MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-sixth Session
March 14, 2011

The Senate Committee on Health and Human Services was called to order by Chair Allison Copening at 3:30 p.m. on Monday, March 14, 2011, in Room 1214 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to the Grant Sawyer State Office Building, Room 4412, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Allison Copening, Chair
Senator Valerie Wiener, Vice Chair
Senator Sheila Leslie
Senator Ruben J. Kihuen
Senator Joseph (Joe) P. Hardy
Senator Ben Kieckhefer
Senator Greg Brower

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Policy Analyst
Risa Lang, Counsel
Shauna Kirk, Committee Secretary

OTHERS PRESENT:

Neil Rombardo, Carson City District Attorney
Stuart Stoloff, M.D. FAAAAI, FAAFP, Clinical Professor, Department of Family & Community Medicine, University of Nevada School of Medicine
David M. Marlon, M.B.A., CADC-I, C.Ad., President Solutions Recovery; Executive Director, Care Coalition
Kent Shaw, Assistant Chief, California Department of Justice, Office of the Attorney General, Division of Law Enforcement, Bureau of Narcotic Enforcement
Rob Bovett, Lincoln County, Oregon, District Attorney
Sergeant Stanley Salyards, Louisville, Kentucky, Metro Police Narcotics Team

Kevin Schiller, Social Services Director, Department of Social Services, Washoe County
Frank Adams, Nevada Sheriffs' and Chiefs' Association
Allen Veil, Lyon County Sheriff; Secretary/Treasurer, Nevada Sheriffs' and Chiefs' Association
Chris Ferrari, Consumer Healthcare Products Association
Kevin J. Kraushaar, Esq. Consultant, Consumer Healthcare Products Association
Tom Nielsen, Account Executive, Government Information Services, Appriss, Inc.
Bryan Wachter, Retail Association of Nevada
Lawrence P. Matheis, Nevada State Medical Association
Daniel G. Bellingham, Healthcare Distribution and Management Association
Helen Foley, Nevadans for Affordable Healthcare
Maurice White

CHAIR COPENING:
We will open the Senate Committee on Health and Human Services meeting with Senate Bill (S.B.) 203.

SENATE BILL 203: Revises provisions relating to the classification and dispensing of certain precursors to methamphetamine. (BDR 40-648)

SENATOR SHEILA LESLIE (Washoe County Senatorial District No. 1):
Senate Bill 203 is a bill about getting rid of methamphetamine (meth) and the resulting damage it does to our community through wasted lives, increased crime, and most importantly, damage to children whose meth-using parents are incapable of nurturing or protecting them.

The bill puts the essential ingredient needed to produce meth back on the prescription-only list where it was before 1976. The decision to let this ingredient into the marketplace was a tragic one for our country, and it is the major cause of the meth epidemic, which has ravaged Nevada over the past 30 years.

You will hear from experts today, some local and some who have flown in from around the Country, who will tell you about their experience with this horrific drug and confirm what we all know. The only solution to getting meth off our streets and away from our children and families is to put the ingredient needed to manufacture it back on the prescription-only list.

Those in opposition to this bill will tell you this is about health access, and ask why law-abiding citizens should bear the burden of inconvenience and cost just to get their cold medication. There are 115 other cold and allergy products manufactured by the same companies that do not contain pseudoephedrine (PSE). I went to my local CVS Pharmacy this weekend and stopped counting at 52 alternatives. For many people, PSE is contraindicated, and these other products are actually safer and just as effective for many people.

The opposition will offer you a solution of an electronic tracking system they have offered other states. However, it does not work.

At least 13 other states are taking up a similar bill in 2011, including our super-lab neighbor California, where their bill failed by just one vote last year. The latest state that almost passed the bill last week was West Virginia where it passed the house, had the Governor's support, but suddenly on the way to the senate, one senator switched sides and another went missing, and the vote was 16 to 16 and failed.

I am under no illusion about the persuasive power of the drug companies that will do their best today to convince you this is about health access. They will try to sell you on electronic tracking (e-tracking).

