MINUTES OF THE
SENATE COMMITTEE ON COMMERCE, LABOR AND ENERGY

Seventy-sixth Session
April 6, 2011

The Senate Committee on Commerce, Labor and Energy was called to order by Chair Michael A. Schneider at 1:28 p.m. on Wednesday, April 6, 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) P. Hardy, Clark County Senatorial District No. 12
Senator Steven A. Horsford, Clark County Senatorial District No. 4

STAFF MEMBERS PRESENT:

Scott Young, Policy Analyst
Matt Nichols, Counsel
Suzanne Efford, Committee Secretary

OTHERS PRESENT:

Rudy Manthei, D.O., HealthCare Partners of Nevada
Amber Joiner, Nevada State Medical Association
Brett J. Barratt, Commissioner of Insurance, Division of Insurance, Department of Business and Industry

Victoria Robinson, Manager, Risk, Compensation and Benefits, City of Las Vegas
Rusty McAllister, Professional Firefighters of Nevada
Charles Duarte, Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Jack Mallory, Southern Nevada Building and Construction Trades Council; International Union of Painters and Allied Trades, District Council 15
Michael Hillerby, Nevada Association of Health Plans
Jack Kim, Nevada Association of Health Plans
Daniel Liebsack
S. Rowan Wilson
John Wagner, Independent American Party
Elizabeth Conboy, Chief, Investigation Division, Department of Public Safety
Rebecca Gasca, Legislative and Policy Director, American Civil Liberties Union of Nevada
John Griffin, Sprint; Amazon.com; DIRECTV; DISH Network; TechAmerica
Randy Brown, AT&T
Chris MacKenzie, American Express
Michael Brown, Melanoma Education Foundation, Nevada Chapter
Caroline Graham, 4th Year Medical Student, University of Nevada School of Medicine; Cindi Lamerson, M.D., American Academy of Dermatology
Gary Milliken, Indoor Tanning Association

CHAIR SCHNEIDER:
Senate Bill (S.B.) 440 has to be rereferred to the Senate Committee on Finance. It relates to the creation of the Silver State Health Insurance Exchange, but should be heard in the Senate Committee on Finance.

SENATE BILL 440: Creates the Silver State Health Insurance Exchange. (BDR 57-1172)

SENATOR COPENING MOVED TO REREFER S.B. 440 TO THE SENATE COMMITTEE ON FINANCE.

SENATOR BREEDEN SECONDED THE MOTION.

THE MOTION CARRIED. (SENATOR PARKS WAS ABSENT FOR THE VOTE.)

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CHAIR SCHNEIDER:
We will open the hearing on S.B. 278.

SENATE BILL 278: Revises provisions relating to health care and health insurance. (BDR 57-253)

SENATOR STEVEN A. HORSFORD (Clark County Senatorial District No. 4):
Senate Bill 278 is forward-looking legislation intended to improve and streamline our health-care delivery system for primary care. It is forward-looking because it anticipates a major element of federal health-care reform which is the emphasis on primary care provided by family physicians and others.

Under health-care reform, more Nevadans will have access to primary care physicians. Primary care physicians will have more responsibility in ensuring quality of care and a continuum of care. Senate Bill 278 is intended to help primary care physicians deliver quality care by streamlining administrative procedures, reducing unnecessary authorizations by insurers which impede a continuum of care and ensuring primary care physicians are fairly informed about changes in payments by insurers.

Senate Bill 278 seeks to bring more transparency to the levels of reimbursement of physicians by health insurers by shedding more light on how third-party payers are reimbursing physicians and other medical providers.

Senate Bill 278 gives more autonomy to nonprofit health insurance organizations to decide which benefits they will offer going forward so they can better manage their costs and keep their rates affordable to the people who depend on them.

I have provided a mock-up proposed amendment 6038 to S.B. 278 (Exhibit C). After the introduction of this bill, and before the hearing today, we received more information that necessitated changes in the bill. I am anticipating you will hear more suggestions and recommendations from various groups, including physicians, about other ways to improve S.B. 278 in its mock-up form. I want

to emphasize I am open to these recommendations if they reinforce the intent of the bill which ultimately is to improve the quality of primary care in Nevada by helping the physicians who provide it.

Section 2 of the proposed amendment takes an important step toward the streamlining I referred to earlier. It would establish a task force consisting of the commissioner of insurance (COI), Division of Insurance (DOI), Department of Business and Industry (DBI), the director of the Department of Health and Human Services (DHHS) and three other individuals knowledgeable in health insurance or health care to study and report on the concept of using electronic health identification (ID) cards in doctors' offices.

Electronic health ID cards are basically insurance cards which can be swiped through a reader as you do with bank automated teller machine cards. This was suggested to us by physicians as a means of more efficiently introducing patients into their office systems and more effectively processing health insurance claims. This system has the potential to verify insurance eligibility and benefits more quickly, and reduce administrative overhead costs in physicians' offices.

Electronic health ID card programs are being implemented in other states. We are proposing to study the issue thoroughly to assess costs and benefits and then decide after the study is conducted whether to proceed in the next Session, in time for the full implementation of the Patient Protection and Affordable Care Act in 2014.

The second important area of the proposed amendment to S.B. 278 is section 6. This section addresses another concern of primary care physicians and their patients which is having to receive repetitive and unnecessary prior authorizations for treatment and referrals to specialists. The intent of this section is to allow an ongoing continuum of care for a patient once there is a proof-positive diagnosis of a condition needing continued treatment. This provision also is in line with one of the tenets of federal health-care reform of giving primary care physicians more discretion about the best ways to manage the ongoing care of their patients properly.

We sought to balance this greater autonomy with adequate checks to ensure ongoing specialty treatment meets the criteria of being medically necessary, is carried out by a qualified provider and is covered under a patient's insurance

plan. Others may have different ideas about how to achieve this same end, and I hope the Committee will evaluate them as potential improvements to S.B. 278. Section 7 of the proposed amendment is an extension of section 6 and was not contained in the original bill. It would exempt mandated benefits from prior authorization requirements as is the case in other sections of State law pertaining to health-care plans. This was included by our Legislative Counsel Bureau to conform this bill to other parts of State law.

Sections 8-12, 14 and 15 of the proposed amendment relate to notification of physicians about changes in reimbursement rates by health insurers. It is in response to concerns by physicians that they do not receive adequate notice of changes in reimbursement rates in their contracts with insurers. We changed this notice requirement from 30 days to 90 days but later determined a 45-day notice would be sufficient. The noticing requirement should apply to changes in fee schedules in contracts which really determine how physicians are reimbursed. The intent is to cover changes in these fee schedules in the noticing requirements.

Another major change in S.B. 278 from the original version is in regard to the transparency in reimbursement rates. Originally, we sought to set a floor for reimbursement rates based on the 2002 Medicare rates. However, we determined this would have multiple impacts on the State Medicaid program which, as a state, we cannot afford in our current budget crisis. As a result, section 16 of the proposed amendment now requires the director of DHHS to post, on the DHHS Website, a schedule of reimburse rates for all health-care insurers who are reimbursing medical providers at rates below the 2002 Medicare rates. This will yield a clear picture of levels of reimbursement by health-care insurers and perhaps provide better insight into the correlation between the levels of reimbursement and the extent and quality of care.

