MINUTES OF THE SUBCOMMITTEE OF THE SENATE COMMITTEE ON COMMERCE AND LABOR

Seventy-fourth Session
March 26, 2007

The subcommittee of the Senate Committee on Commerce and Labor was called to order by Chair Randolph J. Townsend at 8:30 a.m. on Monday, March 26, 2007, in Room 2135 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412E, 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.

SUBCOMMITTEE MEMBERS PRESENT:

Senator Maggie Carlton, Chair
Senator Joseph J. Heck

STAFF MEMBERS PRESENT:

Scott Young, Committee Policy Analyst
Lori Johnson, Committee Secretary
Laura Adler, Committee Secretary

OTHERS PRESENT:

Liz MacMenamin, Retail Association of Nevada
Carol Livingston, Vice President, Wolters Kluwer Health
Robert J. Hunkler, Director, Professional Relations, IMS Health, Incorporated
Roger N. Morris, R.Ph., Quarles & Brady Streich Lang, LLP
Randolph B. Frankel, Vice President, Public Affairs, IMS Health, Incorporated
Barry Gold, Director, Government Relations, AARP Nevada

CHAIR CARLTON:
This is the time set for the subcommittee meeting on Senate Bill (S.B.) 231.

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

This is how this subcommittee works. Since there are only two members, and it takes a motion, a second and a vote, there will be no votes coming out of this

subcommittee. If Senator Heck has one opinion and I have another, we will present them both, and the full committee will make the decision.

During the hearing on S.B. 231, there were a number of concerns about a couple of the different provisions in the bill. I would like Senator Heck to start, and then if there are amendments, I will take those.

Previously, I had asked for information on the gap discussed in this bill on where the information started and where it ended, and what path it actually took. I hope I can get that answer today.

SENATOR HECK:
I moved to have the bill go to subcommittee to allow those parties that were interested to provide further documentation or potential amendments, as they felt they had not had enough opportunity since August 2006 to come up with that information.

I have not been contacted by anybody with any potential amendments. Last night I did receive a letter from IMS Health (IMS) outlining the reasons why they feel the information is important. They provided a legal opinion saying our legal opinion is wrong. I would take exception to some of that. Most of the comments were the same comments provided in a letter sent two years ago. Since I have not received any contact other than this letter, I have nothing else to add.

CHAIR CARLTON:
The clarification I need to make, from speaking with others after the last meeting, was that we were under the impression someone was relaying information they should not have been and were breaking the law. Upon further review, the wording says "the pharmacist"; it may not be the pharmacist, it may be the pharmacy, which is a different entity. It could be the third-party administrator, the insurance company or a number of other people involved in sharing this information. That is why I would like to understand how this information flows through the system.

LIZ MACMENAMIN (Retail Association of Nevada):
It is my understanding that the information coming from the pharmacies is "de-identified," pooled, sorted by zip code and then forwarded to the data company. Everything done in the pharmacy is processed, sent to our corporate offices, and they take care of de-identifying the information, sorting and sending it out.

CHAIR CARLTON:
So, the patient is still protected, even though you are getting around this by not actually releasing it through the pharmacist. It is coming out of the pharmacy, but the patient information is still protected.

MS. MACMENAMIN:
That is correct, Senator.

CHAIR CARLTON:
Can you tell me how valuable this information is?

MS. MACMENAMIN:
I know it is valuable for a number of reasons. It is used in data management, patient disease management and many different areas. I do not have the dollars and cents. It is valuable to the data company, and there is a return on dollars to the pharmacy.

CAROL LIVINGSTON (Vice President, Wolters Kluwer Health):
The data comes from the pharmacy headquarters or a pharmacy management system. The pharmacy management system may be a group of independents as well as smaller chains that do not have their own headquarters. The data is de-identified so the patient information is completely anonymous, then the data is processed and normalized.

CHAIR CARLTON:
Please explain normalized for my understanding.

MS. MACMENAMIN:
We would get a Drug Enforcement Administration number on a physician, a National Council for Prescription Drug Programs or provider identification number for the pharmacy. We go about recognizing those different entities, and making them common, so when they come in they are common elements across

all the data. The data is stored, and depending on the deliverables for the client, it is subset and filtered to provide them the deliverables they need.

CHAIR CARLTON:
Are all the patient protections built in all the way?

