MINUTES OF THE
SENATE COMMITTEE ON COMMERCE, LABOR AND ENERGY

Seventy-Eighth Session
March 18, 2015

The Senate Committee on Commerce, Labor and Energy was called to order by Chair James A. Settelmeyer at 8:33 a.m. on Wednesday, March 18, 2015, in Room 2135 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 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 James A. Settelmeyer, Chair
Senator Patricia Farley, Vice Chair
Senator Joe P. Hardy
Senator Becky Harris
Senator Mark A. Manendo
Senator Kelvin Atkinson
Senator Pat Spearman

STAFF MEMBERS PRESENT:

Marji Paslov Thomas, Policy Analyst
Patricia Devereux, Committee Secretary

OTHERS PRESENT:

Denise Selleck, Nevada Osteopathic Medical Association
Stacy Woodbury, MPA, Executive Director, Nevada State Medical Association
Brett Kant, Special Assistant Attorney General, Office of the Attorney General
Alexander Imas, M.D.
Eric Spratley, Lieutenant, Sheriff's Office Washoe County
Ryan Beaman, President, Clark County Firefighters Local 1908
Hui Lim Ang, Executive Director, Colors of Lupus Nevada
Mary Doss
Jay Parmer, America's Health Insurance Plans
Josh Griffin, Health Services Coalition
Keith Lee, Nevada Association of Health Plans

Liz MacMenamin, Retail Association of Nevada
Dena Schmidt, Deputy Director, Programs, Department of Health and Human Services
A.J. Delap, Las Vegas Metropolitan Police Department
Lorne Malkiewich, Nevada Resort Association

Chair Settelmeyer:
We will open the hearing on Senate Bill (S.B.) 219.

SENATE BILL 219: Revises provisions relating to policies of health insurance. (BDR 57-688)

Senator Joe P. Hardy (Senatorial District No. 12):
On page B1 of the March 18, 2015, *The Wall Street Journal*, is an article entitled, "Holy Grail: Pain Pills Without the High." Abuse of prescription drugs is a problem in the Nation and world. Prescription pain relievers constitute a $57 billion market globally. Manufacturers are trying to develop pain relievers without the "high." Nevada First Lady Kathleen Sandoval wrote a letter (Exhibit C) in support of S.B. 219, as have seven other people with a buy-in on the issue (Exhibit D).

You have a mockup of a proposed amendment for S.B. 219 (Exhibit E), to which I will refer, instead of the bill. Nevada has the fourth highest drug overdose mortality rate in the Nation. The majority of deaths are attributable to prescription drug abuse. According to the Institute for Pain Access, there are 4.5 million Americans who use prescription drugs for nonmedical purposes. Nevada is among the top 20 percent in all age groups of people reporting nonmedical use of pain medications.

Senate Bill 219 does not intend to solve all problems related to prescription drug abuse. It permits State physicians to prescribe new formulations of opioids called abuse-deterrent formulations (ADF). They will provide patients with the same pain relief as do conventional opioids because they are bioequivalent. However, a new technological design prevents use of the product for abusive purposes.

The most common abuse of opioids is crushing the pill and then "snorting," injecting or smoking the resulting powder. I will demonstrate how easily pills are crushed with a hammer (Exhibit F). This is what happens when a normal pill is

crushed to powder. Now, I am crushing an ADF pill, which is a different size. It is hard to smash, and I cannot crush it enough so it turns to powder. It leaves a gel-like residue that cannot be snorted, smoked or injected. A recent study in *The Journal of American Medicine* determined the difference between the two pills could limit initial abuse potential because people cannot isolate the active ingredient.

Senator Farley:
Is the ADF pill's form the deterrent, or is the active ingredient within it nonaddictive?

Senator Hardy:
The pills contain the same medicine, but the ADF pill's structure has been mechanically changed so it is much more difficult to alter. Yes, overdose is still possible, but the ADF pill cannot be used inappropriately without going through the process demonstrated in Exhibit F.

Senator Farley:
When people abuse opioids, do they sell the entire pill or crush it and then sell the powder?