Our first presenter, Carson City District Attorney, Neil Rombardo, will explain the situation in Nevada and show you how much of the product is purchased locally and diverted to the black market through a mechanism called "smurfing." You have a packet of letters worth reading from Nevada law enforcement, county commissioners, physicians, pharmacists and the Allergy and Asthma Network Mothers of Asthmatics (Exhibit C).

I have been asked why I care so much about this issue, especially as someone who has worked hard in Nevada on access to health care for everyone. Several years ago when my daughter's school required her to observe a court session, one of the defendants was asked to choose the drug or her children. She chose the drug. No child should be rejected by their mother because meth was more important. I believe this bill is the only solution to the biggest social problem of our time.

NEIL ROMBARDO (Carson City District Attorney):
I have a presentation entitled "The Next Step to Stop Meth in Nevada" (Exhibit D). How much would you pay for Sudafed? It costs $6.71. I can take this $6.71 item and sell it for as much as $50 to someone who will make methamphetamine in Nevada. Methamphetamine plagues the entire State.

STUART STOLOFF, M.D., FAAAAI, FAAFP (Clinical Professor, Department of Family and Community Medicine, University of Nevada School of Medicine):
I am a family physician in Carson City. I have practiced here for over 32 years. I am also a Clinical Professor at the Department of Family and Community Medicine, University of Nevada School of Medicine. I am one of the authors who wrote "The diagnosis and management of rhinitis: An updated practice parameter" in 2008. As one of the people directly involved in writing that document, I had an opportunity to read and write on all the literature through the year 2008 and most recently, in another review. I looked at Sudafed and all of the ephedrine-like products. We reviewed this information and put it in the "practice parameters." We did not find evidence in efficacy or effectiveness of these medications for the treatment of cold, allergic or nonallergic rhinitis. When they have been combined with drugs such as Allegra and Claritin, they act as a decongestant. I consult for and advise the overwhelming majority of the pharmaceutical companies in the world that are involved in products made for the treatment of allergy, allergic and nonallergic rhinitis and asthma. Among the supporters of this bill are the Allergy and Asthma Network Mothers of Asthmatics. With all the alternative medications, it is perplexing that we allow this medication to be purchased liberally, resulting in a disaster for our society. Everyone I have contacted in health care has the same perceptions I do. This is not alleviating a cold. There are a multitude of other options for alleviating a cold. To decongest, someone could use saltwater. When someone takes Sudafed, they take the risk of several severe side effects. The benefit of removing this molecule from the marketplace is far greater than any risk of lack of availability. People will be able to see their clinician who will write a prescription to purchase for self use.

SENATOR KIECKHEFER:
Are there other drugs listed as prescription-only because of what they can be converted into?

DR. STOLOFF:
Not many. The process for converting this molecule is easy. The difficulty with other molecules that are by prescription is the way they are developed and enveloped make it highly unlikely that you can separate the molecules to put them into something more dangerous for the community.

SENATOR BROWER:
If I understand your answer correctly, this would be the first drug we would make prescription-only because of what it can be turned into illegally and not because of its potential harmful effects.

DR. STOLOFF:
That is correct.

SENATOR LESLIE:
Why was it on the prescription-drug list in this country until 1976?

DR. STOLOFF:
I do not know.

DAVID M. MARLON, M.B.A., CADC-I, C.Ad. (President, Solutions Recovery; Executive Director, Care Coalition):
The number one health problem in Nevada is drug abuse and addiction. We need help reducing the availability of methamphetamines. We represent many groups including law enforcement, school districts and churches, and we support this bill. Several of the coalitions in Nevada also support this. We realize there will be office visits and prescription costs that would be borne. I work every day with people who have become dependent on methamphetamine. I talked to six individuals who confirmed they made this drug by driving to several pharmacies in Las Vegas to purchase Sudafed to make small batches of methamphetamines. I know that "smurfing" is happening now in Las Vegas. If you help us reduce the demand, the children in middle school will be a lot less likely to be offered this drug.

KENT SHAW (Assistant Chief, California Department of Justice, Office of the Attorney General, Division of Law Enforcement, Bureau of Narcotic Enforcement):
I am with the California Department of Justice representing Attorney General Kamala D. Harris. You have been given written testimony which I will read (Exhibit E).

