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

Seventy-Eighth Session
April 29, 2015

The Committee on Commerce and Labor was called to order by Chairman Randy Kirner at 1:45 p.m. on Wednesday, April 29, 2015, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 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 www.leg.state.nv.us/App/NELIS/REL/78th2015. In addition, copies of the audio or video of the meeting may be purchased, for personal use only, through the Legislative Counsel Bureau's Publications Office (email: publications@lcb.state.nv.us; telephone: 775-684-6835).

COMMITTEE MEMBERS PRESENT:

Assemblyman Randy Kirner, Chairman
Assemblywoman Victoria Seaman, Vice Chair
Assemblyman Paul Anderson
Assemblywoman Irene Bustamante Adams
Assemblywoman Maggie Carlton
Assemblywoman Olivia Diaz
Assemblyman John Ellison
Assemblywoman Michele Fiore
Assemblyman Ira Hansen
Assemblywoman Marilyn K. Kirkpatrick
Assemblywoman Dina Neal
Assemblyman Erven T. Nelson
Assemblyman James Ohrenschall
Assemblyman P.K. O'Neill
Assemblyman Stephen H. Silberkraus

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator James A. Settelmeyer, Senate District No. 17
Senator Joe P. Hardy, Senate District No. 12

STAFF MEMBERS PRESENT:

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

OTHERS PRESENT:

Keith L. Lee, representing Board of Medical Examiners and Nevada Association of Health Plans
Kevin D. Bohnenblust, Executive Director, Board of Medicine, State of Wyoming
Edward O. Cousineau, Executive Director, Board of Medical Examiners
Victoria Carreón, Director of Research and Policy, Kenny C. Guinn Center for Policy Priorities
Paul J. Moradkhan, Vice President, Government Affairs, Las Vegas Metro Chamber of Commerce
Elisa P. Cafferata, President and Chief Executive Officer, Nevada Advocates for Planned Parenthood Affiliates
Grayson D. Wilt, representing Nevada State Medical Association
Lesley Pittman, representing Nevada State Society of Anesthesiologists
Dean Polce, D.O., President, Nevada State Society of Anesthesiologists
Jerry Matsumura, M.D., representing Associated Anesthesiologists of Reno
Robert Wagner, Assistant Professor, Department of Anesthesia, College of Health Care Sciences, Nova Southeastern University, Tampa, Florida
Joey Parrish, Private Citizen, Henderson, Nevada
James Wadhams, representing Nevada Hospital Association
Denise Selleck, Executive Director, Nevada Osteopathic Medical Association
Chad A. Brown, Chief Executive Officer, Omnific Breast, Reno, Nevada
Rajeev Khamamkar, M.D., Nevada Anesthesiology Partners, Las Vegas, Nevada
Joseph P. Profeta, M.D., PBS Anesthesia, Las Vegas, Nevada

Curtis Boardman, Certified Registered Nurse Anesthetist, Henderson, Nevada
Richard Bianco, Private Citizen, Las Vegas, Nevada
Quan Haduong, M.D., PBS Anesthesia, Las Vegas, Nevada
Annette Teijeiro, M.D., representing Association of American Physicians and Surgeons
Steven Sertich, representing Nevada Association of Nurse Anesthetists
Joanne Heins, President, Nevada Association of Nurse Anesthetists
Elizabeth MacMenamin, Vice President, Government Affairs, Retail Association of Nevada
Tom McCoy, Nevada Government Relations Director, American Cancer Society Cancer Action Network
Adam Plain, representing Nevada Dental Association
Helen Foley, representing Delta Dental Insurance Company

Chairman Kirner:
[Roll was called. Rules and protocol were stated.] We are going to do our work session first and then transition to hearing the bills. Our Committee Policy Analyst will take us through the work session. Ms. Richard, you may start with Senate Bill 159.

Senate Bill 159: Revises provisions relating to insurance. (BDR 57-829)

Kelly Richard, Committee Policy Analyst:
Senate Bill 159 was heard by the Committee on April 13, 2015, and was sponsored by Senator Kieckhefer. [Referred to work session document (Exhibit C).] This bill requires every policy of health, group, or blanket insurance; contract for hospital or medical services; and evidence of coverage to include a procedure for the arbitration of disputes related to an independent medical evaluation of a dentist's diagnosis and care of a patient. There are no amendments.

Chairman Kirner:
My understanding was that there was an amendment coming forward on S.B. 159. Apparently there are no amendments. Is there any discussion? [There was none.]

ASSEMBLYMAN O'NEILL MOVED TO DO PASS SENATE BILL 159.

ASSEMBLYMAN SILBERKRAUS SECONDED THE MOTION.

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

We will move to Senate Bill 217 (1st Reprint).

Senate Bill 217 (1st Reprint): Revises provisions relating to policies of health insurance. (BDR 57-836)

Kelly Richard, Committee Policy Analyst:
Senate Bill 217 (1st Reprint) was heard on April 13, 2015, and also was sponsored by Senator Kieckhefer. [Read work session document (Exhibit D).] This bill prohibits public and private policies of health insurance and health care plans from denying coverage for covered topical ophthalmic products, if refills are provided early. The bill requires a pharmacist to provide early refills of topical ophthalmic products upon the request of a patient who is experiencing inadvertent wastage of the product due to difficulty applying the product to the eye, and only pursuant to a valid prescription that states specific authorization to refill. Likewise, there were no amendments on this bill.

Chairman Kirner:
Do I have a motion?

> ASSEMBLYWOMAN SEAMAN MOVED TO DO PASS SENATE BILL 217 (1ST REPRINT).
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> ASSEMBLYMAN SILBERKRAUS SECONDED THE MOTION.
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> THE MOTION PASSED. (ASSEMBLYMAN OHRENSCHALL WAS ABSENT FOR THE VOTE.)

We will move to Senate Bill 440 (1st Reprint).

Senate Bill 440 (1st Reprint): Revises provisions relating to insurance. (BDR 57-983)

Kelly Richard, Committee Policy Analyst:
Senate Bill 440 (1st Reprint) was heard in this Committee on April 22, 2015. [Read work session document (Exhibit E).] It provides requirements for motor vehicle insurance coverage for a motor vehicle used by a driver in connection with a transportation network company (TNC). During any period the driver is providing transportation services, a TNC or a driver must continuously maintain insurance for the payment of tort liabilities with liability limits that are specified in the bill. A TNC must disclose in writing, prior to connecting a driver to

a potential passenger using the digital network or software application, the insurance coverage and liability limits the company provides for a driver while he or she is providing transportation services. The TNC must also notify the driver that his or her personal automobile insurance may not provide coverage for the use of a motor vehicle to provide transportation services.

The TNC must provide coverage as primary insurance if the insurance provided by the driver is insufficient. An insurer who provides a policy of TNC insurance is prohibited from requiring a driver's personal automobile insurance policy to deny a claim before providing coverage. Further, a personal automobile insurance policy is not required to include TNC insurance. However, an insurer may include TNC insurance in such a policy and may charge an additional premium for doing so. Finally, a driver must carry proof of TNC insurance at all times when he or she is logged into the digital network or software application service, available to receive requests, or provide transportation services and provide proof of coverage when the driver is involved in an accident.

The amendment, starting on page 2 of the work session document (Exhibit E), was submitted by Senator Settelmeyer. The amendment provides that a TNC or driver, while covered by the insurance provided in the bill, is not subject to regulation as a public utility or a taxicab. The amendment also clarifies in section 6, when a TNC ride ends, and makes the bill effective upon passage and approval.

Chairman Kirner:
Is there any discussion on this bill?

Assemblyman Hansen:
I have not seen any amendment. When was this amendment submitted? If we received it last minute, I would like the opportunity to read the amendment and have a discussion before we vote.

Chairman Kirner:
Fair enough. The amendment mock-up was submitted to the Nevada Electronic Legislative Information System (NELIS).

Assemblyman Hansen:
I am not in favor of rushing this bill at all. This new amendment is something that is worthy of delaying this vote for, to give this Committee an opportunity to review it.

Chairman Kirner:
I think we should talk about the amendment for a moment. Which portions are you concerned about?

Assemblyman Hansen:
It is more than a five-minute discussion when it has some serious ramifications in it. I am concerned about the entire amendment and would like to have an open discussion on it.

Chairman Kirner:
It is just the green language in the amendment. What are you concerned about?

Assemblyman Hansen:
I understand, but I think this is a critical bill. I think when an amendment is dropped in last minute like this, then it is worthy of us delaying the vote to give us the opportunity to entertain the impacts of the amendments.

Chairman Kirner:
Your concern is noted. Is there any more discussion?

Assemblyman Paul Anderson:
I would appreciate some clarifications on section 6.7 in helping us understand what we are trying to accomplish in that portion of the amendment.

Chairman Kirner:
Fair enough. I believe the bill sponsor is here. Senator, Assemblyman Hansen has expressed concerns and other members of the Committee would like you to walk through section 6.7 of the amendment.

Senator James A. Settelmeyer, Senate District No. 17:
The concept of section 6.7 in the amendment was to make sure the chapters of *Nevada Revised Statutes* (NRS) apply or do not apply to TNCs. It is my opinion that TNCs are different than taxicabs and should be regulated through a different chapter. We are trying to find a vehicle that is statewide so we can address issues and concerns of TNCs statewide rather than just on a regional basis.

Assemblyman Hansen:
Can the amendment be read into the record?

Senator Settelmeyer:
In its entirety or just section 6.7 of the amendment?

Assemblyman Hansen:
Just section 6.7 of the amendment, please.

Senator Settelmeyer:
Section 6.7 states that the provisions of Chapters 704 and 706 of NRS do not apply to a person who maintains or is otherwise covered by a policy of transportation network company insurance and who is a transportation network company, or driver, while the person is providing transportation services or logged into the digital network or software application service of the transportation network company and available to receive requests for transportation services.

Chairman Kirner:
Are there any questions?

Assemblyman Hansen:
I would like to have more opportunity to sit down and go over this amendment because this changes some of the focus of the bill. With all due respect, without that opportunity, I am going to have to switch my vote to no.

Assemblyman Nelson:
I have a couple of concerns, and I shared them with the sponsor. I had planned to propose an amendment. I am concerned about passing S.B. 440 (R1) without passing Senate Bill 439 (1st Reprint) and having some sort of linkage there. If it is not S.B. 439 (R1), then it could be something else which regulates.

The other issue is on the insurance coverage with $50,000, $100,000, and $25,000 when the application is turned on. I have concerns that this amount is not high enough. I have spoken with Senator Settelmeyer and some insurance representatives about it, and everyone seems to think that is high enough. Can you provide any comfort on those two points?

Senator Settelmeyer:
The concept of the $50,000, $100,000, $25,000 is actually five times higher than current liability levels and is only for that phase where the driver is not providing transportation services. As soon as the driver accepts picking up a passenger, the amount automatically goes to $1.5 million. Within the amendment, we made sure to add in the portion when they fully disembark. We did not want just the concept of shutting the door; we wanted the actual concept that all their possessions are completely out of the vehicle. In other

words, they must fully disembark to ensure that the $1.5 million is no longer the coverage level. On the national agreement, they went to the previous phase period of the $50,000, $100,000; however, I wanted to make sure it was at least a $1.5 million umbrella overall.

Assemblyman Nelson:
How do you feel about passing S.B. 440 (R1) without passing S.B. 439 (R1)? Are we still working on that in the Senate?

Senator Settelmeyer:
We are still working on S.B. 439 (R1) on the Senate. The overall concept is I want to make sure that they at least have insurance. There was some question before if they were allowed to run if they were uninsured. I do not agree with that. I think we need to make sure that people have insurance while driving around. As the law currently is, their personal policy would be void, and they would be driving around with no insurance and that is not acceptable to me.

Assemblyman Nelson:
I have noted my concerns. I will not make an amendment at this point. I will vote to get this bill out of Committee, but I reserve my right to change my vote on the floor.

Chairman Kirner:
I would like to entertain a motion.

> ASSEMBLYWOMAN SEAMAN MOVED TO AMEND AND DO PASS SENATE BILL 440 (1ST REPRINT).
>
> ASSEMBLYWOMAN FIORE SECONDED THE MOTION.

Is there any further discussion?

Assemblyman Ellison:
I will vote to get this out of Committee, but I reserve my right to change my vote on the floor.

Assemblyman Silberkraus:
I would like to echo the concerns of Assemblyman Nelson. I have issue with the insurance level from application on to accepting the fare. I do not think that is sufficient especially if somebody gets killed during that window of opportunity. I will vote to get it out of Committee with the understanding that we will look at that in the future.

Chairman Kirner:
My perception is that this bill is an insurance bill. This is not authorizing Uber or Uber-like businesses to operate in the state until such time as there are regulations in place.

Assemblyman Nelson:
Would Matt Mundy, our Committee Counsel, agree with that?

Chairman Kirner:
While Mr. Mundy is thinking about that, we will answer other questions.

Assemblywoman Kirkpatrick:
This is not going to be politically correct comment, but it is going to be the truth. I have been in this building a very long time and when we create a cottage industry, we have a lot of discussion on it. I am trying to keep my composure because I feel like I should scream at the top of my lungs just on the process. In all fairness, I get it. I understand that times have changed, but this is a cottage industry that we are creating. Whether or not any other bill passes, we asked questions and the lobbyists felt they did not have to follow up with many Committee members, especially on my side. I never disrespected anybody in the minority party on that process, and I am not going to be part of shenanigans where we have to ask only one question and we cannot have a real discussion on bills. If that is the way the last 34 days are going to go, you can count me as a no on every bill that comes out of this Committee.

Chairman Kirner:
To be clear, I have asked for discussion and have asked everyone to participate. If you choose not to, that is your choice. I would like you to.

Assemblywoman Carlton:
I echo the Minority Leader's sentiment. I have never been a one question girl, and it is not going to happen because my constituents deserve more than that. This is an insurance bill setting up an insurance policy for a practice which is currently illegal in this state. The company that did this went out and did it anyway and now they are here asking to be recognized. I believe by giving them an insurance product, we are recognizing them as a legal entity in this state. I cannot go there without the policy discussion on Uber. If we are going to have a policy discussion, let us have it. I am not going to back-door a process and put people at risk with an insurance bill. It is not fair to the public, and it is not transparent. I believe this bill will be used as a vehicle at 11 p.m. on day 118 of this legislative session to get done what needs to get done.

Chairman Kirner:
Thank you. Are there any other comments?

Assemblyman Paul Anderson:
Based on the amount of information that we want to seek out and better understand, I wonder if the makers of the motion might retract their motions and move this bill to another day.

Assemblyman Hansen:
I would second that request.

Chairman Kirner:
Senator Roberson has asked us to push S.B. 440 (R1) to work session this Friday. I am inclined to do that.

> ASSEMBLYWOMAN SEAMAN WITHDREW HER MOTION TO AMEND AND DO PASS SENATE BILL 440 (1ST REPRINT).
>
> ASSEMBLYWOMAN FIORE WITHDREW HER SECOND.

We will roll that bill until work session on Friday, May 1, 2015.

Assemblywoman Kirkpatrick:
Mr. Chairman, could we figure out how we are going to have a real, public discussion on this particular piece? In the past, we have had work sessions or working groups. We need to have some real discussion on this because otherwise we are going to be in the same boat on Friday. All we did was give us another day to have 50 lobbyists come before us to give us their side, but we did not ever talk about this publicly so that people understand what it is this Committee is charged with.

Chairman Kirner:
We had a public hearing on this bill. I would like to try to engage with you between now and Friday so that we can have that conversation. Would that be acceptable to you?

Assemblywoman Kirkpatrick:
I accept that.

Chairman Kirner:
I will close the work session. We have five bills to hear. I will open the hearing on Senate Bill 251.

