MINUTES OF THE
SENATE COMMITTEE ON COMMERCE AND LABOR

Eightieth Session
May 1, 2019

The Senate Committee on Commerce and Labor was called to order by Chair Pat Spearman at 1:40 p.m. on Wednesday, May 1, 2019, in Room 2135 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Pat Spearman, Chair
Senator Marilyn Dondero Loop, Vice Chair
Senator Nicole J. Cannizzaro
Senator Chris Brooks
Senator Joseph P. Hardy
Senator James A. Settelmeyer
Senator Heidi Seevers Gansert

GUEST LEGISLATORS PRESENT:

Assemblywoman Teresa Benitez-Thompson, Assembly District No. 27
Assemblyman Jason Frierson, Assembly District No. 8
Assemblywoman Melissa Hardy, Assembly District No. 22
Assemblyman Glen Leavitt, Assembly District No. 23

STAFF MEMBERS PRESENT:

Cesar Melgarejo, Committee Policy Analyst
Bryan Fernley, Committee Counsel
Jennifer Richardson, Committee Secretary

OTHERS PRESENT:

Catherine M. O'Mara, Executive Director, Nevada State Medical Association
David Wuest R.Ph., Executive Secretary, Board of Pharmacy
Connor Cain, Comprehensive Cancer Centers of Nevada

Chelsea Capurro, Nevada Advanced Practice Nurses Association
Elizabeth MacMenamin, Retail Association of Nevada
Helen O'Hanlan
John Bilstein, Executive Director, Comprehensive Cancer Centers of Nevada
Maggie O'Flaherty, Nevada Orthopaedic Society
Jessica Ferrato, Nevada Nurses Association
Robert Talley D.D.S, Nevada Dental Association
Michael Hackett, Nevada Academy of Physician Assistants
Sara Cholhagian, Dignity Health St. Rose Dominican
Keith Lee, Nevada Board of Medical Examiners
Brian O'Callaghan, Las Vegas Metropolitan Police Department
Tyre Gray, CVS Health
Tray Abney, Cigna; America's Health Insurance Plans; Recovery Advocacy Project, Inc.
Joan Hall, Nevada Rural Hospital Partners Foundation
Paul Young, Pharmaceutical Care Management Association
Jeanette Belz, Nevada Psychiatric Association
Stewart Ferry, National Multiple Sclerosis Society
Todd Inglasbee, Professional Firefighters of Nevada
Rusty McAllister, Nevada State AFL-CIO
Lea Cartwright, Nevada Psychiatric Association
Maya Holmes, Culinary Health Fund
Scott Weiss, Parkway Recovery Care Center

CHAIR SPEARMAN:
We will open the work session on Assembly Bill (A.B.) 25.

ASSEMBLY BILL 25 (1st Reprint): Makes various changes to provisions governing contractors. (BDR 54-234)

CESAR MELGAREJO (Policy Analyst):
I have the work session document (Exhibit C) which explains A.B. 25 and the proposed amendment.

CHAIR SPEARMAN:
We will take a vote on A.B. 25.

SENATOR SEEVERS GANSERT MOVED TO AMEND AND DO PASS A.B. 25 AS AMENDED.

SENATOR DONDERO LOOP SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR SPEARMAN:
We will close the work session on A.B. 25. We will open the work session on A.B. 27.

ASSEMBLY BILL 27 (1st Reprint): Revises provisions governing cease and desist orders issued by the State Contractors' Board. (BDR 54-240)

MR. MELGAREJO:
I have the work session document (Exhibit D) which explains A.B. 27.

CHAIR SPEARMAN:
We will take a vote on A.B. 27.

SENATOR HARDY MOVED TO DO PASS A.B. 27.

SENATOR SEEVERS GANSERT SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR SPEARMAN:
We will close the work session on A.B. 27. We will open the work session on A.B. 29.

ASSEMBLY BILL 29 (1st Reprint): Revises provisions relating to contractors and construction projects. (BDR 54-241)

MR. MELGAREJO:
I have the work session document (Exhibit E) which explains A.B. 29.

CHAIR SPEARMAN:
We will take a vote on A.B. 29.

SENATOR HARDY MOVED TO DO PASS A.B. 29.

SENATOR DONDERO LOOP SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR SPEARMAN:
We will close the work session on A.B. 29. We will open the work session on A.B. 181.

ASSEMBLY BILL 181 (1st Reprint): Revises provisions governing employment attendance practices. (BDR 53-833)

MR. MELGAREJO:
I have the work session document (Exhibit F) which explains A.B. 181.

