MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Ninth Session
May 24, 2017

The Committee on Health and Human Services was called to order by Chairman Michael C. Sprinkle at 2:08 p.m. on Wednesday, May 24, 2017, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/79th2017.

COMMITTEE MEMBERS PRESENT:

Assemblyman Michael C. Sprinkle, Chairman
Assemblywoman Amber Joiner, Vice Chair
Assemblywoman Teresa Benitez-Thompson
Assemblyman Richard Carrillo
Assemblyman Chris Edwards
Assemblyman John Hambrick
Assemblyman William McCurdy II
Assemblywoman Brittney Miller
Assemblyman James Oscarson
Assemblyman Tyrone Thompson
Assemblywoman Robin L. Titus
Assemblyman Steve Yeager

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Senator Yvanna D. Cancela, Senate District No. 10

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Committee Policy Analyst
Mike Morton, Committee Counsel
Kailey Taylor, Committee Secretary
Cheryl Williams, Committee Assistant

OTHERS PRESENT:

Bonnie Jeanne Sedich, Private Citizen, Las Vegas, Nevada
Christine M. Reynoso, representing Culinary Health Fund
Praveen Jayakumar, Medical Director, Culinary Health Fund
Bobbette Bond, Policy Director, Unite Here Health; and representing Health Services Coalition
Tanya George, Private Citizen, Las Vegas, Nevada
Christopher Hughes, Private Citizen, Las Vegas, Nevada
Josh Griffin, representing MGM Resorts International
Ryan Beaman, President, Clark County Firefighters, Union Local 1908
Rusty McAllister, Executive Secretary-Treasurer, Nevada State AFL-CIO
Geoconda Hughes, Private Citizen, Las Vegas, Nevada
Stacie Sasso, Executive Director, Health Services Coalition
Maya Holmes, Research Director, Culinary Workers Union Local 226
Mike Alonso, representing Caesars Entertainment
Marlene Lockard, representing Service Employees International Union Nevada Local 1107; Las Vegas Police Protective Association Civilian Employees; Retired Public Employees of Nevada; and Nevada Women's Lobby
Russell Rowe, representing Boyd Gaming Corporation
Todd Ingalsbee, Legislative Representative, Professional Fire Fighters of Nevada
Priscilla Maloney, Government Affairs, Retiree Chapter, American Federation of State, County and Municipal Employees, Local 4041, AFL-CIO
Brad Keating, Legislative Representative, Community and Government Relations, Clark County School District
Ruben R. Murillo, Jr., President, Nevada State Education Association
Regan J. Comis, representing Nevada Association of Health Plans
Brenda L. Gleason, President and Founder, M2 Health Care Consulting LLC, representing Pharmaceutical Research Manufacturers of America
Jessica Ferrato, representing Sanofi US
Chris Ferrari, representing Pfizer Inc.
Jeff A. Buel, Director, Government Affairs, Johnson & Johnson
George Ross, representing Biotechnology Innovation Organization
Khanh Pham, Pharmacy Director, DOLCrx
Catherine M. O'Mara, Executive Director, Nevada State Medical Association
Julie Kotchevar, Manager, Primary Care Workforce Development Office, Department of Health and Human Services
Beth A. Handler, Chief, Bureau of Child, Family, and Community Wellness, Division of Public and Behavioral Health, Department of Health and Human Services
DuAne Young, Chief III, Behavioral Health and Pharmacy Services, Division of Health Care Financing and Policy, Department of Health and Human Services

Chairman Sprinkle:
[Roll was called. Committee rules and protocol were explained.] We will do the hearing on Senate Bill 265 (3rd Reprint) first and then do the work session afterward. We always expect courtesy and respect from those testifying and those on the Committee. There are a lot of people planning to testify today. I intend to allow good public testimony; however, we have two weeks left in session, and there is a lot going on today. Please do not take it personally or take offense if I ask you to wrap things up. When I say wrap things up, that means give me your last sentence. If you are saying something that has already been said, we would love the word "ditto." I will make my best effort to give ample time and equal time to all sides of the issue today. I will open the hearing on Senate Bill 265 (3rd Reprint).

Senate Bill 265 (3rd Reprint): Revises provisions relating to prescription drugs. (BDR 40-809)

Senator Yvanna D. Cancela, Senate District No. 10:
For the presentation of today's bill, I would like to outline why I brought the bill forward, and then we have two doctors in Las Vegas that will speak to the need for the bill, as well as a patient. Then I will go through the bill section by section. I want to talk a little about diabetes in Nevada, why this is such a serious public health issue, and why we as a body have a responsibility to take action.

Today, 12 percent of all Nevadans have diabetes. Thirty-eight percent of Nevadans are prediabetic, and we are on track to double our population of people diagnosed with diabetes by the year 2030. At the same time, depending on the kind of insulin you look at, the cost of insulin has skyrocketed. Increases in the last 5 years have gone as high as 150 percent. In the last 20 years, some brands of insulin have increased by 700 percent and others by 1,000 percent. What could be called a business opportunity is, in my opinion, a public health crisis. This bill aims to answer the question, "Why are diabetes drugs so expensive?" by shedding transparency, not only on the manufacturers, but also on different entities involved in the discussion around prescription drugs. I will now turn it over to one of our patients in Las Vegas.

Bonnie Jeanne Sedich, Private Citizen, Las Vegas, Nevada:
I am the Streeter children's mother, and I am here representing four children diagnosed with juvenile diabetes. We have no family history of diabetes. My son, Jeffrey, was diagnosed at the age of 3, and his body was found along the freeway in California at the age of 19. An empty bottle of insulin was how they traced him to me. Chris was diagnosed in his late 20s and Greg in his early 30s. Both are fighting the complications of diabetes.

First off, I would like to address the pharmaceutical companies. We understand what your research has developed over the years to make truly wonderful and effective insulin, and we would like to thank you for that. However, what good does it do us if we cannot afford it? Somehow that makes it worse for us because we know it is going to make us feel better and live longer and lead productive lives, but it is not within our grasp. You have made a drug for the rich.

Such was the case with my daughter, Mary Elizabeth Streeter, a diabetic from the age of eight years. The cost of her insulin for six bottles for one month was $2,108. Even when Medicare paid for it, her copay was $400. After three months, her allowance for prescriptions was used up, and she hit her gap referred to as a "donut hole." She had type 1 diabetes, chronic progressive kidney disease stage 5, high blood pressure, cardiac arrhythmias, atherosclerotic cardiovascular disease, was 99 percent dependent on a pacemaker, and on 24-hour oxygen—to name a few. All were complications of diabetes. She had 15 different medications to pay for besides diabetes care and could not afford it on her $1,500 disability check that took over 3 years to get after she could no longer work. She used up all of her money, maxed out her credit card, maxed out our credit cards, and all our savings were gone. At this point, she was totally stressed out, calling her doctors actually begging for samples and writing pharmaceutical companies for help.

On June 3, she had a major stroke that damaged 50 percent of her brain, left her completely paralyzed on the right side and unable to move, talk, or swallow—even her saliva had to be constantly suctioned. She had a feeding tube for her Glucerna and crushed pills. She wore a diaper, and she was catheterized. Each move she made had to be done by hand or the Hoyer lifts. She lived six months like that in our care.

The last two weeks of her life her kidneys started giving out and her body swelled from just under 200 pounds to over 400 pounds. We put her back in the hospital, and her lungs started hemorrhaging blood to the point they had to suction the blood out to get enough oxygen in her lungs. At that point, her heart gave out on November 21, just six months ago, at the age of 51. She never complained or cried about her lot in life, and she always had a smile for you. It is hard to see your children or family members in that condition because they could not afford to stay alive.

So, I ask you to look into your hearts as well as your minds. See what our reality is and make insulin affordable to all people from all walks of life. Even you are not exempt from diabetes. It has no respect for persons. It can attack anyone, anywhere, any time as it did my family. I ask you to please vote yes on S.B. 265 (R3) and help us live. I sincerely thank you for your consideration. The laws you make today are the laws that we have to live with tomorrow.

Chairman Sprinkle:
Thank you for your testimony and story; we know how difficult that was.

Christine M. Reynoso, representing Culinary Health Fund:
I have been practicing medicine in Nevada since 2004. Over the years, numerous diabetic patients, like Mary Elizabeth, have confided to me that they were not taking their diabetic medication because they could not afford it. When diabetics do not take their essential medication, they die from their disease. Back in 1993, the *New England Journal of Medicine* published a landmark study that changed the way we care for diabetes to this day. The Diabetes Control and Complications Trial proved that better control of blood sugar with insulin reduced the eye, nerve, and kidney damage up to 76 percent.

However, people are still admitted to intensive care units every day in diabetic ketoacidosis from not getting their insulin. This condition is a complete derangement of a person's metabolism due to a lack of insulin, which can quickly cause coma and death.

Diabetes damages most organ systems in the body. It plays a significant role in many chronic health problems that create daily hardships for people, interfere with their productivity, require hospitalizations, and increase health care costs. Some examples are damaged nerves causing poor sensation, trouble walking, falls, poor blood supply to feet and legs, nonhealing wounds which progress to bone infection and can result in amputation, heart attacks, heart failure, strokes, blindness, and kidney failure. All of these are potentially preventable or reducible if people can afford and take their essential diabetic medications. Thank you.

Praveen Jayakumar, Medical Director, Culinary Health Fund:
Thank you for this opportunity to talk about insulin. I will go over some slides (Exhibit C) that were uploaded to the Nevada Electronic Legislative Information System (NELIS). One hundred years ago, diabetes was a death sentence. The reason it is a manageable disease today is that insulin was discovered. The team of researchers in Toronto discovered insulin in 1921, patented it for $3, and sold it to the University of Toronto. This is because they were troubled by the idea of profiting from such a lifesaving drug.

One may ask the question, "How is insulin different today?" Insulin in the 1920s was extracted from the pancreas of cattle and pigs. It took two tons of pig parts to get eight ounces of insulin. In the early 1980s, recombinant (biosynthetic) human insulin was on the market. This is insulin grown in labs from strings of bacteria and yeast. These advances made insulin less expensive to manufacture and reduced immune reactions that were once a common side effect of animal-derived insulins. That brings us to the question, "How much does 97-year-old insulin cost today?" Insulin found in 1921 was called regular insulin. What we have today is regular insulin in recombinant form that was based on the discovery in the 1980s; a version of that regular insulin carried a list price of $17 a vial in 1977. That has an average list price of $152 today. Even in the last five years, the price of regular human insulin has gone up by 138 percent. Page 4 (Exhibit C) shows that NOVOLIN R has gone up 138 percent in the last 5 years.

