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

Seventy-Ninth Session
April 3, 2017

The Committee on Health and Human Services was called to order by Chairman Michael C. Sprinkle at 1:06 p.m. on Monday, April 3, 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:

None

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Committee Policy Analyst
Mike Morton, Committee Counsel
Kailey Taylor, Committee Secretary
Trinity Thom, Committee Assistant

OTHERS PRESENT:

Sunshine Moore, Regional Director, State Affairs, America's Health Insurance Plans
Bobbette Bond, Director of Public Policy, Culinary Health Fund
Barry Gold, Director, Government Relations, AARP Nevada
Chelsea Capurro, representing Health Services Coalition; Nevada Advanced Practice Nurses Association; and Regional Emergency Medical Services Authority
Regan Comis, representing Nevada Association of Health Plans; and Board of Medical Examiners
Bailey Bortolin, representing Legal Aid Center of Southern Nevada; Washoe Legal Services; Volunteer Attorneys of Rural Nevada; and Southern Nevada Senior Law Program
Jim Sullivan, representing Culinary Workers Union, Local 226
Saiza Elayda, Director, State Policy, Pharmaceutical Research and Manufacturers of America, Washington, D.C.
Brenda L. Gleason, President, M2 Health Care Consulting, representing Pfizer Inc.
George Ross, representing Biotechnology Innovation Organization, Washington, D.C.; and Comprehensive Cancer Centers of Nevada
Michael J. Willden, Chief of Staff, Office of the Governor
Elyse Monroy, Policy Analyst, Office of the Governor
John DiMuro, Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services
J. David Wuest, Deputy Secretary, State Board of Pharmacy
S. Paul Edwards, General Counsel, State Board of Pharmacy
Susan Fisher, representing State Board of Osteopathic Medicine
Cathy Dinauer, Executive Director, State Board of Nursing
Michael Hillerby, representing State Board of Nursing; and State Board of Pharmacy
Liz MacMenamin, Vice President of Government Affairs, Retail Association of Nevada
William Horne, representing Board of Dental Examiners of Nevada
John T. Jones, Jr., Chief Deputy District Attorney and Legislative Liaison, Office of the District Attorney, Clark County; and representing Nevada District Attorneys Association
Nick Vander Poel, representing Nevada Osteopathic Medical Association
Corey Solferino, Sergeant, Legislative Liaison, Washoe County Sheriff's Office
A.J. Delap, Government Liaison, Office of Intergovernmental Services, Las Vegas Metropolitan Police Department
Kathleen A. Conaboy, representing Nevada Orthopaedic Society
Keith L. Lee, representing Board of Medical Examiners
Ryan Beaman, President, Clark County Firefighters Union Local 1908
Todd Ingalsbee, Legislative Representative, Professional Fire Fighters of Nevada
Richard L. Martin, Private Citizen, Henderson, Nevada
Sean B. Sullivan, Deputy Public Defender, Washoe County Public Defender's Office

Catherine O'Mara, Executive Director, Nevada State Medical Association
Jared Busker, Policy Analyst, Children's Advocacy Alliance
Carrie Paldi, Private Citizen, Henderson, Nevada

Chairman Sprinkle:
[Roll was called. Committee rules and protocol were explained.] Normally, I have public comment at the beginning of the meeting; however, for the next two weeks I will skip that. We will still have public comment at the end. I do want to let the Committee and everyone in the audience know that for the next two weeks, we are under a time frame. Please do not take it personally or the wrong way if I ask you to wrap up your comments, especially if you are being redundant, to something that someone else has already said. I would appreciate it if you just state that you are in agreement with someone else's comments. Otherwise, I will be interrupting you and cutting you off. We simply do not have enough time. Please keep your comments short. We are always happy to take comments in writing as opposed to lengthy comments on the record. With that, I will open the hearing on Assembly Bill 215.

Assembly Bill 215: Requires the reporting of certain information relating to prescription drugs. (BDR 57-284)

Assemblywoman Amber Joiner, Assembly District No. 24:
Thank you for considering Assembly Bill 215 today. The purpose of this bill is to provide greater transparency for the public regarding the complex issue of prescription drug costs. High prescription drug costs affect us all in one way or another; personally in our family finances, emotionally as we watch friends and family suffer to afford the prescription drugs they need, or fiscally in our publicly funded medical systems. It has been well-publicized nationally in the last few years how prescription drug costs are continuing to rise. A few essential drugs have especially caught our attention because of their extremely high prices or because of their sudden jumps in price. It has struck a chord with many of us, because when such costs for life-saving drugs are extreme, it goes against our sense of fairness. The idea that a few wealthy corporations or individuals can profit off our misfortune goes against our values as a community.

You will notice in my testimony today that I will not name or call out any particular drugs or companies. I am not here to shame any of them or rehash what has already been reported in the news or investigated through congressional inquiries. I truly want to figure out a way that prescription drug companies can be more transparent with consumers while deterring bad actors in the industry from profiteering on our sick and vulnerable without accountability.

Assembly Bill 215 is very simple. It requires that pharmaceutical companies publicly report information about some of their highest-cost drugs. The origin of this bill is very personal to me. A few years ago when I was a deputy director at the Department of Health and Human Services, I received calls from people who could not afford their prescription drugs.

In that process of trying to find people help, I remember that many did not qualify for our state Senior Rx program. I struggled to help them find other ways to meet their bills. It became very clear that this is a major source of financial strain and stress for families.

A year and a half ago in September 2015, just after the last legislative session, I started noticing that when I met people at public events, or when I was door-knocking, a theme was emerging. I often ask constituents I meet about their major concerns and ask them what I can be working on at the Legislature. More and more frequently, the cost of prescription drugs is at the top of people's lists. It used to be that I would hear that from older people on a fixed income, but more and more it became parents talking about their children and the cost of drugs and middle-aged people regarding their own drug costs. It became abundantly clear to me that something needed to be done to help people understand prescription drug costs better and to somehow deter prescription drug companies from being able to jack up prices for no reason just because they can.

Now I want to stop there and say very clearly that I believe that pharmaceutical companies do amazing work in creating life-saving drugs; there is no disputing that. This legislation is not meant to vilify them as a group. I also want to make clear that some drugs are legitimately expensive, because they were very expensive to develop or because their ingredients are expensive. This legislation will allow pharmaceutical companies to explain that story. Ultimately, when the consumers have the ability to learn about why a certain drug is so expensive, they will have the ability to make more informed decisions. After deciding that I needed to do something about prescription drugs over a year and a half ago, I researched many options for this legislation. Ultimately, I found that other groups were working on the same issue. There was a model bill already circulating, and other states recently considered legislation that is very similar to this one. That is the foundation of the language you see here.

The bill has been out for two weeks, and I have not heard from any of the companies about possible amendments. Unfortunately, right now the pharmaceutical companies are in pure opposition mode, but I am hopeful they will come to the table, and we can talk through some of these things to figure out what is feasible in a way that gives people real information that they can use. In the months leading up to session, I had an open door about this legislation and did meet with some pharmaceutical companies before session and since session started. They will oppose the bill today. I have been up-front with them about my willingness to discuss possible amendments, but so far, they are simply opposing. I want to address some of the arguments they made to me that I am sure you will hear today.

First, these pharmaceutical companies have told me that the information we are asking for is proprietary and harms their business. In response to that, when I walk through the bill in a minute, I will direct your attention to sections 3 and 5, which allow some of the information to be held confidential and not be subject to open records requests. Specifically, in section 3, they will not have to report publicly anything that would cause harm to them competitively. It is very important that everyone understands that. I did put that exemption in the bill and do not want to harm them.

In a different conversation, another pharmaceutical company told me that they already report "a ton of information" to the federal government. I said, "Great like what? Show me a list!" Maybe all we need to do is take that information, put it into layperson terms, and post it on the website. I have not seen that list yet, but I am still hopeful that maybe there is one out there and that maybe that is a possible solution for this legislation. They have not taken me up on the offer to amend the list of required reporting items in the bill.

The Committee will also hear today that the pharmaceutical companies are not the only reason that prices are high. I understand that, and I think that the public deserves to understand that too. What I do not want to have happen with this bill is for people to say, Well there are other entities involved in pricing; and therefore, we should not do anything. I think this is an important first step. I have told the pharmaceutical companies that if they report their cost and their pricing and there is clearly a difference between that and the ultimate price that we see as consumers, then it will be clear that they are not the cause of the high prices. The reality is, for the most part, the initial price from the pharmaceutical company is the driving force behind the costs, so we are starting with that piece.

Finally, you will hear, as I have, that it is just a few bad actors that make the pharmaceutical industry look bad, and most companies do not intentionally make a profit off sick people just because they can. I have told them directly that I think they have a great opportunity to denounce the bad actors by supporting this legislation. If there are legitimate reasons for high costs, such as expensive ingredients, manufacturing, or innovative research and development, then being up-front with the public about that should be something that companies welcome. The bad actors only doing it for profit will be apparent, and the rest of the industry can win back some of the trust they have lost. So far, they have not taken me up on that, but I still believe that is the right thing to do. They say they have legitimate reasons for high drug costs. This bill gives them the opportunity to prove it, to try being honest with the public about why they have to raise the price of a certain drug or why it costs more than most people can afford in a year.

Now I would like to walk through the bill. In section 2, which is where the provisions begin, notice that the drafters refer to a Division. For the purposes of this bill, currently it is drafted that the Division of Insurance of the Department of Business and Industry would be the entity to provide the public website where this information would be provided. I did want to let the Committee know that they are having conversations about whether this is the correct entity to have this website. We originally requested that it be drafted there. I thought it would be a good idea because they do this with insurance companies, and they have a website. In talking to them, they think that they may not have the appropriate expertise on staff. I have also been talking to the Department of Health and Human Services as a possible portal, because they do have Medicaid and deal with pharmaceutical costs frequently. That is one area that as a Committee, you may want to consider where you think the best house would be for it. Ultimately, it is pretty simple; they receive information from the pharmaceutical company, and they post it on the website.

In lines 9 through 18 on page 2, you will see the criteria for triggering a report. Not all pharmaceutical drugs would need to be reported, only those that cost over $10,000 per year in wholesale costs, if the drug is used according to the instructions of the manufacturer; if it is $10,000 or more for a course of treatment; or if it increases more than 25 percent in one year would need to be reported. Only the highest-cost drugs would require this type of reporting. You will see section 2, subsection 2, paragraphs (a), (b), and (c) referenced throughout the bill. In paragraph (a), the total cost of research and development would need to be reported, paragraph (b) is any other cost of producing the drugs such as administration, and paragraph (c) is the total administrative expenditures relating to the drug including marketing and advertising.

Those of us who talk to pharmaceutical companies frequently know they often say that it is research and development and marketing that are so expensive. This gives them the opportunity to explain to the public why drugs cost as much as they do. Paragraph (e) is the total amount of financial assistance. Paragraphs (e) and (f) give them the opportunity to talk about the discounts that they give to the patients. Sometimes they do have good programs providing discounts or coupons. We want them to have the ability to give that full picture.

You will see under section 2, subsection 3 the wholesale acquisition cost. There are different ways to measure prescription drug costs, but in this case, we chose the wholesale acquisition cost. This is the manufacturer's list price for the drug. You will hear testimony from them today that this is not a true picture of what the cost of the drug is, but it is the most stable number that we could find. If there are other ways that they think they would rather report, I am open to that. I just want the public to have information that they can understand about these drugs. In section 3, you will see that there is an advisory group to create the form, so there is input by all sides about what this reporting would look like.

Clearly, in section 3, subsection 2, you can see that I put that exemption in there so that anything that causes competitive harm to the manufacturer would be held confidential. In section 3, subsection 4, you see the requirement for posting on the Internet and reporting to the Legislative Committee on Health Care during the interim or at the Legislature if it is during the legislative year.

Section 5 is carrying over where they do not have to comply with the open records law if it is related to competitiveness and would harm the business. With that, I would like to pass the testimony over to Sunshine, who has more information about some of the issues we have been seeing with prescription drug costs.

Sunshine Moore, Regional Director, State Affairs, America's Health Insurance Plans:
America's Health Insurance Plans (AHIP) is the national trade association whose members provide health care and related services to more than 200 million Americans. We provide major medical and supplemental benefits through large and small businesses, public programs like Medicare and Medicaid, and individual and family policies both on and off health care exchanges.

First, we want to thank the sponsor for bringing attention to the skyrocketing costs of prescription drugs—a growing and unsettling trend in our nation. Prescription drug coverage is an essential health benefit under the Affordable Care Act. Health insurers recognize that life-saving and life-improving medications have revolutionized the treatment of certain diseases, especially for patients with chronic diseases. Health plans use innovative programs, medication management strategies, competitive formulary placement, and other tools to ensure consumers have access to appropriate treatments at more affordable costs. However, rising drug costs are having a dramatic impact on our health care in this country by endangering that access to needed medications, blowing up state and local budgets, and threatening the taxpayer's ability to pay for pharmaceutical innovation. Prescription drugs now represent the largest segment of the health care dollar. It is more than 22 cents of every dollar in premiums. That is more than the share for hospitals and for physicians. Drugs also account for 19 percent of all Medicare spending.