MS. MACMENAMIN:
Absolutely. They are built in all the way through the process. We adhere to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and are certified annually.

SENATOR HECK:
Is data coming to you with the patient name and de-identified at your level or de-identified at the pharmacy level before it comes to you?

MS. MACMENAMIN:
Typically, it is de-identified at the pharmacy before we receive it. However, we have an additional process in place that de-identifies it.

SENATOR HECK:
So, if somebody provided information with patient data, would it be identified at your level?

MS. LIVINGSTON:
Correct. It is identified outside our organization. The HIPAA key is held outside our organization and maintained so we cannot get to it. The other information is presented that way to us.

CHAIR CARLTON:
Since we are de-identifying the patient, it seems not more than a keystroke to de-identify the provider. Can anyone remember why we did not originally include the provider? If not, what is your policy reason for making sure the practitioner is still included?

ROBERT J. HUNKLER (Director, Professional Relations, IMS Health, Incorporated):
I would like to echo what Ms. Livingston said. All of the information that comes to IMS Health, all of the prescription information is, indeed, patient de-identified; it is all HIPAA-compliant. The prescriber is not de-identified because that is where the value of the information is to all who receive the information.

Pharmaceutical companies, governmental entities and researchers need to know the identity of the practitioner, so they can make judgments and observations about the prescribing behavior.

ROGER N. MORRIS, R.PH. (Quarles & Brady Streich Lang, LLP):
I am the author of the opinion Senator Heck mentioned regarding the Nevada law (Exhibit C). I am a professor of pharmacy law, past president of the American Society for Pharmacy Law, and thought it would make sense to briefly go through the current law and the understandings that exist. I have read the Legislative Counsel Bureau's (LCB) counsel's opinion. My concerns play well in this bill and what is going on.

Nevada has a comprehensive scheme of protection of patient health care records that Nevada has recognized, as does the federal government with the HIPAA. Nevada also set up a comprehensive scheme for the regulation of physicians, nurses, nurse practitioners, physician assistants, pharmacists and the like, to set up the rules for the protection of all of those pieces of information. There are a number of things I disagree with in the LCB's opinion; particularly, the difference between pharmacist and pharmacy. Those are distinct issues. At least the State Board of Pharmacy, since its existence, has differentiated in its rule making and its enforcement as to what you can enforce for each pharmacist and pharmacy. My major comment is, if you take the LCB's opinion at its face value, and were to enforce it, every single pharmacy in this State would be in violation for the last 40 years. If you were to enforce it as it is written, and as they interpret it, unlike the way I do, every single prescription would require a patient to sign an authorization before any communication could be done with the insurer, with the Pharmacy Benefit Management Institute, with anything to get it approved. We would, at minimum, double the amount of time for every prescription to be filled with patient authorizations that exist. That is why I come to the conclusion that clearly 40 years of history on this, and the fact that no state in the Union, including Nevada, has ever enforced a law like this in any manner, means that when I look at a statutory interpretation, I am required to find something that makes sense as a practical value.

The law itself seems to prohibit the communication of any piece of information on the prescription itself. As an example, the article by the Institute for Safe Medication Practices in the March 2007 edition of *Pharmacy Today* (Exhibit D) talks about the number of patient deaths that occur from pharmaceuticals used inappropriately exceed those of cancer and human immunodeficiency virus.

Within every article they publish, they illustrate parts of prescriptions to show, as an educational benefit, how prescriptions have been written wrong or have inappropriate interpretations. This is education we want to give to our prescribers. If you interpret the existing Nevada law, the LCB's opinion is that Nevada would never participate in this. Nevada would never be part of it. We would not be educating our Nevada physicians, pharmacists and practitioners about the dangers that exist. I am left to conclude that the Nevada law cannot be the way the LCB intended, because it has never been read that way, it has not been enforced that way and the practices do not exist that way, as we sit here today. I thought rather than send a letter, I would appear to answer your questions.

SENATOR HECK:
I appreciate the letter because it brings up other areas of the law that will most likely be addressed in an amendment. I do not want a point counterpoint throughout the letter, as I believe a lot of the statements made have no application to prescriptions, especially when referencing the Department of Health and Human Services needs, and encouragement of utilizing de-identified data. Most of that has nothing to do with prescriptions, it is a blanket paragraph about the need for de-identified data in medical research. The letter brought up some important issues. I plan on addressing those issues as we move the bill forward with an amendment.

