MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Seventy-fourth Session
March 14, 2007

The Senate Committee on Commerce and Labor was called to order by Chair Randolph J. Townsend at 8:02 a.m. on Wednesday, March 14, 2007, in Room 2135 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412, 555 East Washington Avenue, 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 Randolph J. Townsend, Chair
Senator Warren B. Hardy II, Vice Chair
Senator Joseph J. Heck
Senator Michael A. Schneider
Senator Maggie Carlton

GUEST LEGISLATORS PRESENT:

Senator Barbara K. Cegavske, Clark County Senatorial District No. 8
Senator Valerie Wiener, Clark County Senatorial District No. 3
Assemblywoman Sheila Leslie, Assembly District No. 27

STAFF MEMBERS PRESENT:

Kelly S. Gregory, Committee Policy Analyst
Wil Keane, Committee Counsel
Lori Johnson, Committee Secretary
Scott Young, Committee Policy Analyst
Laura Adler, Committee Secretary

OTHERS PRESENT:

Larry L. Pinson, Executive Secretary, State Board of Pharmacy
Harry Spring, Chairman, State Health Information and Policy Analysis Advisory Council, State of Florida
Barry Gold, Director, AARP Nevada

Elizabeth MacMenamin, Retail Association of Nevada
Sarah Bieski, Director, Nevada Diabetes Association
Lawrence P. Matheis, Executive Director, Nevada State Medical Association
John B. DuBois
John P. Sande III, Nevada Bankers Association
Alfredo T. Alonso, HSBC
Steven Kondrup, Acting Commissioner, Division of Financial Institutions, Department of Business and Industry
Fred L. Hillerby, Nevada State Board of Pharmacy
Carol Livingston, Vice President, Wolters Kluwer Health
James Franklin, Wolters Kluwer Health
Robert J. Hunkler, Director, Professional Affairs, IMS Health
Randolph B. Frankel, Vice President, Public Affairs, IMS Health
James W. Morgan, Pharmaceutical Research and Manufacturers of America
Andrea Jean Douglas, MPH, Director, State Policy, Pharmaceutical Research and Manufacturers of America

CHAIR TOWNSEND:
We will open the hearing on Senate Bill (S.B.) 197.

SENATE BILL 197: Requires the State Board of Pharmacy to make available to consumers certain information relating to pharmacies and the prices of commonly prescribed prescription drugs. (BDR 54-67)

SENATOR VALERIE WIENER (Clark County Senatorial District No. 3):
I seek your support for S.B. 197. This legislation requires the State Board of Pharmacy to compile and provide on a regularly updated Web site, important prescription-drug information, including pricing and where sold (**Exhibit C**).

CHAIR TOWNSEND:
You need $35,000, right? Just tell the State Board of Pharmacy to do the Web site and give them the money.

SENATOR WIENER:
I do not know, I cannot answer that. I believe we need to establish it.

CHAIR TOWNSEND:
Who is here from the Board? Can we tell you to do this and give you the money? Because Senator Wiener has worked on this for two Legislative

Sessions, and Assemblywoman Leslie has worked tirelessly on this issue, we would like to get it going.

LARRY L. PINSON (Executive Secretary, State Board of Pharmacy):
The answer is yes. We have redesigned our Web site. It is in great shape, and we can make it happen. The Department of Information Technology estimated 265 hours of programming time. The numbers put forth would financially take care of that.

SENATOR WIENER:
Mr. Chair, if you would indulge me, we have a witness from Florida that is online. He is instrumental in establishing the Florida site, and can answer any questions you may have.

HARRY SPRING (Chairman, State Health Information and Policy Analysis Advisory Council, State of Florida):
We have been given the responsibility to create our various initiatives on transparency; one of which is prescription drugs. We did research in 2004 when we passed legislation to show that 69 percent of people in Florida use the Internet as their primary source for health information. Primarily, they used it to look at disease and medical problems, but the next most frequent time they used the Internet for health purposes, was for prescription and over-the-counter drug costs (**Exhibit D** is on file in the Research Library to illustrate our Web site, and **Exhibit E**).

We looked at business decision-makers and media in a subgrouping in terms of survey work, and found the cost of prescription drugs was the most important thing to both employers and the media in terms of their priorities around health care issues.

We created this in conjunction with our attorney general, who is now our governor, and worked with our department of agriculture which does our consumer services. These groups put together a consumer Web site to allow consumers to shop for the 100 most commonly used name-brand drugs. The consumer can search by city, county or a broader geography. The search automatically includes the ability to look at the generic alternative pricing.

We have 3,400 pharmacies authorized as Medicare providers in our system. We use the customary Medicaid report that pharmacies submit monthly for regular updates.

There is a picture on the Web site showing one medication, Xanax, showing a 2 mg tablet and the usual and customary charges. At the top is the lowest price in Miami, $11.16 for a three months' supply. Normally, it would be a one-month supply as that is the most commonly ordered quantity. The list goes down to the second page to a high of $482. You are talking about a 4,000-percent differential. As of March this year, the highest price in terms of impact of this program has dropped to $40. There has been a slight impact on the lower price which has gone to $12. We have gone from 4,000- to 400-percent differential in two months' period by making it public.

It cost us 160 hours to design and develop a test. From a programming standpoint, we do a monthly data extract, which takes an hour each month. We have an automated process that takes 14 hours a month to clean the data and to confirm accuracy of the data.

CHAIR TOWNSEND:
We appreciate what you have done as it makes it easier to learn from someone who has done it correctly.

Assemblywoman Leslie and I discussed this yesterday. While there is a huge value to the public, we wondered how far it could be gotten into the public domain. Do you provide this to local access channels for people who cannot access the Internet?

MR. SPRING:
We have not tried that, but it is a wonderful idea and I will present that to my group.

CHAIR TOWNSEND:
Hopefully, we can count on our Board to talk to Mr. Spring to save time in implementing it here.

MR. SPRING:
We are finishing a quickie user guide to be available to all senior centers and public libraries. We will be training people to help folks who do not have Internet capabilities.

CHAIR TOWNSEND:
All those avenues have value to get the information into the public domain. We would invite people involved in public access to talk to us about this. The key would be regular updating for accurate and current information to match what is required in the bill.

ASSEMBLYWOMAN SHEILA LESLIE (Assembly District No. 27):
I have a similar bill, Assembly Bill (A.B.) 232. I support Senator Wiener, and hear any concerns the Committee members may have. I know the retailers have some concerns to bring before you. I look forward to working with everyone to have this program in place as soon as possible. It is the same way people shop for gasoline. This enables everyone to shop for the lowest price on their prescription drugs. This is a consumer-friendly idea.

ASSEMBLY BILL 232: Requires the State Board of Pharmacy to make available to consumers certain information relating to pharmacies and the prices of commonly prescribed prescription drugs. (BDR 54-856)

SENATOR WIENER:
In section 8 of S.B. 197, there is a provision about gifts, grants and bequests, which I include in many of my bills. With confidence that others may support this financially when signed into law, I will donate $1,000 to this project.

BARRY GOLD (Director, AARP Nevada):
I have prepared testimony in support of the bill, which I would like to read (**Exhibit F**).