Section 17.5 of the proposed amendment seeks to give nonprofit health insurance companies more latitude to determine the packages of benefits they will offer to the people they insure. These nonprofit companies are instrumental in providing affordable insurance to Nevadans and as the Patient Protection and Affordable Care Act comes on line, more programs, including the Nevada Health Insurance Exchange, will be done through nonprofit companies. To maintain this ability, S.B. 278 exempts nonprofit companies from having to comply with any mandated benefits adopted in State law going forward from this year. It also

gives these insurance companies increased flexibility to offer their plan members the benefits that serve them best at a cost they can afford.

SENATOR JOSEPH (JOE) P. HARDY (Clark County Senatorial District No. 12):
I have to disclose "I am a family physician, primary care doctor for the record, and yes, this will probably affect me as well as everybody else in similar ways, whatever comes out of it."

When we start looking at insurance interactions and what happens with reimbursements to physicians, the physicians often are not sure what the reimbursement will be, how they will receive it and how long the contract will exist. Physicians are anxious about this, but this bill tries to allay some of those anxieties and add more transparency to the process.

This bill addresses health insurance ID cards, improving time frames and clearing up the confusion with prior authorizations. The schedule of reimbursement rates will be helpful, and the exemptions illustrate that some people recognize this as a problem. This is a work in progress.

SENATOR HORSFORD:
In section 6, subsection 1, paragraphs (a)-(e) of the bill, there may need to be some more narrowing of those areas for the prior authorization. Paragraphs (a) and (b) are critical. Paragraphs (c)-(e) may be overly broad. We were not able to reach full consensus coming into this hearing. Also, in section 6, subsection 2, paragraphs (a)-(d) have the same issues. I am open to hear from those who are impacted by this bill, on both sides of the issue, to come to the best policy this Committee will be able to shape.

Our primary care physicians are becoming like teachers. I do not know why anyone would want to do this job anymore. Physicians, in some cases, are overly burdened with administration and other requirements on them to enable them to treat their patients and be properly reimbursed. In order to do their jobs as physicians, they have to jump through a lot of hoops.

I have spoken with physicians who are making 30 cents on the dollar to provide care for people. When you talk to individuals who are going into medical school, they are not planning to become primary care physicians; they are planning to become specialists, because there is no incentive in being a primary care physician. This issue is bigger than anything we can do alone, but the intent of

this bill is to give more autonomy and more flexibility to our primary care physicians so they can treat people who need care.

Going forward after 2014, there will be more access for people to get insurance, but there will be fewer people qualified and interested in being primary care doctors. I view this bill as one attempt at trying to help show the physician community they are important, they went to school for a reason and that we should give them the autonomy and the flexibility to do their jobs unhampered by overly broad restrictions.

SENATOR SETTELMEYER:
Does the proposed amendment help change the fiscal note?

SENATOR HARDY:
You will probably hear testimony that it helps. I am sure you will hear other concerns about this issue. Realistically, we are going to have to address those concerns and I appreciate the Committee's influence on the process.

RUDY MANTHEI, D.O. (HealthCare Partners of Nevada):
HealthCare Partners of Nevada (HCP-NV) is a transformative Nevada company. Since our inception 20 years ago, our mission has been to create a primary care driven, patient-centric care model which applies extensive resources to prevention and coordinating care for the patients' benefit.

The HCP-NV primary care physicians care for about 27,000 Medicare Advantage members and about 300,000 other patients under well over 100 different payers. We are highly supportive of S.B. 278 as amended, and I would like to comment on five issues:

1. We support the work of the task force for electronic health ID cards.
2. We support the elimination of the precertification requirement for severe chronic conditions. Precertification requirements often work against the interests of patients, and many payers across the United States have dropped them. Our model relies on primary care physicians taking the responsibility for coordinating the care of their patients. In our model, the medical home is accountable for the outcomes. If this is not the case, patient outcomes deteriorate as care becomes duplicative, ineffective or inefficient. The focus of the review and approval should rest with primary care homes, not external precertification programs. We trust any

modifications you make will not take the primary care physicians out of the loop.

3. The bill does not go far enough regarding the 45-day notice of contract modifications. The notice requirement should specifically define the modifications to include any changes to a physician fee schedule. Fee schedule changes are often done arbitrarily with no notice at all.
4. We support section 16. The State does not need to create fee-for-service payment floors nor take any other actions to reinforce unmanaged fee-for-service medicine. This is not the direction health-care reform is taking. We need to create medical homes, dedicate significant resources to managing care and prevention, and get away from a fee-for-service mentality. Fee-for-service reimbursement as currently construed undervalues care coordination and prevention activities. These activities can thrive under primary care global risk arrangements. Under risk arrangements, companies like HCP-NV are incentivized to invest resources in two key areas of prevention and care coordination.
5. We support standardization of not only credentialing but also authorization in claims. This will decrease the cost of the health-care delivery process to providers.

AMBER JOINER (Nevada State Medical Association):
We support the intent of S.B. 278. However, our members have not had a chance to review the amendment. The changes in section 16 address one of our concerns.

We have concerns with sections 2-5 regarding the electronic ID cards. This is a good idea; however, we understand this is already underway through our high-tech efforts. We want to make sure this effort is not being duplicated, or worse, that we have to separate projects happening that may compete or end up not being compatible. We also have federal funds to work on that.

In sections 6 and 18, our concerns relate to determining the qualifications for health-care providers. Section 6 would leave the determination up to the COI, and section 18 would leave it up to some local government entities. We are not sure they are qualified or up to the task of doing this. We are not sure it is currently in their scope. We welcome the opportunity to work with the sponsors on furthering this bill.

BRETT J. BARRATT (Commissioner of Insurance, Division of Insurance, Department of Business and Industry):
Sections 2-5 of the bill create a task force to study the use of electronic ID cards to be used for verification of health insurance. To accomplish this, the DOI has submitted a fiscal note to cover the expenses of the task force. However, as just pointed out, this may actually be a duplication of effort and cost because the Office of Health Information Technology (HIT), DHHS, has a federally funded program with similar goals. The program is managed by Lynn O'Mara, the State's HIT task force coordinator.

The HIT task force expects to begin a feasibility study in the third quarter of 2012, and implement a pilot program in 2014. This would be a coordinated effort between DHHS, Medicaid, Public Employees' Benefit Program, the COI and other stakeholders to develop one health smart card to complement and support the utilization of electronic health records and health information exchange.

My second concern is with section 6 which calls for the COI to adopt regulations defining severe or chronic conditions for which a health insurer could not require prior authorization for the treatment. In some instances, it may be impossible to have a complete and comprehensive list of what is deemed to be severe or chronic.

The COI must also determine the qualifications for a provider of health care to be considered specialized. This is an area for which the DOI currently does not have any expertise, and we would hope we could work with other boards if that provision is left in the bill.