I want to highlight an article that came out in the *Journal of the American Medical Association* in 2016 that looked at the price of insulin. It showed that insulin tripled in price from 2002 to 2013. The cost of insulin tripled from $231 to $736 a year, per patient. The graph on page 6 is from that study that showed that while the cost of most other diabetic medications went down, the price of insulin consistently went up. There is public data available that pharmaceutical industries, including the ones that exclusively produce insulin, spend more money on sales and marketing versus actual research and development. The 5-year trend lines for all types of insulin have gone up, whereas the price for biguanides, oral generic drugs, have stayed stable and cost less than $10 a prescription versus the

hundreds of thousands of dollars that insulin costs right now. In the following slides, we break up the cost per prescription for all of the manufacturers and all of the different types of insulin. The consistent theme is that they have all gone up dramatically. That being said, I hope you will support this bill and our patients.

Senator Cancela:
I would now like to walk through the sections of the bill and answer what I think are some of the arguments the Committee will hear today. We will start with the bill in section 6. Section 6 asks the Department of Health and Human Services (DHHS) to compile a list of drugs essential to treat diabetes. The primary focus of this list will be insulin and biguanides. Something I have learned in the process of working on this bill is that biguanides are drugs for people who have diabetes and are insulin resistant. Section 7 deals with the transparency requirements. These are transparency data points asked of the manufacturers of the drugs listed in section 6, so the manufacturers primarily of insulin and biguanides.

There are a couple of arguments I suspect we will hear today about the transparency language. The first is that you will likely hear the word "compliance" quite a bit. In meetings with the manufacturer's legal counsel and with our legal counsel, it became clear, based on what was said in that meeting, that there were no legal issues with compliance. Rather, there were compliance questions. You all should have a note on NELIS that outlines what happened in that meeting where our legal counsel spoke with the pharmaceutical legal counsel and indicated there were no legal challenges to this section (Exhibit D).

Specifically, this section requires that manufacturers disclose a number of data points that, in my opinion, are important to answering why the skyrocketing has happened in insulin and biguanides. It asks for the cost of producing the drug, administrative expenditures, profits that the manufacturers have earned, what percentage of all profits those profits make up, total amount of financial assistance—things given in patient-assistance programs and costs associated with coupons—wholesale acquisition costs of the drug, a history of increases, aggregate amount of rebates given to pharmacy benefit managers, and additional information that may be necessary.

Another argument you may hear today is that this bill only looks at manufacturers, and it does not look across the health care system. That is correct in saying that this bill is heavily focused on the manufacturers. That is true for a couple of reasons. The first is that drug pricing is unbelievably complicated, but it starts with the manufacturers. Every entity in the chain, whether it is pharmacy benefit managers, insurers, or wholesalers, adjust to the manufacturers' behavior. In my opinion, they are the most appropriate starting point.

I specifically responded to changes that were asked on the Senate side. The first was to remove research and development from the transparency section. I thought that was a reasonable change. That was taken out. The second was to include the data that would allow us to see what kinds of rebates are given to pharmacy benefit managers. The intent of the language in section 7, subsection 1, paragraph (i) is to have one aggregate number that says this is the amount of money that is given to manufacturers. It is not from manufacturers

to pharmacy benefit managers; it is not to have this diced out by drug or by pharmacy benefit managers. That is necessary to avoid any sort of challenges based on competition, but I do still believe that is important.

Section 8 asks for a 90-day notification from manufacturers if they are going to increase the wholesale acquisition costs. It asks for that data to be given to the Department of Health and Human Services within 90 days before that increase. Section 8.5 has been an evolution. Originally, this piece started as a licensing of pharmaceutical representatives meant to mirror what has been done in Washington, D.C., for over eight years. It was just passed in Chicago about a year ago. We found that might not be the best approach for our state; this was crafted instead. I believe it is not only good for Nevada, but will give us some critical information.

Section 8.5 says that a manufacturer will provide to the state the list of authorized sales representatives in the state. That is different from educational representatives. I want to make sure that is on the record. Health care providers will have access to that list and will be encouraged to make sure they check that list before taking meetings with sales representatives. More importantly, in this section is the data captured in section 8.5, subsection 5 where it is clear what data the sales representatives will distribute to the Department of Health and Human Services at the end of the year. The intent is to be able to understand if there is a correlation between what drugs are prescribed and used in the state, and what drugs are discussed with those involved in the health care space. I want to make sure it is clear that folks recognize that this data is confidential. The Department will analyze the data and make public a report on that data.

Something you may hear about today is that this kind of data being "out there" could have a chilling effect on drug samples. I want to make clear that the data is confidential. There are already federal reporting requirements on drug samples that should have created that kind of chilling effect. If the argument is that drug samples are necessary because people cannot access medications, it is all the more reason why we need this kind of a bill. People should not be relying on drug samples to subsidize incredibly expensive drugs.

Section 9 deals with nonprofit transparency. Perhaps this section has been most enlightening in my opinion. Something I did not know is that according to a study published in May in the *New England Journal of Medicine,* about 80 percent of all nonprofits in the health care space receive some sort of funding from drug manufacturers,. From that study came a recommendation that there should be more transparency in that space. This has gone so far as to reach the federal level, where recently they were preparing to have hearings on opioid addiction, the opioid crisis, and how to handle it. A Senator from Oregon asked that everyone who was set to speak on the panel disclose their connection to drug manufacturers. The majority of those chosen were then asked to not be on the panel. It is not in any way meant to be a slight on the work that our nonprofits in the health care space do; they do tremendous and important work. Rather, it is just meant to help us understand whom we are talking to when we are in that space.

The bill asks that nonprofits either publicly post information on their website about the contributions they receive from manufacturers, pharmacy benefit managers, and insurers, or in the event they do not have a website, they can submit that data to the DHHS for them to post online. I should also add that grants are not intended to be captured in section 9. Those have very different processes and are usually designed for a specific outcome. That is different from a gift or a contribution.

Section 12 is the next space that has language to it that deals with exactly what the Department of Health and Human Services will be posting on their website. Section 13 is conforming changes.

Section 16 deals with the penalties that the Department may issue. None of these are mandated. They are, in fact, designed to be there to make sure there is compliance, but certainly the intent is to work with all parties, so the data can be correctly distributed and reported, not to have unnecessary fines imposed on manufacturers and nonprofits.

Section 27 is the last piece of the bill. This is meant to codify what is currently permissible in public, private, and charter schools. The language lays out a process by which a student would be able to self-administer insulin or asthma medication when he or she is on school property. That is the end of the bill. I am available for questions.

Chairman Sprinkle:
Thank you. You got through 20 pages pretty quickly. Committee, are there questions on this bill?

Assemblywoman Titus:
Thank you for bringing the bill forward. I appreciate where your heart is, and I appreciate that diabetes in my world is an increasing diagnosis and the cost of insulin has gone up. Frequently, patients cannot afford it. Unfortunately, I do not see this bill solving the problem. As a matter of fact, I think it may make it more complicated. Specifically, regarding the bill, in section 8.5 the manufacturer has to submit a list of their pharmaceutical representatives, and then that list has to be maintained and updated. A busy family practice physician would then be obligated to check that list on a monthly basis to see who is on there and who is not. Is that how this reads?

Senator Cancela:
Before a meeting, you would be encouraged to check the list to make sure that person is on the list. Certainly, through the regulation process, the intent is not to be overly burdensome on either party. It is likely that we would be able to facilitate some sort of documentation that that person is on the list, so the requirements would not have to be on the doctor, but would rather just be something that indicates that person has been and continues to be on the registry.

Assemblywoman Titus:
Then looking in the same section 8.5, on line 4, it prohibits me from communicating about a prescription drug with a pharmaceutical representative who is not on the list. I go to meetings all over this country, and I have been to international meetings. Frequently, they are about diabetes. We will discuss current treatments and treatments of diabetes. There are members from the industry there talking about their latest discoveries and drugs. Those folks will not be on the list. There may be some unintended consequences. Is this only going to apply within the state of Nevada? That could really have an impact on my own education of what drugs are out there.

Senator Cancela:
I considered those different educational opportunities. If you look into section 8.5, subsection 1, it specifically uses the words "markets prescription drugs" because marketing is different from educational purposes. The situation you are describing would not be captured by the bill. The bill would only capture situations in which there is clear marketing of a drug to a doctor, a pharmacy operator, or folks within the health care space. It is not the intent to have education be treated the same way as marketing.

Assemblywoman Titus:
Part of the relevance of my questions is regarding sampling. I am the only doctor within 30 miles in any direction. Frequently, patients cannot make it to a pharmacy. They are ill when they come to see me and do not feel like driving to town. I have samples provided to me. Frequently, they are types of insulin samples. I am concerned about the pushback from sampling. I do not prescribe based on a pharmacy representative coming to see me and saying to prescribe their drug. I make no profit on what I prescribe. I try to look at what is the most efficient medication, the best medication, and I make sure they can afford the medication. I have samples of types of insulin that I have given out to patients. I have also used them in the office in an emergency. I am curious about the regulations on the pharmacy industry in this bill. When I see a pharmacy representative, I always tell them that they are an endangered species. I am concerned that this bill may be their death knell. Hopefully, that is not what is going to happen.

Senator Cancela:
I just want to make sure it is clear to you that data is to remain confidential. That is similar today to what happens at the federal level. In 1987, the federal government said that doctors would have to disclose when they request samples and that manufacturers would have to disclose when they leave behind samples. That data has begun to be reported to the Food and Drug Administration (FDA). The FDA now keeps that data. It is not public. This would be no different from that in that the Department of Health and Human Services would have that data. It would be confidential within the Department and only in a reporting capacity would that data be shared. It would not be specific to a doctor's office. It would just be specific to trends in the state.

Assemblyman Hambrick:
I was wondering if you could give us the genesis of the bill.