CHAIR SPEARMAN:
We will take a vote on A.B. 181.

SENATOR SETTELMEYER MOVED TO DO PASS A.B. 181.

SENATOR DONDERO LOOP SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR SPEARMAN:
We will close the work session on A.B. 181. We will open the work session on A.B. 455.

ASSEMBLY BILL 455 (1st Reprint): Makes various changes relating to families of injured workers. (BDR 53-1102)

MR. MELGAREJO:
I have the work session document (Exhibit G) which explains A.B. 455.

CHAIR SPEARMAN:
We will take a vote on A.B. 455.

SENATOR SEEVERS GANSERT MOVED TO DO PASS A.B. 455.

SENATOR DONDERO LOOP SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY.

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CHAIR SPEARMAN:
We will close the work session on A.B. 455 and open the work session on A.B. 457.

ASSEMBLY BILL 457 (1st Reprint): Revises provisions governing chiropractic physicians and chiropractor's assistants. (BDR 54-933)

MR. MELGAREJO:
I have the work session documents (Exhibit H) which explain A.B. 457 and the three proposed amendments.

SENATOR HARDY:
I am uncomfortable with the issue of dry needling.

SENATOR SETTELMEYER:
I understand Senator Hardy's opposition to the bill. I am not opposed to the concept of dry needling. I oppose a State board proceeding with dry needling without authorization.

CHAIR SPEARMAN:
We will take a vote on A.B. 457.

SENATOR DONDERO LOOP MOVED TO AMEND AND DO PASS A.B. 457 AS AMENDED.

SENATOR BROOKS SECONDED THE MOTION.

THE MOTION CARRIED. (SENATOR HARDY VOTED NO.)

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CHAIR SPEARMAN:
We will close the work session on A.B. 457. We will open the hearing on A.B. 239.

ASSEMBLY BILL 239 (1st Reprint): Revises provisions relating to controlled substances. (BDR 54-703)

ASSEMBLYWOMAN TERESA BENITEZ-THOMPSON (Assembly District No. 27):
I am presenting A.B. 239. Catherine O'Mara will present the bill with me.

CATHERINE M. O'MARA (Executive Director, Nevada State Medical Association):
I am presenting A.B. 239. The implementation of A.B. No. 474 of the 79th Session has not gone as intended. We have seen an impact to patients as a result.

Assembly Bill 239 is a culmination of work to preserve the positive aspects of the previous legislation. The intent of this bill is to provide clinical judgement, streamlined processes and clearer directions for physicians so that patient care is reinstated.

In 2018, the National Safety Council (NSC) awarded Nevada an "A" grade for our response to the opioid crisis based off of legislation passed in 2017. The grade was based on six safety measures: mandating prescriber education, implementing opioid prescribing guidelines, integrating campaigns at the clinical setting, improving data collection, treating opioid overdose and increasing availability of opioid use disorder treatment.

When we researched the problems that physicians and patients were having with the implementation of A.B. No. 474 of the 79th Session, we did it with the idea that we wanted to preserve the six safety measures. We refined the work of those provisions.

Mr. Wuest is here from the Board of Pharmacy (BOP). He will speak about the specific statistics regarding the level of prescribing that is reduced in the State.

The reduction of prescriptions was most significant for the acute pain settings and less significant for chronic pain settings.

DAVID WUEST R.PH. (Executive Secretary, Board of Pharmacy):
I submitted a presentation to the Assembly Committee on Commerce and Labor if you wish to reference the data from previous hearings. The presentation contains the Prescription Monitoring Program (PMP) data from the year before implementation of A.B. No. 474 of the 79th Session.

There was a 50 percent decrease in new patients being exposed to opioids. Patients with chronic pain were able to obtain their medications. However, there are people who need medications who are not getting them. We worked to address that issue. The PMP in Nevada was the first in the Country. The intent of the PMP was to reduce the number of doctor shoppers or people who frequent many doctors and pharmacies in order to obtain more opioid prescriptions.

In 2013, the algorithm we used to identify doctor shoppers found there were 300 people per quarter who were doctor shopping. In 2018, there were 14, 13, 17 and 12 people in quarters 1, 2, 3 and 4, respectively. The PMP has been effective in reducing doctor shopping. This is why Nevada was highly recognized by the NSC.

The bill before us will not affect the six safety measures implemented by A.B. No. 474 of the 79th Session. We are one of two states in the U.S. that meets all the safety measures set out by the NSC.