Senate Bill 251: Ratifies the Interstate Medical Licensure Compact. (BDR 54-576)

Keith L. Lee, representing Board of Medical Examiners:
Before you, for your consideration is Senate Bill 251. It is the Interstate Medical Licensure Compact. Senator Joe P. Hardy brought this bill on behalf of the Board of Medical Examiners. By way of some brief history, we spent most of last interim working with Senator Hardy on this Interstate Medical Licensure Compact. This Committee processed Assembly Bill 89 (1st Reprint) earlier this session One of the provisions of that bill encourages medical professional licensing boards under Title 54 to enter into reciprocal agreements with other states to provide for an expedited licensure of their particular discipline.

Rather than a reciprocal agreement, this bill creates an Interstate Medical Licensure Compact. Let me put a couple of issues to rest. It is not a substitute for but an addition to the current avenues of licensure, and it does not reduce the ability of the Board of Medical Examiners to review license applicants for their own qualifications. Our qualifications in the state of Nevada will still be applied. We have the ability to take fingerprints and process those. It important to know that it keeps the definition of the practice of medicine as the place where the patient is located. When a patient in Nevada is being treated, that person will be treated by a licensed physician in Nevada.

We have previously distributed information [not an exhibit] regarding the brief history of how we got to this bill. We stand prepared to answer any questions.

Kevin D. Bohnenblust, Executive Director, Board of Medicine, State of Wyoming:
I appreciate the opportunity to appear before you. I am not here to tell you what to do. I want to give you some background and talk to you about what we are trying to accomplish with this Compact. The state of Wyoming was the first state to adopt it. In this session, there have now been a total of six states adopting the Compact, and with the seventh state adopting, then the Compact will really come to life and we will start the process of trying to make it work.

The reason the Compact came about was because, like your state, my state has worked very hard to try to make it easier for physicians to get licensed, not lowering standards, but making the process work better and faster. It was at the strong encouragement of state legislators in Wyoming that we pushed hard to do that. We got about as much then as we could at our level, but we need to look at a national-type picture. We want it to be a state-driven process. We want regulation to remain with the states, and we want to be able to protect the public in our states. We arrived at the idea of forming an

Interstate Medical Licensure Compact. Wyoming was the first state to propose it to the Federation of State Medical Boards two years ago. It passed in the House of Delegates unanimously. I was fortunate to be a part of the drafting team that worked on this. I was very proud of my legislature for making it law in our state.

We want to make it easier for physicians to get licensed, and we want to maintain strong protections for the public and the patients in our state. As Keith Lee pointed out, one of the main points is making it clear in law that the practice of medicine occurs where the patient is, not where the physician is, because it is the patient the laws are created to protect. We also want to have free flow of information between those states that are licensing physicians and to be as transparent as possible. We want to know everything about the physicians practicing in our state even if they are not physically present.

One thing we did to make sure this was going to work correctly was set high licensure standards. This combination of standards and the requirement for successful completion of a postgraduate training program, board certification, and zero criminal history is the most stringent standard across the board in this country. There is no state that demands that much. Any state that has any other requirements is certainly fine, but these are higher standards. We estimate that about 75 percent of physicians in the United States would qualify to use this; it does not mean they will, but they will qualify. If you are familiar with licensure, that means that it is only 1 or 2 percent of your licensees that cause problems. We figure we are in good shape having about 75 percent be eligible, but not every physician on the street will do it.

Even in states such as Wyoming, which does not have a 100 percent criminal background check of applicants, if a physician wants to become licensed through us into the Compact and start licensing with other states, we will run a criminal background check on him. We will get that information before that person is able to go into the Compact system and get licensed in other states.

I would like to be able to answer questions if you have them. I am sure you have read the bill. I saw the preparation materials given to you by Keith Lee. They are very comprehensive. I would rather answer questions and relate to you what my legislators thought when they saw this bill. I am here to be a resource for you.

Edward O. Cousineau, Executive Director, Board of Medical Examiners:
I have no further input on Mr. Lee's or Mr. Bohnenblust's comments. I am available to answer any questions that are related to board matters.

Chairman Kirner:
Are there any questions?

Assemblywoman Neal:
On page 5, lines 1 through 10 of the bill, I would like you to educate me on the function of this. When it says that you are going to qualify the principal place of business in order to indicate the residency of the physician, how does subsection (b) work when the physician may redesignate a member state as the state of principal license at any time as long as the state meets the requirements in subsection (a)? Meaning it is simply a member of the Compact, I am assuming. It could constantly change all the time. Can you help me understand why that language is there and why a person would be able to move so often if the residency piece is supposed to be such an important piece of the license?

Kevin Bohnenblust:
That is a great question. We had to recognize the fact that physicians will move from place to place. We are not anticipating this would be a constant moving process, but we had to have some flexibility. If a physician got into the Compact but then moved to another state, we wanted him to keep that continuous licensure and make sure there was continuous jurisdiction over that physician. It was more to address what we anticipated as kind of a rare occasion. It will be fleshed out somewhat in rule-making how that will be applied. We recognized there had to be some flexibility because physicians move. Moreover, it could be entirely possible that a state could withdraw from the Compact and a physician would want to be able to continue to participate, but he could participate with another state as his principal state of licensure. We want the flexibility there to address the things that happen in life.

Assemblywoman Kirkpatrick:
I think this bill is a good thing. We have been working for a long time to at least get on the mental health side of it within the Compact so that we could share resources. I think to share resources, skills, and knowledge so that can extend our funding formula as far as we can is the intent of the bill. Currently we have traveling nurses for the same sort of reason. Until we can build our own workforce, it is helpful to be able to work with others.

I know how important compacts are for many reasons. However, I do not understand a couple of parts. First, it refers to medical as a whole and then limits it to one type of compact. I want to be clear if it is everybody within the medical field or if it is limited. Second, I want to talk about Article 19 and how the dispute resolution works. I want to be clear what the expectation is so that

future legislators understand. I compare this to the bistate compact on Lake Tahoe that started in the 1960s, or the Interstate Compact on Mental Health that we worked toward to help with mental health concerns. I will sleep better knowing we did our job as legislators.

Kevin Bohnenblust:
This only applies to physicians at this point: doctors of medicine and doctors of osteopathy. There was some discussion of it being extended to physician assistants, but that was problematic because of the supervision arrangements so we did not go that far.

We are trying to get this one piece in place. When we drafted the bill, we looked at the Nurse Licensure Compact (NLC), which has been frozen at about 24 participating states. I think neither your state nor mine is a member of that right now for various reasons. We tried to correct some of those things we are holding back with the NLC. The NLC is revising their compact to basically copy a lot of things we did to improve their compact. Now the state of Wyoming is interested in doing it. I think this is going to be a catalyst for other professions that are under different practice acts. It will do what you are hoping it will do. It will need to be on a profession-by-profession basis because they have separate practice acts.

The best representation I heard relative to the dispute resolution process was from an attorney, Rick Masters, with the Council of State Governments (CSG). He literally helped write the book on compacts; four attorneys wrote what is, for lack of a better term, the bible on interstate compacts. Mr. Masters also helped draft this bill. He likens these to a contract because it is really an agreement between the member states. I believe a good contract has a way to resolve a dispute. This is very much a boilerplate. If there is a dispute between states, it is not just a matter of what do we do now, but that we have a process we can follow. We can resolve it short of a state withdrawing. From time to time, there will be questions you want to address so that was the main reason we put that in the bill.

Assemblywoman Kirkpatrick:
I need more specific detail because I want to make sure there is some transparency and public participation within setting up these rules. Basically, the Interstate Medical Licensure Compact Commission will set up the rules, but how will we, as good Nevada stewards, ensure that we are being represented well within the rule-making?

Kevin Bohnenblust:
If you enact this, it will be very transparent because the two commissioners will be a representative from the Board of Examiners and a representative from the State Board of Osteopathic Medicine. In Wyoming, the commissioners are appointed by the governor, so they will be responsible to the governor, among others. If they do not carry their weight, he will let them know. In addition, elsewhere in the Compact, there is a requirement that each member state will report to its governor and legislature each year as to what it is doing. There is a provision for that kind of report to this body. If you wanted, a designated person could come to this Committee.

All of the meetings of the Commission would be public. Of course, if the meetings are in a location like Louisville, Kentucky, it would be hard for the public to attend, but they will be open to the public. I anticipate that there will be a fairly large number of meetings that will take place via videoconference, which would also be available publicly. There would be ample opportunity for oversight both by this Committee and by the Governor, plus the public will be able to watch this and see what is going on. It is remarkable how much interest there is from everybody from the American Medical Association and large hospital systems and how this is going to work. I think there will be a lot of people very interested in how we go about doing this.

Assemblyman Nelson:
We have had some telehealth bills that we have heard. Is the Compact flexible enough to accommodate telehealth? Also, is that going on in Wyoming?

Kevin Bohnenblust:
It is really intended to be very flexible. We did not want to differentiate between telemedicine and face-to-face medicine. Medicine is medicine no matter how you are practicing it. We drafted it to be basically blind to telemedicine, that it should cover any kind of physician-patient interaction. For example, it would also accommodate a physician from the University of Utah School of Medicine coming into western Wyoming on a monthly basis and holding in-person clinics, whether they do in-person or by videoconference or by telephone, we do not care. This would cover all circumstances. Wyoming, for instance, has two child and adolescent psychiatrists in the entire state. State Medicaid has had a desperate need for child and adolescent psychiatrists. They have been sending patients out of state to get care. They have licensed a number of faculty members from the University of Washington School of Medicine's Department of Psychiatry and Behavioral Sciences, and now they are providing care to Wyoming children in the Medicaid program. They have saved hundreds of thousands of dollars in transportation costs. It is working very well as far as we can tell.

Assemblywoman Bustamante Adams:
I did not receive the information about the states in the Compact. Could you mention which six those were? If Nevada goes forward with this, what kind of time frame are you thinking about for its full implementation? Lastly, how does Article 6, which is about the fees, affect our doctors in Nevada? What would be the amount they might have to pay in order to participate?

Kevin Bohnenblust:
The six states so far are Wyoming, Utah, Idaho, Montana, South Dakota, and West Virginia. I understand that there is a likelihood Alabama will also adopt it. The bill is being presented in about a dozen other states with mixed results. Given that this is the first legislative session we have had to run this bill, I am ecstatic we have gotten this far. The regionalization will give us a chance to show what we can do with the care that crosses state lines. For instance, the University of Utah School of Medicine told me that about 40 percent of their patient base comes from Wyoming, Idaho, Montana, or Nevada. If Nevada comes into it, you have Utah also and now you have a pool of physicians who are able to extend care to patients in those states using the Compact. I am hopeful that is going to happen.

Since this has never been done, I will guess on the time frame. We are going to ride out the rest of the legislative session, so it would probably be into July before the last legislature goes out. We want to give any states that are looking at it a chance to adopt. At that point, we would start looking at setting an initial meeting for the states to sit down and discuss the first steps. I am hoping that will be taking place within the next six months. After that, the key to this is going to be having a very robust information system. We need information to flow very quickly between the states. That is where we are going to want to get it right. I think this will be one of the biggest challenges. If I had to guess, I would say it would probably take us about a year to get that in place because we do not want to foul it up coming out of the chutes. Being able to do it with a brand-new system and having the collective knowledge of the licensing people and the information system people from our various states, I think it is possible to do it in a year's time. We are exploring federal grants to help support this process. There is also some private grant money we are looking for. I would say after about a year-and-a-half we could have it functioning and licensing physicians.

In the meantime, physicians can still use the traditional licensing process in each of our states. In Article 6 regarding fees, we said that each state should set its own fee. If you want to set the fee at exactly what you charge physicians to come to Nevada and practice in person, that is great. If you feel that there is a higher cost that should be paid, your board can justify that. If you want to

have a lower fee to try to encourage physicians to use this, you can do that. We wanted to make sure that each state could set its own fee because that was one of the shortcomings of the NLC. If a state was not the principal state of licensure, had no licensing fees, but still had obligations and requirements to do investigations and discipline, then we would not want to take that away from each member state.

Assemblywoman Carlton:
I have a little concern about the severability clause because although there are some things in here that will give me a level of comfort, if we find out they do not work, they could go away and that would be an issue. I really want to understand Article 13, "Finance Powers." How will this exactly be levied on the states? Who in the state will actually pay for it? It seems like a catch-22. Should the State General Fund pay for it? I do not think so. Do we ask doctors to pay for it out of their licensure fees to bring in competition against themselves? I am trying to understand how the finance part of this will actually work.

Kevin Bohnenblust:
I agree that sometimes we do not like having the severability clause in there, but it is a good drafting tool to use because you do not want to lose the whole thing because you lost one segment of the act. I think the ultimate protection for any state is, if this thing turns out to be something you do not want, you can withdraw. We will have regulations in place to transfer physicians back and forth. It is always at the pleasure of the state whether they are going to be in or not. If the legislature and the governor know you are out, then you are out.

As far as finance powers, everyone blanches at that idea of being able to levy an assessment of each state. The way it was explained to me was, to make this an instrument of state government and in order to have that held up at a court challenge, you need to have the ability to say the state has an obligation to pay. We view it as the payer of last resort. I have no desire to go back to my legislature and say I need a bunch of money. I do not think anyone wants to see us come before you asking for money to make this thing happen. That is sort of the fail-safe at the very end. To get to that point, it would take an affirmative vote of the majority of that Commission. Again, there would be two seats at that table, but we all would have skin in that game to go back to our legislators and ask for money.

I told the legislators in Wyoming that the licensing fees through the Compact will come into the Board of Medicine and into our special fund. We are a separate, self-funded account. We get zero General Fund dollars. I would

expect that any cost would then be borne out of that fund as well because that is where the money comes in and self-supports. I would have to defer to Mr. Cousineau to be completely sure.

Edward Cousineau:
The Board of Medical Examiners is well aware that there may be some initial negative fiscal outlays as it relates to the Compact. We certainly are in a position where we can afford those outlays. There is no concern on my part, or the Board's part, that we would have to go back to the Legislature to seek funds to support our effort for the first two years.

Ultimately, we believe the Compact fees that are generated from those eventually will be self-sustaining. The Board also strongly believes that the long-term benefits of the Interstate Compact certainly outweigh any short-term fiscal costs that will be borne by the Board. There is very little chance that we would have to burden the General Fund as it relates to the Compact being put in place.

Assemblywoman Carlton:
Are you going to pay for this out of your reserves, your licensing dollars?

Edward Cousineau:
Yes, we would. We do not anticipate it to be a significant amount but obviously it depends on the number of states that are a part of the initial stand-up for the Compact, as well as the number of the licensees in these various states. It is my understanding that those are going to be spread among the individual Compact states. At this point, we anticipate that there will be some initial negative fiscal outlay. The Board is comfortable with it, and we have discussed it.

Assemblywoman Carlton:
As a member of the Assembly Committee on Ways and Means, I am always interested in the number. Have we discussed how much this is going to cost your licensees?

Edward Cousineau:
I cannot speak to that. I think there are some variables out there such as how many states are involved in the Compact and how many licensees we obtain through the Compact. As Mr. Bohnenblust already explained, we are going to stand up the Commission. This is part of the rule-making process. When we do that, I think we will have a better idea as to what the cost of the Compact will be to each member state. By analogy, I could use an example from when I spoke to the Federation of State Medical Boards' Senior Counsel. He made

reference to the NLC. I believe he indicated that their annual operating budget is a little over $100,000. I am not saying that would be the operating budget of the Compact or the Commission, but that is just an example I can give you. I do not believe that the numbers will be staggering.