The spending continues to rise much faster than other sectors of health care. In recent years, the spending slowed to historically low levels, rising at about 4 percent per year and then upticking a bit in 2015-2016, while prescription drug spending grew in the double digits in 2014 and about 9 percent in 2015. Again, that is faster than overall health care spending and faster than the rate of growth for hospitals or physician services. These disturbing trends are affecting consumers at the pharmacy, employers and employees through their premiums and out-of-pocket costs, and state agencies and policy makers working to deliver a balanced budget.

While part of the increase in spending can be attributed to higher utilization, the primary driver of cost growth is the ever-increasing prices for new medications coming to market and astronomical increases on existing drugs, some of which have been around for many years, or even decades. This is particularly evident among specialty medications. That is the focus of A.B. 215. Specialty drugs represent less than 2 percent of all prescriptions, but more than one-third of all drug spending. That share could increase to about half of all drug spending in the next couple of years. In 2015, while overall drug spending grew at 8.5 percent, spending on specialty drugs grew 20 percent, and that is after discounts and rebates. We have seen prices for many cancer drug treatments double over the past decade from an average price of $5,000 per month to $10,000 per month. That equals $120,000 per year for an average brand-name cancer medication. Manufacturers are raising prices on older, reliable HIV medications that face patent expiration in order to switch patients to newer, patent-protected antiviral therapies. Net prices for 30 out of 39 blockbuster medications have increased at more than double the rate of inflation since 2009. I could spend this entire hearing quoting statistics, studies, and data, but I will stop there.

The truth is, we do not know for sure what is driving these price tags that cost as much as a house, or why prices for certain medications seem to rise, rather than fall, over time. We applaud efforts to bring greater transparency to drug pricing so that states, consumers, and health plans can better understand the factors that go into drug pricing and why drug prices are rising so fast over such an extended period of time. Our member plans share the

principles of bringing relief to consumers, slowing the escalating costs of prescription drugs, and minimizing the impact of rising drug prices on consumers, businesses, and taxpayers. We believe A.B. 215 would help shed some light on a highly opaque system.

Take research and development, for example. The inherent risks of innovation are often cited as a contributing factor to high drug prices. It is true that the top ten drug makers in 2013 spent $66 billion on research and development. That same year, those same drug makers spent $98 billion on marketing and advertising. Private companies are not the only funders of research and development. Nearly half of research and development comes from taxpayers and other sources such as the National Institutes of Health, which is now doing clinical trials on a Zika vaccine. Academic institutions, research hospitals, donations to charitable organizations, and state and local governments all fund research and development as well.

Many manufacturers also spend millions of dollars to fund assistance programs that, while laudable in their intent, effectively mask the true cost of medications. Instead, these programs keep prices artificially high by incenting patients to choose one brand over another when a clinically equivalent alternative or generic competitor is available at a lower price. Again, this would bring some transparency and data to what those actual numbers are.

The fact is 8 out of 10 Americans think drug prices are unreasonable and 9 out of 10 Americans support policies that would require drug companies to report information to the public about how they set their prices. We cannot address runaway drug prices without accurate information about what goes into drug pricing. Assembly Bill 215 would bring these costs into the light.

Health coverage provides financial protection to patients, particularly those with chronic conditions, by covering the lion's share of medical benefits and services, including prescription drug costs. We are all aware of the strains on affordability and our health care system that result when the underlying price of prescription drugs continue to climb. Health plans are required by law to spend 80 to 85 cents of every premium dollar on direct medical care. If they do not, they have to issue rebates at the end of the year to make up the difference. Rising costs for prescription drugs have a direct impact on premiums, out-of-pocket costs, and taxpayer funding for public programs and insurance subsidies.

As health plan providers, we will continue to do our part to foster competition in the market and to develop public-private solutions that focus on affordability, value, and transparency. We would encourage all players to come to the table and offer solutions, rather than deflect and deny, so that we can continue to provide access to safe and effective medications at a reasonable cost to consumers, purchasers, and the public. Again, thank you for the opportunity to speak in support of A.B. 215.

Assemblywoman Joiner:
Ms. Moore's testimony actually reminded me of a discussion we have been having. Section 2 specifically discusses name-brand drugs being subject to this. I wanted to clarify that we

actually believe any pharmaceutical company that meets these criteria of being extremely expensive should be included. I would offer that as a possible conceptual amendment for the Committee. The reason we drafted this originally with the brand names is that a year and a half ago, when I was thinking about this bill, generic brands were the cheaper alternative, but we also saw this last fall that one of our generic companies actually jacked up the prices extremely high for a life-saving anaphylactic medication. Apparently, we do need the generics to be included. I do not expect them to be there very often, but I would like it to be uniform that any pharmaceutical company that meets these criteria would need to report.

Chairman Sprinkle:
Thank you for that very thorough presentation.

Assemblyman Oscarson:
Your presentation was very informative. Usually when you look at a cost analysis, you look at a benefit analysis as well. Have the pharmaceutical companies or anyone come to you about the benefits? Or, have you explored what the benefits of these drugs really are? What is the cost savings from hospitalizations, lost work time, and those things? Has that ever been evaluated? Could it be evaluated and figured into what you are trying to do?

Assemblywoman Joiner:
Looking at that cost-benefit analysis is something that, if it could be included in this report, would be beneficial for people to understand. I would say that it is something we could add to the report if a pharmaceutical company wanted there to be a clearer picture of how many lives they have saved, for example. I would have no problem with that being included in the form that is developed. The intent here is for people to understand the full picture. That is something that is less quantifiable, but if there were an ability to calculate that, it would be fine to add to the form.

Sunshine Moore:
Some organizations do that. The Institute for Clinical and Economic Review does this. There are independent groups looking at whether the prices really justify the offsetting to other things like hospitalizations and missed days at work and whether or not the claim that prices are set as high as the market will bear is actually true. I agree with the point that having that information would help fuel the discussion. There are organizations looking at that. I think they assessed that some of the new cholesterol drugs that hit the market in the past 18 months could be priced maybe 70 percent higher than their relative value. That is their assessment. That is a conversation worth having.

Assemblyman Oscarson:
The drugs that are currently coming out are increased in value as they see the other drugs that have worked in the past. Cholesterol medication, for one—there is always a new generation of a cholesterol medication that seems to work a little better. I always looked at the drug industry like the mining industry. The mining industry takes a tremendous amount of time to bring a product to market, to bring it to fruition where it is able to be utilized. As you have stated in your testimony, there are significant costs that go along with bringing a drug to

market. There are failed drugs, and all of those other things that are brought to market. How do you factor in the fact that these drugs take time to become more effective? The efficacy is shown and proven to be better and to lower and decrease some of the other costs. My thought process is that would have to be part of the equation for us. We would need to look at a cost in that cost-benefit analysis to what the drugs are doing and how efficacious they actually are.

Sunshine Moore:
I agree with you. I think that is an important point as well. This bill does allow companies to quantify and report that information. As you mentioned, there are definitely breakthrough therapies and first-in-class innovations that are bringing a lot of value to the health care system. One study looked at all of the Food and Drug Administration (FDA) newly approved cancer treatments from 2009 to 2013. There were 51 new cancer drugs. There were 29 that were called "first in class." There were 31 that you would call a "me too" drug, a follow-on that does something similar. These would be competitors. There was virtually no price difference between the 29 first-in-class and the 31 follow-on competitors. In other markets, competition tends to lower prices, but in this market, the first is setting the price floor rather than the price ceiling. Another drug will come out that is priced virtually the same. If you are the first in your class, there is no competition. The price you set is the price until a competitor reaches the market. With hepatitis C, the first treatment was on the market for 12 months before the next treatment hit the market. The second treatment was priced at 1 percent of the first treatment.

The second thing I would say is, for a drug that has been on the market for 15 years that goes from $30,000 to $100,000, that is not an innovation; it is not a new breakthrough. Maybe it was when it hit the market, and that is fantastic, but 15 years down the road, to be paying $100,000 for the exact same medication is very different from other markets. I think it is important to ask why that is happening and allow companies to provide that information.

Assemblyman Yeager:
I know you covered this briefly, but I just wanted to ask again. Can you explain again, what exactly the wholesale acquisition cost is?

Assemblywoman Joiner:
There was discussion about this. The definition is on page 3 of the bill. It means the "manufacturer's list price for the drug to wholesalers or direct purchasers in the United States, not including discounts, rebates or reductions in price, as reported in the wholesale price guides or other publications of drug pricing data." That is the most stable number that we have because once they enter into contracts with pharmacies, with pharmacy benefit managers (PBMs), or different providers, the prices start to change depending on what that contract is. This is what the price is before any of those factors are taken into consideration.

Assemblyman Carrillo:
How many states are doing this to the same effect that you are?

Sunshine Moore:
There are probably two dozen states looking at many different ways to tackle rising drug costs. I think people around the country are asking questions and policy makers are asking questions. Several states have introduced similar transparency legislation. It is probably a couple dozen states. Vermont is the only state to have passed legislation last year that identified the top 15 most expensive drugs. The report that came out of that legislation still did not give a whole lot of information. They may be looking at additional legislation this year. Many states are in full swing of session, just like Nevada, really trying to get at these underlying factors.

Assemblyman Edwards:
You mentioned that you see this as the first step in the process. I am wondering what the next steps are. I am also wondering how many companies are involved with your $10,000 price there. Is this a manageable effort or is this going to overwhelm the system?

Assemblywoman Joiner:
We are still working on the $10,000 threshold and what that would mean because the prices change. We are hoping that with this legislation, it would be a deterrent and there would be less reporting. To your question regarding the next steps—I believe I made that comment in responding to the pharmaceutical companies' arguments that they are not the only ones who set the prices, and that there are other factors and people involved. What I mean by a first step is that, in my mind, they are the largest reason for the price. Understanding there are other factors, I do not know what steps two and three are. There may not be any. What I really want is the transparency for the public to understand this process, and if in the future, we review that and we find that there are steps we should be taking, we take them. I do not necessarily see a step two and step three; it was more me saying that because they are the greatest factor in the cost, we should focus on them first. It is really obfuscating the issue when you try to point fingers, blame other people, and try to say that you are not to blame as well for some of the high costs. If we are truly just looking for the bad actors and not vilifying the whole industry, which is my interest, then we should use this as our first step.

Sunshine Moore:
As I mentioned, there are a couple dozen states that have legislation with different prices or triggers, so it is hard to quantify the exact number for every state. We are analyzing that. As an example, of the top 100 best-selling drugs in the United States in 2010, about a quarter of those were over $10,000 and 75 percent were under that. Four years later, about half of those were over $10,000, and the other half were under it. That is not the exact number of drugs. There are thousands of drugs on the market, and this bill has two parts to it about the $10,000 increases. It just demonstrates the trend towards higher and higher cost medications. We think the number would be manageable for reporting requirements. Health plans, hospitals, and physicians all have reporting and transparency requirements that they are required to meet. We are working on numbers, and as I said, it varies by state, but I would be happy to follow up on that.

Assemblyman Edwards:
I would like to follow up because I do have other concerns.

Assemblywoman Titus:
I appreciate your bringing this forward and your concerns. On a daily basis, I see patients who cannot afford the medication I think would be best for them. However, the last time I checked, we are a free-market society. There is a cost of doing business. I am concerned we are setting a very bad precedent here by asking companies who spend monies to do research and development to justify the costs on paper. I worry that is a very scary slope. I think in the end, it may discourage research and development. I know that you mentioned that you would look into generic medications.

One of the issues is some of the costs of the generics that have been out there forever. However, I do not see under the cost of development, that you have added for future liability risks on these drugs. One of the things that can happen with these companies is that when a company first develops a drug, it may be the best thing since sliced bread, but five years down the road, they found it was great at stopping one disease, but it created another disease. They are then left with incredible liability. I do not see where that is taken into account. I am wondering if you addressed that with the companies and what your thoughts are on that.

Assemblywoman Joiner:
Regarding the issue of free-market—part of the reason that I think this is a very valid step to take is that health care is unique in that it is life or death for people. It is not the same as selling a product for fun. Our hospitals and our physicians, as well as insurance companies, are highly regulated and do a lot of reporting. The pharmaceutical company is one of those places that we have the least transparency, and the least ability to see what the source of the cost is. There is no check on that free market. If they see an opportunity, some of them are taking it. That is what we do not want—the profiteering off our most vulnerable and sick. We do need legislation as a check and deterrent on those people who would profit just because they can.

On the issue of liability and future risks—I did consider legislation that would have capped what people can charge in the state. I think that if I were doing a piece of legislation like that, I would understand your concerns about risk and liability. I am not limiting what they are able to charge, and I am not limiting what they can accumulate in their bank accounts to offset that risk in the future. All I am saying is that if they are going to be very expensive, I think the public has the right to know what the source of those costs are.

Assemblywoman Titus:
You are saying this is something we need, and you are limiting it to pharmaceutical companies at this point in time, but there are other things that folks need or require other than medication. I require tires on my car for safety, but I am not asking the industry to give me why it costs what it does. How is this different?

Assemblywoman Joiner:
At any moment, any of us could fall victim to an illness or an accident that would require us to fall under the mercy of a drug company and needing a drug. To me, tires are completely different. You can take the bus, or you do not have to buy a car. I do see them as completely different, and I think when we are talking about the medical industry and looking at parity across the industry. The insurance companies and the hospitals are highly regulated. This is one of the main areas where there is the least amount of information for the public.

