MINUTES OF THE MEETING
OF THE
COMMITTEE ON COMMERCE AND LABOR

Seventy-Eighth Session
March 11, 2015

The Committee on Commerce and Labor was called to order by Chairman Randy Kirner at 1:40 p.m. on Wednesday, March 11, 2015, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at 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:

Assemblyman Brent A. Jones, Assembly District No. 35
Assemblywoman Robin L. Titus, Assembly District No. 38

STAFF MEMBERS PRESENT:

Kelly Richard, Committee Policy Analyst
Matt Mundy, Committee Counsel
Leslie Danihel, Committee Manager
Connie Jo Smith, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

James T. Overland Sr., President, Nevada Chiropractic Association
Jason D. Mills, Attorney, Neeman and Mills, Las Vegas, Nevada
Michael A. Glick, D.O., Private Citizen, Reno, Nevada
Craig Kidwell, Private Citizen, Elko, Nevada
Mendy Elliott, representing Chiropractic Physicians' Board of Nevada
Stacy M. Woodbury, Executive Director, Nevada State Medical Association
Maria Carrillo, Private Citizen, Las Vegas, Nevada
Tim Andrus, Private Citizen, Las Vegas, Nevada
Darnell Irvin, Private Citizen, Las Vegas, Nevada
Cora Flanigan, Private Citizen, Las Vegas, Nevada
Valerie Williams, Private Citizen, Las Vegas, Nevada
Henry Thorne, Private Citizen, Las Vegas, Nevada
Linda Nash, Private Citizen, Las Vegas, Nevada
Robert Ostrovsky, representing Employers Insurance Group
Donald E. Jayne, representing Nevada Self-Insurers Association
Jaron S. Hildebrand, Manager, Government Affairs, Nevada Trucking Association
Ray Bacon, representing Nevada Manufacturers Association
Liz MacMenamin, Vice President, Government Affairs, Retail Association of Nevada
James L. Wadhams, representing American Insurance Association; and Las Vegas Metro Chamber of Commerce
Michael M. DeLee, Private Citizen, Amargosa Valley, Nevada
Brian Reeder, Government Affairs Coordinator, Nevada Chapter, Associated General Contractors
Joanna Jacob, representing Las Vegas Chapter, Associated General Contractors; and Nevada Contractors Association

Richard Peel, representing Southern Nevada/Las Vegas Chapter, National Electrical Contractors Association
Brett Kandt, Special Assistant Attorney General, Office of the Attorney General
Keith Marcher, Chief Deputy Attorney General, Office of the Attorney General

Chairman Kirner:
Those who are presenting Assembly Bill 187 are invited to the table.

Assembly Bill 187: Revises provisions governing the selection of providers of health care. (BDR 53-898)

Assemblyman Brent A. Jones, Assembly District No. 35:
Assembly Bill 187 is about two things. First, it is about better patient care. Second, it is about more free-market access and better access to our health care system while utilizing free-market principles, which will result in better care and, in the long run, reduce costs.

Before getting into the bill, I would like to introduce three colleagues who will be participating in the presentation of this bill. Assemblywoman Robin Titus's background includes a doctor of medicine degree from the University of Nevada School of Medicine in 1981. She took over the practice of a venerable physician, Dr. Mary Fulstone, in Lyon County in 1984, and has practiced for more than 30 years. Dr. Titus is one of the few physicians who maintains her obligation to make house calls as the right thing to do. She also covers the emergency room at the local hospital while continuing to serve as the county's health officer. She has served on state committees, specialty boards, licensure boards, and appointed positions while remaining an active, rural preceptor for residents and medical students in the University of Nevada's School of Medicine.

Dr. James T. Overland Sr. has 35 years of experience as a chiropractor and is president of the Nevada Chiropractic Association. He is a member of the Medical Advisory Committee of the Nevada Interscholastic Activities Association (NIAA), a fellow of The Academy of Chiropractic Orthopedists, a certified independent chiropractic examiner since 2000, and a diplomate of the American Board of Forensic Professionals. He is also a member of the Nevada Panel of Rating Physicians and Chiropractors, which has to do with industrial relations.

Attorney Jason D. Mills was born and raised in southern Nevada, attended UNLV, received his law degree, and for the past 15 years has been working

tirelessly as an advocate for injured clients. As you can see, this is a group of experienced individuals at the table.

As I mentioned, this bill is first about patient care. The existing system has limited access to doctors. Regarding workers' compensation, if you are injured, you can only go to a very narrow range of doctors. That means your choice is limited. If you have a regular doctor, you cannot see him or her. You can only go to the specified doctor. A survey of over 3,500 medical providers by the Division of Industrial Relations (DIR), Department of Business and Industry, found that less than 10 percent of the providers on the list could serve injured workers. For chiropractors, that figure is between 5 and 7 percent who can serve injured workers. The current system restricts doctor availability to a narrow range of people, which results in limited access.

The second part of this bill is free-market influences. I believe that the United States has become the most powerful nation in the world based on free-market principles. If you do not have free-market principles, you have what is called "crony capitalism," or very limited access. If we allow more free-market principles into this system, the result will be better patient care for the patients and, in the long run, reduced costs because competition is always a good thing.

Finally, if our workers' compensation system works effectively and efficiently, more employers would feel confident with the system when they come to Nevada because we can always use more jobs.

With that, I will turn to Assemblywoman Robin Titus, who will give further presentation on Assembly Bill 187.

Assemblywoman Robin L. Titus, Assembly District No. 38:
I am here as a family practice doctor who sees injured workers. I would first like to make an observation, because it may be a historic moment in the history of this Legislature. At this table there is a businessman, a physician, a chiropractor, and an attorney, and we are all supporting the same bill—that does not happen often.

I offered two amendments to this bill (Exhibit C), which I hope you received. One of my issues with the injured worker system is that we cannot find doctors. When I see an injured worker, I have to see him or her immediately when they are in the emergency room. We cannot turn that person away. It is not about who is on the program. When I see an injured worker and think about referring him for a magnetic resonance imaging (MRI), it is a lot less expensive to refer the person to a specialist who then can decide if the person really needs

to get that MRI. That test costs thousands of dollars, as opposed to $100 for the visit. It can literally take months for patients to see the specialist. It is often difficult to find an orthopedist in the rurals. There is one orthopedist who usually comes to our hospital once a week. Otherwise, injured workers have to drive quite a distance to see an orthopedist who might be on this list, and there is a real delay in care.

I asked if we could make sure the names of physicians who are on the list provided by the DIR could be updated yearly or semiannually. That was my amendment to keep the list current. Not uncommonly, when I first looked at this list, it had hundreds of doctors, but many of them, such as pediatric surgeons and pediatricians, had nothing to do with industrial relations or worker injuries. This is a friendly amendment.

The other amendment is offered to protect the employers. I want to be sure that not just any provider could be signed up on this list. It is important not only that they understand what a worker's injury is about, but also if they know about a light-duty job or if there are other jobs within that employment that the worker could return to, as opposed to taking time off. I have seen this happen where the injured person is out of work for nine months for an injured finger. I questioned the person that the worker saw. Did the person understand that there are other things to do within that realm of employment to get the worker back to work in a timely manner and make sure that not only the employer but also the employee is protected?

I signed onto this bill because, hopefully, this bill will allow us to use competent providers with knowledge of industrial workers' injuries, making sure they are not looking out for the employee or the employer or the insurance company, but making sure that the provider does the best practice for the injured worker and also is respectful of the company for whom the injured person works.

Chairman Kirner:
We will go through all four of these and then open this to Committee members' questions.

James T. Overland Sr., President, Nevada Chiropractic Association:
As background, A.B. 187 has been a work in progress for the past several years. Originally, we had input from medical providers, attorneys, union and business leaders, and chiropractors regarding the difficulty within the system for access of patient care to the injured employees of Nevada. [Referred to written testimony (Exhibit D).]

The bottom line of this bill is to improve access to any and all individual injured employees. It allows injured workers to be part of the decision regarding who they want to see and how and where they want to be treated with respect to their injuries. Currently, many injured employees are directed to a certain physician, a specialist, or a medical facility for their care from a very limited list of providers. They generally have no recourse other than to comply. If the worker does not comply, he or she is often told that their case may be in jeopardy and even closed. Should the injured employee also have a past relationship with their personal physician, very often they want to see their personal physician because of the history they have together regarding their health care and needs with respect to treatment of the current injury. The injured worker is not allowed to see their personal physician unless that physician is on a panel from one of these insurance companies or the entities they are forced to see and be treated.

This scenario is often more true, and perhaps even more pronounced, in rural areas. Many injured employees are denied access to their local medical provider and have to travel long distances from their community to find a panel provider. As an example, in the Elko and Ely areas, injured employees have to either be driven to or travel themselves to Carson City or Reno for treatment.

When working on this bill, crafting the language was important because it neither changes nor takes away the current provisions for care from any insurance entity, any employer, or any medical panel provider. The bill's language simply expands access for care to other medical providers. The language of this bill will not result in increased costs for these entities or increase the cost to the Division of Industrial Relations. It should not have an overall or significant fiscal impact.

In closing, I would like to share a brief scenario with respect to continuity of treatment care. I am on the panel of the Division of Industrial Relations for permanent, partial, and disability evaluations. I have been giving these evaluations for over 13 years. I recently provided an assessment on an injured worker who, after injuring his shoulder, was taken to one of the quick care centers. He spent eight hours with his employer before he was seen. He subsequently had five visits with a provider. On those five visits he saw five different medical providers. Each and every time he had to retell the story of his shoulder injury. It was even entered into the record that one of the providers indicated he injured his shoulder while working in Texas. The shoulder was dislocated, the claim was reduced, and now he is back in Las Vegas for follow-up care. He never had been in Texas.

Out of these five providers, two of them were physician assistants. In the course of those five visits, three of the providers prescribed six different medications, in addition to the other medications he was already taking. He went to the quick care center the same day he was injured, and it took approximately 38 days from the injury before an MRI was finally ordered. He subsequently underwent shoulder surgery for the significant tear he had, and that was an additional two months of treatment. It took almost three and one-half months before this individual was seen with respect to his injury. This patient's case could have been taken care of a lot quicker with continuity of care and with an individual provider managing his care. Continuity of care with additional access is very important.