SENATOR KIECKHEFER:
The Carson City district attorney indicated there is not a lot of methamphetamine crossing from Mexico into the United States. You have said there is methamphetamine crossing over the border.

MR. SHAW:
There is a large amount of it coming from Mexico. It is an inferior form. We still have a huge production issue.

SENATOR KIECKHEFER:
The drug being made in Mexico is not made with PSE.

MR. SHAW:
They are increasingly using less and less of it.

SENATOR KIECKHEFER:
If we reduce access to PSE, would they not start using the older method again?

MR. SHAW:
No. We effectively eliminated that as a method and are confident we can continue to do so. It is a far more difficult process to make, and they cannot get their hands on those chemicals.

ROB BOVETT (Lincoln County, Oregon, District Attorney):
I have a presentation titled "Meth Epidemic Solutions The Oregon Experience" (Exhibit F) and written testimony that I will read (Exhibit G).

SENATOR HARDY:
Did Oregon try to use the prescription monitoring program as a methodology of controlling "smurfing?"

MR. BOVETT:
No. We collated all of the logs from sales and entered it into a database. We discovered so many "smurfers," we were overwhelmed.

SENATOR HARDY:
When we write a prescription, it goes into a database. Are you using a different database than we are?

MR. BOVETT:
We have not seen prescription-doctor shopping of Sudafed, because it is not a drug of abuse. It is a way for someone to make money.

SENATOR HARDY:
Are you saying "smurfers" do not go to doctors?

MR. BOVETT:
That is correct.

SENATOR WIENER:
What is your theory regarding the 1976 threshold date?

MR. BOVETT:
Prior to 1976, Sudafed was a schedule II controlled substance. It was there because it would raise blood pressure, complicate hypertension and complicate heart issues. Many of the doctors I have talked to believe this should be dispensed by prescription anyway. There are large classes of people who should not take this drug. There is also the interaction with other drugs. It should not have been made an over-the-counter (OTC) drug for just personal health and quality-of-care issues.

SENATOR WIENER:
What was the rationale for making it an OTC drug?

MR. BOVETT:
In 1976, there was an extensive rule-making proceeding in the Federal Register which explained why these drugs were safe and had efficacy. Interestingly, a number of these drugs within this class have been removed from the market for safety reasons.

SERGEANT STANLEY SALYARDS (Louisville, Kentucky, Metro Police Narcotics Team):
Methamphetamine is the only drug for which you can go to a retail store and purchase everything needed to manufacture it. In 2008, Kentucky was the first state to have e-tracking. We were also the first state to pay for it. We paid approximately $1 million for full access for every law enforcement officer throughout the commonwealth for about 18 months. In 2008, we had approximately 428 methamphetamine labs. In 2009, we had 741 meth labs. Police agencies that cleaned up those labs looked at those numbers and how they were found. Only 10 percent of the meth labs were found through e-tracking statewide. In 2010, it was less than 10 percent, and we had 1,078 meth labs. Electronic tracking cost Kentucky $2.5 million last year to clean up meth labs. That is only for law enforcement. Our judicial system spent $32 million in prosecution and incarceration.

SENATOR HARDY:
Define meth lab.

SERGEANT SALYARDS:
Most of our labs are found through dump sites, informants or police work. These are the one-pot meth labs you are hearing about. Usually, it is cooking in a Gatorade bottle.

KEVIN SCHILLER (Social Services Director, Department of Social Services, Washoe County):
Methamphetamine in Washoe County and at a statewide level has an impact on parents that goes beyond anything you have seen in Mr. Rombardo's PowerPoint. This chemical changes the functioning of the brain. Substance abuse is an identified factor in 70 percent of our cases where we have a referral and an open case of child abuse and neglect. Of that 70 percent, 50 percent of them involve methamphetamine. The average length of time to reunify a child is 18 months. The foster care, medical and staffing costs total over $30,000 per child where meth is involved. It is twice as hard to get the parents to engage in treatment. The cost, on average, in Washoe County is $1 million for the treatment and the ability to reunify that child. Parents who have a picture before the use of meth and a picture after the use of meth for two years look like they have aged 25 years. Anything we can do to stop this epidemic should be done. We strongly support this bill.

