MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON COMMERCE AND LABOR

Eightieth Session
May 6, 2019

The Committee on Commerce and Labor was called to order by Chair Ellen B. Spiegel at 1:38 p.m. on Monday, May 6, 2019, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/80th2019.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Ellen B. Spiegel, Chair
Assemblyman Jason Frierson, Vice Chair
Assemblywoman Maggie Carlton
Assemblyman Skip Daly
Assemblyman Chris Edwards
Assemblywoman Melissa Hardy
Assemblywoman Sandra Jauregui
Assemblyman Al Kramer
Assemblywoman Susie Martinez
Assemblyman William McCurdy II
Assemblywoman Jill Tolles
Assemblyman Steve Yeager

COMMITTEE MEMBERS ABSENT:

Assemblywoman Dina Neal (excused)

GUEST LEGISLATORS PRESENT:

Senator Pat Spearman, Senate District No. 1
Senator Keith F. Pickard, Senate District No. 20

STAFF MEMBERS PRESENT:

Kelly Richard, Committee Policy Analyst
Wil Keane, Committee Counsel
Karen Easton, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Jared Busker, Associate Director, Children's Advocacy Alliance
Gary W. Olsen, Private Citizen, Reno, Nevada
Candace Emerson, Private Citizen, Las Vegas, Nevada
Marlene Lockard, representing Nevada Women's Lobby
Tom Clark, representing Nevada Association of Health Plans
Tray Abney, representing America's Health Insurance Plans
Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services
Will Adler, representing Scientists for Consumer Safety; and Silver State Government Relations
Lisa Foster, representing Nevada Veterinary Medical Association
Jennifer Pedigo, Executive Director, Nevada State Board of Veterinary Medical Examiners
Leo M. Drozdoff, representing Western States Hemp
Lea Cartwright, representing State Board of Cosmetology
Sandra J. Anderson, Executive Director, Board of Massage Therapy
Bianca R. Smith, Compliance Inspector, Board of Massage Therapy
Garth Harris, Private Citizen, Las Vegas, Nevada
Joanna Jacob, representing Nevada Dental Association
Mark Lee, President, Nevada Optometric Association

Chair Spiegel:
[Roll was taken. Committee rules were explained.] We will open the meeting with Senate Bill 200 (1st Reprint).

Senate Bill 200 (1st Reprint): Requires health insurers to provide coverage for certain services and equipment. (BDR 57-43)

Senator Pat Spearman, Senate District No. 1:
I am here to present Senate Bill 200 (1st Reprint) for your consideration. With intervention in mind, S.B. 200 (R1) takes action to ensure Nevada's children are covered to receive screening and obtain the devices they need to receive early treatment for hearing loss.

According to the American Academy of Pediatrics, approximately 3 infants per 1,000 are born with moderate, profound, or severe hearing loss. If hearing loss is not detected and treated early, it can impede speech, language, and cognitive development. Over time, such

a delay can lead to significant educational costs and learning difficulties. Senate Bill 200 (1st Reprint) requires health insurers—including Medicaid and Children's Health Insurance Program (CHIP)—to cover hearing devices, including medically necessary expenses such as ear molds, batteries, retention accessories, and frequency modulated services for insured individuals who are younger than 18 years of age.

We do not have a school for children who are deaf or hard of hearing in Nevada. Without some type of assistance in making sure these children get the hearing aids that they need, they are already behind academically when they start school. What we are trying to do is bring parity and equity for children who, through no fault of their own, have challenges with respect to learning.

Jared Busker, Associate Director, Children's Advocacy Alliance:
[Testimony included excerpts from (Exhibit C).] Hearing loss is the most common congenital condition present at birth in the United States. Approximately 3 out of every 1,000 children in the United States are born deaf or with some degree of hearing loss, and more lose their hearing later during childhood.

As a child learns his or her first language, it is not taught like a school subject; rather it is caught as children pick up on words through continuous exposure to spoken language through listening. If hearing loss is left undetected and untreated, a child’s spoken speech and language acquisition, academic achievement, and social and emotional development can be harmed. It is critical that a child with hearing loss receive appropriate hearing devices and access to early intervention services as early as possible.

According to the American Speech-Language-Hearing Association, hearing aids represent a relatively inexpensive intervention for the amount of benefit gained, especially when calculating the long-term benefits of early intervention to children and society. When infants with hearing loss have access to hearing devices and start intervention by six months of age, they are often able to have the same language abilities as their peers when they enter kindergarten.

Nevada Medicaid, which covers 61 percent of Nevada’s children, and Nevada Check Up cover hearing tests, hearing devices, batteries for hearing devices, and speech therapy. However, many commercial insurance plans in Nevada do not fully cover hearing devices, leaving many families unable to afford and obtain these necessary and life-changing devices.

Senate Bill 200 (1st Reprint) looks to address these high costs by requiring certain health insurance policies, health plans, and benefit plans to include coverage for ear molds, batteries, retention accessories, and personal frequency modulated services. We have submitted a friendly amendment (Exhibit D) which further defines each of these devices.

I will walk you through the amendments to the bill. Section 2.5 amends *Nevada Revised Statutes* (NRS) Chapter 689A to require [page 2, (Exhibit D)]:

> 1. A policy of health insurance must include coverage for a hearing device and any related device, supplies, accessory and service which are medically necessary, including, without limitation, ear molds, batteries, retention accessories and personal frequency modulation systems that are prescribed for an insured who is less than 18 years of age.
>
> 2. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2020, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

The friendly amendment also includes:

> 3. As used in this section: (a) "Battery" means a device for generating an electric current by chemical reaction. (b) "Bone conduction hearing device" means a device which transfers sound by bone vibration directly to the cochlea, bypassing the outer and middle ear. (c) "Ear mold" means any of various types of fittings, usually made of plastic, designed to fit in the auricle of the ear and conduct amplified sound from a hearing device to the ear canal. (d) "Personal frequency modulation system" means a system which: (1) Transmits radio waves on special frequencies designated for personal use to send speech and other signals to a hearing device; and (2) Typically consists of: (I) A microphone and transmitter which are used by a person who is speaking; and (II) A receiver which is used by a person who is listening and which may be connected to, or integrated with, another hearing device which is used by the person who is listening. (e) "Hearing device" means a hearing aid, bone conduction hearing device or other device which is designated to make sound perceptible to a person with hearing loss. (f) "Retention accessory" means a clip, cord, adhesive, hat or other item of clothing or other device designed to retain a hearing device or related device, supplies or accessory securely to the ear or other part of the body to prevent unwanted movement, loss or damage.

This section repeats itself multiple times, so I will not read it over. The bill also makes changes to NRS Chapters 689B, 689C, 695A, 695B, 695C, and 695G. The changes are similar to those previously read.

Senator Spearman:
I just wanted add that one of the things we are attempting to do with the bills that deal with hearing issues is to build on one of our former colleagues' bills, Senator Shelia Leslie. Assembly Bill 250 of the 71st Session was a bill she sponsored while in the Assembly which

required all children born in Nevada to be tested for hearing loss; they follow them through three years of age. During the 79th Session, when we worked to get the Commission for the Deaf and Hard of Hearing established, it was heartbreaking to hear parents who have children who are deaf, or those who are hard of hearing, and to find out we have no formal education services in Nevada, which exacerbates an already bad situation. We are bringing this bill with the hope that you will think favorably upon it, because it is not my child, and maybe it is not your child, but one day it could be. I think all these children deserve the right to receive a good foundation for education.

