MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Seventy-fifth Session
March 23, 2009

The Senate Committee on Commerce and Labor was called to order by Chair Maggie Carlton at 1:40 p.m. on Monday, March 23, 2009, 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.

COMMITTEE MEMBERS PRESENT:

Senator Maggie Carlton, Chair
Senator Michael A. Schneider, Vice Chair
Senator David R. Parks
Senator Allison Copening
Senator Dean A. Rhoads
Senator Mark E. Amodei
Senator Warren B. Hardy II

GUEST LEGISLATORS PRESENT:

Senator Barbara K. Cegavske, Clark County Senatorial District No. 8
Senator Bernice Mathews, Washoe County Senatorial District No. 1

STAFF MEMBERS PRESENT:

Kelly S. Gregory, Committee Policy Analyst
Daniel Peinado, Committee Counsel
Suzanne Efford, Committee Secretary

OTHERS PRESENT:

Barbara Morrow, Director of State Government Affairs, Astellas Pharma
Jason Schwartz, M.D.
Debbie Pinjuv, Director, The Transplant Network
Tracy Copeland
Heidi Smith

Mylan Hawkins, Executive Director, Nevada Diabetes Association
Linda Ash-Jackson, M.D., Medical Director, Hometown Health
Judy Britt, Pharm. D, Manager, Pharmacy Services, Hometown Health
Jack Kim, Nevada Association of Health Plans
Bobbette Bond, Culinary Health Fund; Health Services Coalition
Edward Jacobson
Carol Crane
Peter Peckham
Gay Elliker
Bill Hance
Alexis Miller, City of Reno
Frank Adams, Executive Director, Nevada Sheriffs' and Chiefs' Association
Mechele Ray, Executive Director, Private Investigator's Licensing Board
Dan Crate, Private Investigator's Licensing Board
Rocky Finseth, Private Investigator's Licensing Board
Lieutenant Tom Roberts, Las Vegas Metropolitan Police Department
Captain Tim Kuzanek, Washoe County Sheriff's Office
Scott Scherer, Nevada Registered Agents Association
Captain P. K. O'Neill, Chief, Records and Technology Division, Department of Public Safety
Barry Smith, Nevada Press Association
Brian Gresh, University of Southern Nevada
Neena Laxalt, Nevada State Board of Veterinary Medical Examiners
Dennis Wilson, D.V.M., President, Nevada Veterinary Medical Association
Debbie Machen, Executive Director, Nevada State Board of Veterinary Medical Examiners
Jack Walther, D.V.M.
Steve Holloway, Executive Vice President, Associated General Contractors, Las Vegas Chapter

CHAIR CARLTON:
I have a Committee Bill Draft Request (BDR) 53-1170 to introduce.

BILL DRAFT REQUEST 53-1170: Provides for change in the Unemployment Insurance tax rate methodology to allow for a joint account among business entities that have substantially common ownership. (Later introduced as Senate Bill 386.)

SENATOR COPENING MOVED TO INTRODUCE BDR 53-1170.

SENATOR AMODEI SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR CARLTON:
I will open the hearing on Senate Bill (S.B.) 192.

SENATE BILL 192: Revises provisions related to required insurance coverage for certain prescription drugs. (BDR 57-720)

SENATOR BERNICE MATHEWS (Washoe County Senatorial District No. 1):
Senate Bill 192 is an insurance coverage prescription bill. The intent of this bill is to revise certain provisions governing required insurance coverage for previously approved prescription drugs. The bill also seeks to prohibit insurers from increasing the insured's cost-sharing obligation for certain prescription drugs.

Senate Bill 192 requires insurers to provide coverage for prescription drugs if the drug has previously been approved for coverage, or if the insured's healthcare provider continues to prescribe the drug for medical treatment.

The bill prohibits the insurance provider from increasing the insured's cost-sharing obligation for narrow therapeutic index (NTI) drugs. This is a narrow group of drugs, not every drug in the formulary.

Senate Bill 192 is important because, since 2007, the cost of the most common prescription drugs has risen 7.4 percent. In contrast, the average inflation rate has only been 2.85 percent. This bill helps keep the cost of prescription drugs low for health-insured citizens.

There are several drugs designed to treat the same disorder, but not all of these drugs have the same success in treating all people. Sometimes a particular drug is more effective in treating a person than another drug designed for the same treatment.

The bill makes certain that an insured will be able to purchase the most effective drug as prescribed by their health-care provider, even if the drug is dropped from the insurer's formulary.

Narrow therapeutic index drugs are very expensive and critical for adequate treatment. This bill prevents insurers from increasing the percentage of the total cost the insured must pay for an NTI drug.

BARBARA MORROW, (Director of State Government Affairs, Astellas Pharma):
One of the drugs we sell is Prograf, an antirejection drug for organ transplant patients. Prograf went off patent in April 2008. We expect the generic to be on the market at any time.

Once a transplant patient has become stable on a particular drug, the physician wants the patient to remain on that drug because of the risk of the patient becoming unstable and possibly rejecting the transplanted organ.

The current continuity of care statute in effect in Nevada applies only to privately insured patients, and only for contracts that are not Employee Retirement Income Security Act (ERISA) preempted. An ERISA-preempted contract is usually a self-insured insurance contract which is covered by federal law.

I was advised that a couple of unions are going to oppose this bill. Most union insurance contracts are self-insured. The mandates of this bill would not apply to those contracts.

The continuity of care statute states that if an insurance company changes the drug formulary for a drug, which an insured patient is currently taking, the insurer must continue to provide that drug to the insured. However, the statute also states that the insurer can increase the copay or the out-of-pocket cost to the insured.

We were advised by transplant physicians that even if the insurer continues to provide the drug, the patient would not be able to afford the increased cost and would be forced to take less of the drug or to take another drug that the physician is not aware of. As a result, the patient's blood is not monitored.

We have limited the bill to catastrophic cases by adding NTI drugs. This bill does not cover hundreds of drugs. There are very few categories of drugs that fall under the definition of an NTI drug.

