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

Eightieth Session
May 13, 2019

The Committee on Health and Human Services was called to order by Chairwoman Lesley E. Cohen at 12:35 p.m. on Monday, May 13, 2019, in Room 3138 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4406 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/80th2019.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Lesley E. Cohen, Chairwoman
Assemblyman Richard Carrillo, Vice Chairman
Assemblyman Alex Assefa
Assemblywoman Bea Duran
Assemblywoman Michelle Gorelow
Assemblyman Gregory T. Hafen II
Assemblywoman Connie Munk
Assemblywoman Rochelle T. Nguyen
Assemblywoman Robin L. Titus

COMMITTEE MEMBERS ABSENT:

Assemblyman John Hambrick (excused)
Assemblywoman Lisa Krasner (excused)

GUEST LEGISLATORS PRESENT:

Senator Yvanna D. Cancela, Senate District No. 10
Senator Dallas Harris, Senate District No. 11
Senator Nicole J. Cannizzaro, Senate District No. 6

STAFF MEMBERS PRESENT:

Marsheilah Lyons, Committee Policy Analyst
Karly O'Krent, Committee Counsel
Terry Horgan, Committee Secretary
Alejandra Medina, Committee Assistant

OTHERS PRESENT:

Barry Gold, Director, Government Relations, AARP Nevada
Bobbette Bond, Senior Director of Health Policy, Unite Here Health
Christi Cabrera, representing Nevada Conservation League
Keith Lee, representing Nevada Association of Health Plans
Rusty McAllister, Executive Secretary-Treasurer, Nevada State AFL-CIO
Rocky Finseth, representing Pharmaceutical Research and Manufacturers of America
Elisa Cafferata, representing Biotechnology Innovation Organization
Jay Parmer, representing Association for Accessible Medicines
John Yacenda, Private Citizen, Las Vegas, Nevada
Carmen F. Jones, M.D., Wildflower Consulting, Las Vegas, Nevada
Will Adler, representing Scientists for Consumer Safety
Riana Durrett, Executive Director, Nevada Dispensary Association
Margot Chappel, Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services

Chairwoman Cohen:
[Roll was taken. Committee rules and protocol were explained.] We are going to start with the work session today, and Marsheilah Lyons will take us through it.

Marsheilah Lyons, Committee Policy Analyst:
Members of the Committee should have before them a copy of the work session document. It is also available to the public on the Nevada Electronic Legislative Information System. The first bill in the work session document is Senate Bill 24 (1st Reprint).

Senate Bill 24 (1st Reprint): Revises provisions governing the Nevada Silver Haired Legislative Forum. (BDR 38-534)

Marsheilah Lyons, Committee Policy Analyst:
[Marsheilah Lyons read from the work session document (Exhibit C).] Senate Bill 24 (1st Reprint) amends provisions relating to the Nevada Silver Haired Legislative Forum's organization structure, membership, terms and duties of office, and ex officio membership of the Nevada delegates to the National Silver Haired Congress. More specifically, the bill:

1. Excludes ex officio members from serving as officers of the Forum;

2. Retains the voting privileges of ex officio members, if they meet certain qualifications;

3. Clarifies the terms and duties of the president and vice president;

4. Eliminates the officer positions of secretary and treasurer and requires the president, with the assistance of the Legislative Counsel Bureau instead of the treasurer, to administer any account in which money received by the Forum is deposited;

5. Creates two new officer positions to serve as facilitators whose duties are to gather information on issues of importance to senior citizens and report on those issues at each meeting of the Forum; and

6. Authorizes the Forum to appoint one or more advisory members, sets forth the duties of advisory members, and defines their term of office, which must not exceed 12 months.

There were no amendments for this measure.

Chairwoman Cohen:
Are there any questions about this measure? [There was no response.] I am looking for a motion to do pass.

> ASSEMBLYWOMAN TITUS MADE A MOTION TO DO PASS SENATE BILL 24 (1ST REPRINT).
>
> ASSEMBLYWOMAN NGUYEN SECONDED THE MOTION.

Are there any comments? [There were none.] We really appreciate the work our Nevada Silver Haired Legislative Forum does for us, the people in our state, and especially for seniors—although the work you do affects us all—so thank you for that.

> THE MOTION PASSED. (ASSEMBLYMEN HAMBRICK AND KRASNER WERE ABSENT FOR THE VOTE.)

I will assign the floor statement to Assemblywoman Munk. We will move on to Senate Bill 134 (1st Reprint).

Senate Bill 134 (1st Reprint): Makes various changes relating to advanced practice registered nurses. (BDR 43-63)

Marsheilah Lyons, Committee Policy Analyst:
[Marsheilah Lyons read from the work session document (Exhibit D).] Senate Bill 134 (1st Reprint) authorizes a qualified advanced practice registered nurse (APRN) to sign, certify, stamp, verify, or endorse certain Department of Motor Vehicle (DMV) documents when a signature, certification, stamp, verification, or endorsement by a physician is required.

The measure also authorizes an APRN to make certain determinations and certifications required to be made by a physician or other provider of health care regarding a power of attorney, a custodial trust, and verification of a person's physical or mental disability for the purpose of making the person with the disability eligible for certain free or reduced rates for certain modes of transportation.

The State Board of Nursing must adopt regulations for the psychiatric training and experience necessary for an APRN to be authorized to evaluate offenders and determine if the offender is an abuser of alcohol and drugs and whether the offender can be treated successfully. Additionally, the DMV must adopt any regulations or make any revisions to its policies and procedures or its forms that are necessary to carry out the amendatory provisions of this bill. There were no amendments for this measure.

Chairwoman Cohen:
Are there any questions about this measure? [There was no response.] I will take a motion to do pass.

> ASSEMBLYWOMAN TITUS MOVED TO DO PASS SENATE BILL 134 (1ST REPRINT).
>
> ASSEMBLYWOMAN GORELOW SECONDED THE MOTION.

Are there any comments? [There were none.]

> THE MOTION PASSED. (ASSEMBLYMEN HAMBRICK AND KRASNER WERE ABSENT FOR THE VOTE.)

I will ask Assemblywoman Titus to take the floor statement. We will move on to Senate Bill 179 (1st Reprint).

Senate Bill 179 (1st Reprint): Revises provisions relating to abortions. (BDR 40-567)

Marsheilah Lyons, Committee Policy Analyst:
[Marsheilah Lyons read from the work session document (Exhibit E).] Senate Bill 179 (1st Reprint) makes various changes related to abortions. Specifically, it:

1. Revises the requirements for informed consent for abortion;

2. Removes the requirement that a physician certify a pregnant woman's marital status and age before performing an abortion;

3. Removes the requirement that a physician certify in writing that a woman gave her informed written consent;

4. Provides informed consent shall be deemed to have been given when the form indicating consent has been signed and dated by certain persons; and

5. Requires a physician or other qualified person to explain certain information, through an interpreter if necessary; offer to answer questions; and provide a copy of the consent form.

There were no amendments for this measure, although we did have a request to add Assemblyman Carrillo as a sponsor.

Chairwoman Cohen:
Are there any questions on the bill?

Assemblywoman Titus:
I want to acknowledge the hearing on the bill and how well it was run. I appreciate your running an excellent hearing. I am going to vote "no" on S.B. 179 (R1). I have significant concerns about not mandating that the age of the person seeking the abortion be requested. We could not get a definition of what a "woman" was, and since I see children as young as 10, 11, and 12 years of age starting menarche, that causes me great concern.