Assemblyman McCurdy:
I do believe this is a good first step. In section 3, who creates the advisory group?

Assemblywoman Joiner:
In section 3, it says the Division does. Under that portion of *Nevada Revised Statutes* (NRS), the "Division" is the Division of Insurance as it is throughout the bill. If there were another home for it, it would be whichever division is in charge of posting it on the website. The purpose of that advisory committee is to create that form and to ensure that all of the stakeholders are at the table to create something that is feasible.

Chairman Sprinkle:
Where did you come up with the $10,000 and the 25 percent? Why not $12,000 and 50 percent? How did you land on those numbers?

Assemblywoman Joiner:
In compiling all of the research of the different options and looking at prescription drug costs, there was model legislation out there, but the states that are currently trying it have also picked those thresholds. Last year, California had it at 10 percent. I thought 25 percent was being very generous. California had a trigger on one of their amendments so if the drug increased by 10 percent in one year, they would have to report. I was not trying to be harsh; I was trying to be reasonable. I think that those costs honestly had been evaluated by other entities and considered by other states. At the time, it looked to me like those were reasonable.

Chairman Sprinkle:
Part of the reason I am asking is because it seems like in some of the high-profile cases, we are not looking at a 25 percent increase, we are looking at hundreds of percent increases. That is why that number seems low to me. Maybe we will catch more than just the bad actors. You have brought up several times now that you are talking about not utilizing information that would cause competitive harm. How exactly do you define competitive harm, and who is to make that determination?

Assemblywoman Joiner:
In the bill, the Division of Insurance determines what to post on the website and what not to. That is the expertise that I was referring to in discussions that they think they may not have currently, and they may want to hire for or that maybe it would be better housed elsewhere, for example, the Department of Health and Human Services. However, at the time that the

companies are filling out the form, the form is not going to ask them for any information that is going to harm their competiveness. That is the point of having that advisory committee create the form. There will not be a place on the form for that type of competitive information. That is the second check on it. Not only is it not subject to public records, if there is information that makes it on the form, the Division of Insurance chooses not to put it on the website. That is where section 4 comes into play, and where it is exempt from public records requests. I see it as a multistep process. It is the formal check for it, but then the Division will not put it on the website.

Chairman Sprinkle:
Is the form different from all of the different requirements in section 2? It seems to me that if you start delving into research and development cost expenditures that could be competitive and proprietary in nature. Is that a separate requirement, or is this the same?

Assemblywoman Joiner:
The form should include those provisions, but if any information got through that was considered competitive information, page 3, line 36 says the Division will determine whether any information contained in the reports submitted on the form would cause competitive harm to the manufacturer. It would hold that confidential, not make it public, and it would not be subject to open record.

Chairman Sprinkle:
To me, I am not quite sure how the Division of Insurance can decide whether an individual company is providing competitive information. There seems to be a disconnect for me.

Assemblywoman Joiner:
That is why we thought it would be good to house it in the Division of Insurance, because they do that currently for insurance companies.

Sunshine Moore:
Our industry submits significant financial and pricing information on how we set our premiums. We have to meet financial solvency requirements; we have to submit our medical loss ratio information. I understand the author's efforts that there are subject matter experts who review our rates and are able to shield anything that could harm innovation or competitively sensitive information from the public's eye. I understand there are sections in the bill that would require reporting to the Division that may not make it to the final, publicly available report. We are subject to quite a number of requirements for requests of information that we have to submit, and there are protections for us as well.

Chairman Sprinkle:
Will there be some sort of wraparound to the individual companies, so if something does get out, it appears to this advisory group that this could be competitive nature, maybe proprietary? Would there be communication back with that initial company that submitted the report to confirm?

Assemblywoman Joiner:
Adding something like that or some sort of appeal process would be fine with me. I do not see that in the current bill language. I believe there is already that provision for insurance companies, for example. I would have to look at their regulations to see how they handle that, but I believe there is a process for that in what we currently do, so it would make sense to me to add that here.

Assemblyman Edwards:
What happens if the appeal fails, and we go forward with the information and the company is harmed? Who has liability for that?

Assemblywoman Joiner:
I will look into how they handle it currently with the insurance providers and get back to you on that.

Chairman Sprinkle:
Thank you for your presentation. Those here in support of Assembly Bill 215 can come forward. Once again, please keep your comments brief, to the point, and please do not be redundant. We will start in southern Nevada.

Bobbette Bond, Director of Public Policy, Culinary Health Fund:
The Culinary Health Fund is a nonprofit health plan that works with the hospitality industry and hospitality union. I wanted to express our appreciation for Assemblywoman Joiner as well as the 12 cosponsors of the bill. In order not to be redundant, we agree with everything both speakers have said. In 2016, a Bloomberg study found that discounts and rebates off of list price have not kept up with the multiple price increases of the wholesale acquisition cost (WAC). That is one reason we need a little more transparency to begin in this state. This is a little more transparency, but it is still a much lighter transparency bill than would be happening in the hospital industry, the health care industry, or the health insurance industry. We would like to see what is causing those increases to be so far above and beyond what is keeping pace with discounts and rebates because they are outgrowing us. The prices are outgrowing what the health plans can absorb.

While we have seen many bills this session about managing prescription costs by limiting copays and collapsing tiers, those are all strategies that have only been put in place to control the top of the ticket, which is the price that is set by the pharmaceutical companies. We are not in the business of being able to set those prices. We are in the business of having to absorb those prices and make sure that our members and participants and patients can get the medication that will make them better.

We are happy to see that generics have been included in the bill. We cannot see why the long-established drug prices are going up. We believe that we should know that at this point. We have one example we would like to give. We cover a drug called Subsys. We have one person using Subsys that we pay $115,000 for. They have a copay of $400 on that. We are thrilled with our copay, and we are disturbed by our cost. We have 59 drugs for which we

pay more than $10,000 per year. That total amount that we pay for those 59 drugs is almost $12 million dollars. Our copays for that were less than $23,000. We are absorbing a large percentage of the cost and cost increases. We believe that in any other field, transparency would be available to understand what that is based on.

Senate Bill 17 from California does add some of the value-based proposition that Assemblyman Oscarson asked about. It would be great to look at that bill and see if it could be built into some of this bill if there is appetite for the value side of this. Hospitals have to report a chargemaster, which has every single price that they charge in the hospital. Our industry, as you have heard, has to create a lot of documentation about medical loss ratio and what we pay for and what we make off of that. Health care is different, as Assemblywoman Joiner said. You cannot decide when you are going to be sick, and you cannot decide how to get well. You are relying on others to do that. Wholesale acquisition cost is not perfect, which I am sure the Pharmaceutical Research and Manufacturers of America representatives will talk about, but it is the top of the ticket, and it is the best place to start because nothing else has been provided by them for us to use. It is a circular argument. If not WAC, then what? Only transparency is going to help us get there. In section 3, subsection 2, we would like to make sure marketing is excluded as proprietary.

We think the marketing dollars need transparency. We would like to see generic brands added, and we would like to see clarification that specialty drugs are in the bill. The medical Consumer Price Index is trending at 5 to 6 percent. For us not to capture a drug until it goes up 25 percent, which is four times what is happening in the rest of the medical industry, is very generous. We would like to see it at 10 percent.

Barry Gold, Director, Government Relations, AARP Nevada:
Prescription drugs are a major component of health care, and they are a major cost driver. It has been said that the United States has the most expensive prescription drug prices on the planet. When a prescription drug goes up so much after it has been on the market, people want to know why. We have heard people talk about attributing these costs to research and development, but if it has been on the market so long, where does that come from? They say many prescriptions are sold because people go into the doctor and ask for it by name. That is because of marketing.

I want to talk about insurance companies for a minute. In many states, if insurance companies want to raise their premiums by more than a certain set threshold, which is set by the state, they have to justify why they want their premium to go up so much. They have to provide information as to why they are doing that to get that approved or not. There is some health care information being shared in other states about why the costs are so high. This kind of relates to that.

I want to talk about competitive market forces and how they really do not apply, because most of the drugs we are talking about do not have alternatives. I was going to talk about tires before it was brought up, but I am going to talk about tires and I am going to say that if Discount Tire decides to raise their prices on a $100 tire to $1,000, customers can say

"No thank you." They can go to Big O Tires, or Sears, or somewhere else. With prescription drugs, you cannot do that. You are forced to pay whatever the price is that they are giving. I think it is important that we consider what this market is, and the competitive market forces really do not exist as they do in other free market products. We must find a way for Nevadans to be able to get the medication that they need. On behalf of the 300,000 AARP members across the state, we urge the Committee to pass this bill.

Chairman Sprinkle:
We will now bring it back up to the north.

Chelsea Capurro, representing Health Services Coalition:
I do not want to repeat what has already been said. We will echo the comments from the other proponents, but we want to thank Assemblywoman Joiner for bringing this forward. We think this is the missing piece of the puzzle on something that we are not currently seeing transparency on. We applaud her efforts.

Regan Comis, representing Nevada Association of Health Plans; and Board of Medical Examiners:
We, too, echo the comments of those who have spoken before us, and we would like to mention again that 22 cents of every premium dollar goes towards prescription drug costs. Those rising costs have a direct impact on our premiums. We, as insurers, have to submit our formularies to the Division of Insurance annually, and those have to be approved. Once those have been approved, those prices are locked in. We cannot account for the fluctuations in the market, yet the pharmaceutical manufacturers do not have those same restrictions on them. We want to say thank you to the sponsor for bringing the bill forward, and we support the transparency in A.B. 215.

Bailey Bortolin, representing Legal Aid Center of Southern Nevada; Washoe Legal Services; Volunteer Attorneys of Rural Nevada; and Southern Nevada Senior Law Program:
We want to say, "Me, too." We see this as a positive change for our low-income and vulnerable populations. Thank you.

Jim Sullivan, representing Culinary Workers Union, Local 226:
I will not repeat what a lot of others said, but we are strongly in support of this bill. We believe the price gouging by pharmaceutical companies is out of control, and we support any bill that would address this. I would like to add for the record why this issue is so important for the Culinary Workers Union. When we negotiate contracts, we have three buckets of money. We have pension and retirement, we have wages, and then we have health care. What has happened is these health care prices have gone up dramatically, as we have heard today, 100 to 200 percent, sometimes even more. That means less money for wages and pensions for our workers. This is unacceptable for our workers. We cannot keep giving what could be wage increases to pharmaceutical companies. We strongly support this bill. It is past time for transparency in the pharmaceutical industry, and we support Assemblywoman Joiner's bill.

Chairman Sprinkle:
Is there anyone else in the south in support? [There was no one.] Is there anyone else in the north? [There was no one.] We will move to opposition.

Saiza Elayda, Director, State Policy, Pharmaceutical Research and Manufacturers of America, Washington, D.C.:
Today I am here to voice Pharmaceutical Research and Manufacturers of America's (PhRMA) opposition to A.B. 215, an act that would require pharmaceutical companies to make disclosures about pricing on certain medicines. We understand that controlling and reducing health care costs is on everyone's minds—the state, employers, and especially patients. That is why it is important that discussions on health care costs and affordability are needed. No patient should have to worry about whether they can afford health care that they need. Any approach to transparency and affordability must take a holistic approach to the entire health care continuum rather than singling out one entity. We must also ask ourselves, how will this affect patients and their families?

Legislation like A.B. 215 will not help patients in any way. Seeking information about perceived components on a medicine's price is a precursor to price controls. Last week, the Senate Committee on Health and Human Services heard such a bill, Senate Bill 265. Pharmaceutical Research and Manufacturers of America believes that price controls can jeopardize patient access to innovative treatments that can reduce overall health care spending, stifle competition, and perversely lead to higher prices. The notion that spending on medicines is the primary driver of health care cost growth is false.

QuintilesIMS recently released a report on price growth, which found that after factoring in discounts and rebates negotiated by payers and pharmaceutical benefit managers—this includes the state and private payers—net prices for brand medicines increased by 2.8 percent in 2015, a reduction from 5.1 percent in 2014. Similarly, CVS Pharmacy and Express Scripts released reports showing that actual medical spending growth in 2015 was less than half the spending in 2014. CVS recently stated that its bargaining tactics minimized growth and drug spending at 3.6 percent in the first half of 2016, down from 5 percent in 2015, and 11.8 percent in 2014.

However, we have seen out-of-pocket spending by patients for brand medicines increase over the past several years. This is due to a paradigm shift in benefit design by insurers and pharmacy benefit managers from the first-dollar coverage model to the use of prescription drug deductibles and high deductible health plans. In addition, insurers are increasingly using multitier formularies and coinsurance in those higher tiers.

Further, there is an imbalance in health insurance benefit design. On average, patients pay about 5 percent out of pocket for hospital costs, but for medicines, patients pay about 20 percent or more. Assembly Bill 215 bases its triggers for reporting on the wholesale acquisition cost. The triggers were mentioned earlier. We believe that these triggers are extraordinarily broad and would potentially apply to many medicines for which the impact on premiums of the price increase over these thresholds would essentially be de minimis and

would reflect an imperceptible change in the total cost of care. Wholesale acquisition cost price also does not reflect what purchasers, insurers and PBMs actually pay, and thus overstate the cost of medicines.