We continue to work with doctors and pharmacies to educate them on the provisions in statute. We continue to address the concerns from patients. There is a little fine tuning we can do to improve A.B. No. 474 of the 79th Session.

ASSEMBLYWOMAN BENITEZ-THOMPSON:
When we speak about fine tuning, that is what A.B. 239 intends to accomplish. Sections 1 through 6 outline the regulations for different prescribing boards. The following professions are affected: physicians, dental professionals, nursing professionals, osteopaths, podiatrists and optometrists. These sections repeat language for those relative licensing boards.

The first change affecting these professions strikes the attestation requirement. If a board receives a complaint regarding fraudulent, illegal or inappropriate prescriptions written by a licensee, that board would require the licensee to sign an attestation. After which, the board would proceed with a review process of the complaint. The boards need to conduct the review process to determine whether or not the allegations are founded.

The second change requires the boards to notify their licensees either through written notice or via its websites with a bulletin updating the licensees on the changes in the laws and regulations.

Section 7 creates a definition for a "course of treatment" in reference to treatment of pain in section 7.6. We found these laws work really well except for a handful of conditions. Section 7.6, subsection 1 exempts prescriptions of controlled substances to treat people for cancer, sickle cell disease, hospice or palliative care.

If physicians providing hospice or palliative care are directed by Medicare or Medicaid services, they have to be in compliance with those guidelines as well as follow other federal guidelines.

Section 9 adds the language "medical necessity". This enables doctors to use their own discretion, so they may prescribe medications in certain instances where they feel like there is a medical necessity to do so.

Section 10 refers to the initial prescription that licensees write on controlled substances. This section adds the definition "acute pain" to clearly define what that means. Acute pain does not include cancer, palliative care, hospice care and end of life care in its definition.

Section 11 addresses the evaluation and risk assessment for patients. The added language allows a provision for the physician to prescribe medication based on the source of the patient's pain so long as it relates to the scope of practice for that physician.

Section 12 relates to information and documentation on informed consent and the efforts that need to be made. We have a proposed amendment (Exhibit I) from Ms. O'Mara.

MS. O'MARA:
First, this proposed amendment fixes language in section 7.6, subsection 1 where the bill exempts hospice, palliative, oncology and sickle cell disease. The amendment adds language requiring those practices to follow regulations from the BOP. The *Nevada Revised Statutes* (NRS) 639.23916 is reverted to NRS 639.23915. Where BOP regulations apply to those specialties, they will be required to follow that statute.

Second, the proposed amendment changes language in section 7.6, subsection 2 to include a bona fide relationship with the patient in addition to informed consent. This addresses an issue with federal and State law unrelated to the original opioid bill. There were concerns when exempting the previous specialties from that expressed requirement which created confusion.

SENATOR DONDERO LOOP:
I have a question about the bona fide relationship in the proposed amendment. A constituent shared with me an issue she experienced when her doctor was out of town. She could not obtain the prescription she needed because the doctor she saw was not her regular doctor. How do patients obtain their prescriptions when their regular doctors are not available at the time they need medications?

MS. O'MARA:
Two things are fixed with this bill. The provision for a bona fide relationship existed before this law and will continue to be required regardless of what we do with this bill. A bona fide relationship is established in person, over the phone or through telemedicine. In the case of your constituent, who is a patient going back to a physician they already had a relationship with, the physician should be able to prescribe her medications knowing that they have that relationship.

There are other requirements for opioids. We covered those by defining "course of treatment." This allows practitioners in the same group to share documents such as informed consent. Those doctors will be required to check the PMP for a first-time prescription and at the 90-day mark for an ongoing prescription.

For example, a physician assistant should be able to prescribe medication when the physician is unavailable. There are a lot of multidisciplinary practices. The

BOP regulations allow these kinds of working groups to have the flexibility to hand off these sorts of prescriptions.

Hopefully, your constituent's concerns will be resolved with this bill.

MR. WUEST:
What happened in your constituent's situation could meet the definition of a bona fide relationship. There may have been a misunderstanding. There are no prohibitions against another doctor prescribing her medications when covering for her regular doctor.

SENATOR HARDY:
Does the rule "though shall not write for the same medicine" no longer apply?

MR. WUEST:
That confusion has been taken out of this bill.

CONNOR CAIN (Comprehensive Cancer Centers of Nevada):
We support A.B. 239. The Executive Director for Comprehensive Cancer Centers of Nevada (CCCN) will be reading a letter of support (Exhibit J) from the Practice President of CCCN, Dr. Rupesh J. Parikh. In addition, we have two letters of support (Exhibit K and Exhibit L) from patients of CCCN we would like to submit to the Committee.