Senator Cancela:
In my previous life, I was the political director at the Culinary Union. In that capacity, I was fortunate enough to work with our health fund. Last fall, we partnered with the Center for American Progress to talk about drug pricing. In that forum, one of the presentations we had was on insulin. When I was appointed to this seat, I had three days to come up with great ideas for bills. That presentation really stuck with me because it is true that insulin costs are skyrocketing across the country and here in Nevada. I thought, as a legislature, we have a responsibility to take on some of our state's most important needs.

Assemblyman Oscarson:
First, I want to thank the Senator for reaching out to me. We have had a couple of discussions, and I appreciate that. I have some questions. When we talk about transparency, do you foresee an issue with transparency only being limited to one component of the supply chain? From start to the finish, the manufacturer is the only one that has to be transparent, and the rest of the process does not, including the pharmacy benefit managers, the pharmacies, and the other entities engaged in the supply chain.

Senator Cancela:
I have a couple of things to that point. Do I think there should be transparency all across the drug-pricing spectrum? The answer is absolutely. I think there are a couple of challenges with that. First is contractual information. It is very difficult to access the data between pharmacy benefit managers and insurers because it is contractually protected. However, that does not mean there are not access points to pieces of that data, which is why I included the line on pharmacy benefit manager rebates. When you look at insurers, hospitals, and even pharmacies, they have different sets of transparency requirements. Insurers have close to a couple hundred pages of requirements in statute on what they need to disclose to the Division of Insurance. Hospitals have to disclose everything from the price of an aspirin all the way to certain health code standards.

The one piece of the drug-pricing spectrum where there is not enough, or any, transparency is in drug pricing from the manufacturer. That is why I think they are the most appropriate starting point. Additionally, what happens in drug pricing is that the manufacturer, in my opinion, is the initiator of all other behavior. I believe that the price set by the manufacturer determines the negotiations in rebates. Those negotiations determine formulary decisions. It all trickles down from where the manufacturer starts. It is not as easy as when you push the first domino because it is highly complicated, and I am sure folks will disagree with me on that. In my research and my understanding of drug pricing, that has been the most appropriate starting point.

Assemblyman Oscarson:
When we talk about costs of a product, we should talk about the benefits. I have not seen a cost-benefit analysis. That is really how you determine what costs are. What are the benefits of what these drugs are actually doing? How many people are they keeping out of the hospital? How much comorbidity are they decreasing? How many hospital admissions are we preventing? How do you think this legislation is going to help? In my mind and what

I have seen in my limited experience, compliance is a big issue with diabetes. It is part diet, part taking your insulin on time, and part checking your blood sugars. It has all of those components. How is what you are trying to accomplish going to happen? I know a lot of times the pharmacy benefit managers and the pharmaceutical companies and physicians' offices provide education, which is something that I think is badly missing in a lot of the Pharmaceutical Research and Manufacturers of America (PhRMA) issues we are addressing. They try, but patients are just noncompliant. That is how simple it is. Help me understand that.

Tell me how you think this whole issue is going to impact the rebates. As you well know, some companies pay a significant amount of money in the Medicaid program for example. I know there are some questions about that. Significant amounts of rebates come back to the state and the Medicaid program, where the costs for those patients within that program were significantly negated. We have an AIDS program that is almost completely funded. While it is not diabetes, it is a PhRMA kind of thing. I am not advocating for one entity or another; I am just asking some questions that need to be asked.

Senator Cancela:
Your concerns are correct. Initially, there were concerns about how this could affect the rebates given to both Medicaid and the Public Employees Benefits Program (PEBP). Both Medicaid and PEBP are exempt from the bill. They indicated this would not affect their rebates at all.

The education question is a really important one. It is, in my opinion, something that we as a state, and frankly in private practices, need to do a better job on. Early detection of diabetes is essential. The fact that almost half of our state's population is prediabetic is proof that we need to do better to let folks know how they can take better care of themselves. You are right that this bill does not address that. I am hopeful that in shedding more light on the issues, other entities will continue to build on what has already been done.

At the state level, our Medicaid program does an excellent job at education and prevention measures; PEBP does an incredible job at having a program for their beneficiaries with diabetes. I know there are all sorts of private insurers that give benefits to people with diabetes that manage their care by lowering their costs. I do not know that there is a place where all of those are housed together. I would commit to working on expanding those to the best of my abilities.

Assemblyman Carrillo:
Thank you for bringing this forward. At the beginning of your testimony, you mentioned different percentages. Type 1 and type 2 diabetes are obviously two different animals in the sense that type 2 diabetes is something that is progressive and has not been taken care of, but type 1 diabetes could be something where you came into it early on. I am not saying that I know a lot about it, but for the people that have type 1, it just becomes a part of their life. You have people that have progressively gotten to where, even if they take prescriptions and watch their diet, and they are taking everything they can, their body becomes tolerant to the

medication. The type 1 diabetics do not have a choice. They are on insulin, and that is all they can do. They will not get better. I am not a doctor. I do not know how that stuff works, but I am going by the philosophy and understanding of if you take medication and take care of your body you should not need insulin, but sometimes your body can only go so far before you have to get a stronger dose. A patient is doing everything he can, considering diet and sugars, but he has to start taking insulin. The prescription could be $10 prescriptions depending on what copays you have, but now you are not anticipating insulin costs. You are talking sticker shock for those people who have type 2 diabetes.

Praveen Jayakumar:
The question you put forth was regarding sticker shock for type 2 diabetics when they are put on insulin. So for type 1 diabetics, it is an autoimmune process. The pancreas is basically attacked by our own cells. Type 1 diabetics are dependent on insulin right from the get-go. There are also late-onset type 1 diabetics who get diabetes in their twenties, but most folks with type 1 diabetes are kids. As I mentioned before, one hundred years ago, type 1 diabetics usually did not live beyond the age of twenty. With insulin, they can live full lives.

For type 2 diabetics, there are different types. Most folks start on oral hypoglycemic prescriptions, and then over time, there is a point where some people cannot get their sugars under control with just oral medications. Based on Dr. Reynoso's testimony earlier, there are plenty of good studies from the '90s onward that show that maintaining your blood sugar in the right levels really affects your outcome and organ damage. Getting people on insulin early may be required for a lot of folks based on new guidelines. I hope that answered some of your questions.

Assemblyman Thompson:
I want to thank Senator Cancela for bringing this forward. I love the bill, but I do have some questions. I want to talk about section 27. There are people in my family and community that have diabetes. They are very astute. They know about their medical condition, and they know how to administer the drugs themselves. Is this a protocol that you are using from other states' examples? You have everything from what they are allowed to do on school grounds as well as on the bus. The bus is my concern because, as the Chair of the Assembly Committee on Education, we are going through some protocols on buses, and we do not necessarily have adults on the bus other than the driver. There could be some potential issues with that.

Senator Cancela:
This language was taken from looking at what is permissible in federal statute and what is permissible on public property. The intent was to mirror what happens on public school grounds with private and charter schools. The bus issue is not one that has been brought up before, and I would be interested in following up with you on what is happening in your committee regarding buses to make sure we address any challenges that could come up with that.

Assemblyman Thompson:
I think it is fine in the school. I just think we really need to talk about the school buses because you do not have adult supervisors on the bus.

Senator Cancela:
I think the intent is to have the parent involved in every step of the waiver and signing the necessary paperwork for this to be created, so there is a discussion in that process about buses and where there child would be safe and unsafe in administering. The reason this piece of the bill is the longest section of the bill is because that discussion should happen thoroughly and completely before any self-administering happens.

Assemblyman McCurdy:
Thank you for bringing this bill. To be honest, I have a very high percentage of people who take insulin in my district. In section 16, subsection 2, you start to talk about compliance. It says, "If a manufacturer fails to provide to the Department the information . . . ." It talks about the fine of $5,000 per day when in noncompliance. I am just interested to know where that number came from. Did it come from some language in another place?

Senator Cancela:
First, I want to point out there is a "may" there. Because it is a "may," it is designed to enable both parties to continue to work through any sort of compliance issues and not force the hand of the Department to continuously force unnecessary fees in the event that both parties are working together. The $5,000 figure seemed appropriate to be high enough to push towards compliance, but also low enough to not be overly burdensome. It is a ceiling in my opinion, not a mandatory issuance. There could be a ladder to get to $5,000; it does not necessarily have to be $5,000 every time.

Assemblyman McCurdy:
I did see that. It does say "not more than." It leaves a little bit of flexibility there. Coming up to this bill, I am sure you know there have been many people having meetings and trying to give their point of view. Was there any thought around looking at the rebates that were passed down to the consumer in regard to this legislation?

Senator Cancela:
There are different rebates in the process. Are you looking at the rebates that are given directly to low-income consumers through coupon books, or other rebates given directly from manufacturers to consumers? There are also rebates given from pharmacy benefit managers to insurers. There are rebates given from manufacturers to pharmacy benefit managers. So, there are numerous ones in the process. I want to make sure I am clear on which ones you are talking about.

Assemblyman McCurdy:
I am talking about the ones to the low-income consumers.

Senator Cancela:
In section 7, subsection 1, paragraph (e), regarding the transparency, it asks specifically for disclosure in coupons and in paragraph (d), it asks for financial assistance programs, so we would be able to understand those. Something that I am interested in long-term is figuring out how we let more people know about those manufacturer assistance programs. I do think they can be tremendously beneficial to patients.

Assemblyman McCurdy:
How do you anticipate getting the word out once we have acquired the piece of information we have gained from this legislation?

Senator Cancela:
It would be public information, and it would be published on the Department's website. I think I would certainly make the commitment to letting as many people know that information is public, but I also think those interested in it have been looking for it for a long time. I think patients are always asking how their insulin went from $17 to $50 per vial. I think they themselves would be interested in accessing it.

Assemblyman Edwards:
I can say that I empathize with you that this is a complicated process when trying to figure out who is on first, who is on second, and who is in the middle, but that is what we are going to try to do. We know that there are multiple groups between the manufacturer and the patient. The manufacturer tells me that they have about a 4 to 6 percent increase in cost per year. In talking with the Culinary Union, I asked them how much their members pay for it. They told me $0, which rather surprised me. There are others who pay $10, some pay $35, and then there are others who do pay hundreds of dollars. I am trying to figure this out. Are we able to collect the kind of data we need from all of the players involved, so we actually understand the situation and can come to the proper conclusion? It seems as though your best efforts—and they are great efforts—do not cover several of the middlemen involved. It does not extract the information from them. Can we even collect the applicable data, given all of the confidentiality agreements that you talked about? Would we not be left with incomplete data and incomplete answers at a great cost?