Assemblywoman Carlton:
When the Affordable Care Act (ACA) went into effect and we established essential health benefits for the state, there was a discussion regarding another mandate being added, and how it would be addressed. I have not been able to find that provision. I have reached out to some people to make sure that as we move along we are cognizant of what those possible impacts might be. I did see that Medicaid coverage was excluded from the bill. Could you give me the thought process on that? It is always difficult for us to mandate one benefit on one group of insurers, but not apply that same mandate to the state to do the right thing for kids.

Senator Spearman:
Medicaid already covers hearing aids; they cover them wholly. What this bill does is provide parity; Medicaid and CHIP already provide that. We are trying to get coverage for those children whose parents do not qualify for Medicaid.

Assemblyman Edwards:
Do you have an idea of how many kids we are talking about?

Senator Spearman:
Unfortunately we do not—we are probably talking more than 3,000. There is no way to keep track because we do not have a system in place. Should this bill pass, it will give us information on how many children are accessing these benefits, what type of hearing loss they have, what the costs may be, et cetera. We do not have that information now because there is no way to reach out and identify how many children we have with a hearing loss. Part of that is because there has been no coordinated effort to gather this information. The parents that I have spoken to are just trying to figure it out and do the best they can.

Jared Busker:
We can try to get an approximate number, but we do have the approximately 3 in every 1,000 children [National Institutes of Health].

Assemblyman Edwards:
So the schools do not test for this at all?

Senator Spearman:
After a child turns three years old there is no coordinated support for children. From birth to three years they are covered. Unless their parent or guardian qualifies for Medicaid or CHIP, then they are not covered.

Assemblyman Kramer:
I do not think I read where it says, if somebody is found to need hearing devices they are reported so we can start a database.

Jared Busker:
I do not believe that is included in this bill.

Senator Spearman:
Part of the process of making sure they get these devices will be an application similar to what Medicaid issues. We are also looking at the Department of Health and Human Services having the flexibility to buy hearing aids and accessories in bulk so it would bring the price down. It makes your heart break to see children who are born deaf or become deaf after they are born, and the parents are just trying to figure out on their own how to help their deaf child.

Jared Busker:
Senate Bill 203 is another bill looking at this issue.

Chair Spiegel:
Is there any testimony in support of Senate Bill 200 (1st Reprint)?

Gary W. Olsen, Private Citizen, Reno, Nevada:
[Kim Johnson, Pool Interpreter, Aging and Disability Services Division, Department of Health and Human Services, was the sign language translator for Mr. Olsen.]

I am an advocate for the deaf community in this state and all over the country. However, I think this a wonderful bill. It is significantly needed here in this state. I became deaf when I was 7½ years old; I could not hear anything at that point in time. From that time on it was difficult. I was lucky to live close to the Nebraska School for the Deaf; at that time they used an oral approach. They forced children to use hearing aids all the time, to speak, and to lip read—for me that did not work. It is important that other children do have the benefit of that opportunity. Everything that was mentioned in this bill sounds fine. I am concerned mostly about the fact that there is better equipment and devices available, specifically cochlear implants. They have made huge strides in the technology. Many people do not like them, but there are a majority of people who do like them. It does help with their ability to acquire spoken language, which is the key to everything—without language, what is this? Even sign language has a meaning.

I am mostly concerned to make sure you give full consideration to the possibility of including cochlear implants in this language for those who want them. They should be able to have that choice. That will make a world of difference for the children, and it is our number one concern. We want the children to benefit, to be able to compete with their hearing peers, and we can and do have many successful deaf people in the community. Without their hearing it is tough—except if they are able to communicate via sign language interpreters, which makes a world of difference. I emphasize the fact that children do deserve the best and 18 to me is not an appropriate age; it should go beyond that age, but that is another story. I hope you will consider and support this bill, because it gives us one step further for more improvements for the people who will be there later down the road. Thank you very much.

Chair Spiegel:
According to our Committee rules, if you testify in support of a bill it means you would accept the bill as is. If you would only support the bill if there were changes made, that is technically opposition. I would like to clarify your position on the record, whether you support the bill as is, but have a wish list for other things you would to see in it. Or if you do not support the bill unless it would also include cochlear implants and looking at raising the age above 18.

Gary Olsen:
I am not opposed to anything; this is a major step forward. These things can be added later on. I am fine with it as written. I understand with the Legislature these things cannot always be changed.

Candace Emerson, Private Citizen, Las Vegas, Nevada:
I am the parent of a six-year-old who was born with a hearing loss. I also work as a parent guide for the nonprofit corporation, Nevada Hands and Voices, which supports families with deaf and hard of hearing children. My journey began about six years ago when my son failed the newborn hearing screening. After about a year and a half of different tests—seeing audiologists and ear, nose, and throat doctors—we got in touch with a pediatric provider who informed us that our son would need hearing aids to access sound and use spoken language—which is what we use in our house. This was all very new to us. There was no history of hearing loss in our family. The only people I know with hearing aids are my elderly grandparents.

In navigating this journey and working with our insurance, we found that despite paying about $400 a month in premiums, we were going to have to pay the first $500 for the hearing aids, and insurance would cover about 90 percent, but not exceeding $2,500. These devices are very expensive; our total bill was $680 for the hearing aids alone. We then had to pay $60 for each ear mold. In addition, every hearing test to make sure he is getting the best access was an in-office copay, as well as the remaining 10 percent of the bill. To say this was a burden we were not expecting would be quite the understatement. We were new parents on a single income. Just raising a child is expensive, but with the added expenses just for our son to hear, it was a big pill to swallow.

Over the years we have had to get new hearing aids. Hearing aids last approximately five years, but children tend to do things to them, like throw them out the window or let the dog get to them. Our son's hearing aids have cost our family a significant amount of money. Senator Spearman touched on a good point that after age three, you are responsible to pay for a lot of these services—there are speech therapies and language play groups.

Each year we have to buy new ear molds which cost $60; we are almost done on a payment plan for his second hearing aids. This causes us to cut back in other areas. I do have another child and sometimes we have to hold back buying things for him because his brother's needs have to come first.

The Nevada Early Hearing Detection and Intervention Program keeps really good track of the births of children born with a hearing loss. I am happy to provide contact information to the Children's Advocacy Alliance. The families that do have children who fail the hearing screening do get retested and set up with early intervention. The nonprofit then provides family support. I work with a lot of families with children from birth to three years whose children have a hearing loss, and one of the most common things I hear is, We do not know how we are going to afford these hearing aids and/or cochlear implants. I am under the impression that the bill covers cochlear implants, as well as bone conduction hearing aids, because the verbiage hearing device is used, not hearing aids. That was our understanding when we were working with the Children's Advocacy Alliance.

I also want to say that our nonprofit runs a loaner hearing aid bank, just to show the need that families do have for access to devices. If hearing aids or bone conduction hearing aids are donated to our bank, a family can go through the application process to borrow one. This is a really great service that families have taken advantage of. However, if the right device is not in the bank, they are just putting a bandage on a wound that is more severe than the bandage would cover. Offering a law to have insurance companies cover these devices and not having to rely on loaner banks would be really amazing for these families.

Marlene Lockard, representing Nevada Women's Lobby:
We support this bill.

[(Exhibit E) was submitted but not discussed and will become part of the record.]

Chair Spiegel:
Is there anyone to testify in opposition to Senate Bill 200 (1st Reprint)?