Senator Hardy:
If they abuse pills that are not ADF, they steal them, get them from a friend or obtain more pills than they need from the doctor. They find out the pills relieve their pain and make them feel good and then become addicted to them. Addicts do not use ADF pills as much as the original, crushable formulations or they resort to heroin for their opioid fix.

Chair Settelmeyer:
Would the bill require all drugs to be ADF or just certain prescription pain medications?

Senator Hardy:
The ADF technology is designed to protect people from abusing narcotics. I would expect drug manufacturers to produce ADF antianxiety agents, which also have abuse potential. The ADF pills would cost more.

Senate Bill 219 section 2 is repeated in several places in the bill. Different sections deal with health insurance for individuals, large groups, groups of less

than 50 people, hospital medical service corporations, health maintenance organizations, managed-care plans and municipal self-insured plans. The bill does not cover Medicaid plans. The proposed amendment, Exhibit E, removes paragraph (b) of section 2, subsection 1 of the bill, which requires a higher deductible, copayments or higher out-of-pocket costs for ADF drugs. The new paragraph (b) of the proposed amendment removes step processes and prior authorization for prescribing ADF drugs. The new paragraph (d) specifies that patients do not have to start on another medication to prove they are addicted before receiving ADF drugs. The bill's effective date would be October 1, 2015, which may be too soon.

Denise Selleck (Nevada Osteopathic Medical Association):
The Nevada Osteopathic Medical Association supports S.B. 219 in order to help patients avoid drug abuse. We particularly like the lack of step processes or prior authorization. That benefits patients by allowing physicians to treat them more effectively.

Stacy Woodbury, MPA (Executive Director, Nevada State Medical Association):
The Nevada State Medical Association endorses S.B. 219. The use of ADF drugs is one of the easiest ways to combat addiction.

Brett Kant (Special Assistant Attorney General, Office of the Attorney General):
Attorney General Adam Paul Laxalt is the chair of the Substance Abuse Working Group, which is trying to solve the problem of substance abuse, including that of prescription drugs. He supports S.B. 219 as another tool to address the problem.

Alexander Imas, M.D.:
I am a board-certified physical medicine and rehabilitation physician. I am also dual board certified in addictionology. I have practiced in pain management for 12 years. My patients' ailments range from spinal cord injuries, traumatic brain injuries, strokes, neuromuscular and skeletal pain conditions, and acute and chronic pain. I do a lot of addiction medicine detoxification with successful reductions in patients' opioid medication consumption or complete cessation of opioid medications, when appropriate. I treat patients in every stage of pain and those with addiction problems. Pain medications fortunately—or unfortunately—play an instrumental role in helping me accomplish my goals.

Inadequate control of acute and chronic pain is a major health problem. An example is the recent astronomical increase in heroin abuse. My colleagues and I struggle every day in helping chronic pain and addiction patients get the ADF medications they need to get them off their short-acting, abuse-prone pain medications. My daily battle includes insurance denials, prior authorizations with a multitude of appeals, letters from insurance companies offering cheaper and more addictive pain medication substitutions, and the need to trial two or three different addictive, short-acting, traditional pain medications before I am allowed to use ADF drugs.

I fight these insurance companies and their denials because I will not compromise patient safety for insurance cost efficiency. Senate Bill 219 would allow Nevada's doctors to practice safer medicine. I support S.B. 219 because it does not push medications on my patients; it gives them a choice. Patients have the right to use safer, less potentially abusive medications and to have easier access to them. I have seen a reduction in abuse of cheaper, non-ADF medications as a result of the use of ADF medications.

I inherited a patient with chronic pain who was dependent on short-acting, high dosages of opioids prescribed by a primary care doctor. The patient came to me after his doctor lost his medical license because of "pill-pushing" and overprescribing issues. I converted the patient to long-acting ADF medications. In a follow-up appointment a month later, he said he wanted to stop taking the ADF medications. He had tried crushing them in his mouth to extract their short-acting component, but all he did was break all of his back teeth. It was a long struggle to convert him from the short-acting narcotics to longer-acting ones to manage his pain. As a physician, my foremost duty is to ensure patients' safety. Give doctors easier access to the tools necessary to accomplish that goal.

