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

Seventy-Seventh Session
April 8, 2013

The Committee on Commerce and Labor was called to order by Chairman David P. Bobzien at 12:46 p.m. on Monday, April 8, 2013, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at nelis.leg.state.nv.us/77th2013. In addition, copies of the audio record may be purchased through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblyman David P. Bobzien, Chairman
Assemblywoman Marilyn K. Kirkpatrick, Vice Chairwoman
Assemblywoman Irene Bustamante Adams
Assemblywoman Maggie Carlton
Assemblyman Skip Daly
Assemblywoman Olivia Diaz
Assemblyman John Ellison
Assemblyman Jason Frierson
Assemblyman Tom Grady
Assemblyman Ira Hansen
Assemblyman Cresent Hardy
Assemblyman James W. Healey
Assemblyman William C. Horne
Assemblyman Pete Livermore
Assemblyman James Ohrenschall

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

None

STAFF MEMBERS PRESENT:

Kelly Richard, Committee Policy Analyst
Matt Mundy, Committee Counsel
Leslie Danihel, Committee Manager
Earlene Miller, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

James Jackson, representing Board of Homeopathic Medical Examiners
Diane Kennedy, President, Board of Homeopathic Medical Examiners
Herb Santos Jr., representing Nevada Justice Association
Kathleen Sigurdson, representing Nevada Justice Association
James Kemp, representing Nevada Justice Association
Danny Thompson, representing Nevada State AFL-CIO
Jack Mallory, representing Southern Nevada Building and Construction Trades Council
George Ross, representing Nevada Self-Insurers Association and Las Vegas Metro Chamber of Commerce
Robert Ostrovsky, representing Nevada Resort Association, City of Las Vegas, and Employers Insurance Group
Bryan Wachter, representing Retail Association of Nevada
Jeanette Belz, representing Property Casualty Insurers Association of America and Associated General Contractors, Nevada Chapter
Constance Brooks, representing Nevada System of Higher Education
Randy Waterman, representing Public Agency Compensation Trust
Charles Nort, Third-Party Administrator, Nevada Alternative Solutions, Las Vegas
David Oakden, President, S & C Claims Services. Inc., Las Vegas
Rusty McAllister, representing Professional Fire Fighters of Nevada
John McGee, Private Citizen, Henderson, Nevada
Jim Werbeckes, representing Employers Insurance Group
David Goldwater, representing CBL Toxicology
Lawrence P. Matheis, Executive Director, Nevada State Medical Association
Denise Selleck Davis, representing Nevada Osteopathic Medical Association
Bill Welch, representing Nevada Hospital Association

Fred Hillerby, representing Board of Dental Examiners of Nevada, State Board of Nursing, State Board of Pharmacy, and Nevada Optometric Association
Peter Krueger, representing Chiropractic Physicians' Board of Nevada
John Griffin, representing Nevada Advanced Practice Nurses Association
Paula Berkley, representing Board of Occupational Therapy and State Board of Physical Therapy Examiners
Marlene Lockard, representing the Nevada Speech-Language Hearing Association
Lindsay Culbert, President, Nevada Speech-Language Hearing Association
Diane Ross, Chief Executive Officer/President, The Continuum, Reno

Chairman Bobzien:
We will begin with a work session today and ask our Committee Policy Analyst to walk through the bills starting with Assembly Bill 179.

Assembly Bill 179: Revises provisions governing audits of certain regulatory boards of this State. (BDR 17-770)

Kelly Richard, Committee Policy Analyst:
Assembly Bill 179 was heard in Committee on March 18, 2013, and was sponsored by Assemblyman Oscarson. [Read from work session document (Exhibit C.)]

Chairman Bobzien:
I want to thank Assemblywoman Carlton for working with the bill sponsor to make this bill better and I will be willing to entertain a motion.

ASSEMBLYMAN HORNE MOVED TO AMEND AND DO PASS ASSEMBLY BILL 179.

ASSEMBLYMAN GRADY SECONDED THE MOTION.

Is there any discussion? [There was none.]

THE MOTION PASSED. (ASSEMBLYMAN DALY WAS ABSENT FOR THE VOTE.)

Assembly Bill 334: Provides certain exemptions from provisions relating to contractors. (BDR 54-921)

Kelly Richard, Committee Policy Analyst:
Assembly Bill 334 was heard in Committee on March 27, 2013, and was sponsored by Assemblyman Healey. [Read from work session document (Exhibit D).]

Chairman Bobzien:
I will allow the bill sponsor give us an overview.

Assemblyman Healey:
We feel the amendment achieves the intent of the bill, which is to allow these homes to be sold or rented. We were able to add a cap of $10,000. It also adds a provision that if a licensed real estate professional and/or property manager is found to be not using a licensed contractor to perform any of the work, disciplinary action can be taken against them by the Real Estate Division. It puts a time limit of six months with the cap, which will keep the time from being expanded. All of this work must be performed by a licensed contractor and cannot be performed by the real estate professional or the property manager. There was a note that I would like to make on the work session document, which states that a new definition is added to clarify that a residential property consists of not more than four residential units. It is not a new definition; it is the definition that exists in *Nevada Revised Statutes* (NRS) 645.8711, which was added into the bill for clarification of what residential property means.

Chairman Bobzien:
I will entertain a motion.

> ASSEMBLYWOMAN DIAZ MOVED TO AMEND AND DO PASS ASSEMBLY BILL 334.
>
> ASSEMBLYMAN FRIERSON SECONDED THE MOTION.

Is there any discussion?

Assemblyman Hansen:
Does the amendment include the information from Real Estate Division Administrator Gail Anderson? And, if the real estate brokers fail to keep these records, what happens?

Assemblyman Healey:
We did add that they must maintain these records. It will be in statute that they have to keep these invoices of work, which are kept with the broker and/or property manager.

Matt Mundy, Committee Counsel:
We used the term "shall" with regard to the duty of the reporting requirements, so that places a legal duty for them to meet the reporting requirements or they would be subject to disciplinary action under the chapter, including administrative fines.

THE MOTION PASSED UNANIMOUSLY.

Chairman Bobzien:
I will close our work session and open Assembly Bill 341.

Assembly Bill 341: Revises provisions relating to homeopathic medicine. (BDR 54-1032)

Assemblywoman Maggie Carlton, Clark County Assembly District No. 14:
This bill was brought to me by request toward the end of the requesting period. It went through a couple of iterations, and, therefore, you have a bill with an amendment (Exhibit E) to address some of the issues. I truly see this as a cleanup-type bill dealing with fingerprinting and a couple of other technical issues that I believe the Board of Homeopathic Medical Examiners needs to do. You will see a lot of changes in language, and that represents changes in the way the profession is practiced. Almost all of our homeopathic doctors in the state have either an "M.D." or a "D.O." behind their name. They go through a lot of medical training.

Chairman Bobzien:
A brief overview of the bill would be helpful.

James Jackson, representing Board of Homeopathic Medical Examiners:
In the past couple of sessions, there have been other homeopathic practice-related bills that have been too broad, tried to encompass too much, and collapsed under their own weight. We are not attempting to reach toward or in any way rub against any other medical practice in the state of Nevada, whether licensed or unlicensed. This has to do with the Board of Homeopathic Medical Examiners, in particular the fingerprint and background portion used in the vetting process of applicants. The other changes are designed to improve the function of the Board and the practice of homeopathy in the state.

Diane Kennedy, President, Board of Homeopathic Medical Examiners:
Many of the things in our statutes are conflicting, so this bill is truly a matter of housekeeping. It is designed so that all licensees and certificate holders are held to the same standards. The amendment is to *Nevada Revised Statutes* (NRS) 630A.110, where subsection 5 was left out and needs to be added

because it is the only place in our statute that describes "healing art." The other issue is in NRS 630A.230, NRS 630A.293, and NRS 630A.297, which is to enhance and increase the training in the requirements for our licensees.

James Jackson:
There is some discussion about advanced licensed practitioners and homeopathic assistants. Those occur in a number of places, and the purpose of including them in so many places is to make sure the difference between a license holder and a certificate holder is defined. An advanced practitioner holds a certificate, but must work under the auspices and direction of a licensee. They must also present to the Board a written plan for how their work is to be conducted, and the licensee is always held responsible for any of the actions that one of his assistants may do in terms of his care and treatment of a patient. The certificate holder can also be held accountable by the Board.

Chairman Bobzien:
I have two questions on the amendment. The reference to NRS 630A.230 in subsection 2, paragraph (b) reads, "Has received the degree of doctor of medicine or doctor of osteopathic medicine, or their equivalent." What are the equivalents? Most of the part where it says, "from the school he or she attended during the 2 years immediately preceding the granting of the degree" is stricken, but the result is an incomplete sentence.

James Jackson:
That is a drafting error that we can correct. We have increased the amount of time a person has to do a postgraduate program of study in paragraph (d) of that same subsection. Those have to be read in conjunction. We are changing it from two to three years. The equivalence piece would allow someone from out of the country who has attended schools, which is covered in NRS 630A.240, to present to the Board evidence that they have received a qualified education and can otherwise pass the vetting process. Then they can apply for licensing and be approved by the Board.

Chairman Bobzien:
Please get together with our legal counsel to clarify that. Also, in the amendment regarding NRS 630A.240, in subsection 1, paragraph (a), there is an enumerated list of degrees with a lot of letters. It may be helpful to get the actual names of the degrees and maybe we can get a better mock-up. Are there other questions?

Assemblywoman Kirkpatrick:
Why is there a reference to the United Kingdom?

James Jackson:
We would include the United Kingdom as a country from which someone who has been trained could apply. Canada is already on the list, and it only expands the list by that one country based on the quality and extent of their education. It does not guarantee admission or licensing in the state.

Chairman Bobzien:
Are there additional questions? [There were none.] Is there additional testimony in support?

James Jackson:
This bill was vetted; the amendment was vetted and fully approved by the entire Board. We are here speaking on all of their behalf as well as all of the practitioners. I have not received any indication of opposition or additional amendments.

Chairman Bobzien:
Is there anyone else to testify in support of this bill? [There was no response.] Is there any opposition? [There was no response.] Is there anyone to testify from a neutral position? [There was no response.] I will close the hearing on A.B. 341. I will open the hearing on Assembly Bill 427.

Assembly Bill 427: Revises various provisions governing workers' compensation. (BDR 53-754)

Herb Santos Jr., representing Nevada Justice Association:
I am here in support of A.B. 427. I would like to give a brief background of workers' compensation law in Nevada. In Nevada we have our Nevada Industrial Insurance Act, which covers employee injuries that arise out of and are suffered in the course and scope of employment. Workers' compensation is the exclusive remedy for the injured worker. Exclusive remedy means that an injured employee generally cannot sue an employer for work-related injuries if the employer has purchased workers' compensation insurance as required by Nevada law. The overall system was created to help provide timely and adequate medical services and reasonable benefits to the employee so he essentially does not become a burden upon the social service agencies of our state. You can imagine what it would be like if the family provider all of a sudden did not have the weekly paycheck but did have a huge amount of bills to pay.