FRANK ADAMS (Nevada Sheriffs' and Chiefs' Association):
With me today is Sheriff Allen Veil from Lyon County. Sheriff Veil is the Secretary/Treasurer of the Nevada Sheriff's and Chiefs' Association. We support this bill.

ALLEN VEIL (Lyon County Sheriff; Secretary/Treasurer, Nevada Sheriffs' and Chiefs' Association):
Methamphetamine is our number one concern. A majority of the crimes we see are drug-related. The intent of this bill is to make PSE more difficult to obtain. A small inconvenience is a small price to pay. We are in support of this bill.

CHRIS FERRARI (Consumer Healthcare Products Association):
We agree that methamphetamine is a huge problem in this State. We disagree about the solution and would like to offer a solution that works and is working across the Country. The National Precursor Log Exchange program (NPLEx) has support from law enforcement, elected officials, drug investigators and patients from our State and across the Country. These organizations have acknowledged NPLEx as an effective tracking system that is making a difference in blocking sales. Our system is part of the solution to "smurfing." There is no system that is going to rid us of this problem completely. The NPLEx system offers a real-time tracking system that can stop "smurfing" effectively. People can buy a legal allotment and when they go to a second store, they will be stopped. Nevada put products containing PSE behind the counter in 2007. As you can see in my graph (Exhibit H) in 2006 to 2008, Nevada did not put in a prescription-drug system nor did the state of Washington. You can see a very similar decline. Based on what Nevada did in 2007, we have controlled a large portion of the laboratory problem. Now we should address the use. The High Intensity Drug Trafficking Area (HIDTA) under the U.S. Department of Justice (DOJ) studied the meth problem around the country. They said:

> Analysis suggests that despite continued declines reflected by some indicators, methamphetamine use remains at a high level in the state [Oregon]. While some regional differences exist, more than 80 percent of Oregon law enforcement agencies surveyed in 2010 report methamphetamine as their area's greatest drug threat, with the majority indicating methamphetamine as the drug which contributes most toward violent crime (89 percent) and property crime (98 percent). Methamphetamine-related crimes, such as identity theft, abused and neglected children, and other serious

> person and property crimes continue to be a daily problem and is prevalent throughout the state.
>
> While reported methamphetamine labs declined to an historic low in Oregon during 2009 (13), crystal meth continued to be available as Mexican drug traffickers imported the finished product from labs outside the state and from Mexico.

We have support for the NPLEx system from physicians, the State Board of Pharmacy, Saint Therese Center HIV Outreach and many others. On a broader level, we have support for the NPLEx tracking system from the National Sheriffs' Association; The Latino Coalition; National Association of Hispanic Nurses; attorneys general from the states of Washington and Alabama; the Washington Association of Sheriffs' and Police Chiefs'; Illinois State Police; the National Consumers League, etc. People allege that our member companies do not care, or they are making money through black-market sales and, therefore, have no intention of stopping the problem. If that were the case, we would simply not be here today and would not be offering a solution that is working in 12 states. Something you did not hear in previous testimony is why it did not pass in other states. Why have 12 other states adopted NPLEx and 2 others have not? In South Carolina alone, in its first month of implementation, 5,800 sales were stopped. The district attorney will talk about finding 10 percent, 20 percent or 30 percent effectiveness rate, or it is not working. To us, 10 percent, 12 percent or 15 percent is working. When you incorporate a prescription-only system, it will just go further into the black market, as we see in Oregon. More than 80 percent of their law enforcement personnel still acknowledge it is the number one problem. This system is free to the State. It is something the industry has taken on because they acknowledge the problem. It is a public-private partnership in the greater sense of it. It reduces the burden on the taxpayer and provides a real solution. Most importantly as we talk about the policy debate, it gives tools to law enforcement to take this problem and solve it. There has been mention of Louisiana which has a tracking system that is not working. If you look to the other states that surround Louisiana where PSE sales have increased, 259 percent after its July 2010 implementation, Tennessee increased 349 percent and Alabama increased 222 percent. This pushed it over the border, but it is still coming back to the state, as we have seen in Oregon. We want a real solution that is going to allow us to track with other states and their law enforcement arms and end the problem.

