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

Eightieth Session
March 4, 2019

The Committee on Commerce and Labor was called to order by Chair Ellen B. Spiegel at 1:35 p.m. on Monday, March 4, 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 Dina Neal
Assemblywoman Jill Tolles
Assemblyman Steve Yeager

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblyman Glen Leavitt, Assembly District No. 23
Assemblywoman Sarah Peters, Assembly District No. 24

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Wil Keane, Committee Counsel

Earlene Miller, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Tom McCoy, Nevada Government Relations Director, American Cancer Society Cancer Action Network
Cari Herington, Executive Director, Nevada Cancer Coalition
Kelly Gonzales, Private Citizen, Las Vegas, Nevada
Paul Young, representing Pharmaceutical Care Management Association
Bryan Wachter, Senior Vice President, Retail Association of Nevada
Catherine O'Mara, Executive Director, Nevada State Medical Association
Loretta L. Ponton, Executive Director, Board of Registered Environmental Health Specialists
Charlene Albee, Division Director, Air Quality Management, Washoe County Health District
Brian Northam, Private Citizen, Las Vegas, Nevada

Chair Spiegel:
[The roll was called.] I will open the hearing on Assembly Bill 141.

Assembly Bill 141: Prohibits a pharmacy benefit manager from imposing certain limitations on the conduct of a pharmacist or pharmacy. (BDR 57-947)

Assemblywoman Melissa Hardy, Assembly District No. 22:
I am pleased to present Assembly Bill 141 for your consideration. Consumers purchased prescription drugs that cost $235 billion in 2015 from local or mail-order pharmacies. Estimates indicate that overall U.S. spending on prescription drugs will be as high as $584 billion by 2020. This is a huge market and health insurers and consumers struggle with the cost of prescription drugs. This bill is an effort to guarantee consumers have access to all available resources to obtain essential medications.

Pharmacy benefit managers (PBM) are third-party administrators of prescription drug programs for commercial health plans; Medicare Part D plans; self-insured employer and union plans; federal employees health benefits program; state government employee plans; managed Medicaid plans; and others. According to the Pharmaceutical Care Management Association, PBMs administer prescription drug plans for more than 266 million Americans who have health insurance. In addition to having a contractual arrangement with a health plan, PBMs will often also have commercial contracts with a pharmacy. The terms of these contracts vary, but sometimes these contracts include provisions that prohibit a pharmacy or pharmacist from sharing certain information or options with a patient. These prohibitions are frequently referred to as gag clauses. These provisions are widespread and at least 30 states, including Nevada, have enacted laws prohibiting certain types of gag clauses.

Senate Bill 539 of the 79th Session became law in 2017. In addition to other provisions, that bill clarified that a PBM has a fiduciary duty to an insurer with which it contracts to manage prescription drug coverage and bans PBMs from prohibiting a pharmacist or pharmacy from providing certain information to a client who is a member of a pharmacy benefits plan. While the bill addressed a pharmacist sharing information about copayment and coinsurance for a prescription drug or informing a patient about the clinical efficacy of a less expensive alternative drug, additional clarification is needed. Assembly Bill 141 expands on these prohibitions with the aim of giving patients access to the most effective drugs at the best price possible. This is a straightforward bill that makes some commonsense changes. Implementing this measure increases the pharmacist's ability to work as a part of the medical team to give patients access to the best information and options.

Assembly Bill 141 clarifies that PBMs may not prohibit a pharmacist or pharmacy from providing information to a covered person concerning: (1) the availability of a less expensive alternative or generic drug, or a more effective drug including information about the clinical efficacy of such a drug, or (2) alternative methods of acquiring a drug which may result in a lower cost for the drug such as retail discount programs, free discount cards, and manufacturers' coupons. The bill prohibits a PBM from penalizing a pharmacist or a pharmacy for providing information regarding a generic or a more effective drug.

The bill does not authorize a pharmacist or pharmacy to dispense a drug in a manner which is not otherwise lawful. A pharmacist or pharmacy may share information regarding less expensive alternatives, generic drugs, or a more effective drug, but dispensing any drug must be done in accordance with the prescription. The last thing we want to do is get between a patient and his or her doctor. The sole purpose of this legislation is to provide additional information about less expensive drugs. I will continue to work with stakeholders to address their issues.

We know that prescription drug costs affect everyone, even the insured. We can make certain that patients benefit from a pharmacist’s knowledge of less expensive, but equally effective, drugs and other cost-saving methods that may help patients acquire vital medications.

Assemblyman Glen Leavitt, Assembly District No. 23:
Assembly Bill 141 would prohibit a PBM from restricting a pharmacist from informing individuals about a less expensive or more effective drug or a less expensive manner of acquiring a drug, a practice commonly referred to as a gag clause.