CHELSEA CAPURRO (Nevada Advanced Practice Nurses Association):
We support A.B. 239.

ELIZABETH MACMENAMIN (Retail Association of Nevada):
We support A.B. 239.

HELEN O'HANLAN:
I support A.B. 239. I am a patient at CCCN. I have ovarian cancer. I have had cancer 8 times in the last 12 years. I have had ten surgeries, three rounds of chemotherapy and two sessions of radiation where one session was last month. I have used many drugs during this time to get to where I am today.

I am a high functioning cancer patient. I continued to work as a general manager at the Marriott until a few years ago. My illness was once considered a terminal disease; it is now considered a chronic disease. Anything that can help

cancer patients to continue to be functional in the environment we are in will benefit us.

JOHN BILSTEIN (Executive Director, Comprehensive Cancer Centers of Nevada):
We support A.B. 239. I am the Executive Director for CCCN. I will read Exhibit J from the Practice President of CCCN, Dr. Rupesh J. Parikh.

MAGGIE O'FLAHERTY (Nevada Orthopaedic Society):
We support A.B. 239. This bill will allow physicians to focus on the care of their patients.

JESSICA FERRATO (Nevada Nurses Association):
We support A.B. 239.

ROBERT TALLEY, D.D.S. (Nevada Dental Association):
We support A.B. 239. I will read a prepared statement (Exhibit M).

MICHAEL HACKETT (Nevada Academy of Physician Assistants):
We support A.B. 239 and the proposed amendment.

SARA CHOLHAGIAN (Dignity Health St. Rose Dominican):
We support A.B. 239. We worked during the Interim to prepare our hospital and medical group to comply with the bill passed in 2017.

SENATOR HARDY:
I have a question for the Nevada Board of Medical Examiners (BME). The BOP has the ability to cut off the prescribing privileges of a physician but not to cut the physician off from their practice. Is that correct?

KEITH LEE (Nevada Board of Medical Examiners):
Yes, that is correct. There is another bill that clarifies the provisions of NRS 639 that applies to licensees under NRS 630. That will be a basis for disciplining license holders under NRS 630 if they violate the provisions under NRS 639.

SENATOR HARDY:
Does that mean the BOP cannot control the physician's ability to prescribe if the physician's licensing board controls the practice?

MR. LEE:
No, A.B. No. 474 of the 79th Session provided that provisions under NRS 639 were applicable to physicians and were enforceable by the BME against those physicians and other practitioners that we license.

SENATOR HARDY:
Therefore, the BOP can control the ability for a physician to prescribe, but it cannot control the physician's ability to practice. The violation issued by the BOP can be used by the BME to discipline the physician.

MR. LEE:
Yes, that is correct.

CHAIR SPEARMAN:
We will close the hearing on A.B. 239 and open the hearing on A.B. 310.

ASSEMBLY BILL 310 (1st Reprint): Revises provisions regarding the manner in which prescriptions are given to pharmacies. (BDR 54-885)

ASSEMBLYMAN JASON FRIERSON (Assembly District No. 8):
I am presenting A.B. 310. This bill represents an effort to help Nevada curb the opioid crisis. One Nevadan died per day in 2017 from an opioid-related overdose. In the same year, more than 800 emergency room encounters and 536 hospital inpatient admissions occurred due to opioid-related poisonings.

While these numbers include opioid poisonings from opium, heroin, methadone and other narcotics, most were poisonings from prescription drugs. The crisis is complex. Many steps have been taken to address it. We continue to work to address the problem.

Assembly Bill 310 requires prescriptions be sent to pharmacies through electronic transmission. This practice is known as electronic prescribing or e-prescribing. This terms refers to securely transmitting an electronically prepared prescription from an authorized prescriber to a pharmacy. It enables physicians and other medical practitioners to send prescriptions to the patient's pharmacy of choice in an electronic format instead of handwriting, faxing or calling it in.

Electronic prescribing is more efficient and it will also benefit patients and practitioners in a variety of ways. Studies have shown that electronic prescriptions are less prone to errors. This technology tracks prescriptions when they are filled and tracks how often they are filled which may help improve patient outcomes.

In addition, the change will reduce forgeries, since e-prescriptions cannot be copied or altered. It will facilitate in removing paper prescription off the streets. This will help to reduce doctor shopping, fraud and drug diversions, all of which contribute to the opioid epidemic.

