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

Seventy-Ninth Session
March 31, 2017

The Committee on Commerce and Labor was called to order by Chair Irene Bustamante Adams at 11:02 a.m. on Friday, March 31, 2017, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/79th2017.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Irene Bustamante Adams, Chair
Assemblywoman Maggie Carlton, Vice Chair
Assemblyman Nelson Araujo
Assemblyman Chris Brooks
Assemblyman Skip Daly
Assemblyman Ira Hansen
Assemblywoman Sandra Jauregui
Assemblyman Al Kramer
Assemblyman Jim Marchant
Assemblywoman Dina Neal
Assemblyman James Ohrenschall
Assemblywoman Jill Tolles

COMMITTEE MEMBERS ABSENT:

Assemblyman Paul Anderson (excused)
Assemblyman Jason Frierson (excused)

GUEST LEGISLATORS PRESENT:

Assemblywoman Melissa Woodbury, Assembly District No. 23
Senator Joseph (Joe) P. Hardy, Senate District No. 12
Assemblyman Al Kramer, Assembly District No. 40
Assemblyman Keith Pickard, Assembly District No. 22

STAFF MEMBERS PRESENT:

Kelly Richard, Committee Policy Analyst
Wil Keane, Committee Counsel
Pamela Carter, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Edward O. Cousineau, Executive Director, Board of Medical Examiners
Keith Lee, representing Board of Medical Examiners; and Nevada Association of Health Plans
Liz MacMenamin, Vice President of Government Affairs, Retail Association of Nevada
Catherine O'Mara, Executive Director, Nevada State Medical Association
Paul Shubert, Chief, Bureau of Health Care Quality and Compliance, Division of Public and Behavioral Health, Department of Health and Human Services
Clay Davis, Private Citizen, Carson City, Nevada
Joseph (J.D.) Decker, Administrator, Division of Industrial Relations, Department of Business and Industry
Chelsea Capurro, representing the Nevada Subcontractors Association; and representing Health Services Coalition
Alexis Motarex, Government Affairs Coordinator, Nevada Chapter, Associated General Contractors of America, Inc.
Rusty McAllister, Executive Secretary-Treasurer, Nevada State AFL-CIO
Nick Vassiliadis, representing Southwest Regional Council of Carpenters, Las Vegas, Nevada
Ryan Beaman, President, Clark County Firefighters Union Local 1908
Erik Jimenez, representing Express Scripts Holding Company
Shannon Sprout, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services
Damon Haycock, Executive Officer, State of Nevada Public Employees' Benefits Program

Chair Bustamante Adams:
[Roll was called and protocol was explained.] We have three bills today. We are going to start with Assembly Bill 339. Assemblywoman Woodbury, if you are in Las Vegas, please make your way to the table. Senator Hardy is here in Carson City. At this time, we will open the hearing on Assembly Bill 339.

Assembly Bill 339: Revises provisions relating to health care. (BDR 54-729)

Assemblywoman Melissa Woodbury, Assembly District No. 23:
Senator Joe Hardy is my cosponsor on this bill, as well as Keith Lee—representing the Board of Medical Examiners—and Edward Cousineau, the Executive Director of the Board of Medical Examiners. We are here to present Assembly Bill 339 for your consideration. We have submitted a mock-up proposed amendment 3342 (Exhibit C) to Assembly Bill 339 for the Committee's consideration. With the Chair's permission, we will be speaking from the mock-up for today's hearing.

Assembly Bill 339 makes various changes to the administrative requirements of the Board of Medical Examiners and its licensees. Section 1 relates to health care records. It authorizes the Board of Medical Examiners to take possession of a licensee's records in the event of the death, disability, incarceration, or other incapacitation leaving the licensee unable to continue to practice. This amendment deletes section 2. Section 3 requires the Board to adopt policies and procedures relating to the placement of information on its website.

A new section 3.5 clarifies that each applicant for a license must submit a copy of a complete set of fingerprints to the Board. Under existing law, an applicant with a license in another state must provide the Board with a description of any complaints filed against him or her as well as any disciplinary action taken in other jurisdictions. Section 4 specifies that anonymous complaints, which were not considered or investigated by other boards and complaints that did not result in disciplinary action do not need to be reported on a licensure application. Section 8 makes the same changes for reports of licensees to the Board during the biennial registration process.

Section 5 provides the Board with discretion in determining whether to impose a fine for failing to provide the Board with a current mailing address. Section 6 changes all references in the statute relating to inactive status from inactive registrant to inactive licensee. Section 7 makes a clarifying change related to the validity of a renewed special volunteer medical license.

The new section 8.5 and section 10 relate to the reporting of sentinel events. The reporting requirement to the Division of Public and Behavioral Health is removed, as is a requirement that a licensee submit a report when a license is renewed, even if no surgery was performed. That concludes my introduction, and with your permission, I would like to turn it over to Senator Hardy to give further explanation of the bill.

Senator Joseph (Joe) P. Hardy, Senate District No. 12:
First, I want to say I appreciate Assemblywoman Woodbury's carrying this bill. The genesis of this bill comes from real life situations when doctors or landlords have closed or locked physicians' offices and not left access to the patient records within. What happens to the records that are Health Insurance Portability and Accountability Act (HIPAA) compliant? What happens to patients' records if the doctor is arrested and the records are locked up in the

office? These are real issues that have already happened, and one of the primary reasons we brought this bill forward. The other reason had to do with the Board of Medical Examiners, as part of their efforts in continuing education in the last year, presented various ways in which we could do better, stay out of trouble, and provide better care to patients.

The Nevada State Board of Medical Examiners had 87 complaints, 62 of which were found to be without merit. Each of those 62 complaints, however, were determined to be "an investigation." The Nevada State Board of Medical Examiners defines "investigations" on page 7 of its application guide, which states:

> If you have *ever been notified* that you were under investigation by any medical licensing board, hospital, medical society, governmental entity or any other agency, whether or not you were charged with or convicted of any violations of a statute, rule, or regulation governing your practice as a physician, you should answer affirmatively to question 31 and submit the appropriate documentation.

Question 31 asks, "Have you EVER been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of a violation of a statute rule or regulation . . . ?" It mirrors language that we already went over. Sixty-two of those 87 physicians would thus have had to check a little box that they had been investigated—and they would have to do so for the rest of their professional lives—even though those complaints were thrown out or found to be without merit. That was one of the other things that came about.

Working with the State Board of Medical Examiners and their representatives has been a pleasure because we are all trying to solve problems that will still allow doctors to come into Nevada, stay in Nevada and still have a quality of care that the Board of Medical Examiners can be responsible for.

The mock-up (Exhibit C) is a wonderful piece of work that, I believe, helps clarify some of the concepts in the bill better than the bill did. For instance, section 4, subsection 4 says:

> An applicant for a license to practice medicine is not required to submit: (a) An anonymous complaint or a complaint from an unknown source that the licensing board of another jurisdiction refused to consider or investigate; or (b) A complaint filed against the applicant that did not result in any disciplinary action taken against the applicant by the licensing board of another jurisdiction.

That language is mirrored in section 8, and that is the extent of the objectives I was initially working with. The Board of Medical Examiners added additional provisions to the bill. I am open to any questions the Committee may have. Otherwise, I will turn it over to Keith Lee and Ed Cousineau, who are the actual experts on this topic.

Chair Bustamante Adams:
We are going to go straight into questions. I think the mock-up helps to answer many of the questions about what you are trying to accomplish. We are going to start with questions about section 1, which has to do with health care records.

Assemblywoman Jauregui:
With your permission, I have a couple of questions. I believe this bill is about trying to give the Board access to medical records. What happens to the medical records now if a doctor dies?

Senator Hardy:
I have an expert who is going to answer that question.

Assemblywoman Jauregui:
Does this bill, in any way, violate HIPAA rights, and can patients opt out of this to have their records shared?

Edward O. Cousineau, Executive Director, Board of Medical Examiners:
I will answer your question about what happens to records first. I am not sure if you are aware, but by statute, medical records are required to be maintained for at least five years beyond the date of production. This bill addresses circumstances where licensees end up passing away or becoming incarcerated or incapacitated. As of now, we really have no mechanisms that afford us the legal authority to come in and take temporary possession of patients' records. We do not want to take permanent custody. We do not want to become the records' custodians, but we do want to get those records to a secure place where we can either farm them out to a third-party vendor, who specializes in record retention and dissemination, or keep them for a finite period and, hopefully, find a new practitioner that might be willing to take those records.

This is what currently happens: I periodically receive calls, usually from an individual whose mother or father was a doctor who has passed away. The individual tells me they have all the records in the medical office, but they do not know what to do with them. Currently, unless the state or someone else is willing to be benevolent and take the responsibility of sending those records on, there is no one there to do it. We try, on a case-by-case basis, to work it out. This bill would give the Board the authority, again, to take possession for a finite period and ensure the records are properly disseminated to the patients who request them.

As far as your second question about HIPAA, the Board is a health oversight entity and already has an exclusion carved out under federal law. I do not think this would be a problem, as long as it is done for a lawful purpose.

Assemblywoman Jauregui:
Can patients opt out of this if they do not want their health records going to anybody else other than the doctor who had them? You said you could give them to the possession of another doctor who is willing to take them. Can patients opt out of this?

Edward Cousineau:
I do not think that has been contemplated, but I think if patients were to specifically speak to that, they probably could be. I think you will notice there is an indication in the proposed language that the new doctor has to receive an acknowledgment from the patient when they initially establish a relationship, so that might be a consideration. As you are also aware, the bill allows the Board to adopt regulations relating to this section. That is probably something we could contemplate according to regulation.