The intent of the bill is to keep the patient on the drug prescribed by the physician.

JASON SCHWARTZ, M.D.:
I am a transplant surgeon certified in doing transplants of the liver, kidney and pancreas (Exhibit C).

This bill deals with NTI drugs. An NTI drug is a drug that, because of the way the body processes it, can be different on a day-to-day basis as a result of other medications, food intake and hydration status. The bioavailability is also different based on those same factors. Bioavailability is how the body absorbs the medication. These processes are so different on a daily basis, as to make a very narrow difference between what is effective and what is toxic in the blood (Exhibit D).

This does not apply to all drugs. This applies to a very narrow spectrum of agents. Even when these drugs are taken as directed, they can have significant variations in concentrations in the blood which can result in very serious side effects.

In transplant patients, this can mean the difference between life and death because it can affect how the transplanted organ functions over the long term. It can mean the difference between rejection occurring, the organ having to be removed and the patient having to go on dialysis in the case of a kidney transplant. If a liver or heart transplant, the patient will die.

Right now, about 25 to 30 percent of patients receiving immunosuppressant drugs experience some sort of complication requiring hospitalization. Those types of complications are fairly serious. It could be renal failure, seizure activity, neurological complications, ulcers, fractures, infections and certain types of cancer. All of these are managed by transplant professionals within a very narrow window. We use medications that have been tested and proven in the transplant population.

Any effort to substitute medications that may be less therapeutic, or that have not been tested in the transplant population, is shortsighted. The substitution of medication is usually based on cost, and does not take into account the other costs that are associated with those types of decisions. For example, in a hospital setting with an oral medication that may be more expensive than an intravenous (IV) medication, the hospital may opt for the less expensive IV medication without taking into account the additional costs for a longer hospital stay, therapeutic drug monitoring, IVs and IV nursing (Exhibit E).

DEBBIE PINJUV (Director, The Transplant Network):
Ten years ago I was sitting here in liver failure. I had a rare autoimmune disease in which my immune system was killing my liver. I was testifying on bills for organ donation. At that time, I was given four weeks left to live. I was lucky to finally get a liver transplant. I did really well, and I had no rejection episodes. My blood was being monitored every three weeks.

Three years later, I got an infection and was given some additional medication which altered my blood levels, and I went into organ rejection. It took nine months to turn the rejection around. That situation cost a lot, but I was so thankful that they were able to reverse the rejection.

I have to do blood work levels every two months. I am on the drug Prograf. There is a normal blood level range, but my blood level does not get to the normal range. My transplant doctors know what is normal for me so I will not reject.

It is very frightening to me to even think about taking a different medication and have the doctors determine all over again what is normal for me. That is life threatening.

TRACY COPELAND:
Eleven years ago I went into liver failure and was sent to Stanford University. Three days later I was in a coma. My family was told that I only had days to live. Two days later I received a liver transplant.

My situation, as everyone else's, is unique. I was given a wide assortment of drugs that I had to take for a long time. Fortunately for me, I was weaned off of all the drugs with the exception of Prograf, which I currently take. I have been on this antirejection medication for 11 years. I have had no signs of rejection.

I have fairly good insurance. When I started taking Prograf in 1998, it cost me $20 a month. Now my co-pay is $112 a month. I am fortunate because I only take one medication. My friends who are transplant recipients are on many medications. It is very difficult for the doctors to get that "cocktail" just right for them. Sometimes the rejection medication causes infections and other things happen. They spend months, sometimes years, trying to get that "cocktail" just right.

The disease dictates the medication I am on. Prograf has worked for me for 11 years. The idea that I would have to change my drug for any reason which was not required by my doctor is frightening and could be devastating.

HEIDI SMITH:
I have spent most of my life in the health insurance industry. I was the person at the insurance company who denied claims. Insurance companies are trying to keep costs down.

A few years ago I needed a blood transfusion. The blood I received was "dirty," and I suffered liver failure. I was on the transplant list for ten years before they found a compatible liver.

My transplant cost $500,000. That is a lot of money to put into a human being, but it is rather ridiculous to try to cut that life short for a few hundred dollars. Many of us take Prograf, but we do not take the same amount or in the same way. Every person who has a transplant is "tuned" to the medicine. That is the only thing keeping you alive.

I go to the laboratory once a month for blood work. They look at my numbers, and then change the prescription according to a very complicated system. I have a problem right now. I asked my doctor if I could take a different antirejection medication. My doctor told me that the generic medication version we have right now will kill me. We do not have anything that is better than what I am taking.

If they could not fine-tune it, then what is the sense of going through transplants that cost so much to keep people alive, and then kill them because of the medication?

It is very important that the doctor is responsible for the medication. It is our lives that are on the line.

MYLAN HAWKINS (Executive Director, Nevada Diabetes Association):
The Nevada Diabetes Association helps the 7 percent of the population of Nevada who have been diagnosed with diabetes. We work with the rest of the population to prevent the incidence of this chronic and incurable disease.

Many of the people we serve are on dialysis because diabetes has many serious complications. End-stage renal failure is one of those complications, as well as blindness and lower extremity amputations, among other things.

It is really appropriate for the doctor to prescribe what is best for his patient, particularly when there is an organ transplant. It is terrible for a patient who undergoes a pancreas and kidney transplant to go into organ failure. Keeping the organs healthy, because of the cost and the stress of being a transplant patient, is absolutely critical. To interfere with a physician and his patient in what is appropriate treatment is unconscionable.

This bill protects both. It allows the doctor to treat patients appropriately, and it gives the patient security to know they are receiving the best and most appropriate treatment.

LINDA ASH-JACKSON, M.D. (Medical Director, Hometown Health):
We have a large group of community physicians who meet a few times a year to review clinical information around all of the drugs that are currently in use and new drugs released by the Food and Drug Administration (FDA). The physicians do not look at the cost of the drugs, but at the scientific information around the efficacy of the drugs to determine if any of the drugs are better than the current drugs in the same therapeutic class, if they are a new way of attacking disease or if they are absolutely appropriate because they are the only drug for a new condition. This includes drugs that cost hundreds of thousands of dollars a year.