Assemblywoman Carlton:
I am thinking about the legal issues that might arise from this. Every time you try to do something like this, somebody decides they know better and they are going to try to sue you. What would the state's responsibilities be if the organization ended up in some type of legal matter? How would we handle that? I want to make sure that I protect the state and your licensees from this. Ultimately, somebody will have to pay the bill, and I do not want you to have to come in front of the Interim Finance Committee (IFC) or have the Attorney General come in front of IFC and ask us for money for a legal action. Has that been contemplated?

Kevin Bohnenblust:
I think that is how it would be with any other compact that your state is a member of. In other words, any liability or any concerns relevant to your state would be under the purview of your Attorney General. Anything that was looking at the Compact as a body corporate would be the responsibility of the Commission. The way that the Commission would be set up is basically an entity of quasi-government that would have the responsibility for having its own legal counsel.

Assemblywoman Carlton:
I think this is our first medical compact and, in medical malpractice when people start getting listed in a lawsuit, everybody gets listed. If something happens in two other states, we end up getting dragged into it. I think we need to discuss this because I do not want to see the licensees pay for it, but you do not want to show up in IFC and ask for money for this either.

Kevin Bohnenblust:
I will keep that in mind. Hopefully we move forward and we actually stand up the Compact. It is a very real concern. While hospitals may get sued for negligent credentialing, so far no one has found a way to sue a medical board for negligent licensure. Each state would establish its licensure fee, but then the Compact would basically have a service fee that they would charge. I liken it to the Ticketmaster website. You get two tickets for $75 and then you have another $10 you pay for the convenience of not having to go pick up the tickets yourself.

We have heard repeatedly that physicians look at that charge and say it is a godsend compared to what we have to do to get licensed through the normal channels. We anticipate whatever fee will be set by the Commission for that service and processing, that is what would really drive the long-term funding of the Compact.

Assemblyman Ellison:
We are talking about physicians, but are we also talking about dentists and nurse practitioners? Or is this strictly for medical doctors?

Kevin Bohnenblust:
Right now it is just physicians and osteopathic physicians. If this takes off and moves the way that I think it will, you may see other professions start adopting it. Because of the changes they are looking at in the NLC, Wyoming is now looking at going into the NLC, which would affect advanced practice registered nurses. This is a new step forward and if it works the way I think it will, it could affect a lot different medical professions and disciplines.

Assemblywoman Neal:
I have two questions. One is from Article 9 and one is from Article 10. They are both educational points for me. I am tying in the residency piece, being able to move from place to place. In Article 9, subsection (c), where you are allowed to issue a subpoena that shall be enforceable in other member states, how does personal jurisdiction work in those situations when another state is issuing a subpoena within the Compact? Also, Article 10, subsection (c) states if disciplinary action is taken against a physician, any other member board may deem the action conclusive as to matter of law and fact decided. Do other compacts have this language? Do other compacts also have extrajudicial authority where the right to relief is somehow subsided or changed because the board has decided that something is now conclusive as a matter of law, but it was not a court ruling? How does that work?

Kevin Bohnenblust:
When somebody has a license in a state, that is one of the important things that we wanted to make sure of, that somebody would have a license in a state where the patient was located and there is jurisdiction over that physician to a point. But because our subpoenas are issued by state agencies, they run out at the state line. You can go to a court in the state where the physician is and ask the court to perfect your subpoena and everything else, which is a drawn-out process and they can deny it. We wanted to say that because you are part of this network or grouping, subpoenas are not going to run out at state lines, which is going to keep people from being able to say they are on the other side of the state line.

As far as having deemed a matter to have been adjudicated, under the *United States Constitution* and every state constitution, we are required to give licensees due process of law. Before any action is taken, they have to be afforded due process, which usually involves a contested case hearing, opportunity to present evidence and witnesses, et cetera. For example, a physician from Wyoming does something inappropriate in Idaho, and Idaho has already adjudicated a case against him, we do not want to go back and prove all of the evidence over again and drag witnesses to Wyoming to be able to testify. If they have been afforded due process in that state the first time, then the other state will take the record of the case and we may—we do not have to—deem it all to have been proven and decide what sanction we want to apply. I will defer to Mr. Cousineau on that because he can speak to what the *Nevada Revised Statutes* (NRS) says. The idea is rather than them dragging witnesses elsewhere if another state is going to take action, you have a chance to adjudicate it. If it has been resolved and no appeal has gone through, then you have a finished matter.

Assemblywoman Neal:
Is it like judicial authority? They would not have to go court. Moreover, would a judge, not the board, not have to make any kind of decision related to this at all because your process is equal to the court function?

Edward Cousineau:
Currently in our medical practice act [*Nevada Revised Statutes* Chapter 630], Nevada has statutes in place which allow for reciprocal action for out-of-state determinations. The administrative process, while some is separate initially from the courts, is settled at the Board level. The civil courts potentially become involved when there is a matter contested for judicial review, which can be challenged all the way up to the Supreme Court. As to when there has been a final adjudication, I will use California as an example. If that state has adjudicated a revoked licensee and we learn about it in Nevada, we have the ability, under statute, to take reciprocal action. All we need is a certified copy of that record to put on our administrative case. It does not need to be relitigated. Our law recognizes that when they have had their full due process in another jurisdiction, all we need is a document that establishes that it has been ultimately adjudicated. We can use that for our reciprocal or other discipline as we see fit.

Assemblywoman Diaz:
When we talk about reciprocity, it always come to mind about where the other states' standards might be in terms of licensure. I wanted you to speak to those. You mentioned the states that are looking to become part of the Compact. I wanted to know if their requirements for licensure are substantially equivalent to Nevada.

If we got to the point where we thought this Compact was not working for our state and we were not getting what we thought we were going to, how do we withdraw from it? In the bill it says we have to repeal the statute. We are a Legislature that only convenes every other year, so this puts us in a crunch. If we enact this and a year later we figure out trying to implement it is not worth Nevada's time and we want out, we would have to wait until the 2017 Legislative Session. Article 21, subsection (b) says "but shall not take effect until 1 year after the effective date." For us, that is moot because we are bound to this for two years. Is there a middle ground that could be achieved? I know the other states involved probably have a legislature that convenes more often than ours in Nevada.

Kevin Bohnenblust:
First, equivalency between states on the standards is the reason we put very specific standards in the Compact itself. There had to be zero criminal history, zero disciplinary action, zero Drug Enforcement Administration (DEA) actions, and successful completion of a residency program. There is only one state in the country that requires that now and that is South Dakota. We basically took the high-water mark on these key qualifications. If you cannot meet those qualifications, you can go through the usual process and get licensed in the state, but you are not going to go through the Compact because we want to have an assurance that you have hit a very high standard. This sort of overrides all of those other state requirements when it comes to somebody who wants to enter through the Compact. For example, if a physician in Wyoming who has been licensed there for 20 years when the Compact comes into existence now wants to get licensed through the Compact in other states, he is still going to have to meet these requirements, because the board has to be able to issue a statement of qualification to the Compact saying he meets these requirements. It is the higher common denominator coming into play here. It is very important, and we wanted to make sure of this so that states like yours will be very confident and you will be getting the most qualified people.

In regard to withdrawal, it takes legislative action and the governor's signature to get into it. It is your power to decide whether or not your state belongs in the Compact. While I can understand it would be two years before you could potentially withdraw, I do not think you would want to give up that power to

say whether or not you are in. That is my personal perspective. The main reason there is a one-year withdrawal period is because there are going to be physicians who have been licensed through the Compact from your state or working in your state. We want to have a way to transition them so that we do not have disruption of patient care. We will plan to have rules in place and govern how that works so they can get licensed other ways. Similarly, if a Utah physician is working in Nevada under the Compact and Nevada withdraws from the Compact, but the physician wants to keep working, how will Mr. Cousineau get them licensed in Nevada long-term? That is the reason for the one-year transition.

Chairman Kirner:
Thank you. I will allow those in support of the bill to come forward.

Victoria Carreón, Director of Research and Policy, Kenny C. Guinn Center for Policy Priorities:
We believe this Compact can be part of a multifaceted solution to especially address our mental health workforce shortages. We have written a paper entitled, "Nevada's Mental Health Workforce: Shortages and Opportunities," where we encourage the state to adopt compacts such as this. To give you an idea of the significant shortages of mental health services in our state, Nevada ranks 50th in the nation in the number of psychiatrists per 100,000 people. This is particularly pronounced in rural areas. In addition, 53 percent of the population in our state resides in an area designated a mental health professional shortage area by the federal Health Resources and Services Administration. The mental health service penetration rate is lower in Nevada than in the United States, and is particularly low for Latinos and Asians. We have psychiatry residency programs in Nevada; however, of the seven people who graduated from a residency program at the University of Nevada School of Medicine in 2013, only five remained in the state. Two physicians completed a fellowship in child and adolescent psychiatry, and only one remained in the state. You can see the extreme need we have for additional psychiatrists in our state.

Also, At the Department of Health and Human Services in September 2014, 76 percent of senior psychiatrist positions were vacant. To address these vacancies, the state has relied heavily on contract psychiatrists. For example, in fiscal year (FY) 2014, Southern Nevada Adult Mental Health Services spent $5.6 million for contract psychiatrists and physicians. [Referred to prepared written testimony (Exhibit F).]

We believe this Compact would help because it would expedite the process and make Nevada more attractive to psychiatrists who wish to practice in multiple states either in person or using telemedicine, which can be an effective strategy in the practice of psychiatry.

The Compact was a state-driven effort. It also creates very high standards that physicians would have to meet, and control is maintained by the Nevada medical boards. The Board of Medical Examiners and the State Board of Osteopathic Medicine would know exactly who is practicing in Nevada. All of those people would also have to pay fees to practice in Nevada, which would cover the Compact's administrative costs. All of the disciplinary actions of physicians practicing in Nevada would be under the control of Nevada's medical boards. The Compact affirms that the practice of medicine occurs where the patient is located, and therefore requires the physician to be under the jurisdiction of the state medical board where the patient is located.

The Compact creates a great coordinated information system once it is up and running. It efficiently implements reciprocity. Assembly Bill 89 (1st Reprint), which was approved by the Assembly Committee on Commerce and Labor this session, implements a process where different boards could go and negotiate individual reciprocity agreements with states. This is a much more efficient process because there is one central negotiating process and states can join up with the Compact.

There are also other compacts. Senate Bill 299 is currently pending and that is a psychology compact, which is also very new and not running in any other states. There is an existing nursing licensure compact, and unfortunately that has failed three times in the Nevada State Legislature. There is an advanced practice nursing licensure compact that is still being developed, which is something you may want to consider in the future. We think an advantage of joining early is that Nevada would have a say in the initial regulations that are being developed.

Paul J. Moradkhan, Vice President, Government Affairs, Las Vegas Metro Chamber of Commerce:

We, too, offer our support in regard to this bill. We believe it is another facet to us helping address the physician shortage in our state. We are comfortable with the accountability measures that have been discussed with the bill.

Elisa P. Cafferata, President and Chief Executive Officer, Nevada Advocates for Planned Parenthood Affiliates:

We also want to echo the support for this bill, which will help improve access to health care in Nevada. We have been advocating for this for many sessions.

Grayson D. Wilt, representing Nevada State Medical Association:
We support this bill.

[Linda Gray Murphy, on behalf of the American Board of Physician Specialties, submitted talking points (Exhibit G), standards for recertification (Exhibit H), fact sheet (Exhibit I), letter in opposition (Exhibit J), and report on board certification (Exhibit K). Also, James L. Madara of the American Medical Association submitted a letter (Exhibit L) in support of the bill.]

Chairman Kirner:
Are there any questions from the Committee? [There were none.] I will invite those who may be opposed to this bill to come forward. [There was no one.] Is there anyone in neutral on this bill? [There was no one.] Are there any closing comments?

Keith Lee:
If there are remaining questions, I would be happy to answer them individually. We conclude our presentations for the day.

Chairman Kirner:
I will close the hearing on Senate Bill 251. I will now open the hearing on Senate Bill 181 (1st Reprint).

Senate Bill 181 (1st Reprint): Provides for the licensure of certified anesthesiology assistants. (BDR 54-240)

Lesley Pittman, representing Nevada State Society of Anesthesiologists:
I am joined here today by Dr. Dean Polce, a Las Vegas-based anesthesiologist and president of the Nevada State Society of Anesthesiologists. Also here with me is Dr. Jerry Matsumura, a Reno-based anesthesiologist, and Robert Wagner, an anesthesiologist assistant who has been practicing for 25 years.

This legislation was sponsored by Senator Joe P. Hardy. It passed out of the Senate Committee on Commerce, Labor and Energy and the full Senate unanimously. We are very pleased to have the opportunity to present the information we have on this very important legislation to you today.

While this is a rather thick bill, the bulk of the legislation is really in section 2 through section 12. Sections 3 through 6 provide for definitions. Section 3 defines "anesthesia services." Section 4 is the definition of "anesthesiologist assistant," also known as AA, which is "a person who is a graduate of an academic program approved by the Board or who, by general education, practical training and experience determined satisfactory to the Board,

is qualified to perform anesthesia services under the medically direct supervision of a supervising anesthesiologist and who has been issued a license by the Board." Section 5 provides a definition of "medically direct supervision", and that means the physician anesthesiologist who is supervising has to be immediately available. Section 6 provides the definition of the "supervising anesthesiologist." The provisions for what the anesthesiologist assistant who is licensed may be allowed to perform here in the state of Nevada is laid out in section 7. It also identifies things that an anesthesiologist assistant cannot do, such as prescribe controlled substances.

Section 8 of the bill provides for the duties and responsibilities of the Board of Medical Examiners for the licensure. Section 9 outlines the regulations that the Board must adopt, establishing the requirements for licensure. Section 10 identifies what an anesthesiologist assistant shall do and that he must identify himself as an anesthesiologist assistant. Section 11 allows an AA to practice without supervision, but only in a government-declared emergency situation, something we ask most of our health care providers to do in our state from what I understand. Section 12 lays out the requirements of what a supervising anesthesiologist must do for an AA.

The remaining sections are just adding AA into a number of different chapters of existing *Nevada Revised Statutes*. I will now turn it over to Dr. Dean Polce.

Dean Polce, D.O., President, Nevada State Society of Anesthesiologists:
Senate Bill 181 (1st Reprint) introduces AAs into the state of Nevada to be regulated by the Board of Medical Examiners as well as the State Board of Osteopathic Medicine. They are highly qualified and trained anesthesia providers who would work under the direct supervision of an anesthesiologist and an anesthesia care model team. The backdrop for the anesthesiologists who support this bill stems from the 2010 Medicaid cuts of 43 percent. At that time, the physician anesthesiologist and the nurse anesthetist had the option of opting out of Medicaid and they did not. They continued to provide services.

There is a lot of diversity within anesthesia practices. Some anesthesiologists take care of pediatrics and some do cardiac surgery; it is their option. All those subspecialists are difficult to recruit. When you are heavy on one payer, such as Medicaid, and your practice gets cut 43 percent, you have limited options. One option is cost-shifting and the second option is leaving the state, which did happen with several people. When that happens, the burden is shouldered disproportionately by a subspecialist who, at this point, can no longer cost-shift. This bill provides that opportunity.

Medicaid was expanded in the state of Nevada on January 1, 2015. Most states' average expansion was 15 percent. Nevada's expansion was over 60 percent. To give an analogy, if you had a special education class and asked the teacher in her specialty training to double the number of pupils in the class and cut her pay by half, how would that work out? I am sure the superintendent would be upset. I am sure the school board would be upset.

We are not advocating this bill as a cure-all to access to care. This is also not to steamroll any other providers who would be opposed to this bill. We are not here to change anesthesia delivery in the state of Nevada. We are not here to make changes in hospital hiring, anesthesia practices, or other things. This is simply an option for some practices to utilize if they want. It would be at their discretion.

