MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-ninth Session
May 26, 2017

The Senate Committee on Health and Human Services was called to order by Chair Pat Spearman at 3:25 p.m. on Friday, May 26, 2017, in Room 2149 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Pat Spearman, Chair
Senator Julia Ratti, Vice Chair
Senator Joyce Woodhouse
Senator Joseph P. Hardy
Senator Scott Hammond

GUEST LEGISLATORS PRESENT:

Senator Heidi S. Gansert, Senatorial District No. 15
Senator Michael Roberson, Senatorial District No. 20

STAFF MEMBERS PRESENT:

Megan Comlossy, Policy Analyst
Eric Robbins, Counsel
Martha Barnes, Committee Secretary

OTHERS PRESENT:

DuAne Young, Chief, Behavioral Health and Pharmacy Services, Division of Health Care Financing and Policy, Department of Health and Human Services
Khanh Pham, Nevada Pharmacist Association
Julie Kotchevar, Deputy Administrator, Director's Office, Department of Health and Human Services
John Jones, Pharmaceutical Care Management Association

Nick Vassiliadis, Pharmaceutical Care Management Association
Elizabeth MacMenamin, Retail Association of Nevada
Elyse Monroy, Policy Analyst, Office of the Governor

CHAIR SPEARMAN:
We will open the hearing on Assembly Bill (A.B.) 473.

ASSEMBLY BILL 473 (1st Reprint): Temporarily provides for the continued inclusion of certain drugs on the list of preferred prescription drugs to be used for the Medicaid program. (BDR 38-977)

DUANE YOUNG (Chief, Behavioral Health and Pharmacy Services, Division of Health Care Financing and Policy, Department of Health and Human Services):
Assembly Bill 473 extends the sunset language of *Nevada Revised Statutes* 422.4025 until 2019 and allows the Nevada fee-for-service Medicaid program to continue to manage its atypical and typical antipsychotic medications, anticonvulsant medications and antidiabetic medications on the preferred drug list.

The Governor-appointed Pharmacy and Therapeutics Committee consisting of pharmacists and physicians from Nevada reviews and manages Nevada's Medicaid's preferred drug list (PDO). The PDO is not a closed or tiered formulary. The drugs are either preferred or non-preferred. If a non-preferred drug is requested, the prescribing physician is asked to choose a preferred drug unless there is a clinical rational as to why the non-preferred drug is needed. We have implemented measures to allow those to receive non-preferred medications through either treatment failures or continuity of care mechanisms.

CHAIR SPEARMAN:
I will close the hearing on A.B. 473 and open the hearing on Senate Bill (S.B.) 539.

SENATE BILL 539: Revises provisions relating to prescription drugs. (BDR 40-1217)

SENATOR HEIDI S. GANSERT (Senatorial District No. 15):
Over the last few years, the news has highlighted unprecedented increases in drug prices without information to support the increases. Transparency is required in order to help address this issue.

I want to acknowledge Senator Yvanna D. Cancela for her work on S.B. 265. Senator Cancela recognized the need for transparency around prescription drugs essential for treating diabetes and S.B. 265 has gone a long way to create it.

SENATE BILL 265: Revises provisions relating to prescription drugs. (BDR 40-809)

Patients afflicted with diabetes are captive consumers. I have witnessed first-hand the plight of these patients when visiting Nevadans who have suffered from diabetes or who have family members who are impacted. It was clear that their well-being was dependent on insulin-based drugs and they were facing uncertain costs for medications they cannot live without. Thankfully, insulin products are continually improving, leading to a better quality of life for patients. The retail price paid by patients is unpredictable and can escalate to unaffordable levels over short periods. The pricing scheme from drugmakers to wholesalers, to pharmacies and to the formulary approval process, by a pharmacy benefit manager (PBM), is complex and confusing. They are shrouded in secrecy and the final price paid by a patient may be higher than the actual net cost. Simply stated, pricing is uncertain and poorly understood.

The intent of S.B. 539 is to complement the work by Senator Cancela to further increase transparency around the pricing of essential insulin medications and eliminate the "gag rule" pharmacists are required to follow. The "gag rule" precludes pharmacists from working with patients to identify the best price for life-saving medications.

Senate Bill 539 places requirements in statute to provide greater transparency with respect to drugs that are used to treat diabetes sold in this State and to provide regulation for PBMs. I will read from our mock-up of S.B. 539 which shows Proposed Amendment 5037 in conceptual form (Exhibit C).

In section 4 of Exhibit C, the Department of Health and Human Services (DHHS) is required to compile a list of prescription drugs used to treat diabetes and which have undergone a significant increase in the wholesale acquisition cost.

Section 4 also requires a manufacturer of a drug included on the list to prepare a report that explains the reasons for the increase in the wholesale acquisition cost of the drug and submit the report to the DHHS. Finally, section 4 requires a manufacturer of any drug, sold or marketed for sale in the State for the treatment of diabetes, to report annually to the DHHS the wholesale acquisition cost of the drug. The DHHS is required to analyze the information by the manufacturers and compile a report of the reasons for the increase and the effect of the price increase on the costs to residents in the State.

Section 6 of Exhibit C requires the DHHS to place the report on its Website so the public will have access to the information.

Section 8 of Exhibit C provides a penalty if a manufacturer doing business in the State fails to provide the information to the DHHS.

Section 9 of Exhibit C excludes the information that a manufacturer or PBM is required to report under this bill from the definition of trade secrets, but only to the extent that the information is required to be disclosed.

Sections 11 to 21 of Exhibit C have specific requirements for a PBM. A PBM is defined in section 11 as an entity that manages pharmacy benefits that are provided as part of a health care plan offered by an insurer.

Section 18 of Exhibit C prohibits a PBM from operating in this State without a license issued by the Insurance Commissioner and provides the procedure for obtaining a license.

Section 19 of Exhibit C places a fiduciary duty on a PBM with respect to any insurer with which the PBM has a contract to manage pharmacy benefits.

Section 20 of Exhibit C prohibits a PBM from engaging in certain acts that restrict pharmacies and pharmacists. For example, it prohibits restricting a pharmacy or pharmacist from providing certain information to an insured about an alternative drug. It prohibits a PBM from penalizing a pharmacist or pharmacy for providing certain information for less expensive drugs, and it prohibits other conduct that interferes with the conduct of a pharmacy or pharmacist.

Sections 8.4 to 8.8, 26.1, 26.2, 26.25 and 26.4 to 26.9 of Exhibit C prohibit insurers, including public insurers, from engaging in such conduct.