The decisions are based on the therapeutic efficacy of the drugs. We work hard in an attempt to control medical costs at the health plan, but not necessarily in the physicians' group. The group strives for what is best for the patient, and what is available for them.

On the health plan side, we work with a pharmacy benefits manager who takes the first calls on any of the issues. I review from 15 to 20 files every 2 or 3 days for physicians because the drugs they want for their patients require either an override for co-payment because the patient has failed the formulary drugs, or patients require higher quantities of drugs classically provided or they require a drug not on the formulary. Ninety-five percent of the decisions are in favor of the patient. There is clinical input at each point of the process in order to maximize the patient's outcome.

I have two issues with this bill. The first is understanding the definition of an NTI drug. As it is defined now, it includes something that requires monitoring, which I am comfortable with. My concern is with the increase in health-care costs, and the fact that there are many generically equivalent drugs for situations that are not life threatening that patients do very well on.

The other concern is the difficulty we would have in trying to manage this process. We sell plans that have a brand co-pay, a generic co-pay and a co-pay for nonformulary drugs.

For example, if we had an employer buying a $30 co-payment for brand drugs for one year and then next year their medical trend overall is higher, they may decide they cannot afford that plan and ask for a cutback of benefits by increasing the brand co-pay. This will give them a lower rate, and they can continue to offer insurance to their employees.

Because this bill says including, without limitation, a different formulary tier, which would change the patient's cost-sharing, we could be hurting employers who try to lower their overall cost for providing health insurance by restricting us from lowering their co-payments. This could be a problem for us in our attempt to control medical costs in order to offer an affordable product to the marketplace.

SENATOR MATHEWS:
A physician taking care of a patient wants to make sure that decisions are made based on what he knows about that patient, not what is seen on a chart in a group setting.

DR. ASH-JACKSON:
That is correct, which is why I talk to them all the time.

CHAIR CARLTON:
When I was reading this bill, my understanding was that it does not limit what the physician can prescribe; it limits what the patient can be charged. Do I understand the bill correctly?

SENATOR MATHEWS:
Absolutely.

CHAIR CARLTON:
We are not mandating which drug the physician can choose, we are just capping the price that the patient can be charged.

SENATOR MATHEWS:
We are also talking about substituting one drug for another in the same therapeutic grouping. We do not want the drug changed to a generic just because the generic is cheaper. There may be two drugs that treat the same disease, but one of them does not work for the patient. The patient and the physician have to determine which drug is best for the patient.

SENATOR SCHNEIDER:
You said that you work with the doctors and the patients, and 95 percent of the cases turn out favorable for the patient. What happens to the other 5 percent?

DR. ASH-JACKSON:
There is an appeal process that the patient can go through which goes to a different physician and a different level. Most of the time there are no issues with the other 5 percent and when they go to appeal, most of them are upheld.

SENATOR SCHNEIDER:
The three ladies who just testified have been stable for years. What if they have to take a different medication? Some of them might be more sensitive to the new drug. If they have to go into an appeal process and then begin to reject an organ, how long is the appeal process?

DR. ASH-JACKSON:
An expedited appeal is within 24 hours.

SENATOR SCHNEIDER:
So they have to know that they can expedite an appeal?

DR. ASH-JACKSON:
No, we have to know that the request that is made is a life-or-death situation, and we have to respond within 24 hours.

I would never have changed the medication for any of those ladies. Why would an insurer spend $500,000 for a transplant and then argue about a few hundred dollars later on? That is part of the reason why we have a medical director reviewing cases.

SENATOR SCHNEIDER:
You are not the only insurance company.

DR. ASH-JACKSON:
No, we are not.

SENATOR SCHNEIDER:
The public thinks that insurance companies know what they are doing when they substitute one drug for another. This can be pretty dangerous.

DR. ASH-JACKSON:
Once the patient is on a regimen, in a complex situation, it is very difficult to move the regimen.

We do not automatically substitute a generic drug when a brand name drug has been ordered. We rely upon the physician to manage that for us.

SENATOR SCHNEIDER:
Then there is no need for this bill because you really do not do that.

DR. ASH-JACKSON:
We do not do that.

CHAIR CARLTON:
You were talking about the regimen, but this bill deals with the cost. You could change the cost but not the drugs.

DR. ASH-JACKSON:
We get many different requests. When we evaluate a request to override a quantity limitation, we look at the monthly quantity limitation recommendations

set by the FDA. We get requests for payment of nonformulary drugs at formulary rates. We will look at how long the patient has been on the drug, if their blood sugars are in control for diabetes and if we have the appropriate drugs represented on the formulary to which they might be switched. We also get requests for co-payment waivers. We do make cost decisions in some situations. If a patient is on a regimen, 95 percent of the time, we will favor the patient.

CHAIR CARLTON:
With these ladies who testified earlier, there is a finely tuned balancing act within their bodies. Would you make them switch first to determine if the new drug would work before you would do the appeal?

DR. ASH-JACKSON:
I personally would not do that.

CHAIR CARLTON:
Do you know anyone in the insurance industry who might have a policy to have someone try another drug before being allowed to file an appeal?

DR. ASH-JACKSON:
I do not know of anyone doing that.

CHAIR CARLTON:
I want to be sure that we are not putting someone in a position of having to get ill and get better again in nine months before they would have to go through an appeal process. There is no reason to use a cheaper drug and make someone get sick.

DR. ASH-JACKSON:
We try to work through drug issues as quickly as we can.

JUDY BRITT, PHARM. D (Manager, Pharmacy Services, Hometown Health):
I am opposed to this bill for two reasons. There are actually two parts to this bill. I am concerned about the first part because it does not allow insurance plans to have preference for generic equivalents that the FDA has determined to be bioequivalent.