Assemblyman Hafen:
I would like to echo my colleague's comments and add that I think it is a big mistake to eliminate the explanation of the mental health implications of abortion. I would like to make a motion to indefinitely postpone.

Assemblywoman Titus:
Second.

Chairwoman Cohen:
I am not going to accept that motion. I am looking for a motion to amend and do pass.

> ASSEMBLYWOMAN NGUYEN MADE A MOTION TO AMEND AND DO PASS SENATE BILL 179 (1ST REPRINT).
>
> ASSEMBLYMAN CARRILLO SECONDED THE MOTION.

Are there further comments? [There was no response.]

THE MOTION PASSED. (ASSEMBLYMEN HAFEN AND TITUS VOTED NO. ASSEMBLYMEN HAMBRICK AND KRASNER WERE ABSENT FOR THE VOTE.)

Assemblyman Carrillo will take the floor statement. Next is Senate Bill 456 (1st Reprint).

Senate Bill 456 (1st Reprint): Revises provisions relating to staff privileges for advanced practice registered nurses at hospitals. (BDR 40-786)

Marsheilah Lyons, Committee Policy Analyst:
[Marsheilah Lyons read from the work session document (Exhibit F).] Senate Bill 456 (1st Reprint) authorizes a hospital to grant admission to membership on its medical staff to advanced practice registered nurses (APRNs) to perform any authorized act within their scope of practice. The bill prohibits hospitals from automatically admitting or denying an APRN membership on the medical staff solely because he or she is an APRN. There were no amendments for this measure.

Chairwoman Cohen:
I am looking for a motion to do pass.

ASSEMBLYWOMAN TITUS MOVED TO DO PASS SENATE BILL 456 (1ST REPRINT).

ASSEMBLYWOMAN NGUYEN SECONDED THE MOTION.

Are there any questions or comments? [There was no reply.]

THE MOTION PASSED. (ASSEMBLYMEN HAMBRICK AND KRASNER WERE ABSENT FOR THE VOTE.)

Assemblywoman Duran will take the floor statement. The final measure in the work session document is Senate Bill 457 (1st Reprint).

Senate Bill 457 (1st Reprint): Revises provisions relating to health care facilities. (BDR 40-1143)

Marsheilah Lyons, Committee Policy Analyst:
[Marsheilah Lyons read from the work session document (Exhibit G).] Senate Bill 457 (1st Reprint) revises the definition of "sentinel event" to include any death at a medical facility, facility for the dependent, or home operated by a provider of community-based living arrangement services. Such facilities must report to the Division of Public and Behavioral Health of the Department of Health and Human Services the date, time, and a brief description of each sentinel event, including each death that occurs at the facility. The bill also broadens the applicability of existing law regarding reporting and investigating sentinel events to apply to these facilities and homes. The bill provides that a health facility

is not required to investigate a death confirmed to have resulted from natural causes, and certain facilities that care for elderly or terminally ill persons are not required to investigate a death that appears to have resulted from natural causes. In addition, the bill requires the Division to compile and post on an Internet website it maintains information concerning the licensing status and quality of certain facilities and programs for the treatment of alcohol or drugs.

A conceptual amendment was proposed by Senator Julia Ratti:

1. Add the provisions of Senate Bill 288 to Chapter 458 of *Nevada Revised Statutes* (NRS). These provisions prohibit certain entities that provide treatment for the abuse of alcohol or drugs or a person that provides advertising or marketing for such an entity from:

   (a) Providing false or misleading information about the products, goods, services, or locations of the entity in marketing or advertising materials or on the Internet.

   (b) Including on the Internet website of the entity false information, an electronic link to false information, or an electronic link that surreptitiously directs the reader to another Internet website.

   (c) Soliciting or receiving a commission, benefit, bonus, rebate, kickback, or bribe, or engaging in a split-fee arrangement in return for a referral or an acceptance or acknowledgement of treatment from the entity.

   (d) Entering into a contract with a provider of marketing services that agrees to generate referrals or leads for the placement of patients with the entity over the phone or the Internet, unless the entity discloses the arrangement to the patient and provides the patient with instructions for accessing a list of entities that provide treatment for alcohol and drug abuse that is maintained by the Division of Public and Behavioral Health within the Department of Health and Human Services.

2. Make it a misdemeanor to engage in activity prohibited by item 1. Additionally, amend NRS 449.160 to allow the Division to take disciplinary action against a licensed facility, including a residential alcohol and drug treatment program, a halfway house for recovering alcohol and drug abusers, a facility for modified medical detoxification, a psychiatric hospital or a mobile unit, that engages in an activity prohibited by item 1.

3. Exempt from paragraph (d) of item 1 a state agency or entity that receives financial support from the State which refers a person to drug and alcohol treatment that is operated by or receives financial support from the State.

A mock-up of the proposed amendment is attached [pages 3-21, (Exhibit G)].

Chairwoman Cohen:
Does anyone have any questions now that we have the mock-up? [There was no reply.] I am looking for a motion to amend and do pass.

> ASSEMBLYMAN HAFEN MOVED TO AMEND AND DO PASS SENATE BILL 457 (1ST REPRINT).
>
> ASSEMBLYWOMAN MUNK SECONDED THE MOTION.

Are there any comments? [There was no reply.]

> THE MOTION PASSED. (ASSEMBLYMEN HAMBRICK AND KRASNER WERE ABSENT FOR THE VOTE.)

I will ask Assemblywoman Nguyen to take the floor statement. I will open the hearing on Senate Bill 262.

Senate Bill 262: Makes various changes to provide for tracking and reporting of information concerning the pricing of prescription drugs for treating asthma. (BDR 40-55)

Senator Yvanna D. Cancela, Senate District No. 10:
Senate Bill 262 builds on Senate Bill 265 of the 79th Session and Senate Bill 539 of the 79th Session, which created transparency on diabetes drugs. Before there was a critical consciousness around just how awful it is to deal with having lifesaving medication be priced out of your hands, Nevada was leading the way in talking about diabetes drugs—and particularly insulin costs.

After S.B. 539 of the 79th Session was enacted, the state put out a report that gave some critical data on why diabetes drugs are so expensive. The report also put forward solutions for how that could be addressed. It meant a lot to patients, it meant a lot to practitioners in the field, and it has created a data set that is not industry-driven, but is neutral government data, that we can use as policy makers. Senate Bill 262 does the same thing, but for asthma drugs.

Today, about 1 in 10 Nevadans have asthma—a chronic lung disease. It inflames and narrows the airways that carry oxygen to and from the lungs. It can cause shortness of breath, coughing, wheezing, and tightness in the chest. The condition can affect quality of life, productivity at work and school, and health care. It can even become life-shortening without proper treatment.

In 2015, the annual per-person cost of managing asthma was about $3,266, of which 0.560356 percent—or $1,830—was the cost of prescription drugs. According to a 2013 study, the economic burden of asthma in the United States, including medical care, absenteeism, and mortality was about $82 billion per year.

I decided to look at asthma because the numbers in Nevada are higher than the national average. Nationally, about 8 percent of all adults have asthma; in Nevada, it is about 10.4 percent. About 8.1 percent of children have asthma nationally; it is about 11.5 percent in Nevada. The No. 1 reason students in Nevada miss school is because of asthma attacks.

Senate Bill 262 does the same for essential asthma drugs that prior legislation did for diabetes drugs. The first thing that happens is that the Department of Health and Human Services (DHHS) creates a list of essential asthma medications. The language in the bill is open, so DHHS can look across the spectrum from generics to brand-name drugs to ensure we are looking at the highest-used, highest-cost drugs, and DHHS will develop that list. That list of manufacturers and the pharmacy benefit managers (PBMs) that work with those drugs will then disclose information to the state as manufacturers and PBMs have done for diabetes drugs.