Assemblyman Kramer:
Something similar happened in our family. The health maintenance organization (HMO) that we belonged to went bankrupt and went out of business, and our next doctor was never able to gain access to those records. The examples you have shown here do not include a doctor going out of business, so what happens to patient records when a doctor goes out of business? Could that situation also be included in this bill?

Edward Cousineau:
That is not specifically enunciated, but I think there is catchall language in the bill that would allow for that and would protect patients any time one of our licensees is in a circumstance where records are not able to be provided to patients who request them. We have already allocated funding—with the hope that this legislation passes—to get records out to a third party who can provide the records to patients immediately. Again, we do not have specific language relating to an HMO or a physician going out of business, but I think that is part of our consideration, and I believe we would have that availability.

Assemblywoman Neal:
I have a question about the catchall language. If another doctor picks the records up, are they just functioning as a custodian of the records, or are they allowed—as in Assemblyman Kramer's instance where the provider went out of business—to then be given a chance to rediagnose the patient or continue care? What is the relationship outside of custodianship?

Keith Lee, representing Board of Medical Examiners; and Nevada Association of Health Plans:
What the language in section 1 allows the Board to do is take control of medical records of a physician who has closed his office, is incapacitated, or has passed away. Whatever happened, the doors are closed. In any of these cases, the Board takes control of those records, but they are still subject to direction of the patient. Say, for example, we have the records of a physician who has passed away. The patient or third-party vendor will direct us to send the medical file to Doctor So-and-so who will be the new doctor.

Obviously then, all the Board does is take the records and, subject to direction from the patient, send them somewhere. We are presuming that the new physician who receives those records has the authority and will do whatever he or she thinks is necessary to diagnose and continue treatment of the patient. We do not interfere with the doctor-patient relationship. All this bill is intended to do is to allow us to get those records, because oftentimes, they are behind a closed door and no one has legal access to get in to get the records. This gives us the legal authority to get those records and do something with them.

There was a case in Reno several months ago where a physician was arrested, and no one knew what to do with his records. Together with third-party payers and others, we were trying to figure out how to make sure the records were safeguarded and that they were sent to another physician at the direction of the patient.

Assemblyman Ohrenschall:
In that same vein, we have a pain-management physician in his nineties down in Las Vegas who is a defendant in a federal criminal trial. The way our criminal justice system works, he is innocent until proven guilty. He is fighting to be acquitted. I am concerned about the word "incarceration" on page 2, line 4, of the bill. I assume that you mean postconviction, and that you do not mean incarcerated in a county jail where someone could post bond, go to trial, and try to fight the charges and still prove their innocence. I am assuming you would not want to take over the doctor's practice if they are still trying to fight to clear their name.

Edward Cousineau:
We have circumstances where licensees who have been accused of criminal wrongdoing have not been able to post bail, and they are incarcerated. It does not necessarily happen postconviction; it can happen prior to actually going to trial. Perhaps the language needs to be broadened—maybe we can do that through regulation—but I believe that includes pretrial and preconviction. We currently have a licensee who I believe is under that circumstance.

I am aware of the doctor you are talking about in Las Vegas. He was convicted in federal district court last week, and we have been in correspondence with his attorney this week. We are trying to determine how we are going to work out this issue. We think A.B. 339 would be a really good step to address these considerations and give us legal access. We are not going to try to push ourselves upon individuals if they have a plan where a partner or another practitioner is willing to take on that responsibility. That happens in most circumstances, but we want to have this tool available if the circumstances warrant it.

Assemblyman Ohrenschall:
We have been so busy here at the Legislature I did not realize the trial had ended and they had handed out a conviction against that doctor. I would hope that, in most cases, the Board would wait until there is or is not a conviction. I can understand if someone is incarcerated and pending trial, and they do not have anyone to turn their practice over to, which would become an issue. I would hope, however, that in most cases, if they have some kind of a safety net for their practice, they would have the benefit of waiting while they try to clear their name.

Edward Cousineau:
I just want to be clear; we are not trying to seek the authority to just grab records. The Board only comes into the picture when there is no alternative available. It is not our desire to have the authority to barge in and grab records. As I said before, we really do not want to be records custodians because that is not our business. Again—under unique circumstances—we want to have the ability, mainly to ensure that patients related to the licensee are able to maintain a continuity of care.

Assemblywoman Neal:
I have a follow-up question. As far as "incarceration," once you become the custodian of the records, whether temporarily or long-term, does that allow you to answer subpoenas? If the patient is a defendant in the case against the doctor who is incarcerated, does it allow you to pass over records to the attorney for the incarcerated doctor—records that he or she may or may not have wanted to share with the doctor?

Edward Cousineau:
We do that any time we receive a court order that would require us to turn over records. I do not think it would be any different whether it was the Board who was in possession of the records or if it was the licensee or another entity. I think that was a bifurcated question, and I am not sure if there was a second part there, but we have to comply with any lawful mandate from a court.

Assemblywoman Neal:
It was a two-part question, and it may have been fuzzy. It sounds as if the doctor who is incarcerated still has his rights as a defendant or plaintiff. If the Board has the ability to transfer or move records—because the Board is now the custodian—it seems to me that you are substituting, or able to substitute, a legal decision that the doctor and his attorney may make in regard to discovery. Am I correct in my understanding? That is what I am wondering about; how far or how deep does this go?

Edward Cousineau:
There is a requirement in statute—and that is why we are trying to lodge this in NRS Chapter 629—that talks about records retention and dissemination. There is a litany of individuals who can lawfully request records. Whether the licensee who the records belong to is incarcerated or not, I do not believe that dispenses with the requirement that the records be released under NRS Chapter 629 when a lawful individual or a representative of that individual— meaning a patient—is requesting them. I do not believe a criminal proceeding would impact the legal requirement for the record dissemination where appropriate.

Assemblyman Ohrenschall:
Perhaps I am beating this point to death, but let us say the Board has to go and take over the practice. The doctor is arrested and pleads not guilty, and then he is acquitted or the charges are dismissed. In that scenario, is the doctor able to get his records back and return to practice?

Edward Cousineau:
Yes, as long as the doctor's capacity is in place. Our intention—or at least my intention as an executive—is to access the records short-term and then get them to a third-party vendor who specializes in this. Once the licensee is no longer incapacitated, I believe they would have a right to the records. That is something that the third-party vendor would handle—and they are taking custody for a finite period too. Everybody needs to understand, in the big picture, the requirement for records-retention is only five years. Many of the records that may have been maintained may no longer be required to be maintained depending on the length of incarceration, et cetera.

Keith Lee:
I would like to expand on that and add clarity. This bill is not meant to penalize, nor is it in any way trying to affect the doctor. If the doctor still has a license to practice, we have not suspended it or taken action against him, and he is not incarcerated, then presumably he is going to continue his doctor-patient relationship. The patient may decide to change doctors—and that is certainly the patient's right to do so—but we are talking about a situation where the records are locked up. We are talking about what is in the patient's best interest.

We ran into an issue in the Reno case, because patients wanted their records sent to another doctor. One of the first things a doctor will ask in these instances is if another physician is currently seeing the patient. If the answer is yes, the doctor will want to see the patient's records. The patient then signs the appropriate HIPAA form to authorize their records being sent to the new physician—but in the Reno case, the patients did not have access to the records. Assembly Bill 339 intends to allow us to get access to the records and process them at the direction of the patient. If the patient still wants the records to stay with the physician and the physician comes out of incarceration and still has a license to practice medicine, then that record will go back to the physician—who is no longer incapacitated or incarcerated—if that is the patient's desire. The process is driven by the patient's desire in the situation for good continuity of care.

Chair Bustamante Adams:
This is great information to get on the record to make sure we understand what the bill's intent is. Moving on, it looks like section 2 is deleted.

Assemblywoman Carlton:
One of the things you learn in this building is that it is not what is in a bill; it is what is being taken out of the bill that can be just as interesting. I am trying to understand the thought process behind removing section 2, and all the delineated language that goes from line 10 to line 40 on page 2. Then, in section 3, you added, "The Board shall adopt policies and procedures for placing information on its Internet website." Years ago, it was very difficult to get information on the Board's website. I remember a number of the discussions that were had when I was still in the Senate when a number of issues came up about having certain information available on the website. I am concerned that things, such as reports, are being eliminated.

Most concerning to me is the sentinel event language on page 2, line 31 of the mock-up that the Legislature discussed and debated for many years and finally hashed out. In the interest of public safety, we decided we wanted to know what sentinel events were occurring. I need to understand the thought process as to why the Board wants to get rid of public disclosure and public information.

Keith Lee:
The answer is that we are not getting rid of any public disclosure or any of the information we receive from physicians with respect to the various types of sedation, nor for sentinel events. With respect to sentinel events and the various states of sedation currently listed in NRS 630.30665, the reporting requirement of the physician to the Board of Medical Examiners remains the same. All we are deleting in section 2 is the requirement to forward that information to the Department of Public Health.

We spoke with Director Whitley and Paul Shubert, who is the Bureau Chief of the Division of Public and Behavioral Health in Las Vegas. I will not purport to speak for the Department, but it seems that the information the Board gathers from our licensees is not of any value. The Department of Health and Human Services looks at sentinel events with respect to facilities, and there is no link-up between a licensee who reports a sentinel event and the facility it occurs in. The Board of Medical Examiners will still gather that information. That information is still available to us and may very well be used in any investigative process that is commenced against a physician. We are not doing away with the necessity of the physician to report that information to us; all we are asking is that we no longer have to forward that information to the Department of Public Health, because we have been advised it is of no value to them.