Eric Spratley (Lieutenant, Sheriff's Office, Washoe County):
The Washoe County Sheriff's Office supports S.B. 219 because it will increase the use of ADF medications. This will reduce the opioid abuse we see on the front lines of law enforcement.

Ryan Beaman (President, Clark County Firefighters Local 1908):
Clark County Firefighters Local 1908 supports S.B. 219. As emergency medical system first responders, we see abuse of opioids every day. We see patients

crushing the medications to extract components that they then abuse. We routinely encounter patients with chronic pain problems who use opioids.

Hui Lim Ang (Executive Director, Colors of Lupus Nevada):
Colors of Lupus Nevada supports S.B. 219 because it will help patients to access ADF medications. I am an advocate for the end users, the victims of opioid abuse. It is easy to access traditional drugs that can be manipulated effortlessly. I deal with patients who live with lupus and daily suffer from pain, fatigue and depression. They have an average of about 9 to 11 prescriptions.

One of our patients abused her pain medication and showed me how she did it—crushing pills with a hammer exactly like Senator Hardy's demonstration, Exhibit F. She crushed Valium and morphine with a hammer, mixed up the resulting powders and then drank it in coffee or juice. I told her many times that was wrong and tried to stop her from abusing the drugs. However, that proved impossible because she was very addicted. When I asked her why she crushed the pills, she said she had been told that the high and pain relief would be greater. She knew that mixing morphine and Valium would make her sleep better with less pain.

The patient crushed and mixed the pills for quite a while. One day, we got a call from her mother, Mary Doss, saying the patient had fatally overdosed. She left behind a daughter and two grandchildren. Senate Bill 219 contains an easily accomplished solution to the problem. What my patient experienced was just the end part of the problem. I have many other chronically ill patients constantly looking for pain pills. They represent the pipeline of people who could eventually abuse their medications. I urge the Committee to address this issue responsibly.

Mary Doss:
I found my daughter dead of an overdose 2 years ago. Her body was covered in blood after her lungs exploded from all of the pills she had taken. The responding officers searched the house for all of her medications because she had so many. She crushed her pills. I would take her medicine home with me then give her just one pill to take in the morning, as per her doctor's orders. However, she had other pills hidden in her house. Then I found her dead.

I cannot keep from thinking about that. I have been sick and had a heart operation 3 weeks ago after I had a heart attack from the stress of thinking about my dead child. I loved her so much. Something has to be done because

so many parents lose their children from overdoses. It is not a good thing to lose the child you brought into the world; it stays with you for a long time. When you lose a loved one, you never forget it. I cry and pray every day for my daughter. I now have my great-grandchildren and motherless granddaughter. I cannot talk about my daughter around my 8-year-old great-grandson because he breaks down and cries. I am not saying pain medications should be taken off the market, but something has to be done. No matter where you live in Clark County, you will see drugs abused. If something is not done, you may be the one to lose your child, just as I lost mine.

Jay Parmer (America's Health Insurance Plans):
America's Health Insurance Plans is the national trade association for health insurance plans. We recognize that opioid abuse is a serious national problem, and that people who support S.B. 219 do so with the best intentions. While ADF pills are an important tool in fighting opioid addiction, they are not an abuse-prevention point sufficient to justify a radical change in the administration of health plans, as mandated under S.B. 219. Opioid ADF drugs may be part of a comprehensive solution; however, mitigating the prescription opioid abuse problem will require a coordinated strategy involving education, counseling, treatment, law enforcement and other factors.

Senate Bill 219 will prohibit both prior authorization and utilization reviews by health plans. Health plans and pharmacy benefit managers already take many steps to combat opioid abuse. Health information systems utilized by many health plans and product data managers can identify irregularities such as early refills, daily supply compliance, visits to multiple physicians or pharmacies and exceeded dosage limits. Such warning signs may then initiate appropriate patient interventions.

According to IMS Health, the largest U.S. vendor of physician-prescribing data, the opioid market makes $7 billion in profits annually. Not surprisingly, given this figure, as many as 12 pharmaceutical companies are believed to be working on the research and development of ADF drugs. While it may be a while before the U.S. Food and Drug Administration (FDA) approves them, the introduction of new products will inject much-needed competition into this burgeoning market.