Senator Cancela:
It is true that this is wildly complicated, and what one person pays may not be the same as what the person sitting next to them pays. There are different actors that are responsible within the process for making decisions along the way that dictates that difference. The challenging part is that a lot of that data is in fact contractual and proprietary data. What I believe is that if there is more transparency at the top, at the starting point, the system adjusts accordingly. When we know why there are so many price increases, why price-gouging happens, and why drugs are more and more expensive, we know that other entities in the chain will react accordingly, and we understand the data. I also think that data empowers consumers to be able to go to the other actors in that chain and ask appropriate questions about why costs are rising.

I would also say that there is data available to consumers on insurers, on hospitals, on different rates, and different costs of drugs within their chosen medical provider. That is not necessarily true on drug manufacturers. That is why I think this piece of legislation is so critical.

Chairman Sprinkle:
We have other questions, but I think that at this point we can talk about them offline. Thank you for your presentation and for bringing this bill forward. I am going to say one more time that I would certainly appreciate testimonies to be short and to the point. Do not take it personally if I ask you to wrap it up. Look at your neighbor and know you are all thinking the same thing, so think about whether or not you want to testify. That being said, I appreciate you all being here. With that, I will open testimony in support. We will start in southern Nevada.

Bobbette Bond, Policy Director, Unite Here Health; and representing Health Services Coalition:
Unite Here Health is the parent of Culinary Health Fund. I am here today in that role, but also the role of being on the executive committee of the Health Services Coalition. I am proud to be here on behalf of both.

Very briefly, I am very proud of the work that the Culinary Health Fund has been doing to make sure that insulin and diabetic medications remain affordable. I think the reason we are pushing so hard to make sure there is some transparency is that we are really trying to understand these cost increases better than we do now. The process inside the legislative building this session is a testament to how difficult the fight is to understand what is behind the drug costs, the price increases, and the importance of transparency as a first step.

In the 95 years since insulin was developed and the $3 patent sold, manufacturers have been competing. There are three companies that dominate the market, but that has not led to lower prices. When you see the graphs that are in NELIS (Exhibit E) about the cost increases we have been talking about, you can see that they have been phenomenal increases. In an industry that is supposed to be competitive, why is that? In an industry that is supposed to be able to patent things for a certain number of years before they become generic and more widely available, why do these producers tweak their insulin products and allow new patents, but avoid the ability for a healthy generic market to develop? That market is just beginning now. These are questions we really should be asking at a policy level. I think this bill is a start to understanding it better.

Eli Lilly and Company, Novo Nordisk, and Sanofi dominate the insulin market, and between them have over $20 billion in insulin sales. In the meantime, the price of insulin between 2006 and 2013 increased from $190 per year to $736 per year. They are involved in a class action lawsuit that was filed on behalf of eleven diabetic patients accusing the company of unlawfully raising the price of insulin products. That lawsuit is continuing and that research is continuing. There is an investigation on that.

In addition, today, two former pharmaceutical executives involved in a price-fixing scheme agreed to cooperate with a broader investigation into allegations of a widespread anticompetitive activity in the generics industry. I do believe that all of the questions raised about whether this was the only solution or only piece of the solution—it is not. It is a big market, and it is an interesting and complicated market, as Senator Cancela said. We are certainly a piece of it. We believe we are an important piece of it, but we have to start somewhere. There has been no transparency in this industry.

We are excited to see this bill move forward. Insulin has become expensive; generics are not widely available yet. We support S.B. 265 (R3) as a very important step forward in transparency and getting some eventual relief to our Nevadans. We hope the opportunity for a rebate program, such as the one in Maine, is something we can bring to the state eventually. We appreciate this first step.

Tanya George, Private Citizen, Las Vegas, Nevada:
I was first diagnosed with type 2 diabetes twenty years ago. At first, I thought the doctors did not know what they were talking about, so I was not taking insulin. Then, eight years ago, I felt really dizzy and my equilibrium was off, so I went to the emergency room. I went in thinking it was something minor and not life-threatening. They checked my blood sugar, and it was so high that the machine could not read it. I ended up being hospitalized for five days, which led to a $15,000 medical bill that I am still struggling to pay off.

After getting out of the hospital, it was difficult to manage my diabetes because I did not have insurance. The hospital gave me some insulin to take home and advised me to apply for health insurance, but it was too expensive. It was not until three years later, when the Affordable Care Act came about, that the costs decreased, and I was able to afford insurance.

During those three years without insurance, I struggled to manage my diabetes. I was not taking medication regularly. I would call my doctor to try to get free samples and call friends to ask them if they had insulin. A lot of times, I just had to do without. I really worried about my well-being.

Even with insurance, insulin is expensive. My insulin co-pay is $40 a month, a glucometer is $65, and test strips are $240 a month, which I cannot afford, so sometimes I test less. I also take a shot four times a month, which adds another $60.

If you do not have insurance, you are in a lot of trouble. I went to the pharmacy about eight months ago, and they told me my insurance was not covering my insulin. They said I had to pay $480. I had to call the insurance company who needed my doctor to verify that I really needed it, and then they started covering it again. That was scary to think that I would have had to pay $480 for a two-week supply of the insulin pens.

We need affordable insulin now. Please vote yes on S.B 265 (R3).

Christopher Hughes, Private Citizen, Las Vegas, Nevada:
When I was 15 months old, I was really sick, and I was hospitalized when the doctors told my parents I was a type 1 diabetic. To survive, I need to take shots or use my pump for insulin. I take care of my diabetic supplies and am usually on top of the latest technologies that come out. I have never had to worry about whether my insulin or supplies would be there—they just were. My mom explained the cost of the supplies and how lucky I am to have good insurance, because if I did not, we would not be able to afford all of the supplies I need to live. I have friends who do not have everything I have. I asked my friend one day why he was not feeling well. He told me he has not been able to test for three weeks because he simply could not afford the supplies. I asked my mom why he could not borrow some of my stuff. She explained that some laws protect companies from borrowing, and there were a large number of people affected who cannot afford insulin or test strips at all. She showed me the receipt for the insulin and explained what I would have had to pay uninsured. It was $1,400 per month. That is a lot of money for something I cannot live without. My mom and I have talked about what I want to do when I grow up. This was similar to a conversation you have when you are four years old, and they tell you that you can be anything you want when you grow up. Except, I cannot be anything I want because I need a good job with good insurance because of the cost of insulin. Now, I worry about others who will not have the same opportunities as me when I grow up. I worry about the others who cannot afford insulin, and I worry about the possibility of the fact that my insurance will not last forever. I worry that I will not have my mom to have my back forever. The bottom line is that insulin needs to be affordable. That is why I am here today.

Chairman Sprinkle:
Thank you. I would ask anyone who has written comments to submit them for the sake of time. We will upload them to NELIS.

Josh Griffin, representing MGM Resorts International:
We are here strongly in support of S.B. 265 (R3). I know time is short these days, but I will be brief. This presentation and this bill are trying to address the fact that diabetes is a growing health crisis, and it is a growing financial crisis. If this bill does nothing but help give all of us the information to try to figure out what we can do to understand it and better manage it, it is a great start. We are very proud to support the bill.

Ryan Beaman, President, Clark County Firefighters, Union Local 1908:
As firefighters, we run our own self-funded, nonprofit health insurance trust for our members and their dependents along with our retirees. We see the importance of this bill to have the discussion of some transparency. As the chairman of our trust, we see the cost of medications. We do try to keep our copays low because, just as Assemblyman Oscarson said, we see the disease states and how important it is to control that in order to keep people out of the hospitals. Keeping low copays helps. As firefighters, we see the patients that cannot afford insulin. We do runs on them on a consistent basis. They say the reason why they are having issues is that they cannot afford the insulin. We strongly support this bill and appreciate Senator Cancela for bringing it forward.

Rusty McAllister, Executive Secretary-Treasurer, Nevada State AFL-CIO:
I am representing the over 200,000 members of the American Federation of Labor and Congress of Industrial Organization and their families who are in support of this bill. The vast majority of our members are covered by health insurance trust funds that are either Employee Retirement Income Security Act of 1974 (ERISA) or self-insured who are all nonprofit. They make no profit in their health insurance funds, and yet they struggle to survive because they have to watch every dollar that goes in and out of those funds. We believe that this transparency legislation will help us in making better decisions and getting more information to better control the outflow of dollars from our funds.

Chairman Sprinkle:
Thank you. We will go back to the south.

Geoconda Hughes, Private Citizen, Las Vegas, Nevada:
I am a nurse in southern Nevada. I work in an intensive care unit and have firsthand experience with the long-term complications of diabetes. Many Nevadans end up on dialysis, losing a limb, losing sight, and losing their independence. It does not always have to end that way. A common sentiment with many of my patients is that they cannot afford to take care of themselves. They cannot afford the medications, the test strips, or the insulin. It truly pains me that an elderly person has to choose between food and insulin or between having electricity and paying thousands for their monthly insulin. It is not a choice; it is not a compliance issue. For them, it is not a choice that the medication is not affordable.

When I see these cases, I immediately think of my son, the young man that spoke just a few minutes ago. I think of his future. Christopher has had to test his blood sugar four to six times a day, give himself insulin injections, insert insulin pump sites, and be aware of the carbohydrate count for everything he eats. As parents, we had the responsibility of teaching him those tasks, so one day he could independently take care of himself. We thought that was the hard part. The hard part now is our constant worry for his future. We worry about his kidneys, his eyes, and his heart. We worry about whether he will continue to care for himself in the way we taught him, not because he does not know how, but because of the huge financial burden. Right now, Christopher has double coverage. His father and I both carry very good health insurance to cover Christopher's diabetic needs. Today, our insurances cover $1,200 for his monthly insulin. It also covers the costs of his insulin pump supplies, test strips, sensors, and test kits, which add up to $4,400 every three months.

Like most parents, I worry about my children's future. However, I worry most about my son not having health insurance. Like most parents, we have talked to him about going to college, finding an area of work he enjoys, but our emphasis has been and will always be that he finds something with health insurance benefits. He depends on insulin and cannot survive without it, so we worry when we see the prices go up. We worry when health care is less affordable. We worry that meeting his basic insulin needs will get in the way of having a family, owning a home, or enjoying his life. For my son, for his future, and for others like him, I ask you to vote yes.