ELIZABETH MACMENAMIN (Retail Association of Nevada):
While our members can support the concept of this bill, we have to oppose the bill as it is currently written, and submit an outline of the negative impact (**Exhibit G**). Both sponsors of S.B. 197 said they are willing to work with us. After reviewing the Florida language, our members are onboard with that, it would be the most cost-effective method to implement in Nevada. They offered the use of their template for their Web site, which would cut costs

considerably. One thing is to put this in the proper governmental place. Right now, Medicaid receives, monthly, the usual and customary prices within the drug market. That information is already available and easily utilized. As opposed to each pharmacy submitting its pricing, it is already gathered monthly.

CHAIR TOWNSEND:
Does not that defeat the whole purpose?

MS. MACMENAMIN:
In what regard, Sir?

CHAIR TOWNSEND:
I thought the purpose of this was to have all the pharmacies with their prices on the Web site?

MS. MACMENAMIN:
Every pharmacy will be. When they supply the information to Medicaid on their monthly billing, each pharmacy does it individually, but it is all grouped on a state level. The Medicaid department has each individual pharmacy that is billing for the month, and there is the usual and customary. I would have to do more research as to how our Medicaid services does it. That is how it is done in Florida, and that is what they use for their information.

CHAIR TOWNSEND:
Perhaps I did not hear you. It sounded like you were going to have a generic price based on the collation of all pharmacies reporting to Medicaid.

MS. MACMENAMIN:
I apologize, Mr. Chairman; that was not my intent. In Florida, this program is not in the state board of pharmacy, but in the attorney general's office.

I spoke with Assemblywoman Leslie and Senator Wiener about the health advocate's office that our Attorney General has, which is a place this program could sit without being of great expense to the State. One thing we looked for in this bill is to find ways to save some of the money being requested.

CHAIR TOWNSEND:
Senator Wiener, did you look at the possibilities in the Florida bill?

SENATOR WIENER:
Mr. Spring offered a look at the template, but populations of both states are quite different. It may not be appropriate for Nevada to rely on the Medicaid list on which Florida heavily relies. I am not sure we can take it exactly as is; we will have to adjust to the needs of Nevada.

CHAIR TOWNSEND:
We will talk later about placement of the program as I am wondering about the thought process.

SENATOR CARLTON:
In reading this, I thought it should be under the Office for Consumer Health Assistance. Then thinking about what we did last Legislative Session regarding the Canadian drugs and the State Board of Pharmacy, people are already used to going to the State Board of Pharmacy. The two words together would be a natural path for the public. It would not be natural to think of the attorney general. If the Board is willing to do this, it would be a good placement.

MS. MACMENAMIN:
It is my understanding, and I will do more investigation. I thought the Canadian drug prices were in the Office of the Governor. Consumer Health Assistance is not through the State Board of Pharmacy.

SENATOR CARLTON:
Is there a link?

MS. MACMENAMIN:
There may be a link. If not, it would not be a problem to put in a link. People are not typically going to the Board for those Canadian drug prices. Typically, people are going through consumer affairs in which help is given to finance drugs they cannot afford.

SENATOR CARLTON:
We want to make it as easy as possible on the consumer to succeed in getting the correct information.

MS. MACMENAMIN:
Absolutely; I agree.

SARAH BIESKI (Director, Nevada Diabetes Association):
I am in support of S.B. 197 and all the benefits it will provide to the 7.1 percent of Nevadans, including myself, who are diabetic. Diabetes is a $130 billion-a-year industry, and anything we can do for our constituents to make those prices go down would be most beneficial.

LARRY MATHEIS (Executive Director, Nevada State Medical Association):
We do support S.B. 197. It will need some modification along with A.B. 232, and we will help in any way we can. Transparency is an important growing issue that needs to be done right, and this is important information for patients and their families.

CHAIR TOWNSEND:
Our two colleagues have developed a great deal of expertise in this area. Over the next week or so while you decide what you want to do in your House in terms of processing the bill, we will ask the retailer to work directly with you and so will we.

What you have brought forward is an excellent effort to provide an opportunity for consumers to benefit themselves. The more opportunity we give them to drive the market, the better things work in our society.

We will now close the hearing on S.B. 197, and open the hearing on S.B. 209.

SENATE BILL 209: Prohibits a person from selling or issuing checks unless he is affiliated with a depository institution. (BDR 55-680)

SENATOR BARBARA K. CEGAVSKE (Clark County Senatorial District No. 8):
I appreciate the opportunity to come before you today. I will read my prepared testimony on better control of identity theft and checks (**Exhibit H**).

With me is a constituent whose wife contacted me about her bank statement in the mail indicating she had been shopping. To her recollection, she had not been to any of those stores. Upon calling the bank, they learned someone had indeed stolen the numbers of their checking account and were using it to shop. It took a while to clear up the matter.

The main point today is to let everyone know this is happening and can happen to anyone. If there is a way to ensure that is does not happen again, that is our

intention. This bill might not be the perfect avenue, it may need amending, but it is a start.

CHAIR TOWNSEND:
One of your statements that sticks most with many of us is what happens to you in terms of having to clean up the confusion created and the amount of time it takes for the individuals and related businesses.

SENATOR CEGAVSKE:
It is especially difficult for seniors who have to make arrangements to get to the places for new identification and paperwork. Who do you call and where do you start are among the concerns I heard.

CHAIR TOWNSEND:
Do we have a unit in the Attorney General's Office or law enforcement office now where people can call to find out what they do?

SENATOR CEGAVSKE:
Usually, the first thing is to notify the bank. Then, depending on what the bank does, since most have a fraud unit, it goes from there. This is similar to what happened in my son's business where somebody had taken checks and written checks to other places. It took a while to find out what happened. It was not caught at the bank because signatures were not verified, and the bank became liable. It appears the bank is the first place where most people start. They then have to decide if they are going to spend money for a civil suit against somebody.

JOHN B. DUBOIS:
Thank you for allowing me to appear. As Senator Cegavske mentioned, my wife and I went through quite a hassle on this check situation. We write a lot of checks and have a lot of withdrawals. At least every other day my wife checks by telephone to make sure everything is up to par. About a year ago, she noticed that a couple of checks were out of number sequence (**Exhibit I**). Looking at the checks from the bank there were some out of number sequence. For instance, check numbers 1185, 1175, 1164; then number 2832; then it drops back to 1184, 1181; then number 2983. My wife checked with the bank and found one was made out to Marshalls, and another to Bed Bath & Beyond. It took hours on the phone with the bank to find that a Zoe Larner, with a nonexistent Las Vegas address on the checks, had written them on our account.

As you can see, the check has our Wells Fargo Bank routing number and our account number.

Through further investigation, we learned that anyone can order checks from other than a bank as shown (**Exhibit J**); that is, from your computer, or over the telephone. It is my understanding that the person is to send in a voided check on a current account, but how that is done with a computer or by telephone is beyond me. Apparently, there are ways around it, and I am a living witness to that.

The name the culprit put on the check, obviously, is taken from their driver's license and I presume, the same address. It is a simple matter when everything lines up. They just show their identification and sign the check with the name that conforms to the signature on the driver's license, and away they go.