A recent report by the Amundsen Group looked at commercially assured patient prescription drug coverage and found that cost sharing for nearly 1 in 5 prescriptions for brand medicines and more than one-third of specialty medicines was based on the list price. Basing deductibles and coinsurance for medicines on the undiscounted list price effectively shifts the cost burden to the patient and unfairly penalizes sicker patients with higher spending. This is at odds with the traditional notion of insurance, which is to spread the high cost of a small share of individuals across all members of a health plan.

Assembly Bill 215 will not help patients or policy makers understand drug costs in a way that will provide true meaning. It does nothing to address how to alleviate how the cost is affecting patients' wallets such as higher premiums, higher deductibles, higher copayments and coinsurance, and loss of first-dollar coverage for medicines. Assembly Bill 215 also ignores cost savings that medicines provide to the health care system overall. The appropriate use of medicine leads to fewer physician visits, hospitalizations, surgeries, and other preventable procedures.

This legislation also ignores the built-in market realities of developing prescription medicines. In most cases, first-in-class medicines face brand-to-brand competition in less than two years and have patent expirations. Savings from the use of generic medicines is also dramatic. Assembly Bill 215 would require a report to be submitted to the Division of Insurance by a brand manufacturer. This bill calls for an advisory group to be created that would determine whether that information contained in the report would cause competitive harm to the manufacturer. However, there are no guarantees in the bill that the proprietary information would be kept confidential.

The bill also places owner requirements on brand-name prescription drug manufacturers and generates unnecessary work while expending precious resources. Innovative drug manufacturers already disclose a wide range of data on their products. Publicly traded companies make financial disclosures to the public on a quarterly basis regarding the cost for research and development, manufacturing production, and a range of other business expenses. Specific data reported by biopharmaceutical companies to the U.S. Securities and Exchange Commission include research and development expenses, including clinical development costs, costs for research and development acquired through mergers and acquisition, as well information on the research and development pipeline. The research and development costs are provided at the aggregate level and do not reflect the often substantial additional investment that predates the clinical trial phases, nor do they reflect some of the investments that may inform research across other therapeutic areas.

Aggregate data on cost of manufacturing goods produced and sold includes cost of materials that are used to manufacture the prescription drugs as well as labor and overhead costs.

Aggregate data on selling and general administrative costs are reported by the companies, which includes, but is not limited to, marketing costs, costs associated with patient assistance programs, and the Affordable Care Act prescription drug fee.

Further, a wide range of information on drug prices and sales is available through a wide range of public sources including rebate and related data at an aggregate level included in all companies' financial statements. This can also include, at an aggregate level, cash discounts and other deductibles. Average sales price paid by drugs covered by Medicare Part B is publicly reported to the Centers for Medicare and Medicaid Services. Gross sales and net sales are reported by publicly traded biopharmaceutical companies. Earnings, also called net income or profit/loss, are also reported in publicly traded companies' financial disclosure statements. Companies also publicly report information on clinical trials and related research. Companies regularly make clinical trial data available through the website clinicaltrials.gov. Clinical trials on average can take between 10 and 12 years to complete and cost about $2.6 billion for research and development on a new medicine.

Another thing to keep in mind is only 12 percent of drugs that get to the clinical trial stage actually make it to the market. That is an 88 percent failure rate. In 2015 alone, PhRMA member companies invested $58.8 billion in research and development. Assembly Bill 215 fails to recognize the numerous stakeholders involved and the process of manufacturing, storing, shipping, and dispensing prescription medicines. Discussions on transparency and affordability of health care should take a holistic, not siloed, approach.

Pharmaceutical Research and Manufacturers of America is willing to work with policy makers to look at ways to promote value-driven health care, engage and empower consumers, and address market distortions. Any solution that addresses transparency and affordability must keep the patients and their families in mind. We must ask ourselves: Is the patient positively being benefited from this proposed solution? Are the patient and his family being given data that will help them make informed decisions about their health care choices? For these reasons, and those submitted in our written testimony (Exhibit C), we ask that you please consider opposing A.B. 215.

Chairman Sprinkle:
Thank you. I did give you a little extra time because of whom you are representing. I will also allow the Committee to ask you questions.

Assemblyman Thompson:
I am looking at the goals and missions on your website. It is very extensive and impressive. It talks about advocacy and all of those things. I like to compromise and meet in the middle. I know you are coming in opposition, but is PhRMA willing to meet this legislation in the middle? Many of the things that you say are things that are resonated in A.B. 215. I wonder if you can answer to that.

Saiza Elayda:
We are willing to come to the table and discuss compromises, but we feel that we also must be able to protect our member companies' information on how they develop and create their product. We also think that anything that is proposed on transparency and affordability does have meaning to a consumer. How many people are going to comb through these reports? There was a statistic in a *Health Affairs* article last year saying that, on average, people take 4 1/2 minutes to choose their health care plan. That is for their insurance. Most of the time, they are looking at if their provider is in the network and whether their drugs are covered. Sometimes that information is difficult to find. A lot of times, they look at what is the most affordable option. I really do not see how having a huge disclosure such as this is going to help the consumer understand and pick a health plan that works best for them.

Assemblyman Thompson:
I do not think we can underestimate the people who are looking at these medicines. Some of these medicines are life-saving medicines. If they do not understand it, they will find out from advocates in the community how to understand it. I think that transparency part is key.

Assemblyman Carrillo:
If bill reports were based on net prices, would you be willing to submit that information?

Saiza Elayda:
I cannot answer that question at the moment. That is something I would have to discuss with the members of our association to see their comfort level on net prices. I know that companies do release the aggregate rebates they give to payers.

Assemblyman Carrillo:
After you talk to those people, would you be willing to submit that to the Committee?

Saiza Elayda:
I will discuss it with them and come back to you.

Assemblyman Carrillo:
If much of this information was already submitted in a bunch of different places, would you submit it so that it is consolidated?

Saiza Elayda:
We would be happy to work with you to figure out a method in which to consolidate this information, so it is easily found in a single place where consumers and policy makers can access that.

Assemblyman McCurdy:
Prior to you coming today, did you have an opportunity to speak with the sponsor about suggestions or ways to improve this bill?

Saiza Elayda:
We did speak with Assemblywoman Joiner on a couple of occasions to discuss our concerns with the bill.

Assemblyman McCurdy:
Did you come up with any solutions or bring possible ideas to help strengthen and build the bill or allow the bill to remain?

Saiza Elayda:
We brought a couple of suggestions to the table regarding reporting things on the aggregate, which would help to protect privacy and proprietary data disclosures. We were trying to work out what a trigger could look like. If the intent was to find those bad actors, then the thresholds here really would take many prescription medications, especially with the 25 percent increase. You have many low-cost drugs that might have a 25 percent increase—that is just cents—but it would be swept into the reporting structure of this.

Assemblyman McCurdy:
So if some of those were considered within the bill, would you be in support?

Saiza Elayda:
We are definitely willing to be at the table and discuss what are the best transparency options that could inform patients and help them understand their health care spending.

Chairman Sprinkle:
I appreciate your putting in the extra time and taking those questions. There will not be any more questions of those testifying and once again, I ask those testifying to keep your remarks short.

Brenda L. Gleason, President, M2 Health Care Consulting, representing Pfizer Inc.:
Pfizer is a research-based global pharmaceutical company dedicated to the discovery and development of innovative medicines and treatments that improve the quality of life for people around the world. Rising health care costs are a concern for everyone. There was a big headline in the fall on CNN about rising health care costs being the highest in 32 years. Today we are talking about a very narrow piece of the puzzle, which is about transparency related to pharmaceuticals and even a very narrow piece of pharmaceuticals. I would encourage all of us really to think about whether or not this bill solves the problem, if the problem is rising health care costs or if the problem is rising prescription drug costs.

Part of the reason that we are offering opposition today is that this legislation will not fix the problem in front of us. Patients are paying more for their health care costs, not only pharmaceuticals. The testimony before me specifically addressed pharmaceuticals and how patients are being subjected to much higher deductibles and copays. In fact, for an average inpatient hospital visit, a patient only has to pay about 4 percent cost-sharing, but for pharmaceuticals, they have to pay about a 20 percent cost-sharing. This is in part because

health plans and employers are the primary payers outside the government (we will hold Medicare and Medicaid aside for the moment). Most patients do not pay directly for any of these services.

We have been talking a lot about tires today. Part of the reason tires are not an apt metaphor is because most of us buy our own tires, but most of us do not buy our own health insurance. There are very sophisticated players at the table, including health plans, negotiating with pharmaceutical companies, and patients are left to their own devices to find the underlying cause of this. When I hear stories where someone could not get access to a drug, it always makes me wonder exactly what insurance they had. If you are on Medicaid, you are guaranteed access to that drug for a very low price. If you are uninsured or indigent, the pharmaceutical company will give that drug to you. It is only if you have an employer-sponsored plan, if your union covers you, or if you buy insurance in the open market that you can be exposed to these very high cost-sharing amounts. I would just encourage all of us to think about this. The health plans told you all of the information they have to report, and we have not seen that reduce premiums.

Transparency, in this case, is not necessarily the answer to the problem. I would also encourage us to think about the fact that the health care system has really changed and that a lot of spending now happens in a given disease area for pharmaceuticals and not for surgery, for instance. We do not think about generic brain surgeons, but this is the only part of the system where prices do go down, because you have generic drugs.

George Ross, representing Biotechnology Innovation Organization, Washington, D.C.:
We are completely in agreement with everything the two ladies to my right have said. This bill will do nothing to lower prices. There is a bill that some of you will vote on, Assembly Bill 245, which has to do with enabling pharmacists in Nevada. As a body, a committee, and as a state, we have to decide how we care about health. What you really have here is a situation where the evolutions of many of the drugs you are talking about are those that are very expensive to research. As you have heard, they have a very high failure rate, and all of that has to be covered by the successes. At the same time, the successes apply because of the nature of research, which is very specific and very focused on certain problems. The market for any one drug is small. For that drug, you have only a relatively small market. You have to recover those costs on a small number of people—not only the costs associated with that drug, but the cost of all of the failures as well.

If any of you have been involved in finance, you also know that when you are looking at a capital investment, you take into account the time value of money. When you have 15 years from the beginning of an idea to the product coming to market, the money you are getting 15 years down the road is way less than it was worth when you first started that project. I know that is nothing you want to hear. The reality is, you have a lot of companies who are making very specialized, highly technical products that cost a great deal to develop, make, transport, and to store that do add years to people's lives, save lives, and make people's lives far better than we could ever have done 20 years ago. I think it is important that we balance the costs with the processes. This is all a function of planned design. This is not

a one-source issue. Every single person in this building who has to pay more for his or her drugs is paying that amount because of the design of their plan.

We are not opposed to a compromise that would be mutually beneficial. We wish this would not have been brought, but we understand why it was brought. We understand this is a big problem, which we all face. We are willing to talk with the sponsor, but we have been working with PhRMA on this.

Chairman Sprinkle:
Is there anyone else in opposition to this bill? [There was no one.] Is there anyone neutral to this bill? [There was no one.]

Assemblywoman Joiner:
I am trying not to be offended, as a consumer, about the comments that were made about the intelligence of the public relating to how long we take to read things. I really think we deserve to know more about why pharmaceuticals cost as much as they do when it is a matter of life and death. Thank you to Assemblyman McCurdy and Assemblyman Thompson for asking if PhRMA is willing to come to the table. Their responses gave me hope that they are. We did meet at the beginning of session. The last I heard, they were going to check with their attorneys and get back to me on any amendments. I have not received any, but I hope that moving forward in this process that we can come to compromises on information that they are willing to provide to the public to give the public more information about these costs. The deterrent effect for these bad actors is part of the bill, but I truly do not want to vilify the rest of the industry. I am hoping we can come to some sort of conclusion on that.

[(Exhibit D) and (Exhibit E) were submitted but not discussed.]

Chairman Sprinkle:
It goes without saying that we have a deadline coming up. If people are going to be reaching out to you, they need to do so soon. I would highly recommend they do. I will close the hearing on A.B. 215. I am taking bills out of order. We will now hear Assembly Bill 474.

Assembly Bill 474: Makes various changes relating to drug overdoses and prescribing and using drugs. (BDR 40-1102)

Michael J. Willden, Chief of Staff, Office of the Governor:
We are here today to present Assembly Bill 474. We call it the Governor's Prescription Drug Bill. This is the second time in the last two sessions that we have brought forth a prescription drug bill. I want to spend a little bit of time giving you history on how we got here, and then I will turn it over to Elyse Monroy and Dr. John DiMuro to go through the details of the bill.

We started this journey back in 2014 when we became part of the National Governors Association Policy Academy on Prescription Drug Abuse Prevention. At that time, Governor Sandoval chaired the Academy process, and we were selected into what we call the second academy of seven or eight states to look at prescription drug abuse. We spent a great

deal of time during 2014 with those seven or eight other states looking at several issues. We had several meetings throughout the state, and we came up with a plan to move forward based on several recommendations from there.

Part of that process was bringing legislation to the 2015 Legislature, Senate Bill 459 of the 78th Session. That included things such as the Good Samaritan laws, naloxone (NARCAN) programs and availability, continuing education for prescribers and dispensers, and issues related to the prescription drug monitoring program. We thought things were going well after passage of that bill. If you recall, in the spring of 2016, we had a very significant drug event here in Nevada. That forced us to refocus on the issue.