Jason D. Mills, Attorney, Neeman and Mills, Las Vegas, Nevada:
I am a Nevada attorney practicing for the last 15 years primarily in the area of workers' compensation and the Nevada Industrial Insurance Act, as well as the Nevada Occupational Diseases Act. I practice exclusively in this particular area of law. When I was working with Assemblywoman Titus, Dr. Overland, and others in putting together what we thought would be a smart bill, we were essentially trying to only expand access to more providers in the state of Nevada so they could participate in sharing the workers' compensation care for doctors and chiropractors. Currently, the law allows industrial insurers and employers to effectively narrow down or truncate their provider list to a very, very short list of doctors. At present, the statute reads that as long as they have two or more doctors in a particular area, that is sufficient. Number one, the problem arises that these particular doctors can have undue influence placed on them. Number two, it excludes the other small-business owners like Assemblywoman Titus or Dr. Overland or other doctors throughout the state from being able to participate inside the system.

We also wanted the bill to be drafted such that the bill would address a large number of issues of the business and insurance communities. We did not want to alter their 100 percent right to allow and control authorization. That is current law under *Nevada Revised Statutes* (NRS) 616C.135. That is not altered in any way in this particular bill, and we did not seek and do not want that altered. The insurers still maintain that absolute right of authorization of any care request submitted by any doctor or chiropractor.

We did not expand the time frame from the current time frame. Current law allows the injured worker, within the first 90 days after he is injured on the job, to select a physician from the insurer's panel list if he is dissatisfied with his current doctors. We figured that is existing law, and we should maintain that particular provision, but instead of using just their panel list in the first 90 days,

allow for the injured worker to select from the Division of Industrial Relation's panel list.

The current DIR panel list (<dirweb.state.nv.us/wcs/treatingpanel.pdf>) contains the 3,568 physicians and chiropractors in this state who have effectively complied with NRS 616C.090 and have said that they have shown particular special competence and interest to treat industrial patients. The DIR is tasked with controlling and maintaining that particular list, as well as setting forth the regulations which control those doctors on the panel list. [Submitted (Exhibit E).]

An existing regulation allows a number of ways a doctor can be removed from the panel list; for example, for fraudulent billing or reporting, or for failure to observe the rules set forth in the codes on how to treat industrial patients. What I think is important in the current regulation is if doctors are failing to seek authorization from the insurers or from the employers, they can be removed from the list. There are controls in place to remove doctors if they are problematic or do not understand industrial insurance.

The current law in NRS 616C.205 does not allow a lien to be placed on workers' compensation cases. What that means is that doctors, providers, and lawyers cannot get together, have a patient sign a lien, and then work on the bill and go back against the industrial insurer and say, you owe me this big bill. The law does not allow for that, and we did not change or alter that because we think that makes sense.

We also want the exclusion that is still in place that if an insurer, an employer, or a self-insured employer is a true managed care organization (MCO), the claimant should be limited to only using their panel list. We are only talking about the scenario where there are no MCOs, where insurers pick doctors and enter into contracts—not necessarily written contracts—that say the doctor is now the treating physician for our company and for our insurance company to see our injured workers, and the injured worker then must utilize these people.

I can attest that the number-one reason why claimants walk into my office is because of treatment. They are frustrated and angry and feel as if they are getting the runaround. The system encourages that behavior, and that does not make sense to me, even though I am a practicing lawyer. We should have a system where a claimant feels comfortable sitting in his or her doctor's office while they are being treated. If they feel they are receiving adequate care, they do not walk into my office, and litigation does not ensue therefrom.

Another issue we want addressed is that current regulations allow the DIR, if it so chooses, to create even more restrictions or rules for doctors. If doctors want extra training, they have the power and the authority to do that. This law does not change that, and we think that is a viable way, if there is criticism, to address it in that particular realm—create more regulation from that standpoint if there are problems coming about with regard to doctors or driving up costs, if that is what their concerns have been. Because the insurance company requires 100 percent control of the authorization and the fact that there are no liens driving costs in this particular area, we believe that issue is probably not as significant as some of the opponents would indicate.

Chairman Kirner:
Assemblyman Jones, I think it would be helpful if you walked us through your bill.

Assemblyman Jones:
If I could defer to Mr. Mills because he was instrumental in drafting this legislation with the Legislative Counsel Bureau (LCB).

Jason Mills:
In section 1, subsection 1, paragraph (a), of Assembly Bill 187, we seek to amend NRS 616B.527 to add that any MCOs, for the purposes of workers' compensation, should be established and compliant with existing Nevada laws that control MCOs. The Legislature has already written extensive rules on MCOs, and it makes sense that those rules should be followed in industrial care.

In section 1, subsection 2, what we have added here essentially allows physicians or chiropractors to accept the fee schedule. Also, the panel providers can set a rate lower than the fee schedule set by Nevada. If there is one doctor in Nevada out of the 3,568 doctors who are on the DIR panel who is willing to accept an insurance company's lower fee schedule beneath the Nevada fee schedule, then any other doctor who is on the DIR panel list would therefore have to accept that particular lower rate if they wanted to be on the panel list.

Section 3, subsection 1, amends NRS 616C.090 in the manner we were discussing earlier. The administrator, DIR, would publish a list of the panel physicians or chiropractors as they currently do, by area of practice, make it publicly available on the Internet so people have easy access to that information, and make printed copies available if requested by a member of the public. The list should include the office address and telephone numbers of every office maintained by each doctor.

Assemblywoman Titus:
Section 3 is where I offered my amendments. Subsection 1 says the Administrator shall establish a panel of physicians and chiropractors who have demonstrated special competence and interest in industrial health to treat injured employees under NRS Chapter 616A to 616D, or Chapter 617. My concern was, what was that competency? Do the doctors sign a document that says they know about injured workers? To protect not only the workers but also their employers, I offered this amendment that says competency in industrial health requires minimally a signed document that they attest to either having completed a course in industrial health issues or have read the information provided by the Division of Industrial Relations regarding workers' compensation issues. Further down in subsection 1, the bill language says the list must include without limitation the office address and telephone number of every location maintained by each physician or chiropractor on the list. I asked that the list be kept current by updating it semiannually. We found that the list was not very current. It has just been updated after they met with me, so it is interesting that sometimes the threat of legislation drives improvements. The list is now current. When I had checked the list, there were names of doctors who had expired and providers whose names should not have been on the list. Hopefully, the list will be kept up to date at least semiannually, as in my amendment (Exhibit C).

Jason Mills:
In section 3 of the bill, subsection 2 seeks to amend that every insurer or third-party administrator that has not entered into a contract with an organization for managed health care pursuant to NRS 616B.527 maintain a list of their physicians and chiropractors. In this particular part of the bill, we have not removed the ability of an insurer or employer to enter into these particular contracts. The insured employee or third-party administrator should also be required to publish a list similar to the DIR list, make it available on the Internet to members of the employees of that insurer or that employer, and make printed copies available to anyone who requests a printed copy. It should include, without limitation, the office addresses, telephone numbers, and every location maintained by that physician or chiropractor.

Section 3, subsection 3, deals with the injured employee who has not entered into a contract with a managed care organization pursuant to NRS 616B.527 with the right to be seen by any panel doctor, rather than just their smaller, truncated panel provider list. The alternate choice would need to be made within 90 days.

Sometimes in litigation we see scenarios where there is a dispute over the timing of the request. You will note under section 3, subsection 3,

paragraph (a), we also included from the date of the claim acceptance, or paragraph (b), the date their claim is reopened under NRS 616C.390. Those additions clarify the ability to see a doctor on the panel list after the claim is reopened or accepted.

Section 3, subsection 4, allows the injured worker or employee to choose an alternate physician or chiropractor from a third-party administrator within 30 days if their current primary doctor or treating physician has made a transfer of care request to a specialist. This is current law, but there is no time frame in current law. When your treating physician says he cannot help you anymore, and he thinks you need to see a different kind of specialist, current law says the claimant has the right to select another doctor from the insurer's panel list—the closed panel list—but it does not set a time frame, and that creates unnecessary litigation. We think a hard-line rule makes sense so everyone knows what we are dealing with in that scenario. We thought 30 days would be a reasonable time period. If they do not choose a physician within that 30-day time frame under this part of the amendment, then the insurer has the right to select for them.

Continuing in section 3, subsection 5 deals with the injured employee's insurers who have entered into a contract with an organization for managed care and only in the situation with managed care. We did not want to alter the managed care scenarios because those tend to work; it is true managed care. With true managed care organizations, the injured worker would not be able to use the DIR's larger panel list, but would use the MCO's smaller panel list, which makes sense to us because MCOs serve a valuable function in our state.

Chairman Kirner:
The bill contains many references to third-party administrators until we get to section 5, which talks about the managed care, so I think those are all the relevant changes. At this time, I would like to ask the Committee if anyone has questions.

Assemblyman Ellison:
What about the companies that invest in infrastructure and have their own doctors on staff, where they own and operate their own clinic in order to save the employees money? Are you saying that wipes all this out? Can you explain that?

Jason Mills:
We reached out to members of the business community, and we are open to suggestions, but we received no feedback. As this is, that would in fact be the case.

Assemblyman Ellison:
So those who made the investments, because they are not here, would not be on this list. They would have to be self-funded with their own clinics, their own doctors, and their own staff. If this bill passes, whoever made the large investments, because they are not here, would be forced to add other doctors to the list instead of self-funding doctors. Is that what you are saying?

Assemblyman Jones:
I do not think it would wipe out the existing infrastructure. This only applies to people who have a problem with their care and are frustrated because of the small list. If the care being provided is adequate, then the people have no reason to see someone like Mr. Mills, as he testified. The only clients who come into his office are people who are upset and disgruntled because their care has been limited. If the care is being properly provided, it will not be a problem.

Assemblyman Ellison:
But that is not what this bill says. This bill opens it up, and that is my fear. Those who put hundreds of thousands of dollars into their system could be wiped out by this bill, and why should they have the clinic?

Assemblywoman Titus:
I think your point is well taken. I recognize that it is good medicine for companies to have an on-site clinic. I think those points are well taken, and I think we need to make sure this bill does not do away with those clinics because that would be an injustice, not only for the workers but for the companies. That is not the intent of the bill. My honest intent for the bill was to put folks like Attorney Mills "out of business," so that injured workers received care, and they could go back to work and not have to seek attorneys to get back to work or feel as if they were unjustly served.

My issue with the current system is the delay in somebody like myself, in the primary care arena, getting my injured workers a referral and enabling them to see the specialists. It could be months before they get in. In regard to the companies that have excellent employee clinics, I know that many of those providers do a tremendous job, and that is really the best care. When someone has an injury and can get in to see a provider quickly, that sets the tone for recovery. Any delay is an error in care. Assemblyman Jones is the one who wrote this bill, but I think we need to make sure this bill does not destroy the existing clinics that companies have for their employees, because I think that is good practice.

Assemblyman Ellison:
I think we need to make sure that language is put into this bill by amendments. I am trying to get this bill amended, if needed. I want to make sure that those who have millions of dollars in investment are protected.

