MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Eighty-third Session
May 9, 2025

The Senate Committee on Commerce and Labor was called to order by Chair Julie Pazina at 8:32 a.m. on Friday, May 9, 2025, in Room 2134 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 5 of the Nevada Legislature Hearing Rooms, 7120 Amigo Street, Las Vegas, Nevada. Exhibit A is the agenda. Exhibit B is the attendance roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Julie Pazina, Chair
Senator Skip Daly, Vice Chair
Senator Melanie Scheible
Senator Roberta Lange
Senator Edgar Flores
Senator John Ellison
Senator Lori Rogich
Senator John C. Steinbeck

GUEST LEGISLATORS PRESENT:

Assemblymember Cecelia González, Assembly District No. 16
Assemblymember David Orentlicher, Assembly District No. 20

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Jeff Koelemay, Committee Counsel
Bryan Fernley, Committee Counsel
Lynn Hendricks, Committee Secretary

OTHERS PRESENT:

Mark Nelms, LegalShield
Tray Abney, LegalShield

Adam Plain, Insurance Liaison, Division of Insurance, Nevada Department of Business and Industry
Jennifer R. Pierce, Executive Director, Nevada Speech-Language Pathology, Audiology and Hearing Aid Dispensing Board
Izack Tenorio, Nevada Speech-Language Pathology, Audiology and Hearing Aid Dispensing Board
Andy LePeilbet, Chairman, United Veterans Legislative Council
Deven Aschoff, Touro University
Sheila Bray, University of Nevada, Reno
Sarah Bradley, Deputy Executive Director, Nevada State Board of Medical Examiners
Francisco Morales, Northeastern Nevada Regional Hospital
Cathy Dinauer, Executive Director, Nevada State Board of Nursing
Alex Tanchek, Nevada Advanced Practice Nurses Association
Steve Simpson, CEO, Northeastern Nevada Regional Hospital
Jacqueline Nguyen, Policy Director, Nevada State Medical Association
Patrick Kelly, President and CEO, Nevada Hospital Association

CHAIR PAZINA:
Today, we're going to start with Assembly Bill (A.B.) 512.

ASSEMBLY BILL 512 (1st Reprint): Revises provisions relating to casualty insurance. (BDR 57-1089)

MARK NELMS (LegalShield):
We do support A.B. 512. I am very proud of our company. We've been providing legal plans now for over 53 years. Some may not be as familiar with legal plans and so I will talk about those. We actually started doing business in Nevada in 1987. I am very proud of that record as well.

In 1995, the law firm of Dempsey, Roberts & Smith, the current provider law firm for the State of Nevada, began providing services. What's important is LegalShield ourself, the company, does not provide the legal services. What we provide is access to legal help for members who have a legal plan. I'm going to talk about that word "access" later, because that's very important when we talk about access to justice and the real issues that states are having in providing that for their citizens.

I will describe a little bit about how the legal plan works. If you have a family legal plan, you can contact your provider law firm and receive a consultation on any personal legal matter you may have. They can review documents for you, prepare your will and estate plan documents plus they can write letters or make phone calls on behalf of members. There are many other benefits as well as part of that membership.

What's important is our provider law firm model is a non-indemnity type legal services plan. So we don't indemnify a member for legal fees. We don't pay claims, and we don't reimburse members. This proposed legislation will simply bring clarity and modernization to the law and exempt modern non-indemnity legal plans from the insurance code.

This will align Nevada with the vast majority of states where non-indemnity legal plans are substantially treated as insurance by the state insurance regulator. Right now, there are only six other states [that do not], those being Alaska, Massachusetts, New Jersey, New York, Oregon and Virginia.

We also have seen legislative change in many states. Specifically in the states of Washington, Arizona, North Dakota, Nebraska, Texas, Tennessee and also Arkansas. The vast majority of states do not view us as insurance and so we are not regulated.

This will also support—like I talked about—access to justice [which is] the real issue. You know, the judicial system can pose great challenges for somebody who does not have access to legal help. Civil matters can result in detrimental consequences. For example, areas like housing can lead to foreclosure. We have landlord-tenant laws, child custody, wage garnishments and unemployment. All these different things that everyday citizens need legal help for, but they do not have that.

States like Nevada are looking for options to address the need. Almost every state in the United States in the last 10 years to 15 years has looked for ways to better provide legal help for their citizens. Nevada did what my home state of Oklahoma did. The Nevada Supreme Court actually put together a commission on access to justice to try to get help. So our top court in both states recognize the issue.

Legal aid—which I appreciate what they do for citizens—can only address a small number of citizens' needs. You know, most people don't qualify for legal aid. And if they do qualify, legal aid does not handle many areas of law.

On the other side of the spectrum, you have citizens who can't afford to hire an attorney at a full rate. So that's where a legal plan comes in. That big gap—consisting of the majority of citizens—can afford a monthly legal subscription, which gives them access to the legal world. That is why I appreciate what we get to do and what the legal plans do for citizens.

I want to briefly bring up the landlord-tenant example. I heard a very tenured judge talk about this issue years ago and he used a landlord-tenant case as his example. You may think a landlord-tenant matter does not seem like that big of a case, but he showed that for a family that had been evicted, not only did they lose their home but struggled to find any housing after that. If you have a judgment, that judgment is going to go on your credit. Then you can be garnished, and it could affect your employment. So, he showed how just that one case snowballed and impacted that family's life.

I appreciate in my own career that I was able to help a member years ago with a landlord-tenant situation. When I went to court with them, of the ten different defendants that were on that docket, only one had counsel and that was somebody who had a legal plan.

I want to bring your attention to the main issue, access to justice. *The New York Times* just put out an article on this very problem entitled, "Lawyer Up? Increasingly Americans Won't, or Can't." It reads, "It's dangerous to go to court without legal representation—but more Americans are going it alone." This is still today in 2025.

So again, this legislation will support access to justice and will enable us to help more people. And with that, A.B. 512 simply clarifies that non-indemnity legal plans are not insurance products and should not be subject to the insurance code.