The information from manufacturers includes the cost of producing the drug, the administrative expenditures relating to the drug, the profit they have earned from the drug, the percentage of their profit that is attributable to the drug, the total amount of financial assistance provided through patient prescription assistance programs, the cost associated with coupons, the wholesale acquisition cost of the drug, a history of any increase in the wholesale acquisition cost of the drug over the last five years, the aggregate amount of rebates manufacturers have provided to PBMs, and any additional information prescribed by DHHS.

The manufacturers of prescription drugs on DHHS's list of drugs that have been subject to a significant price increase within the immediately preceding two calendar years must also submit an annual report describing the reasons for the increase in the wholesale acquisition cost of the drug. These reports include a list of each factor that contributed to the increase, the percentage of the total increase that is attributable to each factor, an explanation of the role of each factor in the increase, and any other information prescribed by DHHS by regulation.

Finally, S.B. 262 asks PBMs to also submit an annual report. That information will include the total amount of rebates the PBM negotiated with manufacturers during the immediately preceding calendar year, the total amount of all such rebates that were retained by the PBM, and the total amount of all such rebates negotiated for the purchase of such drugs for use by individuals with a variety of types of insurance. The DHHS will take this information and put together an aggregate report for the state that will be housed on DHHS's website for public and legislative access.

With more transparency we are able to make better decisions. There are few things more important that we do here than address the high cost of health care for Nevadans. This bill aims to give us more tools to be able to do that.

Chairwoman Cohen:
Can you talk about what has happened with the diabetes drugs? Have penalties been levied against companies? What information have we received, and how have the last couple of years played out?

Senator Cancela:
The bill passed in 2017. Shortly after, there was a lawsuit, but the lawsuit ended up being dropped. There was a lot of discussion in the regulations about how the information would be collected. At the same time, conversation began about the high cost of diabetes drugs—and insulin in particular—at the national level. Nevada's work was cited across the country as a reason for other states to propose transparency legislation.

Once Nevada started collecting data, there were some challenges in making sure everyone reported, but I do not believe DHHS ever levied any fines on either a PBM or on a manufacturer for not reporting. The full report came out earlier this year. The report gave all sorts of different data points on how many companies there are, why companies increased the costs of their drugs, and what has happened in diabetes care. That report has been used by policy makers at the national and state levels as an explanation for why transparency is necessary and why there should be action taken on the costs of diabetes drugs.

Most recently, Nevada Congressman Steve Horsford [Nevada District 4] used the legislation we passed in 2017 as the model for federal legislation he is championing in Washington, D.C. [U.S. House of Representatives 2069]. I think this has had pretty profound ripple effects on policy making, and at the same time there have been changes in industry practices. Insulin manufacturers have offered some of their products at discounted rates to people who are uninsured. There have been changes in pricing, and Congress has held a couple of panels with drug company chief executive officers to talk about the high cost of prescription drugs.

Assemblywoman Titus:
You mentioned that you chose asthma and gave us some statistics concerning the percent of folks with asthma in the United States. You said that was your reason for choosing asthma medications. Do you have any facts or figures about other disease processes? I am curious about your singling out this medicine and where it might lead to as there are a lot more people who have hypertension and cardiac disease—especially in the state of Nevada. You are addressing what manufacturers are charging for asthma medication, when those have been out a long time and there are tons of generic asthma medications. I have seen my own patients having trouble getting the newest ones on the market, but not any trouble getting the ones that have been out for a long time. I am curious whether you have any information about any other disease and where you think this is going to stop.

Senator Cancela:
I agree that there are tons of chronic conditions that require long-term care and have high drug costs associated with them. I looked at asthma because it is a chronic condition that has a disproportionate effect on children, and because of the way a patient is out of control in

controlling its symptoms because so much relates to air quality. When you look at air quality in Nevada, we do not have the best air quality. Some of that is our own creation and some of that is a result of dealing with wildfire pollution and other naturally occurring things.

To me, asthma was important to look at because it is a chronic condition that disproportionately affects children, where we have seen increasing costs, particularly in innovation around inhalers. For example, the average price of an inhaler went up about 35 percent from 2013 to 2018. That increase was higher than for other drugs for different disease states. Because it has an effect on our state in a way that we cannot necessarily control, it is important information for us to have. I am sure we could spend time looking at all sorts of other disease states, but I thought this was an important next step.

Assemblywoman Titus:
Did you reach out to the Medicaid office and ask them about the rebates they are getting from the manufacturers already and the supply of Medicaid formularies prior to choosing asthma?

Senator Cancela:
I did. Asthma is the third-highest driver of Medicaid costs. Medicaid is different from the private sector because it has to cover every drug, as long as a manufacturer is part of the federal rebate program, it has to be covered by Medicaid. That also means that Medicaid drugs come at no cost to Medicaid participants and oftentimes come heavily subsidized to the state. I did look at whether asthma was a significant expense to Medicaid and it is just based on the disease state treatment.

Chairwoman Cohen:
You spoke about fires and you talked about our air quality. Is there any other indication of why our numbers for asthma are so high in the state?

Senator Cancela:
I am sure there is a thorough analysis. Those are the most common reasons that came up in the search I did.

Chairwoman Cohen:
Are there any other questions?

Assemblyman Hafen:
I see this as being more a national thing, but I understand what you are trying to do. My understanding is the cash price of these drugs, not necessarily insurance copays, is about $30 to $40. With rebates and insurance, is this really something people are being priced out of? Are there any statistics showing how many individuals are struggling to afford their asthma medication?

Senator Cancela:
The bill's intention is to force transparency across the drug pricing chain, so we are looking at both the pharmacy and the pharmacy benefit manager's sides with the intention of having accurate data on what is happening in prescription drugs used to manage the disease state. It is difficult to have a full data set because there are so many different situations a person may fall into—uninsured, on Medicaid, on employer-based insurance, on a state-based exchange plan—there are all sorts of different situations that may distinguish how a person pays for their medication. Someone who is paying out of pocket will have a very different situation than someone covered by an insurance plan.

My research has shown that over the last five years, the costs for some of the most widely used asthma medications have increased pretty significantly. For one drug, the cost increased about 56 percent, from $316 in 2013 to $496 in 2018. Even taking into consideration the different situations people may be in and how they pay for that drug seems very problematic considering that asthma is a chronic condition where medication is required to manage the disease state.

There are lots of ways to look at this problem, and you will get data from different entities involved in the drug-pricing chain that will tell you different things. That is why I think it is most important to have data from a neutral third party that, as policy makers, we would access to figure out solutions that make sense for our state.

Assemblyman Hafen:
I, too, was able to find numbers showing the 56 percent increase—which amounted to a cost of $41 per month. That is the cash price with no discount, copay, or Medicaid. Do we have any data showing how many people are not able to acquire their asthma medication because of affordability?

Senator Cancela:
I do not have overarching data that show that a certain percentage of people are not able to afford their medication. I have heard from patients who have been priced out of affording their medications, patients who have had to make decisions about which bill to pay or which medication to access that month. Because of the different situations any patient has when accessing prescription drugs, it is hard to have one quantifiable number as to how many people are being priced out just based on affordability.

Chairwoman Cohen:
I will call up anyone in support in Las Vegas or Carson City.

