coverage can and will make a difference. The message is very simple: spend very little and save a whole lot more. We support this bill.

AMY BEAULIEU (American Lung Association):
We all agree on the health impact of smoking. The total impact of tobacco use in our State amounts to $2.6 billion annually from medical expenditures, premature death and loss of workplace productivity. Smoking cessation programs are low cost, usually less than 50 cents per worker per month, or $6 per year. I have submitted written testimony (Exhibit K). We think insurance

companies should cover this important benefit to help more Nevadans quit smoking. We support this bill.

ELIZABETH FILDES, ED.D. (Nevada Tobacco Users Helpline):
I am in support of S.B. 253. In Nevada, 3,300 people die every year from tobacco-related diseases. This is equivalent to 10 Boeing 747 jumbo jets crashing at McCarran International Airport every year, with no survivors. Tobacco use emits 7,000 chemicals, carcinogens, toxic metals and poisonous gases. This causes huge DNA damage, inflammation, oxidative stress and addiction. Carbon monoxide levels drop, and there can be immediate benefits from quitting smoking. Tobacco use is an addiction that requires interventions addressing physical, mental, emotional and spiritual components. The National Institute on Drug Abuse considers nicotine addiction a very powerful habit to break. Barriers such as lack of knowledge, smoking-cessation treatment costs and co-payments need to be removed so people can quit.

MARGARET CURLEY, R.N.:
I am a resident of Yerington, a registered nurse and former smoker. I started smoking at age 19 when I was a nursing student at the University of Nevada, Reno (UNR). By the time I was 55, I was smoking three packs of cigarettes a day. Like many smokers, I told myself I could quit anytime. I knew the risks; I saw the effects of smoking in my work every day as a nurse. That should have helped me quit, but it did not. Eventually, I had to acknowledge that my coughing and shortness of breath were not from allergies. One day I was watching television and saw a doctor talking about tobacco cessation. I called him and asked for help. He suggested the Nevada Tobacco Users' Helpline, and I worked with them for five months to quit. I used nicotine replacement and a lot of counseling. That was seven years ago. With the right kind of counseling, anyone can quit. I support this bill and hope you will make this kind of service available to everyone who wants to stop using tobacco.

SENATOR ROBERSON:
I want to know how much money we are talking about here. The estimate is 50 cents per member per month to include the cessation programs. I would like to know how much money this will cost the taxpayers of Nevada to have this added to their insurance policies.

MR. ROLLER:
It would depend on to which health-insurance plan a person belongs. On average, the tobacco cessation benefit costs members 50 cents per month. Based on a 2010 Penn State University study on the cost-benefit analysis of smoking cessation programs, for every dollar spent, Nevada taxpayers save $1.31. The current cost for Medicaid expenditures directly related to smoking is $562 annually per household. The real cost of a pack of cigarettes in Nevada is a little over $19 when you add in all the health-care costs related to smoking.

The recent federal Patient Protection and Affordable Care Act of 2010 (PPACA) includes several measures for preventative services. The U.S. Preventive Service Task Force (USPSTF), U.S. Department of Health and Human Services, recommends the type of coverage we have outlined in this bill. This includes coverage for both counseling and pharmacologic services for smoking cessation. The details need to be worked out before the Jan. 1, 2014, implementation of PPACA, but our hope is that once that implementation takes place, this will be the coverage as outlined by the USPSTF.

SENATOR HARDY:
In 2008, there were federal guidelines that were not mandated. The Committee may want to look at those.

MR. ROLLER:
I can make that data available to Committee members.

SENATOR ROBERSON:
I would like to know the immediate fiscal impact of this proposed bill on the upcoming calendar year. I understand in the long run this will save the State money, but in the worst recession we have ever seen, I would like to know how much more the private sector is going to be paying for these new mandates in the short term.

CHAIR SCHNEIDER:
I have a question about the law. It says that if you have a new health-insurance plan or insurance policy beginning on or after September 23, 2010, this benefit kicks in.