TRAY ABNEY (LegalShield):
I will just walk through what the bill says. So let me start by stating that the new language in section 1 was inserted via work session by Assembly

leadership on the other side. So Mark and I are not prepared to address that language.

However, Adam Plain from the Division of Insurance (DOI) is here in a neutral capacity. You'll see his testimony (Exhibit C) online. Not to throw him under the bus, but if you have questions about that section, Mr. Plain is certainly prepared to talk about it and is much smarter than me on that.

The blue language in section 2 is why we are here in front of you today. You will see that subsection 1, paragraph (o) is existing language and that is where, historically, the DOI has considered legal service plans to be in the miscellaneous category of casualty insurance. What we have done here is add a new section and type of casualty insurance for legal expenses, outlining that if a plan reimburses or pays someone for specific legal services or legal expenses, that is an insurance plan.

But to the point of our testimony, we included language that outlines what is not legal expense casualty insurance in section 2, subsection 1, paragraph (n), subparagraphs (1) through (3). That would be the fixed prearranged payments language you see at the end of the new blue language. I just want to check with Mr. Nelms and make sure I explained that right in my non-lawyer vernacular.

MR. NELMS:
Yes sir, that's correct.

ADAM PLAIN (Insurance Liaison, Division of Insurance, Nevada Department of Business and Industry,):
The Division is neutral on A.B. 512 as Mr. Abney and yourself have stated. We did submit Exhibit C, which includes some supplemental information. It's correspondence from the DOI to an interested party back in 2021, regarding the legal services product issue. It has a little bit of an explanation as to what the DOI's stance was in a nutshell, because legal services insurance is not defined in statute.

We've regulated it as a miscellaneous product. We use what is called a "fortuitous event standard." Basically, if the product looks like the contract holder would benefit in a fortuitous manner from an unknown event, the DOI considers it insurance.

Assembly Bill 512 would put a definition for legal expense insurance into statute. So the DOI would no longer rely upon the fortuitous event standard and would no longer regulate it as a miscellaneous product. We have no preference whether we continue using the existing standard or the new proposal under A.B. 512. I would just bring it to your attention so you have some background on it.

Concerning section 1 of A.B. 512, it is not our language. But, as Mr. Abney stated, if you have questions, I would be happy to answer them. I believe Section 1 stems from an Assembly bill from the last session. There were some unintended consequences from that Assembly bill. The DOI had to pass an emergency regulation, followed it up with a permanent regulation and now the new language in section 1 proposes to adopt the DOI's permanent regulation into statute to give it a little bit more force of effect.

CHAIR PAZINA:
We will close the hearing on A.B. 512, and we will move to the next item on our agenda which is A.B. 177.

ASSEMBLY BILL 177 (1st Reprint): Makes various changes relating to audiology, fitting and dispensing hearing aids and speech-language pathology. (BDR 54-199)

ASSEMBLYMEMBER CECELIA GONZÁLEZ (Assembly District No. 16):
The Speech-Language Pathology, Audiology, and Hearing Aid Dispensing Board licenses and regulates qualified practitioners in Nevada. A speech-language pathologist is an expert in communication and helps people who have problems with speech, sounds, language, social communication, fluency as well as feeding and swallowing.

An audiologist diagnoses, manages and treats hearing, balance or ear problems. They work in the field of audiology—which is the science of hearing imbalance—and determine the severity and type of hearing loss a patient has and develops a treatment plan. A hearing aid dispenser is a licensed professional who fits, sells and adjusts hearing aids for adults.

JENNIFER R. PIERCE (Executive Director, Nevada Speech-Language Pathology, Audiology and Hearing Aid Dispensing Board):
Before addressing the bill, I would like to give you a brief overview of our Board. It was established in the Seventy-eighth Legislative Session through consolidation of the Hearing Aid Specialist Board and the Audiology and Speech Pathology Board. The intent was to increase licensing efficiencies for similar and overlapping professions, as dispensing audiologists were required to hold a license with both Boards.

Our Board is composed of three speech-language pathologists, each of whom must represent a different practice area, including university, public school, hospital or private practice. There also must be two audiologists—one of which must be a dispensing audiologist—as well as one hearing aid specialist and one public member.

We also have the Advisory Committee on Fitting and Dispensing Hearing Aids, which is permanently established in regulation. Then, we convened a temporary Speech-Language Pathology Subcommittee this past year. They were tasked with working on this bill and providing recommendations for future regulation revisions related to speech-language pathology assistance.

The Board is funded solely through licensing and other fees collected. We operate with just a small staff made up of myself, our licensing coordinator, who works half time for our Board, and an investigator used on an as-needed basis. On average, we are able to issue licenses within five calendar days of receiving a complete application when hearing aid dispensing exams are not required. This drops to three days on average for expedited licenses by endorsement and approximately 90 days on average for applicants requiring dispensing exams.

The Board census at the end of March 2025 totaled 1,680 licenses, including 1,396 speech-language pathologists, 63 audiologists, 115 dispensing audiologists, 90 hearing aid specialists and 16 hearing aid specialist apprentices. The Board census has steadily grown by almost 700 licensees since the end of 2016 and 76 percent of our current licensees reside in Nevada. At the end of fiscal year (FY) 2017-2018, out-of-state licenses made up 16 percent of our census, increasing to 24 percent at the end of FY 2023-2024. Of all the licensees with an active Nevada employer on record, 94 percent practice in Carson City, Clark and Washoe Counties.

As referenced in our presentation (Exhibit D), Assembly Bill 177 revises *Nevada Revised Statutes* (NRS) chapter 637B related to all three practitioner types regulated by the Board. It addresses licensing, scope of practice and several administrative sections within the chapter. Two sections [38.3 and 38.6] at the end of the bill also revise NRS chapter 391 related to educational personnel providing speech-language pathology services in schools. These revisions will result in increased consumer access to services, expanded scope of practice, reduction in licensing barriers with faster time to license, expanded licensing eligibility, reciprocity and portability as well as an alignment of the chapter with federal and other laws through the revision or removal of unnecessary, outdated or obsolete references.

