MINUTES OF THE
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-ninth Session
March 29, 2017

The Senate Committee on Health and Human Services was called to order by Chair Pat Spearman at 3:39 p.m. on Wednesday, March 29, 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 Nicole J. Cannizzaro, Senatorial District No. 6
Senator Yvanna D. Cancela, Senatorial District No. 10

STAFF MEMBERS PRESENT:

Megan Comlossy, Policy Analyst
Eric Robbins, Counsel
Debbie Carmichael, Committee Secretary

OTHERS PRESENT:

Sheila Leslie, Social Services, Washoe County
Travis Warren, Police Officer, Police Department, City of Reno
Shawn Marston, Deputy Sheriff, Sheriff's Office, Washoe County
Brandi Planet, Dignity Health – St. Rose Dominican
Marlene Lockard, Nevada Women's Lobby; Human Services Network; Service Employees International Union Local 1107 Nevada
Trey Delap, Group Six Partners

Amy Roukie, Deputy Administrator of Clinical Services, Division of Public and Behavioral Health, Department of Health and Human Services
Jodi Tyson, Three Square
Shane Piccinini, Food Bank of Northern Nevada
Jon Sasser, Washoe Legal Services; Legal Aid Center of Southern Nevada
Denise Tanata, Executive Director, Children's Advocacy Alliance
Edwina Richardson, Macedonia Outreach Social Enrichment Services
Mary Finch, Three Square
Steve H. Fisher, Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services,
Barbara Buckley, Executive Director, Legal Aid Center of Southern Nevada
Mekhi Overton-Jackson
Stephanie Mahler
Elliot Brittain
James Conway, Executive Director, Washoe Legal Services
Jesse Fredzess
Yolanda T. King, County Manager, Office of the County Manager, Clark County
Jodi Stephens, Wynn Resorts, Limited
Kevin Schiller, Assistant County Manager, Washoe County
Praveen Jayakumar, M.D., Medical Director, Culinary Health Fund
Bobette Bond, Executive Director, Nevada Healthcare Policy, Unite Here Health
Kevin Hooks
Tanya George
Rita Neanover
Bonnie Jean Sedich
Peggy Lear Bowen
Christopher Hughes
Keith Lee, Nevada Association of Health Plans
Rusty McAllister, Nevada State AFL-CIO
Jim Sullivan, Culinary Workers Union Local 226
Stacie Sasso, Health Services Coalition
Matt Morrison, Executive Director, Healthcare Operations, MGM Resorts International
Ruben R. Murillo, Nevada State Education Association
Ryan Beaman, Clark County Firefighters Union Local 1908
Todd Ingalsbee, Professional Firefighters of Nevada
Priscilla Maloney, AFSCME - Retirees
Russell Rowe, Boyd Gaming Corp.
Mike Alonso, Caesars Entertainment

Rachel Gumpert, AFSCME International
Randy Soltero, International Alliance of Theatrical Stage Employees
Fran Almaraz, Teamster Local 986; Teamster Local 631
Jeanetta Williams, President, NAACP Tri-State Conference Idaho-Nevada-Utah
Beth Handler, Chief, Bureau of Child, Family and Community Wellness, Division of Public and Behavioral Health, Department of Health and Human Services
DuAne Young, Chief, Behavioral Health and Pharmacy Services, Division of Health Care Financing and Policy, Department of Health and Human Services
Kipp Snider, Pharmaceutical Research and Manufacturers of America
Brian Warren, Biotechnology Innovation Organization
Jeff Buel, Johnson & Johnson Services, Inc.
Chris Ferrari, Pfizer, Inc.

CHAIR SPEARMAN:
I will open the hearing on Senate Bill (S.B.) 192.

SENATE BILL 192: Establishes required hours of operation for certain mobile mental health units. (BDR 39-816)

SENATOR NICOLE J. CANNIZZARO (Senatorial District No. 6):
The reason why S.B. 192 came to my attention deals in part with what I do for a living, which is I am a prosecutor with the Clark County District Attorney's Office. All too often, we struggle when we encounter individuals who are in the court process by virtue of the fact that they have an unaddressed mental illness, or they have not had the resources to intervene to ensure that they are getting the help that they need. Instead, they become the subject of one of the Clark County District Attorney's Office cases. Frankly, it is very difficult for them to encounter those individuals to address with the criminal justice system. I had discussions on how can we better address this situation, so we are not using our criminal justice resources on individuals who deserve treatment. This issue started to percolate, which is the existence of what we have now in Clark County, Washoe County, Lyon County and Carson City, which are mobile mental health units (MMHU). What came out of the discussions was the suggestion that if these MMHUs were more readily available, that we might be able to combat this situation. While S.B. 192 is quite short, its impact could be substantial. Senate Bill 192 requires that any facility within the Department of Health and Human Services (DHHS) in the Division of Public and Behavioral

Health (DPBH), which provides mobile mental health services in Clark and Washoe Counties to ensure the mobile unit is available to provide those services from at least 8:00 a.m. until midnight, 7 days a week, 365 days a year. Currently, this requirement would apply to the mobile outreach safety team (MOST), a program that pairs a behavioral health professional with a law enforcement officer to respond to calls, and provide intervention for those in mental health crises.

In February of 2017 alone, MOST served more than 200 clients statewide including 158 clients in northern Nevada, 15 clients in southern Nevada and 28 in Carson City and Lyon County. This program is extremely popular among law enforcement and the behavioral health community as evidenced by its expansion from Washoe County to rural areas of the State, and in 2015, to southern Nevada. The goal of S.B. 192 is to expand on an already successful program in order to increase the access to much needed services, because mental health crises are not limited to 9:00 a.m. to 5:00 p.m., Monday through Friday. By providing mobile mental health services outside of regular business hours, the State will be able to serve many more Nevadans in crisis when they need care most. This is an important step in that direction, just to require that these services are available, to engage in intervention and to help those individuals who really do need help, and are not receiving it from other sources. One thing that struck me when this issue came up was it only operated during business hours. If you talk to anyone in this building, there are loved ones or family or people they know who have a mental illness or mental health issue and it does not restrict itself or turn on or off at 9:00 a.m. Oftentimes, it can become a larger problem during hours when these services are not available. Mental health is a huge issue not only in this State and I think this is a good way to start to address it. Senate Bill 192 is quite short in terms of policy and is to increase the access of these particular services. There is a fiscal note on S.B. 192 and this is something we will have to address and combat.

SENATOR HAMMOND:
I have questions that may be addressed during the next expert testimonies, but I will ask them now in hopes of them being covered. What divisions will do this right now? How many of the mobile units are deployed right now? What are the limitations to expanding the hours? Who sets the hours now? Why are they those hours? Is it financial or other considerations? I would be interested in seeing the fiscal note.

SENATOR CANNIZZARO:
There are at least four different areas, Washoe County, Clark County, Lyon County and Carson City, which are working within the constructs of mobile mental health units. Senate Bill 192 just addresses the MOST program in Washoe County and Clark County. The limitations are part fiscal and part lack of service providers, which I know is another issue that has been before this Committee and the Legislature, and is an ongoing and important discussion. Even though we are asking to expand the MOST program, we can also work on ways that qualified individuals can be identified and brought to Nevada so we can get some of the services in place.

SHEILA LESLIE (Social Services, Washoe County):
Washoe County Social Services support S.B. 192. I will give you a brief history of the MOST program. In 2009, this legislation came forward in the money committees as a pilot project. The idea came from the Reno Police Department. The officer who is behind "Million-Dollar Murray" brought the idea forward. "Million-Dollar Murray" is a *The New Yorker* article about a homeless man and really tells why Nevada needs MOST teams. Senator Raggio was the Chair of the Senate Committee on Finance at the time, and at the very end he came forward and said this is very important, and we are going to carve out some money and give it a try. It was established as a pilot project in Reno. It was so successful in Reno that it has been replicated, in a slightly different model in Las Vegas and the rural counties.

TRAVIS WARREN (Police Officer, Police Department, City of Reno):
I have been running the MOST team for the last four and a half years. The MOST is a crisis intervention unit that was developed by the Reno Police Department in partnership with Northern Nevada Adult Mental Health Services (NNAMHS). In 2008, as a police department, we started recognizing that we were encountering individuals on the street in calls for service that were in crisis, mental health or situational. Our only tools were either taking them to jail or the hospital. We were limited in what to do for them and recognized we could do something better. We worked with NNAMHS and developed a program called MOST, which pairs a mental health counselor with law enforcement to respond in a first responder type setting. When we encounter these individuals in crisis by the time they get to the hospital, most of the crises have subsided, and the doctors may not see what we are encountering on the street. The person may not get the treatment he or she needs.

Since that time, we have two mental health counselors employed by the State that work alongside both the Reno Police Department, the Washoe County Sheriff's Office and the Sparks Police Department. During my time in the unit we have been able to expand the program to Carson City. Last year we were able to contact over 1,400 people in Washoe County with just 2 mental health counselors, ranging from mental health follow-ups from our detectives to our victims unit to calls for service from police officers on the street who encountered these individuals in crisis. Our working hours are 6:00 a.m. to 4:00 p.m., so the officers working swing shift or graveyard hours do not have the benefit of having these mental health intervention specialists work alongside them. This is due to funding. One area of growth we have identified is expansion of the crisis intervention units into those hours. For the Washoe County area, which includes all three major law enforcement agencies, Pyramid Lake Police Department, Tribal Police Department and the University of Nevada Reno Police Department, a lot of our mental health and suicidal subjects' calls we are encountering are from 10:00 a.m. to midnight. We see a large spike during the late afternoon into evening hours, which is generally when the mental health counselors are not available. While some officers have crisis intervention training it is really important to have a mental health specialist with them to develop the rapport with the individual and help them navigate through the system.

SENATOR HAMMOND:
Does a unit consist of a police officer and a mental health specialist in a car driving around?

MR. WARREN:
Reno is unique in the sense that the Reno Police Department fully funds the position of the MOST coordinator. There is an officer that is strictly assigned to the MOST team. Other agencies, based on availability of officers, deputies or personnel, can mold and shape this program to however it fits best. The primary focus is that the mental health counselor is in the vehicle, responding to the crisis call when it is occurring. The most timely and beneficial services can be provided to get the individual navigated away from the criminal justice system and away from the emergency services into something that will benefit them in the long term.

SENATOR HAMMOND:
I am trying to figure out how the MOST operation works. The number of beds taken by these individuals in emergency rooms where there is no MOST team must be problematic. Is this something you are trying to avoid?

MR. WARREN:
Yes, that is correct. We may go on a call where the person is starting to show signs of crisis, but the key is when the mental health specialist is in the car with us, he or she can identify some of the things before it may become a situation where law enforcement or emergency services has to respond, and take them to the hospital or incarcerate them. There is also the early intervention piece that is really important that helps reduce the calls for service and unnecessary contacts. One thing we try to do is reduce the impact on the community and on the individuals who are in crisis.

SHAWN MARSTON (Deputy Sheriff, Sheriff's Office, Washoe County):
I highly support the MOST program. I am a MOST liaison for the Sherriff's Office. The mental health specialists are primarily assigned to the Reno Police Department. The City of Sparks and the Washoe County Sheriff's deputies need those resources available to them which they do not have, other than on a limited basis. Officer Warren would respond, when he could, into the unincorporated areas of Washoe County and try to assist or I would pick up a MOST worker and go out to the call. When a deputy is out on a call and there are no resources, it is extremely frustrating, especially when the deputy keeps going back to the same house time and time again. We had one incident in Sun Valley, for example, where the deputies had to Taser the mentally ill person. He was living with mom and dad and the incident happened right after payday. The parents were the caretakers and they pulled their hair out because they did not have the resources available to help their son. The following month when payday hit, the same incident occurred and the deputies went out there. Because the deputies only know how to do their job and they did not have knowledge about mental illness, they were actually sending the person and his family on a course of destruction. The MOST worker and I responded to a call at the same home. The MOST worker helped the individual and the family, and connected them to resources to get them back on track. The expansion of the MOST team is needed as we need to fan and farm out the resources to handle these types of calls.

SENATOR RATTI:
Is the intent of S.B. 192, if the $2.9 million fiscal note is met, that the MOST team would be an on-call resource during those hours for anybody within Washoe County or Clark County?

MS. LESLIE:
Washoe County Social Services is in the process of subcontracting with the State so they will have more local control. It has been a concern because there is so much need and so much competition for the resources. Sparks is involved in the regional group and I know they would like to expand as well. The MOST workers are State workers and they are transitioning to be county workers but that has not been completed. With the expansion of money we will sit down with the three jurisdictions to figure out what is the best way to spread the resources and I am not sure how it will look.

SENATOR RATTI:
Senate Bill 192 says there will be at least one MOST worker available during these hours within Washoe County and Clark County.

MS. LESLIE:
Yes, that is my understanding that we will at least expand the hours to be 8:00 a.m. to midnight, seven days a week with one MOST worker.

CHAIR SPEARMAN:
During the Interim, a presentation was made and a figure was shown on what it would cost if the MOST team had not been there, the avoided cost. There is a $3 million fiscal note but sometimes if things are done up front it looks huge but without it what would the cost be?

MR. MARSTON:
In the past six years we have built a program called Crossroads which targets mentally ill homeless people. Our statistics show nationally a mental illness co-occurring disorder is around 55 percent. In our program the male population is 76 percent and the female population is 90 percent. We conducted a one-year look-back from each one of the clients who came into the program, and those individuals on average cost the community $250,000 on average per year.

CHAIR SPEARMAN:
Is that $250,000 per person or $250,000 aggregate?

MR. MARSTON:
Yes, that is $250,000 per year for emergency response. The University of Nevada, Reno did a study showing when police, fire and medical personnel respond to an incident what the cost would be to the taxpayer. Transport to the hospital and emergency room visit is over $10,000, the arrest and other costs equates to $250,000 per person.

CHAIR SPEARMAN:
Are there any trends in terms of presenting problems? If all of the money is not obtained, is there one thing or a combination of things that we can look at proactively to lessen or mitigate the $250,000 per person?

MR. WARREN:
One of the things we have identified is the implementation of a comprehensive case manager. When we have initial contact with an individual, it may be a week or longer before another contact is made with them because of availability of resources. If there was a comprehensive case manager that we could do a warm handoff to, then the case manager could continue to work with the individual throughout the case. There would always be a degree of contact, so the individual does not fall through the cracks. That would be a positive impact in the community.

SENATOR HAMMOND:
Where are the cost savings? Maybe in some cases we do not have to add resources, but shift resources if we know where we are saving the money. Is the $250,000 truly per person?

MR. MARSTON:
It is $250,000 per individual that we encounter and do wrap-around services for. Some of the clients we did the study on were $120,000 per year and some reached up to $1 million. The calls for services that we encounter are for the mentally ill treating themselves with drugs and alcohol.