Tom Clark, representing Nevada Association of Health Plans:
I would like to start off by saying we are in opposition to this legislation as it is written. We have met with the sponsor's staff. We do have some big concerns, one of which is the term "without limitation." That term will drive companies out of the market because that is such a broad phrase to use when you are talking about something like hearing aids. I appreciate the amendment because it gives some definition of the different elements that are included in the bill, and we heard from the sponsor that this is to get parity

with Medicaid. If the parity with Medicaid is the place where we are trying to get without limitation, to us this could mean the Cadillac plan of hearing aids. From an insurance perspective, we do not want to see the insurance companies forced to cover what could be a $7,000 to $8,000 hearing aid when the insurance plan today covers something of a lighter degree. Of our member organizations, not one of them came to me and said they do not cover hearing aids. They do the infant screening and identify the children with problems. Their plan, depending on what they have, does cover the hearing aids they need as they progress and as they grow up. We are not here to say we are against children and hearing aids; the policies we currently have cover the intent of this legislation.

In response to Assemblywoman Carlton's questions, I do have the citation as far as the exchange is concerned. We believe this bill, if passed the way it is today, will create an increased cost to the state to cover the new mandate. Because we have a commitment to work with the sponsor and to work with the proponents of this bill, I will not belabor the point. The other major concern we have is that this bill, as written, only covers 20 percent of the insured. It does not cover the state employees and it does not cover the self-insured plans. Typically, these mandates would be broad-based across all levels but this particular piece of legislation does not.

Assemblywoman Carlton:
What is the citation? I remember the discussion points around it, so I would like to be able to go back and look that up.

Tom Clark:
I think it is *Nevada Revised Statutes* 155.170 [It is not].

Assemblywoman Carlton:
I believe the discussion point was that because the essential health benefits had been set through the ACA, if the state changed those essential health benefits through the exchange, the cost of the changes would be borne by the state. It that correct?

Tom Clark:
That is my understanding.

Tray Abney, representing America's Health Insurance Plans:
I will echo all of the comments Mr. Clark made. I want to continue working with the sponsor of this bill; we had a great discussion this morning with her staff. Obviously, we are always concerned about any bill that will increase health care costs in general, and certainly to the state specifically.

Chair Spiegel:
Is there anyone to testify in neutral? [There was no one.] Senator Spearman, do you have any closing remarks?

Jared Busker:
I just wanted to echo that we are committed to working with the opponents of the bill and trying to get this bill in a place so the Committee can vote it out.

Senator Spearman:
Regarding the issue of cost, there is another bill that will be heard in the Assembly Committee on Health and Human Services. As you will see, we are attempting to use as much of the Medicaid funding as we can—looking for grants and other outside resources to cover those who cannot afford it. If a family's insurance cannot cover it, we want to make sure there is something that will mend the gap. I am cognizant we do not want to make health care plans more expensive. That is one of the reasons why we have worked really hard to try and make sure that we can get this through. The whole intent of this bill is to make sure that we have covered our bases. Senate Bill 203 will cover children from age four through elementary school; but we still have students who are beyond middle school who do not have hearing devices. If we cannot go all the way with it, then maybe we will come back next time and try to get something else going. I just know we have to do as much as we can, however we can, to make sure that these students have an opportunity to be successful.

I am not a parent of a child who is deaf or hard of hearing, but I can only imagine the challenges. One other point to mention, deaf children cannot go to day care. That means if there are two parents in the house, at least one of them has to stay home. There are a number of things that impede a child's progress and their ability to be a child.

We have some other legislation that is working through the house that I hope will address some of the questions. At the end of the day, I am hopeful we can all be committed to making sure that children who are deaf or hard of hearing get the type of support they need. If we had a school for the deaf here, it probably would not be that urgent—but we do not. Parents trying to figure it out on their own make things a bit complicated. We will continue working and, hopefully, we can come up with a solution because I believe all children deserve to hear so they can learn.

Assemblywoman Carlton:
I assumed this means if a health plan does not cover this we would make them cover it. After hearing Mr. Clark's comment regarding "without limitation," it would mean that because it would be after the deductible, you are basically saying there will be no charge for hearing aids, that they will be 100 percent covered. Is that correct?

Senator Spearman:
There is a companion bill that will make its way through this house that will allow for grants and other funding, as much as we have, to cover those children. The Department of Health and Human Services will spend all of what they have, and once it is done they will have a waiting list. It is my hope that we will have some more philanthropic activity and grant activity that will allow us to get this done.

Assemblywoman Carlton:
You are talking toward state employees' children?

Senator Spearman:
That is towards anybody.

Assemblywoman Carlton:
What I am trying to make sure I understand in your bill is, if a plan currently covers hearing aids, but the deductible is a certain amount, your bill will say there will be no more deductible—the plan will fully cover hearing aids and there will be no out-of-pocket expenses for the families. Am I understanding the bill correctly?

Jared Busker:
That is not the intent. It was just to have coverage for children. If we need to revisit the language to ensure that it is not mandating insurance coverage at 100 percent for the entire cost across the board, we will revisit that.

Senator Spearman:
Keep in mind that what we have here is part of a suite of bills that we hope will pass. Those parents who cannot afford it—if it is the deductible, if it is the entire amount—we are hopeful to be able to use a process similar to Medicaid to have them sign up. Also with the Department of Health and Human Services, and with Medicaid, buying in bulk should bring the cost down. We are trying to make sure we have as many children covered for hearing aids as we possibly can.

Chair Spiegel:
We will now close the hearing on Senate Bill 200 (1st Reprint). We will open the hearing on Senate Bill 192 (1st Reprint).

Senate Bill 192 (1st Reprint): Revises provisions relating to health care. (BDR 53-781)

Senator Pat Spearman, Senate District No. 1:
Senate Bill 192 (1st Reprint) does two things: first, it establishes the minimum level of health care benefits an employer must offer in order to be able to pay the lower minimum wage; and second, it requires hospitals to provide a notice of a patient's right to make a complaint and designate a caregiver to whom the hospital must provide instructions concerning aftercare.

Some of us have friends, or even family members, who are working minimum wage jobs and sometimes employers offer what is commonly known as a "skinny plan." They pay $7.25 an hour but the plan they offer is basically worthless, so the person does not have health insurance. This bill will require them to match the standards in the Affordable Care Act and the state mandates.

The *Nevada Constitution* creates the two-tier wage system. The lower rate is the same as the federal minimum wage, currently $7.25 an hour; this rate applies if the employer provides health benefits. The higher tier is $1 more per hour and applies if the employer does not offer health benefits. The state *Constitution* defines health benefits as "health insurance available to the employee for the employee and the employee's dependents at a total cost to the employee for premiums of not more than 10 percent of the employee's gross taxable income" [Article 15, Section 16(A)].

In 2018, the Nevada Supreme Court was asked to clarify the definition of health benefits in *MDC Restaurants, LLC v. Eighth Judicial District Court of Nevada in and for County of Clark*, 383 P.3d 262, (2016), 132 Nev. Adv. Op. 76. The Supreme Court determined that the *Constitution's* minimum wage amendment requires an employer who pays $1 per hour less in wages to provide a benefit in the form of health insurance at least equivalent to the $1 per hour in wages. Senate Bill 192 (1st Reprint) seeks to further clarify the definition of health benefits and to clearly identify exactly what that is.

The bill outlines the specific requirements that health benefits must meet in order to qualify as health benefits under Article 15, Section 16 of the *Constitution.* It also clarifies that a plan of hospital indemnity insurance or fixed indemnity insurance does not qualify as health benefits under the *Constitution*. These changes eliminate any questions regarding what qualifies as health benefits under the *Nevada Constitution* and ensures that Nevadans who are paid the lowest minimum wage also have access to appropriate, affordable health insurance coverage.