MR. MORRIS:
As a final comment; I am a huge believer in both health care transparency and information. I have yet to see anything, with the exception of national defense issues, that is better because it is hidden then exposed. This is a series where we are looking at health care information; the federal and state governments are looking at ways to save money; we are trying to evaluate who are good facilities and hospitals who are good prescribers. To me, the idea of hiding any kind of information, I find exactly opposite of the goals that this State and the federal government are looking for.

SENATOR HECK:
I would agree with you. The big argument that is yet to be closed, is whether or not knowing what a physician prescribes has any impact on any of those things. If you de-identify the patient data, and you know that a physician prescribed drug X, you do not know why they prescribed it, because you do not know anything on the patient side, and you do not know the outcome, because you

do not know the identity of the patient. I find it hard to connect all those dots. That is why when everybody in the previous committee was talking about the greater public good, we decided to put a subcommittee off for two weeks so you could bring us some documentation on the greater public good, and an amendment that would allow that to continue. Unfortunately, to date, I have not received any amendments.

MR. MORRIS:
You will have some things presented to you shortly, at least as to the greater public good.

MR. HUNKLER:
I would like to introduce a number of documents. One is entitled *The Role and Use of Provider Identity in Federal Public Health Programs* (Exhibit E, original is on file in the Research Library), that notes many specific uses of IMS prescribing information for the public good and uses. Also, I have a document noting examples of research and academic research and use of our information (Exhibit F, original is on file in the Research Library).

RANDOLPH B. FRANKEL (Vice President, Public Affairs, IMS Health, Incorporated):
I hope to add some dimension to the number of issues you brought up. Certainly you have heard from Robert Hunkler that we are providing documents about some of the public uses. I would also like Senator Heck to address some of the issues around why provider-level data is important.

In many cases, I would agree that the data do not tell you why things are happening. What the data tell you is what is happening, compared to guidelines or what some judgments might be around percentages of utilization that should be taking place based on those guidelines. You tend to find a benchmark you are for and then try to assess the variability around that benchmark. Often, other databases we have are utilized to understand more about why things are happening. Those could be for medical-claims databases; or it is the beginning of what becomes chart pulls and one-on-one types of research.

There is a lot of material provided to you, but I want to point out that provider-level data has always been a cornerstone of how the data are compiled. The physician is the gatekeeper. They are the most trained, most intelligent, best positioned individuals in our system to make decisions about their patients and we fully support that. What attends that is the need to

understand more about those kinds of decisions. Over many years we have seen uses of antibiotics which have been in the newspapers forever on overuse here, underuse there, but it is always done by looking at provider-level information. We looked at hypertension and how it was treated and found that certain older drugs would actually be just as viable alternatives as some of the newer ones. When you look at treatment and how that occurs, you determine it at a provider-level. The percentage of doctors that follow that approach would be telling in terms of what type of an educational program you would employ. If ten doctors in the country are missing the mark in some way, it is a simple solution. If it is 80 percent of a million prescribers, it is a different approach. Understanding who the decision makers are, how they vary by region or by the medical school they are affiliated with, you will notice differences in those variabilities. It is telling in terms of how to improve outcomes. That is definitely being incorporated into the whole idea of transparency, which is the quality and cost of reporting at a provider-level in pay for performance, and in a number of other areas.

MR. FRANKEL:
The other area I would like to clarify is the U.S. Food and Drug Administration's (FDA) program on risk-management. These are drugs that have serious side effects, but with great benefits. The goal of the risk-management program is to reduce the risk while maintaining those benefits. The FDA requires the drug manufacturer to have an educational and outreach program to physicians who might use these drugs. If it is a broad-based educational program, everyone gets too much, and there are not enough resources to educate this narrower number of physicians who need it. If it is too narrow by using specialty or some other indicator, you miss those who prescribe outside of what might be expected based on their specialty. They require pharmaceutical manufacturers to monitor, and some of them create registries of names of physicians who have had the education so that they are the only ones who can prescribe those drugs. These are monitored at a provider-level. As you see in the document (Exhibit G), there are many uses of academic research and research by federal agencies.