CHAIR COPENING:
What is the NPLEx system?

MR. FERRARI:
I will let Kevin Kraushaar answer that question.

SENATOR WIENER:
Why is tracking going to be more effective than putting it behind the counter where access to a comparable drug without these ingredients would be available?

MR. FERRARI:
With all due respect to Dr. Stoloff, we have a physician, Dr. Damon Zavala, Chief Medical Officer, Saint Mary's Regional Health Center, Reno, who has written a letter that states:

> However, as a physician, I must tell you that while there are "alternatives" available, the "alternatives" are not the same. While there are only two [Food and Drug Administration] FDA-approved drugs within this decongestant class – pseudoephedrine and phenylephrine (PE) and both ingredients are efficacious for treating cold and allergy symptoms, PSE and PE are different and consumers respond differently. This is why it is so critical to allow Nevadans the choice to choose products that work for them.

I am not able to answer that in any greater detail.

SENATOR WIENER:
It is up to us to decide policy. I imagine there are just as many, if not more, doctors saying there is something OTC that would address these issues.

SENATOR LESLIE:
Did you say the Consumer Healthcare Products Association (CHPA) is willing to pay for this system in Nevada, and for how long?

MR. FERRARI:
There are other people here who can answer those questions.

SENATOR LESLIE:
I will ask these questions, and you can address them in your presentation. What about non-CHPA pharmacies; do they get to participate and, specifically, what happened in Kansas?

KEVIN J. KRAUSHAAR, ESQ. (Consultant, Consumer Healthcare Products Association):
The ingredients, PSE in particular, are safe and effective ingredients found in some of the leading cold and allergy medicines that provide congestion relief. An estimated 16 million Americans purchased PSE products in 2010. Federal law and Nevada law limit the amount of PSE that can be sold to a person to 3.6 grams per day and 9 grams in a 30-day period. Twelve states require electronic monitoring. The e-tracking system helps unify the log books that are required to be kept by federal law and state law. In 2007, the Nevada Legislature added to federal law and required these products to be carried behind the counter. The Association opposes the prescription status, because it does not solve the meth problem and denies access of FDA approved products that people rely on every day. We urge policy makers as the alternative to strike the right balance between preventing illegal sales of the products and protecting consumer access for the people who need them. Prescription status did not totally solve the problem in Oregon. According to the HIDTA study, 80 percent of the law enforcement officers surveyed in preparation of that study said that meth was still the number one drug-abuse problem in that state. The report was also called the "2011 Oregon Threat Assessment." We have also heard a tremendous amount of testimony about the increase of meth coming from Mexico.

There was a story in *The Washington Post* that appeared November 30, 2010, which highlighted the meth-tracking problem going on in the southwestern part of the United States. It referred to a report by the DOJ and talked about the amount of meth and PSE and ephedrine that is the precursor chemical being imported from Mexico. Mexico has banned the sale of PSE and ephedrine in the country. However, there is still a large amount being moved through Mexico and into the southwestern part of the United States through smuggling. What the smugglers have done is adapted to the new set of circumstances. We were happy to hear the CVS Caremark employee example being brought up. The CVS case was developed using the NPLEx system. Part of the consent agreement in the settlement with the DOJ and the state of California is with CVS, which is now using NPLEx as their primary system for e-tracking and monitoring

throughout the chain. We are offering a solution to the problem and attempting to get at the problem of "smurfing." At the same time, it will protect what is a very vibrant, dynamic marketplace for consumers to be able to take care of their own illnesses.