The proposed changes to *Nevada Revised Statutes* (NRS) 689A would essentially create a carve-out for the three ADF drugs already approved by the

FDA. Our concern is that such a carve-out could incentivize drug manufacturers to increase prices for ADF drugs, knowing that potentially lower-cost drugs would be less likely to be dispensed to patients who need opioid analgesics for pain. This evergreening of specific-brand drugs would substantially affect prices for commercial health insurers and the State Medicaid program. The Committee needs to take a serious look at the potential consequences of S.B. 219 and consider amending it.

Josh Griffin (Health Services Coalition):
The Health Services Coalition is comprised of self-insured organizations, private companies and employee groups. We represent about 200,000 individuals. We share the same concerns as Mr. Parmer. When managing health plans for employee groups, getting members healthy and back to work as soon as possible is everyone's primary objective. We are working with Senator Hardy on his proposed amendment to S.B. 219, Exhibit E, but to mandate just one way to deal with a valid problem could be expensive and restrictive. We would like to inject other elements into the discussion, including examining how opioid prescriptions are issued.

Keith Lee (Nevada Association of Health Plans):
The Nevada Association of Health Plans is comprised of major carriers used by about 40 percent of insured Nevadans. We are not opposed to a new class of drugs or ADF drugs. In the proposed amendment, Exhibit E, we agree with section 2, subsection 1, paragraph (a), that policies "Must include coverage for any abuse-deterrent opioid analgesic drug which is lawfully prescribed or ordered." The issue is not that these drugs are in the formularies; the issue is S.B. 219 has too many restrictions on plans that manage prescriptions.

The goal of health plans with respect to prescription drugs is to work in conjunction with physicians to ensure the most efficacious drugs are delivered to patients as quickly as needed in an appropriate amount and cost-efficient manner. In S.B. 219 section 2, subsection 1, paragraph (b), lines 11 and 12, we would like to eliminate or shorten the phrase "any type of material inducement or financial incentive." Health plans enter into agreements with providers and health care organizations that provide incentives to physicians and health care organizations to improve outcomes done in an efficient manner. If this language were to prevent us from entering into those types of agreements concerning ADF drugs, it would be nonsensical. We do not do disincentives, so that portion could be eliminated.

Section 2, subsection 1, paragraphs (d) and (e) of S.B. 219 remove insurers' ability to require prior authorization and utilization reviews. They also would not allow us to decide which types of drugs should be administered initially. Paragraphs (d) and (e) should be deleted. There is no public policy reason why this relatively new class of drugs should be treated differently than existing classes. Prior authorization is a management tool that we use for many, but not all, drugs. Utilization review is a continuing review of the effectiveness of a patient's drugs. These are important management tools for patients' insurance and providers' concerns. My comments apply to NRS 689A, 689B, 689C, 695B, 695C, 695G and other portions of S.B. 219. The bill's effective date should be changed to on or after January 1, 2016. Insurance plans are already filed with the Commissioner of Insurance for overall approval, so an October 1, 2015, effective date makes no sense.

A better term to apply to these new drugs is "tamper-deterrent," versus "abuse-deterrent," formulations. We all hope to prevent abuse and have experiences of family or friends who have been part of this terrible plague on the Nation. However, traditional and ADF drugs have the same active ingredients; only the patents are different. It is important to distinguish between tamper-deterrent and ADF medications. We all want to do whatever we can to alleviate the drug abuse problem—particularly that of street drugs—but we are really talking about tamper-deterrent, not ADF, drugs. Whatever is decided, probably about 60 percent of Nevadans with health insurance will not be affected because they are covered by the Taft-Hartley Act or the Employment Retirement Income Security Act.

Senator Farley:
If I were to sell my prescription on the street, would I get more money by crushing the pills or selling intact ADF pills? I have a family member who has been dealing drugs for about 10 years, and it is so hard to stop. Would the use of ADF pills help reduce illegal activity?

Mr. Lee:
We would hope the use of ADF pills would help stop illegal activities. It is tough to break up ADF pills, but whatever the Legislature does, there will always be some evil genius who will figure out a way to crush them. The bill could at least slow down the black market, like when someone steals a valid prescription and tries to market the pills.