Section 21 of Exhibit C requires a PBM to post the rate at which the PBM reimburses each pharmacy in the State for each prescription drug used to treat diabetes that is covered by a plan and managed by the PBM on a publicly available Website that it maintains. In addition, section 21 requires the PBM to submit a report to the Division of Insurance (DOI) each year which includes certain information regarding rebates that the PBM negotiates on prescription drugs used to treat diabetes.

Senate Bill 539 will provide greater transparency regarding the cost of drugs to treat diabetes that are sold in the State and ensure that PBMs are not the sole entities benefiting from rebates provided from the sale of drugs in this State. In addition, S.B. 539 will eliminate the "gag rule" to ensure that pharmacists and pharmacies are not prohibited from discussing less expensive drugs that will meet the needs of the patient.

I would like to show a short video, "How PBMs Lead to Higher Prescription Drug Prices."

SENATOR MICHAEL ROBERSON (Senatorial District No. 20):
The video you just watched illustrates the problem of the gag rule as it applies to the concept of "spread pricing" the PBMs put on retail pharmacists. Spread pricing prevents pharmacists from helping consumers identify alternative low cost drugs or find the same drug for a lower cost.

Section 20 of Exhibit C would eliminate the ability of PBMs to impose a gag rule in the State. Whether it is through this bill or the bill of your choosing, if you do nothing else, I hope you will take action to eliminate the PBM gag rule in our State.

In addition to the gag rule, S.B. 539 focuses on providing increased transparency with regard to rebates received by PBMs from drug manufacturers and who ultimately benefits from those rebates. Forty-three states in this Country have passed laws or regulations addressing PBM transparency. To date, Nevada has done nothing to make PBMs transparent.

The PBMs control the distribution of pharmaceutical drugs in this Country by telling drug manufacturers that they will not sell their drugs or include their drugs in their formularies unless they get rebates off the list prices. This is known as the wholesale acquisition price.

It is my understanding that the rebates extracted by PBMs can equal 50 percent to 70 percent of the list price on many diabetes drugs. The question is, what do the PBMs do with the rebates? Do they make sure they are passed on to the consumer to lower the costs of diabetes drugs or do they pocket the rebates themselves?

A study in January of 2017 from the Centers for Medicare and Medicaid Services reported that while drug companies are paying increasingly larger rebates to PBMs, the PBMs are keeping the money rather than converting the proceeds into lower costs for consumers and government health care programs.

In "How PBMs make the drug price problem worse" in *The Hill* newspaper, David Balto, a former policy director in the Office of Policy and Evaluation for the Federal Trade Commission's Bureau of Competition notes:

> A large portion of PBM profits are derived from rebates they receive from the drug manufacturers, but don't pass on to their consumers. How big is the difference? Unfortunately, we don't know because the information has not been disclosed to the public … .
>
> If there was transparency when prices increase employers could 'follow the money,'—they could figure out what rebates are being paid and who received them. Giving them that information would enable employers to bargain effectively and secure lower prices. That's the way markets are supposed to work.

This is what S.B. 539 aims to accomplish.

I am confident the PBMs will deny the extent to which they do this. They conceal this information from their clients, who are insurance companies and the Employee Retirement Income Security Act of 1974 employers, from retail pharmacies and from the drug manufacturers themselves. If asked by you today, they will conceal this information from this Committee.

There are other issues with the PBMs that this Legislature needs to look at. There is a real problem with vertical integration with regard to the PBMs owning pharmacies, specialty pharmacies, and mail order pharmacies. David Balto continued:

> PBMs own and operate mail order and specialty pharmacies, but considering their purpose is to control drug dispensing costs, it's hard to believe the fox can guard the henhouse. In a PBM's perfect world, there would be no independent pharmacy and no local pharmacist advocating to make sure patients do not overpay for drugs.

There is also a problem concerning generic drugs with the Maximum Allowable Cost (MAC) lists transparency used by PBMs or other payers. It includes prescription drug products that have an upper limit or maximum allowed reimbursement of generic drugs or brand drugs that have a generic version.

The problem is the PBMs use a MAC list as a revenue stream, typically by using aggressively low MAC pricing to pay their pharmacy networks and another MAC list with higher prices to bill their clients, who are the plan sponsors. This is called "the spread." Many states have addressed MAC transparency. We do not address MAC transparency, the spread or vertical integration in S.B. 539.

I knew nothing about this going into this Session, and since I do not serve on this Committee, I did not follow the deliberations as closely as others did. However, once Senator Gansert and others in the building started to look at this problem, it has become truly disturbing. There are 43 states that have started to do something and Congress is debating what to do.

Whether you pass this bill or put portions of this bill into another vehicle, in the waning days of this Session, I hope you do something at a minimum with the gag rule the PBMs place on pharmacists in the State and look at increased transparency on the rebates that PBMs receive.

SENATOR HARDY:
Are the insulin and diabetic products less expensive in Nevada than in the other 43 states?

SENATOR ROBERSON:
I do not know the answer to that question.

SENATOR HARDY:
I believe this is important and is an opportunity to do something that will allow a person to get a less expensive medicine.

SENATOR ROBERSON:
I would agree.

SENATOR HAMMOND:
When we had this discussion a while ago and talked about the whole process of getting the drug manufactured to getting the drug into the consumer's hands, I made it clear that I was in favor of transparency all along the line. In your estimation, without this, where does it leave the consumer?

SENATOR ROBERSON:
Clearly, nothing will change with regard to what the PBM does or does not do. It is not a complete solution without looking at transparency on PBMs. The very least we can do is prevent PBMs from continuing to put a gag order on pharmacists in our State. A pharmacist should be able to explain to customers how they can get a drug cheaper if they pay cash, or that there is an alternative drug that would cost less.

I also support S.B 265 because we have to address every part of this situation and bring transparency to every part of the supply chain. The middleman in this situation is the PBM, and the PBM is the most opaque part of the supply chain. If we really want to make a difference this Session, with the short amount of time left, we can try to lower costs for diabetic patients in this State. To make a difference and lower the costs of drugs, we must do something with regard to the transparency of the PBM.

SENATOR RATTI:
Does the gag rule portion of this bill only apply to diabetic drugs?

SENATOR GANSERT:
No. It is for any medication.

SENATOR RATTI:
It was very important in other hearings to connect the rebates back to the consumer, and I do not see the connection back to the consumer. How does this help the patients in the "doughnut hole" on Medicaid?

SENATOR GANSERT:
The PBMs control what is on the formulary for a benefit plan, and they receive the rebates. To put a drug on a plan, the PBM can get a rebate, but that rebate

is not necessarily passed on to the consumer. Therefore, consumers are captive and do not have a choice.