MS. LESLIE:
This program actually saves lives. Many of the calls law enforcement goes on are active suicides, people who are trying to commit suicide by cop, lots of people who are in horrendous psychotic crisis situations. It is very important for early intervention, but the program provides a vital crisis intervention role and it

helps law enforcement to have these specially trained people with them at the scene.

BRANDI PLANET (Dignity Health – St. Rose Dominican):
Dignity Health – St. Rose Dominican is committed to the principle that health care is a basic human right for all and is in support of S.B. 192.

MARLENE LOCKARD (Nevada Women's Lobby; Human Services Network):
The Nevada Women's Lobby and the Human Services Network strongly support S.B. 192. The mental health needs in our State are astronomic and every little bit we can do to help is gratefully appreciated.

TREY DELAP (Group Six Partners):
Group Six Partners supports S.B. 192. All the areas of my work which is youth mental health first aid, adult mental health first aid and public awareness of suicide intervention has one common thread. It is connecting people to the correct service with the right level of care at the right time. It is interesting to think that this type of service is not available every day. When people are bottled up in the emergency room they are not getting the definitive care that they need for mental health. This program by connecting people to the right kind of care starts them on the path of recovery and reduces the impact into the other systems. There is a lot of support nationally and many states do this differently and there are many collaborative funding mechanisms and accommodation of grants, but all of this points to what has been presented here today. It works by connecting people to the right services at the right time.

AMY ROUKIE (Deputy Administrator of Clinical Services, Division of Public and Behavioral Health, Department of Health and Human Services):
The Division of Public and Behavioral Health is neutral on S.B. 192. Conceptually, the DPBH does support the MOST program. The funds do come to DPBH and it is in the process of sub-granting the funding to Washoe County for local control. The DPBH already does the same in Clark County. The fiscal note that is defined is based solely on increased hours that would be needed in order to cover the new service delivery times. The DPBH is in agreement that crises do not occur between 9:00 a.m. and 5:00 p.m. and this conceptually works very well in the places where it has been expanded and has proven to be very worthwhile. The DPBH is getting requests from other areas of the State saying they need more of this kind of service. The DPBH is here to support the concept. Although the fiscal note is high, it is worth the time. I have worked in

the community with the MOST team, on the provider side, and they are lifesavers. I highly recommend that the program is continued and enhanced in any way possible.

CHAIR SPEARMAN:
I will close the hearing on S.B. 192 and open the hearing on S.B. 323.

SENATE BILL 323: Revises provisions governing the Supplemental Nutrition Assistance Program. (BDR 38-627)

SENATOR YVANNA D. CANCELA (Senatorial District No. 10):
Senate Bill 323 has the potential to make an impact on many lives in Nevada. In 2018, the Supplemental Nutrition Assistance Program (SNAP) is going to undergo some significant changes in the State and S.B. 323 is crafted to make sure that some of our most vulnerable recipients of SNAP benefits are protected and the program functions at its best.

JODI TYSON (Three Square):
We are talking about one specific group of people who receive SNAP benefits, not the entire program. First, I will take you through the program as a whole, then move into the specific pieces that we are talking about in S.B. 323. I have submitted a presentation (Exhibit C) to the Committee. The changes I will talk about relate to the 1996 welfare reform issues that deal with time limits and work requirements. To be eligible for the SNAP benefits, an individual has to meet a certain income means-tested application. It is an entitlement program, and individuals have to apply for a benefit and meet a certain amount of income. Page 2 of Exhibit C shows the maximum amount an individual can make in Nevada to qualify for the SNAP benefits. As the individual's income is closer to the maximum amount, the lower the SNAP benefit will be. There are individuals who apply for benefits and are approved but their benefit amount is zero or maybe $12, because their income is too high. The SNAP benefits are like a step program.

Page 3 of Exhibit C shows in fiscal year 2016-2017, 441,646 Nevadans will benefit during the year from SNAP. All individuals do not stay on the program for the entire year and this is a really important aspect of SNAP. Before the start of the recession, the average amount of time individuals stayed on SNAP was about eight months. During the recession, that went up to about 10 months. By the end of December 2017, we expect to serve 224,436 individuals as shown on page 4 of Exhibit C and what this shows is individuals do not stay on the program for the whole year. A portion of the 441,646 individuals are seen each month throughout the course of the year.

The part of SNAP that is affected by S.B. 323 deals with able-bodied adults without dependents (ABAWD) and page 5 of Exhibit C gives the criteria. If the individual falls within the affected category, he or she cannot receive SNAP benefits for more than 3 months within a 36-month period of time. There are some groups of individuals who are part of the affected group but can be exempted. Groups of individuals can be exempted when the Division of Welfare and Supportive Services (DWSS) requests a waiver from the United States Department of Agriculture (USDA) for geographic areas that exceed 10 percent unemployment or 20 percent higher than the national average. Nevada has had for the last eight years a statewide exemption waiver because our unemployment rate has been high.

Nevada has had small geographic area waivers because of high unemployment. For example, some of the tribal reservations have been exempted as well as a county here and there when a mine pulls out. We can also request waivers for geographic areas that lack sufficient jobs. If the unemployment rate is below 10 percent but there is no job market that would allow individuals to work, then a waiver can be requested for that area. There are programs or opportunities to exempt those who are in work training or workfare through State-sanctioned programs. Only 15 percent of recipients that are subjected to ABAWD waivers can be exempted because they encounter significant barriers to work. People that are homeless or mentally ill are automatically exempted. States are coming back to ABAWDs in droves. In 2016, there were 19 states that came back to ABAWDs and during this time period, it is estimated through the Center on Budget and Policy Priorities that between one-half million and one million SNAP recipients will lose their benefit as the states shown on page 6, Exhibit C, roll back onto the program. Nevada will reinstate ABAWDs on January 1, 2018, and that is when the time clock will start for the three-months benefit. The recipients will have to meet one of the exemptions or they will no longer have SNAP benefits for the next 33 months.

The return of ABAWDs means there will be a significant drop within certain populations that receive SNAP benefits. A few examples that come from the Center on Budget and Policy Priorities are shown on page 7 of Exhibit C. When Kansas brought ABAWDs back, the level of SNAP recipients, around 325,000, significantly dropped off to about 285,000. That relates to those who came off the program due to time limits and work requirements.

Nevada's statewide waiver for ABAWDs will expire on December 31, 2017, and will be reinstated on January 1, 2018. That starts the three-month clock for SNAP recipients and means the recipients could start losing benefits on April 1, 2018. The USDA has not informed Nevada exactly how many individuals will be subjected to ABAWDs, or how many within the 15 percent we could look to exclude. Some initial estimates are that about 59,000 SNAP recipients will be subject to ABAWD waivers and somewhere around 10,000 will be the amount of exemptions we could provide. Of those who are subjected to ABAWDs, the DWSS has the ability to exempt about 15 percent due to significant barriers to employment but those determinations are made on a case-by-case basis. It means that the DWSS will need to meet with thousands of people across the State to determine whether or not they may be eligible for one of the exemptions.

Nationwide, the ABAWDs subjected individuals encounter major barriers to employment as shown on page 9 of Exhibit C. Senate Bill 323 looks at those who have significant barriers to employment and provides guidance to the DWSS for exemptions. Those who are subjected to ABAWDs are among the very low incomes. Some of these individuals are seasonal workers and when they hit a low season, their income is very low. These are things we want people to keep in mind. People may not be working 20 hours a week but have a job and hope to be able to work 20 hours if they can stay in their jobs.

For the food banks, ABAWDs will increase demand as 44 percent of food pantry clients have SNAP benefits right now. Nevadans who lose SNAP benefits will turn to food banks for nutrition assistance. Three Square Food Bank and the Food Bank of Northern Nevada are estimated to serve 502,200 people per month per year and have distributed a combined amount of 56.7 million pounds of food in 2016. The work at the food banks is already significant and the amount of unfunded demand that will come to the food bank because individuals losing their SNAP benefits will be significant.

Senate Bill 323 seeks to mitigate some of the negative impacts of ABAWDs to the level to which the State can address them. This bill, including the friendly amendments, seek to address six areas in which ABAWDs can fix the administrative policy. I will take the Committee through S.B. 323 but will be referring to the proposed friendly amendment (Exhibit D) for clarification. Section 2 of Exhibit D sets a statewide fixed clock, which is advantageous to those who will not have benefits starting on April 1, 2018 until January 1, 2021. The reason for the statewide fixed clock is so that everyone is subjected to the same clock rather than an individual clock that is reset for every individual person. Let us say the statewide clocks starts on January 1 and ends on December 31. An individual applies for benefits in 2019 and receives three months of benefits. The statewide fixed clock starts again in 2021 and the individual is eligible for the next three months. The individual does not necessarily have to wait an entire 36 months in order to get his or her benefit back. Section 2 also affirms that the DWSS has the ability to request statewide or geographic waivers under specific circumstances relating to unemployment or insufficient job markets. The last thing section 2 of Exhibit D does is establish priority groups for potential exemption within the State's 15 percent discretion due to the significant barriers the individual experiences for unemployment. Those employment barriers include employees who are working less than 20 hours a week, those who are recently discharged from the military who may need more of an adjustment time than 3 months, caregivers who are unpaid who are caring for a family member that resides outside of their home and non-custodial parents who are required to provide child support. Remember the State already exempts homeless individuals who are mentally ill.

Section 3 of Exhibit D establishes a voluntary workfare program at a rate equivalent to the State minimum wage. If the individual is in a SNAP employment or training or a Workforce Innovation and Opportunity Act (WIOA) program and has 20 hours or more of job training, the individual can be exempted out of the work requirements. Nevada does not have nearly enough of those work training programs to meet all of the individuals looking for work that are within that group of individuals. We are talking about possibly 60,000 people. A workfare program is an allowable work opportunity through the USDA that individuals can come work at nonprofit organizations like the food bank but instead of getting paid minimum wage they would be clocking in and out as a volunteer, learning job skills and responsibilities, setting their own volunteer hours and what activities they will do. They are responsible to show up and we calculate the hours, and provide them printouts whenever they need them. This helps recipients and also helps nonprofit organizations whose demand for workfare would go up and decrease the nonprofits' burdens when trying to meet volunteer request demands.

Section 4 guides the DWSS to consider contracts with appropriate individuals or entities to interview tens of thousands of ABAWD subjected recipients. For example, the DWSS already contracts with several different nonprofit organizations including both of the food banks in Nevada to do SNAP outreach. Many of the people who may be subjected to time limits on SNAP actually might have applied for their benefits through the food banks or through SNAP outreach programs. They never walked into a welfare office. These individuals may be less inclined, even if they have a potential exemption, to walk into a physical welfare office, which is only open from 8:00 a.m. to 5:00 p.m. They may have applied for benefits in the evening or weekend through programs like SNAP outreach. We would want to provide as much flexibility to DWSS to make sure that they have all opportunities to meet with as many of these ABAWD subjected individuals as possible to make recommendations on who may be eligible for an exemption.

Section 4 of Exhibit D also brings stakeholders to the table with DWSS to discuss ABAWD implementation for a set period of time. For about 18 months after ABAWD comes to be, we would have regular communication with them so we are all on the same page about the challenges and the successes of returning to the time limits.

Section 5 of Exhibit D establishes the effective and end dates of each section and provision of S.B. 323 to be in alignment with the new sections.

SHANE PICCININI (Food Bank of Northern Nevada):
Senate Bill 323 is a helping hand for the unpaid caregivers, the seasonal workers, the construction and building trades or people in the tourist-based economy who need this as a bridge. The food banks would have a hard time trying to meet the needs of those workers, and S.B. 323 goes a long way in helping keep people in food security.

JON SASSER (Washoe Legal Services; Legal Aid Center of Southern Nevada):
Washoe Legal Services and the Legal Aid Center of Southern Nevada support S.B. 323.

DENISE TANATA (Executive Director, Children's Advocacy Alliance):
The Children's Advocacy Alliance supports S.B. 323.

EDWINA RICHARDSON (Macedonia Outreach Social Enrichment Services):
The Macedonia Outreach Social Enrichment Services (MOSES) operates a food pantry in connection with Three Square and receives support from other organizations and businesses in Las Vegas. We serve about 300 families per week and last year distributed 500,000 pounds of food to those in need. The implementation of S.B. 323 would help MOSES significantly as we provide one to two days of food per week. Many individuals are in the category of construction workers or seasonal to the extent that they are underemployed, like working in the gaming or tourist industry and may have lost their jobs. If MOSES is now providing one or two days of food for a family, we are then put in a position of where we are required to provide perhaps seven days worth of food. That more than triples our workload and triples our need to find sources of food to meet this need. When a family cannot receive what they need through a single pantry, they will go to multiple pantries, so the impact on the community is the same whether it is a single pantry or multiple pantries. The Macedonia Outreach Social Enrichment Services support S.B. 323.

MARY FINCH (Three Square):
Three Square supports S.B. 323 as it will allow our veterans to receive the benefits they need once they are discharged after serving our Country, and pending employment and retirement.

STEVE H. FISHER (Administrator, Division of Welfare and Supportive Services, Department of Health and Human Services):
I want to thank Senator Cancela for meeting with us this week and working with us on the amendments for S.B. 323. Because of the amendments to S.B. 323 we are removing the fiscal note.

CHAIR SPEARMAN:
I think it is easy sometimes for people to say derogatory things about individuals who are having a tough time or people who may not have the type of income that they have. Having the presentation helps us to appreciate the struggles of the people who are trying to make it.

SENATOR CANCELA:
The intent of S.B. 323 is to make individuals who are struggling have the help they need, and that we are as prepared as possible for the kick in of the 2018 changes.

CHAIR SPEARMAN:
I close the hearing on S.B. 323 and open the hearing on S.B. 305.

SENATE BILL 305: Revises provisions regarding certain proceedings concerning children. (BDR 38-926)

SENATOR JULIA RATTI (Senatorial District No. 13):
Best practices, recent case law and new guidelines from the U.S. Department of Health and Human Services agree that children have a constitutional due process right to counsel in foster care cases. Currently, only some children in the Nevada foster care system are being appointed counsel, subject to the judge's discretion and the available resources. Today, 87 percent of children in Clark County, which is 3,073 kids, and 50 percent of children in Washoe County are receiving representation. Washoe Legal Services is also contracted to represent children in Lyon, Elko, Humboldt and Pershing Counties.