However, the benefits are not complete. The employee gives up many benefits that would be available in a civil personal injury setting. For example, they only receive two-thirds of their average monthly wage. Even though employees do

not pay taxes on this money, the amount is significantly less than their normal paycheck after normal deductions. They also receive nothing for pain and suffering. At the conclusion of the case, they may, if eligible, receive a permanent partial disability award (PPD), but pain is never included in the analysis.

The PPD is compensation for the effect the permanent impairment has on the employee's earnings. The average monthly wage is also capped at $5,222. It does not matter what the monthly wage is over this amount. If you are successful in business and make $8,000 per month and you are hurt on the job and cannot work, you receive two-thirds of $5,222.63 per month. It is the employer's choice to offer a light-duty job if the employee cannot return to his pre-accident job. If he cannot, vocational rehabilitation benefits commence. The length of the program is limited depending on the PPD rating. Under most circumstances, the time for a vocational rehabilitation plan will be between 6 and 18 months for a person to receive adequate education to commence a whole new occupation.

The rights of the injured worker are limited, and strict deadlines and guidelines are contained in the statutes and regulations as they pertain to the injured worker. The reality is that workers' compensation benefits allow an injured worker to barely survive until he can get back to work. I have yet to see a client in the 22 years I have practiced in this area tell me that he wanted to stay on workers' compensation. They want to get timely and adequate medical treatment so they can return to work, make full wages, and make ends meet for their family.

This system has the best of intentions but needs fine-tuning in order to ensure that the spirit and the intent of the Nevada Industrial Insurance Act is met. What is important to remember is that these rules were intended to have a system so not only does the injured worker receive timely medical attention and benefits, but that the relationship between the employer and the employee is not strained when there is a work injury. We want injured workers to get the treatment needed so they can return to work as soon as possible and continue to provide services to the benefit of their employer.

The Workers' Compensation Committee, which consists of attorneys from the rural counties, Washoe County, Carson City, and Clark County, worked together to put together the proposed legislation contained in A.B. 427 which would serve these important functions.

We want to make things clear for the injured worker and the insurer. We want to ensure that there is timely payment of benefits to the injured worker by

making clear deadlines as to when payments are due. We want to ensure that the injured worker has sufficient information to make informed decisions about his health care choices. We want to ensure that the insurer obtains medical records timely and schedules independent medical examination appointments. We want to ensure that the insurers comply timely with appeals officers' decisions. This bill will protect the injured worker and will provide guidance to the insurer so the correct determinations can be made, which will, in turn, result in less appeals and litigation. It will also foster the relationship between the employee and the employer, as the contested issues between the employer and the insurer will decline, thus taking out the adversarial issues that often arise. It will allow us to focus on ensuring that the injured worker is informed, and receives timely benefits, while clarifying and explaining current law, which will result in fewer contested issues that create extra cost, time, and stress for the injured worker, the employer, and the insurer. It will also result in not taking up judicial resources in the hearings, appeals, District Court, and Supreme Court levels. Kathleen Sigurdson will go through the bill.

Kathleen Sigurdson, representing Nevada Justice Association:
Our first change would be in section 1. This is simply a change so that it includes all other jurisdictions, not just Nevada. Section 1, subsection 1, paragraph (a), subparagraph (1), adds the language "not subject to similar laws of a state or jurisdiction other than Nevada." Next is a language change in section 2, subsection 1, which changes an "and" to an "or." The law would now read "the imposition of fines or benefit penalties."

On page 4 there are more substantive changes. These changes make sure that the insurer uses the properly licensed administrators. By doing so, it limits it to people who have been trained and who are licensed and supervised by the state of Nevada in administering these claims. I have some cases that are administered out of the state of Illinois. By law, they are supposed to have offices here and an 800 number so the claimants can reach them by phone. Arguably, they do, but nonetheless the office where this is being administered and checks are being issued is in Illinois. That is a hardship on the client because he is not getting his checks timely and because he cannot go and talk to anyone if there is a problem. Having face-to-face or meaningful contact with these people helps move the case forward and answer questions.

Section 4 has to do with timely payments of the temporary total disability and other benefits, such as mileage and reimbursement. This section mandates that checks that are due to the claimants be issued on the day that they are due. It is very important to the injured worker that he gets his money timely. There is a loophole that allows checks to be mailed which causes a delay. We are

trying to tighten the system so it is more friendly to all parties and everyone knows what they are supposed to be doing in a timely manner.

Section 5, subsection 1, paragraph (c), gives the claimants the right to know what their options are as far as doctors. By current statute and regulation, the administrators are allowed to identify a preferred provider list just like health insurance companies, but the injured workers do not know who the physicians are on the lists. The insurer must provide a list of doctors that the injured worker can see and provide the list to the worker so he knows what his options are in choosing the physician.

On page 6, the changes fix timelines to some of the obligations of the insurer. These timelines give them specific response times. They must act within 30 days after an order. Within 14 days after an order, they must submit a request to a physician to conduct a medical examination. In section 6, subsection 3, paragraph (b), subparagraph (1), it says if a physician or chiropractor agrees to conduct the medical examination, it has to happen within 14 days. In subparagraph (2), if the physician or chiropractor does not agree to conduct a medical examination within 30 days of the initial request, the insurer must find another doctor. Especially in rural areas, it is difficult to find doctors who are willing to do these requests, but it can cause a delay in the system. The injured worker could be held in suspense in terms of medical care and determinations because something is sitting on the insurer's desk or a physician's desk. This provision gives some timelines to keep his claim moving. It will benefit the injured worker and the insurer.

Section 6, subsection 7, gives the insurers strict timelines to move forward. This assists both the claimant and the insurance company. The biggest cost driver in any workers' compensation claim is the temporary total disability. That is the check the injured worker gets every two weeks. The faster a claim moves forward, the less money an insurer or administrator is going to have to pay on the case. It is important that we have these timelines for the injured workers to get medical care and also for the insurance companies so they save cost.

In section 7, subsection 2, paragraph (a), the language should be changed to "5 business days." There are times when adjustors or somebody administering the claim might not be in the office. The insurer shall send out medical releases to an injured worker if they have any inclination that there may be a preexisting condition that needs to be investigated.

Chairman Bobzien:
Is that the only reference to days and timelines, because some of the opponents had flagged that concern. Is the intention to have business days across the board?

Kathleen Sigurdson:
Yes, it is business days across the board. Under subsection 4, the insurer shall request medical records within five days, provide the injured employee with copies of the requests made to the medical providers, and make reasonable efforts to obtain those medical records within 30 days. All of these are timelines to move the claim forward. It gives the insurer some very specific timelines to keep the case going forward.

In section 8, subsection 2, paragraph (d), we included the words "or jurisdiction." If there are people assigned to work out of state on a temporary basis and their assignment should be to a place that is not a state but under the jurisdiction of the United States, this would include places such as the District of Columbia.

Section 9, subsection 11, adds language which states that the insurer shall comply with the decision rendered by the appeals officer within 15 days. It is currently 30 days. Fifteen days would shorten the time frame in which the compliance has to be done, which means the claim will move forward more timely. It has been brought up that the 15 days for compliance with the appeals officer's decision is not in line with the current standard of 30 days, but section 10 also changes that to 15 days. If the claimant should win at the appeals level and the insurer wants to take it to the next level, they must do that within 15 days. That will give the claimant the opportunity to move on with their life as quickly as possible. Unfortunately, there are cases that last years. I have had one case for six years. There is no reason a person's life should be put on hold for six or seven years while waiting for appeals to happen.

In section 11, subsection 3, paragraph (b) removes the words "or benefit penalty." This is so there could be a benefit penalty if there is an underpayment. The unfortunate reality is that there are always some bad actors in any system. By removing those words, it is putting the option of the benefit penalty back into the system, as an outlet, if there is a bad actor on the insurance side who is not paying claimants enough money.

In section 12, subsection 5, we want to change the words from "cease when" to "continue until." When a doctor says an injured worker is able to return to work or participate in vocational rehabilitation, the temporary disability currently

must stop. We would like the monies to continue until a physician says that the injured worker is capable of returning to work.

Chairman Bobzien:
What is the intention of that change?

Kathleen Sigurdson:
We would like for the claimant to receive benefits as long as possible, which means as long as it is legally available, so he can move forward with his life in a successful manner. We do not want the influence of the insurer to determine when payments will stop. We want the physician to say when the injured party is ready to return to work.

Herb Santos:
One of the benefits to the injured workers is the PPD evaluation. *Nevada Revised Statutes* (NRS) 616C.490 is the statute that governs that. One of the issues that has come up that I have litigated numerous times is the issue of apportionment. The changes we attempt to do in section 13 on page 17 of the bill is to clarify and give guidance to the insurer as to how that apportionment should be done. Currently, we have different PPD rating doctors that apportion PPDs differently. If a person has a preexisting condition, it will determine how that preexisting condition will be apportioned out of the PPD evaluation. Some doctors will see degenerative changes in the spine and apportion that out even though that is not creating any impairment. Nevada has adopted the American Medical Association's (AMA) *Guide to the Evaluation of Permanent Impairment.* Currently we use the fifth edition to determine a person's ratable impairment. The AMA guide was originally published in 1971 and has been around for a long time with various editions. Its goal is to establish a standardized, objective approach to evaluating medical impairments for purposes of workers' compensation benefits. In those guides, it sets forth impairment criteria that certified rating physicians and chiropractors use to evaluate injured workers and give them an impairment percentage or rating.

In addition to the statute, we also have *Nevada Administrative Code* (NAC) 616C.490, which gives further guidance on how to do the apportionments. In decisions in which I have been involved at the appeals level, the rating physician needs to determine what type of impairment the person's preexisting condition had on his daily activities at the time of his industrial injury. If the injured worker was able to do all of his daily activities without any change or loss of range of motion and without any problems, the fact that he has some preexisting condition would not subject the rating to apportionment. Only if that preexisting condition was causing some type of impairment at the time of the industrial injury would it be considered. That is why we are getting

inconsistent PPDs from the rating physicians. I litigate those for my clients, but the concern is for all of the people who may not have legal representation and are automatically getting their ratings apportioned improperly because they have some type of preexisting condition.