The lack of transparency is from the manufacturer, to the wholesaler, to the PBM who is saying what is going to be on a formulary, to the pharmacy. The middleman, the PBM, is controlling what the price ultimately is.

SENATOR ROBERSON:
The client for a PBM is typically an insurance carrier or a self-insured employer. If there is no transparency between the PBM and its client, then the client does not know that the PBM is getting the rebates. Those rebates are not going to the insurer. If those rebates do not go to the insurer, then the insurer cannot reduce the price of the drug for its enrollees, whether it is for the copay or the premium.

SENATOR RATTI:
This Session I have learned that health care issues are complex, and we need to make sure that we are not having unintended consequences with what is an incredibly complex system. Would you please explain the stakeholder process?

SENATOR ROBERSON:
We have been having discussions for well over a month, if not longer. I have spoken with Senator Cancela and with Barbara Richardson, the head of the Division of Insurance, the Legislative Counsel Bureau, and practically every representative, both of the manufacturers and the PBMs in this building. To be clear, the PBMs do not like this and will vehemently oppose S.B. 539.

SENATOR RATTI:
You have spoken to the pharmaceutical companies and PBMs. Have you spoken with the insurers, the hospitals, the medical associations, retail pharmacists and all of the other players who have an interest?

SENATOR ROBERSON:
Yes, I have spoken to all of those groups and talked to all of them about trying to get to a point where we can get some agreement or common ground on this issue. We have spoken to a retail pharmacist in Las Vegas who has very strong opinions on the PBMs and how they work and would like to testify.

SENATOR RATTI:
Is there still a $200,000 fiscal note on this bill?

SENATOR ROBERSON:
The fiscal note was removed when we took out the provision that required at least 80 percent of the rebates to be passed on to the consumer.

SENATOR RATTI:
Is the DOI willing to absorb the costs of the collecting and publishing the data?

SENATOR ROBERSON:
Yes.

CHAIR SPEARMAN:
Who made the gag rule?

SENATOR ROBERSON:
The PBMs require the gag rule when contracting with retail pharmacy networks. It is a requirement of doing business with the PBMs.

The PBMs control this market and can require manufacturers to give rebates, and require insurance companies and retail pharmacies to do their bidding to get the drugs that their customers need on the formulary. They control the market.

SENATOR RATTI:
The video that Senator Gansert presented suggested that insurance companies were also a significant part of the challenge. What was the thinking behind focusing on this piece?

SENATOR ROBERSON:
Insurance companies are the most regulated part of the supply chain. A PBM contracts with an insurer, charging a significantly higher price to a health plan, and then enters into a separate agreement with a retail pharmacy network. Essentially, the PBM tells an insurance company this is the price for the drugs in this formulary, and then separately makes agreements with retail pharmacies at a different price. The price they charge in the health plans is larger than the retail pharmacies, and they pocket the difference, which is spread pricing.

SENATOR RATTI:
My point is the video was specifically pointing at insurance companies, and we are not addressing that piece.

SENATOR ROBERSON:
No. It was pointing at PBMs and not insurance companies. The insurance company charges a copay based on what they have to pay for the drugs from the PBM.

SENATOR GANSERT:
On the video, it showed a copayment of $20, but the price for the drug is only $1.75. Insurance companies probably have to average out the cost of medications, and they charge a flat fee as a copayment trying to cover all costs.

The PBM actually controls what medications are on a formulary for an insurance company and to do that, it gets rebates and deals with the manufacturers and insurance companies. If you are a manufacturer and want a drug on a formulary that the insurance company defines, a certain price has to be paid and the PBM holds this money. The insurance companies are highly regulated and are trying to flatten the out cost so consumers have an expectation of what the cost will be.

SENATOR RATTI:
I understand the explanation and appreciate the detail. During this Session, I have learned that the insurance companies control step therapy, which drugs a patient is allowed to have at a low cost, or no cost, and what the direct cost is going to be to them. This is just a different form of a gag rule, saying a patient cannot use this drug, but can use another drug. It could be this is being done for cost management. I would argue that insurance companies have just as much influence over which drugs patients are getting and the cost of those drugs as PBMs have.

SENATOR GANSERT:
I think it is the entire supply chain. We are striving to complement S.B. 265, so all of the pieces of the supply chain, not just parts of it and the PBMs are a critical piece of that supply chain, can be seen.

SENATOR RATTI:
Contracts have been an issue that you have spoken quite a bit to, and others have spoken to me and say that the contracts actually require the pharmacist to tell a patient when there is a less expensive drug. Some contracts require pharmacists to say there is a generic available. There have been a lot of conversations this Session about contraception, step therapy and the steps folks are taking to manage costs. In those conversations, I wanted to accomplish many things that were not possible because of an insurance company or perhaps a PBM telling a pharmacy it must use a certain drug in all those steps because it is the most cost-effective drug.

I am having a hard time reconciling what I have learned about the system pushing people to the lowest cost drug, even when it is not the most effective drug, with what you are saying.

SENATOR GANSERT:
There are no generics for diabetes medication and insulin-based products. Pharmacists are to tell patients or consumers about generics if they are available, but in this class of medications and insulin-based medications, there are no generics. The gag rule applies to other types of medications that could be used which are less expensive and are not necessarily generics.

SENATOR ROBERSON:
We decided to focus on PBMs because they appear to have the least transparency. Whether a PBM or insurers are telling a retail pharmacist to suggest one drug versus another or whether it is generic or brand, it always comes back to which drugs are on the formulary. There is a profit incentive for the PBM to push the drugs on its formulary with the retail pharmacist.

SENATOR RATTI:
How does it work when the insurance company owns the PBM?

SENATOR ROBERSON:
That gets into the problem of vertical integration, whether it is a PBM, an insurance company or in the case of a PBM and pharmacy chains or specialty pharmacies or mail order pharmacies owned by the same company.

SENATOR RATTI:
Can you tell me about the history of how the PBM became the middleman? What happened before there were PBMs?

SENATOR ROBERSON:
I am not proposing to be an expert; I did read that in 1968, the PBMs were started with the idea that the end user would have lower priced drugs. That has changed over the years.

This is a complicated problem, and there are a lot of less-than-good actors in this system. We are proposing more transparency today and want to know how much a PBM gets in rebates from a drug manufacturer and what the PBM does with those rebates. When we have that information, we can identify why these prices continue to go up and why there is a problem.