The second piece of S.B. 192 (R1) requires hospitals to provide certain information to patients. These provisions merely expand existing law, which already requires a hospital to provide patients notice regarding certain patient rights, the existence of the Bureau for Hospital Patients, and an explanation of services the Bureau offers. Section 18.5 of the bill additionally requires a hospital to provide notice of a patient's right to designate a caregiver to whom the hospital must provide instructions concerning aftercare, as well as notice regarding the patient's right to express complaints and grievances.

We have people who are working at the minimum wage, but the insurance plans their employers offer do not provide them the health insurance they need. I have Dena Schmidt with me from the Aging and Disability Services Division within the Department of Health and Human Services.

Dena Schmidt, Administrator, Aging and Disability Services Division, Department of Health and Human Services:

In section 18.5 the changes are helping individuals who are in hospitals to be notified of their rights. One of the things that the Office for Consumer Health Assistance is responsible for is educating individuals on their rights regarding their health care insurance plans, as well as

their hospital rights. As patients, certain individuals are not aware of how to navigate the system, and it is often based on a lack of information. This bill gives them more information about what they have the ability to do while they are in facilities to receive the appropriate care.

Assemblywoman Carlton:
I noticed in section 1 that coverage for services listed are all the essential health benefits in the state. Then I get to item XI which says, "Any other health care service or coverage level required to be included in an individual or group health benefit plan pursuant to any applicable provision of Title 57 of NRS." Is Title 57 of *Nevada Revised* Statutes (NRS) the professions codes? It then refers to statutorily provide that benefits be actuarially equivalent to 60 percent of the value of other benefit plans, such as a Taft-Hartley trust or an Employee Retirement Income Security Act of 1974 plan. I am just trying to figure out how those components fit together, because those constantly change and are negotiated.

Wil Keane, Committee Counsel:
Your first question was with regard to the language on page 2, lines 28 through 30. Title 57 is the insurance title. The individual or group health benefit plans are handled in NRS Chapters 689A and 689B. Individual health plans are NRS Chapter 689A; group health plans are NRS Chapter 689B. Each of those chapters has specific, mandated benefits that are listed in those chapters. Some mandates also occur in some of the other chapters in a broadly applicable way. I believe that is why the drafters referenced Title 57 of NRS in case there was a requirement that did not occur in one of those two chapters but was still applicable to an individual health plan or a group health plan.

Regarding the Taft-Hartley trust, this is a little bit hard to read. The way this bill is set up, if you look on page 2, lines 8 and 9, you can see that the language says the employer can pay the lower minimum wage only if the employer makes available to the employee and the employee's dependents either (a) or (b). If the employer is providing health benefits pursuant to a Taft-Hartley trust, which is an alternative to supplying the benefits in paragraph (a), the employer would not need to do both; they could do either.

Assemblywoman Carlton:
In section 1, subsection 1, paragraph (a), subparagraph 2, it says, "coverage that is designed to provide benefits that are actuarially equivalent to at least 60 percent" of those plans. The list in paragraph (a)(1) is essential health benefits that should already be covered in the state, but then we are adding an actuarial value to something. I am not sure how that fits.

Wil Keane:
Section 1, subsection 1, paragraph (a)(2), is referring back to the plan that has all the requirements that are set forth in subparagraph 1. I am not an expert on actuarial valuation, but what that language refers back to is the full actuarial value of the benefits that would be provided under subparagraph (1). The level of coverage that has to be offered has to be the actuarially equivalent to at least 60 percent of the full possible actuarial value of those benefits. I am not sure what that means in a financial way.

Assemblywoman Carlton:
I have concerns that we are making people use these essential health benefits now. It appears to me it is going backwards by changing it to where it could only be 60 percent of the value. I think we need to talk to an actuary so we can understand what the provision actually does. Sixty percent of something means 40 percent is missing. I just want to make sure this is not allowing benefits to go backwards.

Chair Spiegel:
I also have a concern regarding how employers would know whether or not the plans they are putting forth meet the 60 percent criteria, and when it changes.

Senator Spearman:
We can change that language to make it clearer. One of the things that happened was there were some insurance plans that did not want to cover pediatric, dental, or optometry. I do not know, but that may be part of the reason it is not at the full 100 percent. If you look on page 3, line 6, it says, "As used in this section, 'health benefit plan' has the meaning ascribed to it in NRS 687B.470." That is what defines what type of health benefit plan an employer has to provide.

Chair Spiegel:
Is there anyone to testify in support of Senate Bill 192 (1st Reprint)? [There was no one.] Is there anyone who wishes to testify in opposition? [There was no one.] Is there anyone to testify in neutral? [There was no one.] We will close the hearing on Senate Bill 192 (1st Reprint). We will now open the hearing on Senate Bill 228 (1st Reprint).

Senate Bill 228 (1st Reprint): Revises provisions relating to industrial hemp. (BDR 54-180)

Senator Pat Spearman, Senate District No. 1:
I am here to present Senate Bill 228 (1st Reprint). This bill seeks to authorize certain health care providers, massage therapists, nail technologists, reflexologists, or structural integration practitioners to administer certain products that contain industrial hemp or cannabidiol (CBD). Specifically, such professionals may administer a product containing industrial hemp or any other product that contains CBD, if it has a tetrahydrocannabinol (THC) concentration of no more than 0.3 percent, if the patient or client provides the product. Senate Bill 228 (1st Reprint) also protects those professionals by prohibiting professional licensing boards from imposing disciplinary action against them for administering such products.

Similarly, section 2.5 of the bill authorizes licensed veterinarians to administer these products to an animal if the owner of an animal provides the product for administration. A veterinarian may also recommend the use of such products to an owner to treat a condition

of the animal. In addition, the Nevada State Board of Veterinary Medical Examiners is prohibited from taking disciplinary action against a licensed veterinarian or the facility in which he or she practices for administering or recommending such products.

I would like to share a personal story. My sister has stage 5 kidney failure and is currently on dialysis. When she first had a port put in it kept on clotting. There was a period of about four months where they were switching arms, then they put a port in her chest. You cannot take ibuprofen or any other type of pain medication if you are in stage 5 kidney failure. I would hear her crying because it hurt so much. I went to the dispensary and got her a jar of the same cream that I use for my knees. I need knee replacements, but if I did not put the cream on in the morning I would not be able to walk. I also found out there are a number of other senior citizens who use this instead of pain pills, because they do not want to get hooked on opioids. They are using it to get relief from the pain. For someone who has a chronic illness for which they cannot take pain medication, the choice is to either suffer or to use this. I will turn it over to Will Adler so he can get into the technical aspects of the bill.

Will Adler, representing Scientists for Consumer Safety; and Silver State Government Relations:

Senator Spearman did an amazing job going through the entirety of the bill as it is written today. As you can see, there are a few amendments and deleted sections in this bill. The bill was an overall marijuana bill for the Cannabis Control Commission and some other issues. The Office of the Governor communicated that they were going to be running their own Cannabis Control Commission bill. The aspects of the bill that remain are ones that are the result of marijuana moving in dog years, and every other industry trying to catch up. Most industries have established practices with everything that comes their way. Marijuana is so new that CBD and THC products are coming into storefronts that are not related to marijuana, and people need to know how to respond to them.

In this instance, cosmetologists—and everyone in that sort of field—have been having problems with not necessarily having products and selling them out, but having patients bring in products that they are already using at home or have already been using for other personal means, and asking if they will apply it to them. This is a problem the State Board of Cosmetology brought up—their members did not know how to respond, they did not know if they were legally allowed to, or if there was something wrong with hemp or CBD. The same is true with veterinarians, and that was added to the bill; veterinarians and veterinary medicine have also had this problem. Owners would bring in their dogs for overnighting after a surgery. There is a suite of pharmaceutical products for animals as well as joint pain remedies, through dog treats that are also being infused with CBD. Again, they did not know where they sat legally, and whether or not they were allowed to administer those products to the animals once they are under their care. Veterinarians do have Drug Enforcement Administration (DEA) licenses, so it is a serious issue for them. This year, the State Board of Pharmacy took a recommendation of CBD and put it under a schedule V drug for hemp and CBD products in the state of Nevada. That gives them the ability to give it to the animals in their care. This is one of the cleanup bills—a lot of people are trying to figure out where CBD and marijuana products fall in their jurisdictions.