Assemblywoman Carlton:
Is it reported to anyone? Gathering information is great, but if nobody knows it exists, it does not do us any good.

Keith Lee:
Under current statute, that information has to be forwarded to the Governor and to the Legislative Counsel Bureau (LCB). That is forwarded already.

Assemblywoman Carlton:
Page 2, line 22, says, "On or before February 15 of each odd-numbered year, the Board shall submit to the Governor and to the Director of the Legislative Counsel Bureau . . . ." That is delineated, deleted language from section 2 as well.

Keith Lee:
Let me explain, if I may. Section 2 deletes the amendment to NRS 630.130 that was suggested in the original bill.

Assemblywoman Carlton:
I do not have the original bill. All I have is the mock-up, and it is really difficult to have to work from this. Working from the mock-up, we would not have known that. Just give me reassurance that information about sentinel events is still going to be reported, and it is still going to be available to the public.

Keith Lee:
It is still being reported to us. It is still available to the public, and it will still be reported to the Governor and LCB by February 15 of each year.

Assemblywoman Carlton:
However, this information will not be on your website.

Keith Lee:
We are trying to expand, not restrict, the information on our website through the language in the bill. We are suggesting that the Board adopt policies and procedures by which information will be posted. Current law says that information can be posted upon recommendation of the Executive Director and approval by the Board. The Board only meets quarterly, so if information that should be posted on the website comes the Monday following our quarterly meeting—which is held on a Friday—then we have to wait three months in order to get approval to post that information on the website. What we are suggesting by this change is that the Board will adopt policies and procedures that will allow a process by which we can post information on the website in a timely fashion.

Assemblywoman Carlton:
Maybe it is just because it is Friday and it has been a very long eight weeks, but in looking at section 2 of the original bill, you are deleting language. Is this a double negative that I am trying to figure out?

Keith Lee:
In the initial bill, in section 2, we deleted the provision about reporting different types of surgeries, et cetera. In the mock-up, we are deleting section 2 in its entirety. We are not amending NRS 630.130 in any way; it remains the same. The mock-up shows that we are no longer amending NRS 630.130.

Assemblywoman Carlton:
I will discuss it with legal, because when you put a line through existing language you are deleting it. Help me, Mr. Keane.

Wil Keane, Committee Counsel:
I created this mock-up, and what I can say is this: Subsection 2 (c) was deleted in the original bill—all of the reporting in NRS 630.30665, which we will be getting to later in the mock-up. I was directed to remove section 2 entirely from the bill. I know the way mock-ups are set up can be confusing, but by removing section 2 entirely from the bill, we are essentially not going to be deleting subsection 2(c). Therefore, that reporting requirement

will still be in place. We deleted some other parts of the reporting later on—which I am sure Mr. Lee will get to— but the lines through this particular section in the mock-up means we are going to take that section out of the bill. Those changes will not be made, and existing statute will remain the same for that particular section of NRS.

Assemblywoman Carlton:
Okay, because when you look at it logically, you are deleting language out of section 2. This makes it look like you are deleting existing language.

Wil Keane:
I agree that it does look that way, and I think that mock-ups can be confusing. When the decision is made not to make any change to an NRS section that is in a bill, the mock-up will just show the whole section as being removed from the bill. I understand that it makes it look like you are deleting the whole section from NRS but, in fact, you are deleting it from the bill.

Assemblywoman Carlton:
That is one of the problems that I have with working from a mock-up when you think you are working from the bill, and I will have more questions when we get to section 8.

The new language in section 3, subsection 2 states, "The Board shall adopt policies and procedures for placing information on its Internet website." I have concerns that we may have no control over that. We do not know what the Board will put on the website. It is not very friendly to the public, and the public has had concerns about the Medical Board's website, so I just want to make sure that we still make available to the public what they would like to have. This was a big issue about eight years ago with a couple of cases that happened. Whenever you give a board too much latitude on what information they will provide, you have no hammer to ask for other information, and that is what we make our decisions on at the Legislature. I am concerned about that. That is why the Legislature delineated what we wanted the Board to do.

Keith Lee:
We are not changing that. If you look at section 3, subsection 3 of the mock-up, those mandates concerning what shall be on the website have not been removed. Those mandates are still there. In fact, I would suggest that the amendment we are proposing—changing physician to licensee—expands more information to be placed on the website. Licensee includes not just physicians, but physician assistants, respiratory therapists, and perfusionists, all of whom are licensed by us. We are expanding information with respect to our other licensees, not just physicians. We are not removing or suggesting that any of the mandatory language of what shall be on the Internet website be removed. All we are talking about is the procedure by which it gets there.

Under current language, the Board has to approve that at its next regularly scheduled meeting. We only meet quarterly, and as I said, we meet on a Friday. If the following Monday we discover information that ought to be posted on the website, we cannot post it until the next regularly scheduled meeting. What we think we are doing by this amendment is, in fact, making it more timely to put information on the website and to expand the information that would go on the website with respect to additional licensees under NRS Chapter 630.

Assemblywoman Carlton:
It was my understanding that the Executive Director could make these adjustments, because they are the day-in-day-out person. Are you saying the Executive Director cannot do that?

Edward Cousineau:
Yes, I do the day-to-day functions. I am going to be honest with you; this law is something that is not tenable. It has not been tenable or practical for years. We receive information every day which needs to be updated on the website, whether it is a formal complaint filing, summary suspension filing, press releases, urgent notices, et cetera. The law put in place in 2003 was in response to concerns by the Legislature that the Board—and administration for the Board—was not being transparent enough as far as what information they were putting on the website. The specifics that are spelled out and the language that is used comes from 2003. As Mr. Lee said, we are trying to make this requirement realistic. I cannot do my job. We cannot properly give notice to the public—and our licensees for that matter— as to what has transpired with matters that are very relevant and need to be timely placed. The way the law reads, as Mr. Lee stated, I would have to wait for an entire quarter, and then have an agenda item for numerous matters that would need to be approved. That is not the reality and that is not how it has been applied for the last several administrations. I am coming to you, and I am being honest with you that we need to get this changed, because we are not in compliance with the law. At the same time, we cannot accomplish our legislative function if we were to abide by the letter of the law.

Assemblywoman Carlton:
I just have a real trust issue when it comes to this Board. When you have been burned once, you are very careful not to get burned twice.

Edward Cousineau:
I would also point out that if we do adopt regulations, we would have to go through the legislative adoption process, and ultimately the Legislative Commission would vet anything that we were trying to push forth.

Chair Bustamante Adams:
Are there any questions on section 3.5? I think this is where you want to expand to include other people aside from doctors. Is that correct?

Edward Cousineau:
That is correct.

Chair Bustamante Adams:
Tell me what NRS 630.167 does, even though the bill does not list it.

Edward Cousineau:
That is our fingerprinting statute.

Chair Bustamante Adams:
Are there any questions on section 3.5? [There were none.] Are there any questions about section 4?

Assemblywoman Jauregui:
Section 4, subsection 4 says, "An applicant for a license to practice medicine is not required to submit: (a) An anonymous complaint . . . that the licensing board of another jurisdiction refused to consider or investigate; or (b) A complaint filed against the applicant that did not result in disciplinary action taken . . . ." Why are we adding that in? Why would we not require that? As a patient, I would want to know if somebody filed a complaint against a doctor, whether or not there was disciplinary action taken. What is disciplinary action?

Senator Hardy:
Periodically, believe it or not, there are unhappy people who call up and claim that a doctor did something to them, and the doctor either did not do it, or what the doctor did was not egregious enough to warrant any disciplinary action. Mr. Cousineau talked about 87 complaints, and 62 were found not to be compatible with going forward. There are issues that occur that doctors do not have a defense against, because they did not do anything.

Assemblywoman Jauregui:
Why can we not add something to say that a complaint was filed but no action was taken, so we are not omitting the information? That way, the information is still there, and we are not just sweeping it under the rug.

Senator Hardy:
The way the application is structured, doctors would still be making that check mark every single time they applied to anything that they were "investigated for in the past." This bill changes that, so doctors are not considered "investigated" for something that either did not happen or was not appreciably indicative of any malpractice.

Assemblywoman Tolles:
I want to follow up on Assemblywoman Jauregui's question. Would this language also pertain to, for example, online forums that may not elevate to the level of investigation? I am thinking of a Yelp review, a medical records forum, or online chat. Would this apply in that regard?

Senator Hardy:
I am over 65, and I do not have a clue what you are talking about.

Edward Cousineau:
I think I understand what you are saying, which is there might be some negative comments about a licensee on one of the rating sites. Right now, when the Medical Board receives a complaint against a licensee, we look for two things. First, if it is one of our licensees, and if the allegations as alleged are true, we look to see if it is a violation of the Nevada Medical Practice Act. If so, we initiate an investigation.

What Senator Hardy is hoping for in section 4, which addresses new applicants to the state—and section 8, which addresses individuals who are licensed in the state and are renewing and responding to the last two-year look-back—concerns cases that resulted in no finding of wrongdoing. Whether the claims are retaliatory or an individual feels they are aggrieved and it is later determined by the Board that they were not, licensees will not have to make a report as to these investigations or complaints that came to the Board.

I do not want to speak for Senator Hardy about his position on several people that he has interacted with, but false claims really cast a negative light on the individual, and it is something they carry with them for perpetuity. Again, our applications for licensure and our renewals are public records. When there is a yes, while we do not provide the explanation to the individual who might be requesting it as a matter of public record, there still would be that yes. I believe the concern is that a licensee could have multiple complaints brought against them over the course of their career where there was no merit. If that information is disclosed, it tends to cast the licensee in a negative light. We are trying to negate the need for reporting where there was no finding of wrongdoing or initiation of formal disciplinary action related to the complaint.