In talking with the Legislative Counsel Bureau, we learned that language to prohibit a gag clause did not exist within the *Nevada Revised Statutes* (NRS). As Assemblywoman Hardy stated in her testimony, Senate Bill 539 of the 79th Session did not go far enough to prohibit this practice. This bill would make it fair across the board and allow a pharmacist to inform patients of other available options at a lower cost.

I believe this bill is essential to allow pharmacists to properly inform individuals and to help to lower drug costs. States around the country have taken action on this issue with positive results. According to the National Conference of State Legislatures, between 2015 and 2018, at least 28 states have enacted laws prohibiting gag clauses.

We hope to find a solution that will protect our residents and consumers, and I ask for the Committee's support for this bill.

Chair Spiegel:
Are there any questions?

Assemblywoman Carlton:
Can you tell me what parts of Senate Bill 539 of the 79th Session need to be clarified?

Assemblywoman Hardy:
We wanted to expand on some parts of that bill, specifically informing customers about generic drugs and alternative methods of acquiring a drug which may result in a lower cost.

Assemblywoman Carlton:
If we knew exactly what you wanted to change, it would be much easier because we could look at the exact language. My concern is adding the terms "generic" or a "more effective drug." Pharmacists do not prescribe—some things cannot be substituted and some patients cannot take generics. The pharmacists would not know that, but the doctor would. What safeguards have you built in to make sure that there is consultation between the pharmacist and the doctor so that the pharmacist is not talking the patient into trying something that is cheaper and may not necessarily work for them?

Assemblyman Leavitt:
This is not seeking to alter the communication between the patient and his or her doctor. The pharmacy would simply inform the patient of available options. It would be up to the patients to consult with their doctor to see if the generic would work for them.

Assemblywoman Carlton:
I am assuming that response also goes for a more effective drug, but how would a pharmacist know what a more effective drug would be for a patient because he is not a doctor? I think that is one of the reasons why it was left out of the previous bill.

Assemblyman Leavitt:
We believe that pharmacists are knowledgeable about certain things. They are trained and are aware of drugs and how they work. However, we do not want them to prescribe; we want them to notify patients regarding potential drugs about which they can consult with their physicians.

Assemblywoman Hardy:
The intent is not to come between the patient and the doctor. We would never want a pharmacist or a pharmacy to have liability in that regard. If the prescription specifically states that you cannot substitute generics, they would adhere to that instruction. This is not an effort to allow a pharmacist to change prescriptions. It would allow the pharmacist to provide information that there may be a less expensive drug available.

Assemblyman Yeager:
Are there PBMs that own pharmacies or run their own pharmacies? If yes, would the language of this bill apply in that circumstance? If it is one company, would the PBM still be precluded from doing the things that are mentioned in the bill? In a normal circumstance, there would be a written contract so they would not be allowed to do that. If it is one and the same company, do you intend this to apply to businesses in that circumstance?

Assemblywoman Hardy:
There are some PBMs that own pharmacies. I do not know how many or which ones. Those are some of the conversations we are having with stakeholders.

Assemblywoman Neal:
It is my understanding that insurance companies will say what they will pay for. If there is an annual contract between a pharmacy and a PBM in which they determine price and what they will offer, are there not enough generic drugs or alternatives being offered so patients can select what is best suited to them? Do less expensive insurance plans have the money to offer certain prescriptions? What data have you found?

Assemblywoman Hardy:
The intent of this bill is to find the least expensive cost for a consumer, and it would save the insurance companies if they were able to pay for generic drugs. The intent is for all parties to pay less and to save money for everyone. I could get information for you as to how many generics are being offered.

Assemblywoman Neal:
I know PBMs have data about how many prescriptions they are selling and how many people buy maintenance prescriptions. Do you know what prescriptions are selling or are they driving the market around certain drugs? Are they pitching certain drugs because that is what they would like to sell for the profit?

Assemblyman Leavitt:
That is probably an unintended consequence of this bill. It was not the goal to go after insurance companies for charging too much, but it may be a consequence if a pharmacy can identify a generic and the insurance company may pay a higher price.

Assemblywoman Neal:
Do you know how the transaction works between the pharmacy and the PBM? What is the markup and how do they get an alternative, generic, or name-brand drug? Do you know how

that transaction occurs because there is a transaction, a contract, and a preexisting relationship?

Assemblyman Leavitt:
We have asked the question but have not received an answer.

Assemblywoman Carlton:
There is a rebate process that I need to understand better. If the pharmacy uses a cheaper drug, is the rebate greater for the PBM, and does the PBM end up making money in the long run? That is a question we need to have answered because there are PBMs that own pharmacies. The last thing I would want to do is incentivize. Some of the articles have talked about the exorbitant profit margins that PBMs are making, so the law of unintended consequences would be cheaper drugs for the constituent, but the PBMs would get more money. We need to figure out how that works.