Like I said, my wife checks our account almost every morning, and after noticing these checks, we closed our account immediately and opened another account. It was easy to close the account, but then dealing with the outstanding checks was a problem.

If we had not closed the account immediately, we could have been hit for quite a bit more as our checking account, at that time, had $9,100 in it. This person could have kept going past these two checks and wiped us out. I highly recommend this bill to help close the gap in this type of fraud that goes on forever.

CHAIR TOWNSEND:
Relative to law enforcement, who else was contacted?

MR. DUBOIS:
The bank was contacted, and I also called the police who said to come down and make out a report. They did not sound too interested, which I can understand as this is a low priority to them. I could have pushed it and filed a police report, but I do not think it would have done any good. I did all the work through the bank. The main thing was to close the account. I had to go to the outstanding checks section and tell them what happened and that another check from my new account would be sent. The bank helped, but was not a big help. The bank settled for one of the illegal checks, but we are still fighting to get the second check for $280 reimbursed. The local branch did not seem to

know what was going on. I had to find someone in the bank's San Francisco office's fraud department. But, they still were not much help for us.

CHAIR TOWNSEND:
Did anyone hear from the district attorney or Attorney General's Office on this bill?

SENATOR CEGAVSKE:
The Attorney General's Office is in the committee hearing that I am missing while doing this.

CHAIR TOWNSEND:
When they are finished there, ask them to come by here, as it would be important to find out what role law enforcement has in this, as this is important.

SENATOR CEGAVSKE:
I know they have the fraud unit, as that was the subject they were on when I left.

CHAIR TOWNSEND:
Mr. DuBois, it is fair to assume the people who did this did not isolate you, but went after other people, too?

MR. DUBOIS:
One problem is that most people wait until they receive their bank statement each month before checking their accounts. The difference for us was that my wife checks our account almost daily.

SENATOR HARDY:
Is this the issue you are fighting over? The bank cleared a check with your account. I always wondered how they verify signatures. Apparently, that is low on their priority list, if they are passing through a check that does not have your name on it. The bank never did catch this?

MR. DUBOIS:
Apparently not.

SENATOR CEGAVSKE:
That is one of the issues brought to my attention. You can have checks printed anywhere, and nobody verifies that number. When his account number was taken, it was never checked, never verified.

SENATOR HARDY:
I order my checks from Deluxe Checks and have for years without a problem. I always knew this was possible, but assumed the bank was going to catch that.

MR. DUBOIS:
Another problem is these checks are done on cheaper paper, making it harder to see the important information printed on the back of checks.

CHAIR TOWNSEND:
What amazes me is there are not more people who ask for photo identification and call the credit card companies; they just swipe the cards, you sign it and leave. What is more surprising is when store personnel apologize for asking for your identification.

SENATOR CEGAVSKE:
I always thank them.

MR. DUBOIS:
In my case, their identification and signature would coincide. The problem is the bank did not check at all.

CHAIR TOWNSEND:
Senator Heck and Senator Schneider sit on that subcommittee.

JOHN P. SANDE III (Nevada Bankers Association):
We understand the concerns expressed and sympathize with them. Unfortunately, as this bill is drafted, it is unworkable. You have heard the testimony that you can get checks over the Internet, out of state or go to Costco for checks. This would be unenforceable unless it was done at the federal level. This would not address the issue because if somebody is going to forge a document such as a check, they are going to do it regardless of whether they comply or do it themselves.

SENATOR HARDY:
I am intrigued by this because I started ordering my checks from the same place my bank gets them. The concern is that if someone can get my account number, they can call under their name to order. It appears the issue is that if the banks are the only ones who can order checks, they can verify the correct check number and name. As you said, once the information is in the hands of the check-printing company, it is unsecured regardless of whose order it is. It appears the issue is some control prior to the order. I knew this was possible, but there is no way it could be pulled off with a bank because they verify signatures, but they passed checks with somebody else's name.

MR. SANDE:
The verification is a difficult issue for financial institutions. If there is a forged check that does not have the signature of the person, the financial institution is responsible. I will look into it and get as much information as I can about the steps they take regarding check cashing, and get back to you.

SENATOR HARDY:
It is the same people the banks use, so we have to trust them. The concern is the bank or the check-printing company would have to verify information, but I do not know how at this time.

ALFREDO T. ALONSO (HSBC):
I am representing Household Banking HSBC and have similar concerns. To give you an idea of how far-reaching this would be; if you purchased a copy of Quicken, you would not be able to order your checks with them any longer. It is something we would like to work on together to see what we can do at the bank level or otherwise. However, this bill would clearly go too far.

CHAIR TOWNSEND:
At first blush, this bill would lead one to believe that if you could narrow the producers of checks, in a competitive market, to be funneled only through the people who provide the service, meaning the banks, that there would be a greater sense of security for the individual. The glitch with the way the bill is written is the same one in most areas of commerce, and that is the Internet through which things from out of state can be ordered.

STEVEN KONDRUP (Acting Commissioner, Division of Financial Institutions, Department of Business and Industry):
My division is responsible for the regulatory enforcement of both State depositories as well as the money transmitters. This bill addresses the *Nevada Revised Statute* (NRS) 671, which is the "issuers of instruments for transmission or payment of money". The definition in the NRS 671 of a check is a draft or money order. One of the areas is the impact of not allowing others to sell money orders. These are retail facilities such as convenience stores, food stores and different retailers that are currently authorized to provide these services. That would have a large impact on the consumers and the State.

The Division of Financial Institutions is not against any legislation that will protect the consumer; on the other hand, the Financial Institutions Division thinks the consumer should have the opportunity to access different services that they can purchase through retailers. We would also like to inform the committee that there are individuals who are unable to have accounts with different banks for various reasons, so they pay their bills through the money-order system.

SENATOR CARLTON:
This is something I have encountered in the past and would like to know why. I needed to purchase a money order because that was what the business would accept. I was not allowed to put the money order on my credit card. I was told it was against the law. Although, I know that is a standard response, I would like to know why.

MR. KONDRUP:
I do not know why. In fact, when I worked in a financial institution prior to coming to work for the State of Nevada, that institution allowed the individuals to purchase money orders and cashier checks by utilizing their credit card.

SENATOR HECK:
Nothing further on the bill, but to be sure we protect Mr. DuBois, I recommend we have the committee secretaries collect the copies of his check draft and make sure they properly dispose of them.

CHAIR TOWNSEND:
Point well taken. For the record and full disclosure, I sit on a bank board and am a shareholder in a bank.

We will close the hearing on S.B. 209, and open the hearing on S.B. 231.

SENATE BILL 231: Revises provisions relating to confidentiality of contents of prescriptions. (BDR 54-524)

SENATOR JOSEPH J. HECK (Clark County Senatorial District No. 5):
I appreciate the opportunity to present S.B. 231, which is a follow-on measure that came to light after this committee deliberated several pharmacy bills during the 2005 Legislative Session. The reason I bring this bill forward this Session is to make clear I am not motivated by whether or not this impacts the cost of prescription drugs. If that is a second order effect of this bill, so be it, but that is not the primary reason why I bring it forward.