Assemblywoman Tolles:
Can we go back to the beginning of the section and get a little more background? I know this is not part of the mock-up or the changes. Section 4, subsection 1, says, "In addition to the other requirements for licensure, an applicant for a license to practice medicine shall submit to the Board information describing: (a) Any claims made against the applicant for malpractice, whether or not a civil action was filed . . . ." That is obviously self-reported, and I would imagine under penalty of perjury if it were falsified. Are there other ways by which we check complaints from out of state, other than just what is self-reported by the applicant? Please forgive me if I missed it in some of the corresponding chapters.

Edward Cousineau:
Yes, there are several ways we can do that. The language in section 4, subsection 1(a) is basically something that is required by statute if an individual is licensed in this state. If an individual is applying for licensure as in this section, we expect them to disclose that. The exception that is being carved out here does not include civil court filings under the new language in paragraph 4. We would still request and require that malpractice claims that emanated from other jurisdictions they may have been licensed in would be reported, and we certainly investigate those claims prior to licensure.

Assemblywoman Neal:
Section 4, subsection 4(a) talks about transferring information to another jurisdiction. In the mock-up, you crossed out the word "state." The first thing that came to my mind, of course, was the Interstate Medical Licensure Compact, Senate Bill 251 of the 78th Session. The final rule allowed the member boards to report a nonpublic complaint and disciplinary or investigatory information. Therefore, investigatory information does not necessarily indicate whether it was anonymous, nor does it indicate whether the Board chose to pursue it; it seems like it is broad enough to capture the language you are excluding in this current bill. Since you struck out "state" and broadened the language to "jurisdiction," I want to have a discussion around that and see what the impact of that is.

Edward Cousineau:
The reason that language was changed was simply because "state" would have limited it to states in the Union. We also have territories such as Guam and Puerto Rico who issue medical licenses, so the change was intended to capture territories as well as states. I do not believe the language as written here would have any impact on the sharing of information under the Interstate Medical Licensure Compact.

Assemblywoman Carlton:
I am going to work from the original bill, so that I understand. If I am wrong, you can point me in the right direction because I am having a hard time. You can tell I grew up in the era when we did not use mock-ups; we had a pencil and a piece of paper and we marked it up.

Section 4, subsection 1(a) of the original bill says that the current standard is ". . . any complaints filed against the applicant with a licensing board of another state and any disciplinary action taken against the applicant by a licensing board of another state." That is the current standard, which we are changing—and I believe this is a significant change. We are deleting the word "and" and we are putting in "that resulted in" any disciplinary action. We will no longer receive disciplinary action reports from people as we currently do. If there was any type of discipline, no matter what happened with it, we are currently aware of that because that is the standard. This will change that standard. Yes or no?

Keith Lee:
No, it will not. If disciplinary action has been taken against a physician in another jurisdiction and that physician is applying for licensure here, he or she must report that disciplinary action. This bill does not delete the responsibility of the applicant to inform us of any disciplinary action taken by a licensing board of another state.

Assemblywoman Carlton:
Then why change the language? What are we fixing?

Senator Hardy:
If there was a complaint filed but there was no disciplinary action—in other words it did not have merit—then the person does not have to report that, whether it was from Guam or Puerto Rico or any of the states.

Assemblywoman Carlton:
Let me expand on that. Currently, we get the complaints, and we get the disciplinary actions. This will eliminate the complaints, and we will only get disciplinary actions. Am I on the right path?

Keith Lee:
The changes that are being suggested in section 4, subsection 4, only refer to anonymous or unknown complaints. Those would not be required to be reported.

Assemblywoman Carlton:
I will have to work through this more, and I will sit down and talk with legal and go through this, but I have some concerns. We fought for years to be able to get this information. I want to make sure that we still have the information available to patients when they are trying to figure out what is going on.

I am not sure I agree with the anonymous aspect; I think there might be other professionals who do not want to have their name associated with the complaint—I do not think it is just patients. I think when you use "anonymous" that would include a possible medical director, a pharmacist, a nurse, or a therapist who may not, as a professional, want their name associated with the complaint for whatever reason. I can understand a patient, but when we get in to the other side, I am not sure about that. If you had a number of anonymous complaints on the same doctor, I think you might want to start looking for a pattern, and I just have some concerns about that.

Assemblyman Daly:
If someone makes a complaint, anonymous or otherwise, does the Board investigate it?

Edward Cousineau:
We do not currently investigate anonymous complaints. The complainant is confidential by statute, so the name would never be disclosed. It is our position that if a person is not willing to put his or her name to a complaint, then their complaint is lacking. Just so you are aware, when we receive a complaint, we immediately submit a confirmation letter indicating that indeed we have assigned it to an investigator.

Sections 4 and 8 talk about other jurisdictions; they are not talking about Nevada. We are talking about individuals licensed in other jurisdictions coming to Nevada. Section 8 talks about renewal, and we will already know about complaints that originate in Nevada. We are still only concerned about other jurisdictions where this may have occurred.

Assemblyman Daly:
As I understand it, the Committee and others would feel more comfortable if you were investigating a complaint, regardless of where it came from. I understand people can submit anonymous complaints because they want to tarnish someone's reputation or because they know the person is going to have to check the box saying they have been investigated. If you do not investigate the complaint to ensure there was nothing there and those anonymous

complaints just get ignored, there may be reasons as to why people would not want to put their name on it. I think you have to look at that. I think the complaint should be investigated, anonymous or not. Maybe you will not find anything, but I think it hurts your argument about what you are trying to eliminate from future reporting if you are not investigating every complaint, anonymous or not. I think it hurts your argument, and that is why I asked the question. I was trying to give some comfort to some people, but your answer did not help me either. If you are not investigating anonymous complaints, I think that is a problem, not having to report them.

Chair Bustamante Adams:
We are going to move on to sections 5 through 8 because we have two other bills to hear today.

Assemblywoman Carlton:
Will sentinel events still be reported? To whom will they be reported, and how does the public access them?

Edward Cousineau:
Yes, they will still be reported. The 14-day requirement is going to exist for our licensees when a sentinel event involves a surgery with conscious sedation or general anesthesia. In most instances, when we receive those reports, we initiate an investigation at the Board level. I am not sure if this is really clear, but 95 percent of the individuals who have to report during the renewal cycle do not engage in surgeries, much less ones that involve conscious sedation or deep sedation and are performed outside of hospital facilities. If there is a sentinel event attached to the complaint, very few of our licensees would even meet the threshold requirement for reporting procedures. In section 8, we deleted the language that required applicants to report sentinel events whether they did or did not perform these procedures. We will still keep the positive reports where licensees have done the procedures, whether it involved a sentinel event or not. Those statistics will be provided to the Governor's Office and LCB. These are not currently a matter of public record pursuant to statute, and we are not changing that either.

Assemblywoman Carlton:
Mr. Keane and I are going to have to spend some time on this bill, because it took far too long for this body to make this issue portable. The last thing I want to do is have it not work for the public anymore. I do not want to see former Senator Leslie coming down the hall, looking for me on this issue. I have fear in my heart. I am going to need a lot more information on this. There is something about this—and I cannot quite put my finger on it but I will, when I am a lot brighter on Monday or Tuesday—that gives me a lot of concern about information that we will no longer be providing. Are we going to store information somewhere where it will be harder for people to find? We are supposed to make our decisions based on information, and if we do not know it is out there, how do we even know it exists?

I am going to be gone in a few years and a lot of the new people in this building are not going to even know that we do this. If the information is not in front of them, they are not going to think to go look for it. I have concerns that this will gradually be whittled away, and I think it is a very important component. These are very important events, and it took a long time to get to this point. We are still not there yet, and it seems like we are going backward instead of forward. I will sit down with Mr. Keane, and I will go through the bill and make sure I understand it at a better level before we get to the point of possibly processing this bill.

Chair Bustamante Adams:
It is important that we have these discussions, and we have the institutional knowledge with us.

Assemblyman Daly:
I have a question about section 8.5. I thought I heard Assemblywoman Carlton ask a question about it. When you are taking the language out in subsection 2, where is it required to still be reported? You said it is still going to be required. Is it somewhere else in statute? Where is it?

Keith Lee:
Referring to the mock-up beginning in section 8.5, subsection 1, it says:

> The Board shall require each holder of a license to practice medicine to submit to the Board, on a form provided by the Board, a report stating the number and type of surgeries requiring conscious sedation, deep sedation or general anesthesia performed by the holder of the license at his or her office or any other facility, excluding any surgical care performed: (a) At a medical facility. . . or (b) Outside of this State.

That is current law and that is not being changed. Current law requires a licensee who performs those types of procedures to report to the Board. Referring to page 8, line 26 of the mock-up, it says:

> The Board shall require each holder of a license to practice medicine to submit a report to the Board concerning the occurrence of any sentinel event arising from a surgery described in subsection 1 within 14 days after the occurrence of the sentinel event. The report must be submitted in the manner described by the Board.

That is current law; we are not changing that. That is the surgical sedation and the sentinel event results from the surgical event. The current law requires that we collect and maintain reports received and that we ensure reports and any additional documents created by the reports are protected adequately from fire, theft, loss, destruction, et cetera. Except as otherwise provided, a report received is confidential and not subject to subpoena or discovery. That is already the current law; we are not changing that. All we are attempting to change by the deletion of section 8.5, subsection 2 and old subsection 5(c) is

the current requirement to report that information to the Department of Behavioral Health. Our understanding is that the information we submit is of no value to them. It does not help them link up their responsibilities to health care facilities regarding sentinel events. That is all we are asking to change.