In June 2016, the Governor called a planning meeting together to examine the crisis that was going on at that time and to review progress made through S.B. 459 of the 78th Session. Chairman Sprinkle, you were a member of that committee and remember some of the work we did. In late August 2016, the Governor convened a prevention summit at the MGM Grand Hotel in Las Vegas. Many of you know that we had over 500 attendees at that meeting, including Secretary Tom Vilsack from the U.S. Department of Agriculture, who was the Obama Administration's point man on drugs and opioids, as well as many other folks. There were many recommendations that came out of the committee, and part of that resulted in the bill that you are going to see today.

I want to give thanks. I spent a lot of time drafting legislation to bring to the Legislature, and I want to say thanks to the licensing boards here today. They have spent a lot of quality time with us, and they really came to the table. In fact, they brought the first draft forward. We have been working off that first draft ever since. We want to thank Elyse Monroy, our policy analyst, who worked on this with Dr. DiMuro and staff from the Department of Health and Human Services. I will now turn it over to Ms. Monroy to run through the highlights of the bill, and Dr. DiMuro will go through some of the technical details. I will be available.

Elyse Monroy, Policy Analyst, Office of the Governor:
I serve as the Health and Human Services Policy Analyst in the Office of the Governor. I have had the pleasure of working on the Governor's Prescription Drug Abuse Prevention Initiative since 2015. I am here today to present Assembly Bill 474, the Governor's Controlled Substance Abuse Prevention Act. This is a priority bill for the Governor. With me at the table is Dr. John DiMuro, Chief Medical Officer for the Division of Public and Behavioral Health (DPBH), Department of Health and Human Services.

Opioid and prescription drug abuse continues to be a growing problem in the Silver State. The Governor's Office has provided a data sheet infographic (Exhibit F) with facts about the problem for your review. Again, in 2016 the Governor held the Prescription Drug Abuse Prevention Summit in order to identify and highlight areas in which Nevada must improve efforts to reduce and eliminate prescription drug abuse and overdose. During the summit and the planning meeting, we heard poignant and heartbreaking stories from people whose opioid addiction started with a legitimate pain prescription. The Centers for Disease Control and Prevention (CDC) tell us that, of people who are the most at risk for prescription drug abuse,

15 percent report buying their prescription drugs from a drug dealer; 27 percent report receiving them from their own doctor's prescription; 26 percent report getting them for free from a friend or relative; and 23 percent report buying them from a friend or relative. Abuse, misuse, and diversion of prescription drugs are still very real problems, and they need to be addressed.

The Governor's Controlled Substance Abuse Prevention Act before you today was developed through review of the summit recommendations (Exhibit G); review of literature and state best practices and lessons learned; it was also developed in collaboration with Department of Health and Human Services subject matter experts, various stakeholder groups, and with the state's occupational licensing boards. This is a comprehensive measure that addresses six main areas: prescriber education, prescribing practices, occupational licensing boards, data collection, the prescription drug monitoring program, and deterrents for criminal activity.

The Governor's Office has provided the Committee a section-by-section breakdown of the bill (Exhibit H). For the sake of time, rather than walking through each of the 64 sections, I will give a concise overview of the major provisions of the bill. After that, Dr. DiMuro will walk you through the prescribing protocols in depth, as this is the core of the bill.

First, A.B. 474 amends the trafficking in controlled substances statute to allow for gram amount aggregation over the course of law enforcement's investigation into illicit pill trafficking. During the summit planning meeting, Clark County District Attorney Steven Wolfson pointed out that the current threshold amounts in statute do not allow for the state's prosecution of large-scale drug trafficking operations. Under the statute as it currently reads, someone would need to have approximately 350 pills at one time to meet the threshold amount for prosecution. Law enforcement has found that those who are engaged in criminal pill trafficking buy and sell the drugs in much smaller quantities over the course of days, weeks, or months. So, at any one time a suspect can only have a handful of pills on them but be responsible for pushing thousands of pills on to the streets. By allowing for gram aggregation over the course of an investigation, A.B. 474 enhances law enforcement's efforts to effectively pursue and prosecute criminal pill trafficking.

This bill makes the collection of data specific to overdose and suspected overdose permanent. Currently, *Nevada Revised Statutes* (NRS) Chapter 441A, Infectious Diseases; Toxic Agents, is used to capture diseases and illnesses that are of public health importance. In the past, this has typically been related to communicable diseases and infections related to biological, chemical, and radiologic events. As has been clearly shown, the opioid epidemic is truly of public health importance in Nevada. The use of opioids is causing ongoing morbidity and addiction issues and death for our residents. The Division of Public and Behavioral Health already reviews suspected overdose data from hospital discharge billing claims. Some of this data is shown on the data sheet you have been provided (Exhibit F). This is already identifiable data, but it has such a delay that an immediate public health response is not possible. This bill would allow for more immediate analysis and response and an ability to target timely interventions.

Within regulation, DPBH would specify the method of reporting, what would constitute a suspected overdose, and the variables to be reported. There was an amendment submitted right before the hearing. The amendment would instead imbed the overdose reporting under the Miscellaneous Diseases statutes in NRS Chapter 441A instead of the Infectious Diseases statutes. It would also move the data reporting from the local health districts to the state. Again, that is a friendly amendment from the Division of Public and Behavioral Health (Exhibit I).

Assembly Bill 474 includes language to require licensing boards to adopt mandatory continuing education requirements for prescribers of controlled substances. This bill makes the permissive language mandatory and increases the requirement from one hour per license year to two hours per license year. This increase came at the request of the prescribers when we were drafting the bill.

Next, this bill adds information to be included on prescriptions for controlled substances. These changes are needed for the prescribing protocol initiative to be implemented. Pharmacies will need to collect additional data points, including the specific number of days a prescription is to be used and specific diagnosis codes.

This bill also makes changes to the prescription drug monitoring program (PDMP). The bill expands PDMP access to paramedics. This bill also clarifies that licensing boards have access to the PDMP to review and investigate notifications of inappropriate prescribing. This bill clarifies that the State Board of Pharmacy can use the PDMP to monitor prescribers' prescribing practices, and it requires the State Board of Pharmacy to notify the appropriate licensing board when they have identified unusually high or otherwise inappropriate prescribing. This bill also requires a prescriber to show proof of enrollment in the PDMP in order to renew or receive their controlled substance license.

While the State Board of Pharmacy has seen a sharp increase in the number of prescribers enrolled in the system since the passage of Senate Bill 459 of the 78th Session—from 16 percent of prescribers enrolled to 81 percent of prescribers enrolled—there are still prescribers of controlled substances who have not signed up for the system. By requiring proof of enrollment in the system before prescribers receive their controlled substance license, we can ensure all prescribers at least have access to the system before being given permission to prescribe controlled substances.

Next, A.B. 474 requires occupational licensing boards to ensure Nevada has a system for the identification and a remedy of inappropriate prescribing. Under this measure, licensing boards are now required to take action when they receive a report of potential inappropriate prescribing. This bill allows for the administrative review and dismissal of inappropriate prescribing notifications.

Additionally, this bill allows for the summary suspension of a controlled substance license if inappropriate prescribing is taking place and is deemed an immediate patient or public safety risk. Please note there is also an amendment from the Nevada State Medical Association to

change the number of days in which a licensing board can render a decision regarding summary suspension (Exhibit J). This change aligns the language in A.B. 474 with the current language in NRS Chapter 630. With these changes, we are placing the responsibility of identifying inappropriate prescribing on the state's licensing boards.

During the summit planning meeting, the Governor's Office was surprised to hear that, while all occupational licensing boards had been receiving unsolicited reports on high or otherwise inappropriate prescribing, only some of the boards were taking action on these reports. We worked with the boards to understand their processes for communicating with their licensees and investigations. Allowing for the administrative review of the controlled substances complaints makes the complaints actionable without complicating their investigations process.

If there are questions, Paul Edwards, general counsel for the State Board of Pharmacy, can provide additional information. There are also members of the licensing boards in the audience. Due to the time constraints of today's hearing, we have had to prioritize sections of this bill for discussion. This is a key component in the state's fight against prescription drug abuse, so if there are any additional questions or any of the members need additional information about these sections, we can provide that. We would like to make sure the record reflects our appreciation for the licensing boards. We worked hand in hand with the State Board of Pharmacy in drafting this bill. They were incredibly helpful throughout this process. Again, a portion of this bill was originally from the boards. We appreciate the boards' engagement in the process while we worked with them to create a bill that created a system for the identification and remedy of inappropriate prescribing in a way that supported the boards' processes for working with licensees.

Finally, this bill establishes mandatory prescribing protocols for prescribers who are treating pain with controlled substances, schedules II, III, and IV drugs. These protocols are being proposed in NRS Chapter 639, the statutes that govern the Nevada State Board of Pharmacy. This bill requires all licensed prescribers to follow the prescribing protocols when prescribing controlled substances for the treatment of pain. This bill requires all licensing boards to enforce the prescribing protocols established in NRS Chapter 639.

This is the core of the Governor's Controlled Substance Abuse Prevention Act. Nevada's approach to addressing the prescription drug abuse epidemic is to preserve individual patient treatment and recalibrate the standard of care for the treatment of pain and prescribing of controlled substances. These mandated protocols ensure patient safety and seek to end misuse, abuse, and diversion of addictive prescribed controlled substances. These prescribing protocols place the responsibility of identifying patient misuse, abuse, and diversion on the prescriber. The prescribing protocols before you today are a product of months of hard work and complex conversations about prescribing, pain management, behavioral health, addiction, and patient care with prescribers in Nevada.

We appreciate the time that prescribers and leaders of their trade associations took to help us create prescribing protocols that are meaningful, reasonable, and implementable. These

protocols are accomplished through an initiative we are calling "Prescribe 365" which ensures that no patient receives more than 365 days of controlled substances in a 365-day period. There are two limits on prescriptions contained in this bill; they are the 365-day limit, and a 14-day limit on an initial prescription for acute pain. Many states have established limits for acute pain prescriptions. Nevada's limit appears to be much more liberal than the three-, five-, or seven-day limits many states have enacted. This is because of Nevada's access to care issues. I am going to hand it over to Dr. DiMuro to walk through the prescribing protocols.

John DiMuro, Chief Medical Officer, Division of Public and Behavioral Health, Department of Health and Human Services:

I am the State of Nevada Chief Medical Officer, and I am board certified in anesthesiology and pain medicine. This bill recognizes that the significant majority of prescribers treat patients within their scope of practice. The spirit of this bill is Nevada's unique approach to protect public health while not interfering with the practice of medicine. This novel approach was created after holding a government-sponsored national opioid summit and multiple engagements with stakeholders for the past few months. Despite the significant amount of resources dedicated to this issue, combined with the increasing media exposure, the statistics are worsening in Nevada. We have seen a 46 percent increase in inpatient admissions for opioid-related hospitalizations in the last year.

In developing the prescriber protocols, we recognized the importance of prioritizing patient safety while upholding the integrity of the patient-prescriber relationship. These protocols require prescribers to adhere to a standard of care, which includes the application of clinical judgment in the prescribing of controlled substances for the treatment of pain. To develop commonsense measures that would account for the complexity in the management of pain across populations and minimize the risk associated with the use of controlled substances for the treatment of pain, we reviewed available research literature, evaluated consensus guidelines established by subject matter experts, assessed the impact of policy decisions in other states, and engaged the provider community in extensive discussions. Prescription drug misuse, abuse, diversion, and risk for adverse events, including overdose, present unique challenges for prescribers and patients alike. The complexity of management of pain using controlled substances and the mitigation of risk from such medications require a multitude of evidence based interventions. We must recognize the limitations of each intervention, acknowledging that it is the cumulative impact of multiple efforts that have the best chance of keeping patients safe and empowering prescribers to practice within a standard of care.

The prescribing protocols in this bill establish standards of care from the initiation of prescription of a controlled substance for pain through ongoing prescribing for long-term management.

Please refer to the handout (Exhibit H) which details the Prescribe 365 provider requirements as I detail the key components of the prescribing protocol as outlined in this bill. These minimal standards were designed to protect both the public and the prescriber. Prior to an initial prescription, a provider must check the PDMP to ensure they have a full record of the

patient's current and past prescriptions for controlled substances. The PDMP review is a well-established clinical practice aimed at providing prescribers with the crucial piece of the information they need to make prescribing decisions.

Assembly Bill 474 revises provisions established in S. B. 459 of the 78th Session. First, this bill closes a small but critical loophole that was left in S.B. 459 of the 78th Session by mandating the PDMP check on all initial prescriptions regardless of duration. Next, we have revised the definition of "initial prescription" to ensure that patients do not experience a disruption in their treatment plan when they are referred to another prescriber for ongoing care. Previously, prescriptions of less than seven days did not require a review of the PDMP, as we have now realized this poor practice helped contribute to drug diversion.

This bill also limits initial prescriptions of a controlled substance for pain in both duration and initial dosage. Over the past year, nine states enacted similar regulations and at least seven additional states have similar limits under consideration through legislation. Assembly Bill 474 limits initial prescriptions to 14 days and to no more than 90 morphine milligram equivalents daily. Unlike other states that limit initial prescriptions to 5 to 7 days, we chose a maximum of 14 days to account for known logistical constraints related to access to care issues in Nevada. This is proactive in ensuring this limit would be reasonably implemented, as our dosing ceiling is higher than the norm.