The ratio of supervising four AAs at one point is consistent with the Centers for Medicaid and Medicare Services (CMS) ratio. This applies not only to AAs but also to certified registered nurse anesthetists (CRNA) as well as resident anesthesiologists. There is nothing new in this bill that deviates from current practice involving supervision of CRNAs in this state at the same ratio of 1 to 4. There are seven boxes that must be checked if I am going to supervise an AA. As an anesthesiologist, this ensures patient safety and makes sure that I am involved in the care of that patient at all times. If I do not meet all of those requirements, I have committed fraud, and it is against the law.

There are 17 other states that have AAs. Those same 17 states have at least two other options for the anesthesia care team model: anesthesiologist residents, who are physicians in training, as well as CRNAs. In the state of Nevada and others outside those 17 states, there is only one option for a care team model of the non-physician health care provider. Any physician boarded through the American Board of Medical Specialists has at least four non-physician health care providers at their discretion. There is only one for an anesthesiologist.

There have been comments made about the number of providers in this state and that the state does not suffer from an access-to-care issue. Although studies point out that there are a number of anesthesiologists per capita and providers in the state to meet certain ratios, we are not complaining about access to care in totality. We are talking about certain payers, Medicaid, Medicare, and the uninsured. Why is that? There is a massive discrepancy between commercial payers for all physicians between what they will pay and what a government entity will pay. That difference is about 67 percent. Patients who are uninsured, on Medicaid or Medicare, do suffer from an access-to-care issue. The biggest proof for that are the hospitals in Nevada that

have now put up money to make sure that these patients are covered. In Reno, there is Renown Regional Medical Center. In the Las Vegas area there are MountainView Hospital, Sunrise Hospital and Medical Center, Spring Valley Hospital Medical Center, and the St. Rose Dominican Hospitals. All of these hospitals have put dollars behind a problem that exists. If everybody was healthy and had cash payment or good insurance, we probably would not be sitting here right now.

My final comments come as a taxpayer and not as an anesthesiologist. Only 22 percent of Nevadans have a bachelor's degree, which ranks us 47th nationally, and 7.6 percent have an advanced degree, and that ranks us 42nd. The median income is $51,000. The biennium budget puts aside $20 billion, of which just under half is for education and health and human services. Senate Bill 181 (1st Reprint) will bring in highly paid workers who will be paid at least double the median income, and who will have at least a master's degree, and it does not cost the taxpayer a dime.

[Dean Polce submitted written testimony (Exhibit M) in support of the bill and submitted a map (Exhibit N) on AA work states.]

Jerry Matsumura, M.D., representing Associated Anesthesiologists of Reno:
You have heard over and over about the shortage of physicians from previous testimony for other bills and in general, and that often refers to doctors in Nevada as a whole. Ten days ago, the headline on the Sunday *Reno Gazette-Journal* read, "Not Enough Doctors." This month's cover of *RENO Magazine* reads, "Just What the Doctor Ordered," talking about the shortage of physicians and the need for the medical school at the University of Nevada, Las Vegas (UNLV). Specific to the anesthesiology market, there is the RAND Corporation study entitled, "An Analysis of the Labor Markets for Anesthesiology" done in 2010. The conclusion of that study was that a shortage of anesthesiologists and CRNAs was highly likely at the national level, and they anticipated by 2020 that this would come to fruition.

I am a member of a 59-doctor anesthesiology group in Reno. You would think at first glance, because we have hired 20 anesthesiologists in the last 18 months, that this may not seem like a shortage and it is an easy job recruiting practitioners to the area. That does not include the five practitioners who were already in Nevada; three of them were already practicing in Reno and we just incorporated their patients and their practice into our group. It also does not mention that within the last year, seven anesthesiologists from Reno left the area. Our net gain is really about eight people. We have learned that it might not be hard to recruit anesthesiologists but to get them to stay may be. I came to this state in 1997 and I love this state, but we find that if you do not

have an anchor for these people when they come to Nevada, such as family or in-laws, that after a few years of practice and having a family, the grandparents start calling them from the other states telling them to move back.

In our recruiting process, we look to find people who have some anchor that will keep them in Nevada. A good example is this new category of anesthesiologist assistant. You will hear today from Joey Parrish, a resident of Nevada who is going to attend an AA school in Florida and wants to return to the state. We also have at least seven AA students around the country who are from Nevada and who have expressed interest in trying to return, but at this point, there is no category for their type of practice here. If we can recruit somebody like that, we know there is a higher rate of retention. There have also been concerns to us that some people are saying that we are trying to displace practitioners. From common sense, we are increasing the number of practitioners. If I am going to be hiring 20 anesthesiologists in my group over the last 18 months, does that sound like I am trying to displace people or bring people in?

There have been concerns about this in respect to the emergency provision. Since I have been practicing in northern Nevada, there has not been a government-declared emergency. The closest thing we had to that in relation to the hospital I work at was the Reno Air Races crash. I was at the hospital that day, and we had so many anesthesiologists they actually had me leave to do some security duties at the Reno Air Races since I was also a reserve deputy with the Washoe County Sheriff's Department at that time. There was also a major bus crash at Mammoth Mountain several years ago. We had anesthesiologists hanging around the operating room looking to help. I would like to think that if there was such an emergency, I would expect a CRNA, a respiratory therapist, or whatever is within their skill set under that type of emergency to do the same.

There was also concern that performing these emergency actions without supervision is a violation of the *Code of Federal Regulations*. In that type of situation, we would not be billing patients in order to be financially humane. We also would not be billing patients because we would fall out of the Good Samaritan Act and lose our liability protection. Overall, I am for increasing the practice capability for all practitioners in every type of medical profession to the full extent of their training, education, and certification as long as it does not interfere with patient safety.

Robert Wagner, Assistant Professor, Department of Anesthesia, College of Health Care Sciences, Nova Southeastern University, Tampa, Florida:
I am a past president and current board member of the American Academy of Anesthesiologist Assistants. Nova Southeastern University has two AA programs, one in Tampa and one in Davey, Florida, which is near Fort Lauderdale. I have been a practicing AA for 25 years in the state of Florida. I want to tell you about the education of AAs. Anesthesiologist assistants must have a bachelor's degree and meet all of the prerequisites to get into medical school. They have to take the Medical College Admission Test (MCAT) and/or the Graduate Record Examination (GRE) in order to get into the program. Some of the past applicants have been biology majors, neuroscience majors, veterinarians, physician assistants (PA), nurse practitioners, nurses, physical therapists, and pharmacists.

The program is at the master's degree level and there are ten programs in the United States that range from 24 to 28 months in length. After extensive training and a minimum of 2,000 clinical hours with direct contact with patients, they are awarded a master's degree in anesthesia. After they receive their degree, they have to wait for a certification exam. The certification exam is administered by the National Commission for Certification of Anesthesiologist Assistants, but is delivered by the National Board of Medical Examiners, the same organization that delivers the physicians' exams to them. The AA exam is a different exam.

Any AAs have to recertify every six years and they have to keep up their continuing medical education every two years. The federal government only recognizes three anesthesia providers in the United States: the physician anesthesiologist, the nurse anesthetist, and the anesthesiologist assistant. Those are the only three that can be reimbursed for services in the United States. With the federal government recognizing AAs, it is dictated that the AA must work under the supervision of an anesthesiologist who is immediately available. That means in-house at the hospital. I have been practicing for 25 years. I can tell you when things get bad, you want as many hands in there as possible, but when you have an AA in the room, the patient is guaranteed an anesthesiologist will be involved in that patient care. This is very important. Every patient deserves a physician involved in his or her care. This also concerns patient safety.

Since this passed in 2004, there has not been one AA brought to the Florida Board of Medicine for any disciplinary action or patient safety issue. We have over 250 AAs certified in that state delivering tens of thousands of anesthetics. The scope of practice is the same as that of a nurse anesthetist except we work

under the anesthesiologist. We have AAs who work at the Emory University School of Medicine, Children's Medical Center of Dallas, Children's Hospital Colorado in Denver, and Nicklaus Children's Hospital in Miami. They assist with everything from liver transplants to heart transplants and basic plastic surgery to general surgery. They are trained in every aspect of anesthesia.

The insurance for AAs falls into two categories. If they work for the anesthesia group, the AA usually falls under the umbrella of the anesthesiologist. If they work directly for a hospital, the hospital is responsible for the insurance. An AA can get his own insurance as well, but the AA has to work under the anesthesiologist. An AA can work in the U.S. Department of Veterans Affairs (VA) system all around the country. It is unfortunate, however, that when the coding for AAs was generated by the government, it was done incorrectly. They can work in a VA hospital, but they work at a lower salary with the same job description as the CRNA. That is being corrected as we speak. There are anesthesiologist assistants who are veterans, but they do not work in the military at this time.

I have testified in many states, and what this really boils down to is competition within a state for non-physician providers. Many Nevada students who have gone to AA school are recognized by the federal government, so why should they not have the right to come back and work in the state? I see approximately 60 to 65 applicants from Nevada per year come through our schools. There is a need and a want for the AA in Nevada.

Chairman Kirner:
Can you compare and contrast the education between the AA and the CRNA?

Robert Wagner:
The CRNAs are nurses first. They have their bachelor's degree in nursing and then go and get their master's in nursing anesthesia. The AA is a pre-medical student who has met all of their pre-medical prerequisites and taken all of the required classes. The AA programs are specifically designed for those individuals who maybe have a bachelor's degree in biology in order to get them to be competent anesthesia providers at the master's level.

Chairman Kirner:
It sounds very similar except the AA might not have a master's degree, whereas the nurse might have her master's degree.

Robert Wagner:
The end result is the same; they both must have their bachelor's degree to get into the master's program. At the end, they both have their master's degrees.

Chairman Kirner:
So it is very similar then?

Robert Wagner:
Yes. The only difference is that the CRNA is a nurse first.

Assemblywoman Neal:
My question stems from section 12 of the bill. If you create the AA position, what is the reimbursement rate under Medicaid? It was stated that AAs could help with the unequal access to care. I was looking at the reimbursement rate in Indiana and Alabama, and it looked like AAs get 60 percent reimbursement under Medicaid. I do not know what it should be, but I am assuming it would be across the board. If there is direct supervision by the anesthesiologist, which is mandatory in order to get your billing and get it paid for, then what does the anesthesiologist get paid in addition to the AA?

Dean Polce:
It is more complicated than it seems. In this state, since there is so much managed care for Medicaid, it is possible to directly negotiate with the payers. For example, if my anesthesiology group wanted to directly negotiate a contract with Robert Wagner, they would be paid according to that contract. Other states we have referenced pay for what is called "fee for service." It is set by the state and there is no managed care entity. In Nevada, about 90 percent of the Medicaid is handled by private companies. They are given a chunk of money from the state and what they do with that money afterward is dependent on two things; what they pay providers per the state rate or the negotiated rates.

To answer your question specifically, if I am medically directing Robert Wagner and we do a Medicaid case, the fees are split. Let us say I would get 50 percent and he would get 50 percent. If they are going to pay $25 for that case and I do it individually, I get $25. If I am medically directing him, I get $12.50 and so does he. At a supervisory ratio of 1 to 4, you would multiply all of that by 4. Does that make sense?

Assemblywoman Neal:
Yes, it does. I am just trying to see what the cost benefit is if the cost is exactly the same with the anesthesiologist and a partner.

Dean Polce:
There are two parts to it. There is cost-shifting and access to care. In a complex case, there is only going to be one person in there, and that is going to be the anesthesiologist. For example, someone who needs congenital

heart surgery, a three-day-old, or a one-month-old, that person is part of a large group who cannot cost-shift that case or share it with anyone else. In another room there may be other cases going on and a partner in that group may help. If you are supervising one person at one time, there is no cost-shifting at all. It is not possible; you split it. There have to be numbers in a group to justify hiring and negotiating contracts that make this work or you are correct because then there is no cost benefit whatsoever.

Assemblywoman Seaman:
The CRNA is now working in the state of Nevada, correct?

Jerry Matsumura:
Yes, that is correct.

Assemblywoman Seaman:
When someone is working under your CRNA program or will be working under your AA, is the patient informed by a form that they are working with you and the AA or CRNA?

Dean Polce:
Yes. When a physician signs your informed consent form, he must let you know who is involved in your care. Currently, the form reads "name of anesthesiologist" and the anesthesiologist has to sign that. It would be similar if a medical student was coming into the room to observe. A doctor must disclose it to the patient beforehand, for obvious reasons, since the patient cannot respond under anesthesia, and the patient may not want total strangers in the room. That happens at all levels for many different providers.

Assemblywoman Seaman:
How long have the CRNAs been working with anesthesiologists in the state of Nevada?

Dean Polce:
I do not know the answer to that question.

Jerry Matsumura:
I do not know the answer, but I believe there will be a CRNA giving testimony today who can answer that.

Chairman Kirner:
The reason we do not have AAs and the reason why we are here today is because we do not have such licensure in Nevada. This bill is all about creating that. Are there any other questions from the Committee?

Assemblywoman Bustamante Adams:
My question has to do with section 5 of the bill regarding direct supervision. It says that the supervisor would be immediately available in "such proximity." Can you expand on that? Does such proximity mean that they cannot leave the room while they are supervising?

Dean Polce:
Admittedly, that definition of "immediately available" is very difficult because it is a nationally recognized definition that is a requirement of Medicare Part A and Medicare Part B conditions of participation. The analogy I usually give for this is the difference between Centennial Hills Hospital in Las Vegas, which will have five or six operating rooms (OR), and Massachusetts General Hospital in Boston, with about 80 ORs. To be immediately available in one hospital or the other is totally different. You can leave the room, but you need to be able to immediately return to the patient's side as soon as called for by the AA, or during the seven specific periods that Medicare requires the person to be paid as medically directing. If you are looking for a time or a distance, it does not exist in language anywhere.

Assemblywoman Bustamante Adams:
Is there a cap on the number of ORs that can be supervised at the same time? Can the anesthesiologist be supervising four or seven and leave the room? I am just trying to understand. Could you also expand on the seven boxes that you said you have to mark in order to make sure that due diligence is being provided?

Robert Wagner:
For the last 25 years, I have practiced with what is called an "anesthesia care team." This consists of the federal government allowing an anesthesiologist to supervise up to four rooms. There will be one anesthesiologist supervising four rooms, which could be two AAs, two CRNAs, or any combination. They are immediately available in the hospital. To answer your question, they are not specifically in the four ORs at all times because that is not feasible.

Jerry Matsumura:
The seven steps under the *Code of Federal Regulations* through the CMS are as follows: the anesthesiologist (1) performs a pre-anesthetic examination evaluation; (2) prescribes the anesthesia plan; (3) personally participates in the most demanding aspects of the anesthesia plan including the induction and the emergent, similar to a pilot taking off and landing in an airplane; (4) ensures that any procedures in the anesthesia plan that he does not perform are performed

by qualified individuals and operating instructions; (5) monitors the course of anesthesia at frequent intervals; (6) remains physically present and available for immediate diagnosis and treatment of emergencies; (7) provides indicated post-anesthesia care.

Assemblywoman Bustamante Adams:
I would like a copy of those, please. Do all seven have to be marked in order for it to apply or can you only meet two of the steps?

Jerry Matsumura:
You have to meet all seven of the requirements for CMS.

Assemblyman O'Neill:
How did you come up with the 1 to 4 ratio?

Dean Polce:
That goes back to the late 1990s. I do not know the exact nidus for it and how they came up that number, but it is the same number that is currently in existence for this state for supervising CRNAs. The difference is the CRNA can be supervised by a physician. Anesthesiologist assistants must be supervised by only an anesthesiologist. It has been about 15 to 20 years, so I really do not know.

Assemblyman O'Neill:
What if you are doing a 1 to 4 ratio and two of the patients go south real fast? Where is your attention and what happens to the other two or three patients who are with the AA?