VICTORIA ROBINSON (Manager, Risk, Compensation and Benefits, City of Las Vegas):
I have submitted correspondence in opposition to portions of S.B. 278 (Exhibit D). The City of Las Vegas has always been committed to ensure its employees have a good health-care plan. We have a nationally recognized health-care and wellness program. We always want to give our employees the tools and resources to make good health-care choices. Our concern is with section 18. This section would severely restrict our ability to do that.

Prior authorization ensures patients are not surprised, following a procedure, to discover it has been done in an out-of-network facility and therefore is more

expensive for them and for the city. An example would be an organ transplant or an extensive course of chemotherapy which takes place in an out-of-network facility. This could cost the city several hundred thousand dollars and leave the patient with large unexpected and unplanned out-of-pocket expenses.

Our plan specifically endorses and encourages, but does not require, primary care physicians. The concept of "medical home" is a great one, and we would like all of our employees to embrace it. We do not ever want to delay testing or treatment unnecessarily. To that end, we require prior authorization on very few procedures, most notably organ transplants.

This bill as written does not provide any language addressing out-of-network treatment or procedures which may be extremely expensive for both the insurer and the patient. We want to support our employees. Fast, effective medicine saves money and is better for the patient. However, at a time when the city is looking at every dollar it spends, we ask you to look at the language and address the issue of the out-of-network facility.

RUSTY MCALLISTER (Professional Firefighters of Nevada):
We support S.B. 278 as amended with the addition of section 17.5 which addresses the concerns and needs of nonprofit health insurance plans. This is beneficial to us.

I am the chairman of a small health insurance trust fund covering approximately 2,000 individuals. As these mandates come, it makes it more and more difficult for us to survive as a health insurance plan. This would allow us to prepare our benefits in an appropriate fashion to match the financial ramifications of our plan. We do not have the ability to get more money for our plan. It has to come as a form of negotiations and is not always an easy thing to do.

CHARLES DUARTE (Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services):
We appreciate the amendment to S.B. 278. The revisions to section 16 in this amendment substantially reduce the fiscal note associated with this bill. We will review and revise the fiscal note to be appropriate to what is being presented here.

We have some concerns with section 6 and the prior authorization requirements. We support primary care and the decision-making processes and

the need to take care of patients and provide a continuum of care with specialists. Unfortunately, our experience has been that sometimes inappropriate medical decisions are made or there is a lack of information available to a specialist who makes duplicative decisions which do need to be reviewed. Prior authorization is a cost-effective mechanism of reviewing those decisions.

If we had to do another practice, it would be retrospective. Prior authorization is reviewing prior to paying the claim. Retrospective is more expensive because it is done after the fact. It includes reviewing the medical claim for medical necessity, and if found necessary, it reduces the payments to the provider in the future. Our preference is always to use prior authorization because it is less onerous for us and for the provider, particularly if we have to take back monies. We would like to work with the Committee on the issues around prior authorizations in section 6.

Section 16 of the bill requires insurers to submit their reimbursement rates to DHHS, and that they get posted. It requires DHHS do this for providers of health care. We would like to get a better definition of a provider of health care. This may be overly broad, and we would like to limit it to physicians, nurse practitioners and whoever are licensed providers of health-care services that we want to include in this bill. We need to have more specific terminology.

The requirement to post the reimbursement rates and use Medicare rates from 2002 as a benchmark may be problematic, because we have had difficulty getting information from Medicare going back to 2002. It might be more effective to use current Medicare rates.

Medicare, Medicaid and commercial health plans do not always pay for the same things and do not pay in a comparable manner. There may be a health plan paying a hospital on a per-day rate as we do in Medicaid. Medicare pays on what is called a disease-related or diagnosis-related grouping which is a bundle rate. The two methodologies of payment are not comparable. I would suggest we look at what information is available, practicable and comparable to be able to post that on the Website and to limit the types of providers that might be involved with this.

We have some concerns with respect to the notification requirements and whether Medicaid is affected by it. We have specific requirements in the

Nevada Revised Statutes (NRS) and under federal law about notification of changes in reimbursement rates in our State plan that we follow. We want to be sure there is no conflict with that.

JACK MALLORY (Southern Nevada Building and Construction Trades Council):
Identification cards containing critical information regarding chronic conditions, allergies and things of that nature are the medical ID bracelets of the next generation. They will facilitate the transformation to paperless, electronic records which would hopefully streamline the processes involved with billing, receiving and transferring care from one physician to another, and ultimately have a cost-controlling effect on health insurance.

I have heard the concerns expressed by others regarding the issue of prior authorization. It is important to note in the bill the prior authorization is waived only if the insurer or organization has confirmed the diagnosis of the severe chronic condition has been made by the provider of health care. It is a critical thing to take this into consideration when you are considering this bill. It will not waive the prior authorization requirements for a number of different things.

MICHAEL HILLERBY (Nevada Association of Health Plans):
We have some concerns about the bill, particularly on section 6 and the prior authorization.

When we talk about these issues, it is important to remember the majority of Nevadans with health care are not regulated by any laws we pass here because they are federally preempted. We are preempted from regulating those in self-insured plans from large employers and Employee Retirement Income Security Act covered plans like the Culinary Health Fund and the Health Services Coalition. A smaller number of people are actually regulated for issues like mandated benefits and anything proposed in this bill.

Specifically, in section 6 we have concerns about the prior authorization. There are some language concerns particularly with “severe or chronic.” Severe may not be chronic. It may be a severe short-term condition. Severe may mean acute in some cases. We want to be sure we understand that. We will work with Senator Horsford and the staff.

Typically, as an insurer we do not confirm a diagnosis so there is a "term of art" in line 43 on page 4. We may receive the diagnosis but we might not actually confirm it. There is a language issue there.

Broadly, prior authorizations are done because they help control costs and provide better care. We do not want our members making unnecessary physician visits. We do not want physicians seeing patients unnecessarily. We would like to get them quickly to the most appropriate level of care. This will ultimately save the patients money because they will not be making unnecessary co-pays on visits or buying expensive drugs. We have interests, both of our own and for our members.

Page 5, line 36 states "As used in this section 'medical or dental service' means any care … ." This probably should be clarified. It should be medically necessary "covered care." This could potentially be interpreted to mean to provide coverage of any care that may not have been part of the policy.

We have just seen the amendment on the shortened notice requirements. This is somewhat better than the 90-day notice. We do have concerns with the new language about certified or registered mail. Typically, with many plans this is done electronically. If you have hundreds or perhaps thousands of providers on a list and make a contract change, using certified or registered mail could be a fairly expensive proposition for the notification.

We have concerns about the rates in section 16, page 11 of the amendment, Exhibit C. Rates are very often the subject of tough negotiations. They are typically private. The providers may not want their competitors to know their rates. We do not disclose the rates either because they are the result of negotiations with different provider groups. Often they are not comparable, depending on who is the payer.