Section 9 adds a new licensing path for speech-language pathology assistants (SLPAs). Sections 2 through 7 add related SLPA definitions and section 10 addresses SLPA practice under supervision, SLP [speech-language pathology] students and related regulations. Comprehensive regulation revisions have already been drafted to further detail licensing, clinical training, supervision and scope of practice.

Regulation of SLPAs is widespread nationally, with approximately 38 states licensing, certifying or registering SLPAs. At least ten other similar professions in Nevada already license assistants, including physical and occupational therapy, which are affiliated rehabilitation disciplines. Nevada has one of the lowest ratios of SLPs to residents. Data from 2023 indicates that we have 32.7 SLPs per 100,000 residents, almost half the national average of 60.8 per 100,000. We believe that assistants can help fill this shortage.

This new path also follows a 2023 regulation revision by the Nevada Department of Education (NDE), wherein on or after October 1, 2026, a person holding a bachelor's degree will no longer be eligible to obtain an endorsement to teach pupils with speech-language disorders. Due to shortages in special education personnel, Nevada was the last state allowing this longstanding historical exception to allow teaching personnel with postbaccalaureate training to fill this critical need, under the direction of SLPs.

After October 1, 2026, a master's degree and either a Certificate of Clinical Competence issued by the American Speech-Language-Hearing Association (ASHA) or a Board license will be required. Under the revised regulation, school district employees holding the active endorsement issued on or before

September 30, 2026, will be grandfathered in and remain unaffected in their current roles, as long as their endorsement remains active.

Per section 9 of the bill, a bachelor's degree in either speech-language pathology or communication sciences and disorders or a current NDE endorsement issued prior to October 1, 2026, will be required to obtain an SLPA license. Applicants must also have either completed 75 combined clinical observation and assisting training hours or must do so under supervision in the first 60 days following issuance of the license.

Section 18 addresses applicability of the chapter as it relates to licensees and school district employees. It ensures that Board licensees working in educational settings will be subject to the requirements of this chapter and only non-licensees holding the NDE endorsement issued on or before September 30, 2026, will remain exempt. These personnel will not be required to obtain a SLPA license and will not be subject to unlicensed practice while in the scope of their school-based employment. However, they may optionally choose to obtain licensure to explore new opportunities for practice in non-educational, contracted or private practice settings.

Sections 38.3 and 38.6 revise NRS chapter 391 to address collective bargaining rights for these employees. This section was added, and section 18 was revised from the original bill in collaboration with the NDE, Clark County School District and Clark County Education Association to ensure continuity for current personnel.

Section 39 removes examination and separate license endorsement requirements for audiologists wishing to fit and dispense hearing aids in Nevada. In addition to a doctoral degree in audiology, both a written and practical hearing aid dispensing examination are required for which combined costs exceed $400 on top of licensing fees. The practical examination also requires travel to Nevada with portable audiometric equipment and a second person to sit as a test subject.

Only 12 other states require an audiologist to hold the separate endorsement to fit and dispense hearing aids. Nine other states require a written exam and just three other states require a practical exam. Our exam pass rate data indicates that audiologists are well prepared to fit and dispense hearing aids. Yet, there

are few available options in our laws, regulations or policies to fully waive these for experienced applicants licensed in other states.

Currently, the exams may be deferred by out-of-state licenses through a temporary license, allowing immediate practice and providing one year to complete the exams. However, this only delays the burden. The Board supports current legislation proposing membership in the Audiology & Speech-Language Pathology Interstate Compact, which also does not require these exams or a separate endorsement to fit and dispense hearing aids.

Sections 17, 19, 31, 32 and 33 of the bill remove the term "dispensing" from the title of audiologist, no longer differentiating which audiologists may fit and dispense hearing aids. Then, sections 20, 23 and 27 remove references to the endorsement of a license, which also currently adds an additional $50 to the licensing fees.

Section 24 removes the requirement that an applicant for a standard hearing aid specialist license has to be certified through the National Board for Certification in Hearing Instrument Sciences (NBCHIS). Instead, the certification will serve as an optional automatic qualifier for a license. This revision intends to change how licensing standards are met, as many of the same elements required to obtain certification will still be required without the certification itself, which is not appropriate as an entry-level requirement per NBCHIS.

However, the certification process is appropriately suited to experienced practitioners seeking advanced training and credentials. It's only required currently in Nevada and Utah. It requires two years of experience and a current state license to sit for the exam, at an additional cost of $225 and may already be deferred by out-of-state licenses with our provisional license, allowing three years to complete training and obtain certification.

Section 25 requires the Board to adopt regulations to address hearing aid specialist and apprentice licensing and training, which already exist in *Nevada Administrative Code* (NAC) chapter 637B but would be revised to include standard license applicants. An exception is also planned to require only one year of training or licensure for an applicant holding an out-of-state license or having completed training in another state. This is consistent with the allowance for an apprentice to practice without direct supervision after one year.

Section 28 addresses the provisional license currently available to those not holding the certification but otherwise eligible for a standard license, which will now simply address the required training and on-site work experience.

Section 14 revises the audiology scope of practice to broaden language from cochlear implants to implantable hearing devices to encompass evolving technology. It removes the requirement for a physician's request or order to diagnose and adds language to align with the FDA final rule on over-the-counter hearing aids. This is to clarify prescription authority, which is also addressed in the revised scope of practice for fitting and dispensing hearing aids in section 15.

Section 16 revises the speech-language pathology scope of practice to clarify, without expanding the scope, using clearer terms that encompass the range of endoscopic methods utilized by SLPs to examine the throat, vocal cords, larynx, nasal cavity and sinuses to assess and treat communication and swallowing disorders.

Section 22 addresses fees charged by the Board, increasing the maximum caps on the actual fees charged as established in regulation. While not a focal point of this bill, all actual fees—except one—are at our maximum caps. No fee increases are planned and drafted regulation revisions will set fees for SPLAs and hearing aid specialist apprentices that are lower than standard license fees. Revisions also clarify and expand eligibility for a 50 percent discount on initial licensing fees for all military-affiliated applicants—including Gold Star family members—as expedited license by endorsement is only available to standard SLP and audiology licenses.