Senator Farley:
When officers see black market transactions, are suspects selling powder or intact pills?

Chair Settelmeyer:
We will follow up outside of Committee about whether the most prevalent black market form is powder or the entire pill. Someone in the audience just told us it is the pill form.

Senator Harris:
Could Mr. Parmer tell us how drug manufacturers price prescriptions? You suggest they might increase prices for ADF, versus traditional, drug formulations. That concerns me, knowing how an increase may affect people struggling to pay for health care and get the prescription drugs they need. I need to understand better how drugs are priced, especially if the new type of drug would help some people.

Mr. Parmer:
There are three ADF products on the market manufactured by two companies. There are another ten companies engaging in research and development of them. You cannot police formulations. Over time, the trend will be to develop more ADF-type drugs, which will inject competition into the marketplace which tends to drive down prices. In the meantime, removing the three existing drugs from prior authorization and utilization review is essentially saying that once a doctor prescribes a brand-name drug, there is no further discussion as to whether a patient is eligible for another drug. That may be done for very good reasons, including if a patient develops sensitivity to a pain medication he or she has long used. Insurers do not have an issue with that.

This discussion is moving toward giving all patients ADF drugs. That presupposes that everyone who takes medications responsibly will become addicted, which does not happen. On the market are generic pain medications and nine tamper-resistant pain medications in formularies that can be prescribed, while keeping down costs. As for prior authorization and utilization reviews, doctors have told us they particularly want ADF drugs, or, if not, they ask if they can prescribe a different analgesic. Giving patients choice will allow them to save on out-of-pocket cost and copayments.

Senator Harris:
What is the availability timeline for ADF drugs? I am concerned we may throw up too many barriers. Someone with a family history of predisposition to addiction may want to choose to take an ADF drug, rather than risk taking the traditional drug responsibly and inadvertently becoming addicted. If patients want to act responsibly, but cannot get the pain medications they need, we do not want to add to that problem.

Mr. Parmer:
Health plans have varying review processes and degrees of prior authorization, so there is no standard timeline for drug-use approval. Typically, if the doctor feels a drug needs to be prescribed for a particular reason and, as per generic-substitution laws, writes, "Dispense as written," the pharmacist will only dispense the specified brand, regardless of the availability of other products. People will be able to get exactly what they need, but still have options if their doctors have a certain comfort level in allowing them to take a variation on the same compound.

Chair Settelmeyer:
How much more would ADF drugs cost—200 percent, 300 percent, 2 percent?

Mr. Parmer:
I do not have that information. Senate Bill 219 refers to transparency, a popular word that sounds like a good idea for how drug manufacturers approach formularies and incentivize prescribers.

Senator Farley:
The reality is there are some bad doctors who put opioids in patients' hands, who then sell them on the street. The ADF drugs will not really be a deterrent because doctors will not suddenly prescribe them, especially if they are "on the take." The drugs would probably be prescribed only for patients who are recovering addicts. Do you agree with that scenario?

Mr. Griffin:
There are multiple ways to solve the pain-medication-addiction problem. Databases exist for prescription shopping between retailers and doctors, but the databases do not always talk to each other. We would like to see partnerships between doctors' disciplinary boards, retailers, health plans and pharmacy benefits managers who work with health services coalitions. Pharmacy benefits

managers review every prescription, if possible. When they see an excess of narcotics being prescribed, they talk to the prescribing physicians. Databases are shared at the federal level in the U.S. Drug Enforcement Administration. When the use of certain drugs is mandated, the cost structure may increase.

Senator Harris:
How long does it take to get prior authorization from an insurance company—hours, days or weeks?

Mr. Griffin:
I will get an exact answer for you.

Senator Spearman:
There is such a thing as an addictive personality. The role of prescribing physicians has been discussed today. We do not know how long prior authorization or the utilization review takes. Doctors must look at patients comprehensively to decide if they have an addictive personality. If pain management is an issue, doctors must deal with that, while at the same time not worsening a potentially bad problem. When I was in the military, I injured my back three times, so I am now in constant pain, which I manage. I do not have an addictive personality. If the utilization review process takes a long time, what are the patient's options for pain control?