The proposed legislation does state that it does not prohibit "... The insurer from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the insured, except that the insurer may not, in any manner, increase the insured's cost-sharing obligations for a narrow therapeutic index drug, including, without limitation, by placing the narrow therapeutic index drug on a different formulary tier as regards the provision of benefits for prescription drugs ... ."

It is not clear from the verbiage if the bill would allow for cost-sharing increases for drugs that have generic equivalents other than NTI drugs. Hometown Health has a Medicare D formulary which is a governmental program. Does the bill allow us to make decisions based on bioequivalence for all drug classes or would that be prohibited because there would be no increase in cost-sharing in those instances?

The proposed legislation also states that is does not prohibit "... The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2597, inclusive ... ." These are State Board of Pharmacy statutes. The State Board of Pharmacy allows for substitution if the generic drug is biologically equivalent to a drug prescribed by the brand name. This statute implies that the substitution of an NTI drug would also be included. Those State Board of Pharmacy statutes would have to be changed as well.

The State Board of Pharmacy statutes also mention that if a person refuses to accept the drug that the pharmacist intends to dispense in substitution, the pharmacist shall dispense the drug prescribed by brand name, unless the pharmacist is being paid for the drug by a governmental agency, in which case the pharmacist shall dispense in substitution.

This is a grey area because, as a health plan that administers a Medicaid program or a Medicare D program, would that mean that we would still have to dispense the generic drug for a Medicaid or Medicare patient? As a pharmacist, I would want to have that clarified in writing before I made that decision at the dispensing counter.

Section 1, subsection 1, paragraph (a), of the bill states that if the drug "... Had previously been approved for coverage by the insurer for a medical condition of an insured and the insured's provider of health care continues to prescribe the drug for the medical condition ... ." Does this mean with no gap in therapy; or if

the patient did not fill his prescription for 30 or 60 days, does that mean that there is a break in coverage and therefore this specific law does not apply? There are a lot of ambiguities in this verbiage that concerns me.

The bill does not allow health insurers to make decisions based on scientific evidence about therapeutic equivalents. In many drug classes, such as proton pump inhibitors, angiotensin-converting enzyme inhibitors and statins, there are many drugs in each of the classes with very different prices. However, their therapeutic effects are very similar, so it is regarded to be safe to have one drug work as well as another.

If the health plan has determined that one drug in a class is more cost-effective, which means it has the same therapeutic effect, but it costs considerably less, we will propose to the pharmacy and therapeutics committee that we make that a preferred drug. This legislation implies that we would not be able to do that.

I have another concern about not being able to make formulary changes and changing the tier. As a drug nears the end of its patent life, or if the market share of the drug has diminished, many times in order to preserve or maximize the revenue from that drug, it is not uncommon for a drug manufacturer to increase the price by 10 or 15 percent in 1 year. We take that information along with the therapeutic information to the pharmacy and therapeutics committee. If they find that one drug is more cost-effective than another, they will recommend moving the drug to a separate tier. This does not imply anything regarding the NTI drugs. It just relates to the first part of the bill.

In response to the NTI drugs, we currently have benefit-defined language to support the legislation for our commercial plans, but not for our "Senior Care Plus." The Centers for Medicare and Medicaid Services (CMS) guidance does not state that any health plan has to prefer NTI drugs and keep them on the same tier. I agree with CMS guidance that these drugs are safe when they have been determined by the FDA that the product is considered a pharmaceutical equivalent if they have the same ingredient of the same dosage form and route of administration as well as identical strength of concentration. Drug products must demonstrate pharmaceutical equivalence and bioequivalence to be considered "A" rated.

The primary reference for therapeutic equivalence by the FDA is called the *Approved Drug Products with Therapeutic Equivalence Evaluations*; commonly

known as the *Orange Book*. This is the "bible" for a pharmacist and for a health plan to determine if a drug is truly bioequivalent to the brand name product. If the FDA has determined the drug is bioequivalent, they will give it an "A" rating, and, therefore, it is safe to use, and that includes NTI drugs. Most states allow for substitution of NTI drugs by the pharmacist, and many of those states do use the *Orange Book* as the reference guide for pharmacists to be able to make that decision.

In the public sector of insurance, changing the tier of these products is not allowed. Would governmental programs that do not have tiers or cost-sharing not be able to use the generic products for the NTI drugs? Does this apply to government? If it does not apply to government agencies such as Medicaid, then I have a problem with that as a pharmacist because, if these drugs were less safe for the public sector, they would definitely be less safe for the Medicaid or Medicare sector. We should not have two areas of decision-making when it comes to something like NTI drugs.

SENATOR MATHEWS:
This bill is not about "less safe." This is about individual decisions made about individual patients. It may be safe for one person but not for another.

MS. BRITT:
That is why we have a formulary exception process. We are sensitive to the needs of providers, physicians and transplant surgeons in the community. I am talking about a general formulary decision process where we make our determinations based on FDA guidance.

SENATOR MATHEWS:
That is what the bill is about. The bill is for the exceptions.

CHAIR CARLTON:
How do people qualify for these drugs? Do people on these drugs have to reapply once a year to keep using them? Do they have to keep proving they need the drugs over and over again?

DR. ASH-JACKSON:
We keep a running list in the system on who has had the overrides in the past. If someone has been given an override in the past, the override will be renewed.

CHAIR CARLTON:
The underlying problem is the costs of drugs are increasing faster than people can afford. This bill is not about the doctor or about the patient, it is all about who pays the bills. If the costs of the drugs did not go up 100, 200 or 300 percent, we probably would not be having this discussion.

JACK KIM (Nevada Association of Health Plans):
The decision to stay on one drug or another, a brand name or a generic, is left up to the doctor. This bill deals with the cost of the drug and how much the patient is responsible for.

Generics are less expensive than the brand names. Health plans are not saying if a doctor orders a brand name, it should not be provided to the patient. It is the cost-sharing. This is about how much these drugs are going to cost. Why is a brand name so much more expensive than a generic if it is equivalent? Maybe the costs on brand names should be capped. If you cap the cost to the member, it will be made up somewhere else. Insurance is a pass-through to the employer. What you are doing is capping the cost on the front end but not capping the cost on the back end.