Page 12, section 17.5 of the amendment, Exhibit C, would be a significant policy change. We want the best for patients at a cost they can afford. We would make the same argument for our plans as well. If we do this for nonprofits, it would be a significant policy change. This would give employers and individuals who purchase our plans an opportunity to save money on the mandated benefits.

JACK KIM (Nevada Association of Health Plans):
A number of companies already have the capability of using an electronic ID card. We will be glad to work with Senator Horsford on this project. This is the way things are going, and it will help speed up claims processing.

We have concerns with section 6 and prior authorizations. Senator Horsford stated this applies to primary care, but it does not actually say that in the bill. It might be the intent, but it appears to apply to everything beyond primary care. If the intent is for primary care only, this needs some work.

In section 8 of the proposed amendment, the 45-day notice provision was to apply to fee schedules and provider payments. It appears to apply to any modifications. If it should only apply to fee schedules or other modifications related to payment, this also needs to be addressed. Right now, it could apply to modifications such as a change of forms or any other changes. I do not know if this is the intent of section 8.

We have concerns about the language in section 16, page 11 of the proposed amendment, Exhibit C, and tying into the Medicare fee schedule. Also, I have concerns in section 16, subsections 2 and 3 of the amendment, Exhibit C, on reporting fee schedules. Nevada Association of Health Plans' insurers cannot share this information with each other, and we cannot share provider rates. If we did, it would be considered an antitrust violation, and a lawsuit could be brought against us. Rates are competitive between plans, and we are required to guard them closely. Doctors do not publish their rates because of this reason.

When we are negotiating contracts with providers, especially the larger ones, we often get additional discounts because they think they will get more membership. Our concern is if this information is made public, it may impact our ability to negotiate and may actually raise costs. This is not the intent of this bill.

Another issue this brings up is that it appears to be related to fee schedules only and not capitation payments. In the insurance and medical worlds, a number of groups are paid a capitation rate. This is a monthly payment to a provider for a member whether they see the member or not. They use it to cover costs. I do not know if capitation payments are meant to be included in this or not. It appears they would be. Capitation rates are also negotiated with providers and are confidential.

Another thing referenced in this bill is the standardized credentialing form. A standardized credentialing form has already been developed. This bill will require hospitals to use the standardized form, which they may already be using.

CHAIR SCHNEIDER:
I just received a message from Bobbette Bond, Health Services Coalition. She is concerned about comments from Mr. Hillerby regarding the Culinary Health Fund. She says the Culinary Health Fund is very supportive of sections of this bill which will assist their primary care doctors. They have very few prior authorization requirements. She is very interested in working with the sponsors of the bill and appreciates the intent to help their primary care doctors. She wanted to get this on the record.

I will close the hearing on S.B. 278 and suggest everyone who has concerns to meet with Senator Horsford. We have also received written comments on S.B. 278 from Liane Lee, Legislative Officer, Department of Administrative Services, City of Las Vegas (Exhibit E).

We will open the hearing on S.B. 328.

SENATE BILL 328: Revises provisions governing the payment and collection of wages and other benefits. (BDR 53-108)

SENATOR HORSFORD:
Senate Bill 328 has an important purpose as another tool for badly needed economic development in this State. On its face, S.B. 328 adds another category of professionals to State law who can be exempt from the overtime requirement just like other salaried professionals.

Senate Bill 328 includes creative professionals in this exempted category as defined in the Code of Federal Regulations (C.F.R.). Title 29, C.F.R., subpart 541.302, defines creative professionals as individuals whose primary duty is the performance of work requiring invention, imagination, originality or talent in a recognized field of creative endeavor. As we have pursued economic development and diversification in this State, one of the things we have heard is there are companies involved in creative work, such as stage production and the film industry, that are interested in setting up shop or expanding in Nevada, and this often serves as the site for creative productions. These companies are interested in hiring locally rather than employing independent contractors from

outside the State, but the overtime requirement is a deterrent. Creative professionals often work odd hours at different stretches, sometimes technically qualifying them for overtime.

This legislation would give companies involved in creative productions the option of allowing employees to work flexible schedules without incurring overtime. Senate Bill 328 is an inducement for job creation in Nevada and an opportunity for creative professionals in our State to gain more work.

SENATOR SETTELMEYER:
I appreciate the problems occurring with the eight-hour bill rules. We have had several bills on the subject. I was curious about the idea of trying to help other individuals. I have had employees come to me and indicate the rules on eight-hour bills have made problems for them. They are looking for something simple like a reset rule. After you work eight hours, then have ten hours of rest, the reset rule would allow them to manage their own schedule. Would this be an acceptable amendment to this bill? Are there individuals coming forward today to testify that employees have a problem with this, and it is not something employers want?

SENATOR HORSFORD:
I respect the position and the interest. I know there are other bills. I would not support an amendment like that because it would be overly broad. My support and issue is on this specific category of creative professionals representing the tourism and entertainment part of our State economy. This is an ancillary part of how we can grow that industry. It came out of the Nevada Vision Stakeholder Group which was created by S.C.R. No. 37 of the 75th Session as one of the strategies we need to implement.

We have a strong industry in gaming, but there are ancillary industries which should be developed around that, and creative professionals are included in one of those industries. As far as employees, I do not have any here today because of what is happening. People from out of the State are being hired as independent contractors on a limited basis to come and perform a limited amount of work. They do that in order to avoid hiring people permanently. I have heard from individuals who want to go into this profession and from employers who want to hire people full-time. They want to have this profession available in Nevada so they do not have to go out of State. We would be able put Nevadans to work for this purpose.

JACK MALLORY (International Union of Painters and Allied Trades, District Council 15):
I have a concern about the definition contained in Title 29 C.F.R., subpart 541.302 because it may include some individuals I currently represent. They would be negatively impacted, although they are covered by a collective bargaining agreement, because of a potential decrease in the standards for their competition. They are scenic artists, muralists and some graphic artists.

Officially, however, we are neutral on the bill.

CHAIR SCHNEIDER:
We will close the hearing on S.B. 328 and open the hearing on S.B. 336.

SENATE BILL 336: Revises certain provisions relating to prescription drugs. (BDR 40-234)

DANIEL LIEBSACK:
Senate Bill 336 revises certain provisions relating to prescription drugs, specifically medical marijuana.

In section 1, the bill requires the State Board of Pharmacy (SBOP) to designate marijuana as a controlled substance included in schedule III. It is currently in schedule I.

Section 2 of the bill requires the SBOP to establish a pilot program for dispensing marijuana by a licensed pharmacy for medical use to persons who hold a valid registry ID card issued pursuant to NRS 453A. The pilot program will last ten years and is going to be set up to determine how it will function. The program now has some issues. We are hoping this bill will move it along.

A qualified pharmacy will be chosen by the SBOP to prepare, compound, package and label marijuana for medical use. The SBOP will also authorize qualified facilities to grow different types, strains and potencies of marijuana.