If the controlled substance prescribed is an opioid, we established the maximum morphine milligram equivalents to 90 morphine milligram equivalents for patients who are not nor were recently issued an opioid prescription. This standard of care allows for a continuity of care for patients who may currently be prescribed opioids while establishing a maximum daily dosage for opiate-naïve patients. This maintains the prescriber's ability to prescribe based on individual patient history and need, and in no way prohibits patients from receiving the care they require.

Protecting both the public and prescribers by identifying and mitigating risk remains of the utmost importance when evaluating factors that may compromise patients' ability to safely and effectively to use controlled substances for pain.

In addition to the PDMP check, we believe it is important for prescribers to have the most current and detailed information they need to make clinical prescribing decisions. Prior to prescribing, A.B. 474 requires prescribers to assess patient risk factors through medical history, physical exam, and a good faith effort to obtain and review medical records, as well as a risk assessment measure. Patients have a right to be active participants in determining the course of their care. Written informed consent provides patients with information needed to understand the risks and benefits associated with taking a controlled substance for pain; the proper use of their prescription and alternative treatments for pain, and their plan of treatment, risks of dependency, addiction and overdose, safe storage, and provider expectations.

Once treatment has been established, if a patient and prescriber agree that pain management with controlled substances will exceed 30 days, a medication agreement is required to be completed, and these are already commonplace in medical practice. Medication agreements go beyond the information contained in written informed consent. They delineate goals of the treatment, consent for testing to monitor compliance when medically necessary, requirements of information-sharing between prescriber and patient, and reasons when a practitioner may change or discontinue a course of treatment. Medication agreements must be updated annually or whenever there are changes made to the patient's treatment plan. The intent of the changes to the medication agreements is to ensure they are updated when the goals of treatment change.

If changes to medications and goals of those changes are clearly detailed within the treatment plan, medication agreements do not need to be updated with every medication change. The intent behind requiring updates to the medication agreements is to ensure they are aligned with treatment plans when the goals of treatment change. For example, a patient may have developed a heart condition or engaged in more risky behaviors since their last update. We would want that documented. The Division of Public and Behavioral Health is committed to stakeholders, offering sample medication agreement forms, and informed-consent forms that can be incorporated into prescribers' practices. We would like to create similar templates for palliative and hospice care providers as well.

Assembly Bill 474 establishes additional protocols prior to prescribing controlled substances for the treatment of pain of a patient who has used a controlled substance for 90 consecutive days or more. The 90-day visit must be in person or through telehealth and include, at a minimum, an assessment of risk, a PDMP review, and a review of the treatment plan. A prescriber must also conduct an evaluation of the patient to determine an evidence based diagnosis for the cause of the pain prior to prescribing controlled substances for pain beyond 90 days. It is no longer acceptable to continue to prescribe controlled substances for merely a diagnosis of back pain. Patients with back pain can have a fracture, a bleed, or even worse, a malignancy. This is why we require the pursuit of an evidence based diagnosis in our bill. The treatment plan must then be updated annually or, as previously stated, when there is a change in the course of the patient's care. These provisions, taken together, are a reasonable plan to improve Nevada's safety related to controlled substances.

The creation of this bill was not taken from a "what is every other state doing" perspective. This bill is intended to protect the public health of our residents while preserving the patient-provider relationship. We feel that this bill provides a rational and commonsense approach to combating the prescription drug epidemic in our state.

Chairman Sprinkle:
Thank you for that presentation. I know I asked a lot of you with the short amount of time that we have. I think you did a good job getting through a rather large bill. Thank you very much for that. I will now allow questions from the Committee.

Assemblyman Yeager:
I had a question on section 12 of the bill, which was essentially changing the definition of trafficking prosecutions in a way that allows investigating agencies to aggregate amounts of pills. My recollection was that there was a bill similar to this last session that moved through the Legislature, but ultimately was not enacted. My concern on this section is I do not want us to be in a position where we are doing anything other than making appropriate arrests as quickly as possible, rather than having a situation where an investigating agency could hold off on making an arrest to see if they could get more pills. Would you be willing to work on that section, perhaps put some kind of time frames in? As it is written right now, it seems to be open-ended where an investigation could go on for weeks, months, or years.

Elyse Monroy:
I absolutely think that we would be willing to continue conversations around that section. I know we will probably hear later that there are some concerns about this section specifically. If there is anything we can do to tighten up the language, I think we would be amenable to that. Again, we just wanted to respond to the Clark County District Attorney's concern that the state at this point cannot prosecute large-scale pill trafficking situations. This was our response, but if the language could be tighter, I would be happy to work with you or any other stakeholders who would like to do that.

Assemblywoman Titus:
I have several questions, and I will stick to the actual bill, although I have a lot of thoughts. In section 8 the text states "for human consumption only." Is there any record or documentation of other professionals such as veterinarians prescribing medication? Do we keep track of that at all?

J. David Wuest, Deputy Secretary, State Board of Pharmacy:
That data can be input into the PDMP. It is not mandated because they are for animals, but we do see that data, and it is used from time to time. It is not so much veterinarians prescribing for people, but unfortunately, we do see some owners get controlled substances for the dog, but they are using it themselves. Those cases are referred to law enforcement.

Assemblywoman Titus:
Thank you. Section 9 allows the paramedics to be certified. Last session there were hundreds of hours of debate over Senate Bill 459 of the 78th Session. I do not want to go back there because we need to go forward. There was a lot of debate on law enforcement access to this because the argument was that in certain cases they needed that information once they were filing complaints. There is a strong limit to who can access that in law enforcement. Would this allow all paramedics access? There is a difference between a paramedic, an emergency medical technician (EMT) II and an EMT I. Is it strictly related to licensed paramedics and not emergency responders? Does anybody with that license apply and then have access to it? Their need to know is in a moment, but now that they are allowed to carry naloxone and some reversible drugs, will they need access? Part of the protocol is to give it if someone is unconscious and you do not know why. I am worried about the time. Is this going to make a difference? Can you explain the addition of the paramedics?

Elyse Monroy:
I will answer the policy questions behind this and then Dr. DiMuro has thoughts on administering naloxone. As the bill is written, we would be expanding access to the PDMP, the prescription drug monitoring program, to paramedics. It allows paramedics to check the system; it does not require them to check the system. We understand that time may be a factor when a paramedic is on the scene, but we also acknowledge that the information that is housed and kept in the prescription drug monitoring program could be an absolutely vital tool in making the differential diagnosis. That was our policy decision behind expanding access to paramedics. We also had support from state emergency medical services for that.

John DiMuro:
Chairman Sprinkle might have some input in this as well. The idea is why would we want to withhold any information from those who provide emergency services? We do not want to see adverse side effects from repeated administrations of antidotes like NARCAN if the patient has a benzodiazepine overdose or a sleeping pill overdose. Obviously, NARCAN can cause some significant issues in and of itself. The idea here was to provide those emergency responders with access, if desired, to the necessary data.

Assemblywoman Titus:
Just another clarification for the record. Folks in my neighborhood, and many other folks out there, will call any first responder a paramedic. There is clearly a difference in licensure. You are really limiting this to a paramedic, not an EMT II or first responder.

John DiMuro:
Yes.

Assemblywoman Titus:
You are mentioning protocols for the prescription medication. You and I know that in our careers, protocols change constantly. There is new research that comes out that changes the protocol. That is why we sit here today. Years ago, when these first came out, we thought these were wonderful drugs. Now we recognize there is a problem. Now we are establishing new protocols. Is there any thought about how often these protocols are reviewed? We are going on current protocols. What happens in a year when we say these are too restrictive? Is there anything in here that would establish without having to come back to us, that these protocols can be adjusted?

Elyse Monroy:
As the bill is written, it requires all of the occupational licensing boards to enforce sections 52 through 58. If we look at section 58, this allows the State Board of Pharmacy to adopt any regulations necessary or convenient to enforce the provisions. If we need to change or further flesh out the prescribing protocols here, the State Board of Pharmacy has the ability to do that.

Chairman Sprinkle:
In section 9, you touched on this a little, but could you describe to me what a scene would look like where this would be a benefit to the paramedic?

Elyse Monroy:
I am not sure how to answer that question. You could probably answer it better than I could. I am not a paramedic; I do not rush to scenes of these incidents. Again, this does not require a paramedic to check the system; it just gives them access to it. We think it is a vital tool in making that differential diagnosis if there is time. I understand that time is definitely a factor, but it might not always be. We just thought that giving them access to the system in making that diagnosis would be a tool.

Chairman Sprinkle:
As I have said to both of you in the past, in my experience, it would be very impractical for us to do this in the middle of an emergency call. It is almost impossible to the point where we would not even think about it. Will this now require all paramedics to sign up and register with the PDMP?

Elyse Monroy:
I might have to ask for backup on this. As written, the bill currently says they may have access. I do not think that would require a paramedic to sign up for the system.

S. Paul Edwards, General Counsel, State Board of Pharmacy:
No, the intent is not for all of the paramedics to have to sign up to have their own access. We may need to add a little bit of language to clarify exactly how they would be given that access. I would imagine we would follow some kind of model similar to what we did for law enforcement in the last session where specific people can be designated. Their supervisors have to sign off on it, and there is an annual renewal. Those are things that could be done as part of this bill, or it may be appropriate to have this done by the State Board of Pharmacy through regulation, but the model would be what is in place for law enforcement.

Chairman Sprinkle:
If this becomes an option for paramedics, and they do not do this, are they now liable for not having checked?

Paul Edwards:
I do not think there would automatically be liability there; however, it may be advisable to add language that says regardless of whether they check, they have some level of immunity. There is existing language in the bill that creates that for prescribers for occupational licensing boards saying that if they are acting in good faith to do their jobs, they will not be liable. If paramedics were given that level of access, something similar to that would be a good idea.

Chairman Sprinkle:
I would agree with you. This is all based off my interpretation as a paramedic that we would not be using this anyway. Under section 56, subsection 2(f), how is the prescriber going to do random checks of the amount of prescriptions in possession of the patient?

John DiMuro:
It is very common practice that the patient is told to come in and bring all of their pill bottles with them. As a subspecialist in pain medicine, I can say it is very common to make patients bring their prescriptions in each time. We put the pills on the counter, and they are counted. Typically, if the patient was coming in for 90-day visits if they are chronic, they would bring in their prescriptions. When you count the pills and check the PDMP, it should come out to an appropriate number. It is a very common practice.

Chairman Sprinkle:
Is there anyone who wishes to come forward in support of this bill? I am not seeing anyone in southern Nevada; we will start in the north.

Susan Fisher, representing State Board of Osteopathic Medicine:
We thank the Governor's Office and his staff for reaching out to us and getting our input on this important piece of legislation. We do not yet have a formal position on it because of the open meeting law requirements; our meeting is next week. We will have a formal position next week. I am authorized to tell you that our board president, Dr. Ronald Hedger, has asked me to let you know that he supports this bill on a personal basis. He encourages passage of this legislation, and if there are any resulting changes from this process, we look forward to working with the Governor's Office.

Cathy Dinauer, Executive Director, State Board of Nursing:
I am here to voice support for A.B. 474. Currently, the State Board of Nursing licenses over 1600 advanced practice registered nurses (APRNs). Of that, 1400 can prescribe controlled substances. We do believe that this will be an additional mechanism to monitor the prescribing processes and practices of our nurse practitioners.

Michael Hillerby, representing State Board of Nursing; and State Board of Pharmacy:
We submitted an exhibit to you (Exhibit K). One of the things that S.B. 459 of the 78th Session did was to require all practitioners to register with the PDMP. It was a little less than clear; this gives you an example of what some of the boards went through. I am happy to say that if you look at the last arrow on the bottom right, all of the APRNs who are eligible to prescribe controlled substances in Nevada are registered with the PDMP. We are at 100 percent compliance. The good news is that, because of the language in section 11 that will now require that before getting your controlled substance registration, you will not see a graph that is quite that complicated in the future. It will be much easier for all of the boards to be sure. We would like to state officially both boards' support for the bill. We appreciate the process that all of the boards went through together with the Governor's Office and everyone else who participated, including legislators, the Drug Abuse Prevention Task Force, and the summit members.

Liz MacMenamin, Vice President of Government Affairs, Retail Association of Nevada:
I am also representing the chain drug committee within the Retail Association of Nevada. I appreciate and thank the Governor's Office for this legislation. I have been personally involved since 2008, when Join Together Northern Nevada brought me on board and asked me to participate and look at the problem that we had in the state of Nevada with prescription drug abuse. We have been part of the conversations; the Governor's Office has included us. I appreciate the work they have done. Elyse Monroy and Dr. DiMuro have done a wonderful job of bringing this legislation forward. I do have some questions about the paramedics, though I have no position on that issue. I always have concerns about having access to the PDMP because of the many laws we have. I came forward a few sessions ago, and I just hope that there are things in place that make sure this information is used in a good way, and not in a way that could be problematic. I thank you, and I urge passage of this legislation.

William Horne, representing Board of Dental Examiners of Nevada:
I am here to echo our support for A.B. 474. We appreciate the Governor's Office in working with the Board of Dental Examiners of Nevada, particularly on the PDMP language. I will not be redundant in offering support.

George Ross, representing Comprehensive Cancer Centers of Nevada:
We support this very important bill, and we especially want to thank the Governor's staff, the Chief Medical Officer, and his staff for meeting with us and taking into account the unique situation regarding those who treat cancer and their use of pain medicine in a different way than most of the rest of the medical community. That has been taken into account, and we very much appreciate that.