Chair Spiegel:
Could you explain how you arrived at the 0.3 percent threshold?

Will Adler:
That is holdover language regarding CBD and hemp products. There is no standard to verify the difference between marijuana and hemp, because they are the same plant. The THC score of 0.3 percent is the only verifiable difference between marijuana and hemp to qualify it as a CBD product. All other products are technically medical or recreational marijuana, depending on the context. The federal law is also changing. Because of the Agriculture Improvement Act of 2018, more commonly referred to as the farm bill, hemp is a legal product to grow nationally and is creating a CBD market there. That language is still intact for now. In Senate Bill 347 and Senate Bill 209 we are amending and putting in a subclause, "that does not exceed the maximum THC concentration established by federal law," because the thought is that the 0.3 percent could reduce or grow in its tolerance levels with the federal language.

Assemblywoman Tolles:
I have relatives who have had a similar experience as your sister and it has helped them tremendously. Was there any consideration for putting in an age limit? If you are under 18 years of age, should there be some sort of sign-off by the parents or a pediatrician? I know there has been tremendous use of these products, especially for children with seizures; there are potential contraindications with other medications. For anyone of any age, some sort of disclosure regarding contraindications with other medications and acknowledgement so you do not run into a complication for the patient or client would be beneficial.

The second issue is sort of a consumer protection piece regarding the no more than 0.3 percent. My concern would be if there was a nail salon or massage parlor that is selling an add-on service and the CBD is diluted—they are charging you for it but you are not getting the therapeutic benefit. Maybe some sort of a disclosure piece could address all three of those concerns—the consumer to actually receive the therapeutic value and not be overcharged, and also addressing any contraindications.

Will Adler:
The question was is there an age restriction with CBD products in general. We are moving at a very quick pace in the marijuana/hemp industry. Cannabidiol has a nonpsychoactive relationship with the human body, so it is not thought of as having an influence on children or the elderly because it is not THC—THC is the psychoactive ingredient that is the stimulant part of marijuana. Because of the lack of a psychoactive effect on the body, we have seen very few places where there is an age restriction on anything but a THC product in the marijuana business. That has held true for a lot of the products in this industry. They are sold everywhere. Even in products that are not CBD-based, there are still trace elements of CBD in them. You can make hemp milk out of the seeds, you can make edible products out of everything that you can buy at Whole Foods today. A lot of those are in the same aspect,

but they obviously are not age-restricted either. Because of the lack of THC or psychoactive reactivity of CBD, it does not have a strict age restriction, and I do not think it is really needed in this bill or this aspect.

There has been a slew of add-ons and other services in other states, especially in Colorado and other tourism-related economies around CBD and THC massages. In this case, the bill as written says if somebody brings it in to you, you may use it. If I bring you a CBD lotion, you may use it. If I bring you THC oil or THC lotion, you may not use it on me because there is contact and worries about absorption for the person applying the massage products. This is strictly limited to CBD because of that. If somebody wishes to advertise they are willing to massage somebody with the product they bring in, that could be part of it. They are not supposed to be providing it; they are supposed to just accept it when it comes in via the language in this bill. They are not selling CBD products themselves, and they are not going to get in trouble if they use them on a client if the client brings them in for use.

Senator Spearman:
I would compare it to when you have a manicure—you have your favorite color and take it to the salon and ask them to use the color you brought in.

Will Adler:
The third part of your question was, is there some sort of verification of CBD products—if they are diluted or not, are you actually getting the full therapeutic effect. That is a larger issue in the entirety of the hemp and CBD industry; we do see mass mislabeling and other issues. We are trying to address that in Senate Bill 209. The concern is with who is verifying what is in the bottle.

Assemblywoman Carlton:
You do not want health care professionals being disciplined for doing this, but there is no prescription involved, so the DEA would not be involved. What authority do the boards have over this? I understand you are trying to be preemptive because of some of their not-breaking-the-law clauses. I am just concerned with all the federal changes and how that will fit together. On the technical side, under section 1, subsection 3, paragraph (c), you have "massage therapist," which falls under *Nevada Revised Statutes* (NRS) Chapter 640C; and under paragraph (f) you have "structural integration practitioner," which is NRS Chapter 640C. The structural integration practitioner is actually licensed by the Board of Massage Therapy. I am not sure if you actually need to delineate both of those, unless there is a particular issue that you are trying to address to say, We not only mean it, but we really, really, mean it because we put it in the bill. I am trying to figure out why we would actually have this in there for the boards. I do not understand how a board could actually discipline on this. If you have any examples, I would love to hear them.

Will Adler:
The reason structural therapists are in the bill is because the Board of Massage Therapy asked for that to be included in the bill. There are some differences between what a massage therapist and structural therapist does; it is more of a deep tissue massage, flexibility,

or range of motion. I am not a massage therapist expert, but that was the explanation on the Senate side of the house—there is a difference between the two, so they asked for both to be listed in the bill.

Last August, the DEA classified CBD as a restricted product federally, but it is not very widely known that they did this. They did not restrict it to the point where it is a Schedule I, II, or III drug. They scheduled it to a IV or V drug to classify it as a DEA drug. It does not have an addictive property or harmful effects, but they did classify it. With the federal classification, the thought was that we should have some sort of assurance with our own products.

In the past, there have been instances where sometimes CBD products were being suggested by doctors. Patients would report that to the state boards to say, Hey my doctor brought up marijuana or CBD as a possible solution and I was not comfortable with it. That has been reported in the past in Nevada. I know a physician who got in trouble for just advocating for marijuana during the 2016 Question 2 campaign [Initiative to Regulate and Tax Marijuana]. That is a totally different issue because it is marijuana, not CBD, but it does have a history of disciplinary actions by boards in Nevada. Is it likely to happen, maybe not—but would this give some more reassurance to those operating in these gray areas right now? Possibly.

Senator Spearman:
I think what Mr. Adler is saying, in terms of this being such a new industry, there are not a whole lot of people who understand the intricacies of it. One of the things we never want to do is put people who have a professional license in jeopardy. We want to make sure if someone brings it in and asks if it can be used, they can do it without losing their license.

Chair Spiegel:
I have not seen this product. Is there any requirement that the product be labeled with the amount of CBD? Since the bill specifies the 0.3 percent threshold, if the patient is providing the product, we are then asking the practitioners to trust the patient and what they are bringing them. The corollary to all of this is if it were over the threshold, the practitioner might not know, but then would be liable for disciplinary action.

Will Adler:
As I read the bill, it is not up to the massage therapist or the veterinarian to verify the product if it is presented to them as a CBD product. I understand that leaves a gray area as well, but that is a bigger issue we are tackling in the CBD and hemp industry as a whole. We are trying to get somewhere to verify and test these products. They are coming in from out of the state and out of the country, because CBD is not restricted by the state boundaries like THC products are in the marijuana industry. There are a lot of products out there right now. We are trying to get a verification process for CBD products in Nevada through a different bill. Right now that is one of the unclear parts with the CBD industry: how do I know what is in this jar is what is on the label? Overall, I do not think it is up to the professional licensee to verify the product, but that is something that, hopefully, the state can tackle in a different bill.