The reason I bring it forward is because it became clear to me during the deliberations last Session, that we already have a law that addresses this issue which is blatantly not being followed. A copy of the current law is one of the exhibits (**Exhibit K**); it is in the NRS 639.238. To me, this clearly states that prescriptions are not public records, and anything contained therein is not to be released to the public, with certain exceptions which are clearly listed in the law.

If it is in the law, I wondered why this practice was still taking place, that maybe I had misread the law. I asked our Legislative Counsel Bureau (LCB) to provide an opinion, which is also provided (**Exhibit L**). It states, much to my happiness, that I was not wrong, and that all contents of a prescription, according to our current law, are not to be divulged. The area in question seems to be whether or not that includes the prescriber data; not the patient data, because everyone would agree that the patient data is not releasable, especially under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Whether or not the prescriber data, that is the name of the physician who is prescribing the medication, is also considered protected, is clear in the LCB opinion that, according to them, the prescriber data is also protected and not to be released.

As you can imagine, once the bill draft came out, there was a great deal of interest generated in this fact. I have heard many different interpretations of the law; one going on the fact that this law was in response to the HIPAA to protect the patient. If you look at the current law, at the bottom, this law was

initially enacted in 1967; way before the HIPAA was a figment of the imagination of the federal government. If you look at the amendments that took place after the HIPAA enactment which were in 2001, 2003 and 2005, none dealt with the confidentiality of the material, but dealt with some administrative issues related to how this chapter was enforced. It was clear that this is not in response to any federal laws that were recently passed.

As the entities that have a vested interest in continuing to obtain these data came forward to ask my motivation, they all said we do not use that data any more for detailing, but there is a lot of public good that comes out of having some of this data. I would remind you that I submitted this bill draft request before the August 2006 deadline; so there has been a fair amount of time for people to speak to me about the bill, and many of them availed themselves over those intervening months.

I asked everyone who came to me saying there is a greater public good, to please provide me with documentation regarding that greater public good, because I may not be prescribing the right drugs. I have never seen any of the greater public good, whether it is a research study, a safety recall and adverse effects, all the things they purport to be done by collecting these data. As of this morning, I have yet to receive any concrete data of any greater public good that is performed through this process of having the actual physician's name and the medication they prescribe.

In fact, I would say I am somewhat loosening this law in that I am allowing the release of aggregate data concerning prescribed medication. The "identified aggregate data" meaning that if somebody wants to know how many pills are sold in a certain ZIP code, they can have that data. They cannot know the identification of the patient or the physician.

You will hear that the American Medical Association (AMA), you may have received the same letter I received from the AMA, opposes this change. Again, there is a reference to the greater public good, but there is no specific evidence of that greater public good. They talk about the opt out program that they have instituted to allow physicians who do not want their data to be released, to have the opportunity to go on to the Web site or provide some documentation that would prohibit their data from being released. While I applaud the effort in giving physicians a choice, my concern with the opt out is that it is a proactive process. It involves somebody to actually do something to stop their data from

being released. As Senator Carlton alluded, and I agree, in a physician's busy practice, the last thing the physician is going to think about is going online to make sure he opts out of a process which in our State is already illegal. Had the process been an opt in procedure, perhaps there would be no need for this bill; however, that is not the case.

Likewise, with all the greater public good that was touted in the intervening months, I have not been presented with any amendment by anybody who opposes the bill to try to allow the purported greater public good to continue to take place; so I have to question what it may be. They talk about targeted recalls. I have been a physician for almost 20 years, I have never subjected or received a target recall; there are blanket letters sent out when something goes wrong. I have never been contacted directly by a pharmaceutical company because of my prescribing habits. I have not been asked to participate in a research project because of my prescribing habits. Again, that may be me; I may be prescribing the wrong drugs.

My major concern with this process now is that it is, according to our own legal counsel, currently against the law. What this bill simply says is it is our law and we mean it.

SENATOR CARLTON:
I would like to boil this down. Right now it is against the law for anyone other than law enforcement to know who the prescriber is. We want to make sure we protect the doctors from someone else finding out how they are practicing or choices they are making between themselves and the patient. It should only follow law enforcement and not to pharmaceutical companies.

SENATOR HECK:
There are some other exceptions currently in statute about who can receive that information, but the pharmaceutical industry is not one of those exceptions.

SENATOR CARLTON:
One thing I would like to clarify from when I and Mr. Young were going through the bill and the law enforcement language; it may have to be adjusted, because under local government for limited purposes all the different people listed as possible peace officers. Mr. Young taught me a lesson in 2001 that when you make a list you have to be careful who you include and who you exclude to make sure we do not include sheriffs, deputies, bailiffs, constables, possibly

security officers and others like that. It would behoove us to review the list to be sure the right people are listed.

SENATOR HECK:
That is a cleanup piece by the drafters, because page 2, line 28 of S.B. 231 is already in the law. It refers to peace officer, but in the definitions there is only the term "officer" to correlate the definition already in the bill. It does not expand or restrict anything from the current law; it was strictly for clarification.

SENATOR CARLTON:
The definition of peace officer is quite broad. I want to be sure this does not apply, for example, to a bailiff.

WIL KEANE (Committee Counsel):
> Actually, if you look on page 3, line 24, the last word there is the first part of peace officer. The term is already, peace officer. What happened is because we included other definitions, they had to capitalize the first letter of peace in peace officer; so they just took out the word peace officer in that line and included it again. So there is actually no change in the defined terms; it is exactly the same defined term.

SENATOR CARLTON:
The confusion I am having is when using the words "peace officer", and there are numerous people being listed as peace officers and only excluding college and school police, then you would be including all other peace officers. I am not sure that was the intention. If someone could clarify that, I would appreciate it.

SENATOR HECK:
It is a peace officer who is operating under subparagraph (1) or (2) of paragraph (j) of subsection 1, section 1. A bailiff, who was not involved in an investigation of a crime with a pharmacy or a search warrant pursuant to a court order, would not have that ability just by purposes of being determined a peace officer.

CHAIR TOWNSEND:
Is it your understanding that since the law is fairly easy to read, and we now have an opinion clarifying it once again, and since this is under the NRS 639, is

there some misunderstanding about the regulatory role of this that may not be interpreted correctly? Have you addressed that with the Board of Pharmacy?

SENATOR HECK:
It is the Board of Pharmacy. This provision is within the pharmacy chapter. No, Mr. Chair, I have not.

FRED L. HILLERBY (Nevada State Board of Pharmacy):
I do not know that. I asked Mr. Pinson to have their legal counsel look at this again, and have an answer to that question.

CHAIR TOWNSEND:
Since this was submitted for the August deadline, could you pick up the pace to get an answer to the question of what part of the NRS 639.238 the Board did not understand?

MR. HILLERBY:
I will relay that message. I remember from two years ago, in working with Senator McGinness, there is a substantial amount of case law around these kinds of statutes about the purpose being to protect the patient's confidentiality, not necessarily the physician's. That is one of the thought processes of two years ago. I will be sure to have the Pharmacy Board get back to you.

CHAIR TOWNSEND:
You might want to read this legal opinion; it contains 12 to 15 cites for cases.

MR. HILLERBY:
I have not seen it, but will get a copy from Senator Heck and read it.

CHAIR TOWNSEND:
It would be helpful to have a quick response to that.