Mr. Lee:
I do not know how long prior authorization takes or what doctors prescribe in the interim. Our insurance companies, particularly those in the Silver State Health Insurance Exchange, have to develop plan formularies for 1 year. We lock in drug, copayment and deductible costs at the beginning of each year. However, drug manufacturers do not lock in how they price drugs for insurers. Let us say a drug costs us $50 in January, but its price could rise every month after that. Insurers have no control over that, and we are bound by health plans approved by the Division of Insurance to offer the January copayment and deductible prices. The 600-pound gorillas in the room, concerning the cost of drugs for patients, are the pharmaceutical companies, not the insurers or the providers.

Senator Spearman:
This bill would be a single step in the right direction. What is the likelihood of working during the 2015-2016 interim Legislative Committee on Health Care

meetings to identify and develop a comprehensive solution, even if it is implemented incrementally? Senate Bill 219 might not cure all of the problems, but I am sensitive to what is happening to addicts like Ms. Doss's daughter. If the bill does not pass, what can we do in the meantime to prevent overdose tragedies?

Mr. Griffin:
The chances are good that the issue will come up in the interim committee. Other ideas are being floated besides mandating a specific prescription drug solution. Health plan insurers have many mandates. The Health Service Coalition members have many mandates and restrictions concerning our costs and medical care we can provide.

Mr. Parmer:
I agree with Mr. Griffin's statements.

Liz MacMenamin (Retail Association of Nevada):
The ADF drugs do not decrease abuse; they deter people from crushing pills to snort. The drug is, however, addictive in its chemical makeup. The Retail Association of Nevada (RAN) worked in the 2013-2014 interim and with Legislators for many years on prescription drug abuse. As noted, "tamper-resistant" is a better term than "abuse-deterrent." In the 1990s, Oxycodone hydrochloride, marketed as OxyContin, was highly abused and killed many people by overdose. When manufacturers were asked to help solve the problem, they developed tamper-resistant pills.

If a person has an addiction problem and goes to a physician for a prescription, ADF drugs are not a cure. However, if someone in your household has an addiction problem, the bill might address that if he or she cannot access their drug. The RAN believes prescribers hold the key to the problem, and they understand which patients need ADF drugs. The RAN has always opposed mandates, such as in this bill. A pharmacist told me there is a simple work-around way to crush ADF pills. Anyone who wants to abuse them can still do so.

Senator Atkinson:
I have several family members prone to additive behaviors, usually with marijuana. Crushed opioid pills can be used in more ways than snorting, including being added to other drugs. Addictive behavior is not necessarily

restricted to illegal drugs. Are you concerned that ADF drugs may be used for illegal purposes?

Ms. MacMenamin:
Yes, we have discussed that problem at length. Prescribers know that some patients have addictive personalities; that relationship will indicate which drugs are appropriate. The pharmacist to whom I referred earlier used the term "quite pricey" when describing the cost of ADF drugs. He will give me the exact figure to provide to the Committee.

Senator Atkinson:
I do not want the Committee to become bogged down on the ADF drug's price. If a person is addicted, the price is irrelevant.

Dena Schmidt (Deputy Director, Programs, Department of Health and Human Services):
The Office of the Governor, the Department of Health and Human Services and many other stakeholders are participating in the National Governors Association Prescription Drug Abuse Policy Academy. We are spending almost a year working with national experts trying to identify and craft a statewide plan to be presented to the Office of the Governor by Dec. 31, 2015. We are in the early planning stages and doing research. We welcome participation by any stakeholders to tackle prescription drug abuse statewide. We are holding a Policy Academy meeting on May 4 and 5, 2015, to gather input from individuals.

A.J. Delap (Las Vegas Metropolitan Police Department):
The Las Vegas Metropolitan Police Department is neutral on S.B. 219; however, because we are a large employer with self-funded insurance, we have concerns about ADF drug costs. As a law enforcement agency, we support any measures to help curb prescription drug abuse.