The Washington legislature had the opportunity to pass a prescription drug bill and chose not to do so. They adopted NPLEx and are moving forward on the implementation of this system. That legislation was supported by their state board of pharmacy, their attorney general and by law enforcement agencies across that state. There is also the likelihood that five additional states this year will pass NPLEx. This system is designed to block illegal sales. It not only makes a record of the attempts, but also sends a record to law enforcement as to who is making the attempt. It does this on a store-by-store basis, directly to law enforcement, in real-time. They can access the data immediately. In four states where NPLEx has been fully implemented, nearly 40 thousand grams of illegal PSE sales per month have been blocked. In the first 30 days of South Carolina's implementation of their system, 5,800 transactions were blocked. The system works; the system reaches across state borders; the system is designed so that law enforcement can access these records across state lines and across county lines. There was a legislative research commission report from Kentucky that was released in 2010 which said that 97.8 percent of the PSE purchases in that state were for legitimate use. The gentleman from Kentucky indicated the report was not officially accepted or was not delivered because of the way the data was complied. I would suggest there is another interpretation for that. The report was prepared on behalf of the people who supported prescription. It did not come to any conclusion in support of a prescription drug bill, and that is why the report was not officially approved or made a part of the record. There are two OTC decongestants on the market. That is PSE and ephedrine. There are products that contain both. Customers are able to make their own decisions about what works best for them. People prefer other ingredients based on how it has an impact on them and their own personal choice.

SENATOR HARDY:
Do you have statistics from South Carolina with the number of PSE pills sold for Sudafed after the 5,800 were blocked? Did they see 80 percent of the sales in Sudafed drop?

MR. KRAUSHAAR:
Consumer Healthcare Products Association and its member companies use data for commercial purposes. There are services that track the amount of sales of these products. We can get you that data. The data is collected based on scanning technologies in about 32,000 stores around the Country.

SENATOR KIECKHEFER:
The district attorney from Carson City said that anywhere from 50 percent to 80 percent is diverted. What was the percentage that was diverted from the Kentucky report that was mentioned?

MR. KRAUSHAAR:
They reported 2.2 percent. That means that 97.8 percent were for legitimate medical use.

CHAIR COPENING:
When did you say the first systems were in place and where?

MR. KRAUSHAAR:
Mr. Nielsen can address the specific date. It started out as something called "Meth Watch" and was used in a handful of states, and it became NPLEx in 2009.

CHAIR COPENING:
Are there any states that have that system in place and are considering legislation similar to S.B. 203?

MR. KRAUSHAAR:
Yes. There are a few states that are considering it.

CHAIR COPENING:
Do you know why they are considering it?

MR. KRAUSHAAR:
I am not in a position to answer that. I am working in only four states, and I can tell you about those four states. In contemplating the bills this year, most of the states have rejected it whether they did or did not have NPLEx.

TOM NIELSEN (Account Executive, Government Information Services, Appriss, Inc.):
Appriss, Inc. is a software company that is one of the leading providers of large law enforcement databases across the country. I am a former law enforcement officer of 19 years. My experience has given me the opportunity to assist Appriss, Inc. and law enforcement officers in becoming more efficient through the use of the new technologies that are out there. The Combat Methamphetamine Epidemic Act of 2005 created all the paper logs. The logs have always been open to law enforcement. There is certain data gathered and the sellers maintain these logs for approximately two years. The logs have been effective, but the illicit drug community has been equally effective figuring out these things. They find a way to combat everything that is effective. These paper logs became ineffective. The opinion of law enforcement on paper logs is that it has become a burden. What technology has allowed law enforcement to do through the NPLEx tool is take those paper logs and put the data into a format that can be used effectively by law enforcement. We are seeing efficiency on the part of law enforcement and the pharmacy staffs. Law enforcement can use the data to run searches efficiently by name, number, store and amounts. An officer looking at this in a paper log is likely not to see a trend. With NPLEx, the officer would be able to see pharmacies or an individual with a high incident of overriding because of the reports that can be run. We cannot afford to have our officers sitting behind the wheel of a car collecting these paper logs and trying to make sense of the logs. We now have this solution that is available to law enforcement and to retailers free to block "smurfing" and sales. Your neighboring states to the north have been effective in using NPLEx to build cases. Having been involved in helping officers and administrators of law enforcement be more efficient, I know this tool has allowed them to do that. The National Association of Drug Diversion Investigators (NADDI) is one of the largest supporters of this. Every time I go to one of their functions, they are beside themselves trying to keep control of the prescription drugs that are being diverted into the community. When I met with the Nevada Narcotics Officers' Association last week, I explained what they could do as law enforcement officers with e-tracking and NPLEx, and every one of them was in favor of doing this.