We all have preexisting conditions, but does it affect a person's daily activities and is it ratable under the AMA guides? This change in the law would make it very clear, when you look at the statute as a whole, that the rating physician has a responsibility to determine what was the impairment, if any, at the time this person suffered his industrial injury. If the person did have an impairment, the apportionment should be proper. In looking at paperwork from the opposition, there was an example of a person with an amputation. It is very clear that a person had a prior amputation, so the doctor would be able to look in the AMA guides to determine how that amputation would be properly apportioned. The guides provide for that. We believe that this will make it very clear for the insurers. The rating physician will have guidance on the standard for the apportionment. This will result in fewer contested issues because it will be very clear whether the PPD should be apportioned or not.

James Kemp, representing Nevada Justice Association:
Section 14 has to do with the PPD lump sum payment that resolves all factual and legal issues in the case and has the claimant waiving his rights with the exception of the right to reopen, the right to vocational rehabilitation, the right to have consideration under NRS 616C.392. This change is contingent upon the repeal in section 17 of NRS 616D.030, which would reestablish a tort claim for insurance bad faith in workers' compensation in Nevada. If that is reinstated, there would be no reason to have this language with respect to benefit penalties. That is all the change in section 14 is doing.

Section 15 has to do with vocational rehabilitation. It is to clarify that a workers' compensation vocational rehabilitation plan does not begin until we know the percentage of permanent impairment. There is an error in language on the top of page 20. It talks about "treating physician or chiropractor" but should say "rating physician or chiropractor." It is important to know what the percentages of disability are. That dictates how long a period of vocational rehabilitation the person receives. It is very important that insurers not begin the process too early. This ensures that the plan for rehabilitation does not start before we know what the percentage is.

Sometimes an injured employee is not able to continue temporarily with a vocational rehabilitation program and the insurance company suspends his benefits. Section 15, subsection 11 clarifies that insurers shall notify injured employees what action is required in order to reinstate the benefits, lift a

suspension, and to make sure there is clear communication about what it takes to get the claim back on track. It also provides that an insurance company assist the worker to get the claim back on track. Subsection 12 adds a provision for the Division of Industrial Relations to engage in a rulemaking process to make it clear, so everybody knows what rules will be followed. The Division of Industrial Relations is the appropriate agency to engage in the rulemaking to make those provisions clear.

In Section 16 there are amendments to NRS 616D.120. The first change is to require the compliance in 15 days from the date of a decision of a court, hearing officer, or appeals officer or the Division unless a stay has been granted. It is generally enough time, especially at the appeals level, where there is a letter sent out and everyone knows what the ruling is going to be. Shortening that time frame makes the case move forward and gets the injured employee his benefits more quickly. The other parts of section 16 have to do with the benefit penalties. On page 24, line 7, it changes the entities that could be charged with a benefit penalty to "an organization for managed care, health care provider, employer or employee leasing company." It takes out the insurer and the third-party administrator. This contemplates a repeal of NRS 616D.030, which would permit insurance bad faith toward actions which existed prior to the mid-1990s. Those would be amendments to that provision to say who benefit penalties will apply to and who it will not.

The final section of the bill would repeal the limitation of liability on the insurer and third-party administrators to the administrative fines and the benefit penalties. We want to repeal that and reinstate insurance bad faith in the workers' compensation context. There are bad actors. They deny claims and benefits without regard to the clear evidence. They make it their priority to not pay the injured employees. When insurance bad faith was taken out of the law in the mid-1990s, it was primarily a state-run system. The State Industrial Insurance System was an arm of the state, and that was a primary consideration in doing away with bad faith at that time. Now we have a profit-motivated private insurance system that has gotten worse and worse as time has gone by. We need to restore the balance of power so insurance companies know that if they act in bad faith, they will face the consequences. The harm that is done is beyond what can be remedied solely by administrative fines and the benefit penalty system, which has not resulted in insurance companies being held to account for the harm they have caused. These bad actors should be judged by a jury and pay the full measure of the harm they have caused. That is why we are seeking the repeal of NRS 616D.030.

Herb Santos:
In some of the opposition paperwork that I saw there was an argument that what we were trying to do by repealing NRS 616D.030 was to take away the exclusive remedy. That is not at all what we are doing. Exclusive remedy prevents the injured worker from suing his employer if they have been injured on the job as long as they maintain workers' compensation insurance. This section brings back the responsibility of the insurer who is administering the claim, so that if he is a bad actor, he will be held accountable for any harm caused to the injured worker. The exclusive remedy is totally different, and it is something in which we strongly believe. Only under the circumstances where an employer does not carry workers' compensation insurance in the state of Nevada will he have the possibility of being held accountable in a civil action. There is another provision that provides that an employee can make an election to either go after his employer, if he does not carry workers' compensation insurance or go in the uninsured fund. The uninsured fund can go after the employer for any benefits they paid. In no way does the repeal of NRS 616D.030 do what the opposition paperwork alleges, which is to take away the exclusive remedy. That will stay in Nevada as a strong part of the law. We want responsibility directed to the bad actors who create harm for the injured workers and their families.

Chairman Bobzien:
Are there any questions? [There were none.] Are there others in support of this bill?

Danny Thompson, representing Nevada State AFL-CIO:
This bill does not eliminate the exclusive remedy in workers' compensation. I will explain the history of the benefit penalty. Prior to 1993, if a person purposely delayed or did not treat an injured worker, the worker had the ability to bring a bad faith lawsuit against him. In its original form, a sweeping reform package in 1993 eliminated 50 percent of the benefits to injured workers. It also negated every positive Supreme Court ruling that was ever made prior to 1993 in favor of injured workers. It put this provision in the law for a benefit penalty instead of the ability to bring forth a bad faith lawsuit. There had never been a bad faith lawsuit in Nevada prior to this being done.

This sweeping reform has hurt people. The section that is proposed to be eliminated, NRS 616D.030, says, in effect, that a person cannot bring any cause of action against an insurer or a third-party administrator (TPA) who violates any provisions of workers' compensation. We found TPAs who were going to insurers and saying they would save them 75 percent on their costs and here is how we will do it. In fact, they did. It is a statistical fact that if you deny 100 percent of claims, only 50 percent will file appeals. Of the 50 percent, the insurer will win 25 percent of the claims. Therefore, the cost

will only be 25 percent. There were actually TPAs in Nevada going to businesses, selling that model, and delivering on it because that is true. It has been a gross injustice to workers.

This provision holds those bad actors accountable. If you are purposely mailing the check to the wrong address, which we also found, and you know the person lives in a different place, or you continue to deny, it gives the injured worker the ability to go to court as with any other insurance policy. This allows you to seek remedy for bad faith. Bad faith is very difficult to prove and to my knowledge there had never been one prior to 1993. We support this bill wholeheartedly.

Jack Mallory, representing Southern Nevada Building and Construction Trades Council:
We thank the sponsors for bringing this bill and this important subject for discussion. One of my members fell into a hole on a job site in Henderson that was covered by opaque plastic in 2009. It was a six-foot fall, and he hurt his back. He followed the procedure and was evaluated. The claim was denied when he answered the questionnaire and said that he had been in a car accident 31 years prior to the incident when he was injured. Three years later, he is still waiting for the final appeal for the resolution of his case. He was found to have been injured, is owed a substantial sum of money, and lost his house, car, and the ability to provide for his training. There was no retraining available for him. The only thing he was able to get was medical care through our trust fund. The man will never be whole. The retraining that should have been paid by workers' compensation was paid by our apprenticeship training trust. He is now able to work and is part of the industry in a different role.

All of this could have been alleviated if the third-party administrator who habitually denied over 90 percent of claims had done the right thing. Instead of focusing on profits, focus on people. Focus on processing claims. Get people back to work, and you will mitigate costs.

Chairman Bobzien:
Are there any questions? [There were none.] Is there anyone else to speak in support of this bill? Seeing none, we will hear opposition testimony.

George Ross, representing Nevada Self-Insurers Association and Las Vegas Metro Chamber of Commerce:
In general we oppose this bill. [Submitted written comments (Exhibit F).] It makes it almost impossible to comply with the statutory time commitments. There will be extraordinarily more lawsuits because, as our people believe, the time limits are not reasonable. Section 3 talks about the insurer being

responsible for the actions of its TPA, including, but not limited to, licensing and the assessment of benefit penalties and administrative fines. I know conceptually why that would be in there, but in reality the TPA has expertise. If he fails to administrate a claim properly and is assessed a fine or penalty, that is appropriately imposed against the at-fault party, which is the TPA. In many cases, the insurer has a contract with the TPA and the insurer is barred from directing claims management. That is the responsibility of the TPA. Essentially, a party that has statutory limits on its ability to direct decision making is being fined. While we talk about benefit penalties here, there are other sections in the bill which seem to eliminate benefit penalties.

Section 4 deals with the question of whether or not a check is received. If this is passed, the only way the checks could be mailed would be by FedEx overnight, which is expensive. If you want to do direct deposit, many banks require a zero-dollar transaction, and that delays the process for a week or two to start. In many cases, the worker is not off work too long and will be back at work before the direct deposit is ready to be made. [Continued to read from comments (Exhibit F).] In section 4, subsection 2, "presumed to be unreasonably delayed" is unacceptable. You need to defend against a presumption that every time it is late, it is wrong.

In reference to section 5, subsection 1, paragraph (c), not all insurers have a website. Some very large corporations in Nevada do not have workers' compensation websites. Not all insurers administer their own claims, as is the case of those who contract with TPAs, which is again the case of many large employers, nor have they been responsible for maintaining a provider list. This also does not specify how often an insurer must send a provider list to the claimant. Currently, *Nevada Administrative Code* 616C.030 requires any party to submit in writing to request a provider list and a statutory timeline of three days for providing it, which is one of the shortest timelines with which the industry has to comply. The new provision would directly contrast with that. There are many things that can happen with emails. Things get lost in junk mail.

Chairman Bobzien:
In this day and age, across health care broadly, whatever we can do to provide greater on-demand access to this sort of information would be good.

George Ross:
We will try working in that direction. Confidentiality is a concern and once something is on the Internet, it changes it in terms of privacy. When a complete provider list is provided, it would probably increase the expense of the

system because people would immediately call a specialist instead of a general practitioner.

Section 6, subsection 3, is a problem for the industry. Many specialists require records prior to allowing the scheduling of an appointment, which can often take a long time. The doctor may not want to see the patient once he has seen the records. If he does agree, it is almost impossible to get an appointment within ten days. If the doctor does not see the injured worker, or he cancels the appointment, these things need to be considered. The 30-day provisions are often outside of the control of the insurer or the TPA. We understand the need to have people seen, but we cannot dictate to the doctors, and sometimes it is worth waiting for a particular doctor.