Continuing in section 2, a physician must obtain certification from the SBOP by paying the SBOP a reasonable fee and receiving periodic training provided by a compounding pharmacy under supervision of the SBOP. If the physician does not comply, the SBOP may impose a fine of no more than $500. The SBOP may

conduct inspections and impose reasonable fees on the compounding pharmacies and take any actions reasonably necessary.

The bill may have a conflict with the Drug Enforcement Agency (DEA), U.S. Department of Justice. The intent of this bill is to regulate and control marijuana in a safe and professional manner. Marijuana is difficult to grow, and the current law is not very scientific and sometimes criminalizes people who seek marijuana for medical use. Patients need to know the tetrahydrocannabinol (THC) level and what is in the marijuana. We do not want it mixed with anything else, and we want to make sure it is free of pesticides. It needs to be regulated.

Marijuana should be professionally grown in a regulated area, and then moved to a place that will package it, license it and send it off.

SENATOR MICHAEL A. SCHNEIDER (Clark County Senatorial District No. 11):
We are coming up against the DEA with this bill. Virtually every week in Las Vegas there is a marijuana bust going on. As people from Las Vegas know, we have had the problems with "Dr. Reefer" and other stores trying to do business. It seems the stores are busted one right after the other by the DEA, the Las Vegas Metropolitan Police Department (Metro) and their Special Weapons and Tactics unit. They are doing things that are not proper.

In Nevada, medical marijuana went to a vote of the people ten years ago, and it passed overwhelmingly. This issue is passing overwhelmingly in the western states. Arizona just passed a medical marijuana issue in their last election cycle. It is passing in very liberal areas like California and in very conservative areas like Arizona. The people are saying yes to medical marijuana. They think there is an application for it and they say it should be prescribed. But, there is a problem with the DEA because they have a rule on the books that marijuana is a schedule I drug. It is totally illegal, but we have the states going square in the face of the federal government on this issue.

I am working on this and trying to develop a better delivery system. In the last ten years, the delivery system has failed. This new delivery system could involve a pharmacy, but I do not want to get a pharmacy in trouble. We are working through this and may need to do a little more work on the bill.

The regulating layers of this bill would include growing and producing marijuana. We would have one entity growing and producing the marijuana, a verification lab for testing and determining the THC levels and a State licensed dispensing pharmacy or center, if we cannot have a pharmacy. This will be a pilot program with the State overseeing every step. The individuals who will be licensed will be screened just as individuals who get a pharmacy or gaming license are licensed. We must know we are getting people who are aboveboard with no criminal backgrounds. This applies to the owners and employers in this pilot project.

We should specify a special degree for people working in the horticultural area of growing marijuana. They will have to be qualified to test the marijuana for pesticides, mold and other problems to be licensed. They will also have to be able to identify the subspecies of marijuana properly and ensure the THC level is appropriate for what is being prescribed. All this will be done in a professional laboratory under the supervision of the State.

The federal government is making a mistake in what they are doing. They have classified marijuana as a schedule I drug. Marijuana is classified higher than cocaine. If marijuana were an addictive drug, we would have heard about it, but it is not addictive. I would like to work with law enforcement agencies, the SBOP and the State Department of Agriculture to develop a ten-year pilot program. We will be able to demonstrate that the program works, and we will share it with other western states.

There is an article in *Time* magazine, from November 22, 2010, titled "The United States of Amarijuana" which lists the states that are growing marijuana for medical purposes: Oregon, California, Nevada, Arizona, Colorado, New Mexico, Nebraska [*sic*] and Minnesota [*sic*]. It is spreading across the nation, all the way to Maine. All the states are doing this, but the federal government is standing in the way. We are attempting to push them out of the way as are all the states.

To be qualified to sell medical marijuana in Nevada and be qualified to assist with individuals' needs, all I would have to do is get a business license and open a retail store. The Legislature is here to protect the public, but we are not doing that right now. Through S.B. 336, we are attempting to set up a pilot program, allow boards or commissions to regulate this program and do whatever it takes to protect the public.

SENATOR COPENING:
You mentioned growing marijuana in your testimony, but your bill does not address growing it. Is there a companion bill?

SENATOR SCHNEIDER:
It was deleted from this bill somehow. We want to allow marijuana to be grown in Nevada so it can be regulated. However, it is not in this bill, so the pilot project may have to buy marijuana from California. Three warehouses have been approved for growing marijuana in Oakland, California. This is a large retail business in California, and the federal government seems to leave California alone.

If we can get the control and the supervision of growing marijuana in Nevada, doctors would be able to prescribe it. Even if doctors cannot prescribe it because of DEA problems, they should be able to make a referral for what the patient needs.

Growing your own does not work. It takes six to eight months before marijuana can be harvested. It is ridiculous to have this process. We tried to craft a scheme to get around the DEA. Maybe we still have to do a scheme to get around the DEA, but Nevada can craft this legislation and lead the nation in the accessibility of medical marijuana and keep it legal and regulated.

SENATOR SETTELMEYER:
I worry about the "Reefer Docs" like they have in California. They admit they are making $125-$150 per prescription when someone walks in and asks for a prescription for marijuana. Is there any way we can address my concerns in S.B. 336 to ensure doctors do not use this for a windfall or to give marijuana to individuals who do not rightfully need it? How do we ensure that we do not allow the errors of California to influence Nevada?

SENATOR SCHNEIDER:
You are correct. This is a good point and we can work on an amendment to the bill. All of the tracking, etc., would be on computer so everything could be verified. We would be able to determine if someone is going to multiple doctors, getting prescriptions from each one, and which doctors are possibly overprescribing. We would be able to create a system which would be reviewed by a qualified board, but nothing is foolproof.

The good news with marijuana is people do not die from an overdose of marijuana as they do with cocaine, OxyContin or morphine.

SENATOR SETTELMEYER:
I understand that, but I still worry that we need to have some form of protection to ensure doctors suddenly do not have 89 percent of their business making prescriptions for medical marijuana. This would probably mean they are not really doing it for medical purposes.

S. ROWAN WILSON:
I am neutral on this bill. Under existing law passed in the 71st Session, only a medical doctor can prescribe medical marijuana. In California, chiropractors, homeopaths and naturopaths are all prescribing medical marijuana.

There was a recent federal ruling involving oncologists, that marijuana does have medicinal purposes, particularly for cancer patients. Most of the raids occurring in Clark County are not by the DEA, they are by Metro. I would like to support any amendment to remove the pharmacy requirement. This bill does not address revising the process of obtaining a Nevada medical marijuana card. This process violates Health Insurance Portability and Accountability Act (HIPAA) laws, requiring registration with the Department of Motor Vehicles (DMV). Patients do not have the time or resources to obtain a card. It is taking six months and longer. Hospice patients have been typically classified to live only six months. We need to amend this bill. The better bill was sponsored by Assemblyman Ed Goedhart in the Assembly.

JOHN WAGNER (Independent American Party):
I support this bill. I met a young man last week who has cerebral palsy and is confined to a wheelchair. He was telling me about his use of marijuana to relieve some of his pain. I was so moved that I have changed my position on medical marijuana. I did not vote for it when it came up as an initiative. It is a good idea.