Assemblywoman Carlton:
Years ago, when all the problems were happening with workers' compensation in this state, we had this same discussion. I would like to go on record that I agree with Assemblywoman Titus that it is all about access. Over the last decade, whether discussing Medicaid, Medicare, workers' compensation, private, specialty, or community health centers, we have heard the word "access" way too often. I believe that is what this bill is trying to address.

When this topic was first addressed, we thought we had the right mix, and for a decade it worked. With the change in the health care world and with many more people having access to health care, it is going to be more difficult for these people to find someone to treat them. We know with injured workers that the first step for their recovery is to be able to see someone. I am not sure about Assemblywoman Titus's amendment. I think I want to understand it a little better, because I thought we had already put those qualifications in NRS for workers' compensation doctors. If the amendment changes that, I would like to understand how, because I would not want us to contradict other sections that are all tied together. It would be appreciated if I could have clarification on that.

Assemblywoman Titus:
I could not find that information specifically. It said they should be competent in workers' compensation, and when I met with the past head of the DIR association, there was no clarification to me as to what "demonstrated special competence" meant. They just had to say they are competent and want to sign up. I want them to have some sort of documentation, a minimum requirement that these folks understand industrial relations, whether it is a brochure they produce or some other documentation. If they already have that, this is not needed. I was not reassured that the folks who have signed up have provided any information, other than signing something that said they want to do this, and can do it. Have we held them to that?

Assemblywoman Neal:
There are statutory timelines for when actions are supposed to occur. In section 3, subsection 4, where it states, "If, within 30 days after the referral, the injured employee has not selected a physician or chiropractor," the language of 30 days was added. Does that affect the date of the claim? Are we pushing that back? Because if this is accurate, the injured worker is supposed to report

the injury to the employer within 7 calendar days and to seek medical treatment within 90 calendar days. The worker is supposed to report to his or her physician within three working days of the initial treatment. You gave the worker an extra 30 days to find a physician.

Jason Mills:
Section 3, subsection 4, deals with treatment by an MCO or a panel physician. It is common on claims that a doctor who is treating the claimant will say they can no longer do anything for you because it is not in their specialty. The doctor will then transfer the care, for example, to a physiatrist, to orthopedic surgery, or to chiropractic care. Current law allows the injured worker to make a selection from the MCO's panel list, but it does not set a time frame, and both sides end up wondering what that means and when they can do that. This amendment does not affect, change, or alter the claim for compensation. This has to do with when the doctor says he wants to transfer you to someone else. Then you could say, "I want to go to Doctor X or Doctor Y, within the specialty that you are referring me to," and then we put a time frame on that request. It has nothing to do with the claim compensability or the acceptance of the claim.

Assemblywoman Neal:
I am curious, because the stricken language in section 3, subsection 4, says, "After receiving the list, the injured employee shall, at the time the referral is made, select a physician." So what is the timing? Do you get the list the day you report the incident to your employer?

Jason Mills:
No. What is being struck is the problem that creates the ambiguity. For example, the injured worker at Dr. Physiatrist who is treating the pain realizes that this person needs orthopedic care. At that moment, the doctor transfers the care to an orthopedic doctor. The claimant is not given a referral list at that time, so the worker cannot make a selection at that point, and it creates a bone of contention between the two parties on when and how the transfer of care timing happens. Is the decision made that day, a week later, or can it be made nine months later? The statute is ambiguous as it currently works in the real world. What we attempted to do was put in a black and white rule covering when the treating physician says he needs to send you to someone else. The injured worker then receives the time frame to select from the panel. That puts a time frame on it. If the worker does not make a selection from the panel, the insurer selects on the worker's behalf.

Chairman Kirner:
Are there any other questions? [There were none.] Will others who are in support of the bill please come forward.

Michael A. Glick, D.O., Private Citizen, Reno, Nevada:
I have been practicing occupational health care and taking care of injured workers for approximately 30 years. I have extensive knowledge in taking care of employees. I am currently on the treating panel for the State of Nevada for occupational injuries. I am also a permanent and partial disability evaluator, which means that when an employee is injured and their treatment is finished, if they have a permanent defect or impairment, he or she is sent to one of the doctors on the rating panel for impairments. I am also on the review panel for the State of Nevada and have performed almost 2,000 disability examinations. In addition, I am a board-certified, independent medical examiner, and I am boarded by that board for approximately 15 years. I am also a medical advisor to the national board that has certified over 5,000 doctors. I have worked in all different types of clinics, including occupational health centers in Reno and Las Vegas and in other states.

I support A.B. 187 because it lets the employee pick a physician from the panel of treating physicians, a physician of his or her choice who has been authorized to treat an employee or an injured worker in the state of Nevada. I think it increases access to care. I think it can improve quality of care and also increase the referral patterns to specialists. As you just heard, if someone needs to see a specialist, there are a limited number of doctors currently on these plans, and the employee may have to wait to see this person. I have worked in these clinics and have always felt that injured workers should have a choice of doctors, as long as it is one of the doctors on the treating panel. I have heard comments that the cost of the workers' compensation health care is going up because injured workers are going to doctors who do not know how to treat these types of injuries. I disagree, because these doctors have been authorized by the regulations and the statutes and whatever legal maneuvers are used to create the criteria for these people.

I have taken care of employees when they are funneled into a limited number of clinics. It seems as if they are waiting at these clinics for hours. I hear that all day long, that the worker has to fight with the system to get taken care of.

I have heard some rebuttals and read on the Internet that this bill will cause problems, such as increasing the cost of a disability examination after the person is injured; that is, the actual payout. I want you to know that the disability process, the permanent, partial disability (PPD) process is separate from the treatment process. The disability process, to judge impairment, set up

by the state does not allow the treating doctor to do these examinations. It has to be a non-treating physician. In addition, I have read a rebuttal that this bill decreases an insurance company's control of doctor performance. I did not understand that, other than I have always felt that a doctor's performance should be under his or her own control and not mandated by an insurance company or someone who thinks they have more knowledge in taking care of that specific employee.

I strongly support this bill, and I hope it will pass.

Craig Kidwell, Private Citizen, Elko, Nevada:
I am a lawyer, and my practice is exclusively in workers' compensation. You may be wondering why there is an attorney in Elko practicing exclusively in workers' compensation. You already heard the answer, which is "access." I have heard this bill titled "Choose Your Doctor," and that is what it does. I hope that is what it does, and I hope it passes for that reason. Elko is approximately 300 miles from Reno, and it takes four to five hours to drive there. There is no commercial air transportation between Reno and Elko. Elko is approximately 450 miles from Las Vegas. To drive that distance takes six to seven hours each way. I asked some of my clients to be here today to talk with you. None are here, but I have submitted a few of their letters (Exhibit F). I could not get anyone to come with me today because of the lengthy drive and, remember, they are injured.

I know Assemblyman Ellison very well, and I know the medical community. They know me and trust me. I am not one of those lawyers who sue the doctors. I help people and have fun doing it. As the law is now, the worker has to be given a choice of doctors, but that is not defined. The choice can be two doctors in Las Vegas. No offense to Las Vegas, but I do not want to be treated in Las Vegas and my clients do not want to be treated there. It can be two doctors in Reno, which is closer but, still, the patients are driving. There are a lot of good doctors in Elko. We have a great hospital. We have an outpatient surgical center, and I know a lot of these doctors well. My dad practiced with them and has a good opinion of the doctors. I will give you some examples, and this may have been presented to you. [Mr. Kidwell referred to the DIR list on the Internet titled "Workers' Compensation, Treating Panel Physicians and Chiropractors."] On that list are over 3,000 names of doctors who can give care. I did not hear the earlier statistic that only 10 percent are on provider lists.

Elko is known for ranching and mining, as are Winnemucca, Battle Mountain, Austin, and Eureka. The state has supplied this provider list. These are doctors and providers who said they would like to offer assistance regarding

workers' compensation. They have applied and made the list. One of the largest mines in Nevada uses this list, which includes hospitals and occupational clinics, orthopedics, ophthalmology, physical therapy, and a physical medicine specialist—that is it, and it is not much of a choice. I think if you were hurt, you would want a choice, as I would.

In Elko, if you are a State of Nevada employee and strain your knee and end up having to have exploratory surgery, you would need an orthopedic surgeon. The most recent third-party administrator's list I have for state employees in Elko lists three orthopedic surgeons. Their addresses are listed in Reno with an Elko address as well. Not one of these surgeons has privileges in Elko. Out of the three listed, one no longer comes to Elko. The other two are in Elko once a month or every other month, and that is when you will see your doctor.

What if you need a scope? In Las Vegas and Reno, it is outpatient surgery. Your spouse or friend drives you there, because when coming out of surgery you are on anesthesia and cannot drive. You have the scope, go into recovery, things usually go well statistically, and you go home. If you are a state worker, you are not going to have it done in Elko or Winnemucca or any other rural town. You are going to have it done in Reno. You will drive, not fly, four hours plus, and stay in a hotel that night. You cannot drive yourself because you will be under anesthesia by the time the procedure is done. There are no provisions in workers' compensation to help you get someone to help you, the injured worker. You will go through the outpatient surgery, and you will probably not come home right away, spending a second night in a hotel.

What if you work in a "cow county," as we Nevadans call them? The list of third-party administrators could have changed because it is not regulated. There is one orthopedic surgeon listed for Elko. This surgeon has no privileges in Elko, so you, the injured worker, will be going to Reno.

One of the previously submitted letters is from Brandon Fordin. He has a claim from 2004 for a back fusion; that was 11 years ago. Why do I still represent him? That is why I am here today. We have a physiatrist in Elko. Mr. Fordin needs ongoing pain management. He had a failed back fusion. Sometimes when a doctor does surgery, the patient needs medication to get through life. Mr. Fordin is on an approved pain management program after his claim closed. The physician he was seeing, and who was on the panel, closed his office. That physician referred him to another physician for pain, where he was treated by that physician for some time until one day a new adjuster was assigned to his case. The adjuster said that the newest treating physician was not on his list and Mr. Fordin had to choose someone on his list. Mr. Fordin did not know that. The adjuster sent a letter saying nothing else would be paid for, and his

claims were disallowed. If you are on lifetime pain medications, there can be drastic side effects. He is paying out of pocket to try to continue his medications while he figures it out. He did not know until he hired me again that he had to ask for a list. It cannot be looked up on the Internet. We finally got a copy of the list, and there is no one in Elko that Mr. Fordin can see. He has to travel to Reno.

Chairman Kirner:
We have the letters from Mr. Fordin and others. I want to make sure everyone has a chance to testify.