CHAIR SPEARMAN:
Senator Parks had a bill in the Senate Committee on Commerce and Labor earlier this Session, and the bill was to allow people who were diagnosed with Stage 4 cancer to not have to do the step therapy. The patients could go straight to the drugs their doctors felt would benefit them the most. We heard from insurers during the course of that hearing that if that bill were to pass, it would not be something they could accommodate, particularly the self-insurers, because the drugs would be too costly. I do not remember hearing from the PBMs. After several questions, we finally were told the price really starts with the manufacturer. Whatever the manufacturer establishes then, that is the price that everyone else has to deal with. I believe it was described as the wholesale acquisition cost. You said you worked with stakeholders; did you talk to a PBM or representatives here in the building?

Senator Gansert, you said there were no generics for diabetic drugs and that is what Senator Cancela's bill deals with because diabetic drug costs are escalating through the roof. I want to put aside the diabetic drugs. Of the other drugs, if the cost originates with the manufacturer, and by the time it gets to the PBM, it is your assertion that they do not tell or cannot tell the consumer that there is a cheaper drug and they keep whatever is rebated. Would not the PBMs have to report this on their income tax?

SENATOR ROBERSON:
I think we are talking about different things here, the issue with the gag rule affects all drugs not just the diabetes drugs.

CHAIR SPEARMAN:
I want to address everything but the diabetic drugs. Your statement was that the PBM gag rule prevents pharmacists from telling the consumer there is a cheaper drug. They keep the money from the discounts and do not give the consumers the discounts. My question is how do they report the money? How do we know that the PBM is keeping the money? The money has to show up either on their income taxes or it has to show up somewhere.

SENATOR ROBERSON:
We are talking about two different things; I am not talking about a gag rule. I believe we are talking about rebates, and the rebates have nothing to do with the gag rule. I am talking about the diabetic patients.

CHAIR SPEARMAN:
No, I took the diabetics drugs out. I specifically said, Senator Gansert said there is no generic for diabetics, so I said we are going to take them off the table and we are not going talk about them. I am talking about every other drug, not diabetic drugs.

SENATOR ROBERSON:
You are talking about rebates, correct?

CHAIR SPEARMAN:
Yes. I am talking about the rebates.

SENATOR ROBERSON:
The rebates are between the manufacturers and the PBMs. There are three PBMs that take up 80 percent of the market. These PBMs have control over whether manufacturers can ultimately sell their drugs to the end user. The PBMs demand rebates from the wholesale acquisition cost or the list price. In many cases, the rebates are 30 percent, 50 percent or 70 percent of the list price.

The health plans that have contracts with the PBMs do not have any idea how much the PBMs are getting in rebates from the manufacturers. The original

concept of a PBM was to help a health plan keep the drug prices low so the health plans could offer the lowest prices to their enrollees. There has been a breakdown in the system with the middleman. It is so opaque, the health plans do not know what the PBMs are actually paying for the drugs from the manufacturers versus the price being charged to the health plans for those drugs. There is no transparency, and this is why Anthem is suing Express Scripts for $15 billion.

SENATOR HARDY:
We are facing two problems in the real world of patients and medicines. Senator Cancela's bill, which focuses on insulin, is something that can actually be done. We read enough in the newspapers to know the cost of medicines that have been around for a long time are going up from $10 one day to $100 another. It was not because the cost of manufacturing went up, but because the middleman is charging more money. We also know that when a company sells its rights to a particular medicine, the new company increases the price.

The concept of looking at the manufacturing is wise. The manufacturers' costs are going up 3 percent, 2 percent or 1 percent. This proposal is looking at where the other 100 percent to 500 percent has gone. The insurers are clear on where their money is going. The pharmacy is stuck and has to sell the drugs at the price they can sell them for.

If we focus on insulin, we will get something done. If we focus on the whole world, I do not believe we will be able to get anything done.

SENATOR GANSERT
Section 19 of Exhibit C creates a fiduciary relationship between the PBMs and insurance companies which does not exist now. A PBM has a fiduciary duty to a third party with which the PBM has entered into a contract. We are requiring it to have a fiduciary responsibility to the insurer and I think that is important.

KHANH PHAM (Nevada Pharmacist Association):
I am a pharmacist and a certified diabetes educator. I am the voice of the patient, your constituent, who you do not see on a daily basis. I commend you for looking into this issue. I see patients who are fully insured and patients who are on Medicaid.

The patients who are in Medicare/Medicaid are well taken care of. But the patients who make a dollar above Medicaid level are not qualified for Medicaid and are the ones who suffer. I see the homeless walking on the street not knowing where to go for their prescriptions. Senate Bill 539 is a common sense bill and will help reduce the financial burden for the patients I serve.

As stated by Senator Roberson, 43 states in this Country already have some transparency to cover this division. I would like to ask you to make it a reality so my patients can benefit from it. A lot of people blame the drugmakers because they do not understand the PBM structure or the way it functions.

The PBMs created the pharmacy network. Pharmacists have to sign a contract with the PBM with a gag order, and if we violate the gag order, we will be kicked out of the network. If you pass this bill, it will reduce the burden for all of us as pharmacists and the patients.

I submitted evidence (Exhibit D) for you to see that the PBM pockets all the money instead of passing the rebates back to the employer or the consumer. For example, last year in November, I had an elderly patient with Alzheimer's disease who is insulin dependent. Right now, everybody is geared towards type 3 diabetes and it is insulin resistant in the brain. The patient's home was foreclosed on and his wife told me his copay was all the money they had, and she did not want her husband to go without his medication. She has severe arthritis and can barely move, but wanted her husband to be taken care of. I had a $75 coupon, but I was not allowed to use it for a patient who is on Medicare because it violates the law. Nobody talks about this. I could have saved them money, but I had to look the other way.

I had a child diagnosed with type 1 diabetes three weeks ago. The parents have insurance but it does not cover enough; when the copayment came back as $800, the mom cried and the dad cried in front of me. I used a voucher coupon given to me by the drugmaker and was able to take care of the child for one and a half months.

The PBMs claim they cover everything that insurance does. I do not know the relationship between the two of them, but I know that my patients suffer and know that the patient's actual out-of-pocket cost is a 169 percent increase according to the Center for Medicare/Medicaid Services. The PBMs mandate patients go through their very own mail order services and have created over

30 percent of waste. The waste is due to a 90-day supply being renewed, the doctor changes the medication and the patient cannot use the old 90-day prescription. Another problem was when my patients tried to stop the prescriptions from being shipped, they kept sending them, and my patients are stuck with the bills and have nowhere to go to resolve the issues.

Today, PBMs control 78 percent of all the prescription benefit transactions in the U.S. Their profit is 600 percent, and they are bigger than Walt Disney, McDonalds and Adidas combined. They delay valued treatment and change the formulary without notifying pharmacists in time to act. The PBMs demand prior authorization or deny medical treatments without any explanation.