JACK KIM (United Healthcare Services, Inc.):
We are officially opposed to this bill. As of September 23, 2010, new health-insurance plans have to be PPACA compliant, which includes smoking-cessation provisions. We are covering smoking cessation. We have built it into our plans. We oppose mandates because of the impact on premiums. This mandate is different, because the provisions in the PPACA will be requiring health plans to cover tobacco cessation programs. Since there are already federal guidelines, by putting in state protocols you create a situation where both state and federal guidelines can potentially be violated.

We do have concerns about the way this bill is outlined. The interesting part about this bill and any other mandate bill this Session, is that the PPACA requires states to pay part of the costs. In 2014, we will be implementing a federal health-insurance exchange. Under the federal requirement, insurance products will be sold through the State-based, health-insurance exchange. In that exchange, health plans must provide essential benefits as outlined by the federal government. There will be a fiscal impact on the State because of the subsidies made available to anyone who buys through the health-insurance exchange. There will be a sliding scale of insurance-premium subsidies based on income.

If the State enacts mandates which are more generous than the federally required benefits, the State will be required to pay for those mandates. This bill requires us to cover over-the-counter drugs, which health-insurance plans typically do not. We have seen this mandate in other states brought forward by various drug companies, cancer groups and some of the same groups that testified today.

I agree that people should not smoke, but there are some smoking cessation drugs that have been associated with very bad side effects. On July 1, 2009, the U.S. Food and Drug Administration, U.S. Department of Health and Human Services, announced a requirement that manufacturers put a written warning on the smoking cessation drugs Chantix and Zyban. Both drugs are associated with serious mental side effects, including changes in behavior, depressed mood, hostility and suicidal thoughts. The way S.B. 253 is written, those drugs would be covered and there would be no additional medical management or step therapy to help patients attempt to quit smoking. My question is, do we really need this bill? The federal government is already requiring us to cover this, and

the State will be liable for some of these claim costs when we go into the health-insurance exchange in 2014.

ERIN MCMULLEN (Las Vegas Chamber of Commerce):
We are opposed to this bill. In this current economic climate, this would just be an added cost to already-burdened small businesses and employers.

CONSTANCE BROOKS (Clark County):
We oppose this bill. We generally support legislation that supports a healthier workforce, but we view S.B. 253 as an unfunded mandate in a time of economic crisis. The wellness portion of our health plan does cover smoking cessation up to $150 per member.

CHAIR SCHNEIDER:
Does Clark County pay up to $150 for someone to work on quitting smoking?

MS. BROOKS:
Yes, through our wellness benefit, which is a subsidiary extension of our self-funded heath-insurance program.

CHAIR SCHNEIDER:
Is Clark County required to comply with PPACA?

MS. BROOKS:
Our wellness program is in alignment with the federal act as it relates to smoking cessation.

RUSTY MCALLISTER, (Professional Firefighters of Nevada):
Firefighters are concerned about public safety and know that smoking reduction would reduce the number of smoking-related fires. I am chair of the Las Vegas Firefighters Health & Welfare Trust, which funds health insurance for members, families and retirees of Las Vegas Firefighters Local 1285. We cover approximately 2,000 people—600 are active workers, 189 are retirees and the rest are dependents. Our trust fund cannot take many more financial hits.

The bill refers to no co-pays, but we need co-pays from our members. The bill also refers to no prior authorizations, and we do not support that. We recognize the need for people to quit smoking and already have a provision in our health plan. It is under our prescription plan and it includes a $500 maximum lifetime

benefit for tobacco cessation. The first time a member wants to quit, it is on us. The next time, it is on them. This proposed bill would mandate the smoking cessation benefit be offered twice a year every year. We oppose S.B. 253.

CHAIR SCHNEIDER:
Since you have heart and lung coverage as firefighters, would this even apply to you?

MR. MCALLISTER:
Heart and lung provisions cover diseases of the heart or the lung, but there are many other diseases to which smoking contributes, including diabetes, poor circulation, cancer, etc. Most of our covered individuals are not firefighters, they are dependents, so this would not apply to them.