I would like to add that if you are going to have a valid ID registry, it should be with a photo ID so there can be no attempts to try to get marijuana illegally. I support getting marijuana legally with a prescription. We should do everything we can to relieve patients' pain.

SENATOR SCHNEIDER:
In the 26th Special Session, we had a hearing in Las Vegas. Doctors from the Nevada Cancer Institute were there and we had a conversation about medical marijuana. They indicated the best pain killer is OxyContin. I asked if there was a use for medical marijuana for cancer patients. One doctor stated he worked in a New York Hospital in the late 1980s, and every Monday morning they received a cigar box of marijuana cigarettes which they dispensed to patients in the hospital.

ELIZABETH CONBOY (Chief, Investigation Division, Department of Public Safety):
The Investigation Division (Division), Department of Public Safety, participates in eight narcotic task forces around the State. One of the Division's primary missions is narcotics enforcement under the authority of NRS 453. The Division also has unique authority under NRS 639 which involves prescription controlled substances.

I am not here to make a policy statement one way or the other on medical marijuana. We have some concerns with placing marijuana on schedule III and the impacts it may have on the Division. We will have to continue to enforce the illegal possession of marijuana by placing it on schedule III as well as any diverting of marijuana for illegal means.

The proposed language on page 2, line 32 of the bill states marijuana will be a schedule III controlled substance in any amount. Under current law, it is a misdemeanor to be in possession of less than one ounce of marijuana without a medical marijuana card. On the other hand, it is a felony to be found in possession of a schedule III controlled substance in any amount. So with the inconsistency in these two penalties, this bill is stating, and what we will be dealing with is, if someone is found in possession of less than one ounce of marijuana or 4,000 marijuana plants, the charge will be the same.

In the last year, the Division has gone to great expense to eradicate many large marijuana groves in rural Nevada that have impacted the environment. We would like to see consideration of consistency in the penalties.

The Division also has unique authority under NRS 639. We receive referrals from the SBOP when they believe there is diversion of prescription controlled substances occurring. If something is made more available, consumption will increase. We have an issue now with the diversion of controlled substances,

schedules II, III and IV, and we are unable to work all the referrals we get from the SBOP. Marijuana is the most common illicit substance we encounter in the field, and by placing it on schedule III and making it a controlled substance by prescription, that will impact us from the diversion standpoint of that controlled substance.

The Division's budget is forcing the elimination of some positions this biennium which include several officers who have the mission of enforcing the narcotics laws. I have submitted a fiscal note which is attached to this bill.

CHAIR SCHNEIDER:
What was the fiscal note?

MS. CONBOY:
Currently proposed is the elimination of our Las Vegas office which includes two sworn officers who conduct diversion crime investigations. I have submitted a fiscal note for two officers in Las Vegas. Also, given the impact of this bill and our ongoing investigation of not only the illegal possession of marijuana but the diversion, I have asked for a position in our Elko office and two positions for Washoe County.

REBECCA GASCA (Legislative and Policy Director, American Civil Liberties Union of Nevada):
Our overriding emphasis is certainly in support of this bill. We really appreciate Senator Schneider bringing this forward. I signed in as for, against, and neutral on the bill because on many different issues the American Civil Liberties Union (ACLU) does not fit in one box and this, especially, is one of those issues.

There are many different aspects to allowing medical marijuana in Nevada. Chief among those is the fact this is a constitutional right in Nevada. This is not like many other states where state legislatures have passed medical marijuana laws allowing patients to engage in the use of medical marijuana under a doctor's supervision. This is actually in our State constitution. This passed in two different election cycles by an overwhelming majority; the first time by 58 percent, and the second time by 65 percent. This was ten years ago. We were a much different State ten years ago. If this needed to be revalidated, you would have an even higher majority supporting the use of medical marijuana in this State now.

The problem in the initiative petition was that it did not provide or specify access to medical marijuana, and as a result the 71st Session came to the table in order to be responsive to the will of the voters and set up what we now believe is a very inadequate system.

Patients are allowed to grow their own medicine, but if they cannot, they cannot pay anybody to grow their medicine for them, and they cannot go anywhere and purchase it legally. So you have a patient with a debilitating condition, who is unable to grow it and who has to go to the black market because there is no other way to obtain the medicine. Even if they are able-bodied, the waiting period to allow for the growth of the medicine is an extensive period. They need their pain to be relieved now. By neglecting that aspect of the access, the State has undermined access in its entirety. This situation has created a "catch-22", and is forcing patients to engage in felonious behavior to access what is a constitutional right.

In that spirit, we are here to commend Senator Schneider for bringing this forward. There needs to be a much broader and extended conversation about access in and of itself. We certainly appreciate his idea in having a scheme to look at the different strains, because as the field of medical marijuana has progressed, patients and doctors have recognized that different strains have different benefits for different conditions. There is a movement nationwide to create a professional system to classify the different strains. Nevada could be on the leading edge if we were to grasp this opportunity and respond accordingly.

One of the interesting things about the petition itself was it required the university community to engage in research related to medical marijuana, which they have not yet done. This could be an area in which the State could mandate expansion and could provide a laboratory for this type of research. Private companies have expressed interest to me and other medical marijuana advocates in investing their resources in this State to further that cause.

We are in opposition to this bill because it does not go far enough. A pilot program, in its infancy, would be commendable, but the problem with a pilot program is if one business was allowed to be in charge of growing the plants, and if there were to be an instance of mold in their facility, and all of their plants were lost, that would limit the access of patients to their medicine. If the

patients are not growing for themselves, they have nowhere else to go to get their medicine, thus further funneling to the black market.

In the City of Las Vegas, we have seen continued raids in the black market. I will respectfully disagree with Senator Schneider when he mentioned he could go out and get a business license and provide this service to patients. Currently, it is not legal to provide medical marijuana in exchange for goods or a fee. This is why the raids have been occurring. By and large, those subject to the raids have been individuals who have been engaging directly in the medical marijuana community and have been supplying directly to individuals who do have their cards. They are not the people on the street corners who are selling to people who are not qualified to engage in the use of medical marijuana. Again, there is a "catch-22." These people who cannot legitimately provide this medicine are trying to because no one else has picked up the ball. They are being caught up and charged in an effort of compassionate care. We are against this bill because it does not go far enough.

I would like to address the "Dr. Reefer" issue and the errors of California. Nevada has the prerogative to deal with those doctors who are overprescribing or who are violating ethical laws. There is a complaint system in place where doctors can be evaluated by the Board of Medical Examiners. It is the prerogative of individuals to put forward those complaints. If the Board is not addressing those complaints, then that is a different issue entirely at which the Legislature needs to look. We do not need to continue faulting these medical marijuana patients for lack of oversight over one or two "Dr. Reefers" or his equivalent in this issue.

The State's arrangement for medical marijuana is fairly narrow in scope, especially as compared to other states. There is a shortage of conditions for which individuals will qualify. That small range of conditions has limited the number of patients who are eligible, but has not, unfortunately, helped in their processing issues. We heard testimony earlier in the Session that some patients are waiting six to eight months to be processed by the DHHS. Some of them have died waiting to be processed, which is very unfair.