Senator Hardy:
Senate Bill 219 is not about a single medication; it is about all ADF medications. Other medications contain abuse deterrents that prevent people from getting high. "Abuse-deterrent formulation" is an FDA term, as opposed to "tamper-resistant." The second pill that I hammered was a tamper-resistant formulation, which is different from the larger class of ADF drugs. Medicaid was never included in S.B. 219, so it would not be affected. Doctors can write

whatever prescriptions they want at whatever time in the appropriate circumstances.

The world of medicine changes. At one time, a prescription for a month of antidepressants could be filled for less than $10. Then a whole new class of antidepressants became available that had fewer side effects, was more effective for more patients and was more expensive. Now, those drugs are cheaper because the manufacturer's 17-year patent ran out, and generic brands became available. Medicine progresses with drugs that cost more, work better and fill a niche.

The reason abusers crush pills for a powder to snort, smoke or swallow is for the side effect of the hit. Under the bill, prior authorization is given for generic equivalents or non-ADF drugs. Insurers can change their formularies at will within a 30- or 60-day window.

Chair Settelmeyer:
We will close the hearing on S.B. 219 and open the hearing on S.B. 256.

SENATE BILL 256: Revises provisions relating to the civil liability of innkeepers. (BDR 54-1018)

Senator Patricia Farley (Senatorial District No. 8):
You have my written testimony (Exhibit G). Hotel operators are expected to provide a safe and secure environment for guests and their property. Since 1367 in England, innkeepers have been responsible for protecting the personal property of guests. Nevada's hospitality industry has an undisputed reputation for providing world-class service. It is important that our hotel guests know the extent to which their valuables are protected and whether they need to make accommodations to guard against loss.

The State limits innkeepers' liability for the loss of or damage to certain personal property on the hotel's premises, including property left in motor vehicles. In 2011, the Nevada Supreme Court ruled the language of NRS 651.010 does not shield innkeepers from liability for the loss of or damage to the vehicle itself. Senate Bill 256 will limit that liability to loss of or damage to patrons' vehicles brought onto the premises, not just loss of or damage to vehicles' contents.

Lorne Malkiewich (Nevada Resort Association):
You have my proposed amendment (Exhibit H) to S.B. 256. Section 1, subsections 2, 3 and 4 do not apply to motor vehicles. Our intent was to have the gross neglect standard in section 1, subsection 1 apply to the vehicle itself, but not its contents. As an example, if someone breaks a vehicle's window to take a purse from the front seat, the gross neglect standard would be applied to the theft, but the simple negligence standard would be applied to the damage to the vehicle.

All we are talking about is the gross neglect standard. The proposed amendment, Exhibit H, creates a new section in NRS 651. Its gross neglect language is identical to section 1, subsection 1 of NRS 651.010; it is delineated from subsections 2, 3 and 4. The intent is not to let innkeepers avoid the $750 liability requirement.

Chair Settelmeyer:
We will close the hearing on S.B. 256. A document was submitted for the Committee's consideration on S.B. 165 (Exhibit I), which we heard on February 25, 2015.

SENATE BILL 165: Enacts the Domestic Workers' Bill of Rights. (BDR 53-135)

Chair Settelmeyer:
Seeing no more business before the Senate Committee on Commerce, Labor and Energy, this meeting is adjourned at 9:48 a.m.

RESPECTFULLY SUBMITTED:

Patricia Devereux,
Committee Secretary

APPROVED BY:

Senator James A. Settelmeyer, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit**		**Witness or Agency**	**Description**
	A	1		Agenda
	B	5		Attendance Roster
S.B. 219	C	2	Kathleen Sandoval	Letter of support
S.B. 219	D	10	Senator Joe P. Hardy	Letters of support
S.B. 219	E	14	Senator Joe P. Hardy	Proposed amendment
S.B. 219	F	3	Senator Joe P. Hardy	Photographs of Senator Hardy crushing opioid pills with hammer
S.B. 256	G	2	Senator Patricia Farley	Written testimony
S.B. 256	H	1	Lorne Malkiewich	Proposed amendment
S.B. 165	I	3	Senator James A. Settelmeyer	Document comparing Domestic Workers Bills of Rights