The other point I want to make for clarity of the record is that current law requires that all physicians report to the Board. As Mr. Cousineau said, 95 percent of our physicians do not perform the type of surgeries referred to in subsection 1, which can result in the sentinel events described in subsection 4. Right now, they have to fill out a form that says that they did not perform those procedures. All we are asking is that doctors only have to report on sentinel events if they perform certain procedures. One of the practical matters we find is that when many physicians go in for the renewal period, they do not fill that form out even though they have to. We then have to circle back with them, and sometimes this causes a delay in issuance of the renewal of the license, because the doctor forgot or was unaware of the responsibility to submit a negative report. All we are suggesting is that licensees should not to have to file a negative report saying they did not do any of this; only those physicians who perform the acts in subsection 1 and 4 should have to report.

Assemblyman Daly:
That was what I was looking for; to find out what it is we are doing if that other language is for another body that does not need it. The Department of Health and Human Services can come up and defend themselves if they do need that information. I hope we will get some additional clarity around this issue.

My final question is about section 10 of the mock-up. You previously suggested the repeal of NRS 630.30665, and now you are not repealing it, but you are still proposing to delete it in this section. Is it supposed to be deleted in that section, or is that an oversight?

Keith Lee:
I will defer to my friend and colleague Mr. Keane, who was so helpful in drafting this mock-up. I understand the reason this may be deleted now is because that section refers only to confidentiality of information. Since we are no longer deleting NRS 630.30665, we do not need to have that included in this particular section. I defer to Mr. Keane for a far more detailed and better explanation than I can give you.

Assemblyman Daly:
I ask because the red strikethrough is language in the original bill as well as section 10.

Keith Lee:
I apologize for that. Section 10 is talking about the Department of Health and Human Services. Since the Department will no longer receive that information under NRS 630.30665, it just has to be deleted.

Assemblyman Daly:
Are you saying that other people are not going to receive the other reports we just talked about?

Keith Lee:
The Governor and LCB will still receive the reports.

Chair Bustamante Adams:
We are going to go ahead and move into testimony in support of A.B. 339.

Liz MacMenamin, Vice President of Government Affairs, Retail Association of Nevada:
I come in support of this bill, especially section 1. I was very involved in a crisis within the northern Nevada community a year ago in April, where more than 800 patients could not access their medical records and were left without a way to continue their care. Section 1 will enable the Board to be able to step in and access those records.

Oftentimes continuum of care is vitally important to patients with chronic diseases. The community came together, and we started looking at ways we could address this issue in the future. I think this was the first time northern Nevada had experienced this kind of crisis and interruption in the service of patient care for their citizens, and the language in section 1 specifically addresses some of those occurrences. We, at Retail Association of Nevada, ask you to support A.B. 339 and look at section 1 as vitally important to the public.

Catherine O'Mara, Executive Director, Nevada State Medical Association:
We are here in support of A.B. 339 and the proposed amendment before you today. I would just like to echo Ms. MacMenamin's support for section 1. When there were 800 displaced patients about a year ago in Washoe County, the physician community was very involved as well. One of the biggest challenges we had while we were trying to help refer those patients to new care was trying to get access to their medical records. We were constantly on the phone with attorneys trying to see how we could do that. It really does impact patient care. The more flexibility and guidance we can give to the Board, where they can come in and really help protect patients, I think the better. We also support the other provisions of this amendment. I am happy to answer any questions the Committee may have.

Chair Bustamante Adams:
Is there anybody in Las Vegas in support of A.B. 339? [There was no one.] Those in opposition, please come forward. [There was no one.] Is there anyone who is neutral on the measure and would like to testify? [There was no one.] I know we have some work to do, and Senator Hardy, I would ask that you and Mr. Lee meet with Assemblywoman Carlton, especially on section 8, to make sure there is an understanding. I will close the hearing on A.B. 339.

Assemblyman Brooks:
Excuse me, Madam Chair; there is someone in Las Vegas who is neutral.

Paul Shubert, Chief, Bureau of Health Care Quality and Compliance, Division of Public and Behavioral Health, Department of Health and Human Services:
I came to the table a little earlier when you were discussing some of the changes, but it sounded like the questions were adequately answered. We are here in the neutral position on this bill. We recognize that the elimination of the reporting requirements to the Division will not necessarily cause any problems with how we conduct our business with regard to outpatient facilities. In particular, those are the facilities that we are looking at in section 10 of A.B. 339, wherein there would be the sentinel event reporting as well as reporting of physicians who are performing sedation and general anesthesia. I am here and available to answer any questions you may still have regarding those issues.

Chair Bustamante Adams:
Are there any questions for the Division? [There were none.] I appreciate your further comments. I will close the hearing on A.B. 339 and open the hearing on Assembly Bill 295.

Assembly Bill 295: Establishes certain safety standards for construction workers. (BDR 53-706)

Assemblyman Al Kramer, Assembly District No. 40:
I am here to introduce Assembly Bill 295, which is a bill that deals with safety standards for construction. With me today is Clay Davis, on whose behalf I submitted this bill. I know he planned to have others join him today, but the timing did not work out, and it was difficult to get everyone here. I am hopeful that the Committee members will understand that they will be talking to someone who actually works on roofs and actually does this job and has done so for many years. I will let Mr. Davis speak to this.

Clay Davis, Private Citizen, Carson City, Nevada:
Thank you for this opportunity to propose A.B. 295. I am currently a Nevada licensed and bonded roofing contractor who has been in the local roofing industry for 40 years. In that amount of time, I have employed countless employees and worked with industry workers. I am currently the owner of a roofing company based in Carson City. I am big on safety, as are my employees. My company has a current written safety program and all my employees have a copy. They have all been trained and have received their Occupational Safety and Health Administration (OSHA) 10- or 30-hour cards. I fully support job safety in the workplace.

Assembly Bill 295 states our desire to raise height and slope requirements and to exclude, in some cases, the use of fall protection and restraint systems on a job site. In my years in business, I have had many conversations with other roofing professionals and, in particular, my employees. With these conversations, we all seem to agree that the current requirements of wearing ropes and harnesses bring clutter to a sloped, but walkable, work surface.

Those are key words that I want to use: "sloped, but walkable" roof surface. We feel that this surface should be as free and clear of as many items as possible, except for the necessary workers' tools and materials to complete the job.

For safety reasons, we feel a worker in the roofing environment should have a clear and precise focus on his work with minimal distractions. We feel the safety devices we are currently required to wear on a walkable surface are themselves a distraction, and therefore, unsafe. We feel that the rope itself is a distraction; it is one more item on the roof that the worker needs to be aware of to keep from tripping, stepping on it, or causing a fall resulting in an injury. In addition, the worker's ability to move around on the roof surface is restricted due to the tendency of that rope to catch on materials, another coworker, or a nail on the deck. When this occurs, the sudden stop can cause a fall or an injury.

I have had two incidents happen to me personally while wearing fall-protection equipment on a walkable surface. I also have witnessed this happening to my employees at the work site. We feel the ropes and harnesses that we are required to wear can be more of a hazard than they are keeping us safe. We also feel that the current requirements of wearing the rope and harness gives the workers a false sense of security, putting them in situations or positions they should not be in.

In the past two years in my company, I have had two incidents of falls to the ground, resulting in minor injuries that were attributed to this false sense of overconfidence of being roped off in our harnesses and ropes. Finally, having to wear restraints and harnesses can bring undue and unnecessary strain and pain on the worker and may have possible long-term physical effects. That has to do with wearing the harness, wearing the rope, having it tugging on you all day long. When workers get home, it wears on their bodies.

Again, I stress that I am in full support of job safety in the workplace. The safety of my employees is paramount to me. They are highly qualified professionals, and I do not want to lose one to injury due to an unsafe work environment. In conclusion, we feel that a happy, comfortable, responsible, and conscientious worker who is able to make some decisions concerning his own safety on a walkable surface will make for a safer and more productive workplace, along with superior service and a satisfied consumer.

Chair Bustamante Adams:
I will open the hearing for questions from the Committee.

Assemblywoman Carlton:
I appreciate where you are coming from, but I think part of the problem is that you can get seriously hurt falling off a roof. We lost Governor Guinn that way; he was cleaning pine needles off his roof. A six-foot fall can be dangerous; it is not the roof, it is when you leave the roof and gravity starts working. That is my concern. I understand the steep grade part of your argument but not eliminating fall protection at that level. It is still dangerous when you fall, and I have some concerns about that.

Clay Davis:
I can understand your position, and I appreciate your concerns. In my experience, however, I spent 30 years on a roof without a harness system—until they were implemented 6 or 7 years ago—and I never fell off the roof because I was careful, conscientious, and aware of my surroundings. I do not think safety harnesses are needed in certain circumstances, and that is what we are trying to do here today. I am all about having safety harnesses when we need them—above certain pitches for example—and in areas where we can get hurt. I do not want to eliminate them, but I do not think in certain situations, on residential properties with a low-slope roof they are needed, and I think they are a hazard.

Assemblyman Daly:
This is not the first time I have seen a bill like this in my time at the Legislature. Correct me if I am wrong, but maybe someone from the Department of Business and Industry or OSHA can come up and answer the question if they are here. My understanding is that the state of Nevada is recognized by OSHA, and that there are minimum standards in Part 1926 of OSHA's health and safety regulations for construction. If I am correct, I believe that the harnesses you are trying to change are not in compliance with what is required by OSHA. In order for us to maintain that recognition, we cannot have lower standards than OSHA requires. We can have more stringent requirements, but we cannot have less than what OSHA requires.