Stacie Sasso, Executive Director, Health Services Coalition:
The Health Services Coalition represents 21 employer and union health plans with a combined total of about 300,000 covered lives. The Coalition's primary focus has always been on accessing quality and affordable health care for the participants of our member groups. We work hard to ensure the member groups pay a fair and reasonable rate for health care services in southern Nevada. Currently, there are no cost controls in place to monitor prescription drug pricing. This allows the expensive life-sustaining drugs, like insulin, to continue to increase in cost at an alarming rate. This is causing a barrier for the patient diagnosed with diabetes to access medications that they need to be able to remain healthy. What we are seeing is that the cost of prescription drugs is increasing faster than the cost of living. That is why transparency requirements are the key to helping us understand the issue. Allowing for transparency of prescription drugs is the start of a change for health care in Nevada. Thank you.

Maya Holmes, Research Director, Culinary Workers Union Local 226:
On behalf of our 57,000 members and 130,000 health fund participants, we strongly support S.B. 265 (R3). This is much-needed legislation, not just for our members and their dependents, but also for all Nevadans. We are disappointed that there is no longer immediate price relief through rebates in the legislation, but S.B. 265 (R3) is certainly needed and it points us in the right direction to understand price increases and help ensure future affordability. This serious disease touches nearly everyone in the state, and the cost of essential diabetes drugs is simply out of control. What does it matter if there are new and better medications if people cannot afford these life-saving drugs? We ask you to do what is right for Nevadans and make sure S.B. 265 (R3) becomes law. There is a very brief video on NELIS of a delegation of people living with diabetes and their family members who came to Carson City on April 19 to share their stories (Exhibit F).

Chairman Sprinkle:
We will bring it back to testimony in the north.

Mike Alonso, representing Caesars Entertainment:
We are in support of S.B. 265 (R3). We want to thank the sponsor for bringing this important piece of legislation. Caesars Entertainment has 33,000 employees in Nevada, and with their families, that is a big number. The matter of expensive drugs is very important to us. We appreciate the transparency and support this bill.

Marlene Lockard, representing Service Employees International Union Nevada Local 1107; Las Vegas Police Protective Association Civilian Employees; Retired Public Employees of Nevada; and Nevada Women's Lobby:
Our retirees in this state are impacted every day by the high cost of prescription drugs. We think this bill is an important step to bringing necessary relief to some of our public employee retirees. We appreciate the sponsor bringing this bill forward.

Russell Rowe, representing Boyd Gaming Corporation:
There are roughly 10,000 employees in southern Nevada and all of their family members whom we insure. We stand strongly in support of this legislation.

Todd Ingalsbee, Legislative Representative, Professional Fire Fighters of Nevada:
We support this bill. We think it is a good start. We think it is not only important for all of our members in our self-funded insurance trust, but also the hundreds of thousands of citizens we see on our calls every day who are affected by this disease.

Priscilla Maloney, Government Affairs, Retiree Chapter, American Federation of State, County and Municipal Employees, Local 4041, AFL-CIO:
I did speak briefly with the Public Employees Benefit Program (PEBP) staff this morning, and I would like to put on the record that even though I do not represent PEBP, and PEBP has been cut out of this bill, we came to a consensus and are in strong agreement that transparency is a great thing. We really appreciate the Senator's hard work on this and totally support this bill.

Brad Keating, Legislative Representative, Community and Government Relations, Clark County School District:
We are here in support of S.B. 265 (R3). We appreciate the Senator bringing this bill forward. Not only does it help our 42,000 employees in the Clark County School District, but more importantly, many of our students have diabetes, and we think this bill goes a long way in the transparency of information, which ultimately benefits our students and their families. We appreciate this bill.

Ruben R. Murillo, Jr., President, Nevada State Education Association:
I am representing over 40,000 educators across the state. We are in support of S.B. 265 (R3), and we commend the sponsor for bringing forward the bill. Everything else has already been said.

Regan J. Comis, representing Nevada Association of Health Plans:
In our plans, insulin has been the number one cost-driver for our prescription drugs. For those reasons, we are in support of the bill.

Chairman Sprinkle:
Thank you all in support of this bill for being here today. I will open up for testimony in opposition of S.B. 265 (R3).

Brenda L. Gleason, President and Founder, M2 Health Care Consulting LLC, representing Pharmaceutical Research and Manufacturers of America:
M2 Health Care Consulting does work in all 50 states for a wide range of clients, including nonprofits, for-profits, and healthcare providers. I also teach health care policy at George Washington University. Today, I am here on behalf of the Pharmaceutical Manufacturers of America (PhRMA). We are in opposition to S.B. 265 (R3). I think it is important from the start to talk about how any approach to transparency and affordability

needs to take a holistic approach to the entire healthcare continuum, not just singling out one entity. More importantly, especially considering the testimony we have heard so far, we need to consider whether this bill would actually help patients and their families address their issues with costs.

In our opinion, this bill will not help patients in any way or help the state when it comes to cost. QuintilesIMS recently released a report on price growth and found that after factoring in the discounts and rebates negotiated by payers, the net prices for brand medicines increased by just 2.8 percent in 2015, and that was a reduction from 5 percent in 2014. However, we have seen out-of-pocket spending go up substantially for brand name medicines. That is in part due to a paradigm shift that has happened in the insurance industry where they are changing what is covered. Insurance benefit design has changed dramatically. For instance, insurers are using many more multi-tiers. They are putting drugs on Tier 2, Tier 3, and Tier 4, which puts certain drugs out of the reach of patients. Perhaps most importantly, there is an imbalance in the way that those copays work across health care services. For instance, a typical patient only pays 5 percent out of pocket for hospital costs, but they pay about 20 percent or more for their prescription drugs.

This bill would require manufacturers of essential diabetes medicines to report to the Department of Health and Human Services, on an annual basis, a laundry list of mostly proprietary information. We appreciate that it seems like common sense to say that more transparency is better, but we have significant concerns with the bill, as written, particularly in section 7 and section 8. In section 7, we are concerned that manufacturers would not be able to meaningfully comply with these provisions.

We are also concerned that even if somehow they could comply with any of these provisions, the confidentiality would be put at risk. Much of what is required, if it could be reported at all, is proprietary and confidential. Requiring companies of any kind, regardless of whether they are pharmaceutical manufacturers, to publicly disclose trade secrets is a terrible precedent to set. It would also require manufacturers to report what is essentially sensitive information, especially between competitors such as the cost of producing a drug, administrative expenditures, marketing and advertising profit, and more, most of which is already reported publicly on an aggregate basis and is publicly available today. As far as compliance goes, manufacturers do not typically track administrative costs or marketing and advertising the costs of production on a per drug, by carrier, by state basis, which is essentially what this bill would require.

Section 8 is also problematic. The 90-day notice on price increases will substantially disrupt the supply chain for drugs nationwide. It would encourage purchasers to capitalize on these notices by stockpiling, which of course would then change patients' access to medicines and encourage secondary distributers to aggressively mark up prices and then sell these critical shortage drugs to the highest bidder. For instance, wholesalers, on average, keep only ten to twelve days' worth of supply of any specific medicine in the warehouse. Those warehouses serve multiple states or otherwise huge geographic areas. Being able to hold this inside of Nevada is not really possible because it is not how the supply chain works. Wholesalers are

also under a general contractual obligation to honor purchasing requests. In other words, if their big customer—for instance, Walgreens—comes to them and says they have to serve them first, they would have to draw from inventory to serve those customers. This is obviously a recipe for disaster.

I appreciate that in Nevada, because you do have some restrictions around stockpiling, maybe it has been implied that this would not affect Nevada, but again, because of the national nature of the drug supply chain, it absolutely would be an issue because it would cause issues in other states that are more relaxed in their monitoring or enforcement. Of course, if these shortages were to occur, it would impact economically fragile and potentially rural communities and providers first, which would add to the access challenges that many of these communities are currently experiencing.

Discussions on transparency and affordability of health care should take a holistic, not siloed, approach. The Pharmaceutical Manufacturers of America are willing to work with policymakers to look at ways to promote value in health care, to engage and empower consumers, and of course, to address market distortions. Any solution needs to keep in mind the patient and their families. With this particular bill, we really need to ask whether the patient is being benefited from this so-called solution, and whether or not the patient is being given information that would actually help them make a better decision about their health care. For these reasons, we would ask you to consider opposing S.B. 265 (R3).

Chairman Sprinkle:
Thank you for being here today. I am going to allow questions from the Committee.

Assemblywoman Miller:
I am very curious, and this is something I have never been able to understand. Forty years ago, the first cellphone cost about $4,000. When I look at technology over the past few decades, from my childhood, our first videocassette recorder in the '80s that cost $400 to now; technology seems to get cheaper and better as time goes on with mass production. Why is it not the same with medication, specifically insulin?

Brenda Gleason:
I am not going to speak specifically to insulin; I think there are other people here that can speak more directly to insulin. I would say that in general there are a couple of things. We are not really comparing apples to apples. The insulin of 95 years ago is not the insulin of today. It is not just a better cellphone. The other, most important, thing to keep in mind is that other people tend not to buy our cellphones. When they do buy cellphones, that price is quite high. That is more like what happens in the health care system. Someone else tends to buy your health care. It is called moral hazard. It is a classic problem in economics where if someone else is buying it the prices go up. In this case, you have a bunch of middlemen and those middlemen drive up those costs. It is that straightforward.

Assemblywoman Miller:

I am thinking of all of the people that I know in my personal life like friends, family, and coworkers that have gone through this rapid and instant increase in insulin without changing their insurance provider. It is the price of the insulin itself going up. Is there a way to prove from the manufacturers that there is an increased cost in research? I know the insulin of 95 years ago might have changed, but I cannot imagine the insulin of last year has changed that much. Can you speak to that?

Brenda Gleason:
It sounds like you are talking about a very specific benefit design. If the drug costs the same patient on the same insurance plan one price in February and a different price in May, I would be really surprised if it was because a manufacturer raised that price and the insurer passed it on. It is much more likely that something else happened. For instance, a pharmacy benefit manufacturer was able to garnish a bigger rebate and the insurer then charged the patient more.

Assemblywoman Miller:
So, is it not because the manufacturer's prices went up?

Brenda Gleason:
It is highly unlikely. In that particular instance you are describing, I do not know. However, that is typically not the way the system works.