John T. Jones, Jr., Chief Deputy District Attorney and Legislative Liaison, Office of the District Attorney, Clark County; and representing Nevada District Attorneys Association:
I am here on behalf of both the Nevada District Attorney's Association and the Clark County District Attorney's Office. We want to thank the Governor's Office for working with us in the crafting of this bill. We want to say that we support the Governor's multipronged approach to tackle this problem. We did specifically want to state our support for section 12, which does provide for some increased flexibility for district attorneys and how we charge those who are violating the trafficking laws with respect to controlled substances. With respect to Assemblyman Yeager's question earlier, we are obviously willing to work with you on any issues that you have with section 12.

Chairman Sprinkle:
Please do reach out to him.

Nick Vander Poel, representing Nevada Osteopathic Medical Association:
Dr. Bruce Fong, the president was unable to attend, but I submitted his testimony (Exhibit L). Specifically, we are here to speak in favor of the measure. The one part of the testimony that is critical is to address opioid prices in our state. This bill was carefully crafted, based upon review of other state regulations, but with a very careful review of what is medically prudent

to properly and safely treat and monitor the patient while preserving the all-important need to be able to continue to maintain the autonomy of the physician based on his or her patient's need. That is maintaining the physician-patient relationship. This is a step in the right direction, and I appreciate your time.

Regan Comis, representing Nevada Association of Health Plans; and Board of Medical Examiners:
We would like to thank the Governor and his staff for including us in this process, and we are happy to support the bill.

Corey Solferino, Sergeant, Legislative Liaison, Washoe County Sheriff's Office:
We support this legislation, and I would like to reach out personally to Assemblyman Yeager and sit down to answer any questions he has on the law enforcement side of the issue. Thank you.

A.J. Delap, Government Liaison, Office of Intergovernmental Services, Las Vegas Metropolitan Police Department:
I would simply echo the sentiment of my fellow law enforcement brothers. We are happy to work with Assemblyman Yeager as well.

Kathleen A Conaboy, representing Nevada Orthopaedic Society:
We too were very pleased to participate with the Governor's Office in the working groups that he pulled together around this issue. We had a very important goal during the deliberations, mainly working to assure that in caring for patients, the ability and responsibility of a physician to exercise clinical judgment was preserved and in the process, the ability to prescribe opioids when appropriate. We believe that the bill reflects this approach and would like to acknowledge the openness and collegiality of the Governor's staff in reaching this point.

Chelsea Capurro, representing Health Services Coalition; Nevada Advanced Practice Nurses Association; and Regional Emergency Medical Services Authority:
We are all in support of this bill and thank the Governor for working so hard on this.

Keith L. Lee, representing Board of Medical Examiners:
We have not taken a formal position because we have not had a board meeting, but we certainly support the direction of this bill. We refer your attention to sections 14 through 20 that impose responsibilities on the Board of Medical Examiners that we are prepared to go forward. We think this is a good step in the direction we need to go with this bill. We support that wholeheartedly. We would like to thank the Governor's staff for reaching out to us and working with us. We look forward to passage of this bill.

Ryan Beaman, President, Clark County Firefighters Union Local 1908:
We appreciate the Governor recognizing the issue that is in our state. As first responders, we do see the problem with drug overdoses day in and day out. I do appreciate

Assemblywoman Titus' question regarding paramedics. For us, it would not change any type of treatment. Our paramedics and advanced EMTs can give NARCAN, so this would not change any treatment for the patient.

Todd Ingalsbee, Legislative Representative, Professional Fire Fighters of Nevada:
We do support the bill, but we have some of the same concerns as Assemblywoman Titus and Chairman Sprinkle regarding the paramedics, and why it is needed. We would love to work with the Governor's staff if we need to.

Chairman Sprinkle:
Is there anyone else in support? [There was no one.] Is there anyone in opposition? [There was no one.] Is there anyone in neutral?

Richard L. Martin, Private Citizen, Henderson, Nevada:
I am a pharmacist with 25 years of hospital experience and 4 years of experience consulting on opioids with oncology patients. I admire the time and effort that was put into this bill by everyone. I am also a patient with chronic pain issues, and I am on high-dose opioids. Some people will be glad that I have toned this down considerably. I think you did a great job putting this bill out. Legislators have tried to fix the opioid epidemic—often with unintended consequences. I am concerned that this bill might create adverse scenarios for all health care providers and patients. It might create a regulatory bureaucracy causing more physicians to quit treating long-term pain patients. Please consider caution with this bill. Please do not create a can of worms.

On the PDMP, I would like to quote from the medical insurance industry, the Healthcare Fraud Prevention Partnership (HFPP) from last fall, "HFPP partners have expressed a desire to access PDMP data to supplement information currently contained in their own data warehouses . . . The PDMP data would also be an additional source for identifying high prescribers and high users." I have also read that the Centers for Medicare and Medicaid Services have hinted at getting more access to the PDMP. In my opinion, everyone wants to get their hands on this information. The PDMP information has lots of private, privileged information. Assembly Bill 474 wants paramedics to have access to the PDMP. I say this with the greatest respect to the paramedics and present members, but I do not know if this is necessary. If a paramedic suspects an overdose, simplistically, he gives one or two shots of NARCAN . If it is an opioid overdose, the patient will respond almost immediately. If there is no response, then supportive care follows as per current protocols.

Also, the majority of unresponsive overdoses will not have any information available as most likely, whatever they overdosed on was obtained illegally. I do not know if the PDMP will be available 24/7 because I do not know if it is available 24/7 now. Considering all of the privacy issues that are facing our country today, I am concerned. Do we need more people accessing this sensitive information? I wish you would consider this information sensitively.

Chairman Sprinkle:
Is there anyone else in southern Nevada in neutral? [There was no one.] We will bring it to neutral in the north.

Sean B. Sullivan, Deputy Public Defender, Washoe County Public Defender's Office:
Initially, I signed in opposition, but I am moving to neutral, having listened to the testimony. Our limiting concern was with what Assemblyman Yeager already raised in section 12. As it reads right now, "during an investigation," and an investigation could take weeks, months, or even years. Most statutes of limitation for drug-related felonies are three or four years. We would like to see some limiting language and hopefully not capture those innocent persons. Also, with the constructive possession and aggregate amount of pills, you may have the elderly who do not discard their pills. They may just keep hoarding the pills in their house, or they may be living with other people who have lawfully prescribed medications. We would just like to see some limiting language in section 12, but after listening to today's testimony, I am confident we can work with all of the stakeholders in the room to capture such language.

Catherine O'Mara, Executive Director, Nevada State Medical Association:
We are here in neutral to this bill, but we are very optimistic that we will be able to support the bill pending more clarification. I wanted to thank the Governor's Office for including us in the discussions leading up to this bill draft and for the incredible amount of work they have done this week since the bill dropped to help us understand what the bill does, so we can educate our own members about what it does and does not do. The task that the Governor's Office has taken on is to establish clear, implementable guidelines while preserving clinical judgment should not be ignored. We certainly appreciate that. We would like to thank the licensing boards for working with us, the State Board of Pharmacy for training our members on how to use the PDMP, and the Board of Medical Examiners for being willing to talk to us about our proposed amendment to make sure that people with suspended prescribing licenses get adjudication as quickly as possible, so they are not standing out there in limbo.

There are a few areas that we need clarification on, although we did receive much clarification today. We have a board meeting tonight, so I am hopeful this will help. Section 60, subsection 1(b), is mandatory language. After you check the PDMP, if you determine that the patient has been issued another prescription for the same controlled substance that provides for ongoing treatment, the practitioner shall not prescribe the controlled substance. I would just like to put on the record some of the clarification I received today from the Governor's Office in that this is meant to get at concurrent prescriptions for similar ailments and not at consecutive prescriptions or even concurrent prescriptions from separate ailments. This may seem like we are splitting hairs here, but it is very important that the prescribers understand how to abide by these guidelines so that they are comfortable continuing to exercise their clinical judgement and being able to continue to prescribe where appropriate. I really appreciate that clarification.

Today we heard from Dr. DiMuro, who has promised since the outset to help create the templates for the informed consent for the medication agreement, and to take into consideration those specific nuances that need to occur for palliative and hospice care. They have very different treatment goals, and their treatment goals are not only managing pain. We really appreciate his willingness to work with us, so there are no unintended consequences to that highly vulnerable population of our patients, and practitioners still feel free to prescribe to their clinical judgment while still documenting when necessary and checking the PDMP as required, but at least having some flexibility so that patients get the care they need.

There are two areas we look forward to working on with the respective bodies. They have to do with reporting overdoses and defining inappropriate prescribing. We look forward to being part of that discussion; we will be contributing members to that dialogue. Again, we really appreciate being involved in the conversation. Much of what is left to do is education—educating our members, the physicians, other prescribers, and ultimately educating the public, so they know what to expect and why they may be getting reduced pain medications. As Dr. DiMuro says, they are taking on some ownership for their own medical treatment. All of that is critically important. My role in this is to make sure our members understand, and we can get to a place where they understand how to use this and not impact patient care. We are neutral to this pending some clarification, and we really appreciate being part of the process.

Chairman Sprinkle:
Is there anyone else neutral to this bill? [There was no one.] You may now come up for closing remarks.

Elyse Monroy:
We heard loud and clear that there are some concerns around the PDMP expansion to paramedics as well as concerns with section 12. We are happy to work with you and all of the stakeholders over the next couple of days to tighten up language or reconsider the policy that we have put forward to make sure that what we are proposing is actually implementable and meaningful. Thank you for hearing our bill today. We look forward to continuing to work with you.

[(Exhibit M) was submitted but not discussed.]

Chairman Sprinkle:
Having worked on this with you for several years now, I cannot tell you how impressed I am with the number of people who showed up in support of this bill and how you have worked with so many different agencies to bring forward a bill that everyone can get behind. Thank you very much. We will close the hearing on A.B. 474. I will open the hearing on Assembly Bill 346.

Assembly Bill 346: Enacts requirements relating to certain providers of child care. (BDR 38-283)

Assemblywoman Amber Joiner, Assembly District No. 24:
Thank you for hearing Assembly Bill 346 today. Today I am here as a parent who, like many of you, has been through the struggle of trying to find quality child care for my children. I am also here as a concerned neighbor who wants to make sure that a basic level of security is provided for all children in Nevada who are in child care.

Currently in Nevada, we have people who are watching children in their homes for profit, as a business, who are completely unregulated and unregistered in any way. Currently in Nevada, we only require people to be licensed as a child care facility if they are caring for five or more children. A recent study by the Children's Cabinet found that our licensed facilities only meet 22 percent of the need for child care for children ages birth to five years, so that means that more than three-quarters of our children are in other settings. We know that some are watched by family members, but with 65 percent of our children between the ages of birth and five years living in a home where all parents work, many of them are in for-profit settings that watch fewer than five children. This measure would give us a better picture of the child care capacity in our state and provide protections for those children.

This measure adds a new category of child care called “small child care establishments,” and it would apply to anyone watching between one and four children for profit. It would require them to obtain a background check and register with the Division of Public and Behavioral Health, Department of Health and Human Services (DHHS) to provide a basic level of security for our children.

This bill would also give the Division of Public and Behavioral Health the ability to inspect and fine these small child care providers if there is reason to believe they are violating laws relating to the number of children or have not received a background check. This is necessary, because as you will hear today from other presenters, we have received reports of people watching more than four children who refuse to become licensed and comply with licensing requirements, and the Division has no recourse but to send cease and desist letters, which they simply ignore. This creates a very dangerous situation for children as the adult-to-child ratios get higher and higher as well as the situation of some of them not having background checks.

I have provided three brief conceptual amendments for you today on the Nevada Electronic Legislative Information System (NELIS) in the form of a handout (Exhibit N), and I would like to walk through the bill and explain those requested changes before handing the presentation over to Jared Busker from the Children's Advocacy Alliance.

If we look at the bill, in section 2 it defines "small child care establishment." I want to be very clear that this is not intended to affect friends and family, occasional babysitting, or nannies that are in the child's own home. This is purely, as you will see on page 2, line 9, people receiving monetary compensation outside the home and outside the presence of the parents or guardians of the children for at least six hours each day, at least four days each week, and more than three consecutive weeks. Clearly, this is just for those people who are

making a profit off child care. In section 3, you can see that before providing the child care, which leads into conceptual amendment 1, they would have to register with the Department of Health and Human Services and receive a background check.

In discussing with this with DHHS staff who have been incredibly helpful and supportive, we discovered that right now, the bill was drafted in the wrong division. The Division of Welfare and Supportive Services, DHHS actually already has a registry like the one being proposed in this bill. Instead of creating a new one, we will use the Family, Friend, or Neighbor Provider program through the Division of Welfare and Supportive Services, DHHS. Section 4 talks about the name-based search of records within the Central Repository for Nevada Records of Criminal History. This is the background check. We always intended for the background check of these people to be the full Federal Bureau of Investigation (FBI) fingerprint background check, so we had a clear picture of their entire criminal history nationwide, just as we do for the larger facilities. The way it is drafted right now is just a name-based check. What I realized is that I was not clear with our drafters about a receiving agency. In order for the FBI to do the check, you have to have an agency in the state overseeing it. I am grateful to the Division of Public and Behavioral Health. They have agreed to be the sponsoring agency for the purposes of those background checks to allow us to do the full background check. That is just a clarification on the type of background check.