Chair Spiegel:
Is there any testimony in support of S.B. 228 (R1)?

Lisa Foster, representing Nevada Veterinary Medical Association:
The Nevada Veterinary Medical Association is in support of this bill. Section 2.5 of the bill amends NRS Chapter 638 to allow a veterinarian to answer questions pet owners may have on how to use products with CBD. This has been an area of uncertainty for veterinarians and this change will give these practitioners the freedom to discuss the products and answer questions without concern. We appreciate the sponsor bringing this bill forward.

Jennifer Pedigo, Executive Director, Nevada State Board of Veterinary Medical Examiners:
I, too, wanted to testify in support, with the clarification that in section 2.5, subsection 1, paragraph (a), the language should read, "other than inhalation if the owner of the animal provides the product to the licensed veterinarian." We just wanted to clarify that this would be for oral ingestion only through treats, tinctures, et cetera.

Assemblywoman Carlton:
I know some things are injected and we are not talking about any injectable here. We are just talking about inhalation and topical, but nowhere in the bill do I see anything about injections. If you really want to restrict it, you would want that in the bill as well?

Jennifer Pedigo:
It is my understanding that this is not an injectable in terms of animal medicine. Everything that has been studied so far has been limited. The limitation for animals would be skin application—the research that is being done is for oral ingestion.

Leo M. Drozdoff, representing Western States Hemp:
We are in support of the bill as written. I would like to provide a little clarification on some of the questions. The farm bill, which was passed in December of 2018, is what established hemp as a legal product and also used the limit of 0.3 percent THC. As you could imagine, a federal bill of that significance passing in December has caused a level of confusion about the number throughout. There are two other hemp-related bills that are still active in this session. Senate Bill 347 is Senator Settelmeyer's bill. That sets up a hemp program to be administered by the State Department of Agriculture. Senate Bill 209 sets up a consumer product safety program that will be jointly administered by the State Department of Agriculture and the Department of Health and Human Services. In those bills, the term "industrial hemp" has been changed and the term hemp has been used—I point that out because the three bills should probably carry the same designation. Hemp is used because that was used in the farm bill. Similarly, the 0.3 percent THC language was pulled from the farm bill. In the other two bills, the language that has been used in lieu of that, is that it does not exceed maximum THC concentration established by federal law for hemp. The reason why that is being used is because what is happening at the federal level is changing so rapidly; it is possible, if not likely, that number will change.

Chair Spiegel:
Is there anyone to testify in opposition to S.B. 228 (R1)? [There was no one.] Is there anyone to testify in neutral?

Lea Cartwright, representing State Board of Cosmetology:
We are in the neutral position. Just to clarify, we at the State Board of Cosmetology have no position on this bill. Cosmetologists and licensed nail technologists can apply any legal substance to their client. There is no separate board for aestheticians—they are licensed within the State Board of Cosmetology.

Sandra J. Anderson, Executive Director, Board of Massage Therapy:
I would like to thank Senator Spearman for her work on this bill. Our licensees have questioned whether or not they could apply topicals for quite some time. The Board of Massage Therapy had to remain completely neutral on the issue because of the federal regulations, so we could not give them an answer. This bill will allow them to apply topicals. It was mentioned that the Board of Massage Therapy requested the designation of the three license types from our Board. The bill came out with this language to begin with; we do not have any attachment. There could be a reference to NRS Chapter 640C instead of listing each of the license types and we would be fine with that.

Bianca R. Smith, Compliance Inspector, Board of Massage Therapy:
I saw that our Executive Director, Sandy Anderson, addressed all your questions—I was here just in case she referred anything to me.

Senator Spearman:
I think it is important to note that the State Department of Agriculture is going to be monitoring this. A couple of things people do not know about hemp is that it has a lot of different uses. If you use hemp when building your house, you probably will not have termites or carpenter ants. It has a lot of uses, and this is just one of them. It is one that a lot of people are requesting we make a decision on so they can use it as part of their craft.

Chair Spiegel:
We will close the hearing on Senate Bill 228 (1st Reprint) and open the hearing on Senate Bill 187 (1st Reprint).

Senate Bill 187 (1st Reprint): Revises provisions governing prescriptions for controlled substances by a dentist, optometrist or physician for the treatment of pain. (BDR 54-39)

Senator Keith F. Pickard, Senate District No. 20:
I am here to present Senate Bill 187 (1st Reprint) for your consideration. I also have two practitioners, Dr. Mark Lee, who is an optometrist, and Dr. Garth Harris, who is a dentist, who are hopefully down in Las Vegas and will provide some supportive testimony after the presentation. Assembly Bill 474 of the 79th Session was passed by the Legislature which established many prescribing restrictions and required that a practitioner who intends

to prescribe or dispense a controlled substance listed in schedules II, III or IV to consider certain factors, take specific actions, and document certain information before initiating such a prescription. Among other provisions, the statute now requires that before issuing an initial prescription for a controlled substance, a practitioner must perform an evaluation and risk assessment of the patient, including obtaining and reviewing the patient's medical history, conducting a full physical examination, making a good faith effort to obtain and review all medical records of the patient, and document such efforts to obtain all other records. Finally, they are to assess the mental health and risk of abuse, dependency, and addiction propensity of the patient. These requirements passed when it was apparent that Nevada was dealing with an opioid crisis. Today, the Division of Public Behavioral Health, Department of Health and Human Services, reports there is a 30 percent reduction in prescribing opioids statewide. The restrictions, requirements, and factors that a practitioner must consider are working.

As with many bills of a sweeping nature, such as Assembly Bill 474 of the 79th Session, there were some unintended consequences. Some of these requirements have made it burdensome and too restrictive for certain practitioners to adequately care for their patients. This bill addresses two of them.

First, upon enactment of that 2017 legislation, the regulatory boards over those who could prescribe opioids adjusted their practice acts as necessary to address the prescribing practices, as did the State Board of Pharmacy. Many dentists and optometrists interpreted the new prescribing rules to that require they do complete physical exams, because there was no language restricting those exams to their ordinary scope of practice. Understandably, a good many practitioners interpreted the language to require full physical examinations for which they are simply not qualified to do.

Second, providers such as dentists and optometrists are currently required to do record reviews prior to prescribing these medications. Similar to the requirement that they do unlimited physical exams, they are also required to do record reviews beyond their scope of practice. Again, they are not necessarily qualified to do that. As a result, dentists and optometrists are declining to issue prescriptions for necessary and useful pain medications, simply to make sure their licenses are not put in jeopardy. Instead, they send patients to the emergency room or pain management specialists if ibuprofen or similar medications did not resolve the pain. Of course, emergency rooms are already overused, and pain management specialists handle chronic pain, not short-term issues; patients were not getting the relief they needed. Let us be clear, dentists and optometrists have never been identified as the problem prescribers that Assembly Bill 474 of the 79th Session intended to stop.

To their credit, the Board of Pharmacy did try to address this in revised language they brought before the Legislative Commission during the interim. I sat on the Legislative Commission and we discussed some of those changes. Many practitioners did not think it was clear enough as the revision still did not expressly limit the physical exams and record reviews to the relevant practice areas of the providers. Thus, Senate Bill 187 seeks to

alleviate some of the heavy prescribing restrictions for dentists and optometrists when prescribing a controlled substance for a period of less than 7 days, and physicians when prescribing a controlled substance for a period of less than 14 days.