Finally, this section also provides new authority to waive fees as deemed appropriate. In other general revisions, sections 13, 32 and 34 make a number of changes to also align with the FDA final rule on over-the-counter hearing aids. This took effect in late 2022 and permits the direct retail or online sale of hearing aids to adults 18 and older with perceived mild to moderate hearing loss without a medical exam or prescription.

Previously, only prescription devices could be labeled as hearing aids, though amplification devices were available over the counter for many years. The final rule ensures that the public has access to hearing aid technology through

regulated devices to ensure safety and effectiveness. Prescription hearing aids may still only be ordered when filled and dispensed by a licensed professional.

Sections 27, 28 and 29 clarify requirements for temporary, provisional and limited licenses. Sections 30 and 39 streamline procedures for issuing expedited licenses by endorsement. In summary, it is our intent through this bill to both improve access for consumers and remove licensing barriers to expand eligibility, reciprocity and portability for our licensees.

SENATOR SCHEIBLE:
My question is less about the bill and more about the practice of speech-language pathology and audiology here in Nevada. I understand the relationship between the two of them. Is the education actually the same to become a speech-language pathologist or to become an audiologist?

MS. PIERCE:
No. In 2007, the doctoral degree in audiology became the terminal degree for audiologists and it is a completely separate curriculum. There may be some overlap, but speech-language pathology and communication sciences and disorders in a master's degree program is the degree for a speech-language pathologist. So there's some overlap, but no.

SENATOR SCHEIBLE:
Okay, so what I was wanting to clarify—as we're talking about the practice of speech-language pathology, audiologists and fitting hearing aids—is that these are really two different career paths. You wouldn't likely have somebody licensed by your Board who is switching between a classroom setting and then going to fit hearing aids. They're different careers. But I understand that they are covered by the same Board because of the relationship between the practices. Is that accurate?

MS. PIERCE:
Correct. Historically, I think the two original Boards that were merged—I think in 1979—were audiology and speech-pathology. We have had just a handful of licensees who have held both licenses. So possibly, but no, typically not.

SENATOR DALY:
I had some similar questions. What's the difference in what the process is? But my first question is in section 6, where it talks about how a person is allowed to

have quote "direct supervision, indirect supervision and telesupervision." So, what is indirect supervision?

MS. PIERCE:
Indirect supervision, compared to direct, would be when a supervisor is available but not necessarily on-site and in the room doing line-of-sight supervision. So they have access to a supervisor but may be doing that independently.

SENATOR DALY:
So, they are on-site on the indirect?

MS. PIERCE:
Yes, but it can also be through telesupervision. So not necessarily in the same physical location.

SENATOR DALY:
That was the next question. So, telesupervision means they are on the computer talking and then the student hangs up and then does what they just talked about? Does it have to happen every time, or can it just be "I checked in with them once a day, once every three days, whatever." So, tell me a little bit about telesupervision versus regular supervision.

We've had these discussions on many other Boards where you have people, and they are supervised. When do they have to be there? You know, how often do they have to do it? What is the actual supervision?

MS. PIERCE:
We established these in the drafted regulations. I have them in the room with me but not in front of me. The supervising SLP will essentially supervise the SLPA in a manner that is specific to the competency level of the SLPA, their training, where they're at in their career and their progress. So it could be any one of those things that you mentioned.

It could be that they're not necessarily doing telesupervision in the beginning; they can move to that later, once the person has more experience. Direct supervision would mean that, again, the supervisor is in the room. Indirect or telesupervision could mean that they are checking in periodically throughout the

day and/or are on the call during the treatment session. But it could vary depending on the patient's needs and the setting as well.

SENATOR DALY:
My next question as I was reading through the bill was regarding section 10, subsection 3 where it says, "The Board shall adopt regulations regarding the supervision of speech-language [pathology assistants]…". You said you have some draft regulations, and I understand regulations, I support regulations. We can do a lot of things there that don't necessarily belong in legislation. But some people have different views on that.

What is it that you are anticipating in that regulation? Is it the type of supervision, like we just talked about? What is the number of people that you are thinking of having under supervision per licensee? I mean, those are all relative factors, we see those in other actual legislation on how many they can have. I think it's a relative question in this case as well.

MS. PIERCE:
Yes, for the question. We did draft that in our regulations. We put in quite a bit more in the regulations, feeling like that was going to be a much more lengthy section. The supervising SLP will be allowed to have a maximum of three persons under them, made up of no more than two SLPAs, two SLP students or two provisional SLPs.

A provisional SLP is someone who holds our Board license, has finished their master's degree and is undergoing the one-year clinical experience that they need to earn the ASHA Certificate of Clinical Competence. Or they're called in under the direction of an SLP who is currently in the *Medicaid Services Manual* as well. Then an SLPA would be allowed to have no more than three supervising SLPs per employer, because the Subcommittee understood that they may have multiple employers and the supervising SLP must have the same employer as the SLPA.

SENATOR ROGICH:
We need so many more people in the school districts and I really appreciate your efforts. I have two questions in regard to the telesupervision. The first one being, is the supervisor actually within the State of Nevada or can that person be outside the State, coming through the televised supervision?

MS. PIERCE:
The supervisor has to be a licensee in Nevada. They must have the same employer as the SLPA. However, I don't think that we have dictated in the regulation that they would necessarily have to be in the State. So as long as you're treating a Nevada resident or are a Nevada resident who wants to be licensed, you would hold the Nevada license. So they could theoretically, I guess, be in another state.

SENATOR ROGICH:
But as long as that person is licensed as well…

MS. PIERCE:
Correct, in Nevada.

SENATOR ROGICH:
Which brings me to the next question: I just wanted to clarify that there's not going to be the use of a certain type of software application, where it may not be a person and it may just be an AI component to it.

MS. PIERCE:
Providing this…

SENATOR ROGICH:
Providing the provision.

MS. PIERCE:
Yes. Again, I do not think that we thought to include that in the regulations, but I can make a note about that. We've basically taken the—and I can send this along—definition that the ASHA has for telesupervision and we adopted quite a lot of their work. So it would be similar to that.

CHAIR PAZINA:
Just to confirm, it couldn't be—I would imagine—artificial intelligence, because artificial intelligence would not be licensed in the State…

MS. PIERCE:
Correct.