I think this bill would jeopardize our status and recognition by OSHA, as well as the state's adoption of OSHA standards. We can write our own book—basically tear OSHA's cover off, and put our cover on—so I would have to hear from OSHA. I do not think this bill, even if it passed, would allow for what you are asking. My understanding of the bill, and maybe someone can set me straight, is that it would lower the federal standard, and it would put our state out of compliance with our agreement with the federal government.

Assemblyman Kramer:
You are absolutely correct. If this bill passed, all it would do is direct our Nevada OSHA to ask federal OSHA for an exemption, which could very easily be denied. Yes, this is a first step; it is not a deciding step.

Assemblyman Hansen:
My brother owns Scott Roofing in Reno, and my dad owned it before he was killed in a car accident. I just read the bill this morning, but I called and talked to my brother about it and he is 100 percent supportive. He agrees completely that this safety gear actually ends up making workers less safe rather than safer. An example that he gave me was that you have to have a tie-off point with a certain tension. In many cases, roofers are called to repair roofs that have holes in them, but under the OSHA requirement, roofers literally have to cut a hole in the roof so they can tie off to a point that is strong enough to withhold the fall protection standards. There is a lot of really goofy stuff about OSHA, and a lack of pragmatism and practical application in the field, which is what you are getting at.

Therefore, I would be fully supportive of this measure, even if, as my colleague Assemblyman Daly points out, it may be technically in violation of OSHA. We have to start somewhere, and there has to be a little bit of practical reality about how things are actually done in the field versus how some guy who is sitting around and dreaming about ways to come up with new OSHA regulations. As you point out in your testimony as well, after doing this for 30 years, this makes things less safe from a man who has been on the roof for a long time. I only did a little bit of roofing. Thank goodness my dad bought that company after I was a little older and I ended up being a plumber instead. I can see where we could potentially have a conflict in the direction you are taking, but clearly, I think this is a great idea. You might elaborate a little bit on that point of tying off on the roof, so some of the people on this Committee can get an understanding of what people like you, in the field, have to deal with, with these onerous regulations.

Clay Davis:
You bring up an interesting point, Assemblyman Hansen. When we arrive at a job and we climb up on a roof, we have to set the ladder and walk up the roof, unharnessed, and set the anchor point prior to putting our ropes and harnesses on. It takes 10 or 15 minutes. Then we climb down, put all of our safety gear on, and then we go back up and hook onto the anchor point. When we are finished with the job, we do the same procedure. We have to take the anchor point off, take our ropes and harnesses off, and get off the roof. There is a point there where we are unsafe, so we have to be responsible and conscientious about installing our harness points and taking our harness points off, and I am trying to open that up to the whole roof on a walkable surface. Regulators allow us to do that for 15 or 20 minutes each way, coming on and off that roof. We are conscientious about it, and we never have any incidents. I feel that it can work on the whole roof.

Chair Bustamante Adams:
I do not see any other questions. We will turn to testimony in support.

Assemblywoman Neal:
Assemblyman Daly had wanted to hear from OSHA. We have an OSHA representative here at the table in Las Vegas.

Joseph (J.D.) Decker, Administrator, Division of Industrial Relations, Department of Business and Industry:
I am an administrator with the Division of Industrial Relations, which contains the OSHA section. I am available to answer any questions, but in response to Assemblyman Daly's question, it does impact the program. The *Code of Federal Regulations* (CFR) Part 1902 requires the state OSHA program to be at least as effective as the federal program, which means maintaining the federal regulations, and CFR 1926 talks about fall protection. Without any value judgments as to what is contained in the bill, the fall protection is currently set at six feet. That is the standard that the federal OSHA requires us to maintain in order to continue to operate the OSHA program based on federal funding and the delegation of authority to the state program.

Assemblyman Hansen:
You obviously heard the testimony. What we are trying to accomplish here is to get some reasonableness out of the federal rules. They are excessively stringent. As the people who are actually in the field have recognized, in many cases they actually make it more dangerous for people working on roofs. If we passed this bill, we would be out of compliance, but that may start the amendment process that hopefully the federal OSHA would take a look at. Would you object to that?

J.D. Decker:
With all due respect, I would leave that to you and the legislative body. I am not taking a position on the details of the bill. I am only here to tell you what we see as the potential impact, and we have discussed this with the federal OSHA. I could relate to the Committee what it is they have told us, in addition to their pointing to Arizona, who apparently has had some experience in this area in the past as well.

Assemblyman Hansen:
Madam Chair, would it be all right if he shared that with the Committee? I am curious. How do they deal with it?

Chair Bustamante Adams:
Do you have that information now, or did you have that in writing?

J.D. Decker:
I have the information now, and I can give you a brief summary of the timeline. Federal OSHA adopted the height restrictions in 2010. In 2012, the Arizona legislature passed legislation to trigger fall protection at 15 feet, in excess of the federal standard. In 2014, federal OSHA identified that the trigger height change did not meet the "at least as effective" requirement. They notified the Arizona OSHA program and the Arizona legislature passed a provision to their previous bill that said if federal OSHA were to officially reject Arizona's position, it would automatically rescind the previous bill that raised the fall protection. In 2015, OSHA officially announced the rejection, and Arizona began the process of public notification of revision of the bill. Unfortunately, in using that example, I am not sure that is the result that Assemblyman Hansen was talking about, but we do know that historically that has been the most recent experience we have had with this.

Assemblyman Hansen:
I think if enough states start making this request, even the federal government will eventually listen in some cases. Even if they came back and told Nevada they did not support this—if Nevada, Arizona, Montana, and other states started making similar requests—hopefully the government would respond. Even if this is a little bit of a Hail Mary pass, or even a strictly symbolic gesture, it seems this would be a good step forward for the industry.

Chair Bustamante Adams:
If I could have a copy of that, it would be helpful.

Assemblywoman Neal:
Mr. Decker, I want to know if there is any flexibility within the state law that deals with public policy where we could change the design of the safety material rather than discarding it. Have there been any cases where it has been argued to change the design, so it is better suited for the work, so the workers are safe?

J.D. Decker:
As long as the change complied with federal regulations, there would be whatever latitude the marketplace would come up with. The fall protection trigger at six feet does not get too much more specific than that; however, I do understand what the sponsor is saying about a scenario with numerous people on a roof with lines and people having to watch out for various fall protection devices. The federal standards do not necessarily specify what fall protection is used to that specific degree, as long as something is used.

Chair Bustamante Adams:
We are going to move on to testimony in support of A.B. 295.

Chelsea Capurro, representing the Nevada Subcontractors Association:
We just want to say we are in support of this bill. Some of our roofers have had issues with this tripping and tangling type of situation.

Chair Bustamante Adams:
Is there anyone in opposition to A.B. 295? If you can be specific, that would help our Committee.

Alexis Motarex, Government Affairs Coordinator, Nevada Chapter, Associated General Contractors of America, Inc.:
We are here today in opposition to A.B. 295. The construction industry is inherently dangerous, and as an industry, we work really hard to make sure that all of our employees and our job sites are safe. Roofers have one of the highest numbers of fatal accidents on job sites, and fall injuries are the leading cause of fatalities. We cannot, in good conscience, support any attempt to roll back safety precautions.

Many of you have been on a tour of Academy for Career Education (ACE) High School in Reno. Those children are OSHA trained and certified, and they get up on the roof. They built a home as one of their projects. When they are up on roofs, they are tied-off—they are taught to do that—and taught that safety is always first and foremost. I cannot imagine sending a recent, 19-year-old graduate out into the field where they are not tied off on a roof and something happens. That is just simply not worth the risk.

Rusty McAllister, Executive Secretary-Treasurer, Nevada State AFL-CIO:
I am here on behalf of our members who are involved in this field of work. We are in opposition to A.B. 295. I certainly understand Assemblyman Kramer's and his witness's position. I learned a lot more about this subject after reading through a hearing that took place last year.

California is one of the states that had a standard outside of the federal OSHA standard that was changed in 2010 to a height of six feet. California had two standards: seven-and-a-half feet for a steeper pitch and ten to fifteen feet for less steeply pitched roofs. I have the minutes from a meeting in Costa Mesa, California, from California OSHA where the federal OSHA came in, talked to them about their roofing standards, and told the state they were not in compliance—and they were pretty straight up. They said there have been seven states, including California, that have trigger heights higher than federal standard or do not match federal standard, and six have complied and changed their standard. We are encouraging everyone to do so, and California is the only one that has not. The bottom line is California was told to change their standard to match or to be equal to the federal standard.

At one point in the hearing, a person from the federal OSHA stated if California did not comply, the federal OSHA would issue a show cause letter to California with 30 days' notice, prior to concurrent jurisdiction, and the federal OSHA would begin to enforce federal construction standards. Another administrator from the federal OSHA stated the state is required to provide protection equal to the comparable federal standard. She said that the federal standard for residential construction requires fall protection at six feet, and since California's standards are different, there is nothing comparable that gives the employee protection at six feet.

She stated that if the state did not comply, the federal OSHA is obligated to step in and ensure the employees are protected. She was asked how broad the federal OSHA's takeover would be if the board decides not to comply, and she stated that the federal OSHA can only enforce the federal standard, and in this case, it would take charge of all construction safety orders, not just the orders regarding rooftop safety. They are very adamant.

There is extensive debate here; about 15 pages. Ultimately, the board took a motion to comply with the federal standard. They would put together a subcommittee. They would look at the parts of California's standard that worked, and they would still be in compliance with the federal standard, and then put something together to match the federal standard.

For those reasons, I know that the people I represent are not in favor of the federal OSHA coming in and taking over our safety plan, because they believe that would lead to less oversight. They are not in support of that. For those reasons, we are in opposition to A.B. 295.