This example was done in conjunction with the California Medical Association. They were arguing that pharmaceutical manufacturers have the data and doctors do not have it. We started in 2004. It took so long because we went through studies and focus groups until we got to what we think is a clinically relevant approach. This is an educational program based on a disease. The American Medical Association (AMA) is responsible for developing all the

content. It is a continuing medical education program, and there are four diseases a year, one a quarter, on which to look at medical-claims data based on therapeutic guidelines or best practices on how the disease is treated. Based on those same claims and what drugs are used to treat it, we then get to a point of actually showing a physician how they use the drugs compared to other physicians at the state or federal level. This is just the beginning.

I would be the first to say it does not go far enough. How do we know whether your prescribing is appropriate or the nation's prescribing is appropriate? What we are doing is drilling down and starting to look at combining information and best practices, and feedback to the individual physician in preparation for what will become a fairly routine practice of continued quality improvement; and the pay-for-performance model that is being conducted in hundreds of experiments and tests through Centers for Medicare and Medicaid Services, and by many state Medicaid directors and their staffs. We are trying to help work with the AMA to train physicians and give them a chance for self-evaluation in preparation for those kinds of events.

I believe this is more the trend and this is where the data will be used more and more over time. I would argue that our data had been underutilized outside the pharmaceutical industry, but I believe that will not last long because of where we are going and how you need to improve quality and manage cost.

SENATOR HECK:
I appreciate the use of the information in that regard. I have previously seen some of the *Therapeutic Insights* newsletters. When talking about prescribing practices and what 85 percent of physicians in the United States are prescribing for a certain ailment, that is aggregate data. That is knowing there are a thousand physicians, and of those thousand how many prescribe drug X versus drug Y. It is not doctor X prescribing drug Y.

I would ask almost a rhetorical question. If this data was so valuable to the entire process, then why did the AMA start an opt-out program? What if every doctor in the United States overloaded their Web site and opted out? What would happen?

MR. FRANKEL:
The difference is between some of the state laws that totally restrict the use of the data and eliminates it from all purposes, while an opt out is a choice by

physicians while some doctors do not object to it. I do not want to be the one to tell them they have to opt out, but the issue is that the data would still be permitted for these other business and public good uses. It was carefully done working with the AMA delegates, and working with the state medical societies to ensure the work could be done in a way that did not interfere with where the health care system was going, but gave doctors the choice. I will add that there has been some objection about the low level of enrollment. We have had many conversations with the AMA, and we realize it takes time in an opt out. It is not unlike the Federal Trade Commission program "do not call" list, which, in the end, has been successful. You have to maintain awareness. The AMA is doing that. I know they sent letters to every state medical society. We have offered you a list of all the publications. They have assured us they will continue to maintain a heavy outreach in terms of journals, letters and other placements to keep the level of awareness up, so that anyone who wants it, will know how to do it. I have been told by a physician that the system takes two or three minutes. We are taking the approach that rather than make it a summary decision that everyone has to opt out and eliminate it from the health care system, to give doctors the choice, maintain the awareness level and provide the opportunity to use it.

SENATOR HECK:
I understand it. Basically, what the AMA opt-out program does is allow the data to be released, but it is de-identified on both ends, to doctors and on the patient end.

MR. FRANKEL:
The de-identified data would not be used by anyone with direct contact with physicians. It would still be used by the marketing people to determine strategies. I was a product manager in a pharmaceutical company. We used to use the data to estimate the potential market for a new drug in development, and the cost to promote and market it, because it was important to know whether the market was 20,000 doctors or 200,000 doctors. That is how we used the data. That was in the back room and did not get to the sales force. That would be permitted with the AMA program.

MR. HUNKLER:
One point of clarification is the AMA opt-out program, as mentioned, prohibits the release of the information to pharmaceutical sales forces. That was not done in a vacuum. The AMA surveyed physicians nationwide, and the finding it

reached was that the vast majority of them either had no concerns about the use of this information or would have their concerns allayed by the existence of exactly this kind of program. I believe the number was 84 percent of the doctors nationally would be satisfied with the existence of a program of this type. In answer to the criticism about the AMA not necessarily promoting this as loudly as they might, we have gotten a list of the publications of other media in which they have touted the availability of this service. Also, IMS has maintained a separate list of airplay that the existence of the Physician Data Restriction Program (PDRP) opt-out program has received in the mainstream media. It is better now.