BARRY GOLD (Director, Government Relations, AARP Nevada):
I have prepared an introduction on Senate Bill 231 (**Exhibit M**) which deals with prescriber profiling. This is a marketing practice where the drug companies buy information on the medicine your doctor prescribes, and use it as a commercial marketing strategy. This is an invasion of privacy for both doctors and patients.

I have provided copies of a *The Wall Street Journal* online article dated May 4, 2006 (**Exhibit N**), relating to prescriber profiling and the New Hampshire experience about an opt out program that is supposed to solve the issue.

The New York Times article (**Exhibit O**) describes doctors who were outraged when drug salespeople told them how many times they prescribed a medication.

CHAIR TOWNSEND:
For full disclosure purposes, I am a member of the AARP.

LAWRENCE P. MATHEIS (Executive Director, Nevada State Medical Association):
In S.B. 231, Senator Heck seems to restate and clarify current Nevada law related to the release of information regarding prescription drugs. The Nevada State Medical Association (NSMA) supports the current law, therefore supports the bill.

Our understanding of the current law is the same as your legal counsel, the same as Senator Heck's, and you should find the same for the Board of Pharmacy.

Essentially, a prescription is treated as an extension of an individual's medical record. It is a directive from the prescribing physician or practitioner to a pharmacist to dispense a specific controlled substance in a specific dosage and amount for a specific patient's use. The pharmacist and pharmacy are not permitted to release the information, except for those listed circumstances.

Section 1, subsection 1 of the bill reiterates this in clear language so that even lawyers can understand it. Section 1, subsection 5 restates in detail that collecting aggregated prescription-drug data for whatever research purposes, which can currently be done, can still be done. This does not in any way affect clinical trials or other scientific research on effectiveness of drugs. It only clarifies the use of individual patient and prescriber information is inappropriate.

It must be noted for many reasons, but primarily related to cost of pharmaceutical products, that dispensing prescription drugs is now done via national, regional or Internet pharmacies that do not come under state law. There also has developed a lucrative commercial prescription-drug collection industry that collects and sells individual prescriber's information. There have been several national efforts to restrict the inappropriate use of prescriber's data

by pharmaceutical companies and others. Most recently, the AMA has developed the "Physician Data Restriction Program" (PDRP). The PDRP allows physicians to opt out from having their individual prescribing information used by pharmaceutical companies or their representatives however they may get the data.

The pharmaceutical industries agreed to this voluntary program which allows physicians to report any misuse of this information or other inappropriate behavior by pharmaceutical sales representatives or companies.

The voluntary program is self-enforcing and relies upon the commitment of the various parties, which we are sure has been pledged in good faith. The Nevada State Medical Association supports the AMA's PDRP program as one approach to dealing with the multiplicity of sources of these data, and to allow for some mechanism to deal nationally with the problem of misuse of prescription information. That does not mean that we should not enforce our law. It means that their data cannot come from a lot of different sources now that are outside of the reach of the State of Nevada.

Mr. Chairman, there is something I have hesitated to raise, but think I have to do so. There are occasions when we all deal in these public-policy discussions, and know that sometimes they become heated. Occasionally, advocates for one side or the other make inappropriate comments about the consequences of taking a position on a matter. There have been communications which may have been misinterpreted about possible repercussions for physicians who support this legislation or the similar bill being processed in the other chamber. While we want to believe that these are merely misunderstandings, it is the intention of the NSMA to bring any specific acts of retaliation against the NSMA members because of the association's positions on legislation before this Committee to attention of the Chair for appropriate legislative action.

CAROL LIVINGSTON (Vice President, Wolters Kluwer Health):
Wolters Kluwer Health is one of the three major health-information organizations in the United States. We provide products and services to the pharmaceutical industry. We collect, aggregate and standardize prescription data. Our data processes strictly adhere to HIPAA regulations in order to protect patient privacy, and we are certified each year.

Our concern with S.B. 231 is that by not allowing health-information organizations and pharmaceutical manufacturers to receive prescriber-identifiable data, the pharmaceutical companies cannot efficiently provide educational information to physicians. Additionally, by not knowing which physicians prescribe which drugs, manufacturers cannot provide samples to the doctors whose patients might not otherwise be able to afford the drug.

Medicare is increasingly monitoring and limiting physicians' discretion in their selection of appropriate treatments for their patients. If we limit their access to product information offered through dialogue with a manufacturer's representative, we will be inadvertently endangering the very lives the physician seeks to protect, the patient.

Ms. LIVINGSTON:
We do not apologize for the commercial aspect of our business; however, it is important to understand that without the commercial side of this business, the availability of this comprehensive information used for public good and safety benefits would not exist. Additionally, the expense of collecting and managing these data is currently funded by the private sector; yet it is used by governmental entities such as the Food and Drug Administration (FDA) and the Drug Enforcement Administration (DEA). The FDA uses these data to identify regional health trends and epidemic outbreaks or to monitor off-label prescribing. The DEA uses these data to recognize controlled-substance abuse. The pharmaceutical companies use these data to identify doctors who are good candidates to run clinical trials and to immediately notify appropriate physicians of drug alerts and safety precautions.

While the doctors may not like the occasional ill-mannered sales representative, a behavior that Wolters Kluwer does not condone, this bill could deny physicians updated information on cutting edge specialized uses of treatments. We have already heard about the AMA program that allows the doctor to choose to opt out, so their data and prescribing behavior are not available to the pharmaceutical representatives and their management.

Included in your exhibits is a handout showing what a doctor needs to do in order to opt out (**Exhibit P**). It is a quick computer screen with links a doctor can go through that would remove his or her data from the pharmaceutical manufacturers' hands.

Our concern with this bill is that it has unintended, unknown ramifications and is somewhat overreaching and imprecise in its application.

SENATOR HECK:
Since this is already the law, I would like to know how you believe you are legally collecting these data in the State of Nevada?

MS. LIVINGSTON:
The subscriber-level data has been out in the industry for more than 14 years. It is not new. I am not sure why it has not been addressed by the appropriate legal authorities.

SENATOR HARDY:
This is a valid point. This legal opinion is an 800-pound gorilla standing in the corner that this Committee cannot ignore. This whole discussion based on this might be moot.

JAMES FRANKLIN (Wolters Kluwer Health):
We have contracts with our data vendors that state that we, as well as our data vendors, will meet any applicable laws. We will not do anything against the law. If that is determined, we will be in compliance with the law.

We would like to be part of the process of creating carefully crafted language that codifies the behavior or bad behavior of representatives while referencing the PDRP, and still allows that program to evolve. Again, it may be a moot point if this makes it against the law. Unfortunately, we did not know about this law until recently. That may be a problem on our side, but we were not made aware of the language of the law until a few weeks ago, or we would have met with you sooner.

SENATOR HECK:
I can appreciate not knowing the language of the law, but how long have you been doing business in or getting data from the State of Nevada?

MS. LIVINGSTON:
Technically, I am not sure that we actually received data from any institution or company from Nevada. The prescriptions we receive come from the headquarters of the major chains, as well as the pharmacy management companies that collect data on some of the smaller chains and independents.

Although data comes to us from pharmacies in Nevada, the actual shipment to us most likely does not come from Nevada.