Senate Bill 305 will require that all children have an attorney in a *Nevada Revised Statutes* (NRS) 432B foster care case and in any related NRS 128 termination of parental rights case. These attorneys give children a voice and an advocate to help them navigate one of the hardest and most confusing times in their lives, creating better outcomes for children. These changes bring Nevada in line with best practices and the national norm. Thirty states have solidified this right to counsel for children, thirteen states have a qualified right and only seven states, including Nevada, only have a discretionary appointment of counsel for children. Our experiences show that attorneys ensure children's voices are heard in court, protect children from unnecessary removals from their homes, help children succeed in school, ensure children have access to medical and dental care, monitor and ensure appropriate use of psychotropic medication, and ensure children who have to testify in court are protected. We are prepared to share examples of each of these positive outcomes.

The proposed amendment (Exhibit E) provides a funding source for the counties to meet the mandate. The funding source will be an increase in recording fees from $3 to $6. The proposed amendment enables the county commission to implement the fee to fund the programs.

BARBARA BUCKLEY (Executive Director, Legal Aid Center of Southern Nevada):
The Legal Aid Center of Southern Nevada is a nonprofit organization that provides free legal representation to vulnerable communities. Among those are children who are abused or neglected. About 18 years ago, I received a phone call from the Clark County Manager's Office, who said we are one of the last organizations in the metropolitan areas in the nation that does not provide independent legal representation to kids and this needs to change. Forty years ago, kids were thought of as property or an afterthought in abuse and neglect. The parent accused of abuse got an attorney, there was an attorney for the child welfare agency, there was a court appointed special advocate (CASA), but who let the court know what the child thought? Who represented their interest? The Children's Attorneys Project (CAP) in Clark County was born after the phone call. We received our first seed grant, hired our first lawyer and took our first case. Fast forward to today, we are representing over 3,000 children with 20 staff attorneys and 300 volunteer attorneys. These volunteer attorneys are some of the best lawyers in the State. They come from big firms, small firms and general counsel. We give them a crash course training and then assign them to one of our lawyers to be a mentor. We put all the pleadings they may need on a Website and then they are introduced to the clients. One memorable conversation I had was with Justice Hardesty, Justice Douglas and a managing partner of a construction defense firm said his CAP case is the most meaningful thing in his legal career, nothing he is doing compares to representing a kid in the foster care system. Now is the time to take Nevada off the list of seven discretionary states. Due to the collaborative work with Clark and Washoe Counties, the children's programs in both jurisdictions, through the judges appointing private counsel and Washoe Legal Services in the rural communities, we are almost there. This funding will get us through the last mile.

SENATOR HAMMOND:
The proposed amendment doubles the fees collected for recording a document. Those fees were originally set at $3 when A.B. No. 192 of the 76th Session passed. I remember Ms. Buckley testifying that we could cover all the children in the State for $3. Has the number of children doubled?

MS. BUCKLEY:
It has not doubled, but it has gone up. The amount of money was not sufficient. In 2013, we were at 1,225 children. Today, we are at 3,033 children. Senate Bill 305 does create an unfunded mandate. We went to the counties and worked out an amendment. The language on the proposed amendment says up

to $3. In Clark County, we estimate that $1 to $1.50 would get us to 100 percent. In Washoe County, they estimate $3 to get to 100 percent. One of the questions Clark County asked us was if we would dismantle the pro bono program if they were supportive of the raised fees. The answer is no, we would not dismantle the pro bono program. It is helpful for our lawyers to get involved as they see the unmet legal needs for children. We have had attorneys adopt kids. We like having the attorneys involved in the system.

SENATOR HAMMOND:
The increase of the fee from $3 to $6 does not mean the county recorder's office will charge $6, but can charge up to $6. Is that correct? The proposed amendment says impose by ordinance a fee of not more than $6. So the fee is being increased 100 percent.

MS. BUCKLEY:
Yes, that is correct. The proposed amendment allows up to $6 but it does not require that. It allows the local communities to determine their own needs. Clark County does not need the full $3 increase.

SENATOR HAMMOND:
In 2011, you testified that the $3 would cover the attorneys for every child in the State, but that has not happened even though we have fewer foster care children. Is that correct?

MS. BUCKLEY:
I do not think we have fewer children in foster care. In 1999, when the program was set up there were 1,600 children in care. Today, there are 3,500 children in care, and that counts the kids that are between 18 and 21 years old, but the caseloads have gone up as the population has gone up.

SENATOR HAMMOND:
What about in 2011, when you came to us and asked for the $3?

MS. BUCKLEY:
I will provide the number because I do not want to misquote it as it is not off the top of my head.

SENATOR HAMMOND:
The one part of S.B. 305 that does give me pause is section 2, subsection 1, paragraph (c) as it states the attorney must not be an attorney appointed to represent the child pursuant to NRS 432B.420. Are we talking about a guardian ad litem?

MS. BUCKLEY:
Yes, that is correct.

SENATOR HAMMOND:
In 2015, attorneys were allowed to be guardian ad litems when S.B. No. 394 of the 78th Session passed. In two years we are changing the language. Is there a reason for this? Are attorneys guardians ad litem in other states? If they are allowed in other states, why are we not allowing attorneys to be guardians ad litem?

MS. BUCKLEY:
The American Bar Association (ABA) and its section for children and the law recommend that attorneys represent children as their lawyers, to represent their wishes. The National Association of Counsel for Children (NACC) does as well. In Nevada, we have settled on a guardian ad litem program and it is called the CASA program. There are CASA programs in different counties in the State. The court-appointed special advocates recruit volunteers to serve as the guardians ad litem for children. The volunteers represent the children's best interest, to visit them in their homes and to give a court report on what they have seen. Some states use lawyers for that. In some states two lawyers are used to represent the child. In Nevada that does not make sense as we have limited resources and we have a guardian ad litem program. The Blue Ribbon For Kids Commission is unanimous in its support of the work CASAs do. That is why an attorney representing a child cannot be a guardian ad litem and to recognize the importance of the CASA programs.

SENATOR HAMMOND:
I do not agree with the reasoning as I do not mind having an attorney be a guardian ad litem as well. There are the wishes of the child and there is the best interest of the child, and those are two different things. This is one part of S.B. 305 that I have a problem with and I would be happy to speak with the ABA about it.

SENATOR RATTI:
I want to clarify that S.B. 305 does not stop attorneys from being guardians ad litem, it only stops the attorney who is appointed to represent that child from also being that child's guardian ad litem. We are making sure the child has both a guardian ad litem and an attorney. Senate Bill 305 just makes sure that the child's attorney does not play both roles.

SENATOR HAMMOND:
I understand that, but here is the pause, section 2, subsection 1, paragraph (c) states, "Must not be an attorney appointed to represent the child pursuant to NRS 432B.420" and paragraph (d) states, "Is not entitled to compensation or payment for expenses." The amount of people who can do the job is cut down and not many attorneys will be willing to do that.

MS. BUCKLEY:
We have 350 attorneys representing 888 children pro bono. This is an amazing number, probably one of the highest in the nation. If a lawyer is told he or she will get paid by the county, if a bill to do guardian ad litem work is submitted, it interferes with the model of volunteerism that has been developed and grown to an incredible level. One of the reasons why the ABA and the NACC are so strong on this is lawyers are trained to be lawyers. They are trained to listen to clients, to represent the clients' wishes in court and to present evidence but they are not very good at substituting their own opinions, judgements and morals in a situation. The reason these organizations have recommended this model so strongly, and they have convened groups around the Nation to study and debate this, is because they think lawyers have a role and they should stick to that role. I am happy to share all the studies with the Committee.

SENATOR HAMMOND:
I would like to see the studies. I keep going back to two years ago when we had a particular bill in the Senate Committee on Health and Human Services and an attorney you are familiar with said sometimes they do not care what the children need, they care about what they want. When there is a nonverbal child, it is important to represent the need. That is why I like a guardian ad litem that is also a lawyer. Then the lawyer can do both and bring a different perspective. It is admirable that there are so many lawyers that do pro bono work, and come from one perspective, but I think there is room for another as well. When we are talking about kids, it is certainly not a disadvantage to have two lawyers representing two different viewpoints. For years, parents had lawyers, almost

everyone else had lawyers, the only ones who did not were children. They are the ones who are the most vulnerable. I certainly do not want to take away the ability to have someone who is a guardian ad litem with the training of a lawyer. That is why I am adamant about it.

SENATOR HARDY:
Ms. Buckley came into my office this morning and we talked about the best interest of the child. Just because you are the attorney for the child does not mean you quit caring for the best interest of the child even. When the attorney and the guardian ad litem were married together, the best interest of the child took precedence. I do not understand the proposed amendment where it states if an attorney is paid through the legal services program in a county, that attorney is not entitled to compensation under this statute. Are we are talking about increasing a fee so we can pay the attorneys, but we are not allowed to pay them if they are being paid?

MS. BUCKLEY:
Right now, the compensation for lawyers in this system is they would bill the county, similar to what is done in criminal defense. We have never utilized that in Clark County or Washoe County, but they do utilize that process in the rural counties. If instead we are able to develop this fee mechanism and the county gives a contract, for example, to a legal services organization, then that legal services organization attorney cannot bill the county under the criminal rate. That is all that it does, to make sure the services are only paid for once.

With regard to best interest, that is still the standard and it is in the law now. When we first started CAP, I thought we would be representing a lot of positions the kids had that were not in their best interest. That hardly ever happens. What kids want is not to be separated from their brothers or sisters or to go to the high schools they have been going to for all these years.

SENATOR HARDY:
If an attorney is being paid, he or she cannot be paid under this statute. Is that correct? For me, that is counterintuitive of what we are doing.

SENATOR RATTI:
The key point is if the attorney is being paid through a legal services program. We do not want to impact a county that does not have the benefit of a legal service program today. It was mentioned that there is coverage in Clark County

and Washoe County, and Washoe Legal Services also provides services in four other counties. In the counties that do not have the benefit of a legal aid organization, we are leaving them the flexibility to be able to pay for services the way they are paying for services now. The key phraseology is if the attorney is paid through a legal services program. That is what we are carving out.

SENATOR HARDY:
Where is the money going?

SENATOR RATTI:
The county commission has the ability to enable the fee and retains the authority over its budgeting process. In Clark County, Washoe County and the other counties where Washoe Legal Services has a program, a contract is entered into between the county and legal aid organization through the local government budgeting process. In the counties that do not have a legal aid program, the $3 fee could be used to pay an attorney directly at the order of a judge.

SENATOR HARDY:
I am going to provide a scenario. I live in Clark County and I have a document recorded and the cost is $6. The $6 goes to the county and the county commission gives it to the legal aid society and the legal aid society pays the attorney $6 cumulative. The legal aid society cannot do that if the proposed amendment to S.B. 305 says the attorney is not entitled to compensation under this statute.

SENATOR RATTI:
I understand your point and we will work to add language to the proposed amendment to make the intent more clear. The intent is really what Ms. Buckley said, as we do not want attorneys to double-dip.

CHAIR SPEARMAN:
Could you complete this sentence? The fee that is collected does…

MS. BUCKLEY:
The fee that is collected does allow every child in the foster care system in the State to finally have a voice and to have an advocate in court.

CHAIR SPEARMAN:
This morning in another committee, we heard S.B. 406 regarding court reporters.

SENATE BILL 406: Revises provisions relating to court reporters and court reporting firms. (BDR 54-949)

The question I asked at the time was, how many attorneys are doing pro bono work? One group said they typically do pro bono work and the other group said there are times when they also do pro bono work. Attorney's fees and court fees are going up. I have researched the cost of living and the cost for legal counsel in 2009, 2011, 2015 and 2017. It appears during the recession, 2009 and 2011, the costs were not quite as steep, but coming out of the recession, the costs have begun to escalate. I understand why there is a proposed fee increase. We have talked about the care for children, and the cost of incarceration. If S.B. 305 does not happen, what is the cost of incarceration? Is it $6 or less?

MS. BUCKLEY:
The cost of incarceration is $10,000 or more. One of the saddest studies I ever saw on Nevada kids in foster care was done by Dr. Tom Riley, when he was at the University of Nevada, Las Vegas. He did an exit survey of kids in foster care and found an alarming number in jail, prison and homeless. One kid was rationing his insulin and died. That is when all the reforms started. We wanted to give a bridge to kids from 18 years old to 21 years old. We started representing kids in foster care to make sure they had a voice so they were not so traumatized. So they felt like someone listened to them. Now, of course, they have Medicaid under the Affordable Care Act. We have made progress, but if we do not invest in our kids now, we pay for it later, which is your point.

CHAIR SPEARMAN:
If a child was not in foster care and the parent could afford an attorney, would the child still have the same option or is it just children that are in foster care that we are having a difficult time with?

MS. BUCKLEY:
Most of the families in foster care are poor. Occasionally, we have families of means, but mostly they are in the sexual abuse cases, where we represent the kids. They are usually girls, and we are so fortunate to have a female attorney

that is all she does, and she is nationally certified. Regardless of the parent's means, we represent the child. The judge might assess fees against the parents, but we go in from day one. We get the kids into counseling as quickly as possible. It is so imperative, and sometimes it does not happen because of bureaucratic reasons, so we are there right away to say the child needs counseling.

CHAIR SPEARMAN:
The fee is paid so every child in Nevada can have attorney representation. The cost of incarceration is in excess of $10,000 and we have not even talked about the cost of life, the quality of life. So $6 for the fee or $10,000 for incarceration seems like an easy decision. I am trying to reconcile the difference between the lenses of family values and valuing families.

MEKHI OVERTON-JACKSON:
I am 19 years old. I was originally put into the foster care system when I was 15 years old. It was a result of my mother having a serious alcohol problem and having a really abusive boyfriend that would lash out at me and my younger brother. It took my mom kicking me out of the house before I made my way to my grandmother's house and called Child Protective Services (CPS) to tell them what was going on. From then on, I stayed in the foster care system until I turned 18 years old and aged out. Before my lawyer Janice came into my life, things were essentially going nowhere. I battled depression when I was going through the system. I was separated from my younger brother constantly. I bounced between homes. My life was going nowhere. I felt the caseworker I had at the time did not serve my best interest. I was breathing, had a home, and had necessities, but whether I was happy at these homes or if I was thriving was not the caseworker's goal. When Janice came into my life and took charge, the caseworker was removed and replaced with a new one. I was placed with my grandmother, found work and went back to school. Things got back on the right track after I was able to vocalize and make things known to people. Before, when I said things and needed things, it was disregarded because I was a child. I was too young to know what I wanted or I did not have the right state of mind. Once Janice came into my life and became my voice, things started taking a turn for the better. I feel no kid should have to go through the things I went through when I was in foster care. I believe the lawyer was the first step in me being able to take control of my future. I support S.B. 305.