This bill requires a prescription be given through electronic transmission, but it allows for a few exceptions. Section 7 outlines the exceptions. Exceptions include prescriptions from a veterinarian, situations where e-prescriptions are not practical, prescriptions issued and dispensed by the same practitioner, prescriptions not issued to a specific person or issued pursuant to protocol for research and when a waiver is granted by the BOP.

This bill was amended in the Assembly to take into account the concerns of several stakeholders to make sure we allow the adequate amount of exceptions and flexibilities. There are folks who do not currently issue e-prescriptions. I found many do issue e-prescriptions. This bill intends to allow flexibility for practitioners while limiting the ability to exploit prescriptions.

MS. MACMENAMIN:
The pharmacy community is committed to finding good policy solutions to help with the opioid crisis. This crisis has taken more lives per year than auto accidents. It is time we address the crisis in every aspect that we can. E-prescribing is a critical component.

Other states that have implemented this law have shown the law to help achieve this goal. New York was one of the first states to mandate e-prescribing. We utilized a lot of data when working with the medical community as we went forward with our policies.

New York published the *2018 National Progress Report* (Exhibit N contains copyrighted material. Original is available on request of the Research Library.) This report outlines data from different states and trends that have been observed. In 2003, Nevada ranked third in the state listings. In 2017, Nevada

ranked forty-fifth. Today, Nevada ranks forty-seventh. This legislation should improve those numbers.

There are many benefits for mandating e-prescribing. Because these prescriptions cannot be altered, this mandate will reduce the opportunities for drug diversions. Due to strict Drug Enforcement Administration (DEA) security measures, these prescriptions are electronically trackable.

E-prescribing is positive for patients. This system has shown to improve patient adherence in states that have implemented e-prescriptions. This bill will improve workflow at pharmacies and practitioner's offices. E-prescribing has reduced phone calls from pharmacies verifying handwritten prescriptions by 20 percent.

We recognize e-prescribing as a best practice that helps turn the tide of this opioid epidemic. We urge the Committee to look at this legislation and recognize the importance of it going forward.

The Retail Association is part of the Drug Take-Back program with the Reno Police Department. During our recent event Saturday, the Reno Police Department collected 1,969 pounds of drugs. As a community, we can address this issue that has impacted everyone.

SENATOR SETTELMEYER:
Prescriptions for narcotics were required to be hand-delivered. How long have prescriptions for narcotics been available for e-prescribing?

MS. MACMENAMIN:
I do not recall if e-prescriptions for controlled substances were allowed at any time in the State. I would have to ask the expert from the BOP about that question.

MR. WUEST:
E-prescriptions for narcotics were available beginning six years ago. E-prescribing for most controlled substances were available eight years ago with the exception of Schedule II controlled substances. As of today, all controlled substances are permitted to be e-prescribed. What you experienced was a misunderstanding.

SENATOR SETTELMEYER:
It was a dentist prescribing Vicodin who told me that.

MS. MACMENAMIN:
We know of doctors who have been e-prescribing since 2003. It was a concern within the practitioner's office, because many of them do not know that they can e-prescribe. We may need to educate our practitioners.

SENATOR HARDY:
Some of us view fax machines as electronic transmissions. That may be one of the challenges we have encountered. Do the exemptions for e-prescribing allow me to continue to prescribe medications on the specialized prescription paper pad?

MS. MACMENAMIN:
Yes, the exemptions are outlined in section 7, subsection 3.

SENATOR HARDY:
Do practitioners still need to use the prescription paper pad that is specialized to prevent alterations and fraud?

MS. MACMENAMIN:
Paper prescriptions are not covered in this bill. The medical community and the pharmacies intend to discuss those issues during the next Interim.

CHAIR SPEARMAN:
One issue I do not see addressed by this bill is the issue of cybersecurity. I read a recent report that states medical facilities are a prime target for data and identity theft. What protocols are in place to prevent that?

MS. MACMENAMIN:
Surescripts is one of the major providers of this technology. They have to meet strict DEA requirements. In regard to cybersecurity, I do not have the answer. I will research that question. I believe these networks are tightly audited and closely held.

CHAIR SPEARMAN:
Check with the U.S. Department of Interior, they had a bill that implemented some redundancies in cybersecurity protocols. That is a problem that is on the

rise. If someone gets into your medical records, that person has your life history.