We appreciate that the time is now business days. The signing of a release is not the same as the date of receipt of a signed release. The purpose of a signed release is to obtain any and all prior medical records disclosed on the signed release. This takes time to request and secure. An evaluation will be incomplete and invalid if all pertinent records are not supplied to the evaluating physician. These time constraints are difficult to meet. Many times the evaluating physician may recommend additional diagnostic studies. Under NAC 616C.148, a physician is allowed 14 days to submit medical reporting.

Under point 9 of my submitted comments, there may not always be a determination required following an examination, depending on the purpose of the examination. [Continued to read from comments (Exhibit F).] The industry does not feel they can meet these timelines because many of them are out of the control of the industry. We do not have a surplus of doctors, and it is in the employee's interest that we try to use the best doctors who are willing to accept workers' compensation cases.

In point 7 of the comments, if the claimant denies a preexisting condition, he should also still be required to sign a medical release and indicate "no" on the form. [Continued to read from comments (Exhibit F).]

Under section 13, with this change, a rating physician would not be able to apportion the permanent partial disability (PPD). This changes the whole basis for apportionment. We quoted the opinion of Dr. Jay Betz , a rating physician, regarding Assembly Bill No. 256 of the 76th Session, which was a virtually identical bill (Exhibit F). The new language would similarly limit the ability to apportion for a preexisting condition. [Continued to read from comments (Exhibit F).]

In section 15, this bill inaccurately defines a treating physician or chiropractor as the rating physician. [Continued to read from comments (Exhibit F).] One of the most important parts of this issue is that our people like to get started early to return to work.

Section 15, subsection 11, paragraph (b) does not relate to subsection 11. The functional capacity evaluations must be prescribed by a physician with a medical degree. [Continued to read from comments (Exhibit F).]

The proponents would like to allow bad faith lawsuits. Between the bad faith lawsuits and much of this bill's shortened time frames, my client believes that it would be almost impossible to meet many of the deadlines in a practical sense. This would open a whole world of new lawsuits. Many bills have been presented this session with the intention of improving the business climate, and for that we are grateful. Many have been brought to help businesses come to Nevada and to help businesses that are here. We are looking for ways to create jobs for more Nevadans. This bill, as structured, with the stress on the resumption of bad faith lawsuits, goes in the opposite direction. This bill is contradictory to what you are trying to do.

Several years ago, we had an extensive negotiation about workers' compensation. We laid out a more detailed and extensive regulatory program to penalize the bad actors. We always have, in any industry like this, a situation where the good actors are lumped in with the bad actors. The laws are designed to control the bad actors and that makes the system worse for everybody. We are willing to talk and we have laid that out and think it was a reasonable proposal to deal with certain situations. When the business community in general sees bad faith lawsuits, it scares them tremendously for what is ahead.

Robert Ostrovsky, representing Nevada Resort Association and City of Las Vegas:

If the Committee members were here ten years ago, every day your phone would ring with a call from a claimant who was complaining about his claim. He did not get his check on time, his claim was denied, or no one would talk to him. We made some significant changes in the 1990s and the early 2000s in the way workers' compensation is treated here and how employees are treated. Things got better. We do things in a more timely fashion and we do not have lines of people. The system is not perfect, but it is not as bad as this bill reflects.

We have argued about timeliness for years. Shorter time requirements are almost impossible to meet. We cannot get transcripts of hearings, medical reviews, and claims examiner reviews, so we reject those.

The repeal of right to maintain a lawsuit was put into the benefit penalty section because we had people doing bad things. The Legislature decided at that time that we were going to handle it with fines and benefit penalties, and those funds would flow to the injured worker. We have increased those fines up to $50,000. We hear that there are lots of violations, but I disagree with that. I think the only one who knows that is the Department of Industrial Relations (DIR), which adjudicates benefit penalties, collects them, and pays them out. We have to look at their reports to determine how we are doing. In general, I think we are doing pretty good. Today it was stated that 90 percent of claims are denied by certain TPAs. I would like to see that record. I do not believe the DIR has seen it, and they maintain an audit program for TPAs and insurers.

Never let us forget that Nevada is the only state that has lifetime reopening. If a worker gets injured in California and gets paid a benefit, at the end of the claim, he gets a settlement. There are rules and procedures related to the settlement procedure, but it is like an automobile accident. You get a check, sign a final document, and the case is completely and totally settled. In Nevada, the worker can come back years later to reopen the claim. That puts a special burden on our ability to manage these claims appropriately and go back to get old records and make decisions on claims that are very old. There were a lot of trade-offs made when we added exclusive remedy for the employee to the statute. It is the same as exclusive remedy you will find in almost every state in the nation. Texas does not even have mandatory workers' compensation insurance.

The grand bargain is, no matter how an employee was hurt at work, whether it was their fault or the employer's fault, we are going to pay for the claim. We take all comers and we pay all claims. In exchange for that, we have certain duties and obligations in the statute. If we violate those, we get pounded by DIR. We think that is the appropriate way to do that. We would be happy to meet with the other party. I think we are a long way apart relative to what is or is not fair.

Chairman Bobzien:
Are there any questions?

Assemblyman Hansen:
Do the sections that are being deleted in section 17 of this bill go back to the Nevada Industrial Commission and the State Industrial Insurance System? The benefit penalties are being removed, and currently the fines are up to $50,000. Do they get those without having a lawyer bring a lawsuit?

Robert Ostrovsky:
There is no lawsuit involved. It is an administrative procedure. In Nevada there is a free attorney offered to any injured worker. That attorney is known as the Nevada Attorney for Injured Workers and is paid for by the insurance industry, which gets an assessment. That office is in southern Nevada. That budget goes through the Legislature like any other budget. We fund that. The worker gets a free attorney if he needs one, but you do not need an attorney to file for a benefit penalty. It is not a bad idea to have an attorney, but you can get a free one and you do not need to share your award with anyone.

In 1993, we codified the fact that there was no bad faith. It was the State Industrial Insurance System or the Nevada Industrial Commission. There were no third parties except some self-insured employers who just started in the late 1980s and early 1990s. There were a few big self-insured employers. I think lawsuits were contemplated.

We have a new problem. Does the Legislature want to allow lawsuits or find some other administrative remedy? The decision then was the administrative remedy. This Legislature could change that. It could turn the world upside down, get rid of benefit penalties, and change to a tort system if you feel that is more appropriate. I do not think it is more appropriate. I like what we have. If there are problems with the system, we ought to strengthen it. If the fines are not big enough, we ought to talk about them. If it is not fair to one side or the other, we need to talk about it, because it seems that it has worked well. It was the state against the workers back then.

Assemblyman Hansen:
I do not want to see the money going to attorneys versus the injured workers.

Assemblywoman Carlton:
I was around when many of these discussions were taking place. I would have never wanted to give exclusive remedy to a private for-profit corporation. I believe they need to abide by the law and when they do not, someone should be able to call them on it. An administrative fine is nothing but a slap on the wrist because the denials end up profiting that for-profit company. When we turn this into a for-profit entity, I do not think we should give them exclusive remedy. When workers' compensation programs were begun in 1911, it was to

protect employers, not insurance companies. They have a different level of responsibility, not only to the public, but to the employers that are paying premiums. How can an employer think about paying that premium to the company and having the company use their exclusive remedy to protect themselves while they are breaking the law? These are the laws of the state and this is how it is supposed to work. In my mind, this is not a change in bad faith; it is holding the industry that the employer choses to do business with accountable.

Some of the testifiers represent both sides of the coin. We have to be careful. We have the chamber of commerce, employers, self-insurers groups, and insurance companies. What may be good for the insurance companies, may not be good for the employers and vice versa. We need to be sure we put on the record who is being represented, how they are being represented, and what the relationship between the two actually is. I believe in exclusive remedy. I do not believe we should be protecting insurance companies that are denying rights to injured workers who are being paid by employers. The employers are not getting the workers back, and ultimately the goal was to get the worker back to work. If the workers do not get treatment, they do not get back to work, and we have a bigger problem with the state.

This is the underlying discussion that has happened for the last 16 years that I have been in the Legislature. If you get hurt at work and do not see the workers' compensation doctor but rather go through your private insurance, the cost is being shifted to the different health and welfare trusts and the private insurance companies in this state are picking up the cost of injured workers, because the workers do not want to be put through the grist mill of the workers' compensation system in this state when all they want is to get care.

I understand the discussion about bad faith, but I do not believe it applies to insurance companies. It is a protection only for the employers, and eventually all of the employers in the state are going to end up paying for it. I am very wary of who is actually speaking on what side of this issue and who is protecting whom.

Chairman Bobzien:
Are there any further questions? [There were none.]

Bryan Wachter, representing Retail Association of Nevada:
Our members are members of the Nevada Retail Network, which is the largest self-insured group in the state and one of the largest self-insured groups in the country. We are very proud of our group, and we accept between 93 and 96 percent of all claims. We attempt to work on it really quickly. We agree

wholeheartedly with Assemblywoman Carlton that the point of workers' compensation is to bring our employees back to work. We have extensive vocational rehabilitation programs and training in our self-insured group.

The goal for our self-insured group is to get the workers back to work. It is much cheaper to get the worker back to their job than to retrain somebody new. To clarify, because we are a self-insured group, we represent employers. Our members make up the self-insured group and we own the group. That is the key difference. We do not buy an insurance product on the market; we become self-insured. That brings a lot of responsibility. Our business owners become liable for every claim that is administered under our group. It is a huge responsibility that our employers take very seriously. We do not make money off of denying claims. We make money by doing it efficiently and getting our employees back to work and being able to lower our premiums. Our employers will see the most reward in having the most efficient program possible.

For us, in section 3, self-insured groups are different from insuring companies. We cannot have control over our third-party administrator. We do not administer our own claims. For us to have to be responsible for the actions of the TPA, in terms of benefit penalties and administrative fines, there is no control there. It was designed to not have control so they are administered properly, and there is a big division between those two. By changing the statute and adding new sections, our insurers will become liable for the TPAs. They are two different entities and not controlled by the same group.

In section 5, subsection 1, paragraph (c), we provide the list of chiropractors or treating physicians to the extent that they are applicable to the injury. We do not send our entire provider list to everybody. Once there is a determination of the type of injury, we will send our list of appropriate providers. It makes it less burdensome. We hope that you would consider allowing some leeway between providing the whole list and the sections that are useful.

In section 11, subsection 3, paragraph (b), by removing the benefit penalty, the remedy provided in paragraph (a) becomes subject to the imposition of any fine because it is not the TPA that is being considered. All benefits and administrative penalties are going to end up being paid by the employer for self-insured groups. If you can hold the insurer, which in this case is the employer, responsible for the TPA's administering and their fines, it will all come back to our employers.