Chair Spiegel:
I will ask the bill sponsors to get that information for Assemblywoman Carlton. Is there anyone to testify in support?

Tom McCoy, Nevada Government Relations Director, American Cancer Society Cancer Action Network:
The American Cancer Society Cancer Action Network is the nonpartisan advocacy arm of the American Cancer Society. Some PBMs include in their contracts with pharmacies a prohibition against the pharmacy and its staff informing the enrollees that they may be paying a higher out-of-pocket cost using their insurance instead of paying the uninsured cash price for medications. As referenced in A.B. 141, this is a gag clause. Nothing we know of in the NRS prohibits this aspect of the bill. The result of this practice means that some Nevadans are paying more than they should for their needed medications.

I had a personal experience when I picked up two prescriptions. Each of them were generic drugs according to my plan and each had a $15 co-pay. I was told that the cash price was $4, a difference of $26. Each year we get information on medications, and I saw a study from 2013, which I would be happy to reference for the Committee in terms of what the average costs involved are.

Last year the Centers for Medicare and Medicaid Services prohibited Part D Medicare plans from enforcing gag clauses and the U.S. Congress expanded on that prohibition. Assembly Bill 141 is unlikely to affect the high cost of some cancer medications. However, passage could benefit the patient in cases where he or she is purchasing lower-cost drugs that have been on the market for many years. Cancer patients and others dealing with chronic diseases often take maintenance drugs on a regular basis. Over time those costs would add up. The American Cancer Society Cancer Action Network supports the prohibition of and removal of pharmacy gag clauses in all contracts between pharmacies, insurance plans, and PBMs. Passage of A.B. 141 would benefit Nevada's insured patients and could help to lower the price of prescriptions and the overall cost of health care. We would like to see

clarification as to the authority a pharmacist would have to discuss a "more effective drug to a covered person" as written in section 1, subsection 1, paragraph (b).

Cari Herington, Executive Director, Nevada Cancer Coalition:
I concur with Mr. McCoy's comments, and we support policy that increases access to medication for all patients.

Kelly Gonzales, Private Citizen, Las Vegas, Nevada:
I am a patient in the rare disease community in Las Vegas and I have five children, four of whom are also patients here in the community. I want to share with you my experience and problems with PBMs having too much control over our prescriptions and the effect it has on my family. Earlier there was a question asked about insurances that had their own pharmacies. UnitedHealthcare has its own specialty pharmacy where we are mandated to go. Aetna, BlueCross, and BlueShield have PBMs and they own pharmacies. That is a huge problem. As I look at this bill, I would also like clarification if the removal of the gag clauses will apply to the PBMs that have their own pharmacies.

I was insured by a UnitedHealthcare plan in Nevada. They had a PBM and forced my child into utilizing therapy that was less than what was prescribed by the provider. Her condition is a bleeding disorder similar to hemophilia, called von Willebrand disease. She was on a high-cost medication, and she had gone through "fail first" multiple times during this time period. Because UnitedHealthcare's PBM controls its pharmacy and controls the medications that were output, my daughter was told that she had to refill the medication. This was against what the provider had prescribed for her, but the PBM was able to decline her ability to access those medications. As a result of that, in the course of 13 months, my daughter was hospitalized 11 times. I said to UnitedHealthcare, "Would you rather pay hospital bills for my child to get the same medication that was prescribed to her or do you want to keep denying this through the PBM?"

That is a huge problem. My daughter was a young woman at the time and 11 hospitalizations in 13 months impacted her health, her well-being, and it impacted our family financially. It was because the PBM wanted her to be on a lesser medication and not by what the provider had prescribed. The reason I wanted to speak is specifically about A.B. 141, section 1, subsection 1, paragraph (a) where it says, "Prohibit a pharmacist or pharmacy from providing information to a covered person concerning:" Then it lists subparagraphs (1), (2), (3) and paragraphs (b), (c), and (d). Something that impacts the rare disease community that was not mentioned is specific centers which are federally qualified. I know that this applies to the cancer world as well as the hemostasis world that I live in.

There are federally qualified centers such as the Hemostasis and Thrombosis Center of Nevada, which is a qualified center with a highly qualified provider. Our insurance does not allow us to use their plan through the Hemostasis and Thrombosis Center of Nevada or use their pharmacy services even though there was a proposal to utilize those services as long as they were reimbursed at less than or equal to Nevada Medicaid fees. It was not accepted. The situation for me and my family is when we are not able to use the Center because a PBM

is saying use our pharmacy and our medications, things happen as it did with my child—11 hospitalizations in 13 months and 47 days of missed school.

I ask for this to be looked at specifically for people attending federally qualified centers because I think they have their own pharmacies as well. Because they are federally qualified, they should fall under the same protections.