Assemblywoman Miller:
I think that is what this bill is trying to see with the transparency component.

Brenda Gleason:
I appreciate that is what they are trying to see, but because you are only looking at one little pocket, which is the pharmaceutical manufacturers, there are a lot of steps between that price of the pharmaceuticals, pharmacy benefit managers, wholesalers, and insurance benefit design all the way down to the bottom. Picking one pocket will not actually answer the question you have. The question you have is a great one, but this bill would not answer it.

Assemblyman McCurdy:
You touched on a few pieces of the bill. You said you had concerns around compliance, confidentiality, and the potential leaking of trade secrets. It seems to me that all of these prices of insulin are pretty much in line with one another. I do not see the concern with trade secrets being valid here. You also stated that you do not track the marketing. How does PhRMA not track marketing? We listened to a presentation during the introduction to this bill that talked about how this has been marketed and how much money has been spent on marketing, but then you testify and say you do not track marketing.

Brenda Gleason:
I was saying that for the most part, manufacturers do not track marketing and advertising to this level of detail. They do not know it for a particular drug, in a particular geography, for a particular payer. They might have a very general sense, but they do not have it at this level of detail; it would be a national number. I apologize, I did not see that slide about marketing, but that is what would have been represented; it is a national number.

Assemblyman McCurdy:
In regard to confidentiality and your concern around trade secrets, I have noticed that a lot of the price points are pretty much in line with one another. What are the concerns around the trade secrets? What exactly are the issues around compliance? We did read the statement put out by the Legal Division of the Legislative Counsel Bureau in regard to the conversation that was had there. From my understanding, that concern was around the policy that you would have to adhere to.

Brenda Gleason:
I think the issue is about meaningfully complying. I am not a lawyer, and I am sure there is a legal definition regarding compelling compliance. I am saying that whatever information you would get would not be meaningful. If you think about the fact that marketing and advertising is done at the national level, in order to break it down to what you spend in a particular area, it would be like asking what one lightbulb in this room costs in regard to the point of this meeting. You would have to figure out over time how long that light bulb has been in there, and if you bought it from a different person than you bought something else from. Once you got down to that level of detail, you might be able to report it, but you could not report it with any level of confidence. So, that is what I am saying; you could not meaningfully comply. I am not sure it could tell you anything about the cost of producing the diabetes drug. Also, of course, it would be confidential because that would be part of how companies compete. Just like any company, their cost of production, sales, and bringing something to market, is confidential.

Assemblyman McCurdy:
Thank you. You mentioned you would be okay with transparency. Which type of transparency would PhRMA be willing to comply with, and why?

Brenda Gleason:
One piece of transparency that actually is in the bill that we think is terrific, and really gets closer to helping patients, is about formulary information. I believe it is in section 30. That is a great example of transparency because it helps a patient make a meaningful decision regarding what is on formulary and what is not on formulary, and then of course, being told whether something goes off or on formulary in the middle of the year. For more detail on a step by step in section 7, I would say that PhRMA is willing to talk to the author and work through this to keep the conversation going about what might work.

Assemblywoman Benitez-Thompson:
I have a follow-up because I heard something that just does not strike me as right. As I read the language regarding marketing, I do not read the language in the bill to say that we need them to drill down to city by city, moment by moment, what is happening in marketing. It just talks about the overall marketing and advertising costs. However, I cannot help but think the ability to get an aggregate number on what is being spent on marketing and advertising is some type of nebulous number that cannot actually be quantified. If that were true, I would think everyone should get up and go fire your PR firm right now because those ad buys, where you are putting your money and the different kinds of meetings is absolutely a quantified, known entity that a lot of people spend time talking about and analyzing and making big considerations about before they invest money. That piece did not ring true to me, but correct me if I heard you wrong.

Brenda Gleason:
We understand this to say that the manufacturer would have to report marketing and advertising for their particular diabetes drug. Are we in agreement?

Assemblywoman Benitez-Thompson:
Yes. I cannot imagine there is a known marketing package that is well thought out and well played out. That is the piece I am having trouble understanding.

Brenda Gleason:
What is typically reported by pharmaceutical companies is at the national level. Reporting it in more detail than that would be considered confidential and proprietary. If you were to force the company to do it, I would say it would not be meaningful in any way. What will happen is you will get a bunch of people in a room, and they will start arguing about what you mean by marketing and what you mean by advertising. We could probably get another hundred pages that would define exactly what you meant and in what length of time. At some point, you are not meaningfully complying because even if you came up with that number, it would not tell you anything or help get to this question where the author started, which is, "Why do the drugs cost so much?"

Assemblywoman Benitez-Thompson:
I still really struggle with that because I think that with everything laid out there with the rules on what is advertising and what is marketing across different mediums, especially the legal disclosures that accompany marketing, I think it is well-known and probably could be known by region, if we asked for those. That felt off to me.

Chairman Sprinkle:
We need to start wrapping this up, but we have a few more questions.

Assemblyman Oscarson:
Thank you for being here to answer questions. Following up on Assemblywoman Benitez-Thompson's question, advertising budgets can include a bunch of things. They could include your rebates, coupons, or even free and

reduced medications. All of those things are advertising components. I think there is a fine line you walk when you start disclosing that proprietary information, so you say information. We know PhRMA has three different manufacturers of this particular product. I will refer specifically to insulin because that is what this bill is about, but there are some finite things that the disclosure of this information could be considered proprietary. Is this legislation going to reduce costs to people who are experiencing higher costs with insulin?

Brenda Gleason:
No, sir.

Assemblywoman Titus:
You mentioned that this bill would not lower costs, at least in your opinion. Are there any other states that have similar legislation out there that are asking this?

Brenda Gleason:
I would say there are no other states that are asking this. This would be unprecedented.

Assemblywoman Titus:
The reality here is that insulin is expensive. Patients are being harmed by not being able to afford the medications; we are all in agreement with that. Is PhRMA at the table with the insurance companies? You mentioned that there was a section in this bill that you felt would help. Are you still working through this? It is still a problem, even though this bill may not solve that. Hopefully, PhRMA will come forward and expand on sections in the bill that they can get behind. I think that is the missing link. There needs to be a solution. I agree, I do not think that is this bill, but in addition to that one section, is there anything else PhRMA can get behind?

Brenda Gleason:
I would say that PhRMA is happy to sit and talk with the author. We can go through it, and we can try to find other ways.

Assemblyman Edwards:
In another life, I became very sensitive to contracts, and the need for confidentiality and for protecting proprietary information. If I understood you correctly, this bill would require the manufacturer and the other middlemen to break all of those confidentialities, and probably violate several federal laws in the process. I am trying to make sure that we, as lawmakers, do not make a law that requires people to break other laws. Is there any way you can see that giving the confidential information that we would not be breaking laws? Would that even get us to the real question of, "Where is the cost?"

Brenda Gleason:
I am not a lawyer, so I cannot answer that the way you phrased it, but we think this is impossible to comply with as written. No, it would not get us to that ultimate question regarding how to lower costs.

Assemblyman Carrillo:
If PhRMA is now accepting members who spend at least 10 percent of revenue on research and development, how does PhRMA verify that?

Brenda Gleason:
That is an excellent question. I do not know the answer, but I can get it for you.

Assemblyman Carrillo:
That would be great.

Chairman Sprinkle:
I cannot thank you enough for being here today and answering these questions. I think it is helpful for the overall discussion we are having here. We will go ahead with the rest of testimony in opposition, but we do need to start wrapping things up.

Jessica Ferrato, representing Sanofi US:
I just want to preface my comments with a few things. I think everyone in this room knows someone who has been impacted by diabetes. It is a devastating disease that impacts so many Nevadans. In addition, we are all impacted by the cost of health care in the country, and we understand that these costs have a critical impact on patient care. We know that Senator Cancela is working to address these critical issues, but we have concerns about S.B. 265 (R3) and the impact to pharmaceutical companies, doctors, and patients. The Senator has been very gracious about taking her time to meet with us and has continued to have an open door as we discuss our concerns. We oppose S.B. 265 (R3).

Sanofi US is a global health care company with a diversified business. Our North American headquarters are in New Jersey, and we have a distribution center in Reno. We make vaccines, over-the-counter medication, physician-administered biologicals, biologics, and small molecule drugs in a number of therapeutic areas including diabetes, which affects an estimated 29 million people in the United States. Compare that to a small drug to cure Pompe disease, which affects only an estimated 5,000 to 10,000 people worldwide.

Briefly, we want to speak about the innovation as it pertains to insulin. You have heard that there has been little innovation in this area, but we believe that decades of research have undertaken the differentiated insulins we have discovered, and even sometimes created, has changed the lives of people with diabetes for the better, and mostly their quality of life. Sanofi's continuous investment in research is shown in over 2,000 publications, including results with approximately 500 randomized controlled trials, 200 real-world studies, and more than 50 meta-analyses. Our investment and commitment to patients in the health care system continues and is reflected more recently in studies involving different patients, subpopulations, people of older age, and children with diabetes. Real-world studies are conducted in Nevada and across the country by Sanofi with the importance to provide pharmacoeconomic data for research utilization by patients with diabetes. Truly, this is an area where our work is not done, even as our first groundbreaking insulin comes off patent, and we have a biosimilar on the market today.

This is a first-in-the-nation bill that only addresses one disease state and will affect market dynamics. Sanofi is concerned with confidentiality, antitrust, and the ability for competitors to look at this data and find out trade secrets because of the small number of companies that operate in this area of diabetes.

Section 8.5, which is the sales representative portion of the bill, sets up a system that conflicts with and inserts complexities into a federally regulated area such as sampling and reporting of physician interactions. Some of our highly-trained pharmacists and other credentialed medical liaisons may be pulled into this reporting, even though there are very specific legal safeguards to ensure they are resources for prescribers and understand the specific research regarding our drugs but are not specifically salespersons. Sales representatives provide information and support to medical professionals, pharmacists, and others because it helps patients and helps them with the burden of living with diabetes.

I have some examples of Get Started Kits, test insulin injectors, and other things that are provided for patients. For these reasons, and those stated previously by PhRMA, we are here in opposition to the bill. Thank you.