STEPHANIE MAHLER:
I am 14 years old. Since I was real young I watched my mom being abused by my stepfather. Both my mom and step-dad used drugs, and there was a lot of violence between them. One time, when I was 5 years old, they were fighting on the stairs, and I tried to stop my step-dad from hitting my mom. He tripped me and I fell down the stairs. This was the first time CPS entered my life. They did an investigation, but I was not removed from the home. My mom and step-dad later broke up, and my mom got a new boyfriend, who was even more abusive to us both. He was violent all the time. They were both using drugs everyday too. Eventually, they both lost their jobs, and we ended up living in a weekly motel. I was really scared at first, but after a while I got used to living that way. Then one time, when I was 6 years old, my mom left me with a stranger all day. Finally after midnight she called and asked my grandmother to go pick me up, but she could not remember where the person lived, and did not have her phone number. My grandmother was very scared for me, and she drove around the neighborhood for hours where my mom had dropped me off. My grandmother finally found me walking along the street with the person. My grandmother was desperate to keep me safe, and wanted to take me home with her, but first had to start the process. She went to the police to report what had happened, and they called CPS. Legally, my mom still had custody, so I had to go back to her. At least this got CPS to open another investigation into how my mom was treating me.

My grandmother took classes to become my guardian, and I was placed with her from when I was 6 years old until I was 9 years old. I felt really safe with my grandmother. For once I got to sleep in a bed instead of a couch pushed up against the motel room door, but at the same time I had gotten so used to the constant violence and chaos, I could never really relax and believe this was the life I should have been living all along. During this time, my mom completed rehabilitation and came to live with my grandmother and me. I had two different caseworkers with the Clark County Department of Family Services, and they decided my mom had qualified to take custody of me again. No one told me about this change or asked me what I wanted. One day she started making decisions for me again. She met another boyfriend and they got married. I was forced to move away from my grandmother and live with my mom and new step-dad. They were both openly using drugs. My mom got pregnant with twins, a boy and a girl, and my step-dad was very abusive to all of us. The babies were bruised all the time, so someone finally called and reported it to CPS. A new case was opened for the three of us. This time I was able to go back to my grandmother, and get a lawyer of my own through the Legal Aid Center of Southern Nevada.

My lawyer's name is Denise. It was weird to be around my lawyer at first, because I never had anyone who would stand up for me in court, be my voice and fight for my rights. I thought she would be like every other caseworker who said they cared, but really did not. I went to court with Denise on my fourteenth birthday, and I fully expected they would send me back to my mom, and this whole mess would repeat once again. Denise was like a total savior and warrior for me. She fought for what I wanted, which was to stay with my grandmother for good. I was so surprised when the court agreed, and my wish came true. It was the best birthday present I could ever have hoped for. It was a gift that will truly stay with me forever. I will be 15 years old this year, and I am out of care now as my grandmother has guardianship over me. I am so happy living with her. I was accepted into Advanced Technologies Academy where I am majoring in graphic design. I want to study other languages and become an interpreter, especially sign language for the deaf. I support S.B. 305.

ELLIOT BRITTAIN:
I am a University of Nevada, Las Vegas student who is interested in helping those with mental illness and substance addiction. I was born and raised in Las Vegas, and proud to say I am a native Nevadan. From my earliest memories, I remember only a few situations in which I lived with my mother. I never met my father or knew much about him, only his name. I remember living in some neighborhoods that were unsafe, and as a young child, I would wander about without much supervision. One day my mother, who I have a relationship with today and love dearly, was drinking heavily and I ended up getting hurt. She had given me a black eye. For that day on, at the age of four or five years old, I lived with my grandparents, not through foster care. I grew up with them and they ensured that I would grow up happy and become an aspiring young man. I did not think much about growing up with them instead of with my mother or father.

When I was 17 years old, my life changed. My grandfather fell ill and passed away suddenly, followed by my grandmother a few months later. I was not prepared for such a turn in circumstances. I soon became a fostered youth. Though I was almost considered to be an adult, I was still quite young and unprepared to begin my life. When I was called to court to determine if my biological father was really my father I did not feel prepared, or ready to meet this man. That is when I was connected to the foster care system and found many amazing mentors who have helped me become who I am today. Among them was my CAP attorney who helped me navigate the court system. I had been called to court to meet a man I had never seen before and only known by name. I was to see him face-to-face in court for the first time to determine if he was really my father. My CAP attorney walked me through the process. I felt nervous and uneasy at the prospect of showing up to court and meeting this man but my attorney had the knowledge of the court system and provided me the emotional support I needed. My story is similar to other foster youth. I see the benefit of having attorneys on the side of the children who need them most. I am grateful that such a resource existed for me. Senate Bill 305 ensures that all foster kids have access to attorneys. It is through all the cumulative efforts of my mentors that I have gotten to where I am today and I urge your support of S.B. 305.

JAMES CONWAY (Executive Director, Washoe Legal Services):
Washoe Legal Services provides child advocacy services in Washoe, Elko, Lyon, Humboldt and Pershing Counties. Washoe Legal Services is in support of S.B. 305.

JESSE FREDZESS:
Growing up, I faced many forms of abuse at the hands of my parents. Please let your imagination go wild because you would not be wrong. My parents took everything from me including my voice. My voice was taken and suppressed for years until I entered the foster care system. There, an attorney from Washoe County Legal Services was appointed to me. My attorney was the first to speak up for me, listened to every word I had to say, articulated them with the force I was afraid to and the skill I did not know. My attorney was the first of many to give me back my voice. As I learned and gained courage, I reclaimed my voice. I am so thankful for my attorney and everything done for me. I am surprised such a service is not yet in the law. I saw my attorney more than I saw my social worker. My attorney really knew my needs and communicated them for me. Representation for vulnerable children is a just pursuit supporting the well-being of every child in Nevada. We need to be the voice these children do not have because no one else will be. Passing S.B. 305 will be helping the children of Nevada, especially those most vulnerable to gain back their voices. This is exactly what the activity supported by S.B. 305 did for me.

SENATOR HAMMOND:
When the young people testified today and told their stories and backgrounds as to why the need is there, I feel compelled to tell them some things. Because I have asked questions some of you might assume that I might be against the bill. I have had good conversations with Mekhi, Stephanie, Elliot and Jesse and I have told them a little bit about my background so they know where I am coming from. I want them to know the questions that have been asked are necessary, especially the one about the child's best interest.

Mekhi, Stephanie, Elliot, Jesse and I spoke off-line. I am going to pretend that nobody else is here, except the four of you. I have been in your positions; my mother was married at least three times, that I know of. I know she made bad choices, and of course, I had to suffer through those bad choices. I still have a nose that was hit hard enough to break it, and I left it that way as a reminder throughout my life of what I went through. I want you four to know as we are debating S.B. 305, it is not that I do not understand where you coming from, because I do. I spent time in another home that I told you about. My nose is a reminder for me, but I also want you all to know that is not your story. Your story is not done. You know that. You guys are going someplace and your story is not done yet. You do not know what you can be someday. Some people will say you need to be a State Senator, and I do not think that is anything great. It just means I get to represent some people and that is awesome. When we are debating S.B. 305 we are trying to figure out the language of the bill to make it the best we can. I understand your stories and I am grateful you all had attorneys that had your back. I am looking at having your back plus I want to make sure we are covering the interest of us, the ones who have gone through this.

MS. TANATA:
The Children's Advocacy Alliance supports S.B. 305.

YOLANDA T. KING (County Manager, Office of the County Manager, Clark County):
The reference to: If an attorney is paid through the legal services program in a county, that attorney is not entitled to compensation under the statute, is confusing. Looking at the proposed amendment before that statement, there is reference to the same compensation and payment for expenses from the county as provided in NRS 7.125 and NRS 7.135. Those particular statutes outline a fee that is paid to an appointed attorney. The fee for noncapital cases is $100.

The intent of the language is to state if legal aid services is providing a program, that fee of $100 does not apply to that legal aid service or program. As Ms. Buckley stated, currently they are not charging $100. I wanted to ensure going forward, in order to keep the cost down associated with representation, that the $100 does not apply to the legal aid services. Clark County does support S.B. 305 based on the proposed amendment.

As Senator Ratti and Ms. Buckley stated, without the additional fee increase, there would be an additional cost. It would be an unfunded mandate to the counties. In an effort to keep those costs down, there are a couple of items that we brought to the attention of Senator Ratti, as well as Ms. Buckley. The first is the reference to the attorney's fee of $100. I did not want in the future for fees to be charged because the statute allows those fees to be charged, which would increase the cost for representation, and thereby would obviously need to have an increase in the recording fee. The second part has to do with the recording fee and what that looks like going forward. Although Clark County does not need the full $3, there will be a caseload increase. We have seen it just from when the fee was initially imposed. Our preference is to have a little bit of leeway to be able to increase the fee over time if there is an increase in caseload. Obviously, an increase in caseload will definitely mean that there would be an increase in the cost, and therefore could be an additional unfunded mandate to Clark County or any of the other counties. That was the intent of including a fee that would allow us to accommodate or pay for a caseload increase as well as limit the amount of money that is paid to those attorneys. If we look at payment of the representation to those children in Clark County, it would not be Clark County's intent to charge a fee to the maximum of the $3. We anticipate that we will need approximately $1 to represent the remaining children. Ms. Buckley stated she would continue to maintain the pro bono services. If we have a complement of the legal aid programs as well as pro bono services, that will in fact also limit the cost going forward. Ms. Buckley and I have worked on having language within our contracts whereby she would continue to maintain those pro bono services. Ms. Buckley, Senator Ratti, Washoe County and I have worked through some of these issues that would limit the cost and I do not anticipate that the full $3 is needed in Clark County. However, I understand it is needed in Washoe County.

SENATOR HARDY:
The extra money is going to the attorney but also to the county to deal with the other charges the county will be faced with due to the increased caseload. Is that correct?

MS. KING:
It would address future caseload increases. The intent would be for the Clark County Board of Commissioners to increase the fee that is necessary to address the remaining caseload, and if in the future, that fee needs to be increased to address additional costs associated with caseload growth. That would give the Board of Commissioners the ability to increase the fee as needed.

SENATOR HARDY:
Is the silo legal? Is it going to be used for the caseload issues, administration and all the things that go with the increased caseload?

MS. KING:
The way the language is written in S.B. 305, it is specific to legal representation for foster care children. I believe it is written tight enough where it is nondiscretionary in terms of how the dollars can be used.

SENATOR HARDY:
Are you saying because of the $100 cap and increasing the caseload legal fees, you will have legal aid hire more lawyers to take care of the increased caseload?

MS. KING:
Yes, that is correct.

JODI STEPHENS (Wynn Resorts, Limited):
Wynn Resorts, Limited supports S.B. 305 to ensure the children have a voice.

KEVIN SCHILLER (Assistant County Manager, Washoe County):
Washoe County supports S.B. 305. About 16 years ago, Washoe County was part of the initiation of this program. Washoe County operates very similarly to Clark County in terms of contracts. Washoe County has a contract where it pays a portion of the fee and the rest is offset with the $3 filing fee. Washoe County is at about 50 percent represented on a full caseload. It has been said several times that Washoe County needs the full additional $3. It is enabling language, as it will be a slow titration to the 100 percent mark. We are looking

at a 2-year period and may not go to the additional $3, as we are budgeting as it is a priority for Washoe County. It is an issue in child welfare cases and the need for representation, which often helps us with permanency and with reunification. In many cases it actually provides some level of cost saving when we are getting to permanency and representing children correctly in conjunction with public defenders and the Washoe County District Attorney. Washoe County funds this outside of the filing fee and will continue to do so and will approach this from an enabling perspective in terms of what is needed.

SENATOR RATTI:
I want to thank the young adults who came today to share what it was like for them to be in foster care, and in particular, what an impact it made on their lives when they had access to legal counsel. This is our obligation. Every child who is in foster care deserves the right to legal counsel. If the government had to bear the full weight of the cost, we would have a very challenging conversation. We are lucky in Nevada that we have some very talented and innovative legal aid organizations, which through a combination of philanthropy, pro bono work and government contracts are bringing that cost down significantly to the State government to take care of these children. The $3 fee we had before, plus the additional $3 fee, does not come anywhere close to paying 100 percent of the costs. How we get to the 100 percent of the costs is a stellar partnership with the legal aid organizations who are carrying the bulk of the weight. It is our job to get us to the finish line so that every single child in the foster care system has access to legal counsel as they should. I encourage the Committee to support S.B. 305 and it is well past time this happens.

SENATOR HAMMOND:
Ms. King mentioned caseload, and Mr. Schiller said they need to be represented correctly. What are the national best practices? What are the caseloads right now? Are we trying to maintain the caseloads or lower them a little bit with this increase? Do we reach anything close to the national best practices?

MS. BUCKLEY:
One of the goals in providing an attorney for every child is to lower the caseload. Government is a terrible parent, even the best intended workers are no substitute for a loving parent. Whether it is complying with the Adoption and Safe Families Act of 1997 to give parents a chance, if they can; if not, relatives; if not, adoption. That is the goal of permanency in child welfare. If that happens and a lawyer pushes to make that happen, deadlines are met, and

kids get out of the system and caseloads can go down. That is the way it should be. Kids should not be raised in foster care, as it is not healthy.

SENATOR HAMMOND:
Can we talk off-line about the national best practices and the current caseloads?

MS. BUCKLEY:
Yes, we can do that.

CHAIR SPEARMAN:
I close the hearing on S.B. 305. Senate Bill 325 will not be heard today and will be rescheduled to another day.

SENATE BILL 325: Revises provisions governing medical assistance to certain children. (BDR 38-941)

I open the hearing on S.B. 265.

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

SENATOR YVANNA D. CANCELA (Senatorial District No.10):
Senate Bill 265 is intended to address the rapidly increasing cost of diabetes care in Nevada. Twelve percent of all Nevadans are diabetic, thirty eight percent are prediabetic. The total diabetic population of Nevada is on path to double by 2030. Meanwhile, the cost of insulin has inflated across the Country, and certainly here in Nevada, so much so, that the three makers of insulin have been sued for fixing prices in a Massachusetts federal court. You will hear from doctors, who are diabetes experts and experts on the rising cost of insulin and drug purchasing and you will hear about the impact on families and the importance of consumer protection. I suspect you will also hear some of the same arguments that have been advanced in other states as legislatures have attempted to put legislation forward to address the rapidly increasing costs of pharmaceuticals. You might hear the problem with prices is not the industry and see some finger-pointing about who is really in charge. Is it the pharmaceutical benefit managers? Is it the insurance companies? I would ask that you remember the initial starting point for price setting begins with the manufacturers, which is why they are the major target of S.B. 265. You might also hear that spending on diabetes medications reduces other health care costs

such as hospitalization and that is true if folks are able to access diabetes medications. You might hear transparency in prescription drug pricing will stifle innovation. To that, I would say it may be true for other drugs, it is not true for a 95-year-old drug like insulin. You might hear that price gouging is an isolated incident, that there are some bad actors, but the reality is that we have seen price increases across the board in insulin nationally for almost two decades.