When patients go without the necessary treatment, they often end up in the emergency room and have increased hospital stays. I have the statistics for Nevada and will be more than happy to provide them to you.

The cost of hospital stays dating back to 2008 to 2010 for a type 1 or a type 2 diabetes patient was between $98,000 and $102,000 per hospital stay. I do not know why the cost is so high in our State when the cost is $55,000 everywhere else.

CHAIR SPEARMAN:
I am uncomfortable saying that they pocket the money without having some tangible evidence. If there is tangible evidence that the PBMs are pocketing the money, it needs to be presented.

It is the price at the beginning that is high. If drug prices were just made affordable, you would not need to have coupons. Senate Bill 394 was passed authorizing insurance companies to provide HIPAA-compliant information to the PBM for a group.

Senate Bill 394 (2nd Reprint): Revises provisions relating to health insurance. (BDR 57-950)

Without sources, and I would say this to anybody, I am just uncomfortable without a source that saying something is the truth. Without some type of source, we are casting an aspersion that we have not yet justified the statements for.

SENATOR ROBERSON:
To be clear, I am not saying this, I am sourcing, when I referenced the Centers for Medicare and Medicaid Services that was from an article from Alan G. Rosenbloom, President and CEO of the Senior Care Pharmacy Coalition. When I mentioned that the reports from the Centers for Medicare and Medicaid Services found that the PBMs were pocketing the rebates, I referenced David Balto, former policy director of the Office of Policy and Evaluation for the Federal Trade Commission's Bureau of Competition, where he talks about and I quoted him that "they are pocketing rebates." If the PBMs come to the table, they will not dispute that they pocket rebates. The question is how much and what percentage of the rebates.

I also want to make clear there is a distinction between manufacturer coupons that are given to the customer at the pharmacy and PBM rebates. They are very different concepts, and I want to steer away from the coupons, which are not what we are talking about. We are talking about rebates that are demanded by the PBMs in order for the PBMs to agree to sell the drugs to include the manufacturer's product in their formulary.

I believe we have presented to the Committee an article by Business Insider (Exhibit E). I know that you are not going to make a decision right this moment, but I would encourage all of you to spend ten minutes on Google and find source after source that talks about the rebates received by the PBMs and what they do with them. None of us know exactly how much of those rebates are put into their own pockets. They do not want anyone to know, even their own clients. I will give you one more citation, by the National Community Pharmacists Association. They prepared a presentation detailing many common PBM practices that drive up health care cost. This is from the National Community Pharmacists Association.

According to this association,

> Some of the more prominent examples of common PBM practices include classifying certain generic drugs as brand drugs and then charging brand prices. Promoting drugs based on the rebate the PBM obtains, not on the consumer's best interest. PBMs will prefer brands from which they get the highest rebate even if there is an equally well or better-suited drug that is cheaper for the consumer. Sometimes PBMs will even switch patient's prescriptions without

> the knowledge of the patient just so that the PBM can receive the rebate!

Utilizing spread pricing, and that gets back to what happens where the PBM charges the health plan one price for a drug and a different price will be charged by the PBM to the pharmacy network, and then the PBM claws back the difference, or they keep the spread.

The presentation goes on to state,

> They utilize spread pricing by charging health plans more than they reimburse pharmacies and pocketing the difference. And finally, using abusive audit practices and penalizing pharmacies for minor typographical errors on claims, forcing them to forgo reimbursement due to small errors that post no consequence to the claim.

Those are not my allegations; those are the claims of the National Community Pharmacists Association. I want to be clear, everything I have said today has been based on research and using credible nationally recognized sources.

SENATOR HARDY:
Are the 43 states studying this able to find a trend that they can save money for the consumer or the end user of the product?

MS. PHAM:
We are at your mercy as pharmacists. At the pharmacy level, we do not have any authority to make any decisions. All we are allowed to do is dispense the drug. I always, to the best of my ability, use the best medication available for the patient based on what they can afford. Because I know, it cost $2.6 billion to bring one drug on the market. It takes 10 to 20 years to come up with one compound to apply to the Federal Drug Administration. During that time, the drugmakers still have to pay for the scientists, the janitor, and the medical equipment to have the drug come out on the market. The drugmaker has never employed me and I am not speaking on its behalf. I just learned why the drug is expensive.

SENATOR HARDY:
My question is more on the 43 states that are doing the transparency on the PBMs. Have they shown a decrease in the money charged to the patient with anything that they have been able to do in the other states? In other words, when you go to Utah, Arizona or one of the other 43 states, is the insulin cheaper? Is Nevada different or are we in the same challenging time and no one has figured this out yet?

MS. PHAM:
I know for a fact through all the research that I have read there is no increase in cost. However, you can buy a vial of insulin for $25 to $50 for the NPH Insulin R. I know my patients pay $100 out of pocket for one single pen of the sophisticated analog insulin such as Toujeo, Lantis or Tresiba.

I do not know where the claim of a few thousand dollars a month came from. I advise my patients they always have the option to choose a better insurance plan. The cash price for what we have here is standard. With a coupon, the cost can come down $15 or $25 for a month supply.

SENATOR HARDY:
As a physician, somebody will say these are coupons, but they are only good for private insurance not good for cash pay or for Medicare or Medicaid patients. Is this part of the gag rule you are talking about?

MS. PHAM:
I am not allowed to use the coupons for patients who are on Medicare or Medicaid because that is against the law. I have used the coupon for the insulin directly for cash paying patients.

JULIE KOTCHEVAR (Deputy Administrator, Director's Office, Department of Health and Human Services):
We have reviewed the bill and are able to provide the analysis requested without incurring a fiscal impact.

SENATOR RATTI:
Can you speak to the interrelation between the reporting that would be required between S.B. 265 and S.B. 539?

MS. KOTCHEVAR:
Senate Bill 539 requests a different reporting and specifically asks the manufacturers to issue a report explaining why there was an increase if they are on the list of the named drugs that had an increase. Senate Bill 265 asked for specific information about costs related to the manufacturing of drugs. It would be reported to the Department of Health and Human Services and the Department would analyze the information and then an issue a report on the impact of those costs on the overall pricing of the drugs.

SENATOR RATTI:
Does this bill only pertain to an increase versus S.B. 265, which is for all costs?

MS. KOTCHEVAR:
Senate Bill 539 requests the Department to compile a list of drugs that specifically have had an increase of certain amounts based on the Consumer Price Index Medical Care Component. Senate Bill 265 requests a list of essential diabetes drugs and any costs related to them.