Chris Ferrari, representing Pfizer Inc.:
We are here in opposition to Senate Bill 265 (3rd Reprint). We have significant concerns with this bill as outlined by Brenda Gleason, on behalf of PhRMA, mandating the signal in price changes can have negative implications on supply chain, which can reduce patient access to quality drugs. We oppose any mandates that require manufacturers to report, as discussed, proprietary information. Also, from a state perspective, we are on a roll here in terms of economic development. I cannot imagine that we would have that type of precedent in place with regard to disclosures in a competitive, private sector, and if that would create a precedent nationally, not just with the pharmaceutical industry but with other industries looking to move their businesses to Nevada.

In addition, we are asking the Department of Health and Human Services to not only receive this information, but to analyze it and hold it confidentially without any additional financial resources. In the era of cyberattacks and otherwise, that seems to be a weighty task for the agency. As mentioned, we believe that section 30 talks specifically about giving that consumer, when they are going to buy their plan, the knowledge of what is going to be on their formulary and if that is going to change within the plan year. That is going to enable a consumer to make a decision about their health care based on what is being offered.

We also just want to touch briefly on the fact that this is a system, whereby there is a manufacturer and there is an end user. I would equate that to a gallon of gasoline, which starts at a manufacturing level, has to be transported to a certain location. There are local, state, and federal taxes, there are marketing taxes, and refining costs associated with that as well. If you want to dig in to what a gallon of gas really costs, if you look at all of those factors you will get an accurate picture.

Additionally, the concern about this bill strictly being focused on manufacturers, yesterday the Juvenile Diabetes Research Foundation launched its new educational campaign called Coverage2Control, a campaign to urge insurance companies to provide coverage that works for the type 1 diabetes community (Exhibit G). Their number one issue for this campaign is keeping out-of-pocket costs for insulin and diabetes management tools predictable and reasonable, as section 30 in this measure does. There is some merit to what is being said, and we are certainly sympathetic to those that spoke in support of the bill. This is a very serious issue, but is this the vehicle to do it, and will its policy achieve the objective? We stand in opposition of S.B. 265 (R3), and I appreciate the Committee's time.

Jeff A. Buel, Director, Government Affairs, Johnson & Johnson:
Johnson & Johnson opposes S.B. 265 (R3). We believe that it does not address the important issues of maintaining access to needed medicines. The bill may result in several unintended consequences, without really addressing what the public is seeking. Johnson & Johnson believes in solutions about changes in the way we pay for and reimburse for care, and paying for how well medical treatments and interventions work, as opposed to the volume of procedures or medicines. We have recently released our North American transparency report, which provides information about our transparency commitments and our responsible business practices, and this is available as a public document. We want our current and future business partners to know that we are committed to responsible pricing and embracing transparency.

Diabetes is a complex disease. It is among the top ten causes of death in the United States. While death rates have declined, the number of Americans diagnosed with diabetes have more than tripled since 1980, making the need for innovation and innovative medicines greater than ever. Over 29 million people have diabetes, another 86 million people are considered to have prediabetes, so it is imperative to address this disease. This legislation fails to take into consideration the individual treatment and effect of medicines and will potentially limit access to the number of treatments. The diabetes patient needs an armament of treatments that will provide a maximum clinical benefit for the patient's specific needs. Innovation is extremely important. Senate Bill 265 (3rd Reprint) undermines these developments. Insulin is a biological therapy. This is derived from living cells; this is a very complex process.

At Johnson & Johnson, our focus on patient lives, cures, and innovation are the fabric of our credo and our worldwide health care directive. Johnson & Johnson believes that it is imperative to provide patients and physicians with the latest information related to treatment options, largely done by our medical affairs professionals right here in Nevada. Restricting the ability to provide health care professionals with the latest and most accurate scientific data about treatment options would be detrimental to meeting patients' needs in Nevada. Our medical affairs professionals and interactions with doctors and health care professionals are already extremely heavily regulated by the Food and Drug Administration.

Johnson & Johnson embraces the PhRMA code on interactions with health care professionals and we embrace the American Medical Association Guidelines that drive those directives. There are federal laws; there are Centers for Medicare and Medicaid Services (CMS) Sunshine Laws; and the industry is committed to patient safety and ethical interactions with health care professionals. Our medical affairs professionals, and the people who engage with health care professionals, are highly skilled, highly trained professionals who engage in scientific exchange with health care professionals who offered guidance on patient treatment options.

Senate Bill 265 (3rd Reprint) seems to be searching for a cause-and-effect outcome whereas they are trying to find something that is not broken. This is a solution looking for a problem. Our medical affairs professionals provide patient starter kits, patient product samples, patient education pieces, and instruction and information about comorbidities associated with diabetes. The role of a medical affairs professional in this industry is critical to the health and welfare of patients and essential to the providers in Nevada. Thank you for your time.

George Ross, representing Biotechnology Innovation Organization:
The Biotechnology Innovation Organization is the largest organization in the world of biotechnology companies, academics, and state organizations devoted to that. Many of our members are small companies pursuing innovative solutions. I do want to say thank you to the sponsor of this bill. I know she is driven by a tremendous desire to help the folks whom we have seen in the testimony in support. She has had a very open door and has been very willing to discuss this bill. We truly appreciate that and admire her for it. Unfortunately, we do not think this bill, as written, would do anything to help patients understand the true drug costs or to lower those costs because there is a whole chain going through the pharmacy benefit managers and the plans themselves.

More importantly, it would force drug innovators to publicly report confidential and competitively sensitive data, adding unnecessarily complex reporting requirements to small companies developing new therapies. It would also harm our members' ability to compete with other manufactures and to effectively negotiate with health insurers and pharmacy benefit managers.

We agree with the PhRMA representative's comments on the impact of the price aspect of this bill. We agree with Johnson & Johnson's comments regarding sales representatives. Rather than duplicate, I will just note that every single penny a consumer or patient pays for his or her drugs is determined by the insurance company or the health plan. Every single aspect, including copays, deductibles, and coinsurance, is determined by their plan. If one really wanted to impact what the consumers and patients pay for their diabetes drugs, one would start addressing the structure of those plans. I understand where they are coming from. I know they are concerned about what they have to pay, but we need to look at the whole chain because we are not addressing what affects us when we buy our drugs.

[(Exhibit H) was submitted by the Biotechnology Innovation Organization but not discussed.]

Khanh Pham, Pharmacy Director, DOLCrx:
I have no financial affiliation with any drug company or any pharmaceutical industry. I am a pharmacist. I take care of the patient after he walks out of the doctor's office. I am here to tell you about your constituents. I listened to the bill very carefully. I see one major problem. The bill addresses the wrong party. Everyone said the same thing; they cannot afford to get the drugs. Let me tell you something. Everyone drinks coffee at Starbucks, the average price of that is $5. If every morning you have a cup of coffee, that is $150 per month. You have soda during the day, and then on the weekends you go out and have a glass of wine, you are easily spending $200 per month. Your phone bill is $100 per month. One vial of insulin where I work is $25 to $50. The coffee you drink, the alcohol you consume, and the diet sodas do not save your life. The patient that I have pays out-of-pocket money on his own, cheaper than you get from the copay. So, you are pointing the finger at the wrong party here.

I am treating patients ranging from homeless to blind. Many of them are diabetic. I walk in tunnels through sewage to find some. A type 1 diabetic with a suture told me that she is in the club. I asked her what club. She said, "The Zipper Club" because of the scar. She still lives on the street. One expensive pen of insulin, you say is outrageously expensive, paying cash out of pocket is $100. There is a practice of clawback where the patient sometimes pays a lot more than the cost of the drug and none of you are aware of it. The pharmacy is not allowed to tell the patient that there is another cheaper option because if we did it would violate the gag order.

I am asking you to vote no to this bill because it does not solve anything. Please hold off on your decision because I would like to have permission to send you all of the evidence that will shine the light on some of the problems that are making drug prices go up. It is not the drug companies. All of the patients I serve, some at 250 percent below poverty level, rely on the drug company to get their free insulin. Thank you.

Chairman Sprinkle:
Is there anyone else in opposition here or in southern Nevada? [There was none.] I will open up for neutral testimony.

Catherine M. O'Mara, Executive Director, Nevada State Medical Association:
We are here in neutral on S.B. 265 (R3), although we support the efforts that Senator Cancela is trying to do. We definitely support doing whatever we can to reduce the costs of prices for medications for our patients. We do have a few concerns, most of which were addressed on the record by the Senator. In section 8.5, the Senator clarified that the legislative intent here is to capture folks that are marketing the drug and not educating on the drug. We appreciate that clarification as well as requiring the burden of registration to be on the manufacturing representative and not on the physician, so we look forward to working to clarify that.

In section 9, she clarified that it is not the legislative intent to capture grants. We have physicians, especially in Las Vegas, who are doing research right now on acquired immunodeficiency syndrome (AIDS) and cancer. They get national grants from national

entities. They also receive things of value from pharmaceutical companies in order to facilitate these types of research. We would make the recommendation that medical research be stricken from this section or clarified in the regulations because we do not want to impede that ability for them to move forward with their research, which is very important.

I want to focus on the transparency because we do have a few concerns remaining, and again, we really appreciate the Senator working with us all the way up until the start of this hearing. For organized medicine, we are in favor of transparency reporting, but it should not impose a regulatory or paperwork burden on physicians. It should protect physician's rights to challenge falsely misleading reports, and it should provide a meaningfully accurate picture of physician industry interactions.

I want to bring up two things, and all of this comes from section 8.5, subsection 5, paragraphs (a), (b), and (c). Our manufacturers already report two ways to the federal government. One way is the Sunshine Act, which was passed in 2013. That covers section 8.5, paragraphs (a) and (c). That requires reporting of anything of value to a physician. The manufacturers report this information. There is a prepublication period where a physician is allowed to look at that information and ensure that it is accurate. This is important to us because in the first year of reporting, of 1,347 manufacturers that reported to the federal government under the Sunshine Act, 1,228 of the manufacturers reported erroneous information. We want to make sure that if the information is reported that it is accurate, that it can be quantified, and that we can confirm that information. The second way that manufacturers report information to the federal government is in the reporting of samples to the Food and Drug Administration. As you heard Senator Cancela mention, this has been going on for quite some time. This information is kept confidential, and she preserves that confidentiality under the bill. We appreciate her clarifying that for us. We would support that continued reporting.