The State needs to expand its attention to the medical marijuana issue, particularly with privacy implications. The DHHS' sharing information with the DMV is incredibly problematic from a privacy perspective. The ACLU has also heard anecdotal evidence that individuals who are applying for concealed carry

weapons permits are being denied based on their participation in the medical marijuana program. We have also heard complaints that individuals are being denied their opportunity to purchase firearms for being a participant in the medical marijuana program. The DMV is sharing this information. I am not a HIPAA professional, but this is an issue the State really should take a good look at relating to the open liability it may present.

Finally, I would like to disagree with the position of the Department of Public Safety, relating to whether or not a person would be charged with a felony if they had 7,000 plants. They certainly would. The felony charge applies at a much lower threshold for trafficking, and changing the schedule would not affect that.

Changing the schedule is one adequate response the State could have in discussing the use of medical marijuana. Senator Schneider said there are certain instances where there is a medical need. By definition, that proves medical marijuana should not be a schedule I drug. The definition of a schedule I drug is any drug with no medical purpose. The fact the State constitution states there is a medical purpose for medical marijuana means by definition this drug should at least be a schedule II.

I understand the Committee's reluctance to change medical marijuana to a schedule III drug. I can see how you would consider this a big step. You need to know there are other states that do schedule it as a lowest priority. Alaska, Maine and Massachusetts list marijuana in their lower schedules. You would not be alone in adding marijuana to a lower schedule.

This would help the State reorient its priorities away from medical marijuana users and more toward the black market which is a concern many of you have. We need to stop forcing medical marijuana patients to engage in activities in the black market. We need to have an adequate response.

A pilot program could be a good first step as long as it is broad enough. We need to consider oversight, transparency and particularly privacy because without these, this State is going to continue carrying out a medical marijuana program with absolutely no meaning and which fails our patients.

CHAIR SCHNEIDER:
We will close the hearing on S.B. 336 and open the hearing on S.B. 290.

SENATE BILL 290: Revises provisions governing deceptive trade practices. (BDR 52-993)

SENATOR ALLISON COPENING (Clark County Senatorial District No. 6):
I have submitted written testimony (Exhibit F) and a proposed, conceptual amendment on S.B. 290 (Exhibit G).

A small fiscal note was added to the bill by the DBI. They are requesting a full-time consumer affairs compliance investigator. I am hoping the exemptions we will be putting in place will reduce the fiscal note.

JACK MALLORY (International Union of Painters and Allied Trades, District Council 15):
Consumer protection and transparency are obviously things of interest to us because we represent working people. In some cases, these people are vulnerable to the types of practices this bill would affect.

SENATOR COPENING:
This bill came about because of a constituent with issues with one of the satellite television companies. Because of a large class-action lawsuit of which Nevada was a part, this company is now required to submit to various deceptive-trade practices regulations protecting consumers. One of the regulations was if they upgraded their equipment and the customer needed that piece of upgraded equipment to continue with the service, they could not charge for the upgraded equipment. However, this bill does not address this issue.

JOHN GRIFFIN (Sprint; Amazon.com; DIRECTV; DISH Network; TechAmerica):
The clients I represent are opposed to S.B. 290 because it attempts to put a "one-size-fits-all" mentality on automatic renewal contracts. For example, the Apple iTunes contract is entirely different than the Sprint cell phone contract, and the renewal of those contracts is also entirely different. The credit card number left with eBay for purchases or with Amazon.com for renewal purchases is different than the commitment to a contract with DIRECTV which is automatically renewed.

Under the Nevada Unfair Trade Practice Act (Act), the violations to which Senator Copening has referred are already covered under the Act. For any acts of unfair trade practices related to automatic renewals, cancellations,

disclosures or lack of disclosures, the Attorney General (AG) already has the authority, under the Act, to proceed against companies engaging in deceptive-trade practices. Therefore, S.B 290 and some of the provisions on how contracts are renewed are unnecessary because it would apply a "one-size-fits-all" to those contracts.

SENATOR COPENING:
In response to Mr. Griffin, the AG has the authority to start proceedings against companies engaging in deceptive-trade practices, but they must go into lengthy and costly lawsuits. I spoke with the Office of the AG, and settlements are compromises. I would be happy to create amendments to fit some of those companies you specified.

RANDY BROWN (AT&T):
This bill is also problematic for AT&T. This would affect any contract we have with our customers, whether it is residential service, video, wireless, Internet, etc. Senate Bill 290 is about material changes in contracts. Advising customers of a change which positively impacts them, such as reducing their rate, would add a lot of expense and is unnecessary. We would like to work with the sponsor of the bill.

CHRIS MACKENZIE (American Express):
I have not spoken to the sponsor. We might not necessarily be in opposition. This might just be an elaboration on one of the exceptions for American Express. My client would be satisfied if the bill could state that banks, bank holding companies, subsidiaries and affiliates are exempt. There already is jurisdiction under federal legislation which covers many of these concerns for Senator Copening.

CHAIR SCHNEIDER:
If both Mr. Griffin and Mr. MacKenzie could submit amendments or ideas to Senator Copening, she will review them and submit them for the Committee's consideration.

We have received a letter from Mark Sektnan, Vice President, Property Casualty Insurers Association of America, in opposition to S.B. 290 (Exhibit H).

We will close the hearing on S.B. 290 and open the hearing on S.B. 291.

SENATE BILL 291: Revises provisions governing operators of tanning establishments. (BDR 52-957)

MICHAEL BROWN (Melanoma Education Foundation, Nevada Chapter):
I teach high school and middle school students at 192 schools in Nevada. I tell them most skin cancer and melanoma is caused by the sun and tanning beds. If a tanning bed is used ten or more times in one year, the chance of getting melanoma is eight times more likely. This is scary because some of these young people use tanning beds frequently, and tanning beds are not regulated. We need to let parents know this tanning bed law is going to make some action happen. We can talk about this all we want, but nothing is going to happen until someone actually does something and has to pay for something. This is in this bill. Hopefully, this will get the point out that this is so important.

My wife died from melanoma. She was 31, and she died in my arms. The last thing she told me to do was tell people about this. I have to do this for her and for these kids. Melanoma is one of the easiest cancers to cure if it is caught early. Unfortunately, tanning beds will contribute to melanoma cases. This is preventable. I tell young people there are only two ways to get a good tan, spray tans and lotion tans.

I have submitted a document on the mission and background of the Melanoma Education Foundation (Exhibit I), and a number of unbelievable letters from students who heard me speak at their schools (Exhibit J). It tells me they are learning when I speak to them, but that they need to learn more because I cannot be at all of the schools. They need to know about tanning beds and how bad they are. This bill will help stop deaths from melanoma cases in Nevada. There is nothing safe about a tan from a tanning bed.