Nick Vassiliadis, representing Southwest Regional Counsel of Carpenters, Las Vegas, Nevada:
For many of the reasons that you already heard, we are also opposed to A.B. 295. We just do not see any good coming from reducing safety standards.

Chair Bustamante Adams:
Is there anyone else in opposition to A.B. 295? [There was no one.] Is there anyone who would like to testify in the neutral position? I know we already heard from Mr. Decker, but is there anyone else? [There was no one.] Mr. McAllister, if you could submit that for the record that would help. We are going to close the hearing on A.B. 295. Do you have any closing comments, Assemblyman Kramer?

Assemblyman Kramer:
Thank you, Madam Chair, for hearing this bill. The only comment I have is how does one make a protest to the federal OSHA, if not through something like this? To be told something, and to just go away and be quiet is one answer, but it seems there should be some way to express discontent with some of the rules. Even though I heard the prior three testifiers talk about these issues, their complaints were not based on "the last ten years we have had fewer accidents;" it was on the basis that the federal OSHA said so, so we have to do it their way. It seems there should be a way to protest. That is all I wanted to say.

Chair Bustamante Adams:
Thank you, Assemblyman Kramer and Mr. Davis, for being here with us. I will close the hearing on A.B. 295 and open the hearing for Assembly Bill 352, our last bill of the day.

Assembly Bill 352: Provides for continued coverage for health care for certain chronic health conditions. (BDR 57-592)

Assemblyman Keith Pickard, Assembly District No. 22:
I represent Assembly District No. 22 in Henderson, and I am here today to present Assembly Bill 352 for your consideration. To understand the genesis of this bill, I think it is probably easiest to tell you how I came to learn about the problem. When I was knocking on doors on the campaign trail, I met a couple who shared their story with me. The gentleman told me about his wife's total thyroidectomy—the total removal of the thyroid—which resulted in the requirement for her to take a synthetic hormone. The brand name is Synthroid, and she was going to be required to take it for the rest of her life. As many of you probably know, the thyroid is responsible for important body functions such as metabolism, growth, and body temperature. Without the synthetic hormone, the patient can suffer from swelling, increased fluid around the heart and lungs, slowed reflexes, and in some instances, life-threatening conditions. It is not something people can live without.

In this case, the wife's insurance plan required an additional preauthorization process for her Synthroid prescription. For those who do not know what a "preauthorization process" is, it is an opportunity that the insurance companies typically impose upon patients and doctors—at least annually and in some cases every six months—a review the prescriptions provided or the treatments provided, in order to maintain a record and observation that the treatments remain medically necessary and appropriate under the circumstances.

In this case, the woman had seen her doctor and done the things she needed to do, but because of the process of prior authorization and the proximity of those visits to the expiration of her Synthroid prescription, she was denied a refill. Under current rules, insurance companies are required to provide emergency coverage for ongoing medications for such situations, but it was not provided in this case. In fact, the patient went about two months before she got a refill. That, obviously, put her health at significant risk.

While I recognize this issue is important to that couple, it was not a significant issue to me, or at least not one that I thought required a legislative response. Then, within two weeks, I ran into another couple who had exactly the same experience. They had a chronic condition that was not going to go away, and they were denied a refill on a prescription because the insurance company had not completed their prior authorization process. What really got my attention was that a couple of months later, it happened to me.

I have a chronic condition that requires ongoing medication. I will need it the rest of my life. In my case, my refill was denied—at least until I got my insurance company and my doctor's office to fully communicate and resolve the problem that the insurance company needed to resolve. I went about two months without my prescription medication, and were it not for the fact that I have close friends in the medical community, I would have been without. They provided for me during the interim period, so that I could continue to get my prescription.

Assembly Bill 352 seeks to address this type of unnecessary risk for the citizens of Nevada. If passed, it will require insurance providers to continue to refill a prescription for treatment of chronic conditions—those that are not susceptible to recovery or remission—so long as it is a covered treatment under the insured's plan. This bill does not prevent a prior authorization process for instances where a person voluntarily changes their insurance plan, and it does not outright prohibit an insurance company from changing the terms of coverage of a plan. What it does do, however, is require the insurance company to notify insureds at least 60 days before they change the plan, or suspend or terminate a prescription or treatment, allowing the insured to find an alternative before running out of their prescription.

I have met with representatives from the two largest insurers in the state—UnitedHealthcare and Anthem Blue Cross and Blue Shield—as well as representatives from smaller insurance companies. They have been very helpful in working through this bill. I met with the Professional Fire Fighters Association and Clark County, as they are both self-insured. I also met with representatives from the state's Medicaid program to discuss how this bill may work

within their combined state- and federally-mandated system. They have all been immensely helpful in addressing the language of the bill. I expect that today we will hear from many who will be required, under our rules, to testify in opposition to the bill because, quite honestly, we have not finished trying to get to the appropriate language. Because of the timing of the dropping of the bill last week and our busy schedules, we have not really been able to get to that final resolution yet.

I know I am bothered at times when we hear bills that are not fully drafted. Ultimately, we are told that we are not able to look at what we are going to get to. My hope here is that given the level of conversation we have had over the last week—when the language was available to us—and given the fact that everyone at the table agrees that the last thing we want to do is put patients at risk, is that we will be able to find that happy language, or at least language that everyone is happy with, so that we can pass this bill. Until then, I am hopeful that the bill will not change wildly from what you have in front of you. You should have the conceptual amendment as well (Exhibit D). I will also say that those I have been working with are committed to trying to find workable language.

Rather than going through the bill as originally written, let me direct your attention to the conceptual amendment that is on the Nevada Electronic Legislative Information System (NELIS). You should have a copy on your desk as well. Looking at the conceptual amendment, I first want to say that this restates the balance of the substantive portion of the bill's language; the balance is simply conforming changes, which I will not address directly.

Section 1, subsection 1 of the bill sets forth the mandate that once an insurance company determines that an insured actually suffers from a chronic condition and that the treatment—whatever form it takes—is covered and approved under the plan, the insurance company cannot thereafter suspend, alter, or terminate that treatment without 60 days' notice to the insured. Neither can they interrupt coverage for an administrative review without that same 60-day prior notice. The purpose of this provision is simply to assure that the patient continues to receive potentially life-saving treatment, even while the insurance company undertakes its due diligence to detect and avoid fraud or to adjust their plan to accommodate improved treatments or eliminate ineffective ones.

Section 1, subsection 2 of the bill allows an insurer to suspend or terminate a particular course of treatment if they discover credible evidence that suggests the patient no longer suffers from a chronic condition or is in remission. This could happen during the course of treatment as evidenced by a doctor's report where the doctor indicates treatment is no longer medically necessary, among other mechanisms.

Section 1, subsection 3 of the bill requires an insurance company to continue to cover treatment under all circumstances so long as the condition is still covered under the insured's plan and the insurance company does not have credible evidence that the condition no longer requires treatment. This section also provides that an insurance provider may alter or terminate coverage, with notice, so long as it affects all similarly situated insureds. In other words, they cannot make exceptions for one particular patient.

Section 1, subsection 4 provides a civil penalty for an insurance company that violates this rule. Subsection 5 provides definitions for the various terms used within the bill. I will note here that there is an open question as to whether we are able to require Medicaid to adhere to the provisions of the bill as currently required under subsection 5, paragraph (e). As I mentioned, I have met their representatives who are investigating their federal mandates and whether they could perform as required without losing their federal funds. They have assured me they will endeavor to respond in the coming days.

I will also note that I had two providers lined up for supportive testimony today; both notified me at the last minute that they had emergency situations, so they could not be present, but both have committed to providing their testimony in written form. That concludes my introductory remarks, and I am happy to take questions.

Assemblyman Kramer:
I notice this is basically for the continuation of prescriptions. What if a new drug comes out that addresses the condition and the doctor prescribes the new drug, which is the new drug under consideration by the insurance company but has not been approved yet. Does the language in this bill cover that type of situation?

Assemblyman Pickard:
The answer is no. The language as it currently exists actually extends beyond just prescription drugs, because there are likely to be other life-saving treatments that do not fall under a prescription drug paradigm. We want to make sure that continues. To your point, the idea that a doctor may, in advance of an insurance company's decision, know of a drug that is more effective or would be better suited to a particular treatment program that may fall outside the formulary that currently exists under the plan. In such an instance, the doctor would have to work at a variance to the plan to see if the insurance company would cover it.

This bill, instead, simply responds to cases where an insured has a prescription. The insurance company has already determined that it is a chronic condition where this prescription or the treatment plan is necessary, and before they would make any change to the plan, they need to notify the insured. Insurance companies are still allowed to make changes to their plans; this does not inhibit them from doing that.

There are instances, for example, when insurance companies are the first to be aware of the improvement. For example, Kenalog was an injectable allergy treatment. Since its release, however, other methods that are far more efficacious have been developed, so insurance companies phased out Kenalog shots and went to Nasacort AQ and other drugs. Ultimately, insurance companies did it in such a way that they instructed or informed their doctors, and then the doctors made that transition. This bill just allows the insurance company to make those changes and to direct their insureds in a different direction, provided they first give notice. Ultimately, it is to give the insureds the opportunity to either find alternatives or meet with their doctor and get the appropriate medication prescribed.

Assemblywoman Carlton:
The examples you gave were all about prescriptions. I am not sure if Assemblyman Kramer covered this, but your mock-up also mentions procedures and devices. What are we talking about here? I ask because those types of things are usually with a specialist, and the patient would need to get authorization to see the specialist. How do those fit together?