Craig Kidwell:
Every day I talk with someone who is not receiving care. They have to travel to Las Vegas or Reno. What if that third-party administrator chooses two doctors in Elko? That is the choice if you live in Reno or Las Vegas and have to go to Elko. Everyone laughs; that is not going to happen, and it probably would not. But the way the law is now, it can, and there is no choice. You can be made to choose a physician not in your own town. I support A.B. 187 just to help these folks not to have to travel.

Mendy Elliott, representing Chiropractic Physicians' Board of Nevada:
On January 10, the Board was provided an overview of then BDR 53-898, now A.B. 187, by Dr. Overland. After many questions and discussions, the Board voted to support the concept of this bill. Patient access to choice, safety, and quality of care is always top of mind for the physicians and the lay people who comprise the Chiropractic Physicians' Board of Directors. We are strongly in support of A.B. 187.

Stacy M. Woodbury, Executive Director, Nevada State Medical Association:
We represent licensed physicians practicing medicine in Nevada, and we wholeheartedly support this bill.

Assemblyman Ellison:
Mr. Kidwell is a good friend and a well-respected attorney from Elko. I keep referring to Newmont Mining Corporation or Barrick Gold Corporation, who have a large clinic. From my understanding, if there is an issue, usually the injured worker is referred out. If one of the miners gets hurt, he is sent to the clinic, and the clinic refers him. As far as going back and forth to the different hospitals, I totally agree. I traveled that road for three years when my son was dying of cancer. Everybody knows how difficult it is to get from Elko to Salt Lake City.

Could you please address the mines and how this might be done? I think my biggest concern with this bill is the language that will protect the people who have investments in the clinics.

Craig Kidwell:
I think the bill helps the clinic in Elko. It is called the Golden Health Family Medical Clinic, and it is on the list. The doctors are general practitioners. If the injured worker is referred to an orthopedic surgeon, for example, the same scenario applies. The injured worker has no control because he or she must choose from the list. I know whole families who go to the clinic and receive good care. What if the spouse also uses the clinic? That clinic doctor is usually the family doctor. This list is the only directory where I have ever seen any of those doctors listed. So the spouse, who normally goes there for his or her care and whose children go there, would be precluded from going to that provider under the current law. They would have to go to whomever is on their other list, and Golden Health is not on any other list. I think it would help the clinic. I cannot think of a scenario where it would hurt it. The workers are seen from the initial point when they go in and get treatment. It is outside the emergency room; it is a lot cheaper. When they exit the clinic, it is for specialties, and then we are back with the same problem we have now.

Assemblyman O'Neill:
How many orthopedic surgeons are there in Elko who are not on the list?

Craig Kidwell:
There are three.

Assemblyman O'Neill:
Have attempts been made to get on the list? What have been their issues?

Craig Kidwell:
That is a good question. The doctors call and ask me questions such as how they get on these lists. What do we do to treat these people? My answer is: I have no idea. You have to know somebody in the system. Without this bill, there is no way for those groups to get on the list unless they know someone. There is a doctor in Reno who controls one of these two lists. If you do not know the doctor, you are not on these lists.

Chairman Kirner:
Are there others who wish to testify in favor of this bill? [There was no one.] Is anyone neutral?

Maria Carrillo, Private Citizen, Las Vegas, Nevada:
I support A.B. 187. I am an injured worker. Due to no fault of my own, I had a slip and fall at work from a product that had spilled on the floor. My neck, shoulder, hip, and ankle were injured. I was told by my employer to see a doctor. I went to my previous doctor who has helped me with similar problems. He provided me with initial treatment, which was helping. He told me he could no longer treat me because the insurance company stated that he was not on their panel of approved doctors. He asked for permission to treat me and was denied.

I was told by my employer's insurance that I needed to see their doctor. I went to him, and he prescribed medication that made me sick and hurt my stomach. I do not like to take medication. Those doctors sent me to therapy. I asked to be transferred to my previous personal doctor and was told I could not do that. The therapy I was provided was not helping me but causing more pain. I told the therapist and doctors about my pain, but they tell me I have to keep doing it. Because they would not listen to my concerns, I stopped going to therapy.

I am now being treated by my previous doctor and paying for it myself. I am unable to work and am slowly getting better. I know I would get better quicker if I had money to pay my doctors and receive treatment more often, if my employer's insurance company would let me see my previous doctor, because the insurance company and their doctors will not help me. I am in bad health and a bad financial situation. This system is not for injured workers, like myself. It needs to be changed, and this is why I am in support of this bill.

Tim Andrus, Private Citizen, Las Vegas, Nevada:
I am a firefighter in the Las Vegas area. I am 100 percent in support of A.B. 187. In October, I was diagnosed with heart disease. I was seen in the emergency room and was immediately referred to a cardiologist. The cardiologist was not on the workers' compensation list. I was sent out because I needed to have medications. I would go into atrial fibrillation and was sent to have that taken care of. The documentation was sent to workers' compensation, and we continued to wait for workers' compensation to provide me with a cardiologist so I could continue treatment. To this day, workers' compensation has not done a single test or examination on me regarding my heart condition. I continue to see my own doctor because I could not function without the medication.

I have now been sent to a cardiologist. In the Las Vegas area, it takes six to eight weeks to be taken care of. Yesterday, I was supposed to have an ablation recommended by my cardiologist, my specialist, which was postponed because workers' compensation will not accept that from another physician. What this

means is I will continue to have atrial fibrillation, in and out, on a weekly basis. I have been to the hospital three times. I have been cardioverted, which means my heart was shocked back to normal rhythm, and I will continue to have that until workers' compensation decides to send me to a specialist.

It was three weeks ago I was given this appointment. I will continue to do this until workers' compensation decides this is what they want me to do. The unfortunate thing is that I want to get back to work and do my job, serve my community, serve the people who need it, and help them also in medical and other types of situations. I do not want to worry about whether I will be able to get treatment for my heart when I need it.

Darnell Irvin, Private Citizen, Las Vegas, Nevada:
I was injured in 2011. I broke my jaw in half, broke my back in three places, and fractured my neck. I was working for a company in Henderson. The accident happened in Montana, where I had two surgeries and was referred to my primary physician. My primary physician gave me a list of names to see a specialist and have those issues looked at. I went to a Nevada spine doctor who said my back was broken, and that I needed surgery. That doctor was not on the list. By the time I got a physician on the providers' list, they said my back should have healed and surgery was unnecessary.

I went to a jaw doctor who took the wires off my jaw and said I should be all right and to go to therapy. I went to therapy on the providers' list. While checking my jaw, I told them something is wrong. I am having more pain. By the time they figured out that something was wrong, the jawbone had fused to my skull, and I had to go through two more surgeries to get the temporomandibular joint (TMJ) replaced on both sides. I was sent to a pain management doctor. I explained to him that I had never been hurt, never been sick, and never been hospitalized until this accident. Something is wrong with my body, and I am told to take this pill, take that pill. The doctors on the provider list think a pill is a fix for every injury. Everyone's injury and everyone's pain is different. I know my body, and there is something wrong with me. If you do not know what is wrong with me, send me to someone who can help me or at least can try to figure out why I am having these pains. That is why I am in support of this bill.

Cora Flanigan, Private Citizen, Las Vegas, Nevada:
I have been in law enforcement for 28 years, nearly 26 of those years as a police officer for the Las Vegas Metropolitan Police Department. I am currently retired. I was injured in April 2011 as a bicycle officer on the Las Vegas Strip. My right knee, neck, jaw, right arm, and head were injured. Surgery was done on my knee and jaw. Following surgery, I was instructed by my physician to go

to a particular physical therapist. I was told that the physical therapist who specialized in TMJ was not on the list, and I was sent to another physical therapist's office who was on the list. He had to look online as to how to treat my jaw and brought the paperwork out with him to treat my jaw.

Out of my own pocket, I went to the physical therapist that was recommended to do the TMJ, but I could only afford to go to that person for three visits. I was sent to a neurosurgeon. First I was sent to an orthopedic doctor, and when I advised him that I needed a referral to the neurosurgeon and I mentioned the doctor I wanted to go to, he stopped the conversation and completed the paperwork for an MRI and said to go to the neurosurgeon. I had an open MRI performed and saw the neurosurgeon. I was in treatment with the neurosurgeon who was requesting injections in my neck and a closed MRI so he could get a better view of what was going on with the neck. Workers' compensation continued to refuse that. This went on for over a year. Eventually I was told they were sending me to another doctor for a second opinion, and I was sent to a regular orthopedic doctor. That doctor did not do any type of examination, other than pushing on my arms, and stated that he thought it was just arthritis.

I was then sent to another neurosurgeon for a second opinion, and he agreed with the original neurosurgeon who said I needed something done with my neck, and he requested a closed MRI. He also suggested injections in my neck, as the first neurosurgeon had. Eventually, I was approved for injections and to have the closed MRI. When I called my treating physician, he informed me that he had been removed from the list and could no longer write my prescriptions or do any treatments for me. The injections did not work. I requested that he send me to another neurosurgeon who had been recommended to me. He did so, and I went to see that neurosurgeon. As it turns out, I have a ruptured disc in my neck, and I should have had surgery over three years ago. I am still waiting. I do not know if the surgeon who was finally approved is going to be the doctor who does the surgery. They are still talking to the second neurosurgeon. There is a complete lack of communication in the workers' compensation system. That is why I support this bill.

Chairman Kirner:
I need to move the hearing along, and I know a lot of these are very personal issues and that you have individual needs. If you have a similar situation, you can say that you support this bill.

Valerie Williams, Private Citizen, Las Vegas, Nevada:
I am a Clark County firefighter. On October 31, my partner and I were responding to a "fire in a building" call when we were hit at a high rate of

speed, which subsequently totaled our rescue truck. I sustained multiple injuries and was taken to a hospital trauma unit. My issue is that I have not found a single doctor on this list who is willing to document or treat all my injuries. The one doctor I was allowed to see for my shoulder has been approved. However, all the other injuries have been denied, and I have not been able to see a doctor about any of the other injuries sustained in that traffic accident. I am in favor of A.B. 187.

Henry Thorne, Private Citizen, Las Vegas, Nevada:
I am in support of this bill. I have been waiting for this bill for a long time. I was injured on the job in June 1993 when my vehicle was rear-ended at the Spaghetti Bowl in Las Vegas, which propelled me into another vehicle. A witness took me to the hospital, where I was diagnosed with a sprained neck, back, and knee. After that, I received no treatment, even though I was hurt on the job. I was told I had to wait 30 days. I had to use my wife's insurance in order to receive treatment—a fusion in my neck. My employer told me I had to return to work, which I did in November 1993, where I was told to sit at a desk. Then I was told I had to get a permit. On my way back to work from getting the permit, I got hit again and was unable to work.