Barry Gold, Director, Government Relations, AARP Nevada:
AARP has a nationwide prescription drug campaign called "Stop Rx Greed." We call it that because there is a problem with the skyrocketing increasing prices of prescription drugs. No one should have to choose between food and lifesaving medicine. We need to do something about lowering the cost, and AARP across the country is making great gains in state legislatures, which is where a lot of this work gets done. AARP would like to thank

Senator Cancela for her groundbreaking legislation last session, which, as she mentioned, is leading to legislation across the country. I get calls from advocates in other state legislatures asking how I was able to get it passed. That was a great thing to have happened. We need to keep doing this at a state level because sometimes it is a little slower doing things at the national level.

In regard to Assemblyman Hafen's question, we hear about people who do not fill their prescriptions, people who take their prescriptions every other day, or people who cut their pills in half. Unfortunately, a lot of the people who are forced to do that do not step forward and tell us they cut their pills in half because they cannot afford to take them every day, but it is happening. We anecdotally hear about it, and we need to do something about it. Legislation like this will go a long way toward helping us understand what the driving costs of prescription drugs are and how we can lower them. AARP, on behalf of our 348,000 members across the state, strongly urges this Committee and this Legislature to pass this bill to help control the cost of prescription drugs.

Assemblyman Hafen:
Mr. Gold, you stated that members of AARP are telling you they are not able to afford their medication and are having to cut their pills in half. We are here today talking about asthma inhalers. Are they calling you specifically because of asthma medication, or are you talking about people not being able to afford their medications in general?

Barry Gold:
All over the country we are getting a wide variety of different things, so I am speaking more in general. I think if you have an asthma inhaler, instead of taking two puffs, you might just take one puff. There are different kinds of asthma inhalers. There are the emergency relief inhalers you use when you are having an asthma attack. That is something that is necessary. Then there are the maintenance inhalers you take every day. Those are the ones some people, feeling well that day, may decide to skip taking. While I do not have data, some of those inhalers can be used in different ways, and I am sure there are people doing it both ways.

Chairwoman Cohen:
We have all heard from constituents about the cost of drugs, skipping days, and cutting pills in half, so it is not unheard of.

Assemblywoman Titus:
I would like to ask our legal counsel a question. In my practice, especially among seniors, I see more cases of chronic obstructive pulmonary disease (COPD) than I do cases of asthma. What is the definition of asthma versus COPD? Would we be just looking at asthma drugs? There is a difference between asthma drugs and COPD drugs, and I am not sure people understand what drugs we are looking at with this bill. Again, adult-onset asthma is different from COPD.

Karly O'Krent, Committee Counsel:
The term "asthma" is not defined in the bill, and that is something this Committee could certainly do. It is not defined here or elsewhere in the *Nevada Revised Statutes*, so it would be given its plain meaning.

Bobbette Bond, Senior Director of Health Policy, Unite Here Health:
I am the policy director for Unite Here Health, nationally. In Nevada, that is the Culinary Health Fund, and we represent 126,000 lives. There are a lot of children in our health plan and so we are speaking in support of the bill. We were very involved in supporting the diabetes bill last session. For all the reasons you heard explained by Senator Cancela, the ability to create a strong transparency base is the only way we are going to get to answer some of the questions being asked here. We do not know exactly who cannot afford their drugs. We only have episodic data, and we are not sure where the price barriers are. The range of drugs for asthma can be from $10 to $400 a month, depending upon what is prescribed. Understanding prescribing patterns is part of what we are trying to accomplish. As a new, shinier drug comes on the market, there is a lot of effort made to move patients from one drug to another and move that patient up the price cycle. Once we can see this data, we can start tracking who is buying what and when, when new drugs are being introduced, and what is happening in the physicians' offices to push certain drugs. We will have more stories to tell about what is really happening.

I do not think there was a way to create a bill that would cover every drug in the state of Nevada. I agree it would be great to have a federal solution, but all these bills are arising because states are stepping up when the federal government is not. I am grateful that the state is doing it, and I am grateful that we are making some progress. A really good question was asked by Assemblywoman Titus about where it will stop. I do not think it will stop until we get prices lowered. The basic problem is that pharmaceutical drugs cost too much. Until we have ways to limit that, we are going to be back with more.

Chairwoman Cohen:
How many members are on your health fund?

Bobbette Bond:
It fluctuates some, but it is about 126,000.

Chairwoman Cohen:
And that includes their families?

Bobbette Bond:
Yes.

Chairwoman Cohen:
I have said this before to you and to other people. In my day job, I practice in the field of family law, and long before I ever was in the Legislature, long before I ever thought about insurance prices or anything like that, when I would get paperwork from my clients and it

would say that one of the parties was a member of the Culinary Health Fund, I relaxed. I knew we were not going to be fighting over the children's insurance costs and who was going to carry the insurance. We knew this was the better plan, this was the least expensive plan, and this was a thorough plan that was going to cover them. What is the rise in health care prices and insurance prices on prescriptions? How has that affected the plan over the last few years?

Bobbette Bond:
Thank you for the question and thank you for the news. It is always good to hear that the Culinary Health Plan is doing a good job. We are vigilant about health care costs; we are vigilant about issues like this because we have to work so hard to make sure our patients, who are often in low-income occupations, have a chance to keep their health insurance for them and their families.

Asthma ended up being the third-most expensive drug category in our plan, and I think I can verify that. That is why we are so supportive of it being on the legislative radar. That is because so many people in Nevada are using asthma-related drugs of one kind or another. We were happy to see this spectrum addressed. Prescription drugs are the second-most expensive class category for the Culinary Health Fund at this point. They used to be third. They used to be less expensive than physician visits; now they are more expensive. They are now second only to hospital stays. I think our drug costs went up 12 percent last year, which is much higher than the cost of the medical consumer price index.

Christi Cabrera, representing Nevada Conservation League:
We are here in support of S.B. 262. As an environmental organization, the connection between pollution and public health is front and center in our work. Today, throughout Nevada, people with lung disease like asthma are at greater risk from air pollution, as are children, older adults, and people with heart diseases. In no uncertain terms, regardless of category, air pollution impacts low-income communities and communities of color hardest. There are many types of pollutants in our air, but when it comes to two types—ozone and particulate pollution—the American Lung Association gave our two most populous counties poor grades in their State of the Air 2019 report. Clark and Washoe Counties both received Fs for ozone pollution, and Clark County also received an F for particulate pollution. Far too many Nevadans are facing added risk from asthma and pollution. With this risk comes additional financial hardships, not only in missed days of work and school, but also in the costs associated with purchasing drugs and treatments needed to manage these diseases. Any additional opportunity to help asthma patients reduce their financial burdens is a welcome one. We would like to thank Senator Cancela for bringing this bill forward, and we urge the Committee's support.

Keith Lee, representing Nevada Association of Health Plans:
The Nevada Association of Health Plans includes the large commercial carriers that write health insurance in the state under the various iterations of NRS Chapter 689 and NRS Chapter 695. We insure approximately 20 percent of all Nevadans; the others are insured either by self-funded organizations or Medicare or Medicaid. We are here to support

this bill. We supported and worked with Senator Cancela on last session's bill on diabetes. We think this is a step in the right direction. As Bobbette Bond said, prescription drugs seem to be more costly every year to the health plans and to our insureds.

Rusty McAllister, Executive Secretary-Treasurer, Nevada State AFL-CIO:
The Nevada State AFL-CIO is an organization that has a large number of either Employee Retirement Income Security Act of 1974 (ERISA) plans or self-insured plans. Especially for self-insured plans, the shareholders are the members. It is a nonprofit. Any time costs are increased on those plans, there are only certain ways to pay for them—reduce benefits, raise premiums, or raise copays. It is that simple. Either way, it is either a decrease in benefits or a pay cut, so anything we can do to provide more transparency and limit increases in the price of medications so many people use is a good thing. We are in support of this.