SENATOR RATTI:
Senate Bill 539 is focused on an increase. If there is a drug that is already expensive and does not increase significantly, then the transparency provision does not kick in?

MS. KOTCHEVAR:
I do not believe so.

CHAIR SPEARMAN:
You mentioned the manufacturers' pricing, and that is what I was trying to say during the hearing of S.B. 265. All pricing starts with the manufacturers. Do you remember what you just said about manufacturers' pricing?

MS. KOTCHEVAR:
I believe the manufacturers had to report the costs related to their pricing. In S.B. 265, the manufacturers have to report specific costs that would apply to the pricing. In S.B. 539, the manufacturers are asked for an explanation if there was a price increase.

SENATOR HARDY:
Has there been a cost increase to the State's budget for the insulin products?

MS. KOTCHEVAR:
That would be better answered specifically by Medicaid. My understanding is the pharmaceutical costs have increased overall. Whether or not there is data specific to the types of drugs would probably need to come from our Medicaid Services section.

SENATOR HARDY:
Are they here?

MS. KOTCHEVAR:
They are here, but I do not know if they will have the information you are requesting.

JOHN JONES (Pharmaceutical Care Management Association):
I am a pharmacist and have a history of working for health plans in PBM agreements for the last 20 years.

Pharmacy benefit management companies exist because businesses and peers for pharmacy benefits need their services. Typically, if you have a drug card and get a prescription filled, it is through the operations of a PBM.

The National Community Pharmacists Association is the trade group for retail pharmacies. The retail pharmacies are contracted with PBMs and the PBMs strike the best deals possible for their clients. The PBMs' clients include the government, through Medicaid and Medicare, insurers, health plans, unions, large employers, small employers and so on. The clients select their PBMs by use of consultants. The consultants know the business and often have worked for the PBMs.

There are about 60 PBMs throughout the Nation; 3 of them are the largest and command 70 percent to 80 percent of the market. If a health plan, an insurer or a union wants to get a different PBM, they simply select another PBM.

SENATOR RATTI:
Please take us back to the basics. What is the value of a PBM and why are they needed?

MR. JONES:
Pharmacy benefit management companies started in the 1980s as claim processors for prescription benefits. At first, they just paid claims, which were submitted on paper. When electronics came in support of the industry, the PBM would process the claims electronically. Large employers, small employers and so on started to demand more services from the PBMs to manage the drugs that were available to the members of those programs. The PBMs rose to the task of getting a formulary of drugs for the lowest prices possible from the manufacturers for the physicians and pharmacists.

The question was asked as to where do the rebate dollars go. This is intensely negotiated via contract, and in the vast majority of contracts, the rebates are going back to the payer at 100 percent. Whether it is a union or an insurance company, the money goes back to them four and six months after the prescription is filled.

The manufacturers ask why should we pay PBMs. If you have their product and shift the market share to their product, it is worth dollars to the manufacturer. The manufacturer is not going to pay the rebate up front because if its product is not shifted to the market share, why should it? Instead, manufacturers are going to ask you to show them how much of certain prescriptions have shifted to their drug, and they will give rebates on a graduated scale according to how much the market has shifted to their product. The only way this can be done is through a rebate and after the fact. Typically, 90 percent on average goes back to the payer. How they distribute the money is up to them and is nothing the PBM has control over.

Why are the drugs so expensive? Because manufacturers set the price, PBMs do not set the price. We can negotiate for a more aggressive rebate and if those prices go up, we try to get as much in the way of discounts and rebates as possible. That is what our clients demand.

How the clients pay the PBMs varies. Different clients want to pay in different ways. Some clients want to pay an administrative fee and other clients want to share a percentage of rebates. It is up to the client, and the market will determine how the PBMs are paid.

Ninety percent is the average that goes to the payer from the PBM. The PBMs are audited. Every contract that I have ever seen with a client involves auditing

of the PBM so they can determine how many dollars the PBM collected from the manufacturer and how the money was distributed according to the terms of the contract.

CHAIR SPEARMAN:
Please repeat what you just said.

MR. JONES:
The PBM has a contract with whatever payer it is giving services to. That includes the network rate, the rebate amounts, and performance standards. Unless it is a state organization, the contract is private between the contracting entities. It is a public document if the PBM has a contract with Medicaid. It is not considered a public document if it is a commercial document and considered a confidential document. This holds true when you contract with a manufacturer for what you are going to get back in rebates.

The Federal Trade Commission (FTC) and the Congressional Budget Office (CBO) have both said it is necessary that these documents are confidential, otherwise everyone will ask for the same price and there will not be any incentive for the manufacturers to give the lowest price. Why would the manufacturers give you their lowest price? If they give the same price to another client or PBM, it devolves one price for everyone and there would not be any competition.

When the hepatitis C drugs first came out, the cost was $84,000 for a treatment. Once there was a competitor on the scene, the PBM could force the manufacturers to the table to negotiate and demand a significant reduction in price. We did better than the European Union as far as the price discount for those drugs. This was done through the competitive market and competitive bidding. Once a second product came onto the market, there was about a 40 percent reduction in the cost of those drugs. This is aggregate, and it would be defended as a private contract between the manufacturer and the PBM. When looking at Medicare Part D, the FTC and the CBO would agree not to disclose these contracts or the contract between the payer and the PBM. It is a confidential document. Once you disclose the contracts, you will not get the same discounts, and the cost of care would go up.

I talked about the National Community Pharmacists Association (NCPA) which is a trade group. I represent the Pharmaceutical Care Management Association

(PCMA), which is a trade group for the PBMs. The NCPA is a trade group for the Independent pharmacies and they do not like the PBMs because the PBMs drive hard bargains.

The sponsor talked about David Balto, who is a consultant for the NCPA. Mr. Balto is not going to say kind things about PBMs and it has been a long time since he has been at the FTC.

SENATOR RATTI:
We have heard a lot about the gag rule, how does that work in practice?

MR. JONES:
A pharmacy will have a contract with its PBM, and how the PBM pays the pharmacy is confidential. It is not public information to tell every pharmacy what is given to another pharmacy. I have listened to the references to the gag rule. I have not personally had a contract where it says you cannot talk to the patient about his or her therapy.

SENATOR RATTI:
What is a typical profit margin for a PBM, and where do the PBM Chief Executive Officers (CEO) rank in the top paid CEO scale?

MR. JONES:
Of the total dollars, PBMs are 4 percent, pharmacies are 7 percent, wholesalers are 1 percent and the manufacturers are 88 percent.

The PBMs drive hard bargains with the manufacturers and the manufacturers do not like that. The manufacturers point fingers back at the PBMs saying if not for PBMs, their products would cost less. That is not true. If it was not for the PBMs, they would cost more.