This bill has taken out the flexibility for the employer. If the employer wants to change to a plan with different co-pays and different deductibles, under this bill, we would not be able to change the co-pay. It would have to be a really individualized plan.

From a contract standpoint, this bill imposes one set of conditions on a going forward basis onto the next contract. Most health insurance contracts are a year long. After the contract ends, there will be new benefits. This would limit the ability to change that. This is a fundamental change in both contract law and in insurance law.

There are also issues on the consumer side. Under this bill, health plans will have to look carefully at what drugs to allow in their formulary, and at what level. It will be much more difficult to get a brand name drug on the lower tier formulary.

MS. MORROW:
Brand drug manufacturers have a limited amount of patent protection time for the drug on which they have spent billions of dollars in research and

development. We have a time frame given to us by the federal government during which we can recoup those dollars spent on the drug. Once a patent expires, it is usually market forces dictating the price of the medication, which will often be reduced.

BOBBETTE BOND (Culinary Health Fund; Health Services Coalition):
There is more money going into marketing brand drugs than there is going into research and development, which greatly affects pricing.

We are required under the Department of Labor (DOL) to follow all of the Health Insurance Portability and Accountability Act regulations for the appeal process. If we have a patient who needs to determine if a generic or a brand is equivalent, or if they need to stay on a brand, that would go under the DOL requirements of a 24-hour emergency.

The NTI issue is very serious. If someone under the Culinary Health Plan is using one of those drugs, it is treated as a regular brand name drug. We do not allow them to switch to another drug or require them to prove that they should switch.

CHAIR CARLTON:
We will close the hearing on S.B.192 and open the hearing on S.B. 193.

SENATE BILL 193: Revises provisions governing dealers in antiques. (BDR 54-1069)

SENATOR MATHEWS:
Senate Bill 193 was brought to me by the antique dealers. Reno is the only city in the State that is enforcing the secondhand dealers' ordinance against the antique dealers. This bill removes antique dealers from state and local regulations.

EDWARD JACOBSON:
I have submitted written testimony in support of S.B. 193 (Exhibit F).

CAROL CRANE:
I have submitted written testimony, including a letter from the City of Reno, an explanation of purpose and four letters in support of S.B. 193 (Exhibit G).

PETER PECKHAM:
I support S.B. 193. The current law pertaining to background checks and routine reporting of all inventory transactions to law enforcement is an excessive and unnecessary burden for antiques and collectible dealers.

In 2008, my retail space at the antique mall averaged about $32 in net sales per day. I pay approximately $10 a day for rent, plus the 3 days a month I have to work for the mall as part of my agreement to be there. This is not a get-rich-quick enterprise.

In addition to being required to have a city business license, the City of Reno wants to charge me $106 for a personal background check and fingerprinting and a city planning fee of $100. The cost issue aside, I am opposed to the amount of personal information the city wants as part of the background check.

I am required to complete a written application asking for my social security number, my income, sources of my income, living expenses, savings account balance and account number, checking account balance and account number, information on my mortgage payment and balance, information on former employers, former residences and personal references.

Of major concern to me is the application states that this information provided to the city is confidential and requires my permission for it to be photocopied. The form also requires a signed waiver releasing the City from liability for any damages suffered by me as a result of its unauthorized use. I have received no evidence from law enforcement that this level of dealer scrutiny is reasonable and worth the effort in helping to catch criminals.

GAY ELLIKER:
I have submitted written testimony in support of S.B. 193 (Exhibit H) and a letter submitted by Helene Walker also in support this bill (Exhibit I).

CHAIR CARLTON:
We also have some letters in support of S.B. 193 from Paula and Dan Clements (Exhibit J), Patricia Boynton (Exhibit K) and Glen Movey (Exhibit L).

BILL HANCE:
In the past, the elected officials in the City of Reno have been in favor of changing the law. But as the officials change, so do the opinions about this law.

Fingerprinting is an invasion of privacy because it goes farther than just one division.

CHAIR CARLTON:
Miss Miller, can you explain the gun show provision?

ALEXIS MILLER (City of Reno):
I cannot explain the gun show provision, but I will look into it.

We have an attorney general's opinion that explains the intent of the law was to require this of antique dealers. We are just trying to comply with State law and prevent unlawful sale of stolen goods. We were not trying to place undue burden on antique dealers.

CHAIR CARLTON:
No one else in the State has the same viewpoint on this law as the City of Reno.

FRANK ADAMS (Executive Director, Nevada Sheriffs' and Chiefs' Association):
Some of the history behind this law would help. Like pawnshop dealers and secondhand dealers, the term antique is a broad, open definition. The intent behind the law was to try to keep the nefarious individuals who traded in stolen property out of the antique business. It was not to keep "mom and pop" from selling their "buttons."

Not all antique dealers are honorable. There have been stolen antiques that have been recovered. We would like to work this out. It was not our purpose to keep the small "mom and pop" operations out. We do need to have some way when an individual finds a valuable piece of property, to determine if the property is stolen or not.

CHAIR CARLTON:
Mr. Adams, do you think there is a way to resolve the issue of these people having to get fingerprinted? Is there a way to do a civil name check or run a basic record and not have to do the fingerprint card?

MR. ADAMS:
Yes, the civil name check is at the point that we could do that relatively easily, and perhaps that is the way we should go. If there is something that comes up on the civil name check, then we could go further on it.

The issue we are concerned about is secondhand dealers becoming antique dealers.

CHAIR CARLTON:
Could the city do that without legislation? Can that be done with regulation within the business licensing ordinances?

MR. ADAMS:
I do not know.

MS. MILLER:
We would be happy to if that is legal. The statute is clear that antique dealers are required to have a background check. If that is not the case, I can have our city attorneys look at that.

CHAIR CARLTON:
I just want to clarify that if this bill were passed, we would not have to include those provisions in the bill. They could be adopted by ordinance. We would exempt antique dealers and when they apply for a business license, the civil background check could be done to determine if fingerprinting is needed.