Chairwoman Cohen:
Can you give us a brief summary of what an ERISA plan is?

Rusty McAllister:
I may not be the best person to do that. It is a private organization—as an example, the Culinary Health Fund, the International Brotherhood of Electrical Workers, and the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry are all examples of ERISA plans. They are nonprofits and only exist to provide benefits to their members.

Chairwoman Cohen:
Is there anyone else in support in Carson City or Las Vegas? [There was no response.] Then we will move to opposition.

Rocky Finseth, representing Pharmaceutical Research and Manufacturers of America:
I believe you have the Pharmaceutical Research and Manufacturers of America's (PhRMA's) statement on the Nevada Electronic Legislative Information System (Exhibit H). The PhRMA is opposed to S.B. 262, primarily because of the legal issues and concerns raised in the statement. We offered proposed suggestions to the bill's sponsor about how to alleviate those concerns; unfortunately, those were rejected by the bill's sponsor.

Chairwoman Cohen:
Are the legal concerns the same as those addressed in the last lawsuit, or something different?

Rocky Finseth:
The concerns relate to the rulemaking that took place with the Department as part of the settlement between PhRMA and DHHS. In our view, those proprietary protections only applied to the provisions of S.B. 539 of the 79th Session. We do not believe they stretch over to this particular bill; therefore, we were asking for those protections to also be afforded to this particular bill.

Elisa Cafferata, representing Biotechnology Innovation Organization:
The Biotechnology Innovation Organization represents drug manufacturers who have a biotechnical process. We also have our statement on the record [April 3, 2019 meeting of the Senate Committee on Health and Human Services] in opposition to S.B. 262. We do think there are a lot of things—as described in the testimony today—that go into the price of a drug, and that they are not all captured in this particular approach. We would like to recommend sending this bill, and several other bills dealing with the costs of health care, to the Patient Protection Commission where they can be fully vetted, and all aspects that go into the price of a drug will be considered and addressed. Short of that, we do support the amendment that was introduced in the Senate.

Jay Parmer, representing Association for Accessible Medicines:
The Association for Accessible Medicines is the national trade association for the generics and biologics industry. We are here largely because we are concerned about some aspects of the inclusion of generic drugs in the list of drugs that gets studied and reported on with the legislation we saw in S.B. 539 of the 79th Session. It is typical that branded pharmaceuticals and generic pharmaceuticals get painted in public forums with the same brush. It is equally important to understand that in 2017, generic drugs created an overall cost savings of more than $2 billion in Nevada. Generic drug costs were 29-times less than branded drugs per patient. Generic drugs saved the Nevada Medicaid Program $370 million in 2017. While 82 percent of all drugs prescribed to Medicaid patients were generics, generic drugs only amounted to 16 percent of total drug spending by the Nevada Medicaid Program. In 2017, generics saved Medicare Part D $551 million in Nevada, or $1,558 per patient. In 2017, total generic drug sales were $1.59 billion less than branded drug sales. Generic drug prices have also decreased by 6 percent year after year.

After reviewing the reporting required under S.B. 539 of the 79th Session, which looks at essential diabetes drugs, it appears that the inclusion of generic drugs actually skews the reported average cost of diabetes drugs to a lower average cost than if the study only focused on the highest-cost drugs in this category. We are concerned that a similar outcome will manifest itself if generic drugs are included in the requirements of S.B. 262 which requires reporting on costs of asthma drugs.

To avoid this scenario playing out, we have suggested considering a dollar threshold for inclusion of drugs on the required reporting list. There are about four or five states that have looked at various thresholds, starting with a $100 wholesale acquisition cost of a drug over a 30-day period, and then various percentage increases that are reported over various lengths of time. We believe this would help focus the required reporting on the highest-cost drugs in this category, and, as a result, the information generated by the report required by S.B. 262 would provide a clearer picture of the actual drivers of high drug prices.

Chairwoman Cohen:
Are there any questions? [There was no reply.] Is there anyone else in opposition? [There was no reply.] Is there anyone neutral in Las Vegas or Carson City?

John Yacenda, Private Citizen, Las Vegas, Nevada:
I am Forum President, Nevada Silver Haired Legislative Forum, and I represent Forum Senatorial District 16. I am truly neutral on this subject. From the prospective of neutrality, there was so much information presented by both sides. From my perspective just sitting here listening, there were many questions and a lot of confusion. I listened with interest, because I have a grandson and a daughter with asthma. What I heard that troubled me was that there was tremendous confusion over a bill that could ask a bunch of great questions and come up with a lot of information, but you do not know what you are asking for. What I heard was proponents asking for something they wanted and others opposing things they did not want, but I heard no one agreeing about what they did or did not want. You were asking about a point no one made. You were questioning a question no one asked; a statement no one made. That was not productive, and that is my neutral observation.

Chairwoman Cohen:
Seeing no one else in neutral, Senator Cancela, do you want to make any closing statements?

Senator Cancela:
I will briefly address some of the different proposals that were brought forward by those in opposition. The amendment brought forward in the Senate relating to trade secret language was discussed in the regulations. I looked into the language. I believe putting this language in statute will have unintended consequences that could really prevent us from getting the data that we are seeking with this bill. I trust that will be handled in regulations, and I do not want to tie the hands of regulators as they prepare to embark on the same journey they did following the 2017 legislation, which is why I rejected that amendment.

I am confident that the Patient Protection Commission will be a place for robust conversations concerning patient protections and lowering the cost of health care overall. I am just as confident that the Department can continue to do the work with asthma medication that they have done with essential diabetes drugs. There is no reason to move the work into the Patient Protection Commission, particularly when it is a new body and we have an experienced body that has already done this kind of work.

On the question of generics, as I stated in my testimony, the intention of the bill is to allow DHHS to compile the essential asthma medication list based on highest use and highest cost. If it is the case that within that highest-use/highest-cost bracket there are generic medications, we should be looking at those costs. If there are no generics within that category, then they will not be included in the report. I certainly appreciate that generics offer a lower-cost alternative, but if they are driving up the cost of asthma medications, they should be included in the report.

This is a bill that builds on work we have already done and that we have seen has had really good effects for patients, and I am hopeful that getting this legislation done will allow us to do the same for asthma patients in the state.

[(Exhibit I) was submitted but not discussed and is included as an exhibit for this meeting.]

Chairwoman Cohen:
With that, I will close the hearing on S.B. 262. I will open the hearing on Senate Bill 270 (1st Reprint).

Senate Bill 270 (1st Reprint): Requires the Department of Health and Human Services to establish and administer the Nevada Housing Crisis Response System. (BDR 38-792)

Senator Dallas Harris, Senate District No. 11:
According to the United States Department of Housing and Urban Development [as reported by Continuums of Care], on any given day more than 7,000 Nevadans are homeless. This includes approximately 170 families, 725 veterans, 1,400 unaccompanied young adults between the ages of 18 and 24, and 650 chronically homeless individuals. Clearly, homelessness affects a diverse group of people—families, individuals, couples, children, and seniors. In fact, during the 2016-2017 school year, an estimated 20,700 public school students in Nevada experienced homelessness. Nearly 500 of these children were unsheltered; 2,300 spent time in shelters; 2,800 lived in hotels and motels; and 15,150 were in doubled-up living arrangements.