Section 13 talks about a previous condition. If the employee himself is not aware of the condition, it is deemed to have been caused by the accident. If there is no documented medical evidence before the injury that the preexisting

condition resulted in a disability, the apportionment cannot be reduced. As it is now, it is very medically dependent, at least for the self-insured groups. A doctor has to say this is your medical history and here is where we think your apportionment is. We believe that should be based on medical records and not a presumption that if the records do not exist, you automatically do not have to apportion for a preexisting condition.

Our members are members of the Nevada Self-Insurers Association (NSIA), and we prefer the NSIA's comments. If you look at the exclusive remedy, this is a way to get back at employers, especially for the self-insured groups where the insurer is the employer. You are going to hold the employers directly liable in a court. When the proponents mentioned that the goal is to reduce the instance of having to go to court to adjudicate these, or to get an appeal, I think this will have the opposite effect. I think you will see more of these cases in court.

Chairman Bobzien:
Are there any questions?

Assemblyman Ellison:
Do the self-insurers keep track of false claims?

Bryan Wachter:
I am sure we do, but I do not know how they are tracked. I would be happy to get that information to you. We are very diligent on our claims.

Assemblyman Ellison:
If you had an employee with a precondition, could it destroy your budget?

Bryan Wachter:
I think it would be a case where you are holding the employer liable for a preexisting condition without having knowledge of that condition. I can take you to a parallel, which is on our subsequent injury guidelines. We do not allow employers to be held responsible for a subsequent injury if the employer does not have knowledge of the first injury at the time of hire. We would find it difficult to automatically assume that a preexisting condition will be non-apportioned if no medical records exist.

Assemblyman Hansen:
If the insurance company is the bad guy and does not do some of the things that we want him to do, he is only fined up to $1,000, or, in the worst case, up to $50,000. In looking at section 16, subsection 8 of the bill, "The Commissioner may, without complying with the provision . . . withdraw the certification of a self-insured employer, association of self-insured public or

private employers or third-party administrator if, after a hearing, it is shown that the self-insured . . . violated any provision of subsection 1." Subsection 1 gives a list of reasons that would allow the administrator to withdraw the insurer organization's certification. Does that mean if I am an insurance person and they withdraw my certification, I am out of business?

Bryan Wachter:
We do not take a $50,000 fine from the DIR lightly. I do not know if that is because we are not an insurance company or if it is because our members are the ones who are going to be directly impacted. We think the DIR has plenty of teeth to be able to go after the bad actors. That is why there are administrative penalties and benefit penalties. For our self-insured groups, this bill would provide that an independent TPA could make those mistakes and an insurer would be responsible for them. We feel the DIR has adequate tools to do this.

Assemblyman Hansen:
The $50,000 in the insurance world is a drop in the bucket, but to lose your license carries major weight. If there is a bad apple and he loses his license, that is a much more significant penalty. Maybe I should ask our legal counsel.

Matt Mundy:
I do not know if it necessarily puts them out of business; it does not allow them to be a self-insurer. After a hearing, they would be able to withdraw the certification to allow them to operate in the state.

Chairman Bobzien:
Are there additional questions for Mr. Wachter? Seeing none, is there other opposition testimony?

Jeanette Belz, representing Property Casualty Insurers Association of America and Associated General Contractors, Nevada Chapter:
We oppose this bill.

Constance Brooks, representing Nevada System of Higher Education:
We are also opposed to this bill as we are not a part of the state workers' compensation program and are self-insured.

Randy Waterman, representing Public Agency Compensation Trust:
I am here representing a group of 124 self-insured public entities that represent about 11,000 employees. As the previous testimony stated, things like benefit penalties and fines would be a big hit to a self-insured employer. We strongly oppose A.B. 427 as it does nothing to control the cost for Nevada employers, but imposes unreasonable time frames and unnecessary burdens that serve to

increase litigation, frustrate nearly everyone, and increase the cost of doing business. This bill will certainly have a fiscal impact. We estimate that it could increase our workers' compensation cost by as much as 10 percent at a time when employers are beginning to see some signs of recovery at the end of a very protracted economic downturn. This is certainly not the time to enact laws that will stifle our recovery. As such, we ask that you do not support this bill.

Chairman Bobzien:
Are there any questions? Seeing none, is there any other opposition?

Charles Nort, Third-Party Administrator, Nevada Alternative Solutions, Las Vegas:
I would like to offer my total opposition to the bill and concur with the statements previously made by Mr. Ross and Mr. Ostrovsky. I will concentrate on sections 9 and 10 that have been previously discussed and specifically the time frames. In regard to section 10, when we receive a decision from an appeals officer, we have 30 days to appeal and obtain a stay. If that is not complied with in that amount of time, we must comply with the decision and order. To circumvent the appeal time and change the number of days required to 15 days to get into compliance does not even give us the time to appeal. More importantly, to comply with that section, we would have to appeal on day one, to get an order shortening time, to get the record on appeal (ROA) to the district court, and obtain a stay within the 30-day period. To shorten the 30-day period would be catastrophic.

More importantly, with section 17 of the bill, one thing that is not clear is that self-insured employers are actually considered insurers. This means that you are repealing, in essence, the benefit penalties against the TPA, in this case myself. I have been in business 20 years and have been appearing before these committees for that period of time. I noticed the comments today about balance. In the early 1990s, when the State Industrial Insurance System was upside down $2.2 billion, we did major workers' compensation reform to right the ship. During the next session, the pendulum swung the other way to provide the benefits to the injured workers in a timely, prompt fashion and made sure the workers were adequately provided for. What this does now is allow administrative penalties up to $50,000. If that is imposed against a small businessman like me, it would have a significant impact. Much of my time is spent on compliance issues, to be sure. We do not want to make a mistake, but we are only human. If we do something and are guilty for unreasonable delay, I want the bad apples out as well. To remove that penalty, however, and impose administrative fines would mean that if I received four violations in one year, I would be subject to having my license revoked. When the self-insured employer is allowed to be sued, it will be catastrophic for the businessman and

will disrupt the exclusive remedy rule. That was a system within a system developed when workers' compensation laws were made many years ago. When you allow lawsuits to be rendered with unfettered discretion, as I feel would happen, you are opening the door to catastrophe.

This bill does not say bad faith. It says it allows a causative action to be brought and maintained against insurers and TPAs for anything, the way I interpret it. I understand if they are amending that to say bad faith and then we make unreasonable delays, that would be something for a court to decide. I would submit to the Committee that the benefit penalties that are in place, the administrative fines and other regulations that have been imposed on our industry during the past few legislative sessions, are more than adequate.

Last session it was brought up that the TPAs were not being regulated and there was no jurisdiction for the DIR to audit them, impose fines, and do what they had to do in terms of an audit situation. They were auditing insurance companies. In the past year, I have had eight normal scheduled audits with insurance companies. I received a letter last week that they want to audit all of the TPA files again. I do not have individual files as a TPA. I administer self-insured employer files, carrier-based files, and some group insurers. They have already reviewed those files, and the same findings will result. If there are fines to be imposed, they will be. I think that is significant.

David Oakden, President, S & C Claims Services, Inc., Las Vegas:
I have been doing workers' compensation in Nevada since 1982. We are the third-party administrator for about seven different fully insured clients and one self-insured client. Since 1996, for one client, we have handled over 32,000 claims and we denied less than 10 percent. I would like to say "me too" with regard to the fact that we cannot comply with those time frames. I have full-time people working on these cases and trying to get doctors to manipulate their schedules for workers' compensation cases. Especially in northern Nevada, it is very problematic. In southern Nevada we could come close to the time frames, but in northern Nevada we could not reach the time frames if you doubled the time. That will impact additional litigation.

Section 3 talks about the insurer being responsible for a TPA. Contractually, we contract with TPAs to separate the liability. If I make a mistake as a TPA, it should go against me and not my client.

Section 15 addresses the prohibition of early intervention with regard to vocational rehabilitation. Early intervention with vocational rehabilitation was the idea that we do it as soon as we possibly can. It used to be required that we get an evaluation of an injured worker at 90 days. Everybody's goal is to

expedite treatment and vocational rehabilitation. Over 90 percent of my clients were construction companies. Many of those never have light duty and many injured workers have severe injuries. We can predict early in the claim if a person will be able to return to work in a light duty capacity with the employer of record. We know if this person was a roofer and he has two broken legs, he will never be released to be a roofer. So the sooner we can get this person involved in vocational rehabilitation, the better.

The time frames are maximum time periods depending on the percentage of impairment. We may be able to rehabilitate somebody who has some skills in a year. In most cases, due to the severity of the injury, we can predict where that impairment is going to be and what their eligibility level is. The sooner we get the worker involved, everyone's goal of getting him back to work is met timely. Often, in the latter part of a workers' compensation case, the person is receiving physical therapy two or three times a week and doing nothing else. We could, at that point, get him involved with the vocational rehabilitation counselor. They can start to do vocational testing to see what his interests are so we can progress and get him to work sooner. As soon as we get the release to return to work at some level of permanent restrictions, we can start him in a retraining program and establish the limits of the program. We have been doing this for a long time. I have never had a single case where they had to come back and say that we did not give them adequate time within the permanent partial disability to complete the retraining program. When the process is done effectively and appropriately, the injured worker gets the great advantage and saves months in his return to work process.

Chairman Bobzien:
Are there any questions? Seeing none, we will move to other testimony.

Rusty McAllister, representing Professional Fire Fighters of Nevada:
Thank you for hearing the proposal we would like to bring forth. Earlier this session this Committee heard Assembly Bill 11, which dealt with reporting for heart, lung, cancer, and occupational disease claims. We provided information about what we consider to be frivolous denial of benefits that are conclusively presumed to be covered by workers' compensation. Assemblyman Hansen asked the Nevada Self-Insurer's Association if there are any fines or penalties to deny claims, because it seems like you do it often. The response from the association was there are no penalties. I will propose an amendment to this bill because it allows, and is the perfect venue, to have the discussion about the ability to sue insurers. I am not saying that is what we want, but it opens the discussion. We have cases occurring all over the state regarding heart and lung workers' compensation claims that are conclusively presumed and have been since 1989. We are still being denied for these benefits.

Our concerns are in several areas. Timelines have been discussed in this bill, but we are not talking about 5 days or 15 days. We are talking about a year and a half, two years, or three years to get a claim accepted or settled that is a conclusively presumed claim. The insurers have found several loopholes. One loophole is that the claim has to be accepted or denied within 30 days. They deny within 30 days, but they deny pending medical review or medical investigation. That is indefinite and they are taking that to the fullest extent. In the meantime, our firefighters, and police offers too, are in the situation where they file a claim, it is denied, and treatment for their medical condition is being denied by their private health insurance carrier because it is a workers' compensation issue. Workers' compensation says it is denied pending medical review, so the worker is on his own. We are paying for the workers' medical treatment for two to three years at a time. This is the ability for workers' compensation to shift the cost of these benefits to private health insurance or to our health insurance trust funds. In many cases the insurers are denying it because they have provisions that say they do not pay workers' compensation.