We need to have someone look into that to ensure we are going down the right path.

MR. ADAMS:
I agree with that. I would just want to be sure that we have the authority to do civil name checks.

SENATOR MATHEWS:
I do not want to leave it to the City of Reno. We have tried to get an ordinance before which did not happen.

CHAIR CARLTON:
I will close the hearing on S.B. 193. Senate Bill 211 will not be heard.

SENATE BILL 211: Enacts provisions relating to manufacturers and wholesalers of prescription drugs. (BDR 54-1056)

CHAIR CARLTON:
I will open the hearing on S.B. 265.

SENATE BILL 265: Revises provisions relating to the Private Investigator's Licensing Board. (BDR 54-1053)

MECHELE RAY (Executive Director, Private Investigator's Licensing Board):
I have submitted written testimony in support of S.B. 265 (Exhibit M).

CHAIR CARLTON:
Would this licensing scheme be any stricter than what is currently being done?

MS. RAY:
It would be the same background check. The fingerprints would go through the criminal repository and to the FBI.

CHAIR CARLTON:
The only concern I have is the use of the word temporary. I recommend you use the work provisional. If you give a temporary license, then you have to go through a full hearing in order to be able to retract it. If you give the license provisionally upon the completion of the verification of the license, then you do not have to go through the hearing process in order to retract the license if the potential licensee does not meet all of the qualifications.

SENATOR COPENING:
On page 5, line 16, it states "... except clerical personnel ... ." Is it correct that clerical personnel will not go through the registration process?

MS. RAY:
Clerical personnel do obtain a work card but are not registered with the Private Investigator's Licensing Board (PILB).

SENATOR COPENING:
Would section 2 be an area where that needs to be included as well?

MS. RAY:
Section 2 is about quarterly reporting for licensees. Currently, when the quarterly report is provided to the PILB, the listing of clerical personnel is not required.

DAN CRATE (Private Investigator's Licensing Board):
I am a private patrolman. I am chair of the Private Investigator's Licensing Board. I have been in that position for 15 years. The only thing that I want to add is, trying to interpret and apply that legislative intent, it was recognized that as a privileged license and the nature of what private protective services do, some sort of restrictions on the employee background were necessary. As a matter of practicality, the background is assured by deferring to the work card systems that were already in place under Washoe and Clark Counties. Sheriffs' departments have had similar processes in place.

It specifically exempted counties with populations less than 100,000. In the subsequent years, I have had a concern that the rural counties, the other 15 counties that are not specifically included under the umbrella of requirements, an individual can work out there, possess a weapon in connection with their employment, and not have any assurance that a background has been done on that individual.

There are slight variations on cost and on requirements between Washoe and Clark Counties, but we certainly recognize, and appreciate that they have put the infrastructure together. They do a good job. We rely on them to do the background checks. We are looking for the opportunity, in conjunction with the other two counties, with Metro, and the Washoe County Sheriff Department, to integrate the data that we have, standardize the expectations, standardize the cost, make it more cost-effective for the employee and have greater reassurance for the general public, as well as for the employer. This will reduce some of the paperwork, the opportunities for redundancy and mix-ups that happen when you get overly bureaucratic. We are trying to simplify it for the benefit of the employee and for all of the citizens of Nevada so they have a sense of well-being, that the statutes are being uniformly applied.

We are asking that you extend this opportunity to us. We had no objections prior to today. I understand there are concerns. There are some objections, but there is nothing in the way it is written currently that we cannot accommodate.

Those counties get the benefit of prescreened people already being reported in their jurisdictions

ROCKY FINSETH (Private Investigator's Licensing Board):
I know there are issues and concerns with this bill. We are ready to work with you on addressing those issues.

CHAIR CARLTON:
I know there is an amendment on this bill. I would like to go to Mr. Adams and Mr. Roberts and then address the proposed amendment.

MR. ADAMS:
The rurals are not involved in this type of process. They are exempt.

Our concerns are, if we go to this type of process, we want to make sure that requirement is in the bill. We need to change the word from "may" to "shall" on page 6, line 39.

CHAIR CARLTON:
The intent was "shall".

MR. ADAMS:
I represent the rural sheriffs, who are not doing it at this time. The biggest impact will be on Washoe and Clark Counties. We are willing to work with the Committee in any way we can.

LIEUTENANT TOM ROBERTS (Las Vegas Metropolitan Police Department):
We have a couple of issues. We currently do this service for the work card portion. We have built an infrastructure to process those. We have hired employees. We have computer systems and equipment that does this already. This would be taking a load off that system that we have budgeted and paid for.

Another issue is the centralized data base we currently have, on which we can conduct searches when we do enforcement. I would hate to have any kind of gap in that service. We issue approximately 40 citations a quarter on security guards that are noncompliant.

Another issue is the cost. Under this bill, the cost would go up to $135; currently we are doing it for $85. We are willing to help in any way we can.

CHAIR CARLTON:
You already have the system set up and in place. Are you talking about laying off employees?

LT. ROBERTS:
It would depend on the workload. It could result in a reduction in staff. We would not necessarily lay people off. They could be placed somewhere else within the agency. This service is currently performed in the fingerprint bureau. If their workload is reduced enough, then we would reduce the staff.

In this area, the workload is pretty fixed based on work cards and fingerprint cards. If we are not doing them, then the work is not there, and those people would go elsewhere.

CHAIR CARLTON:
How much is the citation for someone who has not gotten their work card?

LT. ROBERTS:
I do not know, but I can get the answer for you.

CHAIR CARLTON:
How many of these do you process?

LT. ROBERTS:
We issue approximately 20 to 40 citations per quarter.

CHAIR CARLTON:
How many work cards do you process?

LT. ROBERTS:
I do not know. I can find out. According to the statewide figures, they issue 40,000 licenses. I do not know what percentage of those is in Clark County.