Section 5 relates to both licensed child care facilities and the smaller establishments and would require that anytime a child is riding a bicycle or a scooter or a skateboard, the child has a helmet on. I know that seems simple, but this is actually out of my personal life. The facility that my children attended had bicycles, and they took some nasty spills. We know all of the important concussion research that has come out, and we know how head injuries can cause life-long problems. It does not make sense to me that many of our cities and counties already require that children on the street have to have bicycle helmets. If you have bicycles in the facilities, it just makes sense to protect their heads. My children went to day care with their helmets every day after taking those spills. It is a pretty simple solution; there are many day cares that already require it. It is a necessary protection for our children in section 5.

Section 8 is where the current law is given teeth, so if they are watching too many kids or they are violating the background checks, the Division can go in and inspect them. This is a necessary component because right now people are acting outside the law, and there is nothing that we can do to stop them.

Section 11 relates to the background checks, which will change because we will be doing the full FBI background check. Then there are just definitions for the rest of the bill. It becomes effective on July 1.

The third proposed change that you have in front of you is to add a provision (Exhibit N). Currently any fines that are issued by the Division would go directly back to the State General Fund. What they are authorized to do now for facilities is actually to recoup

some of their direct costs. We are asking for authority to recoup those direct costs when there is a violation. This makes a lot of sense to me. Those facilities and small establishments that are not in violation would never have to pay a dime. I would like to turn it over to Jared Busker, and then we will be open for questions.

Jared Busker, Policy Analyst, Children's Advocacy Alliance:
I want to thank Assemblywoman Joiner for putting forward this legislation. About a year ago, the Children's Advocacy Alliance received a phone call from a mother who used an unlicensed child care facility. She received a phone call from a police officer that her child was unresponsive and had received brain damage. The child later ended up passing away. The injuries were a result of the child care worker becoming frustrated with the crying child and dropping him on his head. The mother reached out to us because she wanted us to work on some legislation that would be able to decrease the instances of this happening to other parents and children.

We looked into everything, and seeing how often this happened, we found that a child dies in a family-type home or child care center once every two years. Once every two years, there is also a reported case of abuse or neglect at those facilities.

Additionally, we worked with Child Care Licensing in the Division of Public and Behavioral Health and tried to see how many reports they have received regarding unlicensed or license-exempt child care facilities. From November 2012 to early February 2016, they had 103 reports of unlicensed providers and complaints. Some of the complaints were that these people were watching too many children. We found that when inspectors went out to the facilities, they did not have the ability to inspect those facilities. Also, 17 percent of those facilities were substantiated as not operating according to the law. With the passage of this bill, we believe this gives the Division some teeth to inspect. We are also trying to take the first step with the background checks to prevent some of the deaths we are seeing.

Chairman Sprinkle:
Thank you for both of your presentations.

Assemblywoman Miller:
Thank you for bringing this forward. You mentioned that this does not apply to families and friends because they are not being paid. However, I have many friends where one friend watches another one's kids, but they are getting paid. Sometimes, Grandma does get paid also. Would that include the friends and Grandma who are being paid?

Assemblywoman Joiner:
In section 2, there is an "and" which means that it would have to meet all three of those criteria. I have the consanguinity/affinity chart if anyone is interested. If you are in the fourth degree, it does not apply to you. Grandma is definitely exempt, so would be your grandnephews and nieces, your first cousins, your granduncles and aunts, and a wide net of family members.

Assemblywoman Miller:
Does that include friends?

Assemblywoman Joiner:
"Friend" is such a loose term. If friends are receiving compensation and they are doing this for a profit outside of the presence of the parent and outside of the child's home, then yes, they would need to get a background check and register. This is not very onerous on people. We have looked at the background check; it is about $38, and then you simply go online and register your facility. It is not that time-consuming or expensive. Anyone can say their friend is watching their child to be exempt from this. If you have any suggestions on how to improve that, I am open to suggestions.

Assemblywoman Miller:
I am concerned because many times they really are friends. Sometimes there is a stay-at-home mom who offers to watch her friend's kids. While I would imagine they would not mind going to get a background check, it is that concern of well, now do they need to be licensed as a business and jump through other hurdles as well. When we say small children, what is the age?

Assemblywoman Joiner:
Small child is not defined in the bill; I am not sure what your question is relating to. Some of my statistics about the number of children in our current capacity was children aged birth through five years, but the Children's Cabinet had older ages as well.

Assemblywoman Miller:
Section 5 talks about requiring wearing helmets and such for mobile activities; a lot of activities cause mobility for kids. Who is that responsibility on then? Is it on the child care provider to provide those helmets? What if the parents do not bring helmets every day?

Assemblywoman Joiner:
There are many models for that. It just depends, as long as they are complying with a child on a bike. We did not want to prescribe in law how that looks. There are currently child care facilities that have the same number of helmets as the number of bikes, and the helmet travels with the bike. There are some facilities where, if the child does not come with their helmet, they do not ride the bike that day. It can be however the facility decides to implement that, but the responsibility is on the facility to ensure that a child on a bike has a helmet or a child on roller skates, scooters, or other things provided.

Assemblyman Thompson:
Are there any identified funds or resources for those organizations that want to be in compliance, but just do not have the dollars to get the fire extinguisher and to make sure that the gates are proper, you know, some capacity-building type of grants? People who want to do it right may not be able to do it right, so they are going to miss out on that opportunity.

Assemblywoman Joiner:
For these small facilities, we are not requiring anything except the background check. They do not have to comply with everything that a normal facility has; it is purely a background check.

I would also like to clarify to Assemblywoman Miller. We are not requiring a business license either. We tried to do that, but we found that some of these folks are not rising to the level of profit they make to require a business license. If they reach that, other laws may come into effect, but this particular law does not mandate that because they may not be making enough to rise to that threshold. There are no other requirements besides making sure that basic safety of a background check is there.

Assemblyman Thompson:
Are there certain provisions in the background check where it will be allowable? Is it an automatic no if someone has a background, but the background may not necessarily deal with child offenses? If someone did something that, as I said, does not deal with children, that they still might be able to watch kids?

Jared Busker:
The language that is used with the background checks right now would mirror the language that is used for other child care facilities in *Nevada Revised Statutes* (NRS) 432A.170. I believe they would be able to appeal to the Division of Public and Behavioral Health, DHHS.

Assemblyman Hambrick:
Some of my colleagues raised the question about the term "friend." In some neighborhoods, you have an "aunt" or "grandma" where, because of the make-up of the neighborhood, the youngsters call that individual Grandma. It becomes a term of art within that community. How do we get this message out? We have little kids going to some day cares because their older siblings went there years ago. I like the bill, and I will be supporting it, but I am not sure how to get a message out that what these people are doing can no longer be done.

Assemblywoman Joiner:
My hope is that they can keep doing what they are doing. For the most part, people do not have a criminal history. It is just that added bit of security. It is not our intent to disrupt the current child care situation, but we do need to know as a state what is out there. There are folks who are bad actors that care for too many kids for a safe adult-child ratio. Those are the ones that with the registry, we will have a better picture of how many children they are watching. We will know their address, and we will be able to ensure they do not have a criminal background. My hope is that most folks will not be affected, that is not the intent at all, but it is just to add that little bit of security and to let the state know what is out there. We have a scarcity of child care providers right now, so we need a better handle on where our children are receiving care, so we can also try to improve the access that we have to quality child care.

Assemblyman Edwards:
I am concerned about the unintended consequences. You just brought up a great point that we are already lacking in child care facilities and capacity. I am concerned that this might scare away some of the small providers, not just because of the background check, but because the government is coming into their business. I think we need to address how you prevent an overzealous inspector. If there is one thing you do not want, it is someone who is overzealous. The word gets out, and then all of a sudden a lot of people are saying they will not do this because they do not want to face that risk. What kind of protections have you considered for the little folks who are just doing it and do not need a background check, but if they start going down this route, they might have to give up what they are doing, which is providing a very needed service?

Jared Busker:
Right now, we already have three-fourths of all of our providers operating outside of licensing. I do not believe we will see an increase in these unlicensed providers as they are already not licensed. This bill allows us to see who is operating currently and allows us to work with them. As far as an inspector who may be overzealous in doing inspections, right now the only statute the operator would have to be in compliance with is the background check. I do not believe they would be doing a full inspection unless there is a complaint regarding their operating outside of what they are licensed to do already.

Assemblywoman Joiner:
It is the background check but also the number of children and then the helmet. Those are the only things they would be looking for. I would argue that the safety of our children is more important than people who might be worried about this. Someone who does not have a criminal background should not be afraid to take the test and then be proud of that. They are able to advertise with that and say they are a legitimate child care provider. If they have two children, maybe they can take on more.

Assemblyman Edwards:
I understand that would be the hope and the expectation, but I do believe there is a risk that some people could get harmed because of some small thing they did 30 years ago. This could damage the number of kids that could be looked after, which would impact all of the folks who have to go to work and put their kid somewhere. I think this is a well-intentioned idea, but I just do not know if it is an overreach by the government for a problem that maybe is not that significant.

Chairman Sprinkle:
Are there any other questions from the Committee? [There were none.] Is there anyone in support of A.B. 346 either here or in southern Nevada?

Carrie Paldi, Private Citizen, Henderson, Nevada:
When providing care for our children, it is important to make sure that all children are being cared for in a safe environment. One of the cornerstones of safety is to make sure that children are being cared for in a licensed and regulated child care environment. No person or

facility that provides care for children should be exempt from these basic licensing requirements. Currently in Nevada, anyone can provide care for up to four children without a child care license. There are also many public entities and programs that are currently exempted from being licensed, regardless of the number of children they care for.

Although A.B. 346 does not completely address this issue of unlicensed and unregulated child care, it is a step in the right direction. I support the proposed requirement that individuals and public entities who wish to provide care to children are required to register with the Division. I also support requiring these individuals to complete background checks. Once again, I would like to note that while I view A.B. 346 as an important step in the right direction, ultimately, I feel strongly that all environments that provide child care services for children should be licensed and regulated for the safety of the children.

Chairman Sprinkle:
Is there anyone else in support? [There was no one.] Is there anyone in opposition? [There was no one.] Is there anyone neutral? [There was no one.] You may come back for closing remarks.

Assemblywoman Joiner:
I really appreciate your hearing the bill today. Thank you.

[(Exhibit O) was submitted but not discussed.]

Chairman Sprinkle:
We appreciate your coming forward and what you are trying to do with this bill. With that, we will close the hearing on A.B. 346 and open public comment. [There was none.] We have another busy schedule Wednesday. I appreciate everyone's attention. We are adjourned [at 4:00 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 written testimony submitted by Jenny Reese, representing Pharmaceutical Research and Manufacturers of America, Washington D.C., dated April 3, 2017, in opposition to Assembly Bill 215.

Exhibit D is written testimony submitted by Jerianne Gerloff, Director, U.S. Government Relations, Pfizer Inc., dated April 3, 2017, in opposition to Assembly Bill 215.

Exhibit E is written testimony submitted by Brian Warren, Director, State Government Affairs, Western Region, Biotechnology Innovation Organization, Washington D.C., dated April 3, 2017, in opposition to Assembly Bill 215.

Exhibit F is a document titled "The Scope of Opioid Use in Nevada, 2015," dated March 30, 2017, presented by Elyse Monroy, Policy Analyst, Office of the Governor, prepared by the Nevada Division of Public and Behavioral Health, Department of Health and Human Services.

Exhibit G is a document titled "Governor Brian Sandoval's Prescription Drug Abuse Prevention Summit," presented by Elyse Monroy, Policy Analyst, Office of the Governor.

Exhibit H is a document titled "Controlled Substance Abuse Prevention Act, Section Summary," presented by Elyse Monroy, Policy Analyst, Office of the Governor, regarding Assembly Bill 474.

Exhibit I is a proposed amendment to Assembly Bill 474 submitted by Julia Peek, Deputy Administrator, Community Services, Division of Public and Behavioral Health, Department of Health and Human Services, presented by Elyse Monroy, Policy Analyst, Office of the Governor.

Exhibit J is a proposed amendment to Assembly Bill 474 submitted by the Nevada State Medical Association, referenced by Elyse Monroy, Policy Analyst, Office of the Governor.

Exhibit K is a document titled "Nevada State Board of Nursing," presented by Michael Hillerby, representing State Board of Nursing; and State Board of Pharmacy, regarding Assembly Bill 474.

Exhibit L is written testimony submitted by Bruce Fong, D.O., President, Nevada Osteopathic Medical Association, presented by Nick Vander Poel, representing Nevada Osteopathic Medical Association, in support of Assembly Bill 474.

Exhibit M is written testimony submitted by Kevin Dick, District Health Officer, Washoe County Health District, dated March 31, 2017, regarding Assembly Bill 474.

Exhibit N is a handout containing three proposed conceptual amendments to Assembly Bill 346, submitted by Assemblywoman Amber Joiner, Assembly District No. 24.

Exhibit O is written testimony submitted by Wendy Stolyarov, Legislative Director, Libertarian Party of Nevada, dated April 3, 2017, in opposition to Assembly Bill 346.