Chair Spiegel:
Thank you for sharing your story. Seeing no further testimony in support, is there anyone in opposition? Seeing none, is there anyone to testify in the neutral position?

Paul Young, representing Pharmaceutical Care Management Association:
We are here in neutral today. My client supports the majority of the bill. We are concerned about section 1, subsection 1, paragraph (a), subparagraph (3). We are working with the bill sponsor about our concerns.

Assemblywoman Carlton:
Do you represent the pharmacy benefits managers?

Paul Young:
That is correct.

Assemblywoman Carlton:
Did you hear some of the questions that we had about how the rebates work?

Paul Young:
I did.

Assemblywoman Carlton:
Would you be able to provide that information to the Chair and staff so it can be shared with the Committee? It is important for us to understand not only the impact to the patients, but if this is a profit center for the PBMs by diverting people to different drugs so they get larger rebates. That is an important way to understand how these formularies actually work.

Paul Young:
I will work with you and the Chair to get the information.

Assemblywoman Neal:
What was your problem with that section of the bill?

Paul Young:
The concern is the language in section 1, subsection 1, paragraph (a), subparagraph (3) which says, "Alternative methods of acquiring a drug which may result in a lower cost for the drug." That opens a window for pharma coupons. From the PBM side, pharma coupons can

ultimately increase the cost of health care throughout the industry, not just for PBM, but for the patient.

Assemblywoman Neal:
How do coupons increase the cost of the drug?

Paul Young:
It will incentivize the patient to stay on the brand-name drug. The brand-name drugs in general are more expensive. There are a bunch of generics and there is an appeals process for patients to use if they want to stay on the brand-name drug if they need to be. In general, they can move to a generic drug, which is ultimately cheaper and a lower cost for the overall health care industry. Pharma coupons are for the brand-name drugs only.

Assemblywoman Neal:
Typically, a person will stay on a brand-name drug because it is better suited for his or her disease or condition. They should have the right as a patient to select that option. Although generics are similar, they are not the exact same chemical makeup. Different drugs are suited for different people. If you are moving toward eliminating that as an option, that poses an issue. If I needed a brand-name drug for my child because it is better for her, I would get the coupon. I do not want a limitation on being able to get it.

Paul Young:
I agree with the general statement and will say that with the appeals process, not everyone is being moved to a generic drug; however, that option is there. A lot of patients ultimately stay on the brand-name drug.

Chair Spiegel:
Are there any questions? [There were none.]

Bryan Wachter, Senior Vice President, Retail Association of Nevada:
I represent the retail pharmacies, not the PBMs. We are neutral on the bill. We share concerns in section 1, subsection 1, paragraph (a), subparagraph (3). We think "alternative methods of acquiring" is vague. We are not sure what advice this body or the bill sponsors are looking for the pharmacies to provide to our customers. We want to highlight Assemblywoman Carlton's comments that there is a lot more that goes into the selection of a drug for a patient than just price. Assemblywoman Neal commented that just because a drug is a brand name, it could have a specific working relationship with one patient and a generic drug might have a better working relationship with a different patient. We want that flexibility. We want to emphasize that a lot more goes into this than the price of a particular drug. We will work with the sponsors to see if there is a place where we can meet in the middle.

Catherine O'Mara, Executive Director, Nevada State Medical Association:
We are here in neutral, but we strongly support what the sponsors are trying to do with this legislation. It is important to remember that this is a restriction on PBMs. It is not

authorizing language under the *Nevada Revised Statutes*. It is preventing the PBMs from restricting the pharmacist's communication with the patient. We support the pharmacist being able to explain to the patient less expensive ways to obtain their medications. That is very important for patient care. We have questions about the phrase "a more effective drug." Pharmacists are important partners to physicians in drug management for patients, but ultimately we believe that the prescription authority should be left with the physician, advanced practice registered nurse (APRN), or other prescriber. The discussion should be had between them and the patient about what they should be taking.

To address Assemblywoman Carlton's point, sometimes generics are fine and sometimes they are not. We have existing guidance under NRS when a physician wants to preclude a pharmacist from swapping out a generic, they can write, "Dispense as written." We have taken careful steps whenever we have allowed for something to be interchangeable such as the interchangeable biosimilar legislation that was passed last session. Assembly Bill 245 of the 79th Session still required the pharmacist to notify the physician and those are cases where the drug is so interchangeable that it has been designated at the federal level. We do not want anything to inadvertently change the relationship between the physician, APRN, or other prescriber and their patient. That is not how we read this bill. We read this as a restriction on what the PBMs can restrict pharmacists from in their contracts. The pharmacists would still have to follow the current law in their standard of care.

We would like to continue to work with the sponsor. I think we can get to the point of supporting this bill. I commend the Committee for having these discussions about transparency and PBM pricing, and the important discussions about understanding what rebates and coupons are. We all have a lot of confusion about that and about when a PBM owns their own specialty pharmacy or mail-order pharmacy. We need to think about if there are conflicts of interest built into that. I think the physician community supports the intent behind this bill, the patient access that it seems to be promoting, and the Committee's efforts at looking at this issue.

Chair Spiegel:
Are there any questions from the Committee?

Assemblyman McCurdy:
What language would get you to support the bill?

Catherine O'Mara:
I am not certain that we need a change in the language. The provision we need to better understand is in section 1, subsection 1, paragraph (a), subparagraph (2), where it says "a more effective drug." We are fine with the language that says, "The availability of a less expensive alternative or generic drug." I think pharmacists have a lot of knowledge about the efficacy of a drug but they may not have the patient's medical history. We would want them to prompt the patient to go back to the physician. This is a restriction on what the PBMs can say by contract—they cannot prevent the pharmacist from doing that. Under section 1, subsection 1, paragraph (b) where it says you cannot penalize a pharmacist for selling a more

effective drug, we would not want there to be therapeutic switching at the point of pharmacy. We would not want the pharmacist to tell the patients when they walked in that there is a more effective drug and we are going to swap this out if you want it. It does not seem like this bill does that. We want to be clear what the bill is and is not going to do. The PBMs should not be able to penalize a pharmacist if they sell a less expensive drug. We do not want to change the nature in which a pharmacist, physician, or APRN would work together to determine if there was a more effective drug.

Chair Spiegel:
Do the sponsors have final statements?

Assemblywoman Hardy:
We will continue to work with the stakeholders to address their concerns so the bill reaches our original intent. Our goal is to allow the consumer to get the information about the most effective drug at the lowest price.

Chair Spiegel:
I will close the hearing on A.B. 141 and open the hearing on Assembly Bill 175.

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

Assembly Bill 175: Revises provisions governing environmental health specialists. (BDR 54-669)

Assemblywoman Sarah Peters, Assembly District No. 24:
Assembly Bill 175 modifies existing language in the *Nevada Revised Statutes* (NRS) for environmental health specialists. [Assemblywoman Peters read from prepared text (Exhibit D).] The practice of environmental health means the use of public health principles in the application of sanitary sciences to prevent human injury and illness by identifying and evaluating hazardous physical, chemical, and biological agents that may adversely affect human health and environmental sources of those agents and limit exposure to those agents in air, water, soil, food, and other environmental media or settings. For the record, this is not the work that I do as an environmental engineer.

An environmental health specialist is commonly referred to as a health inspector. Over 90 percent of the registered environmental health specialists and trainees are employed in public service for the Southern Nevada Health District, Washoe County Health Department, Division of Public and Behavioral Health, State Department of Agriculture, and other state and local governments in Nevada, and outside of the state. As of December 31, 2018, the Board of Registered Environmental Health Specialists had 249 current registrants. Registration numbers are highly influenced by public employment, agency authorized positions, and budget authority. Registrants have ranged between 225 and 250 annually.

The Board of Registered Environmental Health Specialists was created in 1987 as the Board of Registered Public Health Sanitarians with voluntary registration of professional

sanitarians. In 1995 the name of the board was revised as the Board of Registered Environmental Health Specialists and the provisional title was changed to Registered Environmental Health Specialists.

Registration became mandatory effective July 1, 2007, by legislation enacted in 2005. The registration of environmental health specialist trainees was added at that time. *Nevada Revised Statutes* 615A.030 created the Board of Registered Environmental Health Specialists consisting of the Chief Medical Officer or a designated representative and four members appointed by the Governor. Of the members appointed by the Governor, two members must be representatives of the public and two are environmental health specialists, one each employed at the Southern Nevada Health District and the Washoe County Health District. The Board is funded solely by registration fees and does not receive funding from the State General Fund. Registration fee amounts were established in 1987 and have not been revised or increased since then. The Board operates on an annual revenue-based budget of approximately $31,000.

Assembly Bill 175 proposes to revise NRS Chapter 625A. In 2016 the Board began to review and revise the Board regulations under *Nevada Administrative Code* Chapter 625A, which is the first update since 2007. During 2017 and 2018, the Board determined NRS Chapter 625A was lacking in conformity with legislative and administrative requirements for boards and did not reflect the evolutionary changes in the field of environmental health on a state and national level. Board work sessions were held followed by public workshops, which engaged stakeholders to participate in the review and revisions of the proposed bill draft language which is before the Committee. Assembly Bill 175 incorporates input from all stakeholders who participated in the review and revision of NRS Chapter 635A. There is also a proposed amendment (Exhibit E).

Loretta L. Ponton, Executive Director, Board of Registered Environmental Health Specialists:

This is our first major revision to NRS Chapter 625A since 2005 which required mandatory registration with the Board when enacted in 2007. Previous to that, there was a voluntary registration. Since then, the Legislature has made several changes to the requirements for regulation of professional bodies. Through our review, we attempted to address most of the major changes that were imposed through legislative action in the sessions since 2005 to incorporate those into our law. The changes we are proposing will make us much more effective and efficient in the management of our administration, regulations, and registration of the environmental health specialists and the environmental health specialist trainees. The proposed bill will provide clear and concise registration processes. It will encourage workforce development by offering temporary registrations, registrations by endorsement, and exemptions from registration for limited practice of not more than 45 days in a calendar year.

The proposed bill provides for a reduced fee for active military personnel, veterans, and their spouses while retaining the existing fee structures from 1987. The bill establishes a provisional registration as an environmental health specialist trainee, which is a pathway to

achieving the training necessary to obtain national certification and registration as an environmental health specialist in this state.

We have a proposed amendment (Exhibit E). The amendment proposes to change section 5, subsection 2 and section 24, subsection 4 to clarify the intent and scope of those sections. Section 5 lists those individuals or persons who are not required to be registered with our Board. Section 2, subsection 2, deletes references to "entities" and specifically identifies the local air pollution control agency as defined in statute. The amendment removes language from section 24, subsection 4, which was added in the original bill that is not applicable to this section and was already contained in the following section and is applicable to the environmental health specialists and not the trainees.

I have provided written testimony (Exhibit F) with the section details and the specifics of the changes to each section. I would like to go over some of the new language. Specifically in section 5, there are other changes in that new section. It adds an exemption for individuals employed by the state in the inspection of medical and recreational marijuana compliance programs unless that product is utilized as an agent or ingredient in food products. It also adds an exemption for those who may be practicing in the state for 45 days or less during a calendar year. After getting input from stakeholders, we added this exemption to assist in possible emergency situations. A scenario that could be addressed here would be interstate transportation of produce in which the truck overturns and the produce is spilled. If this was near a rural area border, we could use the services of health inspectors from both states, allowing inspectors to cross state lines and perform those duties to protect the safety of the products.

Sections 6 and 7 expand on the duties of the Board including investigating complaints, holding hearings, and issuing subpoenas. Previous legislation did not have those as specific activities allowable for the Board to conduct. Section 8 identifies eligibility criteria for all applicants to the Board. Section 9 establishes the Board's authority to adopt regulations, establishing the term of the license, late renewal and reinstatement of a registration, and establishing an inactive status option for those who wish to retain their registration but will not be practicing. Section 10 creates the temporary registration term of six months for individuals who are registered in another state and do not intend to work in Nevada on a continual basis. That would allow us to be able to call in additional people to assist in specific circumstances or cover gaps in employment in this state. The temporary registration would be eligible to be renewed once for a total of a 12-month period. At any time it could be converted to be the regular registration.

Section 11 establishes the procedure to file complaints and the retention period for those complaints. Section 12 provides for the ability to enter into any premise for determining compliance with the law. That is specifically identified for unlicensed practice scenarios. The following sections are all revisions or amendments to the existing statutes.

Chair Spiegel:
Are there any questions from the Committee?

Assemblywoman Carlton:
How many licensees do you have?

Loretta Ponton:
There are currently 238 registrants and trainees.

Assemblywoman Carlton:
Your financial numbers have not changed for a long time and we typically set a ceiling so you can go up to that amount. I am not sure the numbers you propose will address setting a ceiling.

Loretta Ponton:
We are currently at the ceiling. We moved to that ceiling about three years ago and the funding is sufficient to operate into the future.

Assemblywoman Carlton:
We typically try to adjust above the ceiling. If you have to make adjustments, you cannot go over the ceiling without coming back to the Legislature. If you are going to make all of these changes, you should make some financial adjustments because of people coming into the state and growth in the profession.

I would like to clarify section 10. You stated the public purpose behind the temporary registration, but I want to clarify the difference between a temporary and a provisional registration. Provisional means you can take the registration back at any time and do not have to go through a typical revocation process. If a temporary registration is granted, you would have to go through the revocation procedure if you had a problem with one of those registrants. If someone is coming from out of state, he or she may be substantially qualified in another state, but we do not know what other types of things they might have done in the other state. The Board's purpose is to protect the public. I would hate to see you go through a revocation process rather than giving the person a provisional registration.

Assemblywoman Neal:
In section 11, subsections 1 and 2, I like that you were allowing the disciplinary action and saying it had to have such particularity as to enable the defendant to prepare a defense. In subsection 2, where it says it may be filed anonymously, it seems to be in conflict. If the defendant does not know who filed the complaint or the history, how can he or she get to the particularity in order to file the defense? Can you explain that section?

Loretta Ponton:
In the 79th Session, the ability to file a complaint anonymously was added to most of the regulatory language of all regulatory boards. We have a disclaimer that says, unless it is impossible or unfair to the subject of the complaint. We do allow complaints to be filed anonymously in conformance with the actions imposed by the Legislature during the 79th Session.

Assemblywoman Neal:
In section 17, what does "identifying and evaluating hazardous physical" encompass? Does it encompass old energy lines that remain in poor communities? There is some data that there may be carcinogens or other health risks. I know there are many of them in east Las Vegas, North Las Vegas, and parts of west Las Vegas. Would that be defined as "hazardous physical?"

Loretta Ponton:
The scenario you are describing is outside the purview of the registered environmental health specialists and this law. That is probably about energy.

Assemblywoman Neal:
There is harm to a community over time and it may not be covered under energy. I thought with the new definitions, you may be stepping into an area that you may not have considered.

Assemblyman Daly:
In section 19, you are going from one annual board meeting to two and are removing all the things you are supposed to do. I do not know if those things are cumbersome, but I assume you can do all of those things or nothing. Why are we deleting all of those things and what will the Board actually be doing?

Loretta Ponton:
Moving from one meeting to two is a minimum; we meet at least quarterly. We want to ensure that we have a bottom line. We have eliminated the duties of the Board from this section, but we created new sections that incorporate those duties as well as many other duties. Sections 6 and 7 identify specific duties of the Board. Other duties, such as the complaint processes, have been moved to a separate section under duties of the board and have been expanded throughout this legislation. They were not reduced.

Assemblyman Daly:
I saw there were new duties in section 7 to issue subpoenas, administer oaths, and take testimony. In section 22, I believe it says you will be able to authorize hearing officers to do the duties of the Board. What are the qualifications of the hearing officers and how will that be established?

Loretta Ponton:
The Board currently does not have a section that allows us to address complaints. We added in the complaint process and expanded the disciplinary process. We are including the ability to utilize a hearing officer, which has not been defined. If we were to use a hearing officer, we would most likely do a regulatory revision to define the qualifications of a hearing officer and how we could use that type of process in the disciplinary process.

Assemblyman Daly:
I would rather say you shall adopt by regulation what those qualifications might be. If you can do a better regulation, that is fine, but those persons should be qualified and have subject

matter knowledge in order to be overseeing the policy. The sections that are going to be repealed are NRS 625A.070, 625A.080, and 625A.090. If you are repealing NRS 625A.080, and have not given yourself authority somewhere else, you are repealing the section which gives you the ability to adopt regulations. Did you intend to do that or did you give yourself that authority somewhere else in the bill?

Loretta Ponton:
We do have a specific section for duties of the Board that establishes the ability to set regulations and to enact all of the provisions.

Assemblyman Daly:
Is that other than NRS 625A.080 that you are repealing?

Loretta Ponton:
Absolutely. We have records of proceedings which are in sections 6 and 7. Section 6, subsection 2 addresses preparing and maintaining records of our proceedings; and subsection 4 is about adopting standards of practice. We are already required through other legislation to have either a balance sheet or an audit conducted. We are in conformance with filing that balance sheet because we have a minimal amount of income. The biennial report was enacted when the Board was first created so there would be accountability before it was a mandatory registration. We file many reports. The Legislature has required the licensing disciplinary action reports on a quarterly basis, consultant reports, and a variety of other reports to be filed.

Assemblyman Daly:
I am assuming you are going to continue to keep a register of all applicants, which was in NRS 625A.090?

Loretta Ponton:
Yes, we have a database and those are readily available at all times.

Assemblyman Kramer:
Section 12 says, "Any member or agent of the Board may enter any premises in this State where a person who holds a registration issued pursuant to the provisions of this chapter"—that looks like law enforcement powers. I am questioning whether your people have Peace Officer Standards and Training certification or have police protection?

Loretta Ponton:
This is a provision that was added to our law which allows access to premises where people are working to ensure that there is no unlicensed practice going on. If there was unlicensed practice, we have a process for cease and desist, potential civil fine, and referral to law enforcement in cases where it would affect public health and safety.

Assemblyman Kramer:
If you suspected something, would you back off and call law enforcement?

Loretta Ponton:
Absolutely.

Assemblywoman Carlton:
Can you tell me what your reserves are?

Loretta Ponton:
Our cash balance is $50,000. We take in approximately $31,000 per year so we have a little over a year and half of our expenses on hand. We changed our registration process a year and a half ago from everyone renewing at one time to renewing registrations annually from the date of registration to help with the cash flow. We are in good shape now.

Assemblywoman Tolles:
In section 8, it says, "To be eligible for registration by the Board, an applicant for a registration to engage in the practice of environmental health must: 1. Be a natural person of good moral character." We have heard a lot of discussion about this as a prerequisite for people getting certain professional licenses. What constitutes a barrier for entry for somebody to get the license? How do we interpret good moral character?

Loretta Ponton:
The Board has established an internal policy that defines moral character. We are basically asking if they have a conviction in their background. We look at each case individually and want to know if it is directly related to their practice as an environmental health specialist. We look at the timeline—has it been more than ten years and has it been remediated? Have there been disciplinary actions in the previous period of time? We have that fairly well defined in our policy. We do background checks, and I can say with confidence that no applicant has been denied registration because of that background check in the four years I have been with the Board.

Chair Spiegel:
Is there testimony in support of Assembly Bill 175?

Charlene Albee, Division Director, Air Quality Management, Washoe County Health District:
We have submitted a letter of support for the amendment, specifically section 5, subsection 2, which references the definition of a local air pollution control agency (Exhibit G). It has been our experience that anytime we reference a definition that has been adopted in the statutes, it helps to alleviate any interpretation issues that may come up.

Chair Spiegel:
Is there anyone else to testify in support of A.B. 175? [There was no one.] Is there anyone to testify in opposition?

Brian Northam, Private Citizen, Las Vegas, Nevada:
I am an environmental health supervisor at the Southern Nevada Health District. I have been a registered environmental health specialist for over ten years. My concern with this bill is in section 27, subsection 1, where it changes the provisional time for a new hire to register with the Board from 90 days to 30 days. That length of time represents a significant financial burden to a new employee of any of these entities. The vast majority of the individuals we hire are entry-level professionals who may have moved across the country or recently graduated from college. The amount of the fees is $350 which represents approximately 20 percent of their first paycheck. I would argue that asking a new employee to go into debt to keep their job in a very short period of time is not a great idea. I would ask that the time period be left at 90 days to give the individual more time to pay the fees.

Chair Spiegel:
Are there any questions from the Committee?

Assemblywoman Carlton:
Do you represent the Southern Nevada Health District?

Brian Northam:
I am representing myself with the approval of management. We applaud the remainder of the bill.

Assemblywoman Carlton:
When is the next board meeting and will this be on their agenda?

Brian Northam:
Not to my knowledge.

Assemblywoman Carlton:
I want to clarify that you are not representing the board.

Brian Northam:
I am speaking on my own behalf, but my employer is aware that I am here.

Chair Spiegel:
Is there anyone else to speak in opposition? Seeing no one, is there anyone to testify from a neutral position? [There was no one.] Is there a closing statement?

Assemblywoman Peters:
We had conversations with the Southern Nevada Health District and northern Nevada health districts. Loretta Ponton will clarify those conversations.

Loretta Ponton:
We discussed moving from the 90 days to the 30 days at our last Board meeting where Mr. Northam expressed his concerns. I believe we can work this out. Our concern is if an

individual waits 90 days to submit his or her application, and it takes another 30 days to complete a background check, there is a potential that he or she could be practicing without our Board knowing it and potentially causing harm to the public. That is why we changed it back to the 30 days to give the new hire at least an opportunity to complete the paperwork. We are hoping to expedite the registration process. Our law says that the application must be submitted within 30 days and we cannot issue the registration until everything is submitted. We can have more discussions, or look at regulatory language, to allow additional time after we have more public input on this for the receipt of that payment if it is a hardship situation. I do not think it should be an issue. The Board's main concern was individuals practicing in the field of environmental health without being registered with the Board with the assurance of supervision.

Assemblywoman Peters:
I am sympathetic to financial problems when a person is getting certified. I am sure we will be able to work through this and make this bill do what it is meant to do which is help us get the best people on the job and open up jobs for people in the state of Nevada.

Chair Spiegel:
I will close the hearing on A.B. 175. Is there any public comment? [There was none.]

The meeting is adjourned [at 3:08 p.m.].

RESPECTFULLY SUBMITTED:

_____
Earlene Miller
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 letter dated March 1, 2019, in support of Assembly Bill 141 to Chairwoman Spiegel, authored by Steven Schultz, State Director, Advocacy and Access, Arthritis Foundation.

Exhibit D is written testimony presented by Assemblywoman Sarah Peters, Assembly District No. 24, regarding Assembly Bill 175.

Exhibit E is a proposed amendment to Assembly Bill 175 submitted by Loretta L. Ponton, Executive Director, Board of Registered Environmental Health Specialists, and presented by Assemblywoman Sarah Peters, Assembly District No. 24.

Exhibit F is written testimony presented by Loretta L. Ponton, Executive Director, Board of Registered Environmental Health Specialists, regarding Assembly Bill 175.

Exhibit G is a letter dated February 28, 2019, to Chairpersons Spiegel and Spearman, authored and presented by Charlene Albee, Division Director, Air Quality Management, Washoe County Health District, in support of Assembly Bill 175.