The other loophole is in the statute which says if there is a disease, it must be a disabling heart or lung disease. The first thing they do is deny it is a disease. The bottom line is that we have firefighters who are developing cardiac arrhythmias, and these are being determined not a disease, even though the physician ultimately says there is a disease and treats them with a cardiac medication to correct the disease. Once they are convinced it is a disease, they use the provision under NRS Chapter 616 where it says to be considered disabling, you have to have been off for 5 consecutive days in a 20-day period. That provision appears to have been written for employees who work a more normal work schedule than firefighters. Five days for a firefighter would cover 16 calendar days. The people who are helping the injured workers encourage them to take sick leave for five shifts in a 16-day period so they can be considered disabled. The insurance industry is denying the claims based on the fact that they have not been off for five days. They encourage the employee not to come back to work and to take sick leave. That is not the right attitude. The goal is to get these people back to work.

I would like to have John McGee discuss his case. His case is an example of many cases that are occurring across the state. John McGee is a firefighter with the North Las Vegas Fire Department.

John McGee, Private Citizen, Henderson, Nevada:
On June 16, 2011, I was performing a cardiac workout on the treadmill in my fire station. [Read from prepared testimony (Exhibit G).]

I was going to fill out a I-1 form, which refers to NRS 617.457, which deals with heart disease and occupational diseases of firefighters. [Continued to read from prepared testimony (Exhibit G).] In my prepared testimony, I listed approximately 25 correspondences to the attorney and the courts of appeal.

Up to this point, the case is still pending. All of my bills have gone to collection and it affected my credit. My stress level has increased tremendously. On January 16, 2013, I filed an additional workers' compensation claim due to anxiety, stress, and extreme hypertension. [Continued to read from prepared testimony (Exhibit G).]

I am here today because I feel the city needs to acknowledge the fact that my irregular heartbeat was considered "heart disease" as stated in NRS 617.457. [Continued to read from prepared testimony (Exhibit G).]

It is my belief that the city and the insurance companies would rather see us dead than take care of us. As a firefighter, I took an oath to protect and serve. I would like some of that in return.

Chairman Bobzien:
Thank you for your story. Our Committee wishes you all the best. Are there any questions? [There were none.]

Rusty McAllister:
One thing Mr. McGee did not mention, and which will be addressed in the amendment is that this creates financial hardship because the worker does not get his medical bills paid. Depending on where he lives and the attorneys he has to use, that is a 30-year benefit. The worker becomes disabled on a conclusively presumed benefit and he has to pay one-third of the benefit to his attorney. The amendment will provide that if an employer, an insurer, or administrator denies a claim filed under the provisions of NRS 617.455 or NRS 617.457 and the claimant ultimately prevails, then the employer, insurer, or administrator must pay all claimant attorney fees and associated costs in addition to the benefit award given to the employee. As Assemblyman Hansen said, a $1,000 fine and even a $50,000 fine are not enough. We are asking them to pay the attorney fees that they caused him to have by not accepting a claim for a conclusively presumed benefit.

I have another issue. Under the provisions of heart and lung, you have to have an annual physical. The employer for one of my groups has used a very loose definition of the term "employer" regarding the employee's information coming back from the physician. In their interpretation, "employer" means human resources, the fire chief, the town board members, and anyone associated with

the town. The fire chief is going back to the members and using the physical exams that are supposedly protected under the Health Insurance Portability and Accountability Act (HIPAA) to leverage employees. I will submit a proposed amendment, with regard to the provisions of NRS 617.455 and NRS 617.457, that the results of the annual physicals can only be released to the Director of Risk Management, the physician, and the employee and that all HIPAA regulations must be followed.

We are willing to work with the other parties on the bill to come up with a solution because it is a problem. There is no reason why a conclusively presumed benefit should drive someone to bankruptcy, pay their own medical bills, or give away one-third of their benefit.

[Vice Chairwoman Kirkpatrick assumed the Chair.]

Vice Chairwoman Kirkpatrick:
Are there any questions? [There were none.] I will have Mr. Ostrovsky address your concerns. I expect everyone will work together.

Robert Ostrovsky:
I would be happy to meet with the proponents. We do have the Office of the Nevada Attorney for Injured Workers, and if you choose to use them, you do not have to hire a private attorney and you do not have to share any of your recovery with a private lawyer. I think the worker has to make a decision about whether they might get better representation from a private lawyer than from the Nevada Attorney for Injured Workers. If there are concerns about that, we ought to think about strengthening that. The purpose of that office was to avoid having to pay out a portion of the recovery to a private lawyer. With regard to the timelines and the denial of a claim for the purposes of a pending medical investigation, it is permitted under the statute, but there is also a part of the statute that does not permit unreasonable delay. If you have unreasonable delay, there can be administrative action taken and a benefit penalty applied. You have to look at the statute as a whole, and I cannot imagine anyone being delayed a year for a medical investigation.

The unfortunate matter is that litigation is an untimely, unseemly event that takes years, and there has been considerable litigation regarding heart and lung benefits. That is how the courts work and we cannot fix that here. You can fix it policy wise to eliminate litigation. We have put heart and lung in the statute. More and more people have gone through a career as a firefighter or policeman, and many times the question of whether or not it is a qualifying event arises after the worker is retired.

Vice Chairwoman Kirkpatrick:
Will you commit to working with Mr. McAllister?

Robert Ostrovsky:
You have that commitment.

[Mark Sektnan, Vice President, Property Casualty Insurers Association of America, provided a statement of opposition (Exhibit H) to A.B. 427.]

Vice Chairwoman Kirkpatrick:
I will close the hearing on A.B. 427 and open the hearing on Assembly Bill 429.

Assembly Bill 429: Establishes requirements concerning the prescription of certain pain medications to persons covered under policies of industrial insurance. (BDR 53-971)

Robert Ostrovsky, representing Employers Insurance Group:
We have a bill before you today regarding the use of narcotic drugs. We considered bringing a specialist today to testify about addiction, but did not in the interest of time. We know there is an addiction problem in America. If you suffer from addiction, you have three choices in your life. You have recovery, jail, or death. You can ask anybody in the field of recovery; those are your choices. What we are concerned about is that there are a lot of people who get addicted to prescription drugs. We have claimants who become addicted to pain medication that has been appropriately prescribed by a medical professional who is responding to the immediate needs of relieving pain. We are here to suggest to you that we should put in place some structure for physicians and insurance companies to look at the use of these drugs and at what point we tell the treating physician that we need to refer this person to a pain specialist. We need to be concerned, because if the person gets addicted, at the end of his claim, the insurance company has to send him somewhere to try to recover from the addiction. He may or may not recover. It is a serious matter. We would like to discuss one approach, and possible solution, to what we should do about pain medication in the area of workers' compensation.

Jim Werbeckes, representing Employers Insurance Group:
Prescription drugs have reached epidemic status. Someone dies every 19 minutes in this country from prescription drugs. Pharmaceutical painkiller overdoses now claim more lives than auto accidents. From the workplace safety perspective, it is clearly an issue that needs to be addressed. Drug abuse in the workers' compensation arena prolongs the injured worker's ability to reenter the workplace in a full capacity. Assembly Bill 429 attempts to address

this emerging issue. The state of Texas tackled this issue by adopting a closed formulary where physicians were required to get preauthorization before they could dispense schedule II, III, and IV narcotic drugs. In the first two years of that program, they were able to reduce opiate-based prescription drugs by 72 percent.

This bill takes a different approach. It tries to strike a balance between dealing with the serious issues of prescription drugs and protecting our state health care professionals. The legislation requires physicians who administer narcotic drugs to provide a written justification to the employer and/or insurer. The report must include the medical justification for the prescription, a treatment plan for the injured employee, a timeline when the employee can safely return to work, the physician's recommendations for follow-up visits, and potential drug testing of the injured worker through the entire process. This report must be submitted to the insurer or the employer within 20 days of the prescription being dispensed. The bill authorizes an employer or insurer to withhold payment to the physician if the report is not timely. This is the hammer in the bill. If the physician continues to fail to do this, we could request a change of physician for the employee. This bill does not prevent the physician from prescribing any prescription drug. They just have to provide the report. We believe this is a responsible, nonintrusive way to place some reasonable restriction on the dispensing of drugs. These drugs, if not managed correctly, have the potential to ruin lives and kill workers, as is the case today.

I have been told that this is just one more way for the insurance industry to delay, bar claims, and prevent injured workers from receiving the benefits to which they are entitled. I believe that is unjust and this bill goes a long way to try to limit these people from what they are putting into their bodies. We do not place any undue burden for preauthorization in this bill or the threat of litigation of physicians. The medical and legal community, along with the business insurers, must work together to get injured workers back to work, and this bill goes a long way to doing that. When we drafted the language in section 1, subsection 3, paragraph (a), a reference was made to *Nevada Revised Statutes* (NRS) 453.1545 where the physician is required to go into the database and put that information in his report, but he is prohibited from doing that elsewhere in the bill, so that section needs to be removed.

Vice Chairwoman Kirkpatrick:
Are there any questions?

Assemblyman Daly:
You have pharmacy benefit managers who work to get people their drugs, preferred provider contracts with the doctors, and medical reviews, all of which

go into the care plan. The bill says that you are going to give the plan to the employer. I do not think the doctor can write the report on the diagnosis, the drugs, or the justification to the workers' employer. The employer is not entitled to that information.

Jim Werbeckes:
I think that is in there to cover the self-insured people. If we need to address that, I will agree.

Assemblyman Daly:
You have a third-party administrator (TPA) who sees all this information. If there is a question on the treatment or it is outside of the normal course of treatment which is standardized, you have all of these checkpoints in the design of the plan. I do not think you need a law. The TPA has the right to get that information. The employers certainly do not get to see it. You would have to have a medical review person and that is usually done at the TPA level. The employer has no reason to know or check.

Vice Chairwoman Kirkpatrick:
Are there any questions?

Assemblywoman Carlton:
I have a similar question about sharing the information with the Department of Public Safety. What right does the Department of Public Safety have to know what prescriptions I am on? That is between my doctor and me. I do not know how all the entities in section 1, subsection 3, paragraph (a), fit together.

Jim Werbeckes:
I believe I testified to remove that section.

Vice Chairwoman Kirkpatrick:
I think it refers to it in a different section.

Assemblywoman Carlton:
What are you removing?

Jim Werbeckes:
Lines 32 through 37 on page 2 will be removed.

Assemblywoman Carlton:
What about the medication contract?

Jim Werbeckes:
That would be a contract between the doctor and the injured worker.