CHAIR COPENING:
What would your system do to prevent a situation where an employee has several fake identification cards?

MR. NIELSEN:
It was not clear from earlier testimony when that was occurring. They have to have a legitimate identification.

SENATOR LESLIE:
How long is CHPA willing to pay for this?

MR. KRAUSHAAR:
Our member companies are paying for it. They have said they would commit to this program indefinitely.

SENATOR LESLIE:
Is that what they have told other states?

MR. KRAUSHAAR:
I do not know. I know there are other states in which we are working out memorandums of understanding (MOU) with the state board of pharmacy or the state police that contemplate MOUs of two to three years in length. It is not because of a limit on our commitment to this program. It is simply making sure we are staying ahead of technology so if something better comes along, the state is not saddled with a ten-year commitment.

SENATOR LESLIE:
What happened in Kansas?

MR. KRAUSHAAR:
We have just finished working on an MOU with the state pharmacy there.

SENATOR LESLIE:
It is my understanding that it is not up and running in Kansas.

MR. KRAUSHAAR:
It took us a lot longer to work out that agreement.

SENATOR LESLIE:
Was the problem in Kansas that non-CHPA related pharmacies were not allowed to join the system?

MR. KRAUSHAAR:
I was not involved in Kansas. It has come up in the state of Washington. The law will be written in such a way that anybody who wants to sell a product containing PSE or ephedrine in the state will have to be part of the system. We have no control over companies that are not CHPA member companies. Hopefully, the statute can be written in such a way that those people, in order to sell product in this state, would have to be part of the NPLEx system.

SENATOR LESLIE:
Would companies that do not want to become part of the system not be able to sell these products?

MR. KRAUSHAAR:
No. There is approximately only 1 percent of the companies out there not participating.

SENATOR LESLIE:
My understanding is that Alabama and Tennessee are two states that have NPLEx and law enforcement is requesting it be prescription only.

SENATOR KIECKHEFER:
Is there a National Association of Drug Diversion Investigators?

MR. NIELSEN:
Yes.

SENATOR KIECKHEFER:
Do they have an estimate as to what percentage of this drug is diverted into the black market?

MR. NIELSEN:
I will have to find that out for you.

CHAIR COPENING:
Has NADDI been presented with the option of having these drugs go prescription, and if so, are they all in agreement that the electronic-logging system is better than taking these behind the counter as a prescription?

MR. NIELSEN:
I know that NADDI supports NPLEx. I can only speculate that the powers that be were presented with the two and have continued to support e-tracking.

MR. KRAUSHAAR:
Beginning in the early 1970s, the FDA began what they called the OTC drug review. They looked at a number of existing OTC drugs and prescription drugs at that time, and through scientific review panels who looked through the available literature and made the determination as to whether or not a drug should be on prescription or nonprescription status. The determination was made at that time that the PSE was safe and effective, based on the safety profiles and the safety data, in addition to one other decongestant and one additional antihistamine. That was only one panel of FDA experts who made those determinations. They made determinations on a number of different categories. That process is not complete yet. There are many drugs that ended up on what are called monographs. They are the manner in which the FDA regulates the sale, distribution and manufacturing of these products. Even though the process started 40 years ago, there are a number of final monographs in place and a number of tentative final monographs a place.

BRYAN WACHTER (Retail Association of Nevada):
I will also be speaking on behalf of Tray Abney, Director, Government Affairs, Reno Sparks Chamber of Commerce. This Committee has reviewed this particular topic before. The NPLEx system in Nevada is the result of that review. It was not created because of the Nevada review, but it was explored that this program could help address those concerns. It is important to know that making this a prescription-only drug does not solve the problem. It is estimated that nearly 30 percent of Nevada teens between the ages of 12 years and 17 years have abused prescription drugs. That is twice what is currently reported as a number for meth use. We support CHPA and the tracking system.