Dean Polce:
Usually the way this is set up is there is a lot of care put toward who is assigning which cases to whom. If you have four cases where patients are very sick and undermining complex procedures, you do not have one anesthesiologist supervising all four of those cases. One may be a quick case with a healthy patient. Is there a scenario where things go bad? Of course. At that point, that is where the law allows for other anesthesiologists, who did not sign the chart as the supervising physician, to assist. We currently do this for each other on a lot of things. If something goes bad in Dr. Matsumura's room, the first thing you do is ask for help. I hope that answers your question.

Chairman Kirner:
We have a lot of people who wish to testify both in support and opposition. I will take some questions first.

Assemblywoman Carlton:
Currently with the way the systems are set up, there does not have to be a doctor in the OR; there can be a CRNA, and you people are kind of out of the picture. When I go in for my yearly procedure, that is usually the makeup I see. Currently, the anesthesiologists are not in the room on some of those. Would this automatically put you in the room?

Jerry Matsumura:
No, this would not. That arrangement is unaffected by this bill. This bill does not affect CRNAs legislatively.

Assemblywoman Carlton:
Financially, it could. For example, the CRNA stays with me the whole time; she does not leave and supervise other people. In a competition sense, if that surgeon decides to hire you, the anesthesiologist, you can hire four people and do four times as much work, so it spreads the dollars out differently. This really allows you to compete with the CRNA as far as providing this care. Currently, you cannot do this. If it is just you in the room, you cannot leave the room and supervise two or three people; you can only see one patient at a time. This bill expands how many patients you will be able to bill for within that hour; instead of one, it will be four.

Dean Polce:
Currently that is allowable. If an anesthesiologist works with four CRNAs, they are supervising, and so that is allowed. This would add competition to the current model; however, if the OR physician is assuming the supervisory role, it is one-to-one and there is no way around it.

Assemblywoman Carlton:
I was really hoping to talk more about the medical practice act and not the competition that is part of it. I am still trying to figure out what the actual levels on this are. I will keep doing more investigation on the educational levels. I still do not see the public purpose behind changing the scope of practice and bringing in this new practitioner at the next level.

Jerry Matsumura:
In our group in Reno, we did a search for CRNAs and interviewed a couple last year. At Renown Regional Medical Center, we created a category for both of them. We would take any of them, so we created the category for both CRNAs and AAs. It is not that we are trying to compete to put them out of business. We welcome them and have interviewed them and created the category for them to work within our own system.

Chairman Kirner:
I will invite those in support of this bill to the table.

Joey Parrish, Private Citizen, Henderson, Nevada:
I am 21 years old, and I was born and raised in Las Vegas. After I graduated from Coronado High School in 2011, I came to the University of Nevada, Reno, where I decided to major in neuroscience. While finishing my undergraduate degree, I am currently working at Renown Regional Medical Center as a tissue recovery coordinator. I recover things such as corneas, tissue, heart valves, and bone for transplantation. In a few short weeks, I will be moving to Tampa Bay, Florida, where I will continue my education after I graduate. I will be working toward receiving my master's degree in medical science and anesthesiology in order to become an AA.

If you asked me as a child what I wanted to be when I grew up, I would have told you I wanted to be a superhero just like any other kid. Most of my friends would tell you they wanted to be Batman or Superman, but my answer was always that I wanted to be a doctor because they were the superheroes in my eyes. This probably stems from the fact that I spent most of my childhood in the hospital. When I was born, I was diagnosed with biliary atresia, which is a life-threatening illness that causes cirrhosis of the liver and shuts down the gallbladder. My parents were told that there was no cure for my illness and the only thing that could save me would be a liver transplant.

At the age of six months old, I received a Kasai procedure to buy me some time until a suitable liver became available. Unfortunately, as I grew bigger, so did my stomach. I had developed so much fluid on my abdomen that by the time I was two years old, I had to eat all of my meals standing up just to catch my breath in between bites. By the age of three, I could not even make it up the stairs without oxygen. For the first six years of my life, I was in and out of the hospital, constantly fighting for my own life.

Fortunately, on August 21, 1999, I received the life-saving liver transplant. Today I live every day to the fullest and live a perfectly normal life. I will forever be grateful to my donor and my team of medical professionals who helped to save me. Since I have been given a second chance at life, I would like to come back to this great state of Nevada and help others who are in need of medical attention by hopefully one day being an AA in this state.

James Wadhams, representing Nevada Hospital Association:
We are simply here expressing our support for this bill.

Denise Selleck, Executive Director, Nevada Osteopathic Medical Association:
We are in support of this bill and would love to see this go through.

[Charles Duarte of the Community Health Alliance submitted a letter in support of the bill (Exhibit O).]

Chairman Kirner:
Seeing no others in support, I will invite those in opposition to the table.

Chad A. Brown, Chief Executive Officer, Omnific Breast, Reno, Nevada:
I have not had the opportunity to speak with the bill sponsors, but I look forward to doing so. I am a business management consultant with more than 15 years of experience. I am a recent transplant to Nevada. I am a business owner in the health care field. I also have a wife who is a CRNA who could not be here today because she is providing the highest quality of health care.

As a management consult, I see this bill as a brilliant move by physicians. If I were working for them, I would recommend, in order for them to protect their own, that they pass this bill and try to promote anesthesiologist assistants over CRNAs. Before I met my wife, I was naive and I was under the impression that it was the physicians who provided the highest level of care in anesthesia. Now, I know better. I would like to share some facts that have informed my current understanding of the situation. The fact is that the study entitled, "No Harm Found When Nurse Anesthetists Work Without Supervision By Physicians" in the August 2010 edition of *Health Affairs*, is one of many studies that conclude that CRNAs provide the same or higher level of health care as their physician counterparts.

Another study entitled, "Cost Effectiveness Analysis of Anesthesia Providers" in *Nursing Economics* [Volume 28, Number 3] concludes that nurses provide an equal or higher level of care at a much cheaper cost than their physician counterparts. In fact, with the national average income of over $370,000, physicians cost more than twice that of nurses. If we Nevadans take a look at our own state, what we find is not only can CRNAs provide an equal or better level of care, but I was fascinated to learn that in 12 of 17 counties in Nevada, there are no anesthesiologists at all. This bill would do absolutely nothing to bring anesthesia to those 12 counties. In four counties, it is only CRNAs who provide anesthesia, not anesthesiologists at all. Twelve of 17 counties cannot afford physicians to provide their anesthesia, and this will not change if we bring assistants to our state and adopt this bill.

If we expand our view to include the rest of the United States, we learn that since 2014, there are actually more nurses delivering anesthesia than there are physicians. Today, there are almost 47,000 nurses and CRNAs delivering anesthesia. Simply, we should be looking at our nurses, promoting and encouraging them here in Nevada to help lower our own health care costs. Why are anesthesiologists here to promote AAs? Simply because AAs cannot practice without physicians; nurses can and they do nationwide. I do not blame the anesthesiologists for promoting this bill. It actually protects them. Anesthesia is a very competitive business. If I were a consultant for them, I would do the same thing. The problem is I am not consulting for them and when I take a look at this from the perspective of the real families in Nevada, one thing is obvious. We want high quality, affordable health care. Another reason is the simple fact that CRNAs provide the same level of care at a fraction of the physician cost.

This bill is not in the best interest of the majority of citizens of Nevada. Instead I believe it serves the rich and powerful minority of physicians. To the question of whether or not there are CRNAs who are ready and willing to move to this state to provide anesthesia care, it is possible. My wife regularly receives phone calls from more than a dozen CRNAs from more than half a dozen states asking her about available positions in this state. There simply are no positions available. My wife and I chose to move to Nevada six years ago, and at first we could not do so because she could not find a job here. She kept trying and was able to fill one of the very few positions available to CRNAs in this state.

As an owner of a business providing anesthesia, I would much rather have the challenge of pulling applicants from a pool of 47,000 nurses than pulling them from a pool of only 1,800 AAs. Those two numbers are staggering.

Chairman Kirner:
Are there any questions?

Assemblyman Nelson:
Why are there no positions available for the CRNAs?

Chad Brown:
Overall, the anesthesia groups are controlled by the physicians. Honestly, CRNAs are a threat to them because they can provide the same or higher level of health care at less than half the cost as shown by many studies. One model I have noticed following anesthesia throughout the United States is that

anesthesiologists in control of the groups are resisting allowing CRNAs to practice at all. As there is more pressure put on the anesthesia groups to lower cost, they begin to say to themselves, we can hire four CRNAs, supervise them, and actually make money.

There are a few of these anesthesiologists who are more on the business side of things and that is then opening medicine nationwide to nurses state by state. It is a trend. I think after the anesthesiologists saw this happen in dozens of states nationwide, they asked themselves, what can we do to preserve our future and our paychecks? This is completely natural. The answer to that is to promote somebody they can control, and those are assistants who cannot, in any way, threaten them—they have to operate with them where CRNAs do not.

Assemblywoman Seaman:
If I heard you correctly, are you are saying that a CRNA is as qualified as an anesthesiologist?

Chad Brown:
No. Those were not my words.

Assemblywoman Seaman:
Can you please clarify?

Chad Brown:
There are many studies that indicate CRNAs have as high or higher medical outcomes than do anesthesiologists.

Chairman Kirner:
When people bring up studies, I often want to know who did them.

Chad Brown:
One of the studies I mentioned was done by two health economists from the Research Triangle Institute. It is one of dozens of studies if you Google it.

Assemblywoman Seaman:
I think it is fair to say that if you are bringing up a study such as this, you should have given us all copies because we do not know who has done this study.

Chad Brown:
I am not a seasoned lobbyist. I apologize and will provide the study for the Committee.

Chairman Kirner:
We thank you for participating in the process. We will continue to hear testimony in opposition.

Rajeev Khamamkar, M.D., Nevada Anesthesiology Partners, Las Vegas, Nevada:
I would like to start off by saying that I am not opposed to anyone trying to find work. I am not trying to offend anyone; I will just bring up the facts I know. I heard discussion about the credentials and what they are for AAs. From what I understood it to be, they have taken the same undergraduate classes and the same MCATs, but they are the ones who did not get into medical school so now they are going into another field. It gives them a sense of being able to administer anesthesia. I do not understand that; however, I do see a need for them in underserved areas. I have just come to learn about all of this.

Nobody has bothered to mention quality of care. After his undergraduate degree, an anesthesiologist goes through medical school. He spends two years in a base education that is reinforced by another two years of clinical studies of seeing patients in various subspecialties. After the board exams, he goes into an internship of some sort, whether it is general surgery, internal medicine, or a mix of various specialties for that one year. This is followed by going into anesthesia residency for three years at minimum plus fellowship if he so desires.

It is important to note that in the years following medical school, the internship and residency years, he is working a good 100 hours a week in his field. The AA education requires students to have 2,000 hours of clinical training before they graduate. The 100 hours per week, 2,000 hours of total training is 20 weeks of training. An anesthesiologist assistant can do five months of training instead of three years of training and expect to be able to practice on his own. I am not claiming to be any kind of a genius, but I was not comfortable with administering anesthesia without someone to ask questions of or bounce ideas off of until well into my third year of anesthesia training.

I understand that AAs are able to do invasive monitoring and put in central lines. I feel anxious about somebody who has not taken an anatomy class or seen a cadaver putting a line into my neck. They do not know where your lung is to puncture it or where your carotid artery is to not poke it and cause bleeding. Who I think wants AAs are hospitals that do not want to fully subsidize anesthesia like they do in every other part of the country. I also believe that anesthesiologists who are looking to profit from having cheaper trade labor also want this. I personally have sat on every stool in the OR for every case I have

ever done. I intend to do so until I retire, whenever that might be. I do not like the idea of a 1 to 4 ratio. Out of the 300 anesthesiologists in town, maybe 200 will not be able to find work because they are bringing in 200 AAs to do their job.

I can tell you who does not want AAs and this is an area that is not underserved; I am not belittling that point at all. The patients who know the difference between the education and training do not want AAs. Surgeons who I have talked to who also understand the difference do not want AAs. I could only imagine the same people who are proponents of this bill having themselves or their family members go under anesthesia saying, I want an AA over an anesthesiologist who is a physician. I do not see that happening. At what point do we stop dropping our standards for delivering anesthesia? With the gastrointestinal tract scare and now everyone knows about propofol, at what point do we just hand a patient a stick of propofol and say, anesthetize yourself. I am being a little facetious but where does it end?

I do not agree with the supervision factor. I have seen and heard that supervision does not mean the supervision that you or I would expect it to be. It is not what the doctor ordered. I think it comes down to a financial thing. It is true, anesthesiologists are more expensive. For one anesthesiologist, you can have two CRNAs, and for the same amount of money you could have three AAs. This is not difficult to find out.

This is not an issue of people without insurance not getting access to emergent health care. Most of the anesthesia groups or physician groups in town have contracts with the hospitals saying that if an uninsured patient comes in, we will get reimbursed. In my opinion, this is only a Medicare and Medicaid patient population issue and would not have been an issue if Medicaid had not dropped their rates in 2010.

Chairman Kirner:
There are some questions.

Assemblywoman Kirkpatrick:
Specifically where in the bill is your issue? I would like you to tell me. We are at a crossroads. To say, unfortunately, that this is because of a Medicaid issue, frankly a pretty large percentage of Nevadans are Medicaid recipients today. We had projected 300,000, and we have 600,000 people signed up out of our population. That is 1 out of 5 people who are on Medicaid. I worked on this bill, and this is not something that was done in a vacuum in the last 120 days. This is something we have been talking about for four years as the Affordable Care Act (ACA) requirements came about. How are we going to get more

people into the profession so that we can give a quality level of service? Are there things specifically in the bill that concern you on the scope of practice? Last session, we had the same conversation when it came to the scope of practice on other job titles.

For me, this bill is about ensuring that people are no longer waiting to get the care they need or that you are having to schedule a surgery six months out because you cannot get the level of care that you think you should be provided with your insurance. I have a health maintenance organization (HMO), and I have to wait 30 days to get a checkup or go to urgent care and still wait 30 more days. This is about a level of care for people. If there are things within the bill, please tell us. How do we get care to those 600,000 people in our state who are currently Medicaid recipients?

Rajeev Khamamkar:
I literally found out about all of this last night. I have not read the bill itself. About delivering care to these patients, things have been going the same since I have been here. We have built up relationships. This is a surgeon-request town where surgeons tell the hospital which group or individual anesthesiologist they are working with regardless of insurance. This has been the case with all of my surgeons and most of the people I work with.

The bottom line is if we have a working relationship with the surgeon, we go do those cases, all grumbling aside, whether we are getting paid or not to make sure that they are getting the care they need. The people who are not getting the care are patients with surgeons who do not have a rapport with their anesthesiologist for various reasons. They, too, can have access to that care. Aside from developing the relationship, if the hospital stuck up and did what the rest of the country is doing, subsidizing a little bit more of what they are already subsidizing, there would be no issue.

Assemblyman O'Neill:
Do you take Medicaid?

Rajeev Khamamkar:
I do.

Assemblyman O'Neill:
Do you take Medicaid in the group that you are a part of?

Rajeev Khamamkar:
Yes.

Joseph P. Profeta, M.D., PBS Anesthesia, Las Vegas, Nevada:
I have been here since 1992. I agree with what Dr. Rajeev Khamamkar and Dr. Matsumura said. I do not believe there is a shortage of anesthesiologists where we live. There was a meeting last year at Sunrise Hospital with the chief executive officer (CEO). He was complaining that there was not anesthesia for cardiologists, radiologists, and neurosurgeons. I spoke with the CEO at the meeting, and I told him I used to do anesthesia for cardiologists until one crazy cardiologist was telling me to give more propofol to a patient who had lost his airway and whose oxygen level was going down. I tried to explain to the surgeon what was going on and he screamed at me, "Do not tell me how to do my job, just give him more propofol." We do not need more anesthesiologists; we need to get physicians like him into therapy. He actually left the OR table and came around to where I was holding his scalpel, telling me to get out of the room. I took care of the patient and made sure he was stable and could maintain his own airway, then wrote on the chart I was requested to leave by the cardiologist. I later found out that no one would work with this cardiologist and there was no one to do the anesthesia. I was his last resort, and I refused.