Homelessness is closely associated with Nevada's current housing crisis, and we know it comes at a high cost to the individuals and families who experience it, their communities, and the state as a whole. Research shows that communities save money when people have supportive housing, largely because homeless individuals are more likely to experience chronic medical conditions as a result of housing instability. Having access to safe, quality, and affordable housing can improve both physical and mental health as well as numerous other factors. While various state agencies, local governments, and nonprofit organizations have taken steps to address homelessness in Nevada, more can be done.

Senate Bill 270 (1st Reprint) aims to better assist individuals experiencing a housing crisis, those who are transient, at imminent risk of homelessness, or homeless by improving collaboration and coordination among the many state, local, and nonprofit agencies that are already working to address this problem. The bill requires the Department of Health and Human Services (DHHS) to establish and administer the Nevada Housing Crisis Response System.

The idea is to create a centralized system at the state level that can better coordinate existing efforts to prevent and reduce homelessness, and, through coordination and collaboration, truly move the needle on helping people who experience housing crises across the state. The Nevada Housing Crisis Response System is required to coordinate with social service agencies, local governments, and nonprofit organizations to identify, assess, refer, and connect people in crisis to housing, assistance, and services. These may include emergency services, emergency shelters, interim housing, and/or permanent housing.

The bill defines "person in crisis" as "a person who is transient, at imminent risk of homelessness or homeless." The bill requires the Nevada Housing Crisis Response System to operate a system to assist such individuals 24 hours per day, 7 days per week. In addition, the Response System must develop prevention assistance programs to prevent homelessness and help people who need assistance preserving their current housing, identifying alternative housing arrangements, or finding immediate housing arrangements for those whose current housing situation is not safe. The System is further authorized to perform any actions that assist people experiencing a housing crisis and help prevent or address homelessness in Nevada.

The bill clarifies that DHHS may adopt necessary regulations to carry out the provisions of the bill which may require certain community agencies that accept funds from the Department to participate in the Housing Crisis Response System. Finally, the bill authorizes the Director of DHHS to solicit, accept, and expend any gifts, grants, contributions, or other money to carry out the provisions of the bill. Any money received for these purposes must be accounted for separately in the State General Fund and does not revert to the State General Fund at the end of the fiscal year.

Madam Chairwoman, preventing and addressing homelessness requires leadership, collaboration, and coordination among state, local, and nonprofit agencies. It requires stronger outreach and engagement activities, working together, and exploring partnership opportunities. By creating a centralized Nevada Housing Crisis Response System, S.B. 270 (R1) will empower the state and its communities to maximize the effectiveness of existing programs and enhance our response to people in housing crises.

Chairwoman Cohen:
Are there any questions? [There was no response.] In general, can you address mental health issues? We know homelessness and mental health issues often go hand in hand.

Senator Harris:
You are exactly correct. In my hopes and dreams, part of the Response System will offer wraparound services so you will be able to direct people to any service they might need. Maybe the first step would be to get them into some transitional housing, but the idea is that it would provide all those wraparound services we know are associated with homelessness, and ideally, at the end of the day, bring down the costs associated with mental illness.

Chairwoman Cohen:
Can you go further into an explanation about public money? Do we know if there are any grants available? Is there something we have our eyes on, or do we just know that they exist?

Senator Harris:
I have not had an opportunity to identify any specific grants that would be applicable to this. There is a bill this session that is tweaking Medicaid a little bit so that we can try to use some of those dollars for these types of services. I know those two things will be able to work

hand in hand. I have been working with DHHS on this bill, and they are aware that it is coming. I had to add language to the bill stating, "To the extent money is available . . ." at their request, so we know this will be an ongoing search for funding sources.

Chairwoman Cohen:
Are there other questions?

Assemblywoman Titus:
I know we are not a money committee; however, the subject was brought up. Believe me, the concept of this bill is genuine, and I support those concerns. A lot of folks who are homeless have significant health and mental health issues, and supplying them with wraparound services is important. I see that there was a large fiscal note on the bill before it was amended in the Senate, but the bill did not go to the Senate Committee on Finance. It passed from the Senate and came over to the Assembly. Was that because Medicaid had you add the "money is available" language?

Senator Harris:
I believe you are partially correct. The fact that we added the language, "To the extent that money is available," and then allowed there to be a private funding source to be sought, is what was able to remove that fiscal note. Fortunately, DHHS is doing a lot of this already. As to coordination and bringing it together, we are hoping we can make do with what we have.

Chairwoman Cohen:
For the sake of clarity, when you talk about an amendment, that was an amendment added in the Senate and now is included in the first reprint of the bill. Are there any other proposed amendments?

Senator Harris:
That is correct.

Chairwoman Cohen:
Seeing no other questions, I will invite anyone who wishes to testify in support in Las Vegas or Carson City to come forward. [There was no response.] Seeing no one in support, is there anyone in opposition in Las Vegas or Carson City? [There was no response.] Is there anyone neutral? [There was no response.] Senator Harris, I will invite you to make closing remarks.

Senator Harris:
In closing, I think this is one small thing we can do that will make a really big difference, but it does not solve the whole problem. Ideally, I would like to give it $1 billion and get everyone off the street, but this is a really good start and will pay dividends if we invest in it.

Chairwoman Cohen:
I will close the hearing on S.B. 270 (R1) and we will take a recess [at 1:39 p.m.] until Senator Cannizzaro is here to present the next bill.

We will come back to order [at 1:43 p.m.], and I will invite Senator Cannizzaro up to present Senate Bill 430 (1st Reprint).

Senate Bill 430 (1st Reprint): Expanding the definition of "chronic or debilitating medical condition" for certain purposes related to the medical use of marijuana. (BDR 40-1152)

Senator Nicole J. Cannizzaro, Senate District No. 6:
With me is a constituent from Las Vegas, Dr. Carmen Jones. I will walk briefly through the bill, and then turn the presentation over to Dr. Jones who can better illustrate why this piece of legislation is necessary.

Senate Bill 430 (1st Reprint) adds an additional list of ["chronic or debilitating medical condition"] syndromes to the list for which medical marijuana may be requested by a physician. Dr. Carmen Jones works primarily in the area of medical marijuana and sees medical marijuana patients on a regular basis. What S.B. 430 (R1) does is add a number of items to the list under *Nevada Revised Statutes* (NRS) 453A.050—notably, it adds language to include an anxiety disorder, an autism spectrum disorder, and an autoimmune disease. It includes dependence upon or addiction to opioids; it replaces the single word "cachexia" with the phrase "anorexia or cachexia"; it changes the language of "persistent muscle spasms" to simply "muscle spasms"; it changes the definition of "severe nausea" to just "nausea"; and adds chronic pain as a condition for which medical marijuana may be suggested. It also includes language to include an acquired immune deficiency syndrome or human immunodeficiency virus and a neuropathic condition, whether or not that condition causes seizures.

This bill seeks to ensure that those patients who could benefit from the effects of medical marijuana will have access to it in the way in which we allow access for all of the other conditions currently listed in NRS 453A.050. Now, with your permission, I will turn it over to Dr. Jones. She can talk a little bit more about the specifics, why these inclusions are necessary, and also what she sees in her practice.

Carmen F. Jones, M.D., Wildflower Consulting, Las Vegas, Nevada:
Thank you, Senator Cannizzaro, for sponsoring the bill. I have been seeing patients for medical marijuana recommendations since 2012. At some point during this time, I was told I was seeing more patients for this than almost any other physician in the state. The items mentioned in the bill are included in hopes of expanding the qualifications for people to enter the medical marijuana program. It is my understanding that at one point we were up to nearly 25,000 patients in that program. Now, after adult use was introduced, that number has dropped to 17,000. This is significantly lower than other states—for instance, Colorado has

well over 100,000. Naturally, we want people who have conditions for which they can qualify to be able to access the program safely and without consequences. Many of these conditions listed are some I have seen over the last seven years.