SENATOR SETTELMEYER:
Since you have the heart and lung coverage, do you think the State would save money if more people quit smoking?

MR. MCALLISTER:
The heart and lung legislation dictates we get an annual physical. If there are predisposed conditions within our ability to control and change, then we must control and change our behavior. If we do not comply, we are ineligible for the benefit.

ERIN RUSSELL (Aflac):
Aflac provides supplemental health insurance which covers short-term disability, hospitalization and accidents. We fill a niche not normally covered by health insurance. As drafted, sections 2 and 4 of S.B. 253 describe "policy of health insurance," which could include supplemental insurance. We are proposing an amendment (Exhibit L) which would change "policy of health insurance" to "health benefit plan," which is defined in statute under NRS 689A.540 and NRS 689B.410.

LIZ MACMENAMIN (Retail Association of Nevada):
We are opposed to this bill.

ROBERT OSTROVSKY (United HealthCare Services, Inc.):
These mandates cover small group plans, individuals, health maintenance organizations and government-sponsored programs. The bigger employers are all

self-insured and will not be required to provide this coverage. If 30 percent of Nevadans smoke, and it might be higher, 100 percent would have to pay for this smoking cessation benefit, which is basically coverage for bad behavior. There is no language in this bill specifying which prescription drugs it covers and how often they can be prescribed. We do not support this bill.

CHAIR SCHNEIDER:
I know some in the Committee are worried about the cost of this coverage. Kidney cancer can be caused by smoking. What is the cost to remove a kidney and go through cancer care? Much more than $150. I will close the hearing on S.B. 253. I am opening the hearing on S.B. 258.

SENATE BILL 258: Makes various changes relating to anesthesiology. (BDR 54-843)

SENATOR HARDY:
This bill proposes that anesthesiologists have anesthesiologist assistants (AA), much like physicians have physician assistants. Anesthesiologist assistants are physician assistants trained in anesthesiology.

SUSAN FISHER (Nevada Anesthesia Patient Safety PAC):
This bill would allow for the licensure and regulation of AAs. This will not put anyone out of work but will create a new licensure allowing AAs to work in Nevada. It will also allow better access to care, primarily for Medicare and Medicaid patients.

SCOTT FIELDEN, M.D. (Nevada State Society of Anesthesiologists):
I am a working anesthesiologist in Las Vegas. There is a big disparity between the Medicare and Medicaid rates anesthesiologists receive compared to commercial insurance reimbursement rates. We are poorly reimbursed by Medicare. In the 75th Legislative Session, the Legislature cut our Medicaid reimbursements by 43 percent. We see increased stress from our hospital anesthesiology departments when they care for some of these Medicare and Medicaid patients. There is no shortage of anesthesiologists, but there is a shortage of anesthesiologists willing to care for these patients. In other areas of the United States, the formation of an anesthesia care team (ACT) helps hospitals and surgery facilities deal with this dilemma. These ACTs consist of physician anesthesiologists, nurse anesthetists and AAs. The latter are better

trained than nurse anesthetists, but cannot work in Nevada because of the licensure issue.

There are two main issues voiced by those opposing this bill. They worry physicians will lose jobs, and patient care will decline in quality. I disagree with both. This bill would increase the number of people available to work with anesthesiologists, thus enhancing the level of patient care. No jobs will be lost, and no anesthesiologists are being replaced.

One of the anesthesiologists testifying against this bill today stopped treating Medicaid patients last year after the reimbursement rates were lowered by 43 percent. I understand this physician's position, but we need to take care of these patients. The addition of AAs will allow hospitals to provide anesthesia for these patients that others are unwilling to treat. I support this bill.