ROBERT J. HUNKLER (Director, Professional Affairs, IMS Health):
I am in opposition to S.B. 231. As my colleagues have noted, we have not seen this new legal opinion. Recently, we became aware of this statute on the books, and our legal staff's interpretation of that was different. We are eager to see that opinion and learn from it and reconcile our views with that.

We have submitted written testimony (**Exhibit Q**) prepared by our legal staff. There are some points I would like to touch upon to amplify that. The provider-identified prescription information has a wide range of uses by a variety of stakeholders in the health care system. Restriction of this information would harm safety initiatives, government programs and other uses.

Senator Heck, I was not aware of your desire to know more specifics about that, and we would gladly send you references about a number of research applications and for greater public-good applications to which this information has been put in the past.

SENATOR HARDY:
That is a threshold issue for all of us. We would all like to understand the balance. For most of us, there needs to be a compelling public-policy reason to allow this information.

MR. HUNKLER:
I would like to amplify the AMA's PDRP. Indeed, the doctors do have a choice in the access of others to the prescribing information. This program was characterized as self-enforcing, and that is not exactly correct. It is contractually bound, so if the pharmaceutical manufacturers do not abide by it, they risk losing access to the data all together. That is a powerful incentive for them to abide by the guidelines.

The program was not created in a vacuum; it was based upon the AMA's polling of physicians nationally, in which they were told that the vast majority of physicians' concerns about access to these data would be allayed by the existence of a program of this type. Those polls were done in 2004, and we went to work immediately putting this program together. It was enacted in the middle of 2006.

The Wall Street Journal and *The New York Times* articles that were disparaging of the program were written two months prior. Before the program went into effect, they had already decided they were not going to agree with the efficacy of that program.

MR. HUNKLER:
This program is open to all doctors, M.D.s and D.O.s, across the country. The fact that nurse practitioners, physician assistants and dentists do not have the means to participate, frankly, is a red herring. Those individuals when approaching me are more concerned about having their data included into our database. I have never, in my almost 20 years in this role or a similar one, been approached by any other nurse's assistant or physician's assistant about having their data withheld.

The final point is the constitutionality of data restriction of this type was subject to a lawsuit in federal court in Concord, New Hampshire. A previous speaker had mentioned that the state of New Hampshire passed a similar bill restricting access to this kind of information for commercial purposes. A competitor and IMS Health sued the state. That trial ended February 5, 2007, and we anticipate the judge's ruling in the next few weeks. Therefore, we would urge deferring action of this bill until that decision has been issued.

SENATOR HECK:
I am sorry you just recently became aware of the language, but I would direct you back to your own corporate legal files. In 2005, I received a seven-page letter from IMS outlining the same issues, to which I made notes in the margin refuting every one of their arguments, so I know they are aware.

MR. HUNKLER:
We are aware of some controversy about the issue, but our legal opinion did not coincide with the one you presented today, and we are here to see that.

SENATOR HARDY:
As indicated earlier, until this is pursued further with the Attorney General's opinion, lawsuits or whatever, this is going to be the document this Legislature will heavily rely on. For the sake of argument, we are going to assume this is correct. If you know Kevin C. Powers, Senate Legal Counsel and Bill Drafting Advisor, Legal Division, Legislative Counsel Bureau, he rarely gets something wrong, if ever. Does that change your position on the bill relative to the fact

that Senator Heck's bill will allow the aggregate dissemination of the information? If this legal opinion is correct, that is something that is not permitted as I understand it, but Senator Heck's would permit that. Does that change your position?

MR. HUNKLER:
As Ms. Livingston mentioned, it is the commercial applications that really fund a number of other uses of the information. I do not know what the commercial implications would be, if we were limited to only aggregate use of the information. There would also be a number of practical considerations such as, who does the aggregation. If it only comes to us in an aggregated form, there are a number of practical considerations we would have to make. My initial inclination is that I would continue to be opposed.

SENATOR HARDY:
To the untrained eye, I do not understand in terms of the research information and the overall public good, why aggregate information is not good enough. It would be helpful when you provide the information for us to understand that.

MR. HUNKLER:
One application is treatment variability studies. If you do not have access to the information at the individual prescriber level, you are looking at clumps of prescribers rather than individuals whose behavior can be looked at before and after intervention. For example, you can make an educational appeal to them to see how that has changed the prescribing behavior.

SENATOR HARDY:
The other thing I would be interested in getting is information regarding what the information is used for in terms of a breakdown. How much is used for this kind of research, how much is used for marketing and how much is used for these other issues. If we are using research as a way to wave the flag to say why we need the information, but 90 percent of this goes to marketing activities, that would be a matter of concern. I would be interested in a breakdown of the total of each application.

CHAIR TOWNSEND:
This goes to the sponsor's original premise that it did not come up on anybody's legal radar that we already have this prohibition. Is this one of those yes we knew it was there, but as long as they did not enforce it we did not care, or do

you need to find new law firms? If somewhere in your presentations you could address that, we would appreciate it.

RANDOLPH B. FRANKEL (Vice President, Public Affairs, IMS Health):
I would like to say that while we were remiss in not contacting you, Senator Heck, we have information about other uses besides the marketing applications for these data. One of the questions was why aggregate data would not be adequate in some circumstances; it has to do with treatment variability. There have been ample studies at Dartmouth Medical School, Hanover, New Hampshire. Dr. John E. Wennberg and others have demonstrated there is a great deal of treatment variability that cannot be explained by patient demographics or incidents of disease. It is simply that doctors are not consistent across the board in terms of how their decisions are made.

I have over a dozen years in the managed-care environment, some of which was in disease management. Much of that was focused on the variability aspects of patient treatment. It did improve outcomes, it did save lives, and it did reduce costs by knowing about that variability and then focusing educational efforts to physicians. It did not work on an aggregate level; it had to be done based on the decision maker and the caregiver; in that case the physician.

There are similar applications for these data. We have seen studies done for asthma in the treatment of underprivileged individuals in low socioeconomic areas, and discovered suboptimal utilization of asthma-controlling agents. We have seen studies studying the use of ACE inhibitors for congestive heart failure where there is a clear consensus around the value of the data for many patients for whom it might be applicable and were not receiving the drugs. Similarly, beta blockers that were used after myocardial infarctions. It is only by looking at the provider-level data that we are able to see where we need to apply our resources and educational efforts in order to improve quality of care and patient outcomes.

I would like to add as a point of concern that federal and state laws have not recognized a right to privacy for individuals in their professional or work capacities. Attorneys, accountants, architects or dentists, for example, cannot and do not prohibit their customers from disclosing information about their satisfaction of the services. If physicians were to receive this type of right to privacy, then attorneys, accountants and other professionals would require the same thing. In that situation, you can imagine it flies in the face of what we are

calling transparency these days of providing consumers with information about provider quality and cost. In fact, last week Secretary Michael O. Leavitt of the U.S. Department of Health and Human Services, issued a call to action in creating community-based value exchanges to have reporting about providers with regard to quality and cost.

We believe, as a company, that over time, more information is needed and not less in order to enhance transparency and improve quality of care, as well as to manage costs.