PRAVEEN JAYAKUMAR, M.D. (Medical Director, Culinary Health Fund):
The insulins of today are different from the insulins from 95 years ago. The most potent and long-acting insulins were discovered in the year 2000 and all of those are unaffordable if you do not have health insurance. The insulin you can get for $25 at Walmart and Target is called NPH 70/30 and these are combinations that were made in the 1980s. This is the only option for our patients who do not have insurance coverage and it is 2017. Diabetes is a silent killer. Type 1 diabetes affect young children and young adults, and they get to know the symptoms sooner, and they need to be on insulin. Most of the time folks who get diabetes later as a metabolic issue do not know they have diabetes until complications set in. The reason diabetes is such a public health issue is that elevated blood sugars, when uncontrolled for long periods of time, affects every single part of the body. It starts by affecting the microvessels of the nerves, kidneys and the eyes which ultimately leads to kidney damage, loss of vision and loss of sensation in the feet. Ultimately, it affects the large vessels and leads to diseases such as heart disease, heart failure and stroke. It is a silent killer in the folks who do not realize the complications until it is too late. The way progression and complications of diabetes is controlled is through intensively controlling the blood sugar levels. That is where the role of insulin comes in. In the course of my clinical practice, I have treated hundreds of diabetics in Nevada. For these patients, at some point in time, either early on in the course of treatment or later, they all end up on insulin at some point.

I would like to share a story of one of my patients called Jose, who first came to see me when I worked at Lied Clinic at the University of Nevada, Las Vegas, School of Medicine, which is the county hospital. Jose was 46 years old, hardworking, and worked in the fast food sector. He came to see me and his main complaint was he was tired all the time and it was affecting his work. I ran some lab work and found out he had diabetes, his blood sugars were uncontrolled. They were so high, and the guidelines suggested he go on insulin right away. He could not take oral drugs because of how high his blood sugar levels were. We discussed diet, lifestyle changes and other medications but ultimately he needed to be on insulin. He did not have health insurance, so he ended up having to take the lower cost insulin that was available. The problem with these types of insulins, that you get for $25 at Walmart and other places, is that the blood sugar control is not optimal. It goes up and down based on the type of formulation the doctor gives. One of the big side effects of these types of insulin is the patient's blood sugar can drop to a critical low level at which point it becomes a medical emergency. Anyone who has been through that process will never forget it. It makes treating the disease even more difficult because folks get scared of taking insulin with the fear of that one episode of low blood sugar. In the case of Jose, he had that one episode of hypoglycemia when he was at work. He collapsed and had to be taken to the emergency room. I saw him in the hospital later and discussed how he could avoid this with the type of insulin he had. The best option was to cut down the dose of the insulin, help him work with his diet and try to make that work with his work schedule. I did not see Jose for the next year. The last time I saw him was when he was admitted to the hospital and I was performing rounds with my resident team. Jose had developed a foot ulcer which had gotten infected and had gone to his bone. Luckily his foot was saved, but he needed to be on intravenous antibiotics for six weeks. That was six weeks he could not work to support his family and get more in debt.

The team of researchers in Toronto, Canada who discovered insulin in 1921 patented it for $3. They were troubled by the idea of profiting from a drug, which quickly transformed a disease that was a death sentence back then to a manageable disease. The first longer acting insulin was released in 2000, yet the only affordable insulin that is available today are the ones from the 1980s. Unfortunately, for many of Nevada residents, the price of effective long acting insulin today make diabetes a slow but certain death. I wholeheartedly support S.B. 265 and appreciate the opportunity to represent all the thousands of individuals like Jose who live among us.

BOBETTE BOND (Executive Director, Nevada Healthcare Policy, Unite Here Health)
My role has been to try to figure out how we are going to help manage our prescription costs in a strategic way over the long haul in our fund as they increase. That led us to the issue we are seeing with insulin and diabetes management. The cost of insulin has been consistently rising, it has tripled between 2002 and 2013, but this is not the case in other countries. The transparency in S.B. 265 will help us get a better handle on why that is. In the 95 years since insulin was developed and the $3 patent was sold,

manufacturers have been competing for insulin. There have been continual revisions to insulin. Part of the reason is to keep it under patent status, so the patent does not expire and become eligible for generic versions. That is why it has taken 95 years for generics to hit the market. Manufacturers have been competing, which is what they are supposed to do, but competition has not led to lower prices. In fact it has had the opposite effect. We would like to know why prices are going up when competition is in place.

Each of the three dominant insulin producers has been able to tweak its insulin products to remain in patent status and that market is now just beginning to develop. You may hear this year about new biologics coming online that are insulin. Eli Lilly, Novo Nordisk and Sanofi, collectively referred to in our world as the Big Three, dominate the global insulin market in terms of revenue. Earlier this year, the Big Three were subject to a class action suit filed on behalf of 11 diabetic patients, which accuses the companies of unlawfully raising the prices of insulin products, and in doing so violating the Racketeer Influenced and Corrupt Organizations Act and various state consumer protection and antitrust statutes. They have denied these allegations and the review is continuing. A review of recent U.S. Securities and Exchange Commission filings reveals that insulin is a money maker. Diabetes is profitable. Novo Nordisk sold $9.2 billion in insulin products, Sanofi posted $7.5 billion in sales, and Eli Lilly sold $2.8 billion in Humalog and $1.4 billion in humulin. That is almost $21 billion worth of insulin products in 1 year. These competitors appear to be raising their prices in step with one another, which is the opposite of what good competition allows. It appears they are syncing price hikes that result in raised profit, and it seems collaborative with what we would call price gouging.

Meanwhile, the cost for Medicaid patients and those with limited insurance makes insulin compliance unattainable. Without transparency in the pharmacy industry, we will likely never know how the patents are being extended, how prices are being synchronized, if they are, why generics are not being developed more quickly and if prices are set. We support S.B. 265 as an excellent step towards transparency and hopefully long-term affordability. The other parts of S.B. 265 are compilations of strategies that we support to address prescription drug costs.

KEVIN HOOKS:
I am a managed care clinical pharmacist and have been practicing since 1986. On the graphs (Exhibit F) that I have submitted to the Committee, you can see

that insulin costs have risen 387 percent from 2006 to 2013 and it is a proven fact that we live with every day, patient compliance has a direct reflection on the relationship to the cost of the medication. Regardless of whether the patient does or does not have insurance, the costs of these medications are passed on to the patient, and ultimately is a direct reflection on the compliance of the patient. The associated medical costs related to these noncompliant patients is staggering across the board. The United States is paying the bulk of the cost of medications. One basic reason for that is in foreign countries that do not have a political system, no different than we would negotiate for a car, they negotiate a drug based on the drug, the patient outcome and the ultimate best price. In other words, there may be two competing drugs. Both drugs have the same proven outcome, and the cost of that drug in a foreign country would be less based on a bid process they put together. It is completely political here, which has led to an opaque and a complex system. This system has created an environment ripe for profiteering in many ways, not only with the pharmaceutical industry but with other health care players, such as the pharmacy benefit management (PBM). In 1986, I was a retail pharmacist and the system had few pricing benchmarks. There were no formularies, no PBMs, and no rebates. There was nothing to add to the cost of the drug. It was a simple average wholesale price or maybe a wholesale acquisition cost. You understood it and the wholesalers understood it and the doctors for the most part understood it. Today we have over a dozen pricing benchmarks that have created an opaque system. It is an environment ripe for profiteering across the board, starting with the pharmaceutical industry.

Senate Bill 265 has selected wholesale acquisition costs (WAC), which means it is the most recognized spoken-about term in the industry related to pharmacy but it is the list price from the manufacturer to the drug wholesaler. It is pretty simple, well understood and that is why S.B. 265 attaches to WAC pricing. Without question, the pharmaceutical industry has a direct responsibility on how drugs are priced from the time the drugs are approved. This is important when folks think you are picking on the pharmaceutical industry. You can pick anywhere on the plant, the leaves and say this is the problem, that is the problem, but the root of the problem is how the drug is priced from the beginning. As a pharmacist, certain aspects of S.B. 265 hit directly to the root of the problem and I believe pharma will react accordingly with rebate dollars and trying to unwind what has been done to be able to meet the terms of what S.B. 265 puts out.

SENATOR HAMMOND:
You talked about the difference between the WAC and the foreign acquisition costs. How will the foreign price be determined?

MR. HOOKS:
The foreign price is negotiated as they do not use the WAC. It is basically a committee. Each country may be somewhat different, but it is not political. It is negotiating the best price for a drug based on the clinical outcome. If all things are equal, it will be a bid process. Someone will say what the price of the drug is. You probably heard that the U.S. pays for the research and development costs for the world, which is partially true. If pharma is put in a situation where it is forced to change or forced to meet these particular terms, I think that is where we may end up and I do not think it will affect new drugs to the market. They can live within that particular circle.

SENATOR CANCELA:
I will go through a brief overview (Exhibit G) of S.B. 265. The key part of this bill is that the Department of Health and Human Services will compile a list of essential diabetes drugs, insulin and biguanides, and that list will be updated every year. From the list of drugs, the manufacturers included on that list will design a reimbursement process if one of two situations happens. The first situation is when the WAC of the drug exceeds the highest price paid in foreign countries, as looked at through the Organization for Economic Cooperation and Development (OECD). The OECD was started in 1960 that specifically does economic development work and is comprised of 35 developed countries. The second trigger would be when the manufacturer increases the WAC of a drug during the previous calendar year by a percentage larger than the percentage increase in the Consumer Price Index (CPI) medical care component for that year.

There have been a lot of interested folks who have talked to me about this process. I have made a commitment to work through the logistics of how this process works, as it is specifically vague in the bill in order to allow for that process to be laid out by stakeholders. There is a difference for reimbursement if the individual is on a high deductible plan where the reimbursement should go to the individual versus if the individual is on a different kind of health insurance and the reimbursement should go to the insurer. In addition, a manufacturer must post the essential medications on its Website listing all the drugs that are eligible for this reimbursement.

Because transparency is minimal in pharmaceutical pricing, it is very difficult to get to how exactly we choose the best marker. Some people say it is the WAC, some people say it is other things. The starting point is the WAC because it seems to be universal across the different health care entities involved in prescription costs. As a result of the lack of transparency, S.B. 265 asks that manufacturers on the list disclose cost-related information to the DHHS by May 1 of every year and that the list includes things like research and development costs and preclinical and clinical studies, so we have a full picture of how we arrive at these costs. It is language that is also in Assembly Bill 215.

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

There are three other pieces that are related to transparency and that are also in S.B. 265. The first deals with nonprofit organizations in the health care field. It asks that they disclose the amount of each contribution from a manufacturer and what percentage of their overall budget that contribution makes up. It is unfortunate that we end up in situations where folks who are advocating for patients are pressured by donors to not give the most accurate information and we want to make sure that is not happening out there. The DHHS will register pharmaceutical representatives. This is modeled off a program that was passed in the Chicago City Council in response to the opioid crisis there. The intention is to have information on pharmaceutical representatives and their relationships with doctors. The reporting would include information about health care providers they contacted, the drugs they marketed and free samples they provided, among other things. There is no fee for the registration, but DHHS would keep a list and make sure the reports are turned in every year.

The last piece deals with self-medication for diabetic patients. Today, this part includes both employers and private schools. The intention is to strip out the language that is related to employers so it just deals with schools. We are not sure if that language actually protects folks or undermines what is in federal statute. That is the part of S.B. 265 that is being actively worked on.

SENATOR HAMMOND:
The most sensitive part of S.B. 265 is where it is asking for information from private companies in an industry that is very competitive. These companies price things based on several different parts of the business like marketing or how much is put into research and development or transportation costs. There

are many different factors. I am worried that S.B. 265 is asking for specific things. Why not ask more for the aggregate? Are you afraid you will not get the answers you need?

SENATOR CANCELA:
You are right that generally asking for more information in the private sector can be an uncomfortable space. In health care there is already a series of requirements put on almost every other entity that operates within the health care field. Hospitals have to disclose a ton of information, insurers have massive reports that go to the Division of Insurance every year and that is not true for pharma today. The idea would be to increase the amount of transparency that exists specifically with diabetes drugs.

SENATOR HAMMOND:
Is the information you are asking for more in the aggregate or is it very detailed?

SENATOR CANCELA:
Senate Bill 265 does not require any information from hospitals or insurers. It is fairly specific information that is being requested from the manufacturer. I am open to different kinds of information but I believe that getting the most transparency possible and how prices are set is really the only way that we can actually have a discussion about every other player in the system.

SENATOR HAMMOND:
Over the years of listening to several bills, the one thing that sets one business apart from another is the proprietary information of how they set prices. Someone may have found the key to transporting their product more efficiently, and as soon as they disclose that, then the competitors figure out how they can do the same thing.

SENATOR CANCELA:
The intent of S.B. 265 is not to ask for disclosures on every single drug in a portfolio. We are not asking for everything but a very narrow disclosure on a small set of specific drugs.

SENATOR HARDY:
My question pertains to section 6 of S.B. 265. How does a patient know he or she needs a rebate? How does the Health Insurance Portability and Accountability Act of 1996 apply to these people?

SENATOR CANCELA:
These are the kind of questions that the working group will be figuring out to define the exact process. It is left intentionally somewhat vague to allow for those discussions to happen.

TANYA GEORGE:
I support S.B. 265 and have provided my written testimony (Exhibit H) to the Committee.

RITA NEANOVER:
I support S.B. 265 and have provided my written testimony (Exhibit I) to the Committee.

BONNIE JEAN SEDICH:
I support S.B. 265 and have provided my written testimony (Exhibit J) to the Committee.

PEGGY LEAR BOWEN:
I support S.B. 265. My best friend of 50 years is in the process of dying because of price gouging on diabetic medication. She was a State employee for 27 years and thought her health insurance would cover her diabetic medication. Unfortunately, because she worked for another company that paid into social security, her insurance benefits with the State were switched to a different company. My friend would test her blood sugar levels prior to eating and then take her insulin, but because the insurance company covered less, my friend stopped eating because she could not afford the insulin. She was recently admitted to the hospital because of complications with her diabetes. The gouging, lack of insurance coverage and the greed involved in diabetic medication are outrageous.

CHRISTOPHER HUGHES:
When I was 15 months old, I became sick and was hospitalized. The doctors told my parents that I was a Type 1 diabetic. To survive, I need to take shots and use my insulin pump to deliver it. I take care of my diabetic supplies on my own and I am on top of the latest technologies. I have never had to worry about whether the supplies would be there, they just were. My mom has explained the cost of the supplies and how lucky I am to have good insurance because if I did not, my parents could not afford all the supplies that I need to live.