JONATHAN ZUCKER, M.D. (Director, American Society of Anesthesiologists):
I am a practicing anesthesiologist in Las Vegas. In Nevada, anesthesiology care is provided either directly by an anesthesiologist or by an ACT. There are some quality-of-care issues related to some of the ACTs. The recent hepatitis C debacle in Las Vegas highlights failings of ACTs supervised by physicians who are not anesthesiologists. We are allowed to use nurse anesthetists, but not physician assistants, and this bill, S.B. 258, would fix that. Physician assistants and AAs would both be licensed, but the training for the AA is specific to anesthesiology. The AAs would always be supervised by an anesthesiologist, and physician assistants would not be permitted to perform the functions of an AA. If we introduce AAs into Nevada, it will not displace physician anesthesiologists or impede the current ACT model. It will instead allow us to maintain the central role for physician anesthesiologists in the delivery of anesthesia care to our patients. It will provide better patient care for the same cost. We support this bill.

MS. FISHER:
We do have a conceptual amendment for this bill and will have it ready soon.

ROBERT WAGNER (American Academy of Anesthesiologist Assistants):
I am the associate chair of the Health Science Department at Nova Southeastern University in Fort Lauderdale, Florida, and have been an AA for 21 years. The education of AAs is identical to the premedical undergraduate course of study. To get into AA schools, students must first pass the Medical College

Admission Test. We are one of the few AA schools in the United States, and we have students from Nevada who want to come back here to work. They cannot work here today because of the lack of licensure, which S.B. 258 would remedy. The federal government recognizes three providers for anesthesia reimbursement through Medicare and Medicaid: physician anesthesiologists; Certified Registered Nurse Anesthetists (CRNA) and AAs. All Veterans Affairs facilities in the U.S. recognize AAs.

I specialized in cardiac anesthesia at one of the top five cardiac institutions in the United States, St. Joseph's Hospital of Atlanta, where we performed 2,500 heart surgeries. Out of the 12 nonphysician anesthesia providers, there are 11 AAs providing anesthesia along with the anesthesiologist, and only one CRNA. The difference between an AA and a CRNA is that AAs must be supervised by a physician anesthesiologist. In some situations, a CRNA does not have to be supervised by an anesthesiologist but can work under any physician. I have been in many tough situations where more hands are needed for patient safety, and having a physician anesthesiologist on site can be crucial.

The National Board of Medical Examiners certifies AAs. This is the same board that certifies physicians. All seven AA schools are affiliated with a medical school. This bill does not force an anesthesiologist to work with an AA, but would facilitate those who want someone with more advanced training.

SENATOR SETTELMEYER:
What is the level of training for an AA?

MR. WAGNER:
It is a master's level with a minimal requirement for clinical hours. Most schools require 2,000 to 2,500 clinical hours in anesthesia procedures.

MS. FISHER:
We provided a chart that compares AAs to CRNAs (Exhibit M).

DENISE SELLECK DAVIS (Nevada Osteopathic Medical Association):
We are concerned about what "direct supervision" means regarding the AA working under a physician anesthesiologist. Under the *Nevada Administrative Code* (NAC) for osteopathic physicians, direct supervision of physician assistants and nurse practitioners can be telephonic, out of the office or over long distances. We suggest the language in S.B. 258 be clarified to be "on

site," and "within the building." Also under NAC for osteopathic physicians, there is a maximum of three mid-level providers allowed to be under supervision at any one time. This bill calls for a maximum of four, which our members feel is a lot to supervise simultaneously. We are willing to work on this bill, but we do have concerns.

KEITH LEE (Board of Medical Examiners):
The Nevada Board of Medical Examiners has several concerns with this bill since we would be required to license the AAs. First, would this addition enhance quality of care and patient safety? Second, what would it do to the cost of health care? Third, we would want to know if our regulation of the AAs is cost-effective for the Board. The one area we are very concerned about is the question of whether AAs can prescribe medication. We would not support that. The administration of drugs in the course of their treatment is acceptable, but not the ability to prescribe those drugs. We will work with the Committee on this bill.