SENATOR ELLISON:
When you hit on the apprenticeship program or however you do that … My wife had traveled to Idaho the other day because she's having so many problems with the hearing aids that she bought from Costco. They walked in and after making this appointment, the first thing Costco said was, "Well, these things are outdated." She said, "We just paid $5,000 for them four years ago." Then, some other woman came out and said, "No, we still have some of the parts."

What got me was that she traveled all that [way] to get up there. It seemed to me that if they're under apprenticeship or something, there should be something posted that they are going through training or something. Do you do that?

MS. PIERCE:
I would have to look in our regulations. I think that we may have a requirement that requires them to identify that they are an apprentice. But they should also have their license posted and that would identify who's working and if they are an apprentice.

SENATOR ELLISON:
If it wasn't for the woman who had the knowledge that came out, my wife would've drove all the way back. You know, it's not that bad, it's a three-hour drive each way. But she was upset when the girl come out and said, "No, we can't help you, just leave." It seemed to me that it's not a good way to do it when you set the appointment up way beforehand.

SENATOR DALY:
I didn't understand some of the changes concerning ordering. Walk me through who does the prescribing or who can … or is it both? And you have dispensing, ordering and fitting? Are those two different sets of people? Two different licenses?

Because we're deleting, in section 39, dispensing audiologists. Is that what you were saying earlier? They had to have two different licenses if they were just an audiologist versus a dispensing audiologist?

Tell me because I am not sure what all the terms are, who does it, why was ordering not included in some of the stuff and what's entailed in ordering? I'm just not following the whole process because I am not familiar with it, but you are going to tell me.

MS. PIERCE:
Yes, Senator Daly I will. I will start with section 39. The national standard is essentially that if you obtain a license as an audiologist, you can do anything within the scope of audiology, which includes fitting and dispensing hearing aids.

In Nevada, historically, and I am not sure of the history of this, but to fit and dispense hearing aids as an audiologist, we require the separate exams that we are trying to repeal. You pay an extra $50; you add this special endorsement to your license and then your license reads "A123 Dispensing" versus "A123." You are therefore authorized to fit and dispense hearing aids in addition to everything else.

That piece of the audiology scope that involves fitting and dispensing hearing aids is essentially the whole scope for a hearing aid specialist. Hearing aid specialists are limited to dealing with hearing testing and hearing aids. So the ordering language came from the FDA final rule on over-the-counter hearing aids.

When that became effective, there was some initial concern in the professional community. This is because there's now this new legal category of hearing aids. Historically, you could only call something a hearing aid if it was legally a hearing aid under the FDA. Instead, they've established this new official category called, "over-the-counter hearing aids".

Essentially, the ordering language comes from guidance that was sent out to states saying, "This doesn't change prescription authority for an audiologist or a hearing aid specialist to fit and dispense hearing aids to a person with hearing loss or other needs. However, we advise states to add this term, "ordering", because it essentially clarifies that they have that prescribing authority." So the ordering would essentially be the prescription, the fitting and dispensing and getting the molds created, fitting them, troubleshooting, et cetera.

SENATOR DALY:
Thank you, that makes it a little bit clearer. Then the speech pathologist people, although they are under the same Board, [have a] totally different scenario. They do not do dispensing and all the other stuff and ordering; that would be the audiologist that would do that. So same Board, two separate lines of

disciplines. I think that is what we were asking earlier. I think that was all I had; I just was not following it easily in the bill. Thank you for the explanation.

IZACK TENORIO (Nevada Speech-Language Pathology, Audiology and Hearing Aid Dispensing Board):
I am going to simplify it for the Committee. I think this will kind of demonstrate what the Board is. So the Board is three professions in one. It is speech-language pathologists, audiologists and hearing aid specialists. The Board is a little bit different than other boards here in Nevada. This is why the bill is so complex. I think that hopefully simplifies it for the Committee. I understand why there's so much confusion since there's a lot of scope of practice in one bill. Hopefully, that helps.

CHAIR PAZINA:
I'm actually going to have Mr. Koelemay, our legal counsel, respond to the AI question from earlier just to get that on the record.

JEFF KOELEMAY (Committee Counsel):
If it is helpful, section 7 of the bill does contain a definition of telesupervision which states that it means, "the real-time, distance observation by a supervising speech-language pathologist of services delivered..." So, it seems to me that the supervising SLP is a person and not a software entity if that is helpful to the Committee.

ANDY LEPEILBET (Chairman, United Veterans Legislative Council):
We are here in support of the bill. I represent the 250,000 veterans in our State, as well as our active military and our [National] Guard as it relates to laws in Nevada. You're probably surprised to see me. However, section 22 in the bill clearly states why I am here and it covers our veterans, our active military, their spouses and especially our Gold Star families, who have suffered the greatest loss possible, a family member dying in service. Therefore, our position is in favor of this bill.

DEVEN ASCHOFF (Touro University):
We just wanted to put in our support for A.B. 177. We thank Assemblymember González for bringing the bill forward and we urge your support.

SHEILA BRAY (University of Nevada, Reno):
We would like to thank Assemblymember González for bringing forth this bill. The University of Nevada, Reno currently has over 200 undergraduates and 50 graduate students throughout our BS, MS and PhD courses within speech-language and pathology. Assembly Bill 177 works in collaboration with the DOE [NDE] [Nevada Department of Education] to help our university students get into and serve the school system around the State.

This bill will open up the opportunity to create bachelor's level SLPAs, who will work under the direction of certified and licensed master's degree or higher speech-language pathologists. This bill has a dual benefit of not only increasing workforce development of our SLPs but also increasing access to care for those around our State.

We would also like to thank the Nevada Speech-Language Pathology, Audiology and Hearing Aid Dispensing Board for including the university and our faculty that work directly with these students in discussions and creation of this bill. We are in full support.

CHAIR PAZINA:
With that, we will close the hearing on A.B. 177, and we are going to move to the final bill on our agenda this morning, which is A.B. 319.