There was only one neurosurgeon who could not get anesthesia and that was because he used his brother for anesthesia. His brother does not do Medicaid and Medicare, only the high-paying cases. As a surgeon, when you get privileges at Sunrise Hospital, you have to put down who your anesthesiologist is. That anesthesiologist also has to agree. It means that anesthesiologist does all of your cases, not just the ones with good insurance. What we need is not more CRNAs or AAs, but we need the hospital to discipline these people who do not do what they are supposed to do.

If you ask me, as an anesthesiologist, I will say that everyone should be a board-certified anesthesiologist. We already have the two categories that provide, the physicians and the CRNAs. I have actually worked with CRNAs, and I think they are just as competent as physicians. I do not know why we would add a third group that actually has less training. They make it sound like AAs and CRNAs basically have the same training and that is really not true. Certified registered nurse anesthetists do four years of nursing school, and they get their degree in nursing. They then have to work as a nurse before they can get into critical care. They have to do two years of critical care which includes intensive care unit (ICU) care or cardiac care unit work before they can apply to CRNA school, which is three years. It is a lot different than the training of an AA.

There are many CRNAs looking for work. We could fill the spots with CRNAs. They do not want to because AAs are cheaper. It comes down to dollars. Anesthesiologist assistants get paid the same from the payers, but they are paid less leaving more money to split.

Curtis Boardman, Certified Registered Nurse Anesthetist, Henderson, Nevada:
I have been a practicing CRNA in Clark County for more than ten years. I would like to say that I stand against the passing of S.B. 181 (R1). We should not be fooled by the title anesthesiologist assistant. The intent of the AA is to be the anesthesia provider alone with you during surgery to administer and adjust potent anesthetics to maintain oxygenation, support vital signs, and administer blood. The licensure of this little known fringe group of AAs would be a serious mistake and unnecessary burden to the state of Nevada to establish a new regulatory agency.

I believe there is no shortage of anesthesia providers in Nevada. A few of the speakers have already addressed this. By allowing licensure of these AAs, many of our anesthesiologists and CRNAs would be forced out of state. The citizens of Nevada would be left with a diluted, less capable, and admittedly less available pool of anesthesia providers. Also, patient safety would be compromised. Our friends, families, and neighbors in Nevada deserve the most advanced medical care possible. We need to trust when we are admitted into a hospital or surgical center that the anesthesia provider is astute and highly trained.

The physiological changes of the human body undergoing surgery and anesthesia are profound. The care of the surgical patient cannot be left to a technician staring blindly at monitors, but rather to an expert established in the state of Nevada as an anesthesiologist or a CRNA with sound clinical judgement and the ability to keep the patient safe. These providers have years of education, clinical experience, and training. To the respected legislators here today, please consider this. If you or a loved one were having surgery today, who would you trust to administer anesthesia? Who would you trust to maintain fragile physiologic parameters? Who would you trust with split-second clinical decision-making? Who would you trust with your loved one's life? The answer is clear. Our own trusted anesthesiologists and CRNAs are the providers we should stick with for our anesthesia services. I believe that AAs do not belong in Nevada.

Richard Bianco, Private Citizen, Las Vegas, Nevada:
I am a 73-year-old who has been through a lot of operations. I used to belong to HMOs. I am also a VA member and receive Medicare as well as the AARP supplement, which gives me a little extra boost when I go in to see

doctors or have to go to hospitals. My first experience with hospitals was when I was 58 years old, and I had quadruple bypass surgery. It is not the easiest surgery, but I am still living after about 18 years in and out of hospitals.

I feel sorry for a lot of people who have Medicaid. It is better than nothing, but HMOs are trying to convert a lot of people. I belong to the Nevada Seniors Coalition, and I am politically active. Medicare was not given to me by the government; I pay for it. For my AARP supplement I pay an extra $200 per month. When I went for these operations, I sat with my anesthesiologist, who explained everything to me. When I had my throat operations, even my emergency medical technician (EMT) had specifics in treatment. I do not want to end up like Joan Rivers. We are leaning toward that with this bill by hiring different people. I do not want somebody who is a nurse's aide doing my bypass surgery. That can happen out here. I have seen a lot worse.

You do not know who is pulling the plug once you go under anesthesia, so I would rather have an experienced, trained person by my side, not an assistant. If I had no other choice, it would be different. I am trying to survive at age 73. I will be visiting a lot more hospitals and seeing a lot more anesthesiologists. Do not make a big mistake by passing this bill.

Quan Haduong, M.D., PBS Anesthesia, Las Vegas, Nevada:
I am an independent anesthesiologist. I do not understand why you want to put AAs in the system, and you treat the people with Medicaid and Medicare with less qualification. Would any of you be willing to have an AA take care of you or would you rather have an anesthesiologist or a CRNA? You cannot continue to degrade the qualifications of individuals taking care of patients because of the insurance issue. Are people with Medicare or Medicaid aware that they are getting care from a lesser qualification? Just because they are Medicaid, they are being treated differently. To me this bill is basically a way for a big group to eliminate all the independent anesthesiologists and CRNAs. I completely oppose this bill.

Annette Teijeiro, M.D., representing Association of American Physicians and Surgeons:
I am a practicing anesthesiologist in this community. I grew up in Las Vegas, and I came back to practice in Nevada because it is where I want to live. The legislation proposed is going to drastically change the way we do anesthesia in Nevada. I am here to clarify some of the things that have been said.

Part of the problem is the misinformation may make it sound like we are not making a great big difference, but we are. There are over 390 in-state licensed medical doctors. Those numbers come from the Board of Medical Examiners. There are many in-state licensed doctors in osteopathic medicine. There are about 100 CRNAs with in-state licenses who practice in Nevada. So the anesthesia providers in Nevada are about 80 percent physicians and 20 percent nurse anesthetists. By far, when we speak about adding another practitioner, since we already have enough practitioners—and there still is no evidence that we do not—when we replace practitioners, we will actually be replacing physicians in Nevada by a ratio of 1 to 4.

Nevada happens to very lucky in anesthesia. We are not in the severe shortage that there is in primary care. Honestly, I would not like to see us change that

dynamic and add a lower quality of anesthesia training to our long list of being 49th and 48th in the country. Based on the numbers I just provided, I think you will agree that the competition will be 80 percent against having a medical doctor.

There are some disturbing portions of this bill, including the part where the AA is actually allowed to practice during a declared state of emergency without any supervision. I am not aware of any other state that does this, and I certainly did not hear of any cases like this in Oklahoma City when the bombing occurred. I did not hear of any cases in New York City. I think physicians stepped up to the plate from across the country to try to assist in this problem. I did not hear that AAs were on the forefront of the surgical battle.

Dr. Dean Polce stated that all physicians boarded by the American Board of Medical Specialists have at least four non-physician health care providers to assist their practice. There is one difference: anesthesiologists practice acute care medicine. We may have people who help us. We have nurses who help us in the recovery room and we have surgeons in the OR. To be honest, I do not know any orthopedic surgeon who would allow his physician assistant (PA), who is hired by him and perhaps he has four of them, to replace or fix an elderly lady's hip because Medicare does not reimburse him enough. There is a difference in what AAs are proposing to do and what PAs do in the office and what they do to assist surgeons where they are present with them during a surgical procedure. I do not want to belittle that difference because it would actually be comparing apples to oranges.

I am aware of the disproportionate reimbursement when Nevada Medicaid decided to cut anesthesiologists by 43 percent. The Committee also needs to understand that there were cuts, but hospitals only received about 5 percent

cuts, and the rest of the physician community was not only given a reprieve for over a year but received only a 15 percent cut at that time. It is hard for me to fathom how a small business—and that is what doctors are—can survive with the 43 percent cut. We have not denied care. We have stepped up to the plate. We give free care, in essence. If that means we want to bring some other option because we want to reestablish our financial gain, I am not in favor of that.

Board eligibility and certification needs to be addressed. Medical doctors who practice in anesthesia have a certain array of time, about three to four years, where we as anesthesia residents are board-eligible but must finish our board requirements. I could not find anywhere in the osteopathic websites or from any osteopathic doctor that I know that osteopathic physicians have that requirement. If I did not finish my board certification, I would have had to go back for training. That is another discrepancy.

I have provided an information sheet (Exhibit P) on AA and CRNA training and practice. I also provided an information sheet (Exhibit Q) on AA education and training. Please understand that if there is something that simultaneously happens in those four rooms, the person will only get one anesthesiologist at a time. I certainly would not want to be the patient in the second room. I trained in Nevada for medical school, and I came back to my home state because I love everybody who is here and really want the best for everyone.

Steven Sertich, representing Nevada Association of Nurse Anesthetists:
I come before this Committee representing the Nevada Association of Nurse Anesthetists (NVANA) speaking in opposition of S.B. 181 (R1). My testimony from the Senate Committee hearing is in the record and can be reviewed at your leisure. [Referred to written testimony (Exhibit R).]

I would like to mention an article I sent to the Committee from the March 2012 issue of *Anesthesiology*. It confirms that lapses in anesthesiologist supervision of CRNAs are common even when the anesthesiologist is only medically directing two CRNAs at a time. The article was titled, "Influence of Supervision Ratios by Anesthesiologists on First-case Starts and Critical Portions of Anesthetics," and it examined over 15,000 cases in one major hospital. They found that even at ratios of 1 to 2, there was supervision failure 35 percent of the days. Ratios of 1 to 3 would have supervision rate lapses in 99 percent of those days. The journal article defines a supervision lapse as inability of the anesthesiologist to supervise all critical portions of the anesthetic.

The Tax Equity and Fiscal Responsibility Act (TEFRA) includes the seven conditions already mentioned, and they are listed in my testimony (Exhibit R). The anesthesiologist must document in the patient's record that all of these were satisfied. If the anesthesiologist does not fulfill the seven requirements for billing under TEFRA and does it anyway, that would be billing fraud. The federal False Claims Act imposes liability on any person knowingly making a false statement in order to get a false or fraudulent claim paid. Anyone found to have submitted false claims is liable for three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim. The statutes are defined in my testimony (Exhibit R).

If I was being supervised, along with three CRNAs, and the anesthesiologist came in to give me a lunch break, he would be in violation of the TEFRA requirements because he was not available. Some of the Medicare fraud was examined where the supervising anesthesiologist was in another part of the building seeing patients. I know it was specified that they were in the building, but billers are looking at how immediately available. If all four ORs are next to each other and he is giving me lunch, he is not immediately available even though he is next door. The supervision aspect must be looked at.

Another aspect of Dr. Polce's testimony was it took them over a year to get CRNAs to come to work at the hospital. What he did not say was that the entry salary was about $30,000 less than the national average. There was a 2010 RAND study, already previously mentioned, that stated the average CRNA made between $150,000 and $155,000 per year. A 2013 RAND study that was paid for by the American Society of Anesthesiologists put the average CRNA annual salary over $200,000. If either of those salaries would have been offered at Sunrise Hospital, I know people who would have come across the country to work there. Right now there are six CRNAs at Sunrise Hospital. They have raised the pay to $140,000, I understand. They are also hiring a seventh CRNA right now.

Another problem we have in this state, particularly in Las Vegas, is it takes four months to get credentials at a hospital. If I would have started my credentialing January 1, I would not get into the OR until May 1. If you are reducing the requirements, it might be beneficial to look at helping expedite credentialing.

The other troubling aspect is the emergency portion. One of the doctors who spoke said he was only aware of two emergencies or disasters. When I questioned this in front of the Senate Committee, Senator Hardy said if there was someone having a heart attack, he would want anybody there to help. This bill states that an AA must be supervised. However, in a disaster or

emergency, does he not have to be supervised? Are we actually doing the citizens in Nevada a favor? If disasters do not happen that often, then why do we need this verbiage in this bill? We do not want someone who needs to be supervised not being supervised in case of an emergency.

Do we really want to lower the standard of care just because someone is on Medicare? Do we want to lower the standard of care just because of a disaster? In conclusion, when Senator Hardy first introduced this bill in 2011, it said we needed more anesthesia providers. There has been no documentation over the last four years that we have been short of anesthesia providers or that any Nevada citizen had to leave the state of Nevada to get anesthesia care somewhere else.

Joanne Heins, President, Nevada Association of Nurse Anesthetists:
I am a certified registered nurse anesthetist. There are two types of anesthesia providers, CRNAs and physicians. We both have an excellent track record of patient safety and access to care. Anesthesiologist assistants do not have that proven track record, they do not decrease health care expenses, and we do not have a shortage of anesthesia providers. I think Dr. Profeta did a good job of covering my background before I went to anesthesia school versus an AA. Certainly some of those people have good backgrounds. I had hands-on patient care in both nursing school and anesthesia school. I worked as a nurse for ten years in various areas of critical care and then went on to do more.

For clarification, CRNAs have been providing anesthesia in the United States for 150 years. Last year, 34 million anesthetics were given by CRNAs. We are licensed to practice in all 50 states. The military uses only CRNAs and physicians to provide anesthesia. The AAs are licensed in 16 states and are trying to be in other states also. There are no peer reviewed studies in scientific journals regarding the quality of care and outcomes from AAs.

All CRNAs have flexibility. I occasionally provide anesthesia in Mesquite and Pahrump, which are both underserved anesthesia locations. I filled the contract with the Air Force during Operation Desert Storm so their CRNAs could serve overseas. Anesthesiologist assistants would have helped none of those situations. Sunrise Hospital and Southwest Medical Associates have both recently hired CRNAs from out of state who are tickled to be able to come here, find good jobs, and go right to work. Certainly it is possible that they do not have an anchor here and some of them will leave, but I know many people who have lived here a long time and are happy to put down roots and stay and make Nevada a great place to live.

To the young gentleman who wanted to be able to come back to Nevada to practice, obviously there are a multitude of medical professions that he can participate in and live in the great state of Nevada. We could create a CRNA program in our state if we felt there was a real shortage. This bill is not a good choice for the citizens of Nevada. Please consider this carefully and do not support S.B. 181 (R1).

[Letters by Ronald Hedger, President, State Board of Osteopathic Medicine (Exhibit S) and Jason Girouard, Certified Registered Nurse Anesthetist (Exhibit T) in opposition of the bill, both of which were not discussed, were submitted.]

Chairman Kirner:
Is there anyone wishing to testify neutral on the bill? [There was no one.] I will invite Ms. Pittman back to the table for closing remarks.

Lesley Pittman:
This bill is not about money or competition for anesthesiologists. It is not about competition for CRNAs. This bill is about ensuring timely access to quality anesthesia care for our state's Medicaid patients. It is that simple. We clearly have a health care access problem here in our state. Do not take our word for it. I believe you have a copy the letter (Exhibit O) from former Medicaid Division [Division of Health Care Financing and Policy, Department of Health and Human Services] Administrator Charles Duarte, who now works for the Community Health Alliance, regarding his challenges that we heard throughout the interim about getting timely anesthesia care for his pediatric Medicaid patients. We all know that we have challenges in terms of shortages. We are not saying there are shortages of anesthesiologists in Nevada, but there are shortages of anesthesiologists who are willing to take Medicaid patients.

This bill, S.B. 181 (R1), is our solution to that problem without asking the state for additional money in Medicaid payment reimbursements. To those physician anesthesiologists opposed to this bill, I would suggest that maybe they are part of the problem. This is the solution.