BRIAN O'CALLAGHAN (Las Vegas Metropolitan Police Department):
We support A.B. 310. This bill will curb the theft of controlled substances, as well as decrease the incidences of altering prescriptions. The DEA number on the prescriptions will not be available to the patient. If the patient gets that number, the patient can use it to commit identity theft.

TYRE GRAY (CVS Health):
We support A.B. 310. This bill will address problems such as people altering prescriptions by changing numbers. This is a great adherence bill.

TRAY ABNEY (Cigna; America's Health Insurance Plans; Recovery Advocacy Project, Inc.):
We support A.B. 310.

JOAN HALL (Nevada Rural Hospital Partners Foundation):
We support A.B. 310. Our remote rural clinics were concerned over the e-prescription requirement. They do not have the bandwidth needed to ensure e-prescriptions are sent to the pharmacies. Section 7, subsection 1 alleviates their concerns.

MS. FLAHERTY:
We support A.B. 310. We approve of the implementation date, as it allows time for smaller practices to update their systems. We are concerned over the issues e-prescribing will have on our older practitioners who are near retirement or struggle with advancing technology.

PAUL YOUNG (Pharmaceutical Care Management Association):
We support A.B. 310.

MS. CAPURRO:
We support A.B. 310.

MS. O'MARA:
We are neutral toward A.B. 310. We support limiting this bill to controlled substances. This is a mandate on all practitioners, and it will impact the public. We worked on regulations to make sure we have well thought out exemptions

and waivers. We are working with the sponsors to look at the exemptions New York implemented.

One issue that was not addressed was the issue of sending an e-prescription to a pharmacy that is closed. If the e-prescription is sent to a pharmacy that is closed, the patient cannot have that e-prescription transferred to a pharmacy that is open. The patient would have to wait to fill their prescription.

Some people may not know the hours of operation at the pharmacy they pick. This is an issue with visitors to our State. They may be injured while in Nevada and need to fill a prescription. Visitors may not know what pharmacy is near their hotel, and they prefer to have a written prescription to take to the pharmacy.

Physicians had a sincere belief that they were not allowed to e-prescribe controlled substances. There was a DEA regulation that prohibited this from happening. It was not that the doctors were not aware, they were under the belief that they could not e-prescribe.

We will need to upgrade our systems to make sure they are DEA compliant in order for prescriptions to be transmitted securely.

JEANETTE BELZ (Nevada Psychiatric Association):
We are neutral toward A.B. 310. We will work with the sponsor on the exemptions. The exemptions will be important.

DR. TALLEY:
We are neutral toward A.B. 310. I will read a prepared statement (Exhibit O).

MS. MACMENAMIN:
I do not have closing remarks. Mr. Wuest will address your question about cybersecurity.

MR. WUEST:
I agree with what you are saying in regard to monitoring what other states are doing on the issue of cybersecurity. In order to prescribe a controlled substance, you have to be approved by a vendor. Those vendors employ high standards for financial transactions. These standards are robust.

CHAIR SPEARMAN:
On Google Scholar, I found an article, *Cyber-Analytics: Modeling Factors Associated with Healthcare Data Breaches* that might elucidate the subject. One of the bullet points in the article states that the number of healthcare data breaches continue to increase at an alarming rate. This study was conducted in 2018.

What you are doing with this bill is also being done by the U.S. Department of Defense for Tricare. We have to make sure the redundancy is there for cybersecurity breaches. We will close the hearing in A.B. 310 and open the hearing on A.B. 141.

ASSEMBLY BILL 141 (1st Reprint): Prohibits a pharmacy benefit manager from imposing certain limitations on the conduct of a pharmacist or pharmacy. (BDR 57-947)

ASSEMBLYMAN GLEN LEAVITT (Assembly District No. 23):
I am presenting A.B. 141. This bill will prohibit pharmacy benefit managers (PBM) from restricting a pharmacist from informing individuals about a less expensive drug in a practice commonly referred to as a gag clause.

In our discussions with the Legislative Counsel Bureau, we found no language prohibiting a gag clause in NRS. This bill clarified that a PBM has the fiduciary duty to an insurer with which it contracts to manage prescription drug coverage. This bill bans PBMs from prohibiting a pharmacy or a pharmacist from providing certain information to a client who is a member of the pharmacy benefits plan.

The bill addresses a pharmacist sharing information about copayments, coinsurance and clinical efficacy of a less expensive drug. Additional clarification is needed. This bill is essential to freeing pharmacists to properly inform individuals and in lowering drug costs.

States across the Country have taken action on this issue with positive results. Between 2015 and 2018, 30 states have enacted laws prohibiting these gag clauses according to the National Conference of State Legislatures.