Chairwoman Cohen:
From a medical perspective, can you let us know why these conditions should be included on the list? What is it about these illnesses?

Carmen Jones:
The items were mostly to clarify. Many people are already using cannabis medicinally for the conditions that are listed in the bill, but those conditions just had not been included. Anxiety disorders are extremely common, but patients may not have risen to the level of posttraumatic stress syndrome (PTSD), which is one of the qualifiers already listed. The patient may not have been formally diagnosed with PTSD and may simply have anxiety disorder. We already know that cannabis can help someone like that. There are a large number of mothers already using cannabis for their children with autism, but they are not doing it with a card. I believe they are not doing it safely. They may be using CBD [cannabidiol], but I do not know if that is accurate. I would like to offer them additional protections by adding it to the qualifying conditions. Autoimmune disorders are illnesses cannabis addresses very well, particularly in combination with the ever-popular CBD and THC [tetrahydrocannabinol]. There is such a thing called an "entourage effect" when the multiple chemicals found in the plant can help the patient improve his or her condition.

In relation to dependence on opioids, there have been numerous patients who have actually been able to come off opioids with the help of cannabis. Two other conditions are anorexia and cachexia. Anorexia actually means loss of appetite as opposed to what we think of when we hear that word. Cachexia is wasting that often occurs with chronic illness. We know that patients benefit from cannabis when they have poor appetites, which could be based on medications such as chemotherapy; cannabis will actually prevent them from reaching that cachexic state. Often patients will use cannabis to increase their appetites.

The final one I will address is neuropathic conditions. We also know that cannabis can greatly help people with seizures based on some of the public information available. There are other neuropathic conditions such as Parkinson's disease where cannabis can be of great help, and I have seen several elderly patients—my oldest was 91 years old—come in for medical marijuana cards for their Parkinson's disease.

Chairwoman Cohen:
Besides the financial benefit of not paying the added tax when dealing with medical marijuana, what are some other reasons why it would be beneficial to have a patient go through the medical marijuana program as opposed to the adult recreational program? As you said, there are probably people who have moved themselves over to the adult recreational program now that we have legalized that.

Carmen Jones:
This is very concerning to me as a physician because I would like to maintain the medical program. There are lots of patients who are benefitting from the medical program, and not just for the cost benefit, although that is a great deal; but because the dispensaries, at least at one point, were providing a different quality of medicine. The types of products offered to medical patients may differ from that offered for adult use. I do not know how many of you are aware of the products that are available at a dispensary. At one point they offered everything from creams to suppositories. For instance, for a patient who might have endometriosis, a vaginal suppository is a great help. That product was not being offered to the adult-use side of the business. With no disrespect intended, you also face the issue of the 20-year-old bud tender at the dispensary being unable to provide medical guidance as needed. I believe the medical program should remain intact and strong if we can improve access to it with these changes.

Chairwoman Cohen:
There is quality, there is how the product is provided—through what form—and also strength. Did you mention that?

Carmen Jones:
I did not mention it, but I can give you an example I witnessed. There are varying products and better pricing for the medical patients. I will use the example of bath salts that can be sprinkled in your bath for you to soak in. On the adult-use or recreational side, that same product might come in a 100 milligram strength for a certain price. For the same price, the medical patient might get 500 milligrams of medicine in that same volume. It is actually quite beneficial for someone who has full-body pain from rheumatoid arthritis or fibromyalgia to soak in a bath with a stronger amount of product. That does not translate to getting high but makes that person's body feel better. I would like to see that continue.

Chairwoman Cohen:
Are there any questions?

Assemblywoman Titus:
This question is for our legal counsel. I know this bill addresses NRS 453A.050, and I have looked that up. In that statute it says that you can prescribe medical marijuana for chronic or debilitating medical conditions. All this bill would do is add to the categories in there, but I want to be clear that it does not change the definition of chronic debilitating disease in other statute areas.

Karly O'Krent, Committee Counsel:
That is correct.

Assemblywoman Titus:
In my profession as a family physician I look at A, B, and C guidance for best practices. If it is an A practice, then we know it definitely works; for a B practice, maybe it works; for a C practice, well, we do not know if it works, but it does not hurt; and then it goes forward

from there. You mentioned anecdotal reports from patients concerning the conditions you are listing in this bill, in addition to the ones previously listed. We know that there is a 32 percent placebo effect no matter what we do—that people do get better 32 percent of the time, and we have to factor that in during these controlled studies. Do you have any controlled studies—traditional ones in health care that used double-blind controls and factored in the placebo effect—that show these additional chronic medical conditions are helped by medical marijuana?

Carmen Jones:
You know probably better than most that we, as physicians, have Drug Enforcement Administration licenses. For the record, because marijuana is still illegal federally, we do not prescribe medical marijuana. We make recommendations based on the criteria the state sets forth or has approved to date. For that same reason, the federal government listing marijuana in Schedule I has restricted any significant studies. There are other studies from around the world; however, our government is still reluctant to allow them to be used as evidence. It is my understanding that there are multiple research projects underway, but as of now, no, we do not have double-blind studies to prove this. We have to continue based on anecdotal studies; however, this is not the first time nor the last that we will have to use anecdotal studies on various problems and remedies.

Assemblywoman Titus:
I appreciate that, which is why I asked the question. Again, we cannot prescribe it, unless the physician has a special Schedule I prescription license, and I do not. You will be in a unique position because you do have a lot of medical marijuana patients and you are open to new ideas. If this helps with the narcotic and opioid crisis in our state, I am open to it also. It seems like this would be an excellent chance for you as a provider to look at some of these studies. We have a unique position here in Nevada to perhaps answer some of these questions.

Assemblyman Carrillo:
Do we know how many children and adolescents currently have medical marijuana cards?

Carmen Jones:
No, sir, I am not sure, and that is one of my concerns. I have a very strong belief that parents are doing this out of fear and without monitoring. In my seven years, I have probably signed recommendations for ten children; but I have parents of autistic children calling all the time. I think they are using it on their own without telling anyone. I would rather not have that happen.

Assemblyman Carrillo:
By adding autism spectrum disorder, for example, do we anticipate that the number of children and adolescents with medical marijuana cards will increase? Will parents be trying to get these cards for their children for autism spectrum disorder?

Carmen Jones:
Yes, I have already heard from the society thanking me for bringing this bill forward that includes autism. The issue is more parent protection. As I mentioned, I think they are using it anyway, but a lot of them are using it on their own. They talk to each other, but I believe it would be helpful if they could be recognized. With regard to the dispensaries, it is called adult use because one has to be 21 years old, so the parents who need to use the medicine for their children, not just for autism but for any number of illnesses, cannot just go in and buy it. I have a child with PTSD who is 13, but there are restrictions and parents have to be very careful. There are other entities that might look at them if it were discovered that they were trying to use cannabis as a natural method of helping their children.

Assemblyman Carrillo:
The concern I have is because the National Institutes of Health has published papers on this and the fact that there is much that is unknown in relation to cannabis use and brain development in children and adolescents who regularly use cannabis. Obviously, that is a concern on developing brains. You do not necessarily need to speak to that, I just wanted to get that on the record.