In section 8.5, subsection 5, where we already have mechanisms in place to do this kind of reporting, we ask that instead of duplicating the reporting, instead of creating a new structure which adds administrative burden for the physicians and the manufacturers, we ask that we can simply ask the manufacturers to submit the same reports that they submit to the federal government or the FDA to the Nevada Department of Health and Human Services. This will reduce administrative burden on the physicians. The way samples are reported right now, a physician signs the form and that form is sent to the FDA. We would just ask they send those forms to the Department. We think these are common-sense provisions that would ensure this does not create administrative burden that could potentially impact the availability of samples and education materials for our patients, which is really the critical point here.

Julie Kotchevar, Manager, Primary Care Workforce Development Office, Department of Health and Human Services:

We wanted to say that we have reviewed the bill, and what we would be required to do. We will be able to do so without a fiscal impact to the Department. We also did want to note that we do work quite extensively with different industries in the provider groups that we

regulate to develop forms and ways of reporting along with those provider groups to make it something they feel they can submit to us. We are committed to continuing that practice if this bill should pass.

Beth A. Handler, Chief, Bureau of Child, Family, and Community Wellness, Division of Public and Behavioral Health, Department of Health and Human Services:
I have some points of interest to share. We looked at some Medicaid data and Supplemental Nutrition Assistance Program (SNAP) data at the state level. While ages 50 and over account for more diagnoses of diabetes, individuals diagnosed as overweight and obese are disproportionately younger among Medicaid recipients. Females account for more diagnoses in 60 percent of the Medicaid population while statewide data indicates males more often have diabetes. Statewide, the general population—white, non-Hispanics—account for almost half of those affected by chronic disease in Nevada. Diabetes affects the largest proportion of minority groups.

An initial review of Medicaid data demonstrates similar trends. Looking at SNAP, the SNAP eligible are less likely to be overweight, but they are more often obese than the general population. This is especially true for adolescents. In addition to the human disease burden, the epidemic of diabetes and prediabetes imposes a considerable burden on the economy of Nevada. Prevalence of diabetes nationally is expected to almost triple within the next 25 years—113 billion to 336 billion. In 2012, Nevada's total estimated medical cost for diabetes was $2.5 billion, with prediabetes representing $194 million of these costs. Absenteeism associated with diabetes can range from 2 to 7 percent higher than average of total work days lost.

An improved health outcome means a person is better in control of their diabetes or a person with prediabetes is removed from that category. Possibilities for improving health outcomes include interventions that are health focused that create and promote healthy diet and exercise campaigns. Payer systems can collaborate to identify indirect resources toward those diagnosed with prediabetes, overweight, or obese.

Changes in A1C level indicate how well a patient is able to control their diabetes. We can look at ways to standardize reporting, such as through electronic health records. The community health worker model has been successful using interdisciplinary teams with cancer. We can do the same with diabetes and assist clients with medication compliance, health care appointments, and adhering to healthy behaviors in home and with trusted members of the community. Through diabetes self-management, education, and diabetes prevention programs, we can also help prevent and control diabetes. Thank you.

DuAne Young, Chief III, Behavioral Health and Pharmacy Services, Division of Health Care Financing and Policy, Department of Health and Human Services:
As you are well aware, we have over 600,000 members on Medicaid in this state. Of that 600,000, 32,000 take either insulin or some other form of diabetic medication. It is quite aware that we pay for the testing strips, those medications, and the self-management courses.

We are very dependent upon the rebates, so we have worked with the sponsor to ensure that Medicaid is exempt from this bill and that the data being collected is aggregate rebate data. We have removed our fiscal note.

Chairman Sprinkle:
Is there anyone else neutral to this bill? [There was none.] Senator, I will ask you to make some brief closing remarks.

Senator Cancela:
Thank you for a really helpful discussion to understand this issue. I appreciate all of the questions and the attention paid to the issue, despite the busy day. I do want to touch on some of the points that were brought forward to make sure I provide as much clarity as I can based on what I believe is some unfortunate misinformation.

I want to start by saying that the disparity in information is precisely why we need this kind of bill. We do not know what questions to ask because we do not have the right information. Until we are equipped with at least some of the data, it becomes impossible to have these discussions because we will constantly be manipulated into a place of saying, "We cannot talk about that, we do not know that, and we know more than you." That is the situation we are in today as a body, and as a state, and it is certainly the situation that patients are in as consumers of life-saving medication. That is why transparency is so important. Not only does it benefit patients, but it benefits us, as policymakers.

There was a continued emphasis on the ability to comply with the bill. I want to re-emphasize what I said originally. Much of that discussion is intended to happen in the regulatory process. I am hopeful that manufacturers will work with the state in making sure that they can comply. The reality is that they do have the data and it is a question of how they make it available to the state. I want to remind you that Legislative Counsel did provide an opinion that ended with the sentence: "All provisions of Senate Bill 265 (3rd Reprint) are legally defensible." The concern about whether compliance leads to illegalities are moot at this point because we have addressed those and looked at those. I appreciate the seriousness with which the Legal Division has crafted the language in this bill.

There is the question of what happens if we do not pass this bill. What solutions have been brought forward? I will disclose to you all that I have had an open door, and I appreciate that being recognized, but I wish it had been taken advantage of more. Unfortunately, I did not receive an amendment or solutions to the bill until yesterday. The functionality of the amendment gutted the majority of the bill. To me, that is not solution-seeking; that is just trying to punt the problem down the road. With twelve days left in session, I am not interested in those kinds of discussions.

I would lastly say that there is only a risk that we make things better for patients. The status quo leaves us with the kind of stories we heard today. We heard from patients who want this legislation and who believe this legislation will help them and their families. I believe we

have a responsibility to hear them and honor their stories and their hardships by taking action. If we do nothing, we are left in the same black hole and lack of information while drug prices, specifically insulin prices, continue to skyrocket. To me, that is unacceptable. Thank you.

Chairman Sprinkle:
I will say I have had plenty of people in my office on this bill, and without exception, everyone has spoken about how willing you have been to discuss your bill. For that, I would certainly thank you. It is disconcerting to me that it was only yesterday that you received the first of any amendments to this, almost four months into session. Thank you for being here. I will close the hearing on S.B. 265 (R3). [(Exhibit I) was submitted but not discussed.] We do have one bill to work session, Senate Bill 323 (2nd Reprint).

Senate Bill 323 (2nd Reprint): Revises provisions governing the Supplemental Nutrition Assistance Program. (BDR 38-627)

Marsheilah Lyons, Committee Policy Analyst:
Senate Bill 323 (2nd Reprint) makes various changes to the Supplemental Nutrition Assistance Program. Specifically, the bill requires the Department of Health and Human Services to:

- Calculate the 36-month period for determining a person's eligibility for the program such that it begins and ends on fixed dates that are the same for each beneficiary in the state and runs continuously;
- Seek a waiver to replace the existing waiver, which expires on July 1, 2017;
- Establish a voluntary workfare program to assist beneficiaries in meeting work requirements; and
- Allows the Division of Welfare and Supportive Services to give priority of work requirement waivers to certain classifications of recipients, such as veterans or people who are responsible for child support.

In addition, the measure provides that the Department of Health and Human Services may consider contracting with appropriate persons and entities to determine whether beneficiaries are exempt from work requirements. Provisions authorizing the Department to consult with certain persons and entities are effective upon passage and approval. All other provisions are effective upon passage and approval for the purposes of adopting regulations and performing other administrative tasks and on July 1, 2017, for all other purposes.

There are no amendments in the work session document (Exhibit J). The measure was heard on May 22, 2017.

Chairman Sprinkle:
Are there any questions or comments?

Assemblyman Thompson:
I will vote this out of committee, but I think there is some work we can have in section 2, where we talk about this voluntary workfare program where the participants gain job skills. However, I do not see a balance to it. There should be some type of commitment to these organizations and businesses that are getting labor and some type of commitment to hire. I am not quite a yes for the vote on the floor, but I am okay with passing this out of committee.

Chairman Sprinkle:
I appreciate your concerns. We are running out of time, so certainly get with the bill sponsor on that issue. Are there any other questions or comments on this? Seeing none, I will accept a motion for do pass.

> ASSEMBLYWOMAN JOINER MADE A MOTION TO DO PASS SENATE BILL 323 (2ND REPRINT).
>
> ASSEMBLYMAN McCURDY SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYWOMAN BENITEZ-THOMPSON WAS ABSENT FOR THE VOTE.)

I will take the floor statement. I will close the work session. Is there anyone wishing to come forward under public comment? Seeing none, I will close public comment. This meeting is adjourned [at 4:16 p.m.].

RESPECTFULLY SUBMITTED:

_____
Kailey Taylor
Committee Secretary

APPROVED BY:

_____
Assemblyman Michael C. Sprinkle, Chairman

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a copy of a PowerPoint presentation titled "Diabetes and Insulin Presentation," presented by Praveen Jayakumar, Medical Director, Culinary Health Fund, regarding Senate Bill 265 (3rd Reprint).

Exhibit D is a letter from Eric Robbins, Principal Deputy Legislative Counsel, Legal Division, Nevada Legislative Counsel Bureau, to the Assembly Committee on Health and Human Services, regarding Senate Bill 265 (3rd Reprint).

Exhibit E is a document titled "Rising Insulin Prices," regarding Senate Bill 265 (3rd Reprint), presented by Senator Yvanna D. Cancela, Senate District No. 10.

Exhibit F is a link to a video about members of the Nevada Diabetes Political Coalition, submitted by Senator Yvanna D. Cancela, Senate District No. 10, regarding Senate Bill 265 (3rd Reprint).

Exhibit G is a document titled "JDRF Launches 'Coverage2Control,' A Campaign to Urge Insurance Companies to Provide Coverage that Works for the Type 1 Diabetes Community," regarding Senate Bill 265 (3rd Reprint), submitted by Chris Ferrari, representing Pfizer Inc.

Exhibit H is written testimony regarding Senate Bill 265 (3rd Reprint), dated May 23, 2017, submitted by Brian Warren, Director, State Government Affairs, Western Region, Biotechnology Innovation Organization.

Exhibit I is written testimony regarding Senate Bill 265 (3rd Reprint), dated May 23, 2017, submitted by Curt Oltmans, Corporate Vice President, Legal and Corporate Affairs, Novo Nordisk.

Exhibit J is the Work Session Document for Senate Bill 323 (2nd Reprint), presented by Marsheilah Lyons, Committee Policy Analyst.