We also heard testimony that Oregon does not believe doctor-shopping is occurring. That is something that needs to be explored further. Without a prescription-monitoring program live in Oregon, it is hard to determine whether it is happening. How that program works is that a doctor enters in a prescription and other doctors are able to determine whether the drug is being used effectively. We do see this as a cost issue. As a consumer, you have to spend money to see a doctor. If you are uninsured or underinsured, you visit a clinic.

There are alternatives, but we heard testimony that sometimes that alternative is not useful or interacts with something a person is taking or prefers the PSE.

LAWRENCE P. MATHEIS (Nevada State Medical Association):
We are formally neutral on this bill. It is more accurate to say that we do not oppose the bill. We have consulted the Oregon Medical Association concerning physicians' reticence when the issue was raised. It is their experience that it did not create a significant burden, and patients for whom these drugs are appropriate are getting them. It cannot be minimized that we have not gotten control of a huge and growing substance-abuse problem. As a whole, you balance these things. Our position is that we do not oppose the bill, and we would like to see the Committee move as far as you think possible to deal with the meth epidemic.

DANIEL G. BELLINGHAM (Healthcare Distribution and Management Association):
I have written testimony that I will read (Exhibit I). Once something is made a controlled substance, then all the storage and handling regulations kick in through the Drug Enforcement Administration (DEA), United States Department of Justice (DEA). Even though our members' warehouses are secure facilities and highly regulated, this legislation as currently written would require our staff to put all of these cough and cold products within a DEA regulated cage that is within the secure warehouse. We are asking for a brief provision to be inserted into the bill that would not make this necessary. Every state that has made this a controlled substance has included this language.

SENATOR KIECKHEFER:
It is not controlled by the FDA, but because the state puts a regulation on it, you have to follow state regulation.

MR. BELLINGHAM:
Yes. Most states recognize all of the DEA's storage and handling regulations by default if a state makes something a controlled substance, but it is not a controlled substance at the DEA level. All of these requirements still kick in. Every state except Kansas has included it in their language.

HELEN FOLEY (Nevadans for Affordable Healthcare):
I am here representing Nevadans for Affordable Healthcare. I am the mother of an adopted child who was a meth baby. It can get extremely expensive if we all had to go to the doctor and pay our co-pay and then to the pharmacy and pay

another co-pay. If there is a way to know if someone is "smurfing," it would be helpful. I hope we can work together to find some really good solutions that do not make medicine more costly for the average citizen.

MAURICE WHITE:
I am here in support of S.B. 203. Please pass this bill and commit individually and as a Committee to publicly announce your support of this bill.

CHAIR COPENING:
I did get a note from the Fiscal Analysis Division of the Legislative Counsel Bureau stating that prescription drugs are not taxed and the policy change does have implications. The Department of Taxation is going to be submitting a fiscal note regarding that impact soon.

We will close the hearing on S.B. 203 and adjourn the Senate Committee on Health and Human Services at 6:15 p.m.

RESPECTFULLY SUBMITTED:

_____
Shauna Kirk,
Committee Secretary

APPROVED BY:

_____
Senator Allison Copening, Chair

DATE: _____

EXHIBITS			
Bill	**Exhibit**	**Witness / Agency**	**Description**
	A	Agenda	Agenda
	B	Attendance Roster	Attendance Roster
S.B. 203	C	Senator Leslie	Packet of letters of support from several District Attorneys, County Commissions and Willow Springs Center
S.B. 203	D	Neil Rombardo	The Next Step to Stop Meth in Nevada
S.B. 203	E	Kent Shaw	Kamala D. Harris written testimony
S.B. 203	F	Rob Bovett	Meth Epidemic Solutions The Oregon Experience
S.B. 203	G	Rob Bovett	Written Testimony
S.B. 203	H	Chris Ferrari	Decrease in Meth Labs since 2005
S.B. 203	I	Daniel G. Bellingham	Written testimony