Assemblyman Pickard:
We chose that specific language in consultation with the health care providers. They alerted me to the idea that this bill could likely include treatments beyond prescription drugs. The reason why I am referring mostly to prescriptions is because that is my personal experience and that is what comes to mind quickly. Health care providers suggested there may be some device—a prosthetic—that would require changing over time, or some other form of treatment that would be required in order to maintain a person's standard of living. The idea behind this bill is to make sure that if the specialist—and you are right, in those cases a specialist would be involved—prescribed a course of treatment, it would go through the initial authorization process.

We are not touching that. Insurance companies certainly have to be able to maintain their due diligence, and their ability to protect themselves from fraud and the like and to make sure the treatment is covered under the plan that the insured is on. However, once a specialist or physician has prescribed a course of treatment; the insurance company has signed off on it; the insured has been able to begin and continue on that course of treatment; all this bill does is require that the individual be notified before the insurance company makes a change.

Assemblywoman Carlton:
We have had a number of conversations about health insurance and the state, opining on different things we—the Legislature—would like them to do. It has been said from the witness table, numerous times, that we cannot impact Employee Retirement Income Security Act (ERISA) plans or self-insured groups, so that would eliminate a large portion of people from the state. This would, I believe, only apply to privately-funded, independent plans. Is that correct, or have you investigated that?

Assemblyman Pickard:
We have begun the investigation into that, and the representatives we have met with from Medicaid are the ones who are looking into that and are going to get back to me. In our initial investigation, we were told that as long as we are not asking the ERISA-required plans to do something less than the minimum standards required, we could go beyond, as we can in most instances where federal law has not entirely preempted state action. We are still investigating that area. We have met with almost a dozen people so far on this, and we are expecting to get comments on your point.

Assemblywoman Carlton:
I am concerned about this because we have not been able to ask or mandate them to do things in the past. I am not sure how this bill would actually apply. It sounds to me like this is more of a time frame issue than a coverage issue, and that is where you are going with the 60 days. I have been through this experience, so when I look at the prescription bottle, if it says that I only have three refills left, I start the authorization process. I do not wait until I have one refill left because I just cannot get through the system in 30 days. Is that the issue you are trying to resolve?

Assemblyman Pickard:
That is a substantial portion of the issue. Given your experience in this area, I am not at all surprised that you would take those affirmative steps. In my discussion with a number of health care providers, they suggest that some patients will usually try to get in to see their doctor when they receive their last refill. That vast majority, unfortunately by their own habits, will come just as it is about to expire. In some cases that is not enough time due to patient loads at the doctor's office—they cannot get in quickly enough, they cannot get the lab results quickly enough—and thus it delays the prior authorization process. Again, this bill is also narrowed only to chronic conditions; things where it will really impact people's ability to survive or to maintain an adequate standard of living so long as they are on that medication. The medication would continue to be refilled until that prior authorization process goes through. If I might add, in all of our discussions, everyone agrees that the principle goal in all of this is to make sure that patients' lives are not at risk.

Assemblywoman Carlton:
On chronic conditions, would this bill include blood pressure and diabetes? I am just trying to think of some maintenance drugs out there that could also fall within this category.

Assemblyman Pickard:
Yes, that is contemplated if it is a chronic condition, particularly where a patient's life would be in danger without that medication. Ultimately, this bill just requires that the refills continue until the prior authorization is complete and the insured gets notice.

Assemblywoman Carlton:
The experience my family just recently had was that we could not get an appointment in time, but the doctor's office and the pharmacist spoke, and they gave us just enough medication to get through until the appointment. They verified when our appointment was and knew when the prescription would be coming. We did have a way to address that. I am just trying to figure out the other components of this bill.

Assemblyman Pickard:
On that exact point, my understanding is that current regulation requires insurance companies provide at least seven-day emergency coverage, but what we are seeing is that between the patient loads at the doctor's office and the time it is taking to perform those prior authorizations, seven days is often not enough.

Chair Bustamante Adams:
Are there any other questions? [There were none.] We will move into opposition testimony. Assemblyman Brooks, is there anyone in Las Vegas in opposition?

Assemblyman Brooks:
No, there is no one here.

Chelsea Capurro, representing Health Services Coalition:
As Assemblyman Pickard said, we are working with him to get to a point where we can be okay with this bill. We understand his intent, and we are working closely with him. Obviously, things are moving fast, and we just need to make sure that we get some language that works on our end. We appreciate Assemblyman Pickard's taking the time to meet with us and discuss some other options.

Ryan Beaman, President, Clark County Firefighters Union Local 1908:
As discussed before, we run our own self-funded insurance trust. It is a nonprofit trust that provides coverage for our active members, retirees, and Medicare retirees and their families. We appreciate Assemblyman Pickard; he has met with us multiple times on the issue. When we first saw the bill, we had some concerns about individuals moving from one insurance company into our plan and then not having a preauthorization. We might have exclusions under our plan, so it was important for us to have preauthorization. In talking to Assemblyman Pickard, he has assured us that that is not the intent of the bill—individuals changing from one insurance to another. He has worked in the 60-day notice; that is something that we do with our plan when there is a summary plan change with regard to modification to our plan. We provide a 60-day notice to our members, and that is something Assemblyman Pickard put in the bill. He has taken a lot of considerations that we have had with our self-funded plan, and we appreciate that. There are just a couple of other little things that we want to make sure we address in the bill.

Keith Lee, representing Nevada Association of Health Plans:
We, too, echo the comments of my colleagues here at the table. We have appreciated working with Assemblyman Pickard on this, as he recognizes some of the problems we have—functional problems of how to make some of this work while still maintaining the ability to assure, at the end of the day, that the patient is getting the best quality of care possible, particularly under the plan. We are going to continue to work with Assemblyman Pickard on this bill, and we hope to be able to reach some resolution.

Among other things, we have to discuss the meaning of "credible evidence," and how we may get that credible evidence to determine other factors under the bill. With that, I will try to answer any questions you may have, but we look forward to continuing to work with Assemblyman Pickard on this bill. I hope we will come to you with something that works for all of us.

Chair Bustamante Adams:
Is there anyone else in opposition to this bill?

Erik Jimenez, representing Express Scripts Holding Company:
We were originally in opposition to this bill as drafted, and were handed the amendment right before the hearing, so we are still digesting that. Right now, we are opposed to the bill, but we are willing to work with Assemblyman Pickard in any way, shape, or form.

Chair Bustamante Adams:
Seeing no one else in opposition, I will open the hearing to testimony in support of A.B. 352. [There was no one.] Is there anyone in the neutral position who would like to testify?

Shannon Sprout, Deputy Administrator, Division of Health Care Financing and Policy, Department of Health and Human Services:
We have been working with the sponsor and would like to identify a few of the provisions we are neutral on: The Division of Health Care Financing and Policy fee-for-service pharmacy policy, which has provisions for emergency prescriptions, continuity of care, and allows for a 100-day supply of maintenance medications to support medication compliance; and managed care organizations who set their own utilization criteria and preferred drug lists for pharmacies. The provisions of the bill, as it was originally written, would have an undetermined fiscal impact to the state as well as contract entities due to the inability for the utilization management of such conditions. As we work with the sponsor, the things that we are noting and continuing to look at are the provisions of the bill that would require a state plan amendment with approval from the federal government. We will continue to evaluate and address that area and work through this with the sponsor.

Damon Haycock, Executive Officer, State of Nevada Public Employees' Benefits Program:
As you heard in previous comments, we too just saw the proposed amendment, and we still need to digest that information. The Public Employees' Benefits Program (PEBP) Board met to discuss the original bill. The Board had some concerns, although they wanted me to testify in the neutral position. I do not want to go over all of those concerns if the changes are actually going to occur. We are more than willing to work with the sponsor and see if there are any amenable areas. We are mentioned in this bill, so as a self-insured program, under section 4, it points back to us in our statute for our self-insured plan of benefits, so we are very interested in the final language.

Chair Bustamante Adams:
I appreciate your being here and putting that on the record. Is there anyone else in the neutral position on A.B. 352? [There was no one.] Assemblyman Pickard, would you like to make closing comments?

Assemblyman Pickard:
I want to quickly respond to a couple of things. First, with respect to Express Scripts Holding Company, we were not aware of their interest in the bill until moments before the hearing began. We did point them to the conceptual amendment, which they had not yet reviewed, and we look forward to working with them. The other comment I want to make is that because of the lateness of the hour when the language dropped, we simply wanted to drop a net that was cast broadly to make sure we did not inadvertently exclude someone. We are working diligently to try to make sure that this bill will be appropriate—particularly with the state programs—because we also recognize there may be some federal preemption issues that we have to address.

We in no way want to appear to be fixed in our position; this is only about trying to make sure that the patient continues to receive necessary treatment without interruption, and I think all the stakeholders at the table are interested in the same. I expect we will be able to find happy language. With that, I urge passage of the bill, and if the Committee has any questions, comments, or concerns, feel free to reach out to me.

Chair Bustamante Adams:
I will close the hearing on A.B. 352. Is there anyone who would like to make public comment? [There was no one.] Thank you all for being here and being a hard-working Committee; I appreciate it. Have a great weekend. We are adjourned [at 1:08 p.m.].

RESPECTFULLY SUBMITTED:

_____
Pamela Carter
Committee Secretary

_____
Devon Isbell
Transcribing Secretary

APPROVED BY:

_____
Assemblywoman Irene Bustamante Adams, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a proposed amendment to Assembly Bill 339 presented by Senator Joseph (Joe) P. Hardy, Senate District No. 12.

Exhibit D is a proposed amendment to Assembly Bill 352, presented by Assemblyman Keith Pickard, Assembly District No. 22.