CHAIR CARLTON:
If this were to stay with the two major counties, can you think of a way that those work cards would be valid in the rural counties? Possibly, by sharing the information with the PILB, someone would not have to get multiple cards.

LT. ROBERTS:
We could work something out. Rather than replace our system, we could augment it with a statewide system that would service the rural counties and provide a statewide data base. We could accomplish that.

CAPTAIN TIM KUZANEK (Washoe County Sheriff's Office):
We have the personnel and the infrastructure set up to handle this as is. We currently have a 24 hour a day, 7 days a week, accessible system. We are willing to work with whoever we can to work this out.

SCOTT SCHERER (Nevada Registered Agents Association):
The reason we have proposed an amendment to this bill (Exhibit N), is that the definition of private investigator in chapter 648 of the *Nevada Revised Statutes* (NRS) is extremely broad. There is a list of exemptions in NRS 648.018 that narrows that breadth.

Our concern is that many of our clients do searches of corporate records and other types of records and trademarks to determine the status of various companies. They are concerned those searches of public records will cause them to fall under the category of being a private investigator and needing a license. This amendment would allow them to search public records, and only public records, without needing a license.

There are other concerns that our amendment might be too open-ended and might have some unintended consequences. We have limited the amendment by removing the word "person" and replacing it with "commercial registered agent" as defined in chapter 77 of NRS. It would exempt commercial registered agents who file with, and are subject to the regulations of, the Secretary of State.

CAPTAIN P. K. O'NEILL (Chief, Records and Technology Division, Department of Public Safety):
There are a few confusing areas in S.B. 265 that need to be clarified for us. Page 2, lines 27-29 deal with a complete set of fingerprint cards or receipt of two sets of fingerprints. This language is confusing.

There are some other areas dealing with the expense of the background check we would like clarified. Is a background check more than just fingerprints? The only component that I have in any background check is dealing with the fingerprints and the criminal history attached to them. We want to clarify the pricing and that our fees are covered.

BARRY SMITH (Nevada Press Association):
We want to make sure that this bill is not intended for a journalist who does a lot of examining and copying of public records for commercial purposes. If this needs to be an exception, we would like it included in the amendment.

CHAIR CARLTON:
That was not anyone's intention.

SENATOR PARKS:
I received some correspondence from a former member of the Board, who had suggested some change in language on NRS 648.157. I have not had a chance to thoroughly analyze it. I am suggesting that we might want to look at this.

CHAIR CARLTON:
Was that through Senator Care on complying with the language in the other chapter?

MS. RAY:
Yes, that individual brought that item to the Board meeting last week. The Board was okay with repealing NRS 648.157 because it was in conflict with a provision of chapter 481 of NRS.

SENATOR PARKS:
Yes, it was NRS 481.063. As I read this, it is either putting it in conflict or resolving the conflict of those two sections. It will have to be reviewed.

CHAIR CARLTON:
I will close the hearing on S.B. 265 and go into work session. We have a work session document (Exhibit O, original is on file in the Research Library).

We have the Insurance Commissioner's Bill Draft Request 57-1131.

BILL DRAFT REQUEST 57-1131: Revises provisions relating to insurance. (Later introduced as Senate Bill 388.)

SENATOR AMODEI MOVED TO INTRODUCE BDR 57-1131.

SENATOR HARDY SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR CARLTON:
I will open the work session with S.B. 127.

SENATE BILL 127: Exempts qualified persons or groups providing services as a project manager or construction manager to a long-term recovery group from regulation as a contractor. (BDR 54-596)

SENATOR AMODEI MOVED TO AMEND AND DO PASS AS AMENDED S.B. 127.

SENATOR COPENING SECONDED THE MOTION.

SENATOR HARDY:
I will abstain temporarily from the vote until I can determine if my group was involved in any lobbying, and if there is no involvement, I will vote on the Floor. I am the President of the Associated Builders and Contractors of Las Vegas.

THE MOTION CARRIED. (SENATOR HARDY ABSTAINED FROM THE VOTE.)

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CHAIR CARLTON:
I will open the work session on S.B. 72. There is an amendment which addresses nine out of the ten issues brought forward.

SENATE BILL 72: Authorizes a registered pharmacist to perform certain screening tests. (BDR 54-376)

SENATOR BARBARA K. CEGAVSKE (Clark County Senatorial District No. 8):
Everyone who had issues has been contacted.

SENATOR HARDY:
Is this acceptable to Mr. Gresh and his group?

BRIAN GRESH (University of Southern Nevada):
Yes, thank you.

SENATOR HARDY MOVED TO AMEND AND DO PASS AS AMENDED S.B. 72.

SENATOR COPENING SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR CARLTON:
We will now go to S.B. 57. There was a lot of information on S.B. 57. What you see here in the amended bill was a recommendation I made to allow veterinarians from another state to practice in this State.

There were a number of concerns about the permissiveness of the other language and some of the ambiguities. This is the boilerplate credentialing language that I have used with other professionals.

There were also concerns about the tests brought up by the Nevada State Board of Veterinary Medical Examiners. We have removed those from the bill. The testing will remain the same.

The other portion of the amendment deals with the definitions of livestock.

SENATE BILL 57: Makes various changes relating to veterinary medicine. (BDR 54-419)

KELLY S. GREGORY (Committee Policy Analyst):
There was a change in the definition of livestock, a change to the definition of a conditionally licensed vaccine and a change to the name of the organization that

provides credentialing to veterinary technicians. The mock-up deletes sections 2 and 3 of the bill and adds section 5.

SENATOR RHOADS:
Is the foreign reciprocation still in the bill?

CHAIR CARLTON:
No, we have removed that section.

SENATOR SCHNEIDER:
Veterinarians had concerns with both sections 2 and 3. They have been removed.

CHAIR CARLTON:
We have addressed the out-of-state veterinarians coming into this State with the credentialing language.

SENATOR SCHNEIDER:
Will the out-of-state people be educated in the United States, working in clinics out of this State, but have full approval in the state in which they are working?