MR. FRANKEL:
We think that by restricting or limiting the use of this data, it will have an impact on research as well as the number of federal initiatives. One example is risk-management programs associated with high-value, high-risk products. In those situations, there is close collaboration between the pharmaceutical or biotech company, in this case, and the FDA in identifying physicians who have the educational experience necessary to manage these high-risk drugs. This way we can avoid significant risk, even deaths, while providing the substantial benefits associated with those drugs.

Another interesting sidebar to that is these small companies, typically, have small sales forces through which to manage these programs. They make use of provider-level data in order to manage these programs. The availability of provider-level data is essential in terms of managing the risk, and essential in allowing small companies to function like, and compete with, large companies. In essence, provider-level data allows a common knowledge base that will permit smaller companies to identify the major decision makers and affect appropriate adoption of their drugs in the marketplace.

You are asking if there are more applications for this than pharmaceutical marketing. Drug safety and monitoring by the FDA and Centers for Disease Control and Prevention, pay for performance initiatives around the country require provider-level data. Pay for performance is a reimbursement system based on how doctors perform against quality and cost metrics. It is by definition a provider-level process covering the whole idea of transparency of quality and cost, the CMS initiative and program integrity in terms of managing and tracking fraud and abuse among Medicare and Medicaid.

We suggest there are and could be significant unintended consequences if these data were restricted nationwide.

SENATOR HECK:
I am not going to belabor the issue and constantly refute everything that is said; it seems like this is going to a work session or subcommittee.

Our current law does not restrict the release of data to our Medicaid system for quality care and review; that is already one of the exceptions. Arguments brought forward about DEA and diversion; if you recall our Pharmacy Board set the standard in how they have their DEA diversion task force, and we already have that program in this State; it runs through a task force between our pharmacy board and the DEA. The one that most troubles me is that the statement, "education and experience for research on high-risk drugs," is being gleaned on those prescribing practices. If a pharmaceutical company is deciding who they are going to try to recruit for a high-risk drug study based on the drugs they prescribed in the past, that is more reason that these data should not be released.

MR. FRANKEL:
If I misspoke, I apologize. A case in point is a drug, Tysabri, for multiple sclerosis. It was removed from the market then brought back to the market because patients asked for it. The goal was to identify physicians who treated the disease often enough that they would have the personal experience and expertise in managing this high-risk drug. The provider-level data is used by the industry in collaboration with the FDA, it is not isolated, in order to identify how to distribute this drug, manage and monitor the safety and adverse events that occur.

JAMES W. MORGAN (Pharmaceutical Research and Manufacturers of America):
As Senator Heck indicated, the existing Nevada law was enacted in 1967. The data industry, if you will, was born much later than that and the use of these data by a variety of sources in the pharmaceutical industry or any other source became aware of it only after data was begun to be produced. My sense is that my company and other companies did not become aware of existing Nevada law until such time as Senator Heck brought it to our attention. Based on the LCB's decision in August of 2006, now it has erupted and become something new to review. I do not know if that adequately answers your question, but to

put perspective on it, the State law was enacted in 1967, and here it is years later and we are finally discussing it.

ANDREA JEAN DOUGLAS, MPH (Director, State Policy, Pharmaceutical Research and Manufacturers of America):
I want to talk on the issue of prescriber data from the patient perspective and what this information means in terms of patient safety.

Banning the use of prescriber data is, from my perspective, putting patients at risk. This is patient-safety information.

CHAIR TOWNSEND:
Let me stop you for a moment. I have one problem; we already banned it in 1967. I want you to finish your comments, but understand I am waiting for the people who can tell me why they did not enforce the law from the beginning.

You have done what you think is in the best interest of your companies and what they are providing the public, and I respect that. It seems the people who should have been monitoring this are the ones you have an argument with, not us. I wanted to give you the perspective of what we are thinking.

MS. DOUGLAS:
Let me tell you about the role this information plays when we talk about patient care. We use prescriber information to notify physicians of recalls, "Dear Provider" letters, which alerts to new risk data or for treatment of patients with certain co-morbidities. This is effective sample distribution as a way to track adverse events. It is also used for risk-management plans.

In your packet is a legal document prepared by Hogan & Hartson LLP, a law firm in Washington, D.C., that lays out these risk-management plans, the importance of them, the diseases these plans address, and the number of people nationwide (**Exhibit R**). If the State were to not have these data, some of these patients who participate in these programs may not be able to do so. Drugs for diseases such as multiple sclerosis, diabetes, pain management, lymphoma and on, have been approved under the conditions of safety programs where providers, patients and manufacturers work together on targeted safety and use messages. These programs help patients by bringing medications or allowing medications to stay on the market for diseases where otherwise patients would not have any option. The State could possibly be at risk of losing the

opportunity for their patients who have these serious illnesses to partake of these special programs.

CHAIR TOWNSEND:
I went through your material, and I am trying to wear the hat of the people we represent. The worst mistake any of us can make on either side is to underestimate the public. I strongly believe that when someone turns on their television, and see this warm and fuzzy thing about Lunesta and a good night's sleep, they will trust their doctor more than they will trust that ad.

When you talk about how to target things, that might work in the clinical sense, but in the public sense it is troublesome. Whether there is a relationship between the cost of the drug and what is on television are for others to consider; but I assure you that in the public mind there is a direct relationship, and their perception is our reality.

I am not disagreeing with you, but you may be arguing up a tree to the top of which you may not reach. There is the public that drives this system. You may have testified at other states, but in Nevada the public still owns our system, and they are perceptive, and will give you a perspective.

The important point is, as you go through the part of what you represent, you have to understand not just who we answer to, but whose interest we are gathering. Their view of your world is a tough one. We in the West get the feeling that Washington, D.C. is not paying attention to us.

SENATOR CARLTON:
I would like to figure out how you are breaking the law. In putting together a chain of evidence, my doctor writes a prescription that I take to a pharmacy to be filled and then the information becomes part of a database. How does it get from there to the people you get it from? I understand you compile the data, but who are the people in the middle that are actually breaking the law?

MR. FRANKEL:
We receive information from pharmacies, mail-service organizations, nursing homes and a variety of sources around the country without patient identification associated with it, which is stripped out before we see it—never had it, never want it. It also includes the practitioner's information.

SENATOR CARLTON:
In the conversations you have with people gaining these data, how do you make them feel comfortable in sharing it with you? I am sure they also have lawyers, so how do you convince them it is all right?

MR. FRANKEL:
I am not involved in the procurement of the data. I do know we all have lawyers that interpret the laws. In New Hampshire, we stopped providing that information as soon as they passed that law. To the extent of our understanding of the law, we meet all the requirements of the law. There is a misunderstanding or misconnection here that I am not aware of.

My understanding associated with this law is that it has to do with when the patient's identity is involved and not the provider identity. That is an understanding by someone who is not a lawyer, and we will look into this in depth, and respond to it. As a company, if you look into our records, you will not find us in violation of laws of which we are aware and understand.

SENATOR CARLTON:
To the sponsor of the bill, that would be the underlying question. Who is breaking this law? How is this happening?