Chairman Kirner:
I will now close the hearing on S.B. 181 (R1). [The meeting was recessed at 4:34 p.m. and called back to order at 4:50 p.m.] I will now open the hearing on Senate Bill 250 (1st Reprint).

Senate Bill 250 (1st Reprint): Revises provisions relating to policies of health insurance. (BDR 57-687)

Elizabeth MacMenamin, Vice President, Government Affairs, Retail Association of Nevada:
Senate Bill 250 (1st Reprint) is a bill about synchronizing medications. This is important for people who live with chronic diseases such as high blood pressure, diabetes, high cholesterol, or heart disease. Medication is the primary source for their treatment of these chronic diseases. Oftentimes they have difficulty juggling these. They are not all set for the same date. How medication synchronization would work is the patient and the physician, or the patient and the pharmacist, would work together to determine the patient's medications to synchronize. Then they would provide a short fill.

This bill allows for all of this to happen. Research has shown that this is an easy, effective way to get medication adherence. That is one of the important pieces in making sure that we do not see these patients back in emergency rooms (ER) or having to be treated because of costly complications that have come along because they did not take their medications properly. The bill allows the pharmacist or the prescriber to synchronize the medications for a patient who they have determined has medications for chronic needs. There is a definition of "chronic medication" in the bill.

In the Senate, we had a lot of discussions among many of the interested parties in the industry, and we determined that there would be some changes. There were some amendments to the bill. Unfortunately, one of the amendments did not make it into the current bill. In section 1, subsection 1, paragraph (c), it talks about prorating the pharmacy dispensing fee. In sections 1, 3, 4, 6, 7, 10, and 11, it talks about an insurer not being able to prorate the pharmacy dispensing fee. The words and terminology that were supposed to be included said, "unless otherwise provided by contract." We want to be sure that the Committee understands this section since those words were supposed to have been added. We are in support of that and have no problem with it. I am not sure if the Committee has had time to look over anything on the medication synchronization, but if you have any questions, I am able to answer them today.

Denise Selleck, Executive Director, Nevada Osteopathic Medical Association:
I was also asked to speak on behalf of the Nevada State Medical Association. We are in support of this bill. Personally, when I was managing the medications for my almost 90-year-old mother-in-law—who had an enormous pillbox that got her through one week—it would take me two hours to make sure I put the right pill in the right time of day, for each day, so she could get through it all.

Many of these medications were the things that kept her alive. There was high blood pressure medicine, and I sincerely did not want her to have a stroke. I wanted to make sure she got her medications when she was supposed to. Her high blood pressure medications were always filled the week after, so I would get one week all done and then I would have to go back to the pharmacy. I am the daughter-in-law who was trying to be helpful and had to take repeated trips to the pharmacy. This was a real problem for my family that I was taking this time out to do it.

Chairman Kirner:
My understanding is that we already have synchronization available for Medicare. Is that true?

Denise Selleck:
Yes.

Chairman Kirner:
I presume your mother-in-law was on Medicare. You seem very young.

Denise Selleck:
When I started doing this, it was prior to Medicare. It is available for Medicare patients, but there are those of us who are not quite old enough for Medicare who have to pick up these medications at different times. The other issue for many patients is that this is also a budgeting situation where they need to be able to pick up their pills at a particular time on a particular pay cycle. We want to make sure that they are advantaged as well. Studies have shown that patients are more compliant when they have their medications picked up on a regular basis, particularly if they are relying on someone else to get them to a pharmacy or to pick up their medications for them.

We know this can be cost-effective in order to keep patients on the medications they are supposed to take when they are supposed to take them. We want to assist patients in being compliant. Physicians see that when patients get their pills all at once, they do take them more regularly and according to schedule. This is not for every prescription, and it is not even for every patient. But it is for a number of patients who need to make sure they can comply. We ask for your support of passage on this bill.

Chairman Kirner:
Are there any questions?

Assemblyman Ellison:
I did not realize that they only gave you two weeks at a time. I always thought they gave you approximately 30 days or even two months. If you had to go back and forth, what happens if you got sick and somebody did not have the authorization to pick up that prescription and medications were not delivered; does that create a problem?

Denise Selleck:
Yes. The issue was that she was getting prescriptions at different times. Although they would give her 30 days, they were not the same 30 days. That is what this bill corrects. It allows you to take that patient who received a prescription two weeks later—maybe one prescription did not work and had to be replaced—to get all of the pills synchronized so they can pick them up all at one time. If there was a financial issue, they could even separate it out where they get half at one pay period and the other half at the next pay period. This allows the patients to synchronize their pills and prescriptions by having it prorated in between.

Assemblywoman Kirkpatrick:
I would like to know about this letter (Exhibit U) from the Nevada Patient Access Coalition. Can you tell me what they are referring to?

Elizabeth MacMenamin:
I know there have been patient groups who have come forward and who are supporting this. The Nevada Patient Access Coalition is a coalition of organizations that treat and work with patients who have chronic diseases.

Assemblywoman Kirkpatrick:
In the letter (Exhibit U), the coalition said that they support it, but that they wanted to work with the Legislature to ensure that the prorated copay component language is reinstated into the bill. I do not see an amendment, and I am not familiar with them, so I am curious what this means.

Chairman Kirner:
Can you discuss reimbursement on these things? I believe that is their point.

Elizabeth MacMenamin:
The prorated copay was something that was discussed in the original bill. It was one thing that was looked at with the health insurance industry that felt, at this point in time, this program would be very expensive to implement in Nevada. There was an agreement made. If we do not go forward with a prorated copay, I would like to at least study and see how many people actually sign up. This is a voluntary program even if we came out with

a prorated copay. With that said, this is a voluntary program and maybe we can look at how many people access it. I know I would. If I went forward and the pharmacy is offering me seven pills at a copay of $200 and I come back in seven days and I can get 30 days, and I am still going to pay the same copay, I may not opt in to do the medication synchronization.

During the interim, if this is not the pleasure and we go forward with the bill as it is written, then we look at what the prorated copay could actually do and how it could be implemented. I think that is part of getting the health insurance industry at the table to talk about this.

Assemblywoman Kirkpatrick:
Ms. MacMenamin, you always keep your word, and you are probably busier during the interim than during the legislative session. I believe if you committed that to them, you will make it happen.

Chairman Kirner:
I also appreciate those comments. In the original bill, section 1, subsection 4, paragraph (b) was struck out, which called for the prorated daily cost sharing and prorated out of pocket as well. With the description you gave us with seven pills and expensive drugs, it seems that you might not opt in to synchronize. Are we trying to make this easier? It is my opinion that you would want to prorate the copay and the cost of the drug. I know there are factions that probably do not like that, but it is my personal view. Having gone through a similar situation with medication management, albeit with Medicare, I know that this is something that many people think about.

Elizabeth MacMenamin:
You are right. Other states have passed this legislation in its original form. New Mexico just passed it, the governor signed it, and they are moving forward with it. Utah has signed this. Last year, Oregon signed the compromise that we are looking at today, and they are looking at changing it this year. It is up to the Committee to make a decision as to where they go with this bill as opposed to what we are looking at today. In all fairness, I made the commitment to the health insurers and others out there that we would work on this and look at what the first step would do in our state.

Chairman Kirner:
I think that is one of the things the Committee will want to revisit. I will now entertain those who wish to testify in support of this bill.

Elisa P. Cafferata, President and Chief Executive Officer, Nevada Advocates for Planned Parenthood Affiliates:
As many of you know, we have three health centers in Nevada. Part of the quality health care we provide includes testing and treatment for sexually transmitted diseases (STD) and sexually transmitted infections (STI). We have supported this bill in the Senate and continue to support it in the Assembly because of the improved access it would provide for those patients, in particular, with HIV and AIDS.

Chairman Kirner:
Is there anyone opposed to this bill? [There was no one.] Is there anyone in the neutral position?

Tom McCoy, Nevada Government Relations Director, American Cancer Society Cancer Action Network:
We actually supported this bill as originally introduced. In the Senate, I testified on behalf of the bill. We are taking the neutral position because of the proration issue previously discussed. We see that as a definite disincentive for anybody to take advantage of this concept of synchronization. I should note that the Centers for Medicare and Medicaid Services (CMS) for Medicare purposes has proration already in place. For this bill to be effective and to assist Nevadans who are dealing with cancer and other chronic diseases, proration should be a part of any bill that we pass.

Chairman Kirner:
Seeing no others in the neutral position, I will ask the bill sponsor to return for closing remarks. Ms. MacMenamin, thank you for bringing this bill. I have not had the opportunity to discuss this with members of the Committee, but I would wholeheartedly ask you to do that on our behalf. I like the original language of the bill with the proration more than the way it has been amended.

Elizabeth MacMenamin:
Thank you. I will move forward per your request.

Chairman Kirner:
I will close the hearing on S.B. 250 (R1). I will go back to the top of the agenda and open the hearing on Senate Bill 137 (1st Reprint).

Senate Bill 137 (1st Reprint): Enacts provisions governing stand-alone dental benefits and policies of health care. (BDR 57-575)

Adam Plain, representing Nevada Dental Association:
Senate Bill 137 (1st Reprint) is a follow-up from 2013's Senate Bill No. 318 of the 77th Session. That bill required the Commissioner of Insurance to do a study about coordination of claims between medical and dental insurance for surgery and other matters. Basically, we have a situation where if I take myself onto a baseball field and take a line drive to the face and end up in the emergency room requiring dental care, my dental and medical insurance may both cover that claim. Additionally, since the Affordable Care Act (ACA) has expanded the essential health benefits to pediatric dental benefits and several plans available for sale in Nevada and other states have quite large deductibles, we find scenarios where parents elect to purchase separate dental coverage for their children even though they may have dental coverage in their medical insurance already, albeit covered by a $4,000, $5,000, or $6,000 deductible.

Our current statutes for insurance handle situations for multiple medical plans fairly well. They do not cover situations where a medical plan and a dental plan require coordination. Based on the study that the Commissioner did during the interim from Senate Bill No. 318 of the 77th Session, we brought forth this bill to try to rectify that situation. We spent a lot of time working with interested parties in the Senate, and during the house changeover we worked very closely with Keith Lee and the Nevada Association of Health Plans.

The bill would, per an amendment submitted by the Nevada Association of Health Plans, dictate that in a situation where you have a stand-alone dental plan and a medical insurance plan, the stand-alone dental coverage is the primary coverage and the medical insurance covers the claim on a secondary basis. It indicates that a dentist is not entitled to receive more payment than he or she would have if one policy were to cover the claim. It also indicates that an insurer who has liability to cover part of the claim cannot arbitrarily deny it until they get a denial from the other insurer. If you have partial liability, you have to step up and assume that responsibility.

An additional component to this fix exists in the *Nevada Administrative Code*, and the Nevada Dental Association has spoken with the health insurance industry and the Commissioner to take care of that issue in the interim. There is a small provision requiring regulations on this matter and that is just to ensure that those regulations get taken care of in the interim. Outside of that, I believe that the issue is somewhat clear. I will leave it to Mr. Lee to add anything further.

Keith L. Lee, representing Nevada Association of Health Plans:
We appreciate working with the Commissioner and particularly with Adam Plain and Chris Ferrari on this bill. You will note that we have submitted an amendment (Exhibit V) and subsequently made a change. We have added new wording to section 1, subsection 1, paragraph (b) so it reads, "Except as otherwise provided in paragraph (a), a health insurer may not deny a claim for which it has liability solely on the basis that another health insurer has liability to pay the claim." I think Mr. Plain talked to that point. We have all agreed to this amendment, which provides for coordination of benefits and establishes the stand-alone dental plan as the primary source of payment, with any other plans that provide coverage as secondary sources of payment.

Chairman Kirner:
Are there any questions?

Assemblyman Nelson:
Are you saying that the stand-alone dental plan will be the primary plan? Would they also be able to get coverage from the other plan? Maybe this is a bad analogy, but I am thinking about stacking in car insurance plans with different policies and net pay. Is this a similar type of situation?

Keith Lee:
The provision provides that the full claim of the dentist will be paid. He looks first to the stand-alone dental plan, which is the primary coverage. To the extent that there is not full payment received on the covered benefit, then you go to the secondary. The last line in section 1, subsection 1 of the amendment (Exhibit V) reads, "The issuer of the secondary policy may not reduce benefits based upon payments under the primary policy, except to avoid overpayment to the dentist." So, the dentist will get paid 100 percent of his claim from either the primary or secondary coverage, but he will not get paid one and a half times.

Assemblyman Nelson:
I presume that the insured will only have to meet one deductible? I would presume there would be a deductible on the dental plan, right? But you would not have to meet on the general medical plan also, correct?

Adam Plain:
Typically, in these situations, the plans have separate deductibles. For example, in the case of a child, the stand-alone plan may have a deductible of nothing, or maybe $100, $200, or $250; it is very low. The embedded medical plan may have a deductible of several thousands of dollars, which is why the parents buy the stand-alone plan to supplement it. When the claims are paid,

the insurance companies pay the claim in a vacuum. They do not take into account that there is other coverage. The claim would be submitted to the primary carrier and they will figure out if the deductible has been met. If not, it is sent back to the consumer. If it has, they will pay their share. The claim then gets sent to the secondary insurer, and they will go through the same process.

Assemblyman Nelson:
Would it be the same analysis with copays?

Adam Plain:
Yes. It would be the same with copays or coinsurance.

Assemblywoman Carlton:
I am a little concerned. I thought right now the patient has the choice on which plan pays first. Am I not allowed to choose which one I wanted to file a claim under? This statute would say that I have to go with the stand-alone dental plan first. If I had better coverage under my medical side and a $2,000 deductible and my stand-alone dental was more ancillary, this would make me go there first. I am curious why the patient is losing choice as to which plan they are paying for gets to be primary.

Adam Plain:
There are current statutory provisions relating to coordination of benefits. There is a specific hierarchy in *Nevada Revised Statutes* (NRS) 689B.064. The statute says that when policies have a coordinated clause in them, there is a specific hierarchy.

Assemblywoman Carlton:
Currently there is no coordination clause, so the patient gets a choice under the scheme as it is now. I am trying to compare now to what you are trying to do. I understand where you are going, but right now, if I had two plans, I would get to choose which one goes first. This will change that choice.

Adam Plain:
I appreciate the clarification. Our dentists have experienced that absent a statutory provision, typically both insurers deny the claims, expecting the other insurer to be the one who is responsible for it. It is not a scenario where the consumer has a choice to send it to one insurer over the other and that insurer just accepts that election and pays the claim.

Currently the provider, in this case a dentist, sends the claim off to one insurer, and the insurer says they are not primary and it needs to go to the other insurer first. They need to deny it before we will actually cover it. So they send it to the second insurer and the second insurer says the same thing. The claim ends up getting ping-ponged back and forth among the insurers until it gets to the point where the dentist has not received payment for several months. They send the patient a bill saying their claims have been denied, and they are ultimately responsible for this claim based on the agreement they signed when they first came into the practice. Having some statutory guidance would solve the problem of the ping-ponging of claims back and forth between carriers who are ultimately under no direction as to which one of them shall pay.

Assemblywoman Carlton:
You chose the dental benefit first because you represent the dentists rather than my medical coverage which might actually be better.

Adam Plain:
From the perspective of dentists, it does not matter which coverage is primary as long as there is some statutory provision stating that someone is primary.

Chairman Kirner:
We are using the word dentist. These days in dentistry, there are specialists. Should we be more specific in terms of which kind of dentist this might apply to?

Adam Plain:
The term dentist is defined in NRS Chapter 631. Basically, any person licensed under that chapter as dentist, regardless of specialty, falls under the definition of dentist. Whether they are an oral and maxillofacial surgeon, an endodontist, a periodontist, or a pediatric dentist, they still meet the statutory definition of dentist.