SENATOR HAMMOND:
Your last statement is very interesting. We are saying there has to be transparency all along the line. It is understood that in order to do business you have to keep some things proprietary.

It is true that there can be more disclosure with government contracts and the PBMs do not want to share all their numbers. Would it hurt to disclose some of the numbers for the rebates, and would it not hurt to give some disclosure in

the aggregate as to what these transactions are and how much money is coming back to the consumer or how much money is sent back to the manufacturers? If there were a little bit more disclosure from the PBMs and the manufacturers, we would have a better idea of what is going on.

MR. JONES:
Ninety percent of the rebates going back is an aggregate statement, and that was through a study of PBMs and rebating practices. Some clients do not want any fees up front and want all of the fees taken through rebates. It varies, but 90 percent is the average number that goes back to the payer.

SENATOR HARDY:
I am still interested in the consumer. How much of the rebate goes back to the consumer? How does the consumer benefit? What is the role of the PBM to the consumer? How do you interface with the consumer to give them assurance they can afford their insulin?

MR. JONES:
Our contract is a business-to-business contract with the payer, whether it is a union or insurer. The payers benefit in the way it is structured, the way the dollars are used, and we have no control over it. Premiums and copays could be decreased; there are any number of ways, but that is up to the payer. There is no way a PBM would have any influence over that.

SENATOR HARDY:
You do not have a gag rule that precludes the pharmacist from telling a consumer they can get the drug cheaper or telling them this insurance would be better than that insurance?

MR. JONES:
Over the years whether I was working for a health plan or a PBM, I did not see any contracts that with that level of granularity in pharmacist-to-patient interaction. Being a pharmacist myself, I always looked out for my patients when I was dispensing.

SENATOR HARDY:
Do I understand correctly that you do not mind the transparency concept?

MR. JONES:
The PCMA understands transparency and supports it to the extent that it is good for the consumer. The minute transparency is driven down to where you cannot get good deals with manufacturers as far as their costs or a pharmacy as far as costs, it then becomes more expensive. The PBMs are there to reduce the cost of things for our clients, not increase those costs.

SENATOR HARDY:
That is your objection to the transparency in S.B. 539, that it would allow private negotiating, decreasing your ability to drive the bargain so that you have a fiduciary responsibility for your client, as well as to make sure your salary still is paid?

MR. JONES:
Yes, the FTC and the CBO agree with that.

SENATOR HARDY:
Would you see a commerce clause issue with this bill?

MR. JONES:
The states where they have pushed for this type of disclosure have found it to be challenged under federal law or repealed. Maine had a law for a while, and it was repealed because they were not getting the reduction.

You asked about which of the 43 states got a reduction. All 43 states are still dealing with the original price of the drug set by the manufacturer.

SENATOR HARDY:
If you were a manufacturer, would you have the same challenges you are having as the PBM sitting here? Is the PBM in favor of S.B. 265?

MR. JONES:
Our organization has not taken a position on S.B. 265. Members of our organization have to negotiate with the pharmaceutical industry on a regular basis, and they look for every angle to reduce those costs.

SENATOR HARDY:
Pretend it is somewhat transparent; are your contracts on a flat fee or percentage of the cost?

MR. JONES:
Every client wants something different. Some clients want great rebates and most clients want the lowest net cost. Some clients want to share a percentage of the rebates to pay the fees and some clients do not want to share any of the rebates to pay the fees. Some clients want everything and want to give a flat fee for administering a program. The reality is the customer is king and the larger the customer, the greater the king.

SENATOR HARDY:
Does the PBM decide the formulary?

MR. JONES:
Would you please restate your question, I want to be sure I answer it correctly.

SENATOR HARDY:
If you are in charge of the formulary and contracting with an insurance company or payer to be able to do the formulary, is there an economic advantage to you to have a formulary that you gain more from than the formulary that would be less?

MR. JONES:
I would say no in the market of today. The customers are very sophisticated and the health plans have their own medical directors and chief pharmacy officers who look closely at a PBM formulary and decide whether to accept that formulary. They understand both the therapeutics and the financials, and do not have to accept the formulary. The customers can depart from that formulary, and some do, but most do not.

It is imperative that the PBM have a high integrity process so the customer adopts the formulary that the PBM has put out there. Typically, people who are not employed by the PBM as full-time employees who are practicing physicians and practicing pharmacists are making those decisions independently and the PBM wants to be able to stand behind their decisions and not say it was a business decision. Therapeutics comes first and then pricing after the therapeutics. If a customer says, "We need this drug on the formulary," you take that and then negotiate your best price.

SENATOR HARDY:
With the competitive market and low margins on insulin, are you putting insulin on your formularies?

MR. JONES:
Insulin has three large manufacturers. You try to get the best price for the products that you need to have on a formulary to serve that population.

CHAIR SPEARMAN:
Is there a specific part of the bill you are opposed to?

NICK VASSILIADIS (Pharmaceutical Care Management Association):
We are opposed to the bill in its entirety. We would be open to discuss the bill as a matter of philosophy.

CHAIR SPEARMAN:
Did you meet with the sponsor of S.B. 539?

MR. VASSILIADIS:
My boss met with the sponsor.

SENATOR HAMMOND:
When you were talking about the gag rule, you said you were unaware of any kind of gag rule, is that correct?

MR. JONES:
The terms of contracts are confidential. I cannot say that I have seen every contract because I have not, but the ones I am aware of do not say you cannot talk to the patients.

SENATOR HAMMOND:
Mr. Jones, you are aware it is a problem. You may not be aware of it in any contract, but surely you have to be aware of the problem.

After you had made that statement, I went online and Googled a few words to find out. I have come up with approximately 20 different articles that talk about how call backs and gag rules are definitely contributing to the higher prices that are occurring among the consumers. I just ran into 10 or 15 articles talking

about the millions being saved by CEOs of companies from PBMs. To be less than aware is maybe a little short of what we need to tell.

MR. JONES:
The people who are writing those articles have a different interpretation on what they can and cannot say. They may have multiple contracts that they are looking at, I am not aware of anyone that cannot describe any therapeutic alternatives. Again, a lot of the people who have complained, are also parties to the contract that are concerned about their reimbursement.

SENATOR HAMMOND:
I will leave with this; I listened to the testimony of a pharmacist who has to be on the front line with the consumer and cannot explain ways for the consumer to save money. These people are the most vulnerable. The elderly woman whose husband is definitely dependent on this medicine and she cannot tell them. The pharmacist's testimony is very compelling when she talks about the 600 percent increase in salary among PBMs being higher than McDonalds, Adidas and Walt Disney combined. Yet, she cannot explain to the person who cannot afford the insulin that they could probably get it cheaper somewhere else. Now you know that there may be a problem out there.