Assemblywoman Carlton:
Would that be shared with the insurance company as part of the report, as I read it, in conjunction with the language above it?

Jim Werbeckes:
I believe you are correct.

Assemblywoman Carlton:
Would that include the medication regime prescribed by the treating physician?

Vice Chairwoman Kirkpatrick:
When you take out paragraph (a), it does not read correctly; and it is not clear what happens to everything else.

Assemblywoman Carlton:
This will have a chilling effect on physicians prescribing what they feel is the best course of medication, because we are adding another burden and we know how scared they are now to prescribe pain medication. If you add something like this, they will be afraid that if they tell you, you will knock them off the network and they will not get your business anymore. I do not see it as the insurer's business as to how my doctor wants to treat me and what medications I am on. The employer who pays you, as an insurance company, pays you to take care of the injured worker, not to manage their care, only to manage their insurance.

Robert Ostrovsky:
The original intent was to ask the physician to check with the State Board of Pharmacy, because they have a system statewide to look for people who are going to more than one physician to get the same drug prescribed because they are selling or abusing it. We thought that would be a good thing for the physician to look at. We decided that was a bad decision, and we want to take it and all references to it out of the bill. With regard to the medical records, insurance companies do see those medical records. We manage the claims and make recommendations about making referrals to specialists and so on. I understand your concern about the employers seeing it. Some employers are self-insured and self-administered. You would be surprised that there may be some employers out there that are covered by Health Insurance Portability and Accountability Act (HIPAA) rules and have to be very careful if they expose any of that information. I understand your concerns, and perhaps there is some way we could modify this. We would just like the physicians to take one step back

and say, are there any alternatives besides these narcotics, or maybe just prescribe 30 instead of 60 pills and ask the patient to come back in 15 days to check again. We think that some balance has to be brought to the system. We have seen the end result for people who have become addicted to these drugs, and we would like to find some way to help them. I know there will be people who will testify against the bill, and we would be happy to work with them or interested Committee members.

Vice Chairwoman Kirkpatrick:
Are there any questions? [There was no response.] Is there another bill to address this issue?

Robert Ostrovsky:
There is a bill in the Senate that seeks to computerize and modernize the State Board of Pharmacy's system. They are trying to get a computerized system that would really flag individuals who have the potential to abuse drugs. We think a lot of the drugs are being consumed but a lot are being sold. That is in a sense one attack at this issue, but it covers anyone and everybody who might be purchasing these drugs no matter where they got the prescription.

Vice Chairwoman Kirkpatrick:
I have a question on section 1, subsection 4, on page 3, line 7. I am concerned about that section, along with subsection 7 which starts on line 34. What happens if somebody does not submit their report? Then you stop paying the bills, and in the end the injured employee could be responsible for all of the bills. The claims will not be processed as stated in subsection 4 if they do not get the right information from the physician. I assume you want to put a penalty in so the physician follows up, but that may be a little steep.

Robert Ostrovsky:
We were trying to develop language that would say if a physician failed to cooperate, we would ask the injured employee to pick another treating physician from the list. We thought that was a way to weed out uncooperative doctors. I have not thought about the issue of whether they would balance bill for that. Clearly we would have to prohibit that if you wanted to pass this bill.

Vice Chairwoman Kirkpatrick:
Is there anyone else to testify in support of A.B. 429?

David Goldwater, representing CBL Toxicology:
We support the intent of this bill. We feel Assemblywoman Carlton's and Assemblywoman Kirkpatrick's comments are right on point, and we think it

would discourage physicians from prescribing pain medication. CBL Toxicology provides a panel of urine tests when a patient presents for a refill for a prescription of a drug of abuse. The physician would order the test, and if the test says the drug is present in the patient's system, the refill is authorized. That is an alternative method to this issue.

Vice Chairwoman Kirkpatrick:
Is there anyone to testify in opposition to this bill?

Lawrence P. Matheis, Executive Director, Nevada State Medical Association:
The issues of drug dependency and addiction are a general problem throughout our state and nation. We do not think this bill gets to the issue. It is very close to requiring a violation of HIPAA in terms of the kinds of information that can only be in a transaction to very limited parties. That would have to be clarified in section 1, subsection 1, following paragraph (c). The question is how the physician can serve the patient's needs. There is a chilling effect. Some years ago we passed an intractable pain bill that requires physicians who are treating patients with intractable pain to follow model guidelines and reporting. We did that because the fear that physicians had of being subject to lawsuits had a chilling effect on their prescribing properly. We do have concerns about that.

There is a prescription drug monitoring program that is computerized and available now. However, a physician who can get access to that, to get information about the patient, their own prescribing habits, or whether or not there are any problems, cannot release the information to any other third party. It is there to help the physician make prescribing decisions. Insurers and others do not have access to the program, but they have access through the claims that physicians write. Physicians have to explain why they are prescribing something or ordering a particular procedure. This requires a different kind of reporting that would have a chilling effect. I would be happy to work with the proponents. I am not sure this bill is an easy skeleton on which to put some meat.

Vice Chairwoman Kirkpatrick:
Do not the insurance parties already get some of those medical records?

Lawrence Matheis:
The information that the doctor has to give to the insurer is fairly well prescribed. It covers what they are proposing to do, what they are proposing to charge, and why they are proposing to do it. They link the code for the procedure or the prescription with the classification of the diagnosis, including the supporting information. This goes way beyond that. This is not the routine

thing that would be used as justification. The question is whether or not that additional information is appropriate.

Denise Selleck Davis, representing Nevada Osteopathic Medical Association:
I support the testimony in opposition to this bill.

Jack Mallory, representing Southern Nevada Building and Construction Trades Council:
When I hear the testimony and the conflicting versions of workers' compensation bills today, I wonder why it is here. Is it creating a layer of insulation for one party against the other? Is it really intended to help the individual who is being covered by workers' compensation? I would ask the Committee to remember it is not employers' compensation, insurer's compensation, or third-party administrators' compensation.

Herb Santos Jr., representing Nevada Justice Association:
This would impose a burden upon a treating physician and would cause interference to a doctor-patient relationship. The reality of what this bill will do is clear when we consider there are not many doctors doing pain management in northern Nevada. By forcing an employee to find another physician because the first physician did not complete the report, makes it more difficult for an employee, because there are not that many choices. That will clearly restrict a person's access to health care.

Section 1, subsection 7, is like a weather report. Are we going to be put in the situation where a lot of folks are denied benefits and have to appeal? When they appeal, the process is going to take 30 days to get before a hearing officer, and that person is going to have to go without the medication for that period of time, which is not appropriate. Due to the fact that it interferes with the doctor-patient relationship, the Nevada Justice Association highly opposes this bill.

[Mark Sektnan, Vice President, Property Casualty Insurers Association of America, provided a statement of support (Exhibit I) for A.B. 429.]

Vice Chairwoman Kirkpatrick:
Are there any questions? [There were none.] Is there anyone to testify from a neutral position? Seeing none, I will close the hearing on A.B. 429. I will open the hearing on Assembly Bill 456.

Assembly Bill 456: Revises provisions governing health care. (BDR 54-1102)

Lawrence P. Matheis, Executive Director, Nevada State Medical Association:
Assembly Bill 456 tries to address the changing environment of the delivery of health care and the growing number of professionals who are a part of larger teams that deliver services. This is a health care professional transparency act. It is intended to make sure that whoever is providing care is clear to the patient about what his license is and what he can do. It is meant to encourage a growing communication about what everybody is on these teams. This is simply an acknowledgement of the realities of the delivery system changes that are going on and have been going on for some time. It is a way of standardizing what patients and their families should be able to expect from health care professionals and what obligations the health care professionals have to make sure the patient and his family understand all of their points. The bill requires written information about what the professional's license is and what he can do. It requires that he affirmatively talk to the patient about what he can do to make sure there is clear understanding.

There is one amendment that was brought to our attention by the National Specialties Society and is included in my testimony (Exhibit J). The change is to section 2, subsection 1, paragraph (d), subparagraph (2), sub-subparagraph (I), on lines 4 through 6 on page 3. It would change the language from a postgraduate training to a successful completion of a postgraduate training program that is approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. It is two small changes which clarify the certification process for physicians. The intent of section 2 is to encourage this communication with the patient or his family as to what they are to do and what they are trained to do.

Section 3 takes one example of a model to help legislatures deal with the growing number of proposed changes to scopes of practice by the health professions. Six states have created processes that allow an expert panel to study the proposal before it gets to the legislature. The particular approach that is recommended here is one that is used in Connecticut and Nebraska. They use their state boards of health to collect any proposed scopes of practice outside of the legislative year and assign a panel of experts to analyze what is being proposed and what the effect would be. Then they report that to the legislature.

Bills addressing scopes of practice would go through an information-gathering process so that the Legislature would be able to start their discussions with some of the complexity already explained and addressed. The approach mentioned in section 3 would provide this under the State Board of Health. It would encourage the gathering of information about why the change is necessary, because there are going to be increasing overlapping scopes of

practice where more than one board may be responsible for oversight of different practitioners doing the same types of things.

Texas, Arizona, Nebraska, Connecticut, and New Mexico have passed laws to help guide the legislature through these assessments so the boards can look more clearly at their own changes and where there are overlapping areas. To try to show the intent of how this could be done, I shared with the Chairman of this Committee an alternative method that may be superior to this. Rather than setting up this process, it may be better to charge the Health and Human Services Committee to set up a subcommittee to look at the models across the country and the issues. They would then bring a recommendation next session to the Legislature of how to provide the Legislature with an independent look at scope of practice changes over the coming years. The changes are only going to increase as we go forward, partially because of health care reform and integrated practice. There really is evolving training and there are a lot more doctors in the health care system than before, but they are not all physicians. They are doctors who have gone on to advanced training in physical therapy, chiropractic, nursing, and pharmacy.

Vice Chairwoman Kirkpatrick:
That is what the Governor's Workforce Investment Board is supposed to be doing. Do you not sit on that Board? Why do we have this? It is amazing that we have about 195 boards and now we are creating one more. My point is we are creating double the work for things we already cannot control. Are there any questions?

Assemblywoman Carlton:
I recognize a number of these provisions because we talked about them at the Governor's Workforce Investment Board Health Care Sector Council. They were also talked about at an interim Legislative Committee on Health Care meeting, but the first time I have seen this proposal is in this bill. No matter what we put in this bill, there is nothing that will stop me from bringing bills to this Legislature so I can convince my colleagues that there are issues in health care that need to be addressed, through licensure, scope of practice, insurance models, and all of the things I have worked on for almost 16 years. It will not circumvent what I plan on working on for the next ten years that I am here. It would be great if we could inform more people about what is going on and get them involved. I do not believe that setting up another layer of bureaucracy will solve a problem. If the Speaker wishes, she can direct the Legislative Committee on Health Care to address this during the interim or even set up a subcommittee of the Legislative Commission to address this issue, which I believe was done 12 years ago when we had subcommittees to deal with scopes of practice.