SENATOR COPENING:
I have submitted written remarks on S.B. 291 (Exhibit K). I have spoken with some people with the Indoor Tanning Association (ITA). They share a concern I have about whether or not a child could get a fake ID and put the tanning facility in harm's way. Parents wanting an easy way to make money could send their children into a tanning facility and set up a fraudulent scheme. We want to work a little bit more on this bill and develop an amendment. There are already laws addressing the use of a fake ID, but I still would like a little more fraud protection in this bill.

SENATOR BREEDEN:
I like this bill. You mentioned fake IDs. How would you verify the authenticity of a written consent? Do you have something in mind to address this issue?

SENATOR COPENING:
I had not thought about what the written consent form would be or whether we would mandate a consistent form rather than something the business can develop on its own with their attorneys. There is some general language used in consent forms. That probably would be the responsibility of the tanning facility.

SENATOR BREEDEN:
Someone could take the form and have a friend sign it and take it back to the tanning salon. Would a parent have to come into the tanning salon?

SENATOR COPENING:
That is a very good point. We actually had talked about it. I do not know if it is addressed in this bill. It probably should be. The intent was that the parent would have to come in and sign the consent form. It was not a takeaway form where they could forge a signature.

SENATOR SETTELMEYER:
On page 2, line 34 should the words “or operator” and the word “establishment” be stricken and just insert “bed?” Why is an individual who owns a tanning bed not just as liable as a tanning salon? If tanning beds are bad, why not impose restrictions on anyone who is allowing someone under age 18 to use a tanning bed?

SENATOR COPENING:
That is a good question. I had not thought about a situation where a minor might use someone’s personal equipment.

SENATOR SETTELMEYER:
Tanning beds only cost about $200 or $300.

SENATOR COPENING:
That is worth looking into.

SENATOR ROBERSON:
Philosophically, I have a problem with this bill. A lot of this is "nanny statism." Right now, in this State, you can get an abortion under the age of 18 without notifying the parents or getting the parents' consent. Yet, we are here today saying you can have an abortion under the age of 18, but you cannot use a tanning bed. There is a problem here with perspective.

CAROLINE GRAHAM (4th Year Medical Student, University of Nevada School of Medicine; Cindi Lamerson, M.D., American Academy of Dermatology):
I support S.B. 291. There is irrefutable evidence of the connection between ultraviolet (UV) radiation from tanning devices and the development of skin cancer, specifically melanoma. Melanoma is the most common cancer in young adults ages 25-29 and the second most common cancer in adolescent and young adults ages 15-25.

Despite industry claims to the contrary, artificial UV radiation from indoor tanning is not a safer alternative to outdoor UV exposure from the sun. High pressure tanning lamps used in tanning facilities emit doses of UVA as much as twelve times that of the sun. No comparable powerful source of UVA radiation exists in nature and the UVA doses per unit of time received by the skin during a typical tanning bed session are far higher than what is experienced during daily outdoor activity or sunbathing.

In 2009, the World Health Organization (WHO) reclassified UV radiation from tanning devices as carcinogenic, meaning it has been proven to cause cancer in humans. This group one classification puts tanning devices in the same category as tobacco, asbestos and mustard gas. In making this determination, the WHO reviewed over 20 studies on UV exposure and the development of skin cancer. They concluded the use of indoor tanning devices before the age of 35 increases the risk of developing melanoma by 75 percent. We know young women make up the vast majority of indoor tanning clients. Almost 70 percent of the 1 million tanners a day are women, and most are within the ages of 16-29.

In 2010, the Federal Trade Commission (FTC) issued a consent order prohibiting the ITA from making false health and safety claims about indoor tanning, further demonstrating the significant health risks associated with this behavior. This government action has reinforced what dermatologists have known for years; it

signified to the public that tanning beds are not healthy, and indoor tanning should be characterized as a risky behavior with a risk of developing cancer.

The FTC consent order is a significant step forward and highlights the importance of adequately informing consumers about the serious health risks associated with indoor tanning and prohibiting the false claims of health benefits from being made by the ITA and other associated organizations. However, more must be done to protect the public.

Senate Bill 291 provides a step in the right direction of regulating the indoor tanning industry in Nevada. The American Academy of Dermatology would recommend prohibiting the use of tanning devices by minors altogether. Multiple research studies have demonstrated parental consent laws are significantly flawed. They are not effective because they are neither followed by salon operators nor are states able to adequately enforce these laws. Unfortunately, parents are not informed of the dangers and health risks associated with indoor tanning, and we find too many parents willing to provide consent. We must do a better job of educating the public about skin cancer and especially melanoma risks associated with indoor tanning.

The American Academy of Dermatology, American Academy of Pediatrics and the American Medical Association have all made strong recommendations that tanning be prohibited for children under the age of 18 due to the increased risk of cancer.

GARY MILLIKEN (Indoor Tanning Association):
I have discussed section 6 of the bill with Senator Copening. We have no opposition to the concept of the bill, only with the proper ID required. The validity of a letter of consent is questionable. We have also had discussions about an ID showing the individual is over the age of 18.

Nevada Revised Statute 205.465 has some language about people who improperly use IDs or have false IDs. I am planning on working with Senator Copening on this issue to find an adequate way to determine who is under the age of 18.

CHAIR SCHNEIDER:
We have received correspondence in support of S.B. 291 from Ronald L. Moy, M.D., F.A.A.D., President, American Academy of Dermatology Association

(Exhibit L), Samantha Guild, AIM at Melanoma (Exhibit M), Ashley McCormick (Exhibit N), Sharon B. Fletcher (Exhibit O), Mary Kranz (Exhibit P), and Sean and Heather Kelley (Exhibit Q).

We will close the hearing on S.B. 291, and having no more business, the Senate Committee on Commerce, Labor and Energy is adjourned at 3:49 p.m.

RESPECTFULLY SUBMITTED:

Suzanne Efford,
Committee Secretary

APPROVED BY:

Senator Michael A. Schneider, Chair

DATE:

EXHIBITS			
Bill	**Exhibit**	**Witness / Agency**	**Description**
	A		Agenda
	B		Attendance Roster
S.B. 278	C	Senator Horsford	Proposed Amendment
S.B. 278	D	Victoria Robinson	Letter of Opposition
S.B. 278	E	Chair Schneider	Letter from Liane Lee
S.B. 290	F	Senator Copening	Written Testimony
S.B. 290	G	Senator Copening	Proposed Amendment
S.B. 290	H	Senator Schneider	Letter from Mark Sektnan
S.B. 291	I	Michael Brown	Mission and Background of Melanoma Education Foundation
S.B. 291	J	Michael Brown	Letters from Students
S.B. 291	K	Senator Copening	Written Remarks
S.B. 291	L	Chair Schneider	Letter from Ronald L. Moy, M.D.
S.B. 291	M	Chair Schneider	Letter from Samantha Guild
S.B. 291	N	Chair Schneider	Letter from Ashley McCormick
S.B. 291	O	Chair Schneider	Sharon B. Fletcher
S.B. 291	P	Chair Schneider	Mary Kranz
S.B. 291	Q	Chair Schneider	Sean and Heather Kelley