I have friends who do not have everything I have. One day I asked a friend how come he was not feeling well and he said he was not able to test for three weeks, all because he simply could not afford the supplies. I asked my mom if my friend could borrow my supplies since we have the same meter and test strips. She explained that laws protect companies, and there is a large number of people who are affected, and cannot afford the insulin at all. She showed me the receipt for the insulin. It was $1,200 a month and that is a lot of money for something I physically cannot live without. My mom and I have talked about what I want to do when I grow up. This was a you can be anything you want kind of talk, except I cannot. I need a job with good health insurance because of the cost of insulin. Now I worry about others who will not have the same opportunities as I do. I worry about the others who will not be able to afford insulin ever and about the possibility that my insurance company has a right to quit on me. The bottom line is insulin needs to be affordable and that is why I support S.B. 265.

KEITH LEE (Nevada Association of Health Plans):
The Nevada Association of Health Plans supports S.B. 265. The Nevada Association of Health Plans is comprised of the major health insurers in the State as well as America's Health Insurance Plans, which is the national trade association for the health insurance companies. The America's Health Insurance Plans has submitted a letter (Exhibit K) to the Committee. The Nevada Association of Health Plans is part of the work group Senator Cancela referred to about dealing with the reimbursement issues, to sort out and minimize, if not completely do away with, the unintended consequences.

RUSTY MCALLISTER (Nevada State AFL-CIO):
The Nevada State AFL-CIO and its 220,000 members have some form of health insurance trust fund or health insurance fund which are negotiating for health care increases. There is not enough money to continue to do this. Senate Bill 265 will not solve the problem, but it is a good first step. We are always talking about the new Nevada and education, but people will not want to come here if they cannot get health care, if it is so expensive they cannot afford it. Let us make the new Nevada cover everything.

JIM SULLIVAN (Culinary Workers Union Local 226):
The Culinary Workers Union Local 226 supports S.B. 265. I will read a statement from the Secretary-Treasurer, Geoconda Arguello-Kline:

> In Nevada today, approximately 280,000 adults or 12.54 percent have diabetes, including 75,000 who do not know they have the disease. Another 787,000 of Nevada adults or 38.5 percent have prediabetes. According to recent estimates, during their lifetime, at least one in three adults will develop diabetes by 2050. Half of all Latinos and half of American African women nationally are projected to develop the disease. Children who develop the disease face a lifetime of medication and disease management. Diabetes is a public health epidemic that costs Nevadans $2.4 billion every year in medical costs. Prescribed retail pharmaceuticals account for an estimated 57.6 percent of total diabetes health care spending. Insulin, the primary drug for controlling diabetes, was discovered 95 years ago, but drug companies have raised insulin prices as much as 450 percent beyond inflation since 1996.
>
> The Culinary Health Fund, which is sponsored by the union and Las Vegas area employers, provides the health insurance coverage for over 143,000 Nevadans, the culinary union's 57,000 members and their dependents. Through the health fund the culinary union is one of the largest health care consumers in the State. The culinary union has thousands of members who are impacted by the diabetes epidemic. The high prices of pharmaceutical drugs, like insulin, drive up the costs of health care, and this affects not just our members and their families but all Nevadans. Diabetes does not discriminate, and this epidemic is not a partisan political issue. Republicans, Independents and Democrats can work together for the good of Nevadans. Thank you.

STACIE SASSO (Health Services Coalition):
The Health Services Coalition represents 21 employer and union health plans with a combined total of 380,000 covered lives. The Coalition has a primary focus of accessing quality and affordable health care for the participants of our member groups. We work to ensure the member groups pay a fair and reasonable rate for health care services in southern Nevada. That is why S.B. 265 is so important to the Coalition. Currently, there is no control in place on either a State or federal level for prescription drug costs. This allows expensive life-sustaining drugs, like insulin, to continue to increase at alarming rates. This is causing a barrier for patients diagnosed with diabetes to access medications they need to remain healthy. Unfortunately, what we are seeing is

the cost of prescription drugs is increasing faster than the cost of living. Many pharma industry representatives have stated that profit margin is needed to continue to innovate, but much more is being spent on marketing rather than innovation. That is why transparency requirements are key to helping us understand this issue. Allowing for transparency for prescription drugs in the State is the start of change in the health care arena for Nevada. The Coalition supports S.B. 265.

MATT MORRISON (Executive Director, Healthcare Operations, MGM Resorts International):
MGM Resorts International supports S.B. 265 and hopes it proceeds to ensure the affordability of diabetic drugs for our health plan members and all Nevadans. The MGM Resorts health plans provide coverage for almost 40,000 residents in Nevada and at least 2,500 of them have diabetes. While MGM Resorts has been able to shelter its diabetic health plan members from double-digit annual price increases and insulin price increases, those increases now threaten MGM's ability to offer the same level of coverage for these as well as other life-saving drugs. The effects of the recent massive increase in the prices of insulin are only compounded by the ever increasing number of diabetics that are seen every year. MGM Resorts supports efforts by the State to bring the pricing of these medications to the light of day and support the concept that competition should work to lower drug costs, not increase them. MGM Resorts supports efforts to ensure sustainable pricing on all critical medications where possible.

RUBEN R. MURILLO (Nevada State Education Association):
The Nevada State Education Association supports S.B. 265. I have provided a letter of support (Exhibit L) to the Committee.

On a personal note, I am a diabetic and most members of my family are diabetics. I will show you two bottles of medication, they are gold. One bottle is Janumet and it costs me $93 a month in co-pay. The other bottle is Jardiance and it costs me $100 a month in co-pay. The prices have been increasing dramatically especially in the last year. I have provided my written testimony (Exhibit M) to the Committee. The Teachers Health Trust that represents the teachers in Clark County has been struggling to reduce the costs of medications, especially for diabetics. The change in companies from Merck-Medco to Caremark to WellDyneRX does nothing to reassure people that the costs of medications are not going to go up. In late 2016, I started to notice an increase in my co-pays. The pharmacist would ask me if I knew how much the co-pays were. I said do I have a choice? My pharmacist suggested I go to the Internet and look for coupons to bring down the price. I thought to myself, coupons on the Internet? I did look on the Internet and found a coupon for Jardiance. It brought it down to $25 but after a year, it will go back up. A person should not depend on coupons on the Internet to offset the cost of diabetic medications. A person should not have to make a decision of choosing to pay for medications or providing for his or her family. I feel like I am in a supermarket for prescriptions. Unfortunately, there are many members who cannot afford their medications. I support S.B. 265.

SENATOR HAMMOND:
Do you feel that the passage of S.B. 265 will guarantee the lowering of the prices of diabetes medications?

MR. MURILLO:
There are no guarantees in life. We are hoping S.B. 265 will start a discussion and maybe some actions that will address the cost of diabetes medications overall.

RYAN BEAMAN (Clark County Firefighters Union Local 1908):
The Clark County Firefighters Union Local 1908 supports S.B. 265. My other job is chairman for the Las Vegas Firefighters Health & Welfare Trust, which is a nonprofit, self-funded insurance trust. The members are the insurers for the group. As chairman, I do see the costs associated with medications and see how important it is to keep the prices down regarding the co-pays and deductibles for the members. Not taking medications creates other problems. The Trust tries to make sure the members are taking their medications but the members do not see the other side of the costs of the medications. I hope, with some type of legislation, discussions about what the costs of medications are and why they are so high take place.

TODD INGALSBEE (Professional Firefighters of Nevada):
The Professional Firefighters of Nevada supports S.B. 265. Firefighters of Nevada run on hundreds of thousands of calls every year and many of those calls are on diabetic patients. I can tell you from personal experience that most of those calls are because the patient could not afford his or her medication. We hope S.B. 265 will spark a discussion about medication rates.

PRISCILLA MALONEY (AFSCME – Retirees):
The AFSCME – Retirees supports S.B. 265. Most of the AFSCME – Retirees members are insured through the Public Employees' Benefits Program (PEBP) and they have filed a fiscal note on S.B. 265. It is my understanding that the sponsor of the bill is working with PEBP on how to word the fiscal note.

MR. SASSER:
Washoe Legal Services and the Legal Aid Center of Southern Nevada are concerned for the low-income clients that come to them about the high cost of drugs, especially those who are on Medicare, and have the drug cost follow them. We are hoping S.B. 265 will put forth conversation and the examination may shed some light on lowering the costs of medications.

RUSSELL ROWE (Boyd Gaming Corp.):
The Boyd Gaming Corp. understands there is some work to be done on S.B. 265, but stands in support of its intent.

MIKE ALONSO (Caesars Entertainment):
Caesars Entertainment supports S.B. 265. Caesars Entertainment employs more than 30,000 team members in Nevada and more than 70,000 team members on a company-wide basis. Caesars Entertainment supports the efforts of additional transparency and cost controls on prescription drugs on behalf of our team members.

RACHEL GUMPERT (AFSCME International):
The AFSCME International has 1.6 million members nationally and represents State workers. You heard testimony from a State worker and member of ours that she has a friend that would be here today but she is literally dying because of the cost of her diabetes medication. State workers do not receive social security, they have poverty wages and they fall through the Part D donut hole. They cannot afford the medications as they stand today. Each of the Legislators before me have members in their districts who are dying because they cannot afford their medications. Please support S.B. 265.

RANDY SOLTERO (International Alliance of Theatrical Stage Employees):
The International Alliance of Theatrical Stage Employees supports S.B. 265.

MARLENE LOCKARD (Service Employees International Union Local 1107 Nevada):
Service Employees International Union Local 1107 Nevada supports S.B. 265.

FRAN ALMARAZ (Teamster Local 986; Teamster Local 631):
The Teamster Local 986 and the Teamster Local 631 support S.B. 265.

JEANETTA WILLIAMS (President, NAACP Tri-State Conference Idaho-Nevada-Utah):
The NAACP stands neutral on S.B. 265. While there are some provisions in S.B. 265 that are beneficial to patients, the NAACP is concerned with some aspects of the bill and the effect it may have on those that suffer from chronic conditions. Ideally, the NAACP would like to see a legislative solution that improves access to quality care, creates a fully transparent system and focuses on "patients first" mentality. Unfortunately, this bill provides an incomplete solution to our overall goal of improving care for patients.

First, in reviewing S.B. 265 and its stipulations on advance notice of a price increase by a pharmaceutical company, a patient's access to needed treatment may be unintentionally affected. The advance notice of a price change may lead to stockpiling by purchasers. This can reduce access to life-saving treatments in some areas for patients living with chronic conditions. Secondly, by ignoring the role of other important stakeholders in this process, we will have an incomplete picture of what medicines truly cost. Are we accurately capturing the cost of treatments in this system when we ignore the role that other stakeholders play such as insurers and the pharmacy benefits managers? The NAACP supports transparency. Transparency should be considered for all areas of health care, not just on patient advocates and manufacturers. Therefore, we should find a solution by evaluating the total cost of care, not just the cost of medicines. Lastly, a piece of legislation like this should be created with the patient in mind. Focus on patient-centered solutions should be continued. In S.B. 265, there is no mention of ensuring affordable co-pays or preventing discrimination based on a medical condition. Solutions such as S.B. 436, A.B. 352 and A.B. 381 should be considered as an avenue to increase access that is affordable.

SENATE BILL 436: Prohibits certain discriminatory designs for prescription drug benefits in health benefits plans. (BDR 57-996)

ASSEMBLY BILL 352: Provides for continued coverage for health care for certain chronic health conditions. (BDR 57-592)

ASSEMBLY BILL 381: Revises provisions governing prescription drugs covered by certain policies of health insurance. (BDR 57-698)

BETH HANDLER (Chief, Bureau of Child, Family and Community Wellness, Division of Public and Behavioral Health, Department of Health and Human Services):

The Division of Public and Behavioral Health stands neutral on S.B. 265. Looking at Medicaid data and SNAP data we see trends where people 50 years old or older are typically diagnosed with diabetes. We see in our younger participants disproportionate amounts are indicated as being overweight or obese, therefore they are considered at risk of diabetes or future diabetes. We also see a disproportionate amount of minority groups affected by diabetes in the Medicaid and SNAP populations. For 2012, Nevada's total estimated medical cost for diabetes was $2.5 billion with prediabetes representing $194 million of this cost. Absenteeism associated with diabetes can range from 2 percent to 10 percent higher of total work days lost. Oftentimes, we like to look at health outcomes and how we can improve them for people with diabetes. That means people in better control of their diabetes, or a person with prediabetes being no longer deemed so, or an overweight or obese client losing weight with the help of his or her physician. Improved outcomes can be achieved through applying interventions to prevent diabetes among Nevadans. This can include health care and payer systems collaborating to identify and direct resources towards those diagnosed as prediabetic, overweight or obese. We can look at accessing A1C levels. Right now we can see billing claims data, but we cannot see the A1C levels, which are an indicator of how people are doing and monitoring their diabetes. We can look at ways to access this through standardized reporting and electronic health records. Another intervention is community health workers or the Promotora de Salud model, which is an imbedded person in the community that works with clients to assist with medication compliance, health care appointments and adhering to healthy behaviors as well as a transition to diabetes self-management education and diabetes prevention programs.

DUANE YOUNG (Chief, Behavioral Health and Pharmacy Services, Division of Health Care Financing and Policy, Department of Health and Human Services):

The Division of Health Care Financing and Policy (DHCFP) is taking a neutral position on S.B. 265. Currently, there are 5,454 fee-for-service Medicaid recipients and 5,537 managed care enrollees on insulin. Over 11,000 managed care and fee-for-service clients are prescribed antidiabetic medications, which are the top 25 medications that have been prescribed as of fiscal year 2015-2016. Medicaid reimburses for individual and group diabetes self-management. Ten hours of this services is offered without previous authorizations. Additional hours for remedial and repeat training may be requested. In addition to maintenance, glucometers, test strips, prevention efforts through house screening and referral services are covered by Medicaid. The WAC is proprietary information to Medspan. The DHCFP would require permission to utilize outside claims of adjudication. No current procedure exists for this. The National Average Drug Acquisition Cost (NADAC) is public information and requires no special permission to utilize. Innovator drugs, like insulin, are priced at the greater of 21.3 percent of the average manufacturer price per unit or the difference between the average manufacturer price and best unit price adjusted by the CPI for all urban customers. This limits our total rebate amount for the innovator drug at 100 percent of the manufacturer price. Fee-for-service utilizes a pharmacy benefits manager to negotiate these rates on our behalf, while network contract offices have their own purchasing mechanisms. The DHCFP has requested a friendly amendment to exempt the recipients of Medicaid and the Children's Health Insurance Program. The DHCFP receives supplemental rebate monies that are negotiated directly with each drug manufacturer for these prescription drugs. Senate Bill 265 would jeopardize the rebate monies if not amended. The amendment will remove the fiscal note.