MR. JONES:
In response to the increasing costs of the drugs, a number of the payers have looked at other ways to keep those costs in alignment. Deductibles are one way and that puts a burden of cost on the patient. It comes down to whether the drug is overly priced and we could come to some agreement and say it should be that high. That is the price that has been increased into the market. I can understand why that is a burden for most people when the first $1,000 is your deductible.

SENATOR HAMMOND:
Since you claim the manufacturer sets the price, there is not much you can do to help on the back end when they are selling the drug. If you actually prohibit somebody from explaining that there is a lower cost option, the competition goes away. If I were buying a cheaper drug repeatedly, then whoever is selling it higher would start to think that they need to lower their price to compete. I think that is a major part of this issue now.

CHAIR SPEARMAN:
You raise a valid point. There was another bill where pharmacists were asking permission to talk with their patients and discuss medications because they see the patient more than the doctors. Those who represent doctors in the medical field were against the bill because they did not want pharmacists talking to patients about medications. It is one thing to say here is a lower costing drug, but at the same time, that drug may have a different composition and might not work well with another. The doctors do not want pharmacists talking to patients and telling them what to take.

You said that it is more of what is in a contract in terms of what can be disclosed because the contents of contracts are proprietary information. The manufacturer sets the price and everything after that is a consequence of what happens at that price setting.

ELIZABETH MACMENAMIN (Retail Association of Nevada):
That was the collaborative practice of pharmacy in which pharmacists will work through a doctor and with a doctor in order to help patients manage their drug therapy.

For the record, my personal pharmacist is more than willing to work with me and always lets me know what the cheaper drug is. I had a very expensive drug prescribed to me a couple of years ago, and my pharmacist told me my copay was going to be $80. We went through the whole process, which is the pharmacist's role. The pharmacists always try to get the patient on a cheaper drug that is just as effective.

CHAIR SPEARMAN:
Would you please repeat the name of the bill we passed?

MS. MACMENAMIN:
It is S.B. 260, the collaborative practice of pharmacy, and it passed the Assembly on May 25.

SENATE BILL 260 (2nd Reprint): Establishes requirements for engaging in the collaborative practice of pharmacy. (BDR 54-973)

SENATOR ROBERSON:
You have heard a lot of denials from the PBM industry. If they have nothing to hide, they should be willing to be more transparent. I just looked at another article from February of 2017 by Bloomberg. If Mr. Jones has not heard of a gag rule or a gag order, then he did not hear that Arkansas passed a law in 2015 prohibiting PBMs and pharmacies from charging customers more than the pharmacy will be paid. This is your claw back issue. In 2016, Louisiana passed a law allowing pharmacists to tell customers how to get the cheapest price for drugs, trumping contract gag clauses. This is a Bloomberg article from February 22, 2017 and is not from big Pharma or the retail pharmacy community.

This Committee is in charge of making policy with regard to health care matters. I am surprised that this has not come up before in previous sessions or early this Session. I know it is late in the Session and you will or will not do whatever you want with this bill. I promise you this, if nothing is done in the next ten days, one of you on this Committee will become more informed on this issue and probably champion this issue in 2019. If Congress has not addressed it by then, I am quite sure you will. Take ten minutes and use Google. You will learn what Mr. Jones does not want you to learn.

CHAIR SPEARMAN:
We are closing the hearing on S.B. 539 and will begin the work session with A.B. 474.

ASSEMBLY BILL 474 (1st Reprint): Makes various changes relating to drug overdoses and prescribing and using drugs. (BDR 40-1102)

MEGAN COMLOSSY (Policy Analyst):
Assembly Bill 474 makes various changes relating to drug overdoses and prescribing and using drugs. It was heard in this Committee on May 17, and sponsored by the Assembly Committee on Health and Human Services on behalf of the Office of the Governor.

The A.B. 474 work session document (Exhibit F) revises certain provisions concerning the prescription drug monitoring program for controlled substances. This bill authorizes certain occupational licensing boards to access the prescription drug monitoring program database and requires such boards to review and evaluate certain information and impose disciplinary action. The

measure permits such an occupational licensing board to suspend the authority of a practitioner to prescribe, administer, or dispense a controlled substance in certain circumstances. In addition, the bill revises various provisions governing the accessibility of health care records in certain investigations.

The bill requires a practitioner, other than a veterinarian, who intends to prescribe or dispense a controlled substance listed in schedule II, III or IV to consider certain factors, take certain actions, and document certain information before initiating such a prescription. Additionally, the bill revises the required contents of certain written prescriptions and requires certain persons to make a report of a drug overdose or suspected drug overdose to the State's Chief Medical Officer. No amendments were proposed for this measure.

CHAIR SPEARMAN:
Would someone please come to the table to clarify the intent in section 51?

ELYSE MONROY (Policy Analyst, Office of the Governor):
During the hearing, there were questions from Senator Hardy regarding confusion with section 51. We want to make sure that the record is clear on our intent with section 51.

We changed the definition of initial prescription, which was added in statute with S. B. No. 459 of the 78th Session.

The sentence added in section 51 is, "The term does not include any act concerning an ongoing prescription that is issued by a practitioner to continue a course of treatment for a new or existing patient of the practitioner." The new language to the definition of initial prescription is to better clarify that if there is a continuation of an existing course of treatment by a new provider and that continuation would not be considered an initial prescription. We are trying to ensure that there is a continuity of care.

SENATOR HARDY MOVED TO DO PASS A.B. 474.

SENATOR RATTI SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

* * * * *

CHAIR SPEARMAN:
What is the pleasure of the Committee with regard to A.B. 473 for continuation of certain drugs on the preferred list for the Medicaid program?

SENATOR RATTI MOVED TO DO PASS A.B. 473.

SENATOR HARDY SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR SPEARMAN:
There being no public comment and no further business before this Committee, the meeting is adjourned at 5:27 p.m.

RESPECTFULLY SUBMITTED:

Tammy Lubich
Committee Secretary

APPROVED BY:

Senator Pat Spearman, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	1		Agenda
	B	4		Attendance Roster
S.B. 539	C	17	Senator Michael Roberson	Proposed Amendment 5037
S.B. 539	D	30	Khanh Pham / Nevada Pharmacist Association	Lift veil on pharmacy benefit managers, reduce prescription costs
S.B. 539	E	7	Senator Michael Roberson	Business Insider Article
A.B. 474	F	1	Megan Comlossy	Work Session Document