SENATOR HECK:
How is the AMA opt-out program policed so that whoever is in charge knows the data is not being released to the sales force?

MR. HUNKLER:
At this point it is early in the evolution of the program, but right now enforcement is based on complaint only. If a physician has opted out and has a complaint that their name has not been added to the list or they do not see the change they anticipated, they report that to the AMA. The recourse that exists is contractual. All of the end users of the information have contracts with the AMA or through the database licensees such as IMS and Wolters Kluwer, but they are bound by contract to use the information in accordance with the AMA's guidelines. If they do not, they lose access to the data altogether.

SENATOR HECK:
How do they lose access? Who is going to cut them off?

MR. HUNKLER:
We are, through the contractual arrangement between the AMA, and the databased license organizations such IMS and Wolters Kluwer.

MR. FRANKEL:
So, you would cut off our pharmaceutical company?

MR. HUNKLER:
We would be bound to by contract.

MR. Frankel:
We create the reports. We would simply prevent that from going forward. That is what happens with the opt out; we are notified and that sales representative never receives it from us. The AMA is the ultimate licensor and the ones to make that decision. They have an internal process where they will investigate and if it comes to the point of someone losing their license, they would notify us and we would execute on it.

SENATOR HECK:
Help me close this loop. A physician opts out. That name is now kept by the AMA and forwarded to entities like yourselves, and that information is not to be released. When you send it on to the pharmaceutical company, they are instructed that that information is not to be utilized for their sales force.

MR. HUNKLER:
That is correct.

SENATOR HECK:
A detail representative comes in to see me and I have opted out, and I get an inclination that they have had access to my data. I file a complaint with the AMA who conducts an investigation. That is the problem. I do not see the AMA conducting an investigation of how a pharmaceutical company has utilized this data, how they have the ability to do such; and once they have reached a conclusion, how that becomes enforceable to you.

MR. HUNKLER:
The business services unit of the AMA is a significant part of their organization, not necessarily the most visible one, but they do police the use of master file information and all databases and uses derived from that database. This is an ongoing process. It is a new application for them.

SENATOR HECK:
They do their investigation, then come back and say, look, pharmaceutical company X is in violation of our agreement, so then you cut them off.

MR. HUNKLER:
They are given the opportunity to remedy the situation first.

SENATOR HECK:
How many times are they allowed to remedy the situation before they are cut off?

MR. HUNKLER:
I am not sure of that.

MR. FRANKEL:
I would like to suggest what you are aptly bringing up is that you have a program that can work, and the question is, what does the enforcement look like. If I were to assume the enforcement was something you were comfortable with, then this program would work in terms of its intention.

SENATOR HECK:
I guess I have a concern with something that is self-enforcing, which is what this is. This is self-policing. Just like the "do not call" list, which I have called, but if you sit around my dinner table at 6 p.m., we are still getting phone calls. This is something that is being done as a self-policing mechanism.

MR. HUNKLER:
I think self-policing implies it is voluntary and does not have any teeth. These are serious teeth. This is valuable information to the pharmaceutical industry, and the risk of losing that information is a strong motivator to comply.

SENATOR HECK:
Is there a financial agreement between the AMA and these other entities, like yourself, to be tabbed in these contractual agreements?

MR. HUNKLER:
Yes.

SENATOR HECK:
Is the AMA on the receiving end?

MR. HUNKLER:
That is correct.

MR. FRANKEL:
We have contracts that require we abide by the PDRP program.

SENATOR HECK:
This is interesting, because I know the AMA. I guess it is another loophole. In one of their press release pieces, they say they do not sell data.

MR. FRANKEL:
They do not sell prescription information. They license access to the master file information, and we purchase prescription information and use their master file as one of our references.

SENATOR HECK:
The master file contains the prescription information.

MR. HUNKLER:
No. Our data contains it. We independently obtain and maintain prescription databases. We simply use the AMA master file as a reference source.

MR. FRANKEL:
We use it as a common denominator to link other data.