ASSEMBLY BILL 319 (1st Reprint): Makes revisions relating to providers of health care. (BDR 54-791)

ASSEMBLYMEMBER DAVID ORENTLICHER (Assembly District No. 20):
Thank you very much for the opportunity to present A.B. 319, which I am sponsoring on behalf of the Nevada Board of Medical Examiners. This bill is largely about updating and cleaning up existing statutory language. Before I turn the presentation over to my co-presenter, I will discuss a couple of other provisions that I put in there.

Under existing law, we [licensed] doctors who were educated and trained in Canada similar to licensure for doctors educated and trained in the United States. If you get a medical degree and do a residency in Canada, it is just like doing it here. You don't have to do a new residency, like a doctor trained in France. Section 14 does the same for doctors from the UK, Australia and New

Zealand. If they get their medical degree and residency in those countries, we'll treat them like Canadian doctors.

Why did I pick those three countries? The American Academy of Family Physicians has reciprocity for board certification for doctors from those countries. So I figure if the Academy of Family Physicians trusts those countries' training, we should too.

The other addition is in sections 7, 68 and 72. These sections say that if you are an adolescent—12 to 18-years-old—and go see a doctor, and advanced practice registered nurse (APRN) or physician assistant for a routine examination, they should screen you for cardiac disease. This is just to make sure that if you have hypertrophic cardiomyopathy, it's not missed.

Then, the conceptual amendment (Exhibit E) that I have submitted revises those sections, after consultation with pediatric cardiologists. So there were two things they were supposed to do, but the amendment deletes the second one because it is duplicative. Those are my additions. There's also a proposed amendment (Exhibit F) that came in just last night on behalf of the Northeastern Nevada Regional Hospital. I think there's a representative here who will talk about that.

SARAH BRADLEY (Deputy Executive Director, Nevada State Board of Medical Examiners):
Most of this bill, I would say, is a cleanup by updating language and removing unnecessary provisions. An important clarification that I want to highlight for you is in regard to section 6. Section 6 clarifies what is meant by "progressive postgraduate education." Existing law says that an applicant has to have done progressive postgraduate education, but it's not explained anywhere. So this is our intent to explain that and make that more clear to applicants.

Another important change is in sections 9 and 82. This is regarding the scope of practice for practitioners of respiratory care. It's our understanding that Nevada is one of the only states that currently requires two licenses for those individuals to do their jobs. They have a license from our Board and then they also have a license from the Division of Public and Behavioral Health.

Our intent here is to clarify that, if those practitioners of respiratory care are doing testing that they're trained for—which is a part of their scope under our

law, with a corresponding change to NRS 652.210—then they will only need the license from the Board. This is because we believe that these are things they are actually trained to do and they do all the time and this would just simplify things for those practitioners.

Section 10 is also important. We've had some requests for this. Currently, other license types are able to do care in Nevada, under the supervision of a licensed person, if they're a student in a program. But for whatever reason, that is not the existing law for perfusionists. We are adding that so our perfusionist students can do some training under a licensed person. And of course, there's a doctor as well that works with perfusionists when they practice.

Sections—there's a lot of them—12, 13, 29, 31, 32, 33, 38, 42, 73, 74, 75, 76, [77, 78, 79], 80 and 81 have changes regarding simultaneous licensure with our Board and the Board of Osteopathic Medicine. So right now, anesthesiologist assistants and physician assistants can have a dual license, and they get a reduced fee. This allows us to actually kind of enforce that and if they don't get that second license from the other board, either way, we can actually ask them to pay that difference. This would prevent people from saying they're going to get a dual license in order to get a reduced fee, then not actually following through.

There's some clarification that is pretty important in NRS 630.160. It's a very big provision. We use it all the time for licensure, but it's not as clear as we'd like. So there are amendments to that provision. We are repealing four provisions that we don't need anymore: NRS 630.254, 632.693, 630.2692 and 630.1606. We are also clarifying the endorsement provisions with regard to what a license in good standing [looks like].

Also, there's one provision that is specific for military members, so we're clarifying that in the provision. This is in order for that provision to be clear, because it says that in our fee section—it's a little confusing. Our fee section says it, but the actual statute didn't, so we are updating that for clarity.

Then, we are also doing some streamlining and updating of our hearing procedures and administrative procedures. Now, instead of referring to something as a "complaint"—which can be confusing because consumers file complaints—we are referring to it as a "charging document," since the Board initiates discipline. Those changes are to put the Board's chapter in line with

NRS 622A, which the Board had to start following in—I want to say 2015, but I might be wrong about that.

But it is a newer thing that we have to follow. The Board used to have independent procedures. Basically, we are just getting rid of anything that is outdated and conflicts with that, as well as just incorporating NRS 622A fully into our chapter.

ASSEMBLYMEMBER ORENTLICHER:
As I said, there was the amendment, Exhibit F, from Northeastern Nevada Regional Medical Center that builds on a bill we passed two years ago for a certified nurse anesthetist in rural hospitals.

FRANCISCO MORALES (Northeastern Nevada Regional Hospital):
Last legislative session, this body unanimously approved S.B. No. 336 of the 82nd Session. The bill allowed CRNAs [certified registered nurse anesthetists] to be able to select, order and administer anesthesia within the scope of their practice and under the supervision of a physician in critical access hospitals. The issue that we have is that although [Elko is] rural—almost frontier I would say—we show the same staffing challenges and recruitment challenges as critical access hospitals.

We are not a critical access hospital because of our size. This is particularly true now that we are in the process and very close to opening a 16-bed behavioral health center. So that bill did not apply to us. With the new regulations that were enacted, we now have the very difficult decision of either amending that law to make sure it includes us—because we are a rural hospital—or having to go find two anesthesiologists to work in Elko and potentially having to disrupt our birthing center and other services that we're providing.

That is all that this proposed amendment, Exhibit F, does. We've selected a population cap of 35,000. So it really only applies to the city of Elko. The other hospitals that would potentially fall under this population cap would be in places like Boulder City and Mesquite. They're already included because they have a critical access hospital established within law. So really this would only apply to the City of Elko—something that we desperately need to avoid service disruption.

CHAIR PAZINA:
I will say I have received numerous emails in opposition to this amendment, Exhibit F, so far today. So I think there needs to be a bit more conversation in regard to this amendment and whether it may endanger the bill.