I am on workers' compensation, although I have not received a dime. I had to pay the medical myself. Fortunately, my wife had insurance. I was sent to a doctor who said I was hurt and was then referred to another doctor who wrote me a prescription. I was released to return to work full time.

I was assigned to another doctor for a five-day evaluation, at the end of which I was again released with no rating and no medication to return to work full duty. We are told that if we return to work, we will be fired. I returned to work and was hurting so badly, I was sent home. I went back to work the second day and, while at work, was rushed to the hospital. I was taken off work duty and received a slip saying I am to be off work. My employer fired me in March 1994. I have paperwork where I was approved for surgery but am still being denied today. I have had no treatment since 1997, when I received a document from a doctor and all the other doctors who said I was hurt. As long as I was paying the insurance through my wife's plan, I returned to the same doctors who told me I was hurt. When I was with workers' compensation, I could go back to work at full duty.

I am told I have a lifetime opening after one year. I have been fighting over 21 years and have seen over 30 surgeons and chiropractors, among others. Every one of them says I need treatment, but I am denied. I am told "our case officers say he is not hurt." Those folks have never seen me because I was never in their office. I pay other doctors to get my case reopened and am still

denied. I had to turn to attorneys handling injured workers. The attorneys said that I lost my case because I could not prove I was hurt. One week later, they were working at the former State Industrial Insurance System, now Employers Insurance Group of Nevada. I was under the old law that said I could choose whichever doctor I wanted on my first accident. When I had the second accident, the law changed, which says the doctor will be chosen for me. I was taken out of the system, saying there was nothing wrong with me, and my case was closed.

Chairman Kirner:
You are in support of A.B. 187?

Henry Thorne:
I am in support. We need to be able to choose our own doctors. We do not need "panels." I have been taught how to be a lawyer. I just do not have the diploma.

Linda Nash, Private Citizen, Las Vegas, Nevada:
No employee asks for a workers' compensation accident. I had a slip and fall in 2013 and finally got to the orthopedic surgeon stage. I was told I needed a rotator cuff repair. I had a surgeon who had worked on me ten years previously, but I could not use him because he was not on the list. Subsequently, the surgeon I went to botched the first operation, and six months later I needed additional surgery. My care was extended, and my injury was extended seven months because I could not choose my own doctor. I am in support.

Chairman Kirner:
I believe we have heard all those who are in support of the bill. Are there those who are neutral? [There were none.] Is there anyone opposed to the bill?

Robert Ostrovsky, representing Employers Insurance Group:
Employers Insurance is what now remains of the old State Industrial Insurance System, and prior to that the Nevada Industrial Commission (NIC). I chaired the advisory committee to the Division of Industrial Relations for almost 20 years. I have seen the system grow and develop.

It sounds like this is a totally unregulated industry—nothing could be further from the truth. *Nevada Revised Statutes* 616B.5273 talks about the adequacy of medical networks. It guarantees that the DIR is responsible for managing these networks in the sense that they would measure their adequacy, be provided in a manner that ensures the availability and access of adequate treatment of injured workers, that the injured worker has an adequate choice of

providers, and that appropriate financial incentives be provided to reduce costs without affecting the quality of care provided to the injured employee.

The original managed care statute was entered into law in 1993. The adequacy language was added in 2003 to assure that these networks were appropriate and provided service. If you look at the networks in the rural areas, I would call them "skinny networks." There are not many providers available in the rural areas. When we ask an injured worker to go to Salt Lake City, or to drive to Reno or Las Vegas, we are paying for them to do that. We pay for him or her to stay overnight. If he or she loses time from work, we are writing that check, too. We have no interest in increasing the cost of that claim. Frequently, the only providers we can get, and grant you they are on our list, are not necessarily local. There may be some but there may not be many in Elko, Winnemucca, or Ely.

We have networks. I heard earlier testimony that this bill, as proposed, would not affect the cost of operating in Nevada. Employers Insurance, who I represent, believes that the rate of workers' compensation insurance will rise 10 percent on the passage of this bill, and here is why. The state has a fee schedule. It outlines what specifically the providers will be paid and who will provide services to injured workers. We create a network of doctors, and some of the agreements we have with doctors lower that rate. We pay below fee schedule. Why do doctors take below fee schedule? It is like any other network. The doctors accept a certain amount of volume that they will receive from my insurance company in exchange for a lower rate. We say, does that sound fair?

There was talk about free market and that in the long run free markets would change the dynamics of the cost of health care. I have talked to the bill's sponsors, and in theory that is correct; it probably would. But medicine is not delivered in a free market. As an example, every private insurance company, including those who probably insure you, provide a network. Medicare Advantage provides a network; HMOs provide a network. The State of Nevada health plan provides a network. Taft-Hartley trust programs that are union-management-sponsored provide a network. Networks have developed ever since HMOs came into existence in 1973 and became the primary type of insurance. Fee-for-service medicine is long leaving the marketplace.

So, if we open our networks to any willing provider—and any willing provider is what this bill asks for—it means any doctor who is non-network who wants to provide services can do it for the same fee. It means the doctors who are in that network will no longer want to be in that network. Then you revert back

to the fee schedule, and you get a substantial increase in the cost that we are paying for that medical care. That translates into higher rates for employers.

Section 1, subsection 1, paragraph (a) of this bill talks about establishing compliance with Chapter 695G of NRS. Workers' compensation networks are overseen and have oversight from the Division of Industrial Relations. The language added to section 1 would give oversight to the Insurance Commissioner, but it does not remove oversight from the DIR. There are two different statutory standards. The adequacy network language that is in the Insurance Commissioner's law is geared toward HMOs and other networks, and the language conflicts. This Committee will have to make a decision as to who will manage networks for workers' compensation. Will it be the DIR, which has had the responsibility since 2003, or will it be the Insurance Commissioner? I have asked the Insurance Commissioner why a fiscal note was not included. His answer was "there is no fiscal note," because whenever he does a network adequacy review, he bills the insurance company. The insurance company builds that cost into the premium and then bills the employer.

There are appeal rights that are granted to individuals under NRS Chapter 695G, in NRS Chapter 616C. The way this bill is drafted there will be two bites of the apple, and you would have to go through the entire appeal process at the Division of Insurance, while you could go through the same appeal process at the DIR, and that makes no sense to us. Regarding the issue of any willing provider, we think of the costs it will incur.

Other things that have been added to this bill include the 30 days to select a physician upon referral. We have never heard that this is a problem. The current law says a list will be provided and at the time they will choose a doctor. We think adding 30 days is not a good standard. If you want to add a fixed number, put seven days in. We are trying to pick a specialist. Once you choose, then you have to get in to see the specialist, and that may take two weeks or longer.

Assemblyman Ellison:
You are saying the injured worker can pick and choose or, if not, you will send him or her to a doctor. If the worker is out of state, does the insurance cover that if employee chooses Salt Lake City as opposed to Reno?

Robert Ostrovsky:
The law requires two things. We try to build networks, which are reflective of the workforce. If you go to the Employers Insurance website, for example, and click on "For Injured Workers," one of the selections is "Provider Locator."

You will find 886 pages of provider listings. The listings are divided by city, the worker's address, and the provider's address, some of which are in Salt Lake City. We try to find the closest provider we can. There is also a standard that says if you do not have a provider in your network, you have to find a provider or permit the employer to choose a provider. The provider lists cover almost everything, but there may be some specialties not otherwise covered.

Assemblyman Ellison:
Will that work for a third-party administrator also? Most third-party administrators do not put the information on the web, is that correct?

Robert Ostrovsky:
You are talking about third-party administrators. They are required to have these lists available to the injured worker. I do not know if it is a requirement that third-party administrators post their information on the website. Don Jayne is here, and perhaps he can answer that.

Donald E. Jayne, representing Nevada Self-Insurers Association:
I believe they are required to provide a copy of the directory. I do not recall there being a requirement to post the information to the Internet, but I will check that for certainty. My recall is that a provider list is required.

Robert Ostrovsky:
In section 3, subsection 3, an additional 30 days has been added into the system. Where it says 90 days, it will now be 120 days. I have heard no testimony or have any record that an additional 30 days is needed. The 90 days seems to be working fine and has been in the statute for over 20 years. If there is an issue there, obviously, talk to the parties. When the additional time is added, we are not only paying the medical bill, but are paying for the worker's time off. We are writing a check for the lost work time. It is not to our advantage or the employer's advantage to keep writing checks for employees to stay home and wait for an appointment. I assure you, we try to get those appointments as timely as we can, because we are writing you that check to stay home. If someone is trying to reopen a claim or has a dispute about an initial claim, there may be delays in those payments. There is clearly a process available to folks.

Looking back to previous years, when we were the State Industrial Insurance System (SIIS), and the problems and complaints we had before putting in managed care—when hundreds of employees lined up outside the SIIS building in Las Vegas and pounded on the walls, or drove through the walls in one

case—we have come a long way. I do not believe there is enough support to indicate that a big change like this is needed.

Chairman Kirner:
We heard testimony from one gentleman that he was injured in 1993, which is more than 20 years ago. He has gone through a number of iterations, seemingly not getting a resolution to his workers' compensation injury. Is our system adequate or not, in terms of available physicians, even in places like Las Vegas?

Robert Ostrovsky:
I believe you can get testimony from the DIR to say that the system is adequate, we believe it is, and that if people look at our website, you will find over one thousand doctors on our network. I cannot tell you that every network in the state is perfect, but the DIR should be able to tell you what network adequacy standards are being used and how the networks are being managed. We have an advantage in size and write a significant amount of business compared to a smaller network. Mr. Jayne may be able to respond to that because he has some smaller networks for the self-insureds that we do not have because we are spread out so much over the state.

I know examples can be found, such as the gentleman whose issues date to 1993. His injuries came before the managed care language was put into the statute. I cannot adjudicate his claim, as I know nothing about his case. It sounds as if he has had a difficult 20 years. I wish there would be no claimant in his shoes. It is in everyone's best interest to settle these matters and get people medically stabilized and back to work—that is the goal.

Assemblyman Ohrenschall:
I am concerned about what I heard, especially from the injured workers who talked about the truncated lists they get, as opposed to the qualified physicians on the DIR list, and about the trouble the physicians have had trying to get approved for that list, even though they seem to be qualified in every other respect. You indicated you have 895 providers on your list. Does current law require you to have that many? Could you elaborate?