CHAIR CARLTON:
No, there is nothing in the bill stating that they must have graduated from a college in this Country. It just states that they are coming from another state and have been practicing for five years. We are looking at their work history in the other state.

SENATOR SCHNEIDER:
There were still some concerns about education in another country.

CHAIR CARLTON:
Those concerns were more about the testing component. They were not about the credentialing provision. That was the foreign medical graduate testing. They wanted to be sure the student had graduated from an accredited college.

SENATOR SCHNEIDER:
I was concerned about the people who will be working with valuable livestock. We have to be sure they are qualified.

CHAIR CARLTON:
The Board can look at the work history for the past five years and determine if there were disciplinary problems, and they can evaluate that person's work history.

NEENA LAXALT (Nevada State Board of Veterinary Medical Examiners):
We looked at this amendment and would like to see this go through and continue working on our concerns.

SENATOR HARDY:
Are you saying that you want to continue working on this?

MS. LAXALT:
Yes, Senator. We are heading in the right direction, and as long as we have approval, we would like to keep working on it.

DENNIS WILSON, D.V.M. (President, Nevada Veterinary Medical Association):
We have been working with the Board and are very close to coming to an agreement.

DEBBIE MACHEN (Executive Director, Nevada State Board of Veterinary Medical Examiners):
There was one section taken out in error on the credentialing of the technicians. This should be put back in the bill.

MS. GREGORY:
I have that, and I will work with the Legal Division to make sure the language regarding the technicians is put in the right place.

JACK WALTHER, D.V.M.:
I have some concern on one part of the amendment. Credentialing after five years should only be for graduates of a school that has been accredited in the United States and not a foreign school.

SENATOR HARDY:
I recognize and understand the concerns with the education in other countries. The language in this bill is sufficient.

SENATOR HARDY MOVED TO AMEND AND DO PASS AS AMENDED S.B. 57.

SENATOR RHOADS SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR CARLTON:
We will not have a work session on S.B. 89. Work is still being done on it.

SENATE BILL 89: Makes various changes to the provisions governing manufactured housing. (BDR 43-427)

CHAIR CARLTON:
We will not have a work session on S.B. 112. There are still a number of concerns.

SENATE BILL 112: Revises provisions relating to the provision of health benefits by employee leasing companies. (BDR 53-622)

CHAIR CARLTON:
We will not have a work session on S.B. 119. There are still a number of issues to be resolved.

SENATE BILL 119: Revises provisions governing massage therapists. (BDR 54-162)

CHAIR CARLTON:
I will open the work session on S.B. 151.

SENATE BILL 151: Provides for the payment of certain claims from the Recovery Fund of the State Contractors' Board. (BDR 54-702)

STEVE HOLLOWAY (Executive Vice President, Associated General Contractors, Las Vegas Chapter):
Our concern was with the "capacity to pay" language in section 1, subsection 3. "Capacity to pay," in that instance, becomes very ambiguous, particularly, if

the money is not due, or if there is a “pay-if-paid” clause or if there is a dispute over a change order request. If you have the capacity to pay, it is not relevant. What is relevant is if you are contractually or statutorily obligated to pay. The amendment addresses that problem.

SENATOR HARDY:
I will be abstaining temporarily from the vote.

SENATOR COPENING MOVED TO AMEND AND DO PASS AS AMENDED S.B. 151.

SENATOR RHOADS SECONDED THE MOTION.

THE MOTION CARRIED. (SENATOR HARDY ABSTAINED FROM THE VOTE.)

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CHAIR CARLTON:
I will open the work session on S.B. 195.

SENATE BILL 195: Revises provisions governing workers' compensation. (BDR 53-1077)

SENATOR AMODEI MOVED TO AMEND AND DO PASS AS AMENDED S.B. 195.

SENATOR COPENING SECONDED THE MOTION.

SENATOR HARDY:
We have tried, through the years, to remove specific reference to specific manuals and refer to the latest manual. I am going to remain consistent and that is the reason for my no vote.

THE MOTION CARRIED. (SENATORS HARDY AND RHOADS VOTED NO.)

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CHAIR CARLTON:
I will open the work session on S.B. 128.

SENATE BILL 128: Requires certain persons to record foreclosure sales and sales of real property under a deed of trust within a certain period of time. (BDR 9-841)

SENATOR PARKS:
There was an amendment to this bill that was proposed by the Nevada Land Title Association. It is amending section 1, subsection 8, which states that within 30 days after the sale of the property, the beneficiary shall cause the trustee's deed upon sale to be recorded in the office of the county recorder, and if the beneficiary fails to cause the recording of the trustee's deed upon sale, as set forth in subsection 8, paragraph a, the beneficiary is liable in a civil action to any party who is a lien holder against the property subject to the sale, to the sum of $500, plus reasonable attorney expenses.

SENATOR COPENING MOVED TO AMEND AND DO PASS AS AMENDED S.B.128.

SENATOR SCHNEIDER SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR CARLTON:
I have another BDR to introduce. It is BDR 52-1143.

BILL DRAFT REQUEST 52-1143: Revises provisions relating to trade. (Later introduced as Senate Bill 397.)

SENATOR HARDY MOVED TO INTRODUCE BDR 52-1143.

SENATOR SCHNEIDER SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR CARLTON:
We need to address a second amendment to Senator Lee's bill, S.B. 6. It deals with the initial employment and the initial examination for volunteer firefighters. We are not rescinding the previous amendment.

SENATE BILL 6: Revises provisions regarding occupational diseases of volunteer firefighters. (BDR 53-46)

MS. GREGORY:
Requesting this amendment and introducing it on the Senate Floor would be a streamlined way of doing it.

CHAIR CARLTON:
We will introduce it on the Senate Floor.

There being no further business, this meeting of the Senate Committee on Commerce and Labor is adjourned at 4:40 p.m.

RESPECTFULLY SUBMITTED:

_____
Suzanne Efford,
Committee Secretary

APPROVED BY:

_____
Senator Maggie Carlton, Chair

DATE:_____