Section 2, subsection 2, authorizes a dentist or optometrist, when prescribing a controlled substance for the treatment of acute pain for less than 7 days, to forego reviewing medical records from other providers of similar scope and practice and documenting efforts to obtain and draw conclusions based on the review of those records. Secondly, conduct a physical examination within the scope of practice of the practitioner, and to the extent deemed appropriate by that practitioner. Section 2, subsection 3, provides that a physician who is prescribing a controlled substance for the treatment of pain for less than 14 days is authorized to conduct a physical examination of the patient within the scope of practice of the physician, and to the extent deemed appropriate by the physician. Second, forego reviewing medical records from other providers of similar scope and practice and documenting efforts to obtain and draw conclusions based on review of those records. Additionally, a physician may renew a prescription for any length of time if the physician determines that the renewal is medically appropriate. That specifically speaks to the issue regarding pain management specialists.

Finally, the bill requires a practitioner to review a patient utilization report under the Nevada Prescription Monitoring Program when conducting an evaluation risk assessment of a patient before issuing an initial prescription for a controlled substance. I will point out that the Prescription Monitoring Program, more commonly referred to as the PMP, will still alert the practitioners if a patient is shopping and seeking multiple prescriptions.

That concludes the presentation. I would like to turn it over to Dr. Harris for some supportive remarks.

Garth Harris, Private Citizen, Las Vegas, Nevada:
One of the limitations the previous legislation created for us was a time treatment conflict. When we treat patients, many times it is an acute scenario. We are treating an emergency where someone has an abscess, or needs some type of pain medication to alleviate a short-term problem. Most of these occur with the first 72 hours of when they have a problem. By being required to get a comprehensive medical exam, which my license limits me to the treatment of the mouth and the teeth, I would have to refer a patient to a medical doctor, and by the time they got an appointment to have that complete physical exam, and to receive the medical records for review, many times that 72-hour window had passed—and the patients had suffered. We appreciate Senator Pickard for bringing this bill, because there are times when patients cannot be treated with Motrin either because they are allergic or have other medical complications, and it leaves them without some type of pain management that is reasonable for their condition.

[Assemblywoman Carlton assumed the Chair.]

Acting Chair Carlton:
Are there any questions for the sponsor or Dr. Harris?

Assemblyman Yeager:
I think this is important. Obviously, dental pain can be some of the most serious pain. It brings me back to a time when I had some dental pain and I could not get my dentist to prescribe anything. He just said, take what you are taking, and thankfully it went away a few days later. I understand what you are trying to get at in the bill. On page 3, starting at line 32, it says in part that a physician may renew a prescription issued for any length of time as long as they comply with the requirements, and it lists two different sections of *Nevada Revised* Statutes (NRS) Chapter 639. In looking at those sections, it looks to be the sections that apply to prescriptions for more than 30 and 90 days. Was it your intent if there was going to be a longer prescription, that some of these requirements would be satisfied? In line 36 it says, "to the extent appropriate." Can you explain how that might qualify the two references to NRS Chapter 639?

Senator Pickard:
The intent of this portion of the bill is to allow the physician to do what they think is medically necessary and appropriate. There are certainly the restrictions to the rules that are built into NRS Chapter 639, but it also goes beyond that—they have to do what is medically appropriate. With the restrictions that were passed in 2017 there was a question as to whether or not they could go to the full extent of what they believe is appropriate. That is what this language intends to do. It clarifies some water that was reportedly muddied as a result of the 2017 legislation, and this just clears that up.

Assemblyman Yeager:
Maybe this is something Dr. Harris can answer. How often are we in a scenario with dentists, in particular, where we have prescriptions that are going out 30 to 90 days? I think the testimony was most of this is two or three days before the issue can be addressed. I want to make sure I understood the answer to the question. I think the answer was, if the particular prescriber feels it is medically appropriate, they would not have to comply with the provisions of NRS Chapter 639 and the two sections listed there. Essentially, there will be a veto if in their mind it is medically appropriate.

Senator Pickard:
That is correct. This allows them to go to the extent that is medically appropriate, and not necessarily abide by the provisions if they are in conflict. This applies to physicians, not to dentists and optometrists—they would have to refer the patient to a medical doctor if the pain medication was required for a longer period of time. This allows the physician to do what they believe is medically appropriate and, therefore, clear up the ambiguity that was created.

Garth Harris:
In my practice, I can count on one hand the prescriptions that exceeded seven days in the entirety of the 20-something years that I have practiced—very rarely do I go past two or three days.

Acting Chair Carlton:
As we were processing the bill, Assembly Bill 474 of the 79th Session, one of the issues that came up was the long-term prescriptions. Allowing people to prescribe to the point—using the terms, "medically appropriate" and "to the extent appropriate"—I read this one section as basically just gutting the opioid bill, and not allowing for some of the restrictions that were put in. We did have another discussion about that bill this session, and I believe some good changes were made to it, but when I read this section, it just opens the door again. A number of the stories I heard was that there were dentists that were prescribing 30 days of pain pills for a wisdom tooth extraction, those pills stayed in the cabinet, and we know the story from there. I just have concerns that when you use those terms in conjunction with each other you are not addressing an issue, you are opening a loophole big enough for a truck to go through. If you could alleviate some of those concerns, that would be helpful.

Senator Pickard:
I appreciate those concerns. That is why we are not opening up the door to long-term prescriptions; we are talking about seven days or fewer. If I recall the testimony we heard in the 2017 legislation, what we were talking about were typically those practitioners who were providing far more than would be medically appropriate, then allowing the patient to shop the doctors, to go around to multiple practitioners to obtain enough to supply their habit, or worse, to market them on the black market. This bill does not expand that at all. In fact, we maintain the 7-day prescription requirements, 14 days if it is a physician. In section 2, subsection 3, we allow the pain management specialists and the doctors that regularly deal with these to prescribe, but certainly only to the extent that is medically appropriate.

Let us not forget, there are also changes in the regulations that the various regulatory boards have instituted on this issue—they have tightened up those rules as well. This does not disturb that at all. The only thing this does is allow a dentist or optometrist, especially for tooth extractions or implants—something that would require some pain medication for a short period of time—to prescribe that, and to do so without having to exceed the scope of their expertise.

If it is a dentist, we are not going beyond the mouth or the teeth for that examination or the medical record review. For an optometrist, say you have corneal abrasion, which is a common occurrence, or if there is some therapy after a surgical procedure where, as many of us know, we have a scratch to the eye, those are quite painful, but they are short-term. We have limited this to medical reviews or exams and records reviews, within their scope of practice, and then to the extent that is necessary within their appropriate practice area.

When we are talking about physicians, we maintain the same kind of prescribing requirements, including the reference to the Prescription Monitoring Program, to make sure they are on top of the use by this particular patient. Now that we have the physicians regularly responding to and recording those prescriptions within the PMP, when they get that real-time data back, they are able to determine whether or not that patient may be abusing it.

That is part of the risk assessment that they are required to do. This does not open the door, it merely allows the dentists and optometrists to resume providing short-term prescriptions for those who need it.

Acting Chair Carlton:
Thank you, Senator Pickard, but I will respectfully disagree with you. On page 3, section 2, subsection 3, between lines 32 and 36, I will have the Committee counsel take a look at this, but when I look at the language you have, it basically takes NRS 639.23913 and NRS 639.23914 and takes the authority out of it by changing this language. I would have concerns with that. I know where you are trying to go. I think you have possibly opened an avenue for someone we may not want in our state prescribing, who has a very good lawyer, to be able to make a case with this language. We just want to make sure that does not happen.

Wil Keane, Committee Counsel:
I agree with you, Assemblywoman Carlton. It appears to me that the renewal does say that NRS 639.23913 and NRS 639.23914 need to be complied with to the extent appropriate, and it would seem like it would be at the discretion of the physician.