Larry Matheis:
Those are other options as well. This is going to be a continuing series of proposals to come forward. It is one of the challenges in adopting health care reform. It has to do with working through how licensing boards deal with overlapping scopes of practice and how the Legislature deals with those proposals as they are presented. It is meant to supplement the role of the Legislature. In the other states, the incentive has come from the legislative bodies that feel inundated with having to work through these issues in a short period of time.

Vice Chairwoman Kirkpatrick:
Are there any other questions? [There were none.] We are often beat up for making so many regulations. Some of these things seem to be bedside manner, which the doctors should have learned when they went through school. We can agree to disagree on what is the right thing to do, but when you start legislating it, it is hard to hold people accountable. I have a lot of concerns.

Lawrence Matheis:
The issue is that there is an ethical concern. This is an attempt to refocus, with the growing number of health professionals who are going to be working in teams with people, that they need to be sure that the patient and his family are comfortable understanding who is there.

Vice Chairwoman Kirkpatrick:
We will hear from the opposition.

Bill Welch, representing Nevada Hospital Association:
I am here to speak specifically in opposition to section 2. This is similar legislation as is being considered in the Senate. While we understand the objective of making sure all patients know who their clinicians are when they go to the physician's office, and what services they are trained and qualified to perform, we believe this is redundant for the hospital setting for those facilities licensed under *Nevada Revised Statutes* (NRS) Chapters 449 and 450. Hospitals, inpatient hospitals, and hospice facilities must go through an extensive credentialing process as required by state and federal regulations where every physician must submit copies of his or her academic degrees, licenses, and certifications. We have a committee process that reviews those. We also go through an extensive physician committee process for allocating privileges that they are able to perform within the hospital setting. We believe that is there to protect the interest of the patient. If we are going to be required to post this information for every physician who is privileged at our hospital, I would point out that our smaller hospitals have dozens of physicians, but our large urban hospitals can have hundreds if not thousands of physicians.

It would be impossible to post this information in every patient room where a physician may be caring for a patient.

We understand the objective of making sure patients are informed, and we are not opposed to the it, but we have processes in place that ensure that the patient's best interests are met. [Mr. Welch supplied a proposed amendment (Exhibit K).]

Vice Chairwoman Kirkpatrick:
Are there any questions?

Assemblywoman Carlton:
The part that I am most concerned about is the name tags. Does everyone in the hospitals that you represent wear name tags while they are on duty?

Bill Welch:
I do not know the answer to that, but I will research it and get an answer.

Assemblywoman Carlton:
The biggest concern we heard in the Health Care Sector Council was that when people went into a patient's room, the patient and family members did not know if they were a nurse, an orderly, a doctor, or an administrator because you cannot tell who is who.

Bill Welch:
Our concern was about the posting of information in the rooms for all of the licenses.

Fred Hillerby, representing Board of Dental Examiners of Nevada, State Board of Nursing, State Board of Pharmacy, and Nevada Optometric Association:
I appreciate what Assemblywoman Carlton said. That is what came to my mind when I read section 3. I do not think the Legislature needs to have someone to screen the issues before you deal with them. This bill says in section 3, subsection 1, "Any person, regulatory body or other entity acting on behalf of a health care profession that proposes to modify the scope of practice . . . ." Let us take one of the boards I represent, the Board of Dental Examiners of Nevada. When it came to modify the scope of practice for a hygienist, although I recognize this is permissive and not mandatory, the Board would have to go to the State Board of Health, to a special panel, to review their reasons for wanting to modify the scope of practice for their licensees. In turf battles between professionals, it is difficult for the legislators to be in the middle. In the case of optometry and other health care professions, the Legislature gets to decide their scope of practice. I see this as an unnecessary step.

Peter Krueger, representing Chiropractic Physicians' Board of Nevada:
We are opposed to the advertising provision in section 2, subsection 3. I would like to call the Committee's attention to our website, where we have "A Chiropractic Physician's Guide to Ethical and Legal Advertising in Nevada." It gives detail on the provisions in the *Nevada Revised Statutes* and how they are applied.

We are also opposed to section 3 because we think the present avenues available for scope of practice issues are sufficient and effective. The Board recently addressed a scope of practice issue through one of the existing avenues, which was to request an opinion from the Office of the Attorney General. The response was timely and appropriate and resolved the issue.

Similarly, the legislative process is a very appropriate process. We brought a bill earlier this session and it is a very workable process. The Board believes that the process set out in section 3 will be used frequently. It is expensive for a small board, and the recommendations to the Legislature will do the same thing once they get a reviewed process. On behalf of the Chiropractic Physicians' Board, we are opposed to this piece of legislation.

Vice Chairwoman Kirkpatrick:
Are there any questions? [There were none.]

John Griffin, representing Nevada Advanced Practice Nurses Association:
We agree with everything Mr. Hillerby said.

Paula Berkley, representing Board of Occupational Therapy and State Board of Physical Therapy Examiners:
We are opposed to the bill.

Marlene Lockard, representing the Nevada Speech-Language Hearing Association:
I have with me the President of the Association, who will itemize our objections to this bill.

Vice Chairwoman Kirkpatrick:
Are there any questions? [There were none.]

Lindsay Culbert, President, Nevada Speech-Language Hearing Association:
I am here to represent over 600 audiologists and speech-language pathologists in our state. I am also supported by the American Speech-Language Hearing Association, which credentials over 160,000 speech pathologists and audiologists in the United States. We are specifically opposed to section 3.

We feel that potentially any entity with little or no knowledge of our profession may submit proposals to the State Board of Health, to which we take particular issue in an autonomous profession such as ours.

Diane Ross, Chief Executive Officer/President, The Continuum, Reno:
I am a speech-language pathologist at The Continuum, which is an outpatient program with physical, occupational, and speech therapists. We have been in business for 20 years. I am here to oppose A.B. 456 as a health care professional and a small business owner. As a speech-language pathologist, I served on the committee that wrote the regulations for the licensure board. Our regulations have served the state very well. They include that we cannot misrepresent our services to the public and that we are open and transparent. If the boards are not doing their job in keeping the practice ethical, they are responsible. If there are changes to be made in the scope of practice, who would know better than the professionals who deliver these services and the national organizations that spend their time in the research of the program.

As a small business owner, I see this bill requiring more unnecessary regulations, as our business already provides the scope of practice and our services in an honest and ethical manner. This bill is requiring that our marketing information be scrutinized. It discusses font size in advertisement and says we have to include limitations to business cards, letterhead, brochures, pamphlets, newsletter, electronic mail, and Internet. We do all that, but who is to say what size font is important? My cohorts who I have worked with in Reno and throughout the state are very transparent, open, and honest. I do not see the necessity of this bill.

Vice Chairwoman Kirkpatrick:
We need to make sure everybody is wearing some type of badge so there is an identity for patients. Is there anyone to testify in opposition? [There was none.] Is there anyone to speak from a neutral position? [There was none.]

Denise Selleck Davis, representing Nevada Osteopathic Medical Association:
We have a national standing on transparency and feel it is very important for patients to know who is treating them and what their scope of practice is. This is something we have felt strongly about for some time. There are people who walk into rooms and treat patients without addressing who they are. It has happened to me. I spent some time in a drop-in clinic at 9 p.m. with a child with a sore throat. When the person came in to treat her, and I asked who he was, he said, "why?" We feel this is an ethical situation. Our schools address patient communication as a core competency that is taught in our four-year medical schools, and we feel it is very important and will be part of

the continuous certification program that is done through osteopathic medicine. We are in full support of transparency.

Vice Chairwoman Kirkpatrick:
Are there any questions? [There was no response.]

Lawrence Matheis:
The purpose of section 2 is not to create new rules and regulations. It does not do that. It tries to make sure that health professionals are alert to the fact that there are growing opportunities for patients not to know who they are or who is in the setting. The problem with the proposal by the Hospital Association is that NRS 449.0151, which would be exempted, would be any services provided in an ambulatory surgery center, an obstetric center, an independent center for emergency medical care, an agency to provide nursing in the home, a facility for intermediate care, a facility for skilled nursing, hospice care, hospitals, or psychiatric hospitals. There are 16 different categories. Maybe that is okay, but those are the settings in which there are the greatest complications and complexity and where patients can get the most confused. I think the idea is to have transparency of the licensees and their activities, especially in the more complex settings, because that is part of what health care reform will do. Another part is to look at whether there may be a way in the future to not limit scopes, but to get better information before the scopes are under consideration.

Vice Chairwoman Kirkpatrick:
Are there any questions?

Assemblyman Livermore:
The hospitals with which I am associated always publish a directory with pictures and all the information discussed. If a patient or a family member wishes to find information about physicians from whom they are seeking advice, that should be the first place they should look.

Larry Matheis:
I agree that is a tool they should use. The point is that, when care is ongoing, there is not the opportunity to do that. To be clearer about who is there and who is doing what, is increasingly something for which we need to take several different approaches.

Vice Chairwoman Kirkpatrick:
You have four days to work on this bill and there is a lot of angst. We, as legislators, are always giving away our ability to be involved in discussions so maybe some of the issues about identification can be included in the

regulations. As we grow into this industry, there will be challenges. The health care sector has done a great job, but they could resolve some of these issues.

Larry Matheis:
The Governor's Workforce Council is trying to identify where our needs are and how to recruit people into the state, but that only adds to the complexity.

Vice Chairwoman Kirkpatrick:
If we did not pay doctors because they did not wear their name badges, I bet they would. There has to be a way to address this. I will close the hearing on A.B. 456. Is there any public testimony? [There was no response.] The meeting is adjourned [at 4:12 p.m.].

RESPECTFULLY SUBMITTED:

_____
Earlene Miller
Committee Secretary

APPROVED BY:

_____
Assemblyman David P. Bobzien, Chairman

DATE: _____

EXHIBITS

Committee Name: Committee on Commerce and Labor

Date: April 8, 2013 **Time of Meeting: 12:46 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
A.B. 179	C	Kelly Richard	Work session document
A.B. 334	D	Kelly Richard	Work session document
A.B. 341	E	Assemblywoman Maggie Carlton	Proposed Amendment
A.B. 427	F	George Ross	Comments
A.B. 427	G	John McGee	Prepared testimony
A.B. 427	H	Mark Sektnan	Statement of Opposition
A.B. 429	I	Mark Sektnan	Statement of Support
A.B. 456	J	Larry Matheis	Testimony
A.B. 456	K	Bill Welch	Proposed Amendment