SENATOR HAMMOND:
Are you offering an amendment because S.B. 265 is complicated and does not do all that is needed?

MR. YOUNG:
Yes, that is correct. We have asked Senator Cancela for an amendment to exclude the recipients of Medicaid and the Children's Health Insurance Program.

SENATOR HAMMOND:
How does a patient know he or she needs a rebate and how do they ask for the rebate? Do we need to worry about the Health Insurance Portability and Accountability Act of 1996 (HIPAA) laws and is that another part of S.B. 265 that needs to be worked on?

MR. YOUNG:
Yes, as I mentioned earlier NADAC is open information. The WAC information is proprietary. Because the DHCFP does not have a mechanism set up to purchase the WAC information, it would have to use the NADAC information.

CHAIR SPEARMAN:
The Committee received a letter from Immunize Nevada (Exhibit N) taking a neutral stand on S.B. 265.

KIPP SNIDER (Pharmaceutical Research and Manufacturers of America):
The Pharmaceutical Research and Manufacturers of America (PhRMA) is in opposition to S.B. 265. I have provided a written statement of opposition (Exhibit O) to the Committee. We appreciate the drug pricing system in the U.S. is not perfect. We have had some bad actors and are bothered when we see people like Martin Shkreli, the self-described PhRMA brother and hoodie, and others who do not represent the values of the research-based pharmaceutical industry. It is an industry that has turned HIV/AIDS from a death sentence into a manageable chronic illness. It has essentially cured hepatitis C, drastically reduced the mortality rates in cancer in the past 20 years and the list goes on. Ninety percent of all the prescriptions filled in the U.S. are generics. We have had major products that have gone off patent with billions of dollars of savings as a result. That is what keeps drug spending in the big picture steady. It is about 10 percent retail drug spending and 10 percent of overall U.S. health care spending. Retail prescription drug spending has stayed on track at about 10 percent over the years. The government actuaries expect it will stay in the same place. The 10 percent piece that retail prescription drugs comprise is the piece of the pie that is by far best positioned to make the entire pie smaller to reduce those larger pieces such as hospitalization expense and physician office expense.

The list prices are almost never what is actually paid in the real marketplace. There are PBM companies that control the overwhelming bulk of lives. They negotiate heavy discounts in the marketplace. Senate Bill 265 is premised on the concept of WAC when that is not the price in play. To base the entire piece of legislation of price control structure on WAC is really misguided. Paying WAC is like paying the hotel rate listed on the back of a hotel door. It is a competitive system, and yes, it is complicated. The principal problem we have is that it is not the pharmaceutical manufacturer that determines what patients pay, it is the PBMs and health insurers. The cost sharing burden that is being placed on patients has gone way up for drugs relative to other pieces of the health care marketplace.

SENATOR HAMMOND:
Can you explain what PBMs are and what they do?

MR. SNIDER:
Pharmaceutical benefit management companies or PBMs negotiate with drug manufacturers for discounts on pharmaceuticals. There are three PBMs in the U.S. that control about 80 percent of the market. They have a huge amount of leverage and purchasing power. They negotiate very large discounts off the WAC price. The insulin market is one of the most competitive markets. The discounts for them are particularly large compared to other sectors. The discounts are negotiated, and that is a good thing because lower net prices are good, but the problem is that the way benefit design works is the discounts are not finding their way to the patients. There are co-pays where a person would pay $10 or $25, a set amount of money for prescriptions. There is coinsurance, which is much more prevalent, where a person might pay 25 percent or 50 percent of the cost of a prescription. Those prices are almost always based on the WAC number, so the discounts the manufacturers are paying back through the complex supply chain are oftentimes not making their way to patients. That is a problem.

SENATOR HARDY:
Since the manufacturer does not have control over its prices and the PBM inflates the prices, who is the bad guy? Who is making money on the insulin? Where is the egregious cost to the patient coming from?

MR. SNIDER:
It is a really complicated system as there are a lot of moving parts. There is a report that is put out by the Berkeley Research Group that tries to sort through all this. The report shows that the overall health care spent in terms of the gross health care expenditure that about 37 cents on the dollar goes to the brand manufacturer. The rest of the dollar is scattered through the system of complicated middlemen. Rebates start with the manufacturers then go to the wholesalers, who take their bite out, then to the PBMs. The PBMs only partially share, if at all, with the patient.

SENATOR HARDY:
How much of the research and development costs go into the costs of the new insulins?

MR. SNIDER:
I cannot give you a specific number on research and development for insulin. Diabetes is a major chronic condition that comprises a huge amount of health

care expenditures in this Country. Research and development spent for the industry is about $58 billion for last year. You hear about the older medications going off patent and there should be a generic competitor coming in right away, but it does not always happen like that. There are problems with backlogs of generic medications at the Federal Drug Administration (FDA) and other factors that go into it. Overall, if you look at prescription drug spending, it is a steady state in terms of the overall spent in the health care dollar. In fact, the growth in prescription drug spending is dropping compared to the other components of the health care sector.

SENATOR HARDY:
Do you foresee a type of insulin coming off patent? What is the hope for the person who has to pay $440 a month to buy his or her insulin?

MR. SNIDER:
Insulin is particularly complicated because it is a biological product and there are different regulatory pathways for getting products approved by the FDA and commercialized. Right now in the insulin marketplace, there is significant brand-on-brand competition. There has been a recent market entrant for a follow-on insulin product. Under the biosimilar pathway, which was approved as part of the ACA, there is a conversion that takes place with respect to insulin and other products that will allow for direct biosimilar competition for those products beginning in 2020. The marketplace is going to change and is already changing in competitive brand-on-brand with significant discounts, but we expect it to become more competitive as the landscape evolves.

SENATOR HARDY:
What happened to the neutral protamine hagedorn insulins and the regular types our grandmothers used? Can we go back to the old insulins?

MR. SNIDER:
Many of the original insulin designs are outdated, and in fact, no longer produced. There has been an evolution of the technology so that newer, more predictable molecules can be engineered that have supplanted the insulins of years ago.

SENATOR HARDY:
Do you anticipate the biosimilar insulin prices will come down just like the prices of the hepatitis drugs did?

MR. SNIDER:
Yes, that is correct.

SENATOR RATTI:
Did you say the percentage of pharmaceutical spending as an overall percentage of the entire spend on health care is staying steady?

MR. SNIDER:
Yes, that is correct.

SENATOR RATTI:
Is it also correct that the entire spend on health care is escalating dramatically?

MR. SNIDER:
Yes, the entire spend is rising. I will read a small snippet from *Health Affairs* published this month which looked at national health care expenditure data and it said, "Among the major goods and services sectors, the category with the largest projected slowdown in 2016 is prescription drug spending."

We are seeing a change. There was a blip that is undeniable in prescription drug spending in 2014 in particular, based on new product introductions. The curve has flattened and it is pretty steady as it goes in terms of the role and spend on drugs.

SENATOR RATTI:
It is steady as a percentage of overall health care spending but overall health care spending has been escalating dramatically. Therefore, pharmaceutical spending has also been escalating dramatically. It is just staying within the same ratio to all the other spend.

MR. SNIDER:
I do not know what dramatically means. I believe some of the net prescription drug spending growth is 5 percent or lower year on year.

SENATOR RATTI:
You stated earlier that PBMs are part of the problem. What S.B. 265 does is shine a light on the manufacturer portion of the process. The premise of this bill is that transparency will at least help to pinpoint the problem. If there was a companion bill that asked for transparency for PBMs, then that would help us

see another part of the issue, and where we can put a finger on what exactly is causing the escalation of prices because people cannot get basic health care. What is specifically in S.B. 265 that PhRMA opposes? There is nothing in the bill that says you cannot charge what you want to charge. There are no price caps. There is nothing that stops PhRMA from making a profit.

MR. SNIDER:
There are multiple provisions that PhRMA opposes and the most fundamental are the price controls that are in S.B. 265. The direct price controls, forcing manufacturers to pay rebates to claimants based on prices outside the U.S. or based on a differential from the CPI medical care component as compared to WAC. Yes, on multiple levels we have a problem with price controls as PhRMA believes it stifles innovation and is simply bad policy. PhRMA believes S.B. 265 is unworkable with respect to many of the details such as references to the prices that are paid in foreign countries. It is not that simple in the real world. Paid by whom? The distribution systems in those countries are also very complex. There are multiple channels and prices within those places. It is not as simple as people may think.

Other provisions in S.B. 265 that we find problematic are the idea of having to give 90-day advance notice of price increases. PhRMA believes it will be highly disruptive to the marketplace, potentially inducing harmful behavior by suppliers with hoarding, potential antitrust violations and requiring the reporting of all the data, research and development profit data and financial data. It is really difficult for manufacturers to report on the true research and development costs for an individual product because the true cost includes the cost of all the failures. Many of the products that go into testing in humans never make it to the market.

SENATOR RATTI:
Do you agree there is a problem that people cannot afford their diabetes medications?

MR. SNIDER:
I agree the system creates challenges for some people and we should work on ways to minimize or eliminate those challenges.

SENATOR RATTI:
Apparently, in your point of view, there is nothing in S.B. 265 that helps the challenges. If not this, then what? What is the solution?

MR. SNIDER:
There are several solutions. One is understanding rebates and how they are passed down or not through the system. Explore ways that if people are paying coinsurance, it is based on a price that is more reflective of the reality of the marketplace. Examination of different pricing models that are based on the value that products bring and advancement at the State level biosimilar substitution legislation which will help to facilitate the new category of drugs that are approved by the FDA. Focusing on consumers' understanding of how their drug benefit works is another solution. We hear time and time again that consumers are running out to select a plan on the exchange, and then immediately gravitate to the plan with the lowest premium even though that plan may not cover their medications. They do not understand what deductibles and co-payments are in many instances and that ends up hurting people.

SENATOR RATTI:
I believe in data-driven decision-making because it is the only way to get to a place of understanding. Is there any data you are willing to share?

MR. SNIDER:
Yes. The industry already shares all sorts of data on overall research and development spend with respect to basic financial information that many of the publicly traded companies are required to file with the U.S. Securities and Exchange Commission. We have seen a movement across the industry where many of our companies are taking steps to provide more information about, for example, aggregate rebates. Doing that will produce a better understanding of how the marketplace actually works.

SENATOR HARDY:
People pick the prescription drug coverage based on a monthly price for the coverage, then the people are told that the insurance will not cover any or only cover a certain price for their prescriptions. The people then have to pay for a prescription that they have to have in order to live. Does this make sense?

MR. SNIDER:
There is no doubt that the burden is on people. What people are actually paying in cost sharing for pharmaceuticals is disproportionate to other pieces of the health care system. It is about 20 percent on average that people are shelling out for cost sharing on medications, about 4 percent for hospitalization and about 10 percent for physician office visits. That number has gone up significantly.

CHAIR SPEARMAN:
If the cost of health care has risen dramatically and the percentage has remained the same, is it fair to deduce that the cost of prescription drugs has gone up dramatically?

MR. SNIDER:
I do not know what dramatically means as I cannot quantify it, but yes, health expenditures are going up. The population is rising, there is inflation that factors into health care costs, and then there is the older segment of the baby boomers who are higher utilizers. If you look back historically at the role of prescription drugs and the overall health care spend, it has been stable and is expected to stay stable.

CHAIR SPEARMAN:
I am talking about stable as connected to health care costs. If health care costs 10 years ago were $100 and that is 10 percent, and now the health care costs go up to $200, but the percentage of prescription drugs now comes down to 5 percent because it has not followed the escalation in price. If prescription drug costs are tied to the escalation of health care costs and health care costs have gone up, then the prescription drug costs have gone up. There is a difference between 15 percent of $1 and 15 percent of $300.

MR. SNIDER:
We can provide data to you on overall health care spending in the U.S. and the different pieces like prescription drugs.

CHAIR SPEARMAN:
Yes, I would like the information. In the testimony heard earlier today, someone showed us a bottle of medicine that cost $93 a month in co-pay and another bottle that cost $100 a month in co-pay, and then the letter I received which addressed other medicines that have to be taken along with the diabetes

medicine. I just want to understand how we get to the place where we are actually looking at health as a human service. How do we bridge the disconnect? Maybe it is just perception, but I do not know that. I would like to get to the heart of the matter. The heart of the matter is there is a drug that will help people who are diabetics. I looked at the information for my district and it is off the charts in terms of the number of people who are either diabetic or prediabetic. I will tell you a personal story. My mother, who is now deceased, could not afford her medicine. She had renal failure as a result of untreated diabetes. I did not tell her, but I was buying her medicine monthly and it was $250 a month. I let her think it was the hospital paying for it. I was doing that because she needed the medicine to keep up her quality of life. I need data to tell the people of my district why I voted yes or no on S.B. 265. People tell me they have insurance now and they want to keep it. They ask me what am I going to do about it. People tell me they have $280 a month in prescription co-pays. They ask me, "What are you doing to help get that co-pay down?" They do not want to hear how the system works or how PBMs work. They want to know what I am doing to get the health care and prescription costs down.

MR. SNIDER:
You can tell your constituents that if they have commercial health insurance, many manufacturers do offer important assistance with cost sharing like rebates or coupons. That can make a real difference in terms of the out-of-pocket burden for people.

BRIAN WARREN (Biotechnology Innovation Organization):
Biotechnology Innovation Organization (BIO) is in opposition to S.B. 265. I have submitted a written statement of opposition (Exhibit P) to the Committee. Biotechnology Innovation Organization's members consist of the companies that research, develop and manufacture biological medications, many of which are injectable medications. Some of our members are names you would recognize but most of them are small academic research institutes and start-up companies. Seventy percent of innovative therapies are coming from small companies and they rely heavily on outside investors to fund their research and development costs. Sometimes funds are from angel investors or it is venture capital funds or partnering with a larger pharmaceutical manufacturer. It takes 10 to 12 years and on average $2.6 billion to bring a new therapy to market. Of the thousands of potential therapies that start out, there are only a handful that make it to clinical trial stage. From those that do make it to the clinical trial

stage, 90 percent of those fail. This is a high cost industry with a high failure rate.

Investing in this industry entails a significant amount of risk. For this to be sustainable and the return on investment to be successful, therapies must make up for the losses on those that are unsuccessful. This is part of the price we pay for the extremely valuable innovation that this industry has brought to patients, the new cures that did not previously exist, and the new therapies that are having a significant benefit to patients. Investors look at risk versus reward. Price caps cap the reward part of the equation. It is an economic law that if one is impacted, the other will go out of whack. If the reward is capped that an investor can make when investing in a small company, the risk will be put out of balance and it will be extremely difficult and have a very detrimental effect on small companies' ability to secure funding. Senate Bill 265 could end up stifling innovation and, in some cases, make it more expensive for small companies to actually obtain the financing they need to move forward with their research and development. The price caps are BIO's significant concerns but we do have other concerns with S.B. 265 and they are noted in Exhibit P.