Acting Chair Carlton:
I think we need to a do a little more work to make sure we are getting to where we are, because the last thing I would want to do with this one sentence is to open it back up again. We will take that under consideration and work on that moving forward.

Senator Pickard:
We are happy to do that. We have been working with the Legislative Counsel Bureau on that very issue. That was one of the critical pieces we wanted to make sure that we did not do, so if there is better language, we are happy to adopt that.

Assemblyman Daly:
I am seeing some of the same concerns, but I am looking at the language that says "to the extent deemed appropriate by the practitioner." I see the language above that where you are trying to say within the scope of work, and you are talking about dentists and optometrists. If I remember the bill from last session, we were trying to stop people from doctor shopping, making sure to have the records, and making sure all these things are being done, including an examination. The chapter we are in is about prescribing, so this does not just limit it to those providers—so it is any doctor, the way I read it. I agree with my two previous colleagues that that creates an issue that we do not quite have our hands around yet.

Senator Pickard:
I do not disagree. We put these people through some pretty intense medical training; then we restrict their practices through the practice acts and their ethical obligations. They are always required to adhere to their standard of care. To the extent we are talking about a dentist, we trust that they will do what is within their scope of practice, but we would not want to expand beyond that. If we are talking about a medical doctor, we are talking about somebody who is

licensed to practice medicine in any aspect. At some point, we have to strike a balance between giving them the discretion and authority to do what they think is medically appropriate within their practice and curtailing their ability to do that through law. That is what we did in 2017. It is not to say we did that with ill intent. I do not think anybody who sat through those hearings and considered the language ever considered this was going to restrict them or prevent them from providing those prescriptions. Again, it is about striking the right balance. To the extent we have a practitioner who is limited in their scope of work, we should not be expecting them to do an exam or a medical records review beyond that. That is what this language specifically limits.

Assemblyman Daly:
In this chapter, which says anybody can prescribe, it is not limited to those people that would be outside their scope. I think that is part of what we were trying to hit on when we put the restrictions in. Unfortunately, we tried to legislate to the worst operator. That being the one who was not doing what they were supposed to and falling back on, "Well, I deemed it to be appropriate, so who are you to say differently?" That is why you need to go through the extra protocols and make sure that it is appropriate, not just because you said so. There were doctors who were prescribing without conscience.

Senator Pickard:
I completely agree. I think there were many bad actors out there, and that was the genesis of the 2017 legislation. By the same token, we are talking about people who have specific medical training and a license from the Drug Enforcement Administration to prescribe an appropriate medication for their specific practice area. This would not open the door to anyone prescribing, but only those who already have prescribing rights; to prescribe within their practice area without the onerous penalties that apply.

If you have someone in acute pain—the person who comes to mind is a friend of mine who just went through dental implants and those are terribly painful for several days. If a dentist is looking at this and says, I could lose my ability to earn a living today if I give them an opioid without reviewing their entire medical records, which is the state of the law today, then that patient goes without relief. I think that is an unintended consequence and a mistake in the present-day law. The whole purpose of this was to allow them to prescribe these medications, which are useful and necessary, and there is no question that these are appropriate medications in these types of situations. Senate Bill 187 (1st Reprint) allows them to prescribe, to give that patient the relief they need, but not subject these practitioners to the really onerous penalties if they do not go to the full extent of the laws that exist today. If there is language that we can find that better meets that intent, I am willing to change it. I am not married to the language, I am married to an intent—which is that we want to get these people the relief they need, because there is no reason not to.

Opioids are abused. I can tell from my personal experience, having facilitated and worked with youth that are hooked on these things, this is a real problem. Dentists and optometrists are not the problem. The problem is those bad actors, and this bill does not prevent prosecutions. It does not relieve or remove any of the penalties that are associated with

improper prescriptions; it is simply about allowing these practitioners to do the medical reviews and the examinations within the scope of their practice, and thereby adhere to their standard of care and yet provide these patients with the relief they seek.

Acting Chair Carlton:
Are there any other questions from the Committee? [There were none.] Thank you, Senator Pickard. I will disagree with you on the dentist side. From the stories we heard, the dentists were just as guilty as the doctors; that is why the bill came about. Is there anyone to testify in support of Senate Bill 187 (1st Reprint)?

Joanna Jacob, representing Nevada Dental Association:
I want to thank you for the discussion today. Assemblywoman Carlton, I do believe everybody has a role to play in fighting opioid abuse, which is why, on behalf of the Nevada Dental Association and our officers, we took it very seriously in implementing Assembly Bill 474 of the 79th Session. We found this to be an unintended consequence, so we appreciate the attention Senator Pickard has paid to perhaps unintended consequences and what this whole Legislature has done. We submitted a letter to the Senate from a Carson City dentist. We are in support of this bill and any possible amendment that is coming out of this Committee to meet the intent in trying to ease the ability for the practitioners to comply with Assembly Bill 474 of the 79th Session. We will continue to work with the other stakeholders and with the state on addressing opioid abuse.

Mark Lee, President, Nevada Optometric Association:
I have been practicing optometry in Nevada for the last 19 years. I can count on one hand the number of times I have had to prescribe a controlled substance. When we do write a prescription for a controlled substance, it is never for more than 72 hours, per NRS 636.2882. As of 2017, with NRS Chapter 639, because of the physical exam requirement, I think optometrists have stopped prescribing opioids or controlled substances for the most part. The requirement of a physical exam would take us out of our scope of practice. Senate Bill 187 (1st Reprint) fixes this requirement by specifying a physical exam is done in a manner that is within our scope. We thank you for your time and consideration for support of this.

Acting Chair Carlton:
Is there anyone to testify in opposition to Senate Bill 187 (1st Reprint)? [There was no one.] Is there anyone to testify in neutral? [There was no one.] We will close the hearing on Senate Bill 187 (1st Reprint). The work session will be rolled to a later date.

Senate Bill 39 (1st Reprint): Revises provisions governing appraisers and appraisal management companies. (BDR 54-224)

[Senate Bill 39 (1st Reprint) was agendized but not considered.]

Senate Bill 40 (1st Reprint): Revises provisions governing penalties for violating occupational safety laws. (BDR 53-222)

[Senate Bill 40 (1st Reprint) was agendized but not considered.]

Senate Bill 119 (1st Reprint): Requires certain health and safety training for workers and supervisors performing work at sites where exhibitions, conventions or trade shows occur. (BDR 53-570)

[Senate Bill 119 (1st Reprint) was agendized but not considered.]

Senate Bill 219 (1st Reprint): Revises provisions relating to certain regulatory bodies. (BDR 54-646)

[Senate Bill 219 (1st Reprint) was agendized but not considered.]

Senate Bill 479: Repeals provisions relating to certain mortgage loan originators. (BDR 55-148)

[Senate Bill 479 was agendized but not considered.]

Is there anyone here wishing to make public comment? Seeing none, the meeting is adjourned [at 3:40 p.m.].

RESPECTFULLY SUBMITTED:

_____
Karen Easton
Committee Secretary

APPROVED BY:

_____
Assemblywoman Ellen B. Spiegel, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a document titled "Policy Brief: Health 2019, Hearing Aids for Children," submitted and presented by Jared Busker, Associate Director, Children's Advocacy Alliance.

Exhibit D is a proposed amendment to Senate Bill 200 (1st Reprint), dated May 5, 2019, submitted by Senator Pat Spearman, Senate District No. 1, and presented by Jared Busker, Associate Director, Children's Advocacy Alliance.

Exhibit E is composed of various emails dated May 5, 2019 in support of Senate Bill 200 (1st Reprint).