MARK CORRIGAN, M.D. (Desert Anesthesiologists):
I have been a practicing anesthesiologist for the past 30 years. I am here to urge caution on this bill. I support Dr. Fielden and Dr. Zucker, our leaders in the Nevada State Society of Anesthesiologists (NSSA). I have practiced anesthesiology one-on-one with patients my whole career and think it is the best model for quality care of patients. As a member of the anesthesia community in Las Vegas, I received some e-mails regarding this issue, and then this meeting came up very quickly. I would like to see more input from NSSA. We have a stagnant economy and negative population growth in Las Vegas right now, and we have too many physician anesthesiologists and anesthesia personnel as it is. The idea that adding AAs will not displace others from their jobs is questionable to me. Imagine you have a hospital with 12 operating rooms and 12 anesthesiologists working with 12 patients. As I understand this bill, you could have 3 anesthesiologists supervising 12 AAs, and that seems like a net loss of 9 anesthesiologists not working. I am opposed to this bill and suggest it be tabled until the next Session so it could be better researched.

ANNETTE TEIJEIRO, M.D.:
I am a practicing anesthesiologist and graduate of the University of Nevada, Las Vegas and medical school at UNR. I have submitted written testimony (Exhibit N) and am against this bill, primarily for patient safety. The training of an AA cannot compare to that of a physician anesthesiologist. If someone in my

family needed anesthesia services, I would request an anesthesiologist over an AA, even with supervision. I would not want to be the patient under anesthesia when the anesthesiologist is attending to one of the other three patients he or she is "directly supervising." This may be okay if none of the patients have a problem, but if one or more patients simultaneously had a problem, a disaster or fatal outcome could result.

Because there are approximately six anesthesiologists for every CRNA in Nevada, we are fortunate to have one of the most highly trained anesthesia workforces in the United States. Every piece of legislation that lowers the standard of care by increasing the scope of practice of a lesser-trained individual weakens this system. I would not be employing any AAs, and most of my peers agree, because we think the one-on-one relationship between anesthesiologist and patient is by far the safest method.

STEVEN M. SERTICH, CRNA, MAE, J.D. (President, Nevada Association of Nurse Anesthetists):
I am a nurse anesthetist and also an attorney. If you look at "direct supervision," you ask what a reasonable person would think that is. It should mean someone is directly watching over the AA and available for assisting. If you say the direct supervision can cover up to four people, does this mean the anesthesiologist would have to be four places at one time? This bill gives AAs the ability to prescribe any medications an anesthesiologist can provide, and no other allied health-care provider has that privilege in Nevada. I have submitted my written testimony (Exhibit O) and am against this bill.

RHETT WIGGEN, CRNA:
I have been a CRNA for 15 years and am against this bill.

CHAIR SCHNEIDER:
Senator Hardy, please work with Ms. Fisher and the others on this bill. We will close the hearing on S.B. 285. The Senate Committee on Commerce, Labor and Energy is adjourned at 4:57 p.m.

RESPECTFULLY SUBMITTED:

Linda Hiller,
Committee Secretary

APPROVED BY:

Senator Michael A. Schneider, Chair

DATE:

EXHIBITS			
Bill	**Exhibit**	**Witness / Agency**	**Description**
	A		Agenda
	B		Attendance Roster
S.B. 252	C	Senator Joseph (Joe) Hardy	Proposed amendment
S.B. 252	D	Erika Loveland	Written Testimony
S.B. 252	E	Tibi Ellis	Written Testimony
S.B. 252	F	Allan Ward	Letter from Eileen Holler
S.B. 252	G	Allan Ward	Letter from Rebecca Caudel
S.B. 252	H	Allan Ward	Letter from Sheila D. Parker
S.B. 252	I	Allan Ward	Letter from Fayann Gramanz
S.B. 253	J	Christopher Roller	Testimony, Information packet
S.B. 253	K	Amy Beaulieu	Written Testimony
S.B. 253	L	Erin Russell	Proposed Amendment
S.B. 258	M	Susan Fisher	Chart
S.B. 258	N	Annette Teijeiro, M.D.	Written Testimony
S.B. 258	O	Steven M Sertich	Written Testimony