SENATOR HARDY:
It is important to make clear that you are not on trial here. This Legislator is satisfied that you are applying the laws. How is the information in terms of the prescribing doctor important to the release of information? That is a threshold issue. It is troubling that it is used for marketing where you can direct your salesman on a doctor. I can understand to the extent the information of the prescribing doctor is vital to the research and is important. I understand why you need the data; I cannot understand why you need the prescribing doctor's name associated with those data.

MR. FRANKEL:
While pharmaceutical companies are our client, we are in the health-information business.

SENATOR HARDY:
I can understand the specialties, but you can extrapolate that if somebody prescribes something specific to a certain client.

MR. FRANKEL:
Take asthma for example. We have had guidelines since 1987 about best practices, and they evolve over time. They were updated in the early 90s and again in 1997. It was a year and a half ago when the preferred agent, based on standard, nationally recognized guidelines, surpassed the other agents that had been historically used. It has taken 15- plus years for that to happen. Practically speaking, that is interesting news, but what do you do about it.

When you look at the use of these drugs by provider level, you can see what we call treatment variability. You might find, and I am making up these numbers to give you a sense of it, 40 percent of physicians are operating according to the standard guidelines, but the other 60 percent have a huge diversity. If you are trying to improve patient outcomes or you are in the process of presenting appropriate use of a medication, the preferred drug for example, you would have a different message to that doctor who does not use that drug than you would to one who does. Over time, that message would be based on confidence, experience and the issues around the drugs. I am not trying to be a detail representative, but it gets down to the provider level in order to make that change.

SENATOR HARDY:
Let us assume you have research that is specifically related to an oncologist, for example, are not there sufficient associations and organizations that could disseminate that information for you?

MR. FRANKEL:
If that were the case, it would not have taken 17 years for asthma guidelines to be adopted in this country.

SENATOR HECK:
Here is the issue. It appears you are digging yourself a deeper hole. The comments you are making, "We use it to track adverse reactions." If you do not know to whom it was prescribed, then how do you know whether or not they had an adverse reaction? The comment was that you use it to track off-label drug usage. If you do not know to whom it was prescribed, then how do you know how it was prescribed and for what it was prescribed, and whether or not because Doctor X prescribed drug Y, what the indication for that prescription was? Driving physician drug choice, even if it is under the basis of following standard guidelines, is still a marketing tool. You can have 40 percent of the

doctors following the guidelines and 60 percent not, and you want to convert those 60 percent to follow the guidelines; that is still driving a marketing tool. You do not know why that 60 percent are not using the new drug. There may be a good explanation, the person may be allergic, it was tried and not responded, and it could be that the physician is not up to date, but there are so many other variables. It comes back to the point that this bill has been in the works for almost nine months.

As a physician, I do not want to impede the public's health, and that is why I provided ample opportunity for somebody to come forward with an amendment that would allow a greater public good and the public-health aspects to be maintained, even if it means amending the law that has been on the books for the last 40 years. The law has been amended at least 12 times since it has been on the books. No problem in amending it again if there is some greater public good that can be brought out of all this; I have yet to receive that amendment.

Mr. Chair, I would move that S.B. 231 go to subcommittee to allow those entities the opportunity to bring an amendment that would protect the greater public good, and bring it to resolution.

CHAIR TOWNSEND:
This is NRS Title 54, which Senator Carlton and Senator Heck are the subcommittee members.

MR. MORGAN:
I would like Ms. Douglas to respond to some of Senator Heck's comments.

MS. DOUGLAS:
I understand the Committee's concern with this bill. I want to clarify how some of this marketing is done, how it is targeted and why this is important. When a pharmaceutical manufacturer gets this information, it uses detailers for physician education and patient education. Instead of going to all of you, if we have a cancer product, we can use that in prescriber-data information to go to the only cancer physician out of a group of four doctors, and make sure we are giving them the best education and information to quickly update the treatment of their patient. If we do not have specific prescriber information, then you have detailers going to all doctors for all indications, and you run the risk of physicians not getting the latest education information.

The other point is about pay-for-performance transparency from the federal side. Not having this kind of information is a step back when you think about pay for performance, quality patient care and transparency; all of the things we are trying to do in state and at the federal level to improve our health care system.

I would like to acknowledge from a public-health perspective that this information is important in terms of treatment of patients, and targeting why some patients in some groups are being treated one way, and why others are being treated another way.

SENATOR HECK:
As each argument comes up, I feel compelled to point out the ridiculousness of the argument. If you are going to identify an oncologist who is a cancer specialist for educational purposes on a new drug based on his or her prescribing practices, you can go to the Board of Medical Examiners or to the college of oncology to find out who practices in that specialty.

As I mentioned before, you are digging yourself a bigger hole. I would also provide some advice for the subcommittee when we meet; do not use the words 'marketing' and 'targeting' in the same sentence when you come forward with your amendment.

MR. FRANKEL:
The interesting thing from practical experience in this industry, is the question about specialty, for example, if it comes up, and why we would not simply use specialty. We have found over the years that specialty is not a particularly good indicator of what a physician treats and how often, because many physicians have subspecialties. Internists who decide they love working in diabetes will focus on that. For example, we found looking at Acquired Immunodeficiency Syndrome/Human Immunodeficiency Virus that one of the largest treating practitioners in the country was a dermatologist. There is simply no way we would ever know that. Those kinds of changes in dynamics in this system are important from the standpoint of being able to identify, notify and educate. It is not that I would necessarily see that is something I would throw to a marketer and tell them something. There are many practical times in disease management, in care coordination and other areas where that kind of information can be helpful and is not obvious.

CHAIR TOWNSEND:
For our new friends here, the subcommittee process in this Committee is established before the Legislative Session so that it is never perceived that we send a bill to pass it or kill it. All Committee members are allowed to pick a subcommittee. We have asked Senator Heck to be part of the subcommittee because he is an actual licensee.

MS. MACMENAMIN:
For the record, in light of this going to subcommittee, I look forward to working with Senator Heck and Senator Carlton on this issue. I will be submitting written testimony.

SENATOR CARLTON:
When we do the subcommittee, I need everyone to be prepared to explain where the law is being broken within this chain of information.

MS. MACMENAMIN:
We will have the requested information available for the subcommittee.

CHAIR TOWNSEND:
All parties will be notified of the subcommittee as soon as possible. To help everyone, the nature of the sponsor's proposal, which the current law prohibits, has not been enforced, and the bill is an expansion of the current law. That should save you time in arguing things not relevant to the debate. You will have the opportunity to bring forth whatever you think is appropriate.

SENATOR CARLTON:
Calendars have been compared, and Monday, March 26, 2007, at 8:30 a.m. in Room 2135, is available.

CHAIR TOWNSEND:
The subcommittee meeting date is set, and it will be videoconferenced in Las Vegas.

SENATOR CARLTON:
Between now and the subcommittee meeting, we can continue to talk this over for a more productive meeting.

CHAIR TOWNSEND:
Hearing no further testimony, the hearing on S.B. 231 is closed.

CHAIR TOWNSEND:
There being no further business before this Senate Committee on Commerce and Labor, the meeting is adjourned at 10:30 a.m.

RESPECTFULLY SUBMITTED:

_____
Laura Adler,
Committee Secretary

APPROVED BY:

_____
Senator Randolph J. Townsend, Chair

DATE:_____