Robert Ostrovsky:
We have over 800 pages of lists that are commingled in various ways by areas, and there may be duplications, so I do not want to testify as to how many doctors are on the list. I will get the exact number for you. The panel that is recognized by the Division of Industrial Relations is a reflection of every licensed physician or licensed chiropractor in the state, unless they are removed from the panel. The DIR can testify about their standards if a doctor wants to be a rating

physician. Generally, to be on the panel, if you are licensed and are in good standing with your medical board, you are a panel physician in the state of Nevada unless you are removed or you remove yourself.

Assemblyman Ohrenschall:
The number of 895 or 1,000, that is not because the current law requires you to have such a wide choice. It is the choice of Employers Insurance. It is your option. Am I understanding that correctly?

Robert Ostrovsky:
Yes. We have to have adequate networks that provide choice by the standard found in NRS Chapter 616B.5273. Our choice was to have a larger network. If you look at the Affordable Care Act (ACA), there are gold, silver, and bronze categories. Part of it is that you are choosing what your deductible will be, and part of that is purchasing a thinner network. Network size has something to do with cost, too.

Chairman Kirner:
The word that strikes me is "adequate." Is this a term that is defined in the law?

Robert Ostrovsky:
The law says, "a manner that ensures the availability and accessibility of adequate treatment to injured employees." To my knowledge, there is no definition. If we believe there is a problem, I think the way to attack it without opening the networks completely is to attack adequacy. If people think the networks are inadequate, that is the first step I would take.

Chairman Kirner:
If you decided it was inadequate, and the way you were going to resolve it was to open the network and increase the access, do we run into problems with the increased costs you referred to earlier, the 10 percent?

Robert Ostrovsky:
You run into a problem if you have any willing provider and open the network to anyone. If you say the DIR suggested that your network is too small and needs to be increased by 50 percent, where you had six doctors and now you are told you need eight or nine doctors, I do not think that would have the economic impact of saying any willing provider. You would still have a network and still have contracts.

Don Jayne:
I represent the Nevada Self-Insurers Association (NSIA), which provides members with the opportunity to confer and discuss the many questions that arise pertaining to workers' compensation. The NSIA represents both stand-alone, self-insured employers, and self-insured groups (SIG), employing and providing workers' compensation coverage to over 200,000 employees. There are many things that Mr. Ostrovsky said that are "me, too" sorts of subjects. I would like to put a few other things on the record.

A stated objective of the Nevada Self-Insurers Association is to ensure that the rights of injured workers and employers are protected, while injured workers receive the best possible medical care and treatment to provide for a prompt return to work. With anecdotal stories and outliers, it might not seem that we are all on the same page. We want to make sure there is an adequate network of providers. A small self-insured employer who may only have a few hundred employees may not need every provider who is on the panel. I think we have acknowledged that the list, in its current format, needs to be improved and Assemblywoman Titus brought forth an amendment to press toward the competency of the individuals on that panel. That is important to her as a doctor. There are some things we have heard today that we probably agree with.

We believe the current language of demonstrating special competence and interest in industrial health to treat injured workers, which is existing language in NRS 616C.090, makes it difficult to answer what does it means. Does it mean you complete a single-page questionnaire? Does it mean you do some classwork? Does it mean you take a test, or that you have practiced in industrial medicine for 2 years, 10 years, or 20 years? Those things are important and probably should be fleshed out.

I tend to go back in history in Nevada when we refer to the former SIIS. I spent a tenure there as the general manager, and as Assemblywoman Carlton said, a lot of work has been done in the workers' compensation arena since the early to mid-1990s. As Mr. Ostrovsky said, this is a heavily regulated industry, on top of having the statutory language backing it up. Every decision that we make is appealable. There are time frames on those decisions. When we go to network adequacy and focus on that aspect, the Self-Insurers Association will acknowledge that we have a problem in the rurals, particularly when it comes to specialist providers and how we deal with those things. On occasion we have a difficult time finding providers who will contract in those rural areas, and perhaps there is something we can do in meeting with the proponents of the bill and working with the Committee to try and alleviate that. That is a concern of the self-insured employers as well.

It is interesting that in the managed care area, MCOs by their own definition limit the number of providers on the list. That is acceptable, yet it is not acceptable on the network side. Maybe that is a discomfort in that the regulations that exist may not be tight enough and maybe are not being applied. I am not sure where that is coming from.

There are two things we see here. We see the issue with the rural areas and share that concern. As Mr. Ostrovsky stated, we end up paying for transportation and travel time. No one wants patients to travel. There may be some way to look at adequacy of the networks and delays and some measures. Maybe there are some examples and models in another section of the statute or regulation.

The Division of Industrial Insurance would seem to be one of the most logical places for that oversight. It exists today in statute combined with regulations. As Mr. Ostrovsky alluded to, we seem to be involving the Division of Insurance, which may or may not be the right place, but they would be regulating the network adequacy and other aspects similar to what was testified to earlier.

We tend to agree with Mr. Ostrovsky's comments that adding 30 days to the choice of physicians, in our opinion, probably delays treatment rather than helping treatment. If we address the network adequacy and make sure there are providers in that network, that may do more for the network than extending the time period for them to select someone. I talked to representatives of the Division of Industrial Relations and asked them how many complaints they have received in the last year as far as adequacy of networks and was told zero. We are not getting complaints there, and they would be the ones who would know what was adequate.

An example used earlier was what if it is decided to place two providers in Elko who are based in Las Vegas. I am not aware of that happening in practice. Maybe it does. If so, I would like to know about it, because I would chase it down personally.

Chairman Kirner:
You heard testimony from individuals in Las Vegas, and they seem to be quite concerned with the adequacy. One of our Assemblymen talked about making long trips and understanding and appreciating what those long trips were about. It seems inadequate if someone in Elko has to travel to Las Vegas or Reno.

Don Jayne:
It certainly seems inadequate if they had to travel from Elko to Reno for treatment.

Chairman Kirner:
Mr. Kidwell testified that there are other people in Elko who have similar problems.

Don Jayne:
We would like to be made aware of those individual circumstances. My folks expressed to me the difficulty in getting providers to sign up in the rural areas.

Chairman Kirner:
Maybe Mr. Kidwell can help you.

Don Jayne:
I would pass along his card, but I suspect there may be, as is often true, more to this story than what meets the eye on some of those things as well.

Chairman Kirner:
I am sure there is. Do you have closing comments you would like to make?

Don Jayne:
We are here to work with the bill's sponsor. We do not see the issue in the same way it is framed. We believe we are putting together networks as allowed within the statutes and the regulations. We felt they were adequate. If there are issues on that side, we would be glad to work with the bill's sponsor to see if there is anything there on which we can come to common agreement.

Jaron S. Hildebrand, Manager, Government Affairs, Nevada Trucking Association:
Our association sponsors a self-insured group through Pro Group Management that works well and is efficient. For purposes of brevity, we oppose A.B. 187 for reasons previously stated.

Assemblywoman Carlton:
I have a question for Mr. Ostrovsky. I was around when we created Employers Insurance Company of Nevada (EICON). What percentage of book does EICON now carry for workers' compensation in Nevada?

Robert Ostrovsky:
I would say less than 20 percent. It is substantially smaller. Employers Insurance represents mostly small employers and low-risk industries. The self-insureds probably own at least 50 percent of the marketplace. The remaining portion of the marketplace is divided up. The Insurance Commissioner has a list of over 200 companies that sell insurance in Nevada. Most of those buy a network. My company buys a network from Coventry, a company that has a network that sells to many insurance companies. Liberty Mutual and State Farm are some of the biggest workers' compensation carriers, now larger than Employers Insurance in terms of total volume of premium.

Assemblywoman Carlton:
I remember when this came about. It was pretty much the self-insured groups and EICON. That has changed dramatically over the last ten years.

Robert Ostrovsky:
In terms of the mix of the sellers and who is buying and insuring, absolutely. You are correct.

Ray Bacon, representing Nevada Manufacturers Association:
I tend to agree with the comments from Mr. Ostrovsky and Mr. Jayne. When you have two masters, I am not sure it improves the situation. We do have an issue with adequacy. That is one of the things that has taken place in the manufacturing sector and, in general, I think ours has been relatively healthy. We have a tendency to be a lot of branch operations from Nashville corporations. We wind up with a situation where they may have a national policy from Aetna or Liberty, for example. Those networks, in some cases, probably are not adequate in this state, but they may take someone and fly them someplace where there is a major clinic to deal with orthopedic issues. That is a decision a company has made and, in most cases, they are getting super adequate care, but it may not be local because we are in a constrained environment as far as medical providers. We have had that situation forever, and I do not know of a quick fix where we can force doctors to move to places like Elko, Winnemucca, or Yerington. The doctors would probably not like it if we did.

It is an issue, but we are light-years from where we were. This will continue to be an issue. When you are in a sparsely populated section of the state, we are going to have adequacy problems that I am not sure we have a solution for.

Liz MacMenamin, Vice President, Government Affairs, Retail Association of Nevada:
With over 1,400 members, we believe that Nevada is a well-controlled state with regard to workers' compensation, and our employees already receive excellent medical treatment. We believe forcing the insurers to contract with any willing provider would be leading us down the road to such out-of-control states as California.

James L. Wadhams, representing American Insurance Association; and Las Vegas Metro Chamber of Commerce:
I cover two clients, the first being the American Insurance Association, a trade association that represents many of the insurance companies that write workers' compensation other than Employers Insurance. We appear in opposition to this bill. I did not hear the first part of Mr. Ostrovsky's testimony, but I would like to iterate that the solution to this problem seems to be regulatory oversight. I would recommend the Committee carefully review the functions of the appeals officers, hearings officers, and the regulators under Chapters 616A, 616B, 616C, and 616D, and the Division of Industrial Relations and what they do to regulate the adequacy and the timeliness of that service. That is statutory, and if that needs to be tightened up, we think that is a fair place to visit.

The second client I represent is the Las Vegas Metro Chamber of Commerce, which is opposed to this bill because it seems to interfere with the freedom to contract and the opportunity for businesses to reach conclusions. That in no way contravenes what I just said. If there is regulatory oversight that needs to be tightened by the regulatory agencies that have that responsibility, that would certainly be appropriate, and we would be happy to work with the bill's sponsors and the proponents in that regard.

Chairman Kirner:
Is there anyone in Las Vegas who is testifying in opposition? [There was no one.] Are there any others in Carson City in opposition? [There were none.] Would the bill's sponsors like to make a closing statement?

Assemblyman Jones:
I would like some clarification on where it was represented that there is a dual oversight by the Insurance Commissioner and the DIR. I do not think that is our intention.

Jason Mills:
That is not the intention. The intention essentially is to create more statutory language that is consistent with NRS Chapter 695G with regard to the

management of managed care organizations, which we think work quite well in this state. Hence, the reason why we think that mimicking those in the workers' compensation field makes a great amount of sense. That was the intent.