BARRY GOLD (Director, Government Relations, AARP Nevada):
A question that was raised in hearings on both sides of the Legislature about the opt-out program, is questions physicians may have about possible repercussions for opting out. Whether they would receive samples or something like that, that might drive the low numbers of people signing up. Another thing I have heard in terms of the contractual arrangements of the data-collection agencies is they contract that they will not share the information, what they call the volume data, with physicians. That is an interesting point, because they have talked about the value of the information. It seems to me, Senator Heck, as a physician, if you could share that information, if you would know what another doctor who had a similar practice was prescribing, that might be of interest, that might be of value to you.

Talking about the value of the data, the underlying theme is the dollars involved, the dollars spent and the dollars earned on this. The question you asked, Senator Carlton, of the Retail Association of Nevada was how much money is involved. They may not know that, but the data-collection agencies might have information on how much they spent to purchase this and in turn, how much they get paid by the drug companies. The value of this data is, obviously, the economic data and how much money it drives in sales.

SENATOR CARLTON:
It is clear on its face, everything has a dollar value associated to it. They would not be in business or talking to us if they did not have something to lose. We got that part of it. I am curious how the money trickles through, because I have learned if you follow the money, you can figure out what is happening.

MR. GOLD:
I understand, and thank you for pointing that out. Nobody has yet put a dollar figure on that. I am curious if this goes into the marketing aspect of drugs, the research aspect or if this is a hidden cost and the public does not know where this money is really being spent.

MR. HUNKLER:
It is actually an efficiency game for the pharmaceutical manufacturers as to where to focus their marketing efforts rather than blanket marketing efforts. It could be readily argued that it is a cost-saving device, spending a few dollars to save many dollars.

In answer to the point about the prohibition of the release of information to physicians, that is an old rule started in the early 90s. The sales representatives were not to share the information directly with physicians, mainly because they did not understand it very well. If they fielded questions about the derivation of the information; where it comes from, what is the sample of pharmacies, how do you project that information to a known universe, they would not know the answer.

As Mr. Frankel noted, we are working with the AMA and with state medical societies to create clinically relevant use of the information being shaped by doctors to show them appropriate use of the information, to help them understand the pharmaceutical marketplace and their practice relative to others. It is a lot more meaningful use of the information than seeing one representative's slice of the view of information.

MR. FRANKEL:
I would be the last one to tell you that we do not make a profit on this information; we do. We fill the gap with this company. I have worked in the pharmaceutical industry, worked in managed care, created the first therapeutic interchange programs in this nation to shift to less-expensive drugs, developed an entire disease management platform for parallel benefit management, and

I have worked with consumer groups through WebMD. I have tried to learn as much about this system as possible. These are used and they have value. This company, IMS, does make a profit. The nature of how that value is provided is a function of being able to do the same or slightly better with less. Every one of the pharmaceutical companies in the country, 10 or 15 years ago, had their own databases. They used some of our data and some of their own. If we disappeared tomorrow, you would have 20 different databases out there with no transparency whatsoever. We provide an economy of scale, if you will, that provides a database everyone uses. You do not have one company driving a particular point of view or a drug without every other company knowing this a doctor who is a prescriber of this medication, balancing that perspective. It does not necessarily drive increased market share, unless it is truly a better product. What it does do is allow them to narrow the number of sales people they have and fine-tune the use of samples, of which more than half are sent through the mail and not personally delivered. Samples are the largest portion of the promotional costs to a manufacturer. The data are creating more efficiency in terms of how they spend their dollars. That is how we are able to price our product based on the value of that efficiency.

MR. GOLD:
In terms of the idea of creating more efficiency, I wonder in terms of the value of practicing good medicine, I would think that high prescribers of the medicine need less education and less visits by the pharmaceutical industry. The prescriber that does this infrequently or only has a few patients on this, is the one who needs the information, so the idea of driving efficiency may not be practicing good medicine, because the ones who are not using a lot of the drug need the education.

MR. FRANKEL:
If you have other questions or need more detailed information, I am available.

MR. MORRIS:
I have a question. Senator Heck, you talked about looking for information, perhaps some proposed amendments. I am looking at the statutes dealing with the Nevada Pharmacy Act on the protection of public health and safety, which is what the State Board of Pharmacy does. I have looked at S.B. 231, and it does not contain a goal. My questions is, if there are amendments you are looking for, can you help me understand the goal of your proposed legislation?

SENATOR HECK:
I realize you got into this late, as we have been talking to most of the people since August 2006. When we first heard the bill and the reports of all the greater public good that were espoused, I said bring me an amendment that would allow the release of all this information that would protect the greater public good, but would have the data de-identified on both the patient and physician ends.