ASSEMBLYWOMAN MELISSA HARDY (Assembly District No. 22):
In 2015, consumers purchased prescription drugs worth $235 billion from local and 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. Health insurers and consumers struggle with the cost of prescription drugs.

This bill guarantees that consumers have access to all available resources in order to help them obtain essential medications. Pharmacy benefit managers are third-party administrators of prescription drug programs for various health plans such as commercial health plans, Medicare Part D plans, self-insured plans, employer union plans, the Federal Employees Health Benefits Program and many 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 have commercial contracts with pharmacies. The terms of these contracts vary. Sometimes these contracts have provisions that prohibit a pharmacy or pharmacist from sharing certain information or options with a patient.

There are at least 30 states including Nevada that have enacted laws prohibiting gag clauses. Assembly Bill 141 would expand on those prohibitions. Implementing this bill increases the pharmacist's ability to work as part of the medical team and to give patients access to the best information and options possible. I have a proposed conceptual amendment (Exhibit P). We intend to remove the words "or a more effective drug".

Section 1 of the bill clarifies that PBMs may not prohibit a pharmacist or pharmacy from providing information to a covered person concerning the availability of a less expensive alternative or a generic drug. This includes information about the clinical efficacy of the drug and the usual and customary price that a pharmacy charges to the general public for a drug.

Second, the bill clarifies that a pharmacist or pharmacy may share information regarding a less expensive alternative or generic drugs but dispensing said drug must be done in accordance with the prescription.

Third, the bill clarifies that it applies to every pharmacy and pharmacist regardless of ownership of the pharmacy with the exception of institutional pharmacies.

STEWART FERRY (National Multiple Sclerosis Society):
We support A.B. 141. Any person living with a chronic health condition should be privy to prescription drug pricing information.

MS. O'MARA:
We support A.B. 141. Patients should have access to the most up-to-date information. They should know what the drug is going to cost them.

TODD INGLASBEE (Professional Firefighters of Nevada):
We oppose A.B. 141. We control a self-funded nonprofit insurance trust for several groups throughout Nevada. We oppose the language in section 1, subsection 3. We are unsure of the intent in this section. We will work with the sponsors to address our concerns.

We have seen similar language in our insurance plans with doctors, but we have not seen it within our PBMs or with our prescription providers. We have no problem being offered a less expensive drug. Section 2 and section 3 appear to accomplish the same thing.

RUSTY MCALLISTER (Nevada State AFL-CIO):
We oppose A.B. 141. We oppose the language in section 1, subsection 3. The bill was amended while in work session in the Assembly. We did not have an opportunity to discuss the amendment. The language was added in at that time.

The language in section 1, subsection 1, paragraph 3, subparagraph (b) was added. Some of our members asked where this language came from and why. We have not been able to get a satisfactory answer. We were referred to a policy person in the caucus of the sponsors. He could not tell us either.

It appears that the cost sharing reduction refers to the usual customary price for Medicare and Medicaid. Those programs offer lower prices, because they have better bargaining abilities since they negotiate drug prices across the Country. Pharmacists will tell our members that they could get a lower price for their medications while leaving out that the price is for Medicare.

This language was used during the 2017 Session by the pharmaceutical industry. The arguments they brought up claimed that the PBMs were causing the cost of drugs to increase. It appears to be a roundabout way to push the PBMs out and create conflict between our members, the PBMs and the pharmacist. We would like clarification from the sponsors on the intent of this language.

SENATOR HARDY:
The bill sponsors intended to provide a means for people to find the least expensive drug or its equivalent. When I write a prescription, I have an opportunity to write "do not substitute." When I indicate that, the pharmacist has to give the exact medicine that I prescribe. Otherwise, the pharmacist may provide a generic in its place.

There is an application available for your phone called "GoodRX." With that application, you can look up a medication and see what it costs and whether it is the cheapest option. You can show the pharmacist and the pharmacist can charge that amount even if the PBM refuses to accept the price on the application. The goal is to get the least expensive medication.

If the PBM states that a pharmacist is not allowed to share information on the usual and customary price, the consumer is allowed to ask a direct question. The consumer can ask if there is a cheaper alternative or if there is a generic brand. If we pass this bill, we will get rid of the gag clause. This a way for the customer to get the least expensive medicine.