MS. BRADLEY:
I did have one more thing that I originally missed. We are also making changes regarding medical assistants and adding a reference to medical assistants to the Nevada State Board of Nursing. The reason for that is that there's a lot of confusion regarding medical assistants; who can delegate to them and what kind of task can they do? Currently, they're in our chapter. We get a lot of questions regarding nurses and their role with medical assistants. The Nevada State Board of Nursing does as well.

The Nevada State Board of Nursing already has a protocol for delegating to unlicensed persons. However, just for clarity and to allow things to work smoother, part of our bill was to add a reference to medical assistants in their chapter and explain that registered nurses and APRNs can delegate to them.

Again, they already have a protocol for this. They just weren't calling them "medical assistants." We think this will help things work better in hospitals, doctor's offices and other places where medical assistants work with both nurses and doctors.

SENATOR ROGICH:
I did have a question with regard to section 65. Looking at subsection 2 of section 65, I was hoping you could explain a little bit further as to location. The language in subsection 2 refers to "...a location that does not meet the requirements of subsection 1." Then, when you go to subsection 1, it sets out what those locations are. I am just a little concerned about what location you are referring to.

MS. BRADLEY:
We have a lot of situations—especially in medical spas and other not as well-regulated places—where procedures are being done, sometimes specifically, under tumescent anesthesia. Right now, existing law says that if you're going to do regular anesthesia—and there's multiple kinds and I do get a little confused—you have to be permitted by the Division of Public and

Behavioral Health in the Nevada Department of Health and Human Services (DHHS).

Most doctors' offices—I am going to say 95 to 99 percent—actually do procedures in their offices. This is true as well for hospitals, surgery centers and similar places. They're already permitted, they can do anesthesia, and we're not concerned about them doing tumescent anesthesia.

However, we're concerned about it happening in places where there's not a permit. This is because people are unable to get the permit from DHHS and then they use tumescent anesthesia to do inappropriate procedures. Our intent here is to clarify that, if you have the permit, you can use all forms of anesthesia.

If you do not have the permit, you have to administer tumescent anesthesia under regulations that the Board will promulgate. I do not quite know what those rules will be yet. We do want to talk to our stakeholders on that first. But we are very concerned. We've had several patients almost die while having procedures done in these unpermitted locations. It's technically legal at the moment and we're trying to deregulate that.

Just for the record, tumescent anesthesia—as I understand it—is lidocaine and epinephrine mixed together and given to a person in an IV. They're actually mostly awake—I believe—while this is going on. Again, the thing that they most commonly do that we have problems with is liposuction procedures done under tumescent anesthesia in an inappropriate location.

We've had several patients that were grateful they are alive today after having that done. Similarly, we've also heard of breast augmentations being done under tumescent anesthesia in unpermitted offices—very horrific. So that is our intent here.

SENATOR ROGICH:
The other question I have is concerning section 70, subsection 2, paragraph (c) in regard to the medical assistant and being able to possess and administer dangerous drugs. I understand there's supervision in this instance, but what type of dangerous drugs are we discussing here?

MS. BRADLEY:
There are provisions on this in NRS chapter 454, as well as in NAC chapter 639. Generally, what they administer is vaccines. They are not able to inject, for example, Botox. That's permitted by law elsewhere. They are not able to administer other items.

But usually, it's vaccines and those are technically considered dangerous drugs. There will still have to be a doctor's order, of course, for everything that they're administering. The doctor or the APRN will be—and this is existing law—examining the patient and writing the order and the medical assistant is allowed to administer certain things. Again, I want to stress it's not Botox nor fillers. It's usually vaccines.

I think sometimes they also will start an IV. They do not normally put the medication in—as far as I know—and I do have representatives from the nursing board if you have more questions about that. It's basically allowing them to do what they do under the supervision of medical doctors and doctors of osteopathic medicine already.

SENATOR ROGICH:
If this individual is not licensed or certified, how are they qualified to do a vaccine or administer drugs under supervision?

MS. BRADLEY:
The Nevada State Board of Nursing has a protocol and I'm sure they may review it and update it. As for the Nevada Board of Medical Examiners, I can tell you we require training. What we say in our regulations for medical assistants is that they have to be trained in whatever tasks are being delegated to them. It's not allowed for them to be delegated a task they don't have training for.

That training has to be documented in their personnel file and the delegating practitioner is—at the moment for us—a physician or physician assistant and they must know that the assistant would be capable of doing that. Again, it has to be in their file. There are trainings, for example, on vaccine administration and blood-borne pathogens.

Overall, there are certain trainings that I think a lot of them have and that's in their personnel file. If we receive a complaint, we ask for that information. We

ask, "Who did the supervision?" We do look into that if and when we are aware of issues.

SENATOR ELLISON:
I have a question about the amendment, Exhibit F, that was proposed by Northeastern Nevada Regional Hospital. Usually, the nurses or whoever is assisting is still under a doctor's watch, who's in close proximity to where the patient is. So why would this be any different than anybody else giving the shot or whatever the drug may be?

MS. BRADLEY:
I am not as familiar with the amendment, Exhibit F, because that was received just last night. So I will defer that question. If you have a question in regard to physicians, I can try to answer that.

MR. MORALES:
We need this because CRNAs are allowed to operate in that model in critical access hospitals. We are not a critical access hospital; we are a rural hospital. That's why we're proposing the amendment, to clarify that the model would apply to us.

SENATOR ELLISON:
For the record, I totally agree because that hospital has to fly a lot of people out because of staff shortages or whatever. I've been there several times and seen the nursing assistants. I don't know what you are going to do or if we are going to have a meeting on this as a committee and get some language back. I think we are at the point where it's critical when a doctor is without an assistant for help with patients.

CHAIR PAZINA:
I would say that we currently have letters—including from the Association of Nurse Anesthetists—that have come out in opposition. So I would say, it's maybe just a discussion that we have offline very soon because the deadlines are coming and we've looked into some of the important aspects of this bill and I want to see it move forward. Let's have those discussions with the Nevada Association of Nurse Anesthetists as well as with others who have written in with concerns after seeing the amendment.