MR. MORRIS:
I think everything is de-identified on the patient end already, so is the goal of the legislation to de-identify on the prescriber end?

SENATOR HECK:
Exactly.

MR. MORRIS:
It is not to create some new confidentiality or rights? It is literally to take the practitioner, prescriber's name out of the scenario?

SENATOR HECK:
Exactly.

MR. MORRIS:
Why?

SENATOR HECK:
For several reasons. Contrary to what the AMA's market study showed about how physicians feel about their data output, the physicians I work with and talk with every day are concerned. In fact, most physicians I spoke with did not know this was going on until I told them. It is hard to be concerned about something if you do not know it is going on.

In essence, it was the opinion of several Legislators that our law was already fairly explicit. Reading through the point counterpoint of the two opinions, while our law does not say it is a health record or a medical record, it clearly states it is a public record not to be divulged. That is it in law; it is a public record of which the contents are not to be divulged.

MR. MORRIS:
It is not a public record.

Senator Heck:
Right, it is not a public record, the contents of which are not to be divulged. Not to mince words, that statement is self-explanatory. Then we get into picking it apart as to what constitutes the contents. Based on personal practice, our LCB's opinion and the physicians' group I work for both in Clark County and throughout the State, all think the contents include the identity of the physician prescribing data.

MR. MORRIS:
Irrespective of the LCB's opinion or my opinion, you obviously proposed a bill that would clarify some of the pieces. If I heard you correctly, is it to protect the physicians from their names being disclosed?

SENATOR HECK:
Correct.

MR. MORRIS:
How does that agree with transparency and more information?

SENATOR HECK:
Actually, your letter brought out one of the potential issues that may need to be cleaned up with the release to the insurance companies, but all those exceptions are already allowed; to be released to the insurer, to the Medicaid program, state and federal, that at least provide insurance and health care, that is already releasable to those entities. This is specifically targeted at having that data released to the pharmaceutical companies.

MR. MORRIS:
That is where the piece is from the pharmaceutical companies. Even as your bill is written now, with the LCB's opinion, there are a lot of work-arounds and the patients clearly have the right to release this information at any point.

SENATOR HECK:
Right.

MR. MORRIS:
There are still exceptions where the insurance carriers and a lot of others who get it appropriately. There are no restrictions on what they do with it. I presume you would want to close those loops as well?

SENATOR HECK:
Right now, we are only dealing with the pharmacy chapter as that is the subject of this bill. What happens after it leaves the pharmacy or pharmacist and gets to one of these other exceptions, what they do with it, is not the subject of this bill.

MR. MORRIS:
I look at it and compare it to some medicine where I was the beneficiary when I studied and did some teaching, to sit in on a number of grand round presentations at hospitals where they flash their patient's X-Rays, magnetic resonance imaging data and the patient's medical charts, and critique the doctors present, all with the patients de-identified for the purpose of promoting health care. We think critically looking at all of that and criticizing the physician appropriately is beneficial to the health care system.

SENATOR HECK:
That is true. That is usually done under the auspices of a peer review under which all that information stated in that room does not leave that room, at least theoretically. It is a worthwhile process to go through peer review; to have your peers look at you and say you did a good job or you could have done the job better.

MR. MORRIS:
Ultimately, any amendment that you are looking for is the physician privacy side, which is a different set of laws that, to my knowledge, no state has said there is a right of physicians, thus far. Nevada may be the first.

SENATOR HECK:
We have been the first in many things.

SENATOR CARLTON:
That is the key issue for me. For years and years we had the debate about patient privacy ending with development of the HIPAA. It took a long time to get to the point in this country where we would value the patient's privacy.

I have a case in point where employees have had problems with employers, because way back the employer knew what was in your medical record, because they paid for your doctor visits. That has been addressed. The key is, do we bestow that privilege upon a licensee who is regulated by the State?

With that, if there is nothing else to come before the subcommittee, Senator Heck and I will take our recommendations to the full committee who will take it from there. This meeting is adjourned at 9:21 a.m.

RESPECTFULLY SUBMITTED:

_____
Laura Adler,
Subcommittee Secretary

APPROVED BY:

_____
Senator Maggie Carlton, Chair

DATE:_____