Assemblyman Jones:
We are more than willing to work with the opponents to provide language they would be amenable to.

Chairman Kirner:
I would encourage that. We will close the hearing on A.B. 187. There are two bill draft requests (BDR) we want to introduce. The first is BDR 10-1143, which provides provisions relating to manufactured homes.

BDR 10-1143—Revises provisions relating to manufactured homes. (Later introduced as Assembly Bill 270.)

The second is BDR 54-1128, which enacts provisions relating to equine dentistry.

BDR 54-1128—Enacts provisions relating to equine dentistry. (Later introduced as Assembly Bill 271.)

ASSEMBLYMAN OHRENSCHALL MOVED FOR COMMITTEE INTRODUCTION OF BDR 10-1143 AND BDR 54-1128.

ASSEMBLYMAN O'NEILL SECONDED THE MOTION.

THE MOTION PASSED. (ASSEMBLYWOMEN DIAZ, FIORE, AND KIRKPATRICK WERE ABSENT FOR THE VOTE.)

We will open the hearing on Assembly Bill 211.

Assembly Bill 211: Revises provisions relating to mechanics' and materialmen's liens involving certain renewable energy projects. (BDR 9-414)

Assemblyman James Ohrenschall, Assembly District No. 12:
I am here to present Assembly Bill 211, and to my left is Michael DeLee, a licensed attorney in the state of Nevada. He is also a Realtor, a broker, and a farmer. Mr. DeLee came to me with an issue that affects a lot of the pioneer counties trying to develop renewable energy projects. Assembly Bill 211 is an attempt to solve that problem and remove hurdles to

development of renewable energy products on private land. I will turn this presentation over to Mr. DeLee.

Michael M. DeLee, Private Citizen, Amargosa Valley, Nevada:
We received the language on this bill after studying how to address this issue. There are deficiencies that were brought to our attention when working with some of the people who are on record in opposition, although I am not sure we can move forward in good conscience. We want to reach a compromise on this bill that meets everyone's needs, and that has been our objective from the beginning. I have been to several of the construction law meetings over the last year to try to garner information, and it is difficult. There is not the same lien issue in other states. It is unique to Nevada.

Chairman Kirner:
Assemblyman Ohrenschall, it sounds as if there is work to do on the bill. Would you prefer we allow you to do that work and that you return with an amendment, or do you wish to proceed?

Assemblyman Ohrenschall:
If anyone has questions on the bill, we are happy to take them now, and I am happy to come back, too. I think we have had a number of good talks with several of the opponents, and I think there is some common ground. What is your pleasure, Mr. Chairman?

Chairman Kirner:
I certainly like bills to be clean when they come forward, but it is up to you since it is your bill.

Assemblyman Ohrenschall:
If Mr. DeLee could walk us through the bill, we can see if there are any questions, and then hopefully we will be able to return with a compromise.

Michael DeLee:
As I go through the bill, there may be a solution as to how this may be worked out based on the conversations we have had with general contractors.

Section 1 of the bill inserts a definition of the "renewable energy project," which will be on leased, private land. That section should also state "above a certain size." It does not, although that language is included elsewhere in the bill, and it should also say our proposal is 18 megawatts or larger.

Section 3 of the bill highlights what is now a two-part method of addressing deficiencies in rights of recovery for contractors. The current status is to

provide for their construction disbursement account or a bond in the amount of 150 percent of the total value of the project. What the bill set out to do was create a definition that allowed the land owner to be protected, so you do not have the possible loss of fee interest for what is not really going to benefit the actual land owner on leased land in a renewable power project, as we are seeing in some of the rural areas.

The change was to redefine the cost of material and equipment, as you can see in section 3, subsection 2, paragraph (b). The change needs to be clarified that it is the equipment provided by the lessee, and that is what we are going to see in an amendment—not just any equipment. This is echoed in section 4, subsection 3, paragraph (b) of the bill. We will clarify that would be the equipment provided by the lessee, who is the developer of the renewable project, whether it is wind or solar, et cetera, and not purchased through a prime contractor or any subcontractor. The intent is to make sure they are all fully covered under a construction control account and not exposed to any risk whatsoever.

Section 5 is what we were proposing to change on the bonding requirements. It is just too complicated to make that change. Since we have the alternative of the construction control account or a bond, we would like to leave the language in the statute as it is currently.

Chairman Kirner:
Does anyone have questions?

Assemblyman Hansen:
I have used this statute on occasion because I am a contractor. I assume you will still set up the account to pay for the labor portion, but not the material. Are those materials that you are personally supplying as part of the project? Will you be purchasing panels or other materials? What protection is there for the materials people? The reason this came about is there were several cases where contractors in good faith performed work, provided the materials, and when the project was complete, there was no money to pay the contractors. If we pass this bill, what protections does the solar panel salesperson have if I sell the materials to you on credit? What if you default? Under today's law, I can go to the disbursement account that you have to put in place or go after the bond. What protection is there for the materials person?

Michael DeLee:
The protections still exist under the bond. We are not proposing to change that. The difference under our proposed change would be that the construction control account is measured by anything that is not going through the

contractor. If a contractor purchases those panels and that is what the contract for development reads, that will still be required to be in the construction disbursement account.

If the developer is, for example, a manufacturer of solar panels, and some of the developers are, they will be procuring their panels from themselves or from a captive company.

Assemblyman Hansen:
I understand. You do not need the full amount in that case because, in effect, they are their own material men.

Michael DeLee:
Correct. It is interesting to contrast this to what we are seeing now, which is a shift away from projects on federal land, such as Bureau of Land Management (BLM) land and so forth. This statute does not affect those projects because you cannot go after the fee interest in the federal government. We are seeing a shift in focus to private lands, and many of those private lands are in rural areas such as parts of farms, that we would like to see continued from one generation to the next. While the wording of the statute as it provides now is for only a small lease income to that family farm, now the family farm itself is in jeopardy, because the fee interest can be attacked on a very large project when it really should not be.

By way of illustration, if you had a piece of land that might be worth $100,000, and it is going to be leased for an income stream, but the project is a $500 million solar project, and maybe only $50 million of that is for building roads and hammering panels into the ground. The construction disbursement account should really be $50 million to protect the contractors, the road builders, suppliers of concrete, and others when the power company is bringing in their own panels and furnishing the material independently, or however it is being secured through the bank and Uniform Commercial Code (UCC) filings. [Submitted table of "Management Actions for Nye County Areas of Ecological Importance" (Exhibit G).]

Assemblyman Hansen:
How many panels is 18 megawatts?

Michael DeLee:
As an example, you may have read about the rooftop solar project on the Mandalay Bay resort on the Las Vegas Strip. I believe that is a 5 or 6 megawatt project. Some of the larger projects in the rural areas are 50 or 100 megawatts over several hundred acres. The technology advances, so I am not exactly sure

how many acres per megawatt. I have been asked where the 18 megawatts came from. We needed a baseline to make sure this was understood to be a large project, so it was not going to be affecting parking lot developments and projects like that.

Assemblyman Nelson:
I presume in all of these situations the landlord or the lessor has entered into a lease. Is the landlord going to file a notice of nonresponsibility as in other sections under NRS Chapter 108, or does this bill affect any of the rights of the landlord?

Michael DeLee:
This bill would make it possible for the landlord to do exactly that. The way I read the statute and how it is being interpreted by others, it is almost impossible for the landlord to be considered a disinterested landlord because of the way the improvements work, even though at the end of the lease of a 20-year power purchase agreement, those panels or windmills are supposed to leave the property, and the land would revert to native desert. It is hard to be considered a disinterested landlord and file a notice of nonresponsibility because measuring the value of the project is what the current statute requires—measuring it from $500 million and not a $50 million value.

Assemblyman Nelson:
The landlords could file a notice of nonresponsibility, and that is your interpretation of the bill?

Michael DeLee:
If we were to pass this bill as we expect to amend it, yes.

Chairman Kirner:
Are there any further questions? [There were none.] Is there anyone in support of this bill? [There was no one.] Is anyone neutral? [There was no one.] Are there those who are opposed?

Brian Reeder, Government Affairs Coordinator, Nevada Chapter, Associated General Contractors:
We are opposed to the bill as written. However, our legal counsel has met with Mr. DeLee and the bill's sponsor, and we are willing to work toward workable changes.

Joanna Jacob, representing Las Vegas Chapter, Associated General Contractors; and Nevada Contractors Association:
For purposes of brevity, we have had the opportunity to speak to Mr. DeLee and the bill's sponsor, and we need to work on a couple of things. We are opposed as written but wanted to hear more about the intent and what they are trying to do.

Richard Peel, representing Southern Nevada/Las Vegas Chapter, National Electrical Contractors Association:
I authored the sections that are being proposed for change in this bill. There is a history why the statute came about with the current language. It was because contractors, subcontractors, and material suppliers were not getting paid for work materials or equipment they provided. Changes were made in the 2003 and 2005 Legislative Sessions. Those changes have been working. We are strongly opposed to modifying the statute. I represent the National Electrical Contractors Association, as well as a host of other subcontractors and contractors who are concerned about being paid in this state. I am happy to work with the sponsor of the bill and try to find language that might be acceptable. We would like to be included in that process.

Assemblyman Nelson:
The opponents have said they are willing to work with the bill's sponsor, but I am curious as to the nature of the opposition.

Chairman Kirner:
I think the bill's sponsor and the testimony talked about a number of issues for amendment.

Joanna Jacob:
I think Assemblyman Hansen described the issue, and Mr. Peel is correct. The reason why these statutes are here is to ensure that contractors and suppliers are paid. We were concerned with some of the problems outlined in their bill presentation about the inconsistency in the definition. When we had contractors review this, they asked what the "18 megawatt" is and what its purpose is. Another concern is about changes that will impact their ability to get paid, especially some of the bonding language. I had some suppliers of heavy equipment who were anxious about exempting some of the language in section 3 regarding the bond "not required to be funded for the cost of any material or equipment." That was disconcerting, and that is why we wanted to talk to Mr. DeLee. We are going to work with him.

Brian Reeder:
My comments are the same concerning the definition and the carve-out for materials in the bond amount.

Chairman Kirner:
Are there any other questions? [There were none.]

Assemblyman Ohrenschall:
I appreciate the contractors, the electrical contractors, and the general contractors who are willing to work with me. I think there is a way to protect the contractors and try to help the private landowners in some of our pioneer counties who are interested in developing renewable energy projects. We will work on this and, hopefully, return to you with a compromise.

Chairman Kirner:
We will close the hearing on A.B. 211. I have received information that former Assemblyman Harry Mortenson, who served from 1996 to 2010, has died. He is remembered for his career as a nuclear physicist and was the chair of the Committee on Constitutional Amendments in 2003. Let us take a moment in his memory. [A moment of silence was observed.]