Chairman Kirner:
I appreciate that. My question is not whether there is a broad definition of dentist and who they might include, but should your bill be more specific or is the word dentist okay?

Adam Plain:
It is my understanding that the broader term is required because of the expansion of the way benefits are handled under the ACA. When the issue was brought forth in 2013, it was originally brought forth as an oral and maxillofacial surgery issue because the essential health benefits had not kicked in yet. They

did not begin until January 1, 2014. It was not as contemplated under the original bill. Expanding it beyond oral and maxillofacial surgery has become necessary because of that pediatric component.

Assemblywoman Kirkpatrick:
The effective date is January 1, 2016, so that is about six months from now. I am assuming that is because of the regulations that need to be adopted. What would those regulations be?

Adam Plain:
The effective date is mainly intended to coincide with the issuance of new health insurance policies under the ACA. The individual market resets on January 1 of every year, which allows the new policies to take into account these statutory provisions. The contemplated regulations referred to a specific form that is used for claim payments. That regulation can be changed at any time, and we are in the process of pursuing that change as soon as the legislative session ends.

Chairman Kirner:
Is there anyone in support of the bill? [There was no one.] Is there anyone in opposition?

Helen Foley, representing Delta Dental Insurance Company:
Delta Dental Insurance Company provides dental insurance to approximately 25 million people in 15 states. We had been working with the dentists as well as the insurers on this bill until just recently. We did not get the chance to see their latest amendment until today. It is a complex issue because of the ACA, which now has stand-alone dental plans as well as embedded plans. An embedded plan is an insurer such as UnitedHealthcare or Anthem, who will also include dental in their overall package. Someone can select an embedded plan, or they can also select a bundled plan, which is that stand-alone offering a separate dental plan, or they can choose a health plan and choose a separate stand-alone plan for their pediatric insurance for their children or any other insurance needs. Many people are covered by stand-alone dental plans through their employers. You end up with a situation like this.

Senate Bill No. 318 of the 77th Session had a specific requirement of the Division of Insurance to take a look at oral and maxillofacial issues. There were a stream of those types of doctors who came before the committee and talked about the problem of getting paid. We understand that need. In fact,

we supported the original intent of the bill because it did not use the term dentist; it said for oral and maxillofacial surgery that one of the plans would be the primary. We want that issue to be taken care of. We think this goes way too far.

The majority of stand-alone dental plans have a deductible of anywhere from zero dollars to maybe $100. However, the embedded plans can go as high as $2,000 or $4,000. What exists is this idea of a bundled plan. It takes into account all of your surgeries and checkups for regular health care, and your dental, all in one plan. It really discourages people from using that bundled or embedded plan.

This legislation is forgetting about all of that. Every time, no matter what, they first go to that stand-alone plan and get paid, so that it drives all of the costs onto the stand-alone dental plans and none of it onto the major medical companies that have an embedded plan in their program. We think this is very unfair.

There is a document that I will provide to you that is kind of a primer for dentists provided by the American Dental Association (ADA) that talks about the consistency of which insurance goes first and what the ACA policy and outline is on that. They have the National Association of Insurance Commissioners (NAIC) model that says things such as "whichever policy was in effect first," or "if two parents have plans, whichever birthday is first." They use those kinds of determinations, but the ADA even says when one of the plans is a medical plan and the other is a dental plan, and a determination cannot be made in accordance with the above, they believe that the medical plan should be considered as primary. This is what the state of California does. They say that the medical plan is primary. We are not even asking for that. We would like to step back and say that the major problem that brought all of this to the table today was the oral and maxillofacial problem.

We know that the ACA has come into effect since then, but we do not really know if that is a major problem. We would like to fix it for the oral surgeons. Therefore, our recommendation would be in section 1, subsection 1, where it says, "The following provisions apply to a claim for payment submitted for services provided by a dentist," to delete the phrase, "a dentist" and add, "an oral or maxillofacial surgeon." That very clearly shows that we will take care of those problems and we can be the first line—that stand-alone plan—and take care of whatever fillings that the dental stand-alone plan is responsible for and pass it over to the medical plan to cover that major medical for the surgery. We think that is fair, and we urge you to do that.

Chairman Kirner:
Are there any questions?

Assemblywoman Kirkpatrick:
If the words oral and maxillofacial surgeon are put into the bill, does it have a different perception than just a dental plan? Because I only get a certain kind of coverage at a specialist as opposed to a regular dentist. For example, when my granddaughter tried to knock out her front teeth, we had to take her to the emergency room (ER) because it was a Saturday evening; how would that work? I would want the dental piece to pay for that visit because maybe her dental coverage is better than her medical at this point. I do not see how that works. I understand both sides, but it is a pain when they want to know which insurance coverage they are going to pay based on what your birthday is, and typically if you have more than one child, everyone has a different primary. It gets complicated, but at the end of the day, you get all of these bills and you are spending more time trying to deal with them. How do you think your provision is going to make this better?

Helen Foley:
I agree with you 100 percent that these major issues seem to always happen on the weekends when doctors' offices are closed. My children get sick on the weekends or late Friday night, so I sympathize with you. It would be an oral or maxillofacial surgeon if she has to have some type of surgery or reconstruction of her jawbone. Those are medically based, and it is clear that it is. Regarding the rest of it, such as fillings and different types of dental procedures, the stand-alone would still be responsible for paying those. They would pay all of those bills up front that do not involve the surgery. Those then would be sent over to the medical plan for coverage.

Assemblywoman Kirkpatrick:
I am not sure if that helps me, but I will think about it.

Helen Foley:
I would like to address Assemblywoman Carlton's comments. If I had two plans and one had a deductible of $4,000, I would probably get rid of the plan myself, but if I had a choice and my husband had a different plan and I had another plan for my child, I would want to submit to the dentist that I wanted one dental plan first before it was sent to the other. Right now, patients have that ability, but under this new legislation, they would not.

Chairman Kirner:
I was following a line of questioning on dental specialty with Adam Plain which you have also brought up. As I recall, he articulated that prior to January 1, 2015, when ACA rules when into effect, there were some issues with that. Even as he talks about it now, he says pediatrics would be left out if we went with your version of this bill. I am trying to reconcile the two thought processes.

Helen Foley:
With the ACA and everyone mandated to have medical insurance, they are also mandated to have dental coverage for pediatrics, but not for adults. In Nevada, people can receive that in a couple of different ways, either through a stand-alone product or an embedded product, which is provided by the medical insurer you choose. There is also a separate plan called "bundled" which joins forces with a medical plan.

Chairman Kirner:
I am assuming if someone has an embedded plan, he does not have a separate dental plan. Is that correct?

Helen Foley:
It is embedded in their plan.

Chairman Kirner:
So there is no issue of who would pay?

Helen Foley:
That is the problem. They are now saying that if one of the parents also has a stand-alone plan, then the embedded plan is never primary; it is always the stand-alone plan. We do not understand the logic behind the embedded plan never having to pay.

Chairman Kirner:
What you are describing is a situation where there are two plans that might cover a minor in this case, correct?

Helen Foley:
Exactly. Which one should pay? They are saying it should always be the stand-alone plan. That is contrary to what California does and what the ADA recommends. They have another procedure where they ask, "Which plan have you had the longest?" "Whose birthday is first?" As Assemblywoman Carlton says, maybe she wants to submit on her husband's plan rather than her own. You will not have that opportunity with this bill.

Chairman Kirner:
The answer to that question was it gets ping-ponged back and forth and nobody pays. I think there are still some remaining questions.

Assemblywoman Kirkpatrick:
I am trying to think back on the last 20 years, and I do not know if I ever got that opportunity to choose which insurance plan I would submit first because they always determined what my primary insurance was for me. I understand that the ACA probably made it messier. I cannot explain to my constituents, let alone my husband, if somebody asked me right now about which insurance I want. I can honestly say that I have never been asked which insurance I want to be primary.

Helen Foley:
I believe that the dentist and his staff can be helpful about who they are going to submit those claims to. We saw that the problem was with the oral and maxillofacial surgeons, but we did not see that there was this huge issue with dentists that they were not getting paid. We would hope that we pass this bill for oral and maxillofacial surgeons, and if we see there is a problem, maybe ask the Division of Insurance to go back and ask if they are experiencing this since the ACA. Because no one has ever shown us that there really is a problem with general dentistry, only with oral and maxillofacial dentistry.

Chairman Kirner:
Are there any more questions?

Assemblyman Nelson:
Mr. Plain testified about the insurers ping-ponging back and forth. I get the impression you are not too concerned with that. Is that true, or are you only concerned with the oral and maxillofacial part?

Helen Foley:
We saw that there was clearly a problem with oral and maxillofacial dentistry. We have not seen that there has been a problem created with the ACA with the general practice of dentistry, but it has been proven to be the case with the other, and that is why we were supportive of including those two professions at the beginning.

Assemblyman Nelson:
If there is this game between the insurers denying coverage, that would be bad faith, right?

Helen Foley:
It would be bad faith. I certainly want the dentists to be covered for the services they provide. I do not want them to be in a bind. I have not seen any evidence that that has occurred and that they are not getting paid.

Chairman Kirner:
Is there anyone in the neutral position? [There was no one.] Mr. Plain, we are hearing contrary points of view. I would like to give you the opportunity to address them in your closing comments.

Adam Plain:
I would submit that the circumstances leading to the problem in the oral and maxillofacial field, that there are two separate insurers of different types, are the same circumstances that are in existence in the pediatric dentistry field. I would reiterate that from the Nevada Dental Association point of view, the concern is not who is paying and who is primary; it does not really matter. As long as there is something that prevents the practice of arbitrary claim denials based on the presence of other coverage, and whether one specific type of insurer is being declared primary or referencing back to the existing statute that Helen Foley referenced, it would need to be amended to fully accommodate the model on which it is based. There are viable alternatives that we would be open to discussing with the Committee.

Chairman Kirner:
This bill passed out of the Senate unanimously. Has it been amended since it left the Senate?

Adam Plain:
The amendment (Exhibit V) that Mr. Lee presented today is the only amendment that has been proposed on the bill since Senate passage.

Chairman Kirner:
Thank you. I will close the hearing on S.B. 137 (R1). I will open the hearing on Senate Bill 273 (1st Reprint).

Senate Bill 273 (1st Reprint): Revises provisions relating to health care records. (BDR 54-589)

Senator Joe P. Hardy, Senate District No. 12:
I am going to paint you a picture. There was an office building that had a bunch of doctors in it. The office building had a lease that was owned by somebody who was an entity that, for whatever reason, closed the door. When the entity closed its doors, the records therein were not accessible by patients

or doctors because this entity was from someplace else, and they did not really care. Senate Bill 273 (1st Reprint) is trying to make sure that we have some control over what happens to the records that patients have brought to their doctor, as well as those created by the doctor. No matter how good you think a bill might be, I am sure that this body will find something as obvious as Senator Smith did. We were in the process of passing the bill and she asked, "Does this only apply to hospitals?"

The exemption that is on page 2 of the amendment (Exhibit W), in section 1, subsection 4, is the intent. If you read line 32 on the first reprint of the bill it says, "hospital or facility that maintains health care records specified" in *Nevada Revised Statutes* (NRS) 629.031. I looked at that, and lo and behold, the intent was to get anybody exempted from this who had an inpatient basis for taking care of people. Turns out, medical facilities defined in NRS Chapter 449 included 16 things, 5 of which are inpatient.

The amendment (Exhibit W) will define the exemptions as paragraphs (a), (b), (c), (d), and (e) of section 4 from the NRS definition of medical facilities. That includes a facility for intermediate care, a facility for skilled nursing, a facility for hospice care, and a psychiatric hospital. Thus, it includes the facilities that are named as inpatient facilities. Inasmuch as there is a huge capital expense for these facilities, they are not going away like the entity did that I described.

Chairman Kirner:
Are there any questions?

Assemblyman Nelson:
Are you saying that the inpatient facilities are exempt from the bill?

Senator Hardy:
Yes. The reason they are exempt from the bill is because they do it anyway. They are not the problem. You can always get your records and other information from the hospital, so they are the ones who have huge economic benefit from not pulling the stunt that someone else did by closing the door to the doctors as well as the patients who saw those doctors.

Assemblyman Nelson:
Are there any issues with the Health Insurance Portability and Accountability Act (HIPPA)?

Senator Hardy:
Huge. In my example, if law enforcement goes into a closed-door situation at what was formerly an office building with more than ten doctors, and they say

they are going to retrieve the records from that building that is closed, you have a HIPPA violation. Who is allowed to do that? The Clark County Health District did not want to, the state did not want to, and the police did not want to. The patients and doctors were up in arms. The doctors not only did not have a place to practice, but they did not have the records of the patients they were seeing. It was a mess.

Assemblyman Ohrenschall:
My question has to do with the gross misdemeanor penalty. Is that common for this kind of violation? It seems I am used to seeing just misdemeanors.

Senator Hardy:
I hope it is common in Nevada after this. I hope it never happens because of the teeth that are in this bill.

Chairman Kirner:
Is there anyone in support? [There was no one.] Is there anyone in opposition? [There was no one.] Is there anyone in the neutral position? [There was no one.] I will close the hearing on S.B. 273 (R1). Is there any public comment? [There was none.] This meeting is adjourned [at 5:50 p.m.].

RESPECTFULLY SUBMITTED:

_____
Janel Davis
Committee Secretary

APPROVED BY:

_____
Assemblyman Randy Kirner, Chairman

DATE: _____

EXHIBITS

Committee Name: Assembly Committee on Commerce and Labor

Date: April 29, 2015 **Time of Meeting: 1:45 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
S.B. 159	C	Kelly Richard, Committee Policy Analyst	Work session document
S.B. 217 (R1)	D	Kelly Richard, Committee Policy Analyst	Work session document
S.B. 440 (R1)	E	Kelly Richard, Committee Policy Analyst	Work session document
S.B. 251	F	Victoria Carreón, Kenny C. Guinn Center for Policy Priorities	Prepared testimony
S.B. 251	G	Linda Gray Murphy, American Board of Physician Specialties	Talking points
S.B. 251	H	Linda Gray Murphy, American Board of Physician Specialties	Standards Information Sheet
S.B. 251	I	Linda Gray Murphy, American Board of Physician Specialties	Fact sheet
S.B. 251	J	Linda Gray Murphy, American Board of Physician Specialties	Letter in opposition
S.B. 251	K	Linda Gray Murphy, American Board of Physician Specialties	Report
S.B. 251	L	James Madara, American Medical Association	Letter in support
S.B. 181 (R1)	M	Dean Polce, Nevada State Society of Anesthesiologists	Written testimony in support

S.B. 181 (R1)	N	Dean Polce, Nevada State Society of Anesthesiologists	AA Work States Map
S.B. 181 (R1)	O	Charles Duarte, Community Health Alliance	Letter in support
S.B. 181 (R1)	P	Annette Teijeiro, Association of American Physicians and Surgeons	Comparison: AA, CRNA Training Practice
S.B. 181 (R1)	Q	Annette Teijeiro, Association of American Physicians and Surgeons	AA Education and Training
S.B. 181 (R1)	R	Steven Sertich, Nevada Association of Nurse Anesthetists	Letter in opposition
S.B. 181 (R1)	S	Ronald Hedger, State Board of Osteopathic Medicine	Letter in opposition
S.B. 181 (R1)	T	Jason Girouard, Certified Registered Nurse Anesthetist	Letter in opposition
S.B. 250 (R1)	U	Nevada Patient Access Coalition	Letter in support
S.B. 137 (R1)	V	Keith L. Lee, Nevada Association of Health Plans	Amendment
S.B. 273 (R1)	W	Senator Hardy	Mock-up amendment