MR. MCALLISTER:
We agree on getting the cheapest drug available. Our issue is with the language. Our carrier works with PBMs to negotiate a rate with our 3,000 members. It stands to reason that under the Code of Federal Regulations (CFR), the usual customer rate is defined by Medicare and Medicaid. They negotiate rates for drugs for many more people than our group, because they negotiate for millions of people as opposed to 3,000.

This creates conflict within our organization, because our members do not know that the lower prices are only available for Medicare. It is not disclosed to the patients that the usual and customary price is for Medicare.

MS. CAPURRO:
We are neutral toward A.B. 141. We have some similar concerns with the language. We support the intent of the bill. We prefer average wholesale price over the usual and customary price. We will work with the sponsors.

MR. YOUNG:
We are neutral toward A.B. 141.

LEA CARTWRIGHT (Nevada Psychiatric Association):
We are neutral toward A.B. 141. We had concerns initially, but our concerns were addressed by removing the more effective drug language.

MAYA HOLMES (Culinary Health Fund):
We are neutral toward A.B. 141. We do have concerns over the lack of clarity on the language mentioned previously.

ASSEMBLYMAN LEAVITT:
The language originated from the CFR, but it is the language used customarily on these issues. We do not intend to bring in Medicaid or Medicare prescription drug prices. The usual and customary pricing would be in accordance with the pharmacy itself. That is where we came up with that language.

ASSEMBLYWOMAN HARDY:
It was not our intention to work around or try to skirt anything at all. We will work with all the stakeholders on this bill.

CHAIR SPEARMAN:
Meet with those who are in opposition to see if there are ways to address the issues with the language. We will close the hearing on A.B. 141 and open the hearing on A.B. 204.

ASSEMBLY BILL 204 (1st Reprint): Revises provisions relating to health care. (BDR 54-932)

ASSEMBLYWOMAN HARDY:
I am presenting A.B. 204. We are bringing this bill to the Committee on behalf of industry. Providing quality and accessibility to health care has been a priority. This bill is in the spirit of that goal.

SCOTT WEISS (Parkway Recovery Care Center):
This bill addresses issues that arose in 2017 when the Health and Human Services State Board of Health (SBH) approved a facility called a recovery care center. These centers are a place where a patient is sent to recover for up to 72 hours following a surgical procedure. When the SBH approved those regulations, we realized there were conflicts with the Board of Pharmacy (BOP). Recovery care centers were not identified in statute to allow facilities to perform the services allowed by the SBH.

This bill fixes those issues by adding a recovery care center to the types of facilities that can order charts. The bill allows the BOP to write regulations to protect the public safety and to allow pharmacies to deliver drugs to a recovery care center and to allow the BOP to charge appropriate fees for these types of facilities. This bill allows these facilities to operate under statute previously overlooked.

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CHAIR SPEARMAN:
We will close the hearing on A.B. 204. With no public comment, the meeting is adjourned at 3:11 p.m.

RESPECTFULLY SUBMITTED:

Jennifer Richardson,
Committee Secretary

APPROVED BY:

Senator Pat Spearman, Chair

DATE:

EXHIBIT SUMMARY				
Bill	**Exhibit / # of pages**		**Witness / Entity**	**Description**
	A	2		Agenda
	B	5		Attendance Roster
A.B. 25	C	1	Cesar Melgarejo	Work Session Document
A.B. 27	D	1	Cesar Melgarejo	Work Session Document
A.B. 29	E	1	Cesar Melgarejo	Work Session Document
A.B. 181	F	1	Cesar Melgarejo	Work Session Document
A.B. 455	G	1	Cesar Melgarejo	Work Session Document
A.B. 457	H	2	Cesar Melgarejo	Work Session Documents
A.B. 239	I	1	Assemblywoman Teresa Benitez-Thompson	Proposed Amendment, Nevada State Medical Association
A.B. 239	J	2	Connor Cain / Comprehensive Cancer Centers of Nevada	Letter of Support, Rupesh J. Parikh, M.D.
A.B. 239	K	2	Connor Cain / Comprehensive Cancer Centers of Nevada	Letter of Support, Kelly Trolia
A.B. 239	L	3	Connor Cain / Comprehensive Cancer Centers of Nevada	Letter of Support, Jet Mitchell, MBA, JD, Esq.
A.B. 239	M	2	Robert Talley / Nevada Dental Association	Written Testimony
A.B. 310	N	16	Liz MacMenamin / Retail Association of Nevada	2018 National Progress Report
A.B. 310	O	2	Robert Talley / Nevada Dental Association	Written Testimony
A.B. 141	P	1	Assemblywoman Melissa Hardy	Proposed Conceptual Amendment