We will begin the work session with Assembly Bill 72.

Assembly Bill 72: Revises provisions governing state professional licensing boards. (BDR 54-161)

Kelly Richard, Committee Policy Analyst:
The first bill is Assembly Bill 72. The bill was heard in Committee on February 9, 2015, and it allows certain occupational and professional licensing boards to issue a citation to someone if the board believes that the person has committed an act in violation of the statutes over which the board has jurisdiction. The measure specifies the types of citations which may be issued and provides an appeals process. [Referred to work session document (Exhibit H).] There is an amendment in the Nevada Electronic Legislative Information System that is not attached to the work session document. It is attached as a separate document, and I will have Mr. Mundy describe the amendment.

Matt Mundy, Committee Counsel:
After a number of conversations with our colleagues in the Office of the Attorney General, we have a conceptual amendment. This is a model citation statute for unlicensed activity that is placed in *Nevada Revised Statutes* (NRS) Chapter 622. [Read from work session document (Exhibit I).]

For the record, there are a number of chapters or boards that can issue citations to licensees, and the amendment would not affect those. Those would remain in effect and not abrogated by this amendment. [Continued to read from work session document (Exhibit I).] We believe it is important to provide that all the boards and the persons subject to the jurisdiction will be put appropriately on notice of what the law is.

If the amendment is included, everything will flow back to this statute and NRS Chapter 622, if the bill is passed.

Chairman Kirner:
There was a lot of work done on this, and a lot of cooperation between agencies. Does the Committee have any questions regarding the conceptual amendment?

Assemblywoman Carlton:
I want to thank Mr. Mundy for all his hard work on this. We are about seven-tenths of the way there. The one concern I still have is the provision of the unlicensed activity. This will allow one board to cite licensees that are regulated by a different board. We are still not protecting the individual licenses. In my 16 years in this building, the toughest fights I have seen are board issues and turf issues over who can treat whom for what, where, when, and how. If we allow certain boards to cite other licensees, it will be open season on anyone who thinks that person should be treating their patient. I have real concerns about that.

Assemblyman Nelson:
It seems as if we have heard two conflicting stories. I understood the amendment to mean the boards would only be able to cite individuals over whom they have jurisdiction. Assemblywoman Carlton seemed to look at it the other way, that the boards would have the ability to cite individuals over whom they do not have authority. I am confused.

Matt Mundy:
The bill is not a vehicle to deal with the naturally overlapping scopes of practice that exist in Title 54 of NRS. There are many different professionals who do different things, and it is not to resolve any differences between the boards as to whether or not those types of activities fall within their scope of practice. The bill simply says that if a board has reasonable belief that someone is engaging in an activity that they can regulate, or that is within their scope of practice to regulate, a citation can be issued.

For example, a licensed dentist is operating a hair braiding operation in his basement. Regardless of the fact that he is a licensee as a dentist, he does not have a cosmetology license, so the cosmetology board would be able to cite him for not having a license to perform that activity. That may not be a realistic example, but I offer it for illustration purposes.

Assemblyman Nelson:
It appears that Assemblywoman Carlton is correct in her interpretation. I received emails from a number of health professionals worried that the doctors would now try to regulate the chiropractors who will try to regulate the therapists. I wonder if that is a concern for Mr. Mundy.

Chairman Kirner:
That seems to be a policy question. Having gone through a number of sessions, I am like Assemblywoman Carlton. We know the scope of practice is always an issue. Is there anyone from the Attorney General's Office who would like to make a comment?

Brett Kandt, Special Assistant Attorney General, Office of the Attorney General:
We believe we are presenting you with two policy considerations. The first is the issue of unlicensed activity. A clear policy statement from the Committee that unlicensed activity in an area which is regulated by Nevada law, one of our Title 54 boards, is unacceptable. Unlicensed activity can pose a danger or a risk to our residents and citizens. We ask you to make a policy decision that unlicensed activity is something that is unacceptable and that you want to direct Title 54 boards to address.

The second policy consideration is, that in their enforcement of Nevada law for the protection and benefit of the public, there be some consistency among all these boards, recognizing that each of these boards is unique in the profession or occupation over which they may have oversight. In their enforcement of Nevada law, there is some level of consistency, and by having a uniform or model citation provision in NRS Chapter 622, we believe you will be promoting that consistency. Those are the two main policy questions we are asking you to consider with this legislation.

Assemblyman Nelson:
A concern from one of my constituents is the possibility of a cease and desist order. If someone who is regulated is given a cease and desist order by the board, the individual can request a hearing and appeal the order. Pending the appeal, would the law be that they are required to shut down their business? That is a big question. If a person follows the letter of the law, cease and

desist means "stop." You cannot operate your business, even before the right of appeal.

Brett Kandt:
I will let others who specialize and represent many of these boards and commissions answer your question because you are talking about the practical application of what we are proposing. I think it is important to clarify how, in practice, this would work.

Keith Marcher, Chief Deputy Attorney General, Office of the Attorney General:
I am Chief Deputy Attorney General for the Boards and Licensing Division in the Office of the Attorney General. The way we would envision the cease and desist working—and we are talking about unlicensed individuals, not people who have licenses—is illustrated in this example regarding the State Board of Nursing. If someone is practicing unlicensed activity who is not a licensed nurse, the board would send a cease and desist letter to that person. If the activity continued, that would then turn into the citation, which would then be what will be appealed and heard before the board. I do not think there is any anticipation that there is authority for them to, necessarily, shut down a business. It is more, "We caught you. You need to stop. If you do not stop, you will receive a ticket, and if you get a ticket, you can appear before the board and appeal the ticket." From that procedure, the person can appeal the matter to the district court. There are many built-in protections.

Assemblyman Nelson:
But that is not the way I read section 1, subsection 1: "If a regulatory body has reason to believe that a person has committed an act which constitutes a violation of any provision of this title," not just doing unlicensed work. Is that wrong?

Brett Kandt:
What we originally submitted to you is not what you are being asked to consider today. We are talking about an amendment in concept. What is straightforward is when you have a bill in front of you but, as your counsel indicated, we are talking about a proposed amendment in concept that would not necessarily reflect the text of the bill before you.

Chairman Kirner:
I would like to see the language of the amendment before we vote. We will hear A.B. 72 at a later date.

We will move to Assembly Bill 87.

Assembly Bill 87: Revises certain provisions governing the duties of insurers with regard to Medicaid. (BDR 57-326)

Kelly Richard, Committee Policy Analyst:
The next bill is Assembly Bill 87 and was heard on February 6, 2015 (Exhibit J). The bill was intended to clarify the third-party entities who were required to pay claims for medical care or services before Medicaid made payment on the claim. The parties met, and there is an amendment attached to the work session document proposed by Express Scripts. The amendment removes the phrase "pharmacy benefit manager" from the list of entities considered to be insurers subject to the requirements of the bill. Instead, a reference to federal statute describes those third-party entities which may be liable for payment or care of services. The Division of Health Care Financing and Policy indicated that they were willing to withdraw the amendment they had offered on the record during the first hearing on the bill and endorse the amendment submitted by the parties.

Assemblywoman Carlton:
When I see citations with letters and numbers, it might as well be algebra to me. Who is this in these citations? It says "provisions of the Social Security Act §1902(a)(25)(A), (G) and (I)."

Matt Mundy:
I will read the applicable provision from federal statute. This is from the Social Security Act and references "health insurers, self-insured plans, group health plans . . ., service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service . . . to pay for care and services available under the plan."

Assemblywoman Carlton:
I did not hear the Employee Retirement Income Security Act (ERISA) .

Matt Mundy:
It does include the Employee Retirement Income Security Act of 1974 service benefit plans—group health plans under ERISA.

Chairman Kirner:
Are there any other comments? I will entertain a motion.

ASSEMBLYMAN SILBERKRAUS MOVED TO AMEND AND DO PASS ASSEMBLY BILL 87.

ASSEMBLYWOMAN CARLTON SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

Chairman Kirner:
We are not going to proceed with Assembly Bill 173.

Assembly Bill 173: Revises provisions governing private investigators (BDR 54-758)

We will move to Senate Bill 85.

Senate Bill 85: Revises certain provisions of the Nevada Insurance Code. (BDR 57-153)

Kelly Richard, Committee Policy Analyst:
The last bill on work session today is Senate Bill 85, which was heard by this Committee last week. [Referred to work session document (Exhibit K).] This bill is from the Office of the Attorney General and it revises the definition of a "policy of insurance" to include, for the purposes of investigation and prosecuting insurance fraud, an insurance policy issued by an authorized insurer in another state that relates to property located in Nevada at the time of the alleged fraudulent act or omission or the incident.

Chairman Kirner:
Is there a motion?

ASSEMBLYWOMAN SEAMAN MOVED TO DO PASS SENATE BILL 85.

ASSEMBLYMAN SILBERKRAUS SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

That completes the work session. Is there any public comment? [There was none.] The meeting is adjourned [at 4:23 p.m.].

RESPECTFULLY SUBMITTED:

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Connie Jo Smith
Committee Secretary

APPROVED BY:

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Assemblyman Randy Kirner, Chairman

DATE: _____

EXHIBITS

Committee Name: Committee on Commerce and Labor

Date: March 11, 2015 **Time of Meeting: 1:40 p.m.**

Bill	Exhibit	Witness / Agency	Description
	A		Agenda
	B		Attendance Roster
A.B. 187	C	Assemblywoman Robin Titus	Proposed Amendment
A.B. 187	D	James T. Overland, Sr., Nevada Chiropractic Association	Prepared Testimony
A.B. 187	E	Jason D. Mills, Esq., Neeman and Mills, Las Vegas, Nevada	Medical Provider Guide
A.B. 187	F	Craig Kidwell, Attorney, Elko	Letters of Support from Brandon Fordin of Elko, Jason Pepper of Spring Creek, Craig T. Eichhorn Sr. of Las Vegas, Susan Scheinberg of Henderson, Richard Haddad of Henderson, Dora Shaffer of Las Vegas, Frank Zoccole of Henderson
A.B. 211	G	Michael DeLee, Private Citizen, Amargosa Valley, Nevada	Management Actions for Nye County Areas of Ecological Importance
A.B. 72	H	Kelly Richard, Committee Policy Analyst	Work Session Document
A.B. 72	I	Kelly Richard, Committee Policy Analyst	Proposed Committee Amendment
A.B. 87	J	Kelly Richard, Committee Policy Analyst	Work Session Document
S.B. 85	K	Kelly Richard, Committee Policy Analyst	Work Session Document