I did want to ask one question about section 25. I noticed a part was deleted. It was section 25, subsection 1, paragraph (b) which reads, "A special license to a licensed physician of another state to come into this State to care for or assist in the treatment of [his or her own] patient in association with a physician licensed in this State." Almost this whole session, we've all been talking about physician and healthcare shortages. I was curious why that part was deleted?

MS. BRADLEY:
That's being removed because we actually do not require them to be licensed. So, NRS 630.047 has a provision that says if a physician who is licensed in another state comes into Nevada to treat a patient in consultation with the Nevada physician, they just have to let the Board know in writing and no license is required. We just want to remove it because it's a burden we don't need to have.

CHAIR PAZINA:
Perfect.

CATHY DINAUER (Executive Director, Nevada State Board of Nursing):
The Nevada State Board of Nursing supports A.B. 319, in particular section 66 of the bill. Allowing nurses to delegate to medical assistants will not only improve access to care in our State but will assist with workforce development efforts. I want to thank Assemblymember Orentlicher and the Nevada Board of Medical Examiners for bringing this important legislation forward. The Board has been a great collaborative partner in this issue.

ALEX TANCHEK (Nevada Advanced Practice Nurses Association):
We support A.B. 319, especially because it includes sections for the Board of Nursing to develop regulations regarding APRN supervision of medical assistants and the performance of clinical tasks. This will be beneficial because it will increase an APRN's capacity to provide health care to the full extent of their license, which in turn will increase the capacity for and the delivery of health care in our State. Thank you very much and we encourage your support.

STEVE SIMPSON (CEO, Northeastern Nevada Regional Hospital):
I want to start by expressing my gratitude to the sponsor for incorporating our amendment, Exhibit F, into A.B. 319. Our concern stems from the passage of S.B. No. 336 of the 82nd Session, which permitted CRNAs in critical access

hospitals to select, order and administer anesthetics. Northeastern Nevada Regional Hospital is a 75-bed acute care hospital that exceeds the federal definition of a critical access hospital, especially with the addition of our new 16-bed behavioral health unit. We face similar challenges related to personnel and healthcare needs due to our remote location.

We believe the intent of S.B. No. 336 of the 82nd Session was to enhance access to high-quality care in Nevada's most remote areas by permitting CRNAs to practice to the top of their license. This amendment, Exhibit F, to A.B. 319 will allow our hospital to benefit from the provisions of S.B. No. 336 of the 82nd Session. It would thereby support the same policy goal of bolstering rural health care. This will significantly improve our ability to provide healthcare access to residents of Elko and the surrounding rural areas of Nevada. Thank you for your consideration and we urge your support for A.B. 319 with the addition of Exhibit F.

JACQUELINE NGUYEN (Policy Director, Nevada State Medical Association):
We are coming in support of the bill. Unfortunately, with the amendment, Exhibit F, which is being proposed, if it is adopted, our position might change. We only received that language this morning. So we'll need further time to review and converse with our members regarding the amendment. However, I do know that—in quickly speaking with stakeholders—our priority, even with Exhibit F is to maintain physician supervision of the CRNAs. But we also see the many benefits of the remainder of the bill. Thank you so much and at this time, we are in support.

PATRICK KELLY (President and CEO, Nevada Hospital Association):
We respect the Board of Medical Examiners trying to update the regulations and we are neutral with respect to that. But I do want to talk about the situation in Elko. Two years ago, during the legislative session, we were trying to help rural hospitals who are having difficulty recruiting anesthesiologists to rural areas. It's even difficult sometimes in urban areas.

The idea was to put together a situation where the CRNAs could practice at the top of their scope of practice. That has been working for two years in the rural areas, but it was limited to critical access hospitals. Northeastern Nevada Regional is not a critical access hospital, but they're in the rural areas and they have the exact same problems that all the other rural hospitals have.

This bill or the amendment, Exhibit F, would put Northeastern Nevada Regional in the same situation as all the other critical access hospitals in the State. So that is why we would ask for your support.

SENATOR ELLISON:
Thank you and thank you for bringing that up. People don't realize that Northeastern might not be a critical hospital, but still we have a large population in Elko, like at the mines and a lot of construction work within the area. My grandson died at the mines just recently. You need to be able to have these doctors. If they would've got him to the hospital in time, they would've maybe been able to do something better than what they did. I really believe that Elko is a critical hospital for the population and the lifestyle around there.

SENATOR STEINBECK:
What keeps Elko from being a critical access hospital? What is the difference?

MR. KELLY:
Critical access hospitals are a federal designation, and you're limited on the number of beds you can have. So I think it is a 23-bed limitation. If you have over 23 beds, you cannot qualify. Elko is over 23 beds. But, as I said, they're still in what's considered a rural area of the State.

SENATOR STEINBECK:
Thank you.

MR. KELLY:
And there are other minor services and implications.

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CHAIR PAZINA:
Thank you so much for the presentation today, Assemblymember Orentlicher. I would be happy to meet after this as well and connect you with those who reached out this morning in opposition so we can get this finalized quickly with deadlines coming.

So, with that, we will close the hearing on A.B. 319. With that, this meeting is adjourned at 9:55 am.

RESPECTFULLY SUBMITTED:

_____
Madison Zajac,
Committee Secretary

APPROVED BY:

_____
Senator Julie Pazina, Chair

DATE: _____

EXHIBIT SUMMARY				
Bill	**Exhibit Letter**	**Introduced on Minute Report Page No.**	**Witness / Entity**	**Description**
	A	1		Agenda
	B	1		Attendance Roster
A.B. 512	C	5	Tray Abney / LegalShield	Neutral Testimony: Adam Plain / Division of Insurance
A.B. 177	D	8	Jennifer Pierce / Nevada Speech-Language Pathology, Audiology and Hearing Aid Dispensing Board	Presentation
A.B. 319	E	20	Assemblymember David Orentlicher	Conceptual Amendment
A.B. 319	F	20	Assemblymember David Orentlicher	Proposed Conceptual Amendment: / Northeastern Nevada Regional Hospital