SENATOR RATTI:
If I understood the testimony in support of S.B. 265, it did not sound like there had been any new innovation in the field of insulin in quite some time. It sounds like the drug has not changed significantly since the early 2000s. How does what you are saying specifically relate to insulin drugs?

MR. WARREN:
I am not familiar with what is currently in the pipeline specifically for insulin. I do know it is still an area where there are innovative companies bringing new products to market to provide better and more efficient treatment for patients with diabetes.

SENATOR RATTI:
Are you familiar specifically with any new innovations?

MR. WARREN:
No, I cannot name specific products in the pipeline right now.

SENATOR RATTI:
Forget about the pipeline, what has been innovative in the last ten years?

MR. WARREN:
I would have to get back to you with a list. Our members do manufacture medications for a number of diseases, not just diabetes, so I would need to get back to you with a list.

CHAIR SPEARMAN:
What is the average amount of time that a patent on a drug is renewed so the drug never reaches the generic stage?

MR. WARREN:
I will have to get back to you with that information. I know that patents granted by the FDA are initially granted for a 20-year timeframe and starts at the beginning of when the patent was filed prior to all the clinical trial stages. I will need to get back to you on the individual therapies and how many times the patent has changed.

MR. SNIDER:
Patents do not get renewed, they expire. When patents expire, that is the end. There are other types of exclusivity under federal law for manufacturers, but once the exclusivity is gone, the marketplace is free for competition to come in. That is what we have talked about. The story that very often does not get told is the big blockbuster medications that go off patent and a patient now pays $6 where he or she used to pay $75. It is important that we look at the entire story. Yes, the U.S. does pay more than its fair share, but the innovations do come from this Country. The innovations do not come from those other countries that are referenced in S.B. 265 nearly to the extent they do here. That is a result of the system that we have established.

CHAIR SPEARMAN:
When people are investing in the research of new drugs is there any understanding with respect to the timeline and the return on investment (ROI)? How do you explain to an investor that the patent will probably expire before the investor gets any money back?

MR. WARREN:
The timeline for the approval process once you get to the clinical trial stage on average is 10 to 12 years. That has increased in recent years and depending on different categories of medications it does vary. The risks and potential of the ROI for individual therapies that investors look at it depends on a significant

number of factors. Those factors range from the overall population of patients that a therapy could potentially treat, the medical benefits the patients receive, and whether some medications provide smaller benefits, but significant above and beyond previous therapies as some are leaps and bounds beyond where previous therapies were. Lot of things are factors that investors might take into account. It is an extremely complicated question and one that is always going to have risks because even the investors that do the most due diligence are still going to fail or invest in failures 90 percent of the time.

SENATOR HAMMOND:
How does insulin affect your direct opposition to S.B. 265, as it is only dealing with insulin and not necessarily other drugs?

MR. WARREN:
Senate Bill 265 does not just impact insulin. It impacts State-designated essential diabetes drugs yet undefined. The total number of therapies and the total number of diagnoses that fall under that category is up to the discretion of that department that is given the authority under S.B. 265. That could be comorbidities that are commonly associated with diabetes. It could be other non-insulin diabetes treatments. It is very difficult to say. Yes, there are innovations in insulin and I will do my due diligence to provide the Committee more information in regard to that specific question.

SENATOR RATTI:
Would you still oppose this bill if S.B. 265 was redrafted to be very specific to insulin and very specific to diabetes medication?

MR. WARREN:
Yes, BIO would still oppose S.B. 265 because it has members who provide research and development to bring new therapies to market in the insulin space and we would not want to deter future innovation in that area.

CHAIR SPEARMAN:
Could you please show me where it says in S.B. 265 that it is not just limited to insulin, but it covers all diabetes medication?

ERIC ROBBINS (Counsel):
Senate Bill 265 requires the DHHS to compile and annually update a list of essential diabetes drugs. The list must include, without limitation, all forms of

insulin and biguanides marketed for sale in this State. It has to include the insulin and biguanides, but because it says without limitation it is not limited to those things. If the Department decides that something else is an essential diabetes drug under this bill, it can put it on the list.

SENATOR RATTI:
Can you acknowledge that the pharmaceutical companies set the first base price, and that price plays a part in what the price is to the consumer?

MR. WARREN:
Yes.

JEFF BUEL (Johnson & Johnson Services, Inc.):
Johnson & Johnson is in opposition to S.B. 265. I have submitted a statement of opposition (Exhibit Q) to the Committee. Senate Bill 265 does not address the important issues of maintaining access to new medicines. This bill may actually result in unintended consequences without really addressing what the public is seeking. Johnson & Johnson believes the solution lies in changing the way we pay for and reimburse for care; paying for how well medical treatments and interventions work as opposed to the volume of procedures or medicines. So everyone involved is held accountable for the value they deliver. Johnson & Johnson and Janssen recently released the North America Transparency report which provides important information about our transparency commitments and responsible business practices. This is available on the Janssen Website. I have committed to speak to the sponsor of S.B 265 about this report.

Johnson & Johnson wants its current and future business partners to know that it is committed to responsible pricing and embracing transparency. Diabetes is a very complex disease and is among the top ten causes of death in the U.S. and while death rates have declined, the number of Americans diagnosed with diabetes has more than tripled since 1980, making the needs for innovative medicines greater than ever before. Over 29 million people have diabetes, and another 86 million are considered to have prediabetes. It is imperative to address this disease.

Senate Bill 265 fails to take into consideration the individual treatment effect of medicines that will potentially limit access to a number of treatments. The diabetes patients need an armament of treatments that will provide a maximum clinical benefit to the specific patient's needs. Innovation is necessary and very important. Senate Bill 265 underestimates or undermines those efforts for these new types of clinical therapies. As drafted, S.B. 265 does not meaningfully provide consumer cost savings given that insurers may collect refunds and are not required to pass them on to consumers. Under the scope of S.B. 265, the manufacturer would pay additional rebates based on foreign prices that do not reflect the U.S. marketplace or the economic system. Johnson & Johnson wants its current and future business partners to know it is committed to responsible pricing and embracing transparency and welcomes the opportunity to be a part of the discussion. As stated before regarding prior notice, S.B. 265 requires prescription drug manufacturers to provide a 90-day advance notice of a planned price increase to the WAC unit, which is very problematic. As a matter of principle, health plans set their premiums on an annual basis, so it is unclear how advance notice of impending price increases will help reduce health plan costs and help patients access their products. Advance notice would create inefficiencies in the market and introduce greater unpredictability for manufacturers, suppliers, payers, patients and providers, and potentially increase the cost of medications.

CHRIS FERRARI (Pfizer, Inc.):
Pfizer, Inc. is in opposition to S.B. 265. I have provided a letter of opposition (Exhibit R) to the Committee. There is no one in this room who is not sympathetic to health care cost and specifically to the stories mentioned previously. Every one of us in this room has been touched by someone who had a challenge with diabetes. We all agree that health care costs are too expensive and there has to be something done about it. Pfizer simply believes this is not the bill or the vehicle to do so. Pfizer has significant concerns regarding drug pricing reimbursement as outlined in section 6, disclosure mandates in section 7 and price increase prenotification in section 8 of S.B. 265. Additionally, Pfizer wants to put on record that it supports the comments made by PhRMA.

Senate Bill 265 mandates a process, regarding drug price reimbursement, in which claims can be submitted to a drug manufacturer, and the manufacturer must directly reimburse a patient or third party purchaser. Pfizer would be happy to work with the sponsor to discuss how that system would work. There is an insurance layer and trying to figure out what is due back to the consumers is a relatively confusing process. A prenotification mandate on pricing can lead to stockpiling of drugs and advance purchasing can lead to shortages and result in medicines sold by unauthorized distributors or on the gray market, disrupting a manufacturer's processes to maintain high quality assurance of its products.

Requiring any industry to report proprietary information such as pricing, research and development, manufacturing costs related to administration, marketing, etc. is a concerning precedence. Some of those items are currently listed in public filings, especially with public companies. Disclosure mandates gather only a narrow slice of information.

If better health care and lower costs are our goals, everyone has to come together and participate to look at all aspects of the system rather than just picking on one to try to find a broader solution.

CHAIR SPEARMAN:
Can you tell more about the gray market?

MR. FERRARI:
I will provide the Committee additional information on the gray market. When price increases are announced in advance, different entities will purchase larger quantities of prescription drugs resulting in oversupply of those prescription drugs and then being filtered into the gray market.

CHAIR SPEARMAN:
Can you explain unauthorized distributors?

MR. FERRARI:
I will also provide to you an explanation of unauthorized distributors.

SENATOR HAMMOND:
Are you referencing section 8 of S.B. 265 when speaking about price increase prenotifications?

MR. FERRARI:
Yes, that is correct.

CHAIR SPEARMAN:
If unauthorized distributors are selling prescription drugs on the gray market, do we have statutes that would address the criminality of that act?

MR. ROBBINS:
Nevada has statutes that deal with controlled substances and dangerous drugs and the unauthorized sale of those substances. There are federal statutes that address the issue to a certain degree. For example, if there was a patented drug coming into the Country, courts have held that there is not patent exhaustion in that case. There is also the general principle of patent exhaustion where if something is sold in this Country, the patent holder can lose his or her rights to it. I can look into that and get back to you.

CHAIR SPEARMAN:
This is a question that you can get back to me with the answer. If there is a federal law that exists that addresses the unauthorized distributors selling prescription drugs on the gray market, how can it be appropriated into the *Nevada Revised Statutes* so they are prosecuted to the fullest extent of the law? If they are unauthorized distributors that means they are putting the people's lives at risk who they are selling to.

The Committee received letters of opposition to S.B. 265 from the following companies: National Taxpayers Union (Exhibit S), Americans for Prosperity Nevada (Exhibit T), Americans for Tax Reform (Exhibit U), Council for Citizens Against Government Waste (Exhibit V), Bristol-Myers Squibb (Exhibit W), Novo Nordisk (Exhibit X), AbbVie Pharmaceuticals (Exhibit Y), Boehringer Ingelheim (Exhibit Z), UCB, Inc. (Exhibit AA), Sanofi (Exhibit BB), Astellas Pharma US, Inc. (Exhibit CC).

SENATOR CANCELA:
I am certainly willing to work with all the people who testified on S.B. 265 and I am open to include them in the working group. It is very easy to look at what is happening with diabetes in this Country, in Nevada and as a business and see it is a growing opportunity. The fact that Nevada is at 12 percent and 38 percent prediabetic means more and more people are going to be relying on insulin in the near future. If we do not take action and look at this as what it is, a public health crisis, then we end up in a situation where we literally put lives at risk. What we heard from the opposition tonight, in very few instances specific to insulin, I ask the Committee to give weight to arguments we heard and the evidence we heard that are specific to price increases on insulin. If it is true that overall pharmaceutical costs are steady, then S.B. 265 would never get enacted in that it is only designed to create equity and reimbursement in the situation when price gouging happens. There are specific measures for what that should

look like. If pricing stays steady, then there would never be a reimbursement enacted. The people who testified in support of S.B. 265 are either groups who represent big health plans or represent a lot of employees. All of these groups would not be testifying in support if it were not for the fact that they too are suffering from the increases in insulin cost, and it is a testament to the fact that action is needed. I am looking forward to working with people who are here tonight and with others to get to a place where we get through the details that were brought up tonight and hopefully end the Session with something that could have a tremendous impact.

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CHAIR SPEARMAN:
This question does not have to be answered right now, but I would like someone to get back to me with an answer. Instead of coupons, is it conceivable that a price reduction could be commensurate with what a coupon does?

I close the hearing on S.B. 265. Seeing no further business, I adjourn the meeting at 8:22 p.m.

RESPECTFULLY SUBMITTED:

Debbie Carmichael,
Committee Secretary

APPROVED BY:

Senator Pat Spearman, Chair

DATE:

EXHIBIT SUMMARY

Bill	Exhibit / # of pages		Witness / Entity	Description
	A	2		Agenda
	B	27		Attendance Roster
S.B. 323	C	15	Jodi Tyson / Three Square	Presentation
S.B. 323	D	2	Jodi Tyson / Three Square	Proposed Friendly Amendment
S.B. 305	E	1	Senator Julia Ratti	Proposed Amendment
S.B. 265	F	1	Kevin Hooks	Rising Insulin Prices Graphs
S.B. 265	G	5	Senator Yvanna D. Cancela	Section by Section Summary
S.B. 265	H	2	Tanya George	Written Testimony in Support
S.B. 265	I	2	Rita Neanover	Written Testimony in Support
S.B. 265	J	2	Bonnie Jean Sedich	Written Testimony in Support
S.B. 265	K	3	Keith Lee	America's Health Insurance Plans Letter
S.B. 265	L	1	Ruben Murillo / NSEA	Letter of Support
S.B. 265	M	1	Ruben Murillo	Written Testimony
S.B. 265	N	2	Heidi Parker / Immunize Nevada	Neutral Letter
S.B. 265	O	4	Kipp Snider / Pharmaceutical Research and Manufacturers of America	Written Statement of Opposition
S.B. 265	P	2	Brian Warren / Biotechnology Innovation Organization	Letter of Opposition
S.B. 265	Q	2	Jeff Buel / Johnson & Johnson Services, Inc.	Statement of Opposition
S.B. 265	R	3	Chris Ferarri / Pfizer, Inc.	Letter of Opposition
S.B. 265	S	1	Pete Sepp / National Taxpayers Union	Letter of Opposition

S.B. 265	T	2	Elliot Malin / Americans for Prosperity Nevada	Letter of Opposition
S.B. 265	U	1	Grover Norquist / Americans for Tax Reform	Letter of Opposition
S.B. 265	V	2	Thomas A. Schatz / Council for Citizens Against Government Waste	Letter of Opposition
S.B. 265	W	3	Tamar Thompson / Bristol-Myers Squibb	Letter of Opposition
S.B. 265	X	2	Tricia Brooks / Novo Nordisk	Letter of Opposition
S.B. 265	Y	2	Floreine R. Kahn / AbbVie Pharmaceuticals	Letter of Opposition
S.B. 265	Z	3	Cheyanne K. Cook / Boehringer Ingelheim	Letter of Opposition
S.B. 265	AA	3	Patricia A. Fritz / UCB, Inc.	Letter of Opposition
S.B. 265	BB	1	Adam Gluck / Sanofi	Letter of Opposition
S.B. 265	CC	2	Joseph F. Devaney / Astellas Pharma US, Inc.	Letter of Opposition