Carmen Jones:
Yes, sir. The studies you are speaking of are referring mostly to THC. There is a concern, but not a conclusion, because of exactly what you said—those children's brains are still developing up to the age of 25. A lot of parents are using variations of the plant. We talk a lot about THC and CBD, but there are hundreds of chemicals in the plant that are helpful including not only the cannabinoids, which those are, but the cannabis terpenes that can help with certain conditions. Of course, this is considered to be an alternative form of medicine. In no way is it suggesting that these children or patients choose this method, it is just so that if they want to try, they have some protection.

Assemblywoman Gorelow:
I have a question regarding section 1, subsection 8, paragraph (d), changing from "severe nausea" to just "nausea." Can you explain what the difference is and what kinds of conditions that would cover?

Carmen Jones:
I do not know how to determine the difference. I am not sure if you are asking if someone is nauseous on occasion, but the fact remains that many people have experienced relief from any type of nausea by using cannabis. There are more people than we know who are nauseous on a regular basis. This language change was so the provider did not have to distinguish what is severe and what is not. We are trying to simplify it.

Assemblywoman Gorelow:
My concern is about pregnant women. A lot of them experience some form of nausea in the beginning of their pregnancy, and I am hearing about doctors prescribing it for pregnant women under that condition. According to the American College of Obstetricians and

Gynecologists (ACOG), that is a huge no-no. It can cause problems including low birth weight and stillbirth, so that is my concern with moving to "nausea" versus "severe nausea" and someone being chronically sick.

Carmen Jones:
I have spoken to obstetricians and gynecologists as well, and there are studies that cannabis can help nausea in pregnant women. The concerns you described are presumed and not proven based on how we talked about cannabis during the 1980s and 1990s. I even spoke to an ob/gyn who did research on it during his residency. If you say you know of doctors who are actually allowing their patients to use it already, then I guess the answer is that it is between the physician and his or her patient to decide whether that would be a viable resource for the patient to use. I do not know that anyone is doing it willy-nilly. I believe there would be a deep discussion about it.

Assemblywoman Gorelow:
I am just stating that ACOG guidelines state that pregnant women should not use marijuana during pregnancy, although I know some doctors unfortunately go outside of recommendations. That can lead to problems that a woman might not fully understand, since she might be going off what her doctor is telling her, not realizing that ACOG is recommending that this is not something a pregnant woman should do. That was my concern. It is one thing for a pregnant woman who is severely nauseous and not able to eat anything for three months as opposed to the woman who is just a little nauseous and thinking that is okay. For some people, it becomes an excuse—Oh, my doctor said it was okay—when that person is not truly in a condition of severe nausea. That is my concern with pre-term birth and pregnant women not totally understanding what smoking marijuana can do during pregnancy.

Carmen Jones:
Smoking marijuana never crossed my mind because there are dozens of ways people can use it that do not include smoking. I do not discount one thing Assemblywoman Gorelow said. I am in agreement with her and also remain concerned that there may be some confusion.

Chairwoman Cohen:
Are there any other questions? [There was no response.] We will now ask for testimony in support of the bill.

Will Adler, representing Scientists for Consumer Safety:
We are in support of S.B. 430 (R1) based upon the fact that many patients have come in throughout the years saying that Nevada had a very restrictive medical marijuana card program. Originally, this was a big barrier to entry during the medical marijuana-only days. Currently, in the recreational marijuana it sort of gives people some assurance that they do have a medical condition they are working with. A big, up-and-coming area is the idea of

opioid rehabilitation using marijuana, using cannabis. It is popular in other countries. Canada has a couple of programs doing this—specifically in Vancouver—that have potential. Speaking in all ways around marijuana in the United States, it is anecdotal evidence only. We have not had in-depth studies in the United States approved by the Food and Drug Administration yet, but we have seen them in some other countries such as Israel.

Riana Durrett, Executive Director, Nevada Dispensary Association:
We support the bill. The medical program is the foundation for legalized cannabis in Nevada, but when it was originally enacted it was projected that there would be approximately 100,000 patients within the first two years. Nevada peaked at 26,000 patients, and we now have about 17,000 patients. The main reason for that was how difficult it was to get a card when the program was originally launched. It took 30 to 60 days to get a card, it involved trips to the post office and trips to the Department of Motor Vehicles. The process has greatly improved since then, but it is still often a barrier to becoming a medical patient, so we support anything that improves patient access to the medicine their doctor has discussed with them that they should be using. I know doctors cannot prescribe it, but they can recommend it.

The Nevada Dispensary Association takes the medical marijuana program very seriously. In fact, several members got into the program because of their own sick children or sick family members. We have members who are conducting their own medical trials. They are investing their own time and money to research how the industry can progress and be able to get the products to consumers in forms that other medicine is currently prescribed to consumers. As an example, one dispensary is working with the Parkinson's Association to provide deeply discounted products to patients with Parkinson's disease to study how it can be used to treat Parkinson's. There are many other studies and a lot of people who are benefitting from the program, so we thank Senator Cannizzaro and Dr. Carmen Jones for helping strengthen the program.

[(Exhibit J) was submitted but not discussed and is included as an exhibit for this meeting.]

Chairwoman Cohen:
Seeing no further questions and no one else in support, we will move to opposition. Is there anyone in Carson City or in Las Vegas who is in opposition? [There was no response.] Is there anyone neutral?

Margot Chappel, Deputy Administrator, Regulatory and Planning Services, Division of Public and Behavioral Health, Department of Health and Human Services:
I wanted to answer a question that was asked by the Committee. As of May 2019, for kids under 18 there were 53 medical marijuana cards. Medical marijuana cards for kids between 18 and 20 years of age, who are technically adults, numbered 338.

Chairwoman Cohen:
Seeing no one else in neutral, I will invite Senator Cannizzaro up for closing statements. Senator Cannizzaro has waived making any closing statement, so we will close the hearing on S.B. 430 (R1). Does anyone have any public comment in either Las Vegas or Carson City? [There was no response.] We have a meeting this coming Wednesday. This meeting is adjourned [at 2:14 p.m.].

RESPECTFULLY SUBMITTED:

_____
Terry Horgan
Committee Secretary

APPROVED BY:

_____
Assemblywoman Lesley E. Cohen, Chairwoman

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is the Work Session Document for Senate Bill 24 (1st Reprint), dated May 13, 2019, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit D is the Work Session Document for Senate Bill 134 (1st Reprint), dated May 13, 2019, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit E is the Work Session Document for Senate Bill 179 (1st Reprint), dated May 13, 2019, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit F is the Work Session Document for Senate Bill 456 (1st Reprint), dated May 13, 2019, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit G is the Work Session Document for Senate Bill 457 (1st Reprint), dated May 13, 2019, presented by Marsheilah Lyons, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit H is a position statement, dated May 13, 2019, written by the Pharmaceutical Research and Manufacturers of America, presented by Rocky Finseth, representing the Pharmaceutical Research and Manufacturers of America, in opposition to Senate Bill 262.

Exhibit I is a letter addressed to Chairwoman Lesley E. Cohen and members of the Assembly Committee on Health and Human Services, dated May 10, 2019, submitted by GlaxoSmithKline, in opposition to Senate Bill 262.

Exhibit J is a letter addressed to Chairwoman Lesley E. Cohen, Vice Chairman Richard Carrillo, and members of the Assembly Committee on Health and Human Services, dated May 13, 2019, submitted by Madisen Saglibene, Executive Director, Nevada State Chapter of NORML, the National Organization for the Reform of Marijuana Laws, in